WILLIAMS: --everyone, and welcome to the Banking, Commerce and Insurance Committee hearing. My name is Matt Williams. I'm from Gothenburg and represent Legislative District 36. And I'm privileged to serve as Chairman of the committee. The committee will take up the bills in the order posted. Our hearing today is your part of the public legislative process. This is your opportunity to express your position on a proposed piece of legislation. The committee members will come and go during the hearing. We have bills to introduce in other committees and are sometimes called away. It's not an indication that we are not interested in the bill being heard by the committee. It's just part of the legislative process. To better facilitate today's proceedings, we ask that you abide by the following procedures. Please silence or turn off your cell phones. Please move to the front row when you are ready to testify. The order of testimony on each bill will be the introducer first, followed by proponents, followed by opponents, then those are the-- that are here in a neutral capacity, and then the introducing senator will be asked to make closing comments. Testifiers, please sign in, hand your pink sign-in sheets to the committee clerk when you come up to testify, and when you testify, please spell your name and state it for the record. And also, we ask that you be concise in your testimony. We will be limiting testimony to five minutes, and we do use a light system which will be in front of you. The green light will be on for four minutes, followed by one minute with the yellow light. And then the red light will come on which is your signal to conclude your testimony. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white tablets outside each entrance where you may leave your name or other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only during testimony. Hand them to the page for distribution to the committee and staff when you come up to testify, and we will need ten copies. If you do not have ten copies, you can raise your hand, and our pages will go make those copies for you. If you have written testimony but do not have your copies, again, they will do that. To my immediate right is Bill Marienau, our committee counsel, and to my left at the end of the table is committee clerk, Natalie Schunk. And most of our committee members are with us today, and I would ask them to introduce themselves starting with Senator McCollister.

McCOLLISTER: Thank you, Senator Williams. I'm John McCollister, representing District 20 in central Omaha.

KOLTERMAN: Mark Kolterman, District 24, Seward, York and Polk Counties.

QUICK: Dan Quick, District 35, Grand Island.

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

GRAGERT: Tim Gragert, District 40 in northeast Nebraska, Cedar, Dixon, Knox, Holt, Boyd, and Rock County.

WILLIAMS: And our pages that are with us today are Tsehaynesh and Kylie. Thank the two of you for being with us. And we will begin by opening the public hearing on LB228 from Senator Hughes to prohibit certain insurance practices relating to a pernan-- person's status as a living organ donor. And we welcome Senator Hughes.

HUGHES: Thank you, Chairman Williams, members of the Banking, Commerce and Insurance Committee. For the record, my name is Dan Hughes, D-a-n H-u-g-h-e-s. I represent the 44th Legislative District. The idea for this bill came to me from a constituent who wants to take away barriers from people becoming living donors. This bill would prohibit insurance companies from discriminating against people based on their status as a living donor by making it unlawful to decline or limit coverage for life, disability, or long-term care insurance, preclude a person from donating all or part of an organ-- organ as a condition of receiving life-- life, disability, or long-term care insurance, and consider the status of a person as-- as a liv-- living donor in determining rates for coverage, and otherwise discriminate against a person under any life, disability, or long-term care insurance policy due to that status of such person as a living organ donor. Violations of this act shall be un-- an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act. In Nebraska alone, there are nearly 450 people waiting for an organ transplant. In 2016, 203 total organ transplants were performed in Nebraska with organ gifts from 70 donors. Transplants from living donors are proven to be-- have better outcome versus transplants from deceased donors. Nearly 6,000 living donors' donations take place each year. That's about four out of every ten donations. Nearly 100,000 Americans are on the transplant list waiting for a kidney. Unfortunately, 13 of those people waiting die each day. Medicare spends approximately $90,971 per patient per year on dialysis

treatment, but only spends $34,870 per year on a transplant patient. According to UNOS, kidneys are the most frequent type of living donor organ donation. You can donate a portion of a liver which has the ability to regenerate and regain full function. In rare cases, you can donate a lobe of a lung. In very rare cases, you can donate a portion of your intestine or your pancreas. Uterus transplants have been formed-- performed as part of clinical trials, and heart a-- domino transplants make some heart-lung recipients living heart donors. When a patient receives a heart-lung block from a deceased donor, his or her healthy heart may be given to an individual waiting for a heart transplant. Extremely rare, this procedure is used when physicians determine that the deceased donor lungs will function best if they are used in conjunction with the deceased donor heart. Overall, I feel this bill will benefit and protect Nebraskans who are giving the gift of life, the best-- the best gift a person can give. Thank you. I'd be happy to try and answer any questions.

WILLIAMS: Thank you, Senator Hughes. Questions for the senator? Seeing none, will you be staying to close?

HUGHES: Yes.

WILLIAMS: Thank you. We would invite the first supporter to the stand to testify please? Welcome,--

GARY BODENHEIMER: Thank you.

WILLIAMS: --and if you would state and spell your name, we would appreciate it.

GARY BODENHEIMER: It's Gary, G-a-r-y, Bodenheimer, B-o-d-e-n-h-e-i-m-e-r, good morning-- or good afternoon. I would like to thank Chairman Williams and all of the members of the committee for allowing me to speak this afternoon. I am testifying on behalf of the National Kidney Foundation, the American Association of Kidney Patients, and the American Kidney Fund. I'm telling you a little bit about myself. I'm in stage four kidney disease. I found out in 2013, May of 2013 to be exact, that I was in stage four kidney disease already. Had not had any symptoms. It just happened that my doctor drew blood and did some other tests and discovered that I was in stage four of kidney disease. We call it the silent killer because you just don't have any symptoms in the early stages. As Senator Hughes said, there are approximately 450 people on the waiting list now for some type of organ. In Nebraska transplants not only save the lives of

dialysis patients and greatly improve the quality of their life, but they also save Medicare more than $55,000 per year per patient compared to kidney dialysis patients. A kidney transplant is the patient's only life-saving treatment other than dialysis. As I said, more than 450 people are waiting, half of the people waiting for an organ transplant here in Nebraska. Last year only 137 Nebraskans received a kidney transplant, approximately. Once you are put on the transplant list, the average waiting time is three to seven years. Average life expectancy on dialysis is five to ten years. The math is sobering. The clock is ticking for each and every one of these 200-- these 450 patients who are suffering from one-- one type of disease or another. Everything we do to help encourage living donations saves lives. It's-- it's the gift of life. Patients seeking a transplant talk to their family, friends, colleagues, and even total strangers. Potential donors go through extensive testing, which by the way, is-- there is no cost to the donor. The patient's insurance covers the costs that are involved for the living donor. Donors may wait for weeks while being tested to make sure they are healthy enough to benefit a transplant. Transplant doctors will not remove an organ if it's going to harm the donor. Of the 59,075 individuals who were living donors from 1998 to 2007, approximately 11 have been listed for a kidney transplant-- plant afterwards. A 2014 study by Johns Hopkins University showed that a quarter of living donors in the study faced discrimination when they tried to obtain or change their life insurance just because they were organ donors. Additionally, the National Kidney Foundation regularly hears from living donors who experience premium changes or other trans-- restrictions on their insurance policies. One story is where one of the people with National Kidney Foundation donated a kidney to his wife, and the insurance company-- he applied-- he already had $500,000 worth of insurance. He applied for an additional $250,000, and the insurance company wanted to charge him $25,000 premium for the new insurance. They did raise the premium on his $500,000 life insurance. They raised it to $760 a month. Quite a difference there. So in closing, it's really important that we support the living-- the LB228 to send a signal to potential donors from you, our legislators, that donating to save the life of Nebraskans should not cause economic hardship or-- and discrimination. Let donors know that they don't have to worry about their premiums increasing or their policy being denied. Thank you.

WILLIAMS: Thank you, Mr. Bodenheimer. Questions? Seeing none, thank you--

GARY BODENHEIMER: Thank you.

WILLIAMS: --for your testimony. Would invite the next supporter? Any additional supporters? I would invite, then, the first person to testify in opposition? Welcome, Mr. Bell.

ROBERT BELL: Thank you, Chairman Williams. Chairman Williams and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell, last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today to testify in opposition to LB222-- LB228, excuse me. First, I want to thank Senator Hughes and his staff for listening to the concerns of the in-- of the insurance industry on LB228 as drafted. As you know, the Nebraska insurance Federation is the primary trade association of insurers domiciled in or with a significant economic presence in Nebraska. Currently the federation consists of 26 member companies and 7 associate members representing a spectrum of insurers from small insurers to Fortune 500 companies. Members write all lines of insurance, including relevant to this bill, writers of life insurance, disability income, and long-term care insurance. One of the goals of the federation is to promote the concepts and importance of insurance products to the public. Nebraska insurers provide high-value, quality insurance products to Nebraskans that help protect Nebraskans during difficult times, and this includes high-value, quality insurance products for living donors. That said, the federation does have some issues with the legislation as drafted. As read by the member insurers, LB228 would prevent an insurer from considering material health conditions outside of the living donor status of the individual. The members of the federation believe this language could be tightened to prohibit discrimination solely for living donor status, products related to disability income, and long-term care. So this is touching on three different products. It's touching on life, disability income, and long-term care. There-- the disability income and long-term care are different matters than the life insurance. With disability income, concerns do arise related to adverse selection which is when a consumer selects a product because they know they're going to utilize it, in its simplest terms. Long-term care insurance is a different matter kind of altogether with its own pricing and underwriting concerns related to any mandated coverage right now. It was interesting hearing the-- the testimony. And it was powerful testimony on the power of-- of-- of don-- of organ donation, and that .25 of these folks that are living donors are being discriminated against. What that tells me, as somebody that's familiar

with the insurance industry, is I hope those folks are going to their insurance agents and shopping for products because very likely three quarters of them are not being discriminated against which means there could be com-- there are companies out there that don't consider this in their underwriting practices related specifically to life insurance. And so, as always, when-- when people are concerned about their premiums going up or their benefits being cut, a message is, go talk to your insurance agent. See what products are available for you. Because one company might be doing this, doesn't mean the other company is. And the market, sometimes, will take care of its con-- of these concerns by itself. So with that, the Nebraska Insurance Federation opposes the passage of LB228 in its current form. And I thank you for the opportunity to testify.

WILLIAMS: Thank you, Mr. Bell. Questions for Mr. Bell? Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Thanks for coming today, Sen-- Mr. Bell. Is it-- you talked about companies that will underwrite people that are living donors. To your knowledge, are there a lot of them that do that?

ROBERT BELL: Well, I'm not an agent, so I don't have specific knowledge. But my understanding is that, yes, companies will-- will provide insurance to-- to these individuals.

KOLTERMAN: And my experience has shown me that there are companies because I've-- I've underwritten several myself.

ROBERT BELL: You have far more experience in selling insurance than I do so.

KOLTERMAN: But I-- but I just wondered-- the other thing that I'm wondering is if-- if I listen to the testimony properly or read this testimony, there was an indication that the rates were raised after the living donor had donated. It's not the practice of insurance companies to change their rates once they've got a product underwritten, is it?

ROBERT BELL: It depends on the product, I think, Senator.

KOLTERMAN: Like-- like a life policy.

ROBERT BELL: Like a--

KOLTERMAN: You buy a whole life policy or universal life or--

ROBERT BELL: Right. Yeah. Absolutely.

KOLTERMAN: --a term policy.

ROBERT BELL: I don't-- that's my understanding that, you know, and it kind of gets into maybe this-- kind of the concerns with the legislation, again as drafted, is that each individual situation can be a little bit different for each individual. And there may be underlying health concerns that are there as well outside of the donor status of the individual. Something could come up in their health later in-- in life, and there's another insurance practice tried to be placed and there could be higher premiums. Now the individual-- the company could be looking at all-- holistically at the whole individual and decide, well, these premiums are going to go up. Well, the question on this legislation is if this person's a living donor, are they immediately excluded from that consideration? And so, yeah.

KOLTERMAN: Well, one-- one of the-- one of the concerns that I have is if that were the case, you'd have people that buy a policy when they're young. They get older. They develop diabetes or heart problems.

ROBERT BELL: Sure.

KOLTERMAN: And they-- and then they would rider the policy. I don't see that happening in the industry.

ROBERT BELL: Um-hum.

KOLTERMAN: So I was kind of taken back by some of the testimony that I read. Maybe I'm reading it wrong, but insurance companies all vary from company to company.

ROBERT BELL: Absolutely.

KOLTERMAN: And I-- my experience, and you tell me if I'm incorrect, would be that many companies will underwrite many of these issues. But there are those that won't. And usually if you've got a company that's out trying to buy the business, they're-- they're hold-- holding the line very closely. And so their margins maybe aren't as good. And then they'll, you know, [INAUDIBLE]--

ROBERT BELL: Right.

KOLTERMAN: --picture.

ROBERT BELL: Right. And-- and-- and in that case then-- that's why you want to go shop for insurance.

KOLTERMAN: OK.

ROBERT BELL: There may be a company out there that fits your particular situation. And honestly, if-- if-- on a kidney donation as an example, I'm not going to go into like a heart and lung situation or something along those lines, but in a kidney situation, if there's truly no health detrimental effects, really the insurance company that doesn't underwrite really just a living donor wins versus the company that does, right? And so when I talk about the market kind of taking care of itself, that's what I'm referring to. There may be advantages for the company to go ahead and provide coverage to those folks that-- that are living donors versus their competitors that do not.

KOLTERMAN: And some of those that don't underwrite, there are companies that won't underwrite--

ROBERT BELL: Sure.

KOLTERMAN: --but typically don't they have a situation where the policy has to be enforced for a certain period of time before they can collect on a death claim, a lot of your senior policies for example?

ROBERT BELL: Yeah. Yeah. Yeah. I mean you can-- you can start getting into all different kinds of hypotheticals as to where this would make sense or where this would not make sense.

KOLTERMAN: Yeah.

ROBERT BELL: But, yeah.

KOLTERMAN: Thank you.

ROBERT BELL: Yes. Thank you Senator.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. And thank you, Mr. Bell, for being here. If I donated a kidney, typically-- and my policy allowed me to do that, would my rates go up?

ROBERT BELL: If you're-- well like, you know, are we talking about a life insurance policy?

McCOLLISTER: Yeah.

ROBERT BELL: I mean if you go onto the policy and it says that you can and your rates won't go up, yeah, your rates are not going to go up.

McCOLLISTER: So once approved for a life insurance policy, would this be a material change, and would it enable the company to raise the rates?

ROBERT BELL: You would have to get into the insurance policy to see. I mean each policy, each company is going to be a little bit different, and there are a lot of life insurance companies to-- to choose from. In fact, I was-- I was looking up my own life insurance policy before I came over here. And another matter came up, so I wasn't able to complete my research, unfortunately, as to whether or not I-- I could provide a-- a kidney and they wouldn't come back on me. But-- but if I wanted to do-- if I wanted to consider that in future, than you know, what I need to do is I need to go talk to my agent. And I need to go shop and find a policy that fits my needs for my life.

McCOLLISTER: Thank you.

WILLIAMS: Additional questions? Mr. Bell, in your discussion with Senator Kolterman you were talking specifically about life insurance. Would it also be your experience that shopping for disability insurance, there may be disability insurance available?

ROBERT BELL: Like I said, that I don't know. Disability insurance is kind of a different animal. I was thinking of a situation where, let's say, you go in for an organ donation, and something happens in the operating room. There's an infection or something along those lines, and you're in the hospital for an extended stay. And-- and you recover and do all that. Well, that policy might pay at that point. And so it's just a little bit of a different-- I think it's a little bit different animal and then a different type of insurance. So whether or not you win-- and it's a little bit-- for lack of a better word it's a little bit more itinerant. So when I was talking about my life

insurance policy, I bought that when I was-- in 1999 when I was 23. If I was going to go buy a disability income product on my own, I would probably do that every year. It wouldn't be a situation where I buy a policy and then, you know, it may be-- I mean every policy is a little bit different, of course. But it may be something I-- you know, if I get a job at someplace that they have disability income, that I might take that as opposed to going on more of the individual market, so.

WILLIAMS: Thank you. Any further questions? Seeing none, thank you for your testimony.

ROBERT BELL: You're welcome.

WILLIAMS: Would invite the next opponent? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, would invite Senator Hughes? Senator Hughes waives closing. That will close the public hearing on LB228. We're looking for Senator Kolowski for LB619. We'll be patient and just wait for a few minutes.

[BREAK]

WILLIAMS: Welcome, everyone. We will now open the public hearing on LB619, Senator Kolowski's legislation to require coverage under insurance policies for mental health services delivered in schools. Welcome, Senator Kolowski.

KOLOWSKI: Thank you, Mr.Chairman, committee members. Good afternoon, Chairman Williams, and members of the Banking, Commerce and Insurance Committees. My name is Senator Rick Kolowski, R-i-c-k K-o-l-o-w-s-k-i, representing District 31 in southwest Omaha. LB619 requires a health insurance plan to pay for behavioral health services rendered in a school or educational setting. It does not expand the behavioral health services a healthcare plan would cover. Nor does it reduce the coverage. Neither does it change the kind of provider that can provide mental health services. LB619 simply states that insurance coverage cannot be denied on the basis of the service being provided at a school. This clarification is necessary because there is confusion in some areas of the state about whether having the school as a place of service should be-- should affect reimbursement. Some insurance companies pay for it, but some do not. In the testimony, you will hear from providers and schools about their struggles getting these services paid for by some insurance policies. In today's educational setting, we need to remove every possible barrier to meeting the needs of children. A child who needs mental health services and receives

those services is better able to learn and to interact appropriately with other children and teachers. LB619 is one small step toward getting our students the mental health services they need. The green copy of LB619 reads like an insurance mandate when my intention was really more of a clarification. Therefore, I am offering AM287. AM287 rewrites the language in a way that makes it clear that it is not a change of coverage for mental health services and therefore not a new coverage mandate. To make it even clearer, the definition of a school, found in another section of statute, is restated in the language of the amendment. AM287, like LB619, does not change insurance coverage of mental health services. The coverage is still determined by the health plan. LB619 is just a necessary reminder that coverage for medically necessary mental health services cannot be denied on the basis of location of service when the location is at a school. I also think the amendment will eliminate the fiscal note written to the original bill. Let me explain for the committee members that a family's insurance coverage is not billed for school services, meaning the school psychologist is not billing for services. Only a provider who is not a school employee bills for their services. There are a variety of reasons a mental health provider might go to a school to provide a service for a student. One example might be because the family can't provide transportation for the student to go to the provider's office. In rural areas, to take a child out of school and drive to the provider could take half a school day. So when the provider is willing to go to the school, it helps the parents, the child, and the school. You'll get a better picture of these scenarios from the testimony that will follow. I'd like to thank the school districts who brought this concern to me and continue to work with me on this bill. I would also like to thank the Blue Cross Blue Shield Company for bringing their concerns to me and working with me on the amendment. At this point, I intend to make LB619 my priority bill. I ask that you support AM287 and LB619 with a vote to advance to General File. I'm happy to answer any questions you may have.

WILLIAMS: Thank you, Senator Kolowski, and could you pass out the--

KOLOWSKI: Oh, I'm sorry.

WILLIAMS: --amendment for us?

KOLOWSKI: Yes.

WILLIAMS: And then we'll take just a minute here, so everybody--

KOLOWSKI: Thank you.

WILLIAMS: --has that in front of them. As we're doing that and-- and people are having a quick chance to look at that, Senator Kolowski,--

KOLOWSKI: Um-hum.

WILLIAMS: --could you address, in-- in maybe a little bit more detail, an example of how this might be used in a school system?

KOLOWSKI: Well, I think the-- the-- the parts I was reading exemplify that, especially in the possible-- state of Nebraska with the number of smaller rural districts that we have. Larger-- larger school-- schools or school districts within the metro areas have a much shorter distance to a medical office or a doctor's office or medical facilities for a checkup for a child. Those with more rural orientation have a longer distance to go and usually, depending on the time of year, the weather issues. All that come into-- into play with that. It's a lot easier for a medical practitioner to do a schedule of schools in his or her district or area rather than trying to get the child to a medical facility that may be many miles and many hours away, depending on the location of the school and the child.

WILLIAMS: And I'm assuming that that's-- I would like to ask-- well, I'll ask this in the form of a question. If the school is equipped with the right technology, could this service be provided with telehealth?

KOLOWSKI: Most-- most likely, yes, depending on what the issue is with the child and what's-- what's being diagnosed on the part of the physician at the other end of the line. That would be the difficult part compared to I-- I physically need to see your child so I can do-- run some personal, physical tests on your child to-- to see what might be ailing your son or daughter compared to--

WILLIAMS: Is your amendment limited to mental health?

KOLOWSKI: Yes, it is. Yes, it is.

WILLIAMS: OK. Thank you.

KOLOWSKI: I was talking more broadly with a larger-- a larger sense of this.

WILLIAMS: Additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Thank you, Senator Kolowski, for bringing the bill. Do you know, are there many practitioners that are willing to go to schools to-- to deliver the care?

KOLOWSKI: Well, having been in-- spent nearly 50 years in schools, I think there's been quite a change in how anyone would look at the delivery of services to a particular location. And I think even in the Omaha area, we've seen situations where the medical facilities or mental health facilities have changed considerably over time. And the-- the service of someone coming to your school on a regular basis as well as the possibility of the child and family going to that medical location, wherever that might be, is an easy flow in a metro area, much more difficult in a rural area.

KOLTERMAN: OK. Thank you.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. Isn't it true, Senator Kolowski, that OneWorld and Charles Drew provide behavior health and mental health services to some schools in Omaha?

KOLOWSKI: Yes, they do. And they also have a mobile unit that they take around to the schools and-- and a van that's all situated to do physical-- to do physicals with students as well as mental health needs could be met by using that facility.

McCOLLISTER: And also, isn't there a state law that obligates insurance companies to cover behavior and mental health problems as well as health problems?

KOLOWSKI: I believe so, but I don't have the-- the law before me. I'd have to look that up again; I'm sorry.

McCOLLISTER: Sure. Thank you

WILLIAMS: Senator Howard.

HOWARD: I would just-- for a point of clarification, I believe Charles Drew and OneWorld operate school-based health centers which are like miniclinics inside of a school. So essentially when you step in the door of a school-based health center, you're in a clinic, and so billing probably isn't an issue. But, Senator Kolowski, when we're

considering the challenge of billing for a mental health provider coming into a school, is it mostly because they're sort of independent contractors or if they're coming into the school to provide a specific service to the student and leaving? And so the issue is where the service is being provided, not the provider itself?

KOLOWSKI: Oh, correct. This is more about the location, in our case, rather than who the provider is.

HOWARD: OK. Perfect. Thank you.

KOLOWSKI: Also, I-- I would want to say that, have-- having been a high school principal, what we did in our school, a very large, 2,300 student, now-- now 2,500 students at Millard West-- that's-- that's a large facility. And to understand what goes on within a school day and within a school week and a school month and a school year, the services we provided with the counseling services, how we organized our counseling services, and how they-- how they reached out to the students and their families, as well as a daily homeroom of 15 minutes that gave the students an anchor in their day, that they had that homeroom teacher for all four years through high school. So I knew my students. I had a homeroom as well as principal of the building. And I shared that with a math teacher. And that-- that knowledge of those students as well as the students knowing you, there is a trust factor that if I'm bothered by something or something is-- is on my plate that I've got to share with others, someone is there to-- to help with that situation and to direct you to the next level of services as needed, makes a big difference.

HOWARD: Thank you.

WILLIAMS: Any additional questions? Seeing none, thank you, Senator Kolowski. Will you be staying to close?

KOLOWSKI: Yes, I will. Thank you.

WILLIAMS: Thank you. I would invite the first proponent? Welcome.

CAROLINE WINCHESTER: Hi. Senator Williams and members of the committee, my name is Caroline, C-a-r-o-l-i-n-e, Winchester, W-i-n-c-h-e-s-t-e-r, and I'm superintendent of Chadron Public Schools. I want to thank you for this opportunity to testify in support of Senator Kolowski's LB619 which requires an insurance company to cover mental health services in educational settings. School age mental

health illness is not only increasing in numbers but increasing in severity. Resources to detect and treat school-aged mental health is very limited in the Panhandle. For this reason, it's imperative insurance companies allow mental health services to be provided in the school setting. At Chadron we are down to only one provider that is able to come into the school and provide services. Our other providers left because of insurance requirements. Many of our students needing services do not have transportation either because both parents work, or in some cases we have families that do not have reliable transportation. And there is no public transportation available. Time in schools is a very precious commodity. So even when there is transportation, the increased loss of instructional time which many students dealing with mental health issues can-- they can't spare. And we do need everything we can to try to provide early mental health intervention. There are a couple other con-- insurance concerns that-- that I would like senators to be aware of, even though they're not directly connected to this bill. But first of all, parents sometimes often refuse consent to services, needing mental health services, because they can't afford the deductible. Insurance requires a DSM-V diagnosis when billing for services. Parents fear a mental health diagnosis will come-- will come-- will be-- will become a widely shared permanent label and impede access to opportunities and success for their child. Some insurance companies require referrals from a primary care physician, which means another additional expense for struggling families. Mental health providers face challenges of being allowed to credential with insurance companies due to provider caps. And finally sometimes often patients cut treatment short or discontinue therapy due to frustration and fear related to insurance issues. From the school perspective, we need to do everything we can to increase access to early mental health intervention and services not only-- not only for the welfare of the particular student, but for the safety of all of our students. Learning cannot help it-- happen unless the student is healthy in both mind and body. LB619 helps our schools improve learning. Again, thank you for the opportunity. And are there any questions?

WILLIAMS: Thank you, Ms. Winchester. Questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Thank you for coming today. Do you utilize telehealth at all in your school system?

CAROLINE WINCHESTER: Well, not within the school system. It is-- I mean we have the ability to do that. I know hospital uses that quite

regularly, but we're very used to, you know, services, you know, trainings, and things. We do a lot with distance learning.

KOLTERMAN: So the concern that you brought up, some of the barriers-- or the high deductible plans, so if somebody has a 5-- $5,000 deductible and they want their child to have coverage, they're maybe not willing to pay for that. Does the school have any kind of a provision where they can step in and help with some of that?

CAROLINE WINCHESTER: Well, this is what I meant. This has come to my attention because we recently received-- one of the three school districts in the state to receive an AWARE grant to provide mental health services. And this is what I meant, a lot-- this stuff is new on my plate. I'm, you know, very naive about all of this. And so this is what-- you know, I was able then, through the grant, to hire a mental health specialist to provide services for our students. And I'm used to, I hire somebody like a counselor or a teacher, and they go right to work providing services. Well, I hired the individual in December, and they've just been able to provide services to a few students here the first of February. So like I said, I'm pretty naive in this-- this insurance area and mental health. But that's just, you know, and so we have-- so I meant, we have somebody that can provide services, but they still have to work through the insurance companies.

KOLTERMAN: So that-- that's-- that's kind of the point I'm making. So if you hire somebody and they're on your payroll--

CAROLINE WINCHESTER: Right.

KOLTERMAN: --through the grant and they see these kids, won't they be reimbursed through the grant?

CAROLINE WINCHESTER: No, because-- that's the prob-- that's one of these frustrating things. The grant will not allow us to provide free services. If they're with an insurance company, then we have to go through the insurance provider. And we-- this-- like I said, this is a new realm for me. We fortunately worked through our service unit in order to hire the mental health provider, and have-- and thank goodness we did because our ESU 13 happens to have a third-party billing service because that gets involved in all of this. If the school provides the service, then you've got to go through this billing. And I meant we-- I meant we would have been lost. We would

have had no place, you know, if it hadn't been that we partnered with ESU 13, so.

KOLTERMAN: So a lot of your-- a lot of the products that are sold today are excess-type products.

CAROLINE WINCHESTER: Pardon?

KOLTERMAN: A lot of the products sold today are excess-type products. So as an example, if you'd buy a policy on your student athletes, their insurance policy has to pay first and then you'd pay secondary. Couldn't this work the same way, so if they've got a $5,000 deductible, they can't collect from that, you could step in and pay up to that amount?

CAROLINE WINCHESTER: I mean--

KOLTERMAN: Would that be an option?

CAROLINE WINCHESTER: --that would be great.

KOLTERMAN: Has it been looked at?

CAROLINE WINCHESTER: I don't know that that's an option right now. At least that's what my people are telling me.

KOLTERMAN: And I don't know, maybe that's what this is designed to do.

CAROLINE WINCHESTER: Yeah.

KOLTERMAN: I'll ask the next--

CAROLINE WINCHESTER: Somebody else--

KOLTERMAN: -- I'll ask the insurance companies.

CAROLINE WINCHESTER: --may be much more knowledgeable in that area.

KOLTERMAN: Thank you.

CAROLINE WINCHESTER: Thank you.

WILLIAMS: Additional questions? When-- Ms. Winchester, when you talked about having one provider then, in your situation that provider is actually an employee of the school system.

CAROLINE WINCHESTER: Well, no. This was-- this would have been an outside provider before--

WILLIAMS: OK.

CAROLINE WINCHESTER: -- we just recently were able to hire somebody.

WILLIAMS: That was an outside provider you were talking about at that point.

CAROLINE WINCHESTER: But before that we had like five or six providers that would come in. And then they dropped out because of insurance requirements or whatever, so we're-- so we're down to just one individual in the community.

WILLIAMS: Thank you. Thank you for your testimony.

CAROLINE WINCHESTER: OK. Thank you for the opportunity.

WILLIAMS: We'd invite the next proponent? Welcome, Mr. Hayes.

JASON HAYES: Chairman Williams and members of the Banking, Commerce and Insurance Committee, my name is Jason Hayes, J-a-s-o-n H-a-y-e-s, and I represent the Nebraska State Education Association. The association supports LB619 and thanks Senator Kolowski for introducing the bill. Also the Nebraska Council of School Administrators asked me to inform you that they are supporting the bill as well. The intent of the bill is to make clear that a student may receive mental health services from a licensed provider in a school building and that those services could be covered by the student's insurance coverage. From a community perspective, this will hopefully enable a student receiving such therapy to miss less time in the classroom because the provider will be able to come to the student rather than the student traveling back and forth from the provider's office. We urge the committee to support LB619 and advance it to General File for debate.

WILLIAMS: Thank you, Mr. Hayes. Questions? Senator Kolterman.

KOLTERMAN: Thanks for coming,--

JASON HAYES: Yeah.

KOLTERMAN: -- Mr. Hayes. So under-- under an insurance policy, there's nothing-- there is nothing that really prevents a provider from going any place to take care of the services. Is this because the schools

don't allow it, and we're now allowing it in schools? I mean there have been house calls for years that are typically covered by insurance.

JASON HAYES: I-- apparently there are some instances where providers are unwilling to come into the school building because either they themselves or somebody in their profession has indicated that their coverage-- or that their services have not been covered. And so it's created a chilling effect within various school districts from providers coming in and offering services because they are concerned that they may not get paid.

KOLTERMAN: I'll ask the insurance companies when they get up here. Thank you.

JASON HAYES: Sure.

WILLIAMS: Mr. Hayes, do most-- do most school districts have a-- a school psychologist?

JASON HAYES: I believe most do. But I'm-- I'm not sure exactly which ones. I would imagine--

WILLIAMS: One of the things I would like to have addressed so at least I have a clearer understanding of this, is when the student would be seeing an already employed person at the school, the school psychologist, to do something, and when it would be deemed medically necessary, I guess would be the term, to see a--

JASON HAYES: Um-hum.

WILLIAMS: --a licensed provider.

JASON HAYES: Yeah. Well I-- you know, I can certainly speak from personal experience. I've got a couple of daughters that have been in and out of therapy for numerous instances, some having to do with Facebook posts and other things. But for instance, one of my daughters saw the school psychologist because of some things that were happening with her IEP. The-- the school psychologist was the one that was actually doing the diagnosis for the IEP, whereas her outside therapist is doing more weekly ther-- therapy visits or as needed. Certainly as a parent, going to the school, picking up your child, getting there to the appointment in time, you know, by the time you turn around after the hour appointment, you know, it's maybe 2.5 hours. So I had some-- some personal connections in working on this

bill. And this came about as a committee of educators, different aspects of the administrators, school boards, and teachers association in identifying what were those areas where we could help provide more mental health services for schools, this was one issue that was-- was singled out. And it seemed like a commonsense solution to make sure that we eliminated this chilling effect by the provisions of the amendment and LB619.

WILLIAMS: Any additional questions? Seeing none, thank you, Mr. Hayes.

JASON HAYES: Thank you.

WILLIAMS: Invite the next proponent? Welcome, Senator Coash.

COLBY COASH: Thank you, Senator Williams. For the record, I am Colby Coash, C-o-l-b-y C-o-a-s-h. I'm happy to be here in front of the Banking and Insurance Committee. Want to, first of all, thank Senator Kolowski for bringing this bill and giving you a little background on it. This-- starting this summer, the School Board Association-- well, starting several summers ago actually, School Board Association had been engaging members across the state, all sizes of districts, about what their needs were and how things were-- were going and a whole realm of issues related to education. And when they started to hear priorities of what-- what schools were dealing with and some of their challenges, the mental health needs of students rose to the top. And as Dr. Winchester illustrated, this is a number one problem because the number of children presenting with mental health needs is growing and the severity of those needs is also increasing. And so that led to a group of stakeholders getting together, and Mr. Hayes alluded to this, where the school boards, school administrators, teachers, providers, all got together to look at what was happening with regard to mental health services for children, particularly within the schools. And one of the things that we learned, among others, was that there was some-- quite-- quite a bit of disparity of how this is being dealt with, with different school districts across the state. And so you know, some districts were able to provide-- get a provider to come in and provide these services to-- to students just by providing a place. They weren't the provider; they just provided the place. And then in other districts, providers are unwilling to come in there because they had tried that before and their payment had been-- had been denied. And so this bill really addresses not what's covered or how it's covered; those are all still under-- under current law. This bill simply says that if the school is the place and you wouldn't otherwise deny services based on that, you should-- you should pay for

that service. Schools really do, I won't say like to provide services a place, but they do it because it's good for students. The drive time goes down, especially in rural areas. The amount of instruction time that is lost is reduced if schools can provide this. And a lot are doing it, but some are not doing it because of their experiences. We feel like this particular bill clarifies that and gives both insurance companies and schools the ability to say, no, you can come in. If you're willing to provide services to a student, you can do that within the building. To that end, Dr. Winchester alluded to this but, I will pass out a small summary of a survey that the School Administrators and the School Board Association jointly did where we sent out a very broad question across the state, to superintendents mainly, but also some providers weighed in, and said, what has been your experience? And when those results came back and some were positive, some were less than positive, that is what drew us to talk to Senator Kolowski about clarifying this-- this issue in law. And so I'm going to submit some of these responses that we got for the record, so that you can look at kind of the disparity of how things were happening across the state. And with that, I'll close and answer any questions.

WILLIAMS: Thank you, Senator Coash. Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Senator Coash, thanks for coming today. Do you know, as an example, at ESU 7, they're spending a lot of time and effort in building a mental health type of program which covers a lot-- some in my district but mostly north of there. Would that be covered under this bill?

COLBY COASH: Well, I think--

KOLTERMAN: I mean an ESU, is that also-- come into play?

COLBY COASH: --well, I think-- I think if it isn't, then the committee should probably work to clarify that it is. ESUs will-- will very frequently play that role of a-- of a space for students. I would think, though, that you would get the same challenge from providers that don't want to come into a school. Without some clarification, they may not want to come into an ESU either. And what we're really talking about in this bill and accompanying amendment is really about the place. You know, as Senator Kolowski indicated, this doesn't change eligibility, payment, anything like that. It just says that if

you're-- if you're in a school, you can be reimbursed for the service you provide.

KOLTERMAN: It-- the other-- can I-- can I keep going, Senator?

WILLIAMS: Yes.

KOLTERMAN: Thank you. The other questions that I would have deal with your committee. You had a committee, and you said the school boards, the school administrators--

COLBY COASH: We met with school administrators, school boards, teachers.

KOLTERMAN: --were parents involved in that committee?

COLBY COASH: No. No.

KOLTERMAN: So there weren't any parents involved.

COLBY COASH: No, but we certainly did work with providers who work directly with those-- with those families, both providers that are external to the school system but also providers who work internally like school psychologists.

KOLTERMAN: And the other question is, since we're dealing with in most cases probably minors, will they have to-- if we pass this type of legislation, would they have to sign a release allowing this to happen as a parent.

COLBY COASH: Parents have to do that now, and they'd have to consent to treatment. And nothing in this bill or amendment would change that requirement that parents have-- have to consent to treatment for their children.

KOLTERMAN: And then probably my final question would be do you know whether Medicaid covers this type of benefit or not?

COLBY COASH: Medicaid can.

KOLTERMAN: Can, not necessarily has to.

COLBY COASH: They have covered this-- this in the past. But Medicaid has its own rules with regard to eligibility, whether you're eligible for it or not.

KOLTERMAN: Well, we're going to have quite a few people on Medicaid.

COLBY COASH: Um-hum.

KOLTERMAN: I would hate to discriminate against those folks because--

COLBY COASH: Well, the providers-- typically providers will tell you that Medicaid's a-- I don't want to speak for the providers, but of course if-- I think you'll have some-- I think you'll have some providers who may be able to speak to that better,--

KOLTERMAN: All right. Thank you.

COLBY COASH: --so I'll let them speak for themselves.

WILLIAMS: Additional questions? Seeing none, thank you for your testimony.

COLBY COASH: Thank you.

WILLIAMS: Invite the next proponent? Welcome.

KATIE McLEESE STEPHENSON: Thank you. Good afternoon, Chairperson Williams and members of the Banking, Commerce and Insurance Committee. My name is Katie McLeese Stephenson, it's spelled K-a-t-i-e M-c-L-e-e-s-e, separate word, no hyphen, Stephenson, S-t-e-p-h-e-n-s-o-n. I'm here today to testify in support of LB619 as amended with AM287 on behalf of the Nebraska Association of Behavioral Health Organizations or NABHO. Our organization is made up of 45 behavioral health organizations, both large and small, across the state of Nebraska. I serve as the executive director of HopeSpoke, formerly known as the Child Guidance Center. We're located here in Lincoln and are celebrating our 70th year in operation this year. We provide an array of behavioral health services, including outpatient therapy in 16 of the Lincoln Public Schools at the elementary, middle, and high school levels. We have a strong partnership with the schools and have provided services for many years within the school setting. Last year our agency served over 1800 individuals, and nearly 400 were served within the schools. There are many advantages to school-based services. The school setting is nonstigmatizing because everyone attends school. Not everyone is willing to walk into a mental health clinic for services. Additionally, many are helped by the school-based services, and the transportation barrier is eliminated as has been discussed. Many families have more than one child. They have a job or more than one job, and they may have unreliable transportation. So for

overscheduled families or those without transportation, eliminating an additional appointment that they need to get their child to is most helpful. Schools-- services that are collocated within the schools also promote a collaborative connection between the clinician and the school personnel who may be able to identify the mental health needs of the child or young person as a significant barrier to their education. This communication level is increased, and together they can provide coordinated responses to the needs of that youth. For these and many other reasons, we strongly support school-based services. An important aspect of providing any service is having adequate access for those in need. Currently the revenue sources for agencies to provide school-based services are either Medicaid for those that qualify or some limited grant funding. Over the years, private health insurance has not generally recognized schools as a site of service and has limited who we can serve. It's frustrating for families and for the schools that there are limitations to who can be served based on funding. The behavioral health needs are certainly not limited to Medicaid recipients. In fact, it is estimated that over 20 percent of students have a mental health or substance use disorder. Many educators identify that the behavioral health needs of students is their number one concern. Creating greater access for students that are in need of behavioral health services by insurance companies recognizing schools as a site of service is exactly what LB619 would help accomplish. As recently as January of 2019, Blue Cross Blue Shield of Nebraska has added schools as a site of service. We applaud that change and will be able to broaden who we serve as a result. We are asking that you support LB619 and advance it out of committee so that services can be received equitably across our state with broad coverage by all insurance plans. A special thanks to Senator Kolowski for his leadership of-- on this bill and helping to find a solution for Nebraska students in need of behavioral health services. I'd be happy to respond to any questions that you might have.

WILLIAMS: Questions? Seeing none, thank you for your testimony. Would invite the next proponent? Welcome.

JASON BUCKINGHAM: Thank you. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Jason Buckingham, J-a-s-o-n B-u-c-k-i-n-g-h-a-m. I'm the business manager for the Ralston Public Schools. I appreciate the opportunity to appear before you today to speak on behalf of our students, staff, and the Ralston Community. I appear before you today in support of LB619. In my experience working the Ralston Public School-- Schools, I

can say with certainty that the last two decades have brought a great amount of change to the way that we view mental health issues "withinside" our schools. Twenty years ago we looked at mental health as a responsibility of the parent alone, and as such, we provided fairly limited services within our buildings. Most students that needed mental healthcare and were fortunate enough to receive it went to therapy or counseling appointments outside the school day. We were formerly a suburban school district with comparatively low levels of free- and reduced-lunch students and Limited English Proficiency students. We've doubled our amount of free- and reduced-lunch students over the course of the last 15 years from 28 percent to 57 percent and increased our number of Limited English Proficiency students by 35 percent over the course of the last 5 years. These statistics represent a dramatic shift in our demographics, and they show that we have increased significantly the number of families served by our district that are in need of assistance. We provide a wide range of services in our district beyond traditional education, like a weekly food pantry, clothing drives, and access to many other resources to help our families. One area that has continually been a need for many of our families is access to mental health services. Due in no small part to our demographics, we have witnessed a growing number of students with untreated mental illness. We offer some supports through our staffing, but we found that we were not capable of keeping up with the increased demand. Five years ago we contracted out with a private counseling company to provide free counseling services and visits to our students and families. This service was used some, but we found that most of our-- most of our-- in that most-- our families that were most in need were unable to get transportation to and from the counseling office. We have since brought the counseling service on-site for visitations for at least ten hours a week, and we're ready to expand. This move was significant in our district in that students with mental health issues are able to receive consistent care within the confines of our schools. Transportation may not seem like much of a barrier to accessing healthcare, but the reality for some of our families is that transportation issues prevented them from seeking the help that they needed. The students that we have attend the in-school counseling sessions rarely miss, and all have benefited greatly from this service. To place an am-- the amount of need in our district in perspective, we wish to make a comparison of the number of mental health referrals made to our staff-- or made by our staff. The 2016-17 school year saw 93 individual students and families referred. We looked at the same time period from August of 2018 to December 2018, and we found that our staff had already referred 64 students. That

puts us on pace for a 37 percent increase in the number of mental health referrals in our district. As a school we consistently attempt to meet students where they are, and-- and we try to take them to where they need to go. Issues of mental health ill-- mental health illness can be a large impediment to student learning as they can contribute to-- extensively to lost instructional time. The ability for a student to receive the care they desperately need should not be restricted. Therefore, we strongly support the measure outlined in LB619 to compel insurance companies to provide coverage for services provided withinside our buildings. It is our belief that the barriers to accessing mental healthcare should not-- should-- should be-- not be reduced-- or excuse me, it's our belief the barriers should be reduced, and that parents with insurance should not be denied coverage regardless of the location of service. Thank you, again, for your time and your continued commitment to the people of the state of Nebraska. I'll try and answer any questions you have for me at this time.

WILLIAMS: Thank you, Mr. Buckingham. Questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Do you know-- and thank you for coming. I know you were here a couple weeks ago for Revenue.

JASON BUCKINGHAM: The Valentine's Day Massacre.

KOLTERMAN: Yeah. [LAUGHTER] That was late-- that was a late night, wasn't it?

JASON BUCKINGHAM: It was.

KOLTERMAN: That was a lot of fun. Anyway, when you-- you've got 60-- you're on track to have a record year of referrals. Are you getting any pushback from parents on the referral process?

JASON BUCKINGHAM: Not at all. What we tend to have in our district, again because of our poverty levels, we have parents that really want to try and do the best for their kids. They may not have the funds or the resources or the availability to do that. When we make referrals, we're very deliberate in those referrals, and we have had very, very limited pushback from our parents. We've had a few that have denied-- or denied the services we've provided. But to be quite honest with you, Senator, almost all of them understand that there's a problem, and they accept it willingly. What makes us unique and kind of changes our situation a little bit is that we're paying for the service itself that exists in the-- inside of our schools. We don't have the

insurance billing issues because we are paying for the service. Now, could I use those resources in other places? Certainly, as you've heard, you know, school finance and the limited resources we have there. But we have not had very many parents at all that have denied access to these services.

KOLTERMAN: And-- and-- and we hear constantly that there's challenges with mental health in our schools. Do you know-- several years ago-- you-- you've been at Ralston quite a few years, haven't you?

JASON BUCKINGHAM: Twenty.

KOLTERMAN: Twenty years. That's what I thought. Several years ago, I think it was four years ago, we had something that was done through the University of Nebraska Med Center that dealt with a tool that you could use to identify students that have--

JASON BUCKINGHAM: Um-hum.

KOLTERMAN: --mental health issues. It was a pilot project. Did you participate in that at all?

JASON BUCKINGHAM: We did. We participated in that, and we found that the numbers were even higher than what we anticipated. The number of kids that were--

KOLTERMAN: Was that a useful tool for you?

JASON BUCKINGHAM: It got us moving in a direction where we expanded the services that we provide.

KOLTERMAN: Do you-- do you know if other schools have utilized that to-- to their advantage or what?

JASON BUCKINGHAM: I'm not sure if they've used that survey or not, but I can tell you in the metro area, you're seeing an increased number of districts that are providing in-house support for mental health illness.

KOLTERMAN: So when we talk about mental health, are we talking about suicide prevention stuff like Facebook?

JASON BUCKINGHAM: Sure. So it-- what we tend to look at encompasses a wide range of mental health issues. It's not only suicidal depression, but it will also involve issues of substance abuse. It will also, in

some cases involve issues of, let's say, aggressive behavior, defiance, behavioral disabilities that exist. So it's not limited only to what you would think are your-- your suicide or your depression issues, but it expands much beyond that.

KOLTERMAN: And-- and your role-- you're a business manager--

JASON BUCKINGHAM: Um-hum.

KOLTERMAN: --at Ralston.

JASON BUCKINGHAM: Yep.

KOLTERMAN: Are you an educator as well?

JASON BUCKINGHAM: I was. Yeah.

KOLTERMAN: OK. Thank you very much.

JASON BUCKINGHAM: You bet.

WILLIAMS: Additional questions? How do you, when you're going down-- or how does a school district, again, go back-- go back to the question I asked earlier, determine whether you use your-- your outside professionals or al-- those that are already involved with providing psychological help?

JASON BUCKINGHAM: OK. So in our instance then-- I hope I answer your question here. In our instance, if we see some issues that are of concern for us, there's a process that we'll go through. We do have school psychologists. I think we have four-- actually five that work in our district. Out of those five, most of the focus of the work that they do is in identifying learning disabilities. Sometimes they'll do some of the behavioral disability part. But they're more looking at reading issues like dyslexia, for example, and trying to diagnose those and determine whether or not a student is special education eligible and whether we can help them through that fashion. For the mental health piece of it, as a district we have not had the staffing in place for us to be able to address those issues. And it's mostly been done by, you know, the parent takes their child to an outside provider. Because of the change in our demographics then, we have gotten to where those needs have been unmet. And we want to try and have every student have the ability to be successful as much as they can to their ability. So we brought this outside company in then. And we've been very successful with them, and they've been great with us.

And-- and I hope that our relationship with them, they would speak highly of us too. But we've seen such an increase in the amount of need that we've had that we've had to not only expand the amount of time and energy and resources we've put into it, but we're also looking at another company to come in to help us with some of our elementary issues as well. See, what we have now with the company we contract out with, their on-site services are exclusively in our high school and middle school. But we've got six elementary buildings. And those six elementary buildings, some of those students unfortunately have some mental health illnesses too. So we're looking at expanding out the amount of services that we provide too. I'm not sure I answered your question,--

WILLIAMS: That's-- that's helpful.

JASON BUCKINGHAM: --but-- but I hope I did in a roundabout way, so.

WILLIAMS: We'll go to Senator McCollister.

McCOLLISTER: To what extent do you use school resources to pay for those outside contractors?

JASON BUCKINGHAM: OK. So in our instance, for the outside contractor to come in itself, we're paying $4,200 a semester for it, OK? And we get ten hours a week for the services that they provide. In addition to that, for parents who are able to take their kid-- or excuse me, take their child off-site to the counseling office, we end up paying a fat-- flat rate of $3 per student for our district. So in our district where we sit at about 3,400 kids, you're looking at what, about $12,000 in addition to that for the year.

McCOLLISTER: So total resources spent in this regard is how much?

JASON BUCKINGHAM: Well, we also use this company for our employee assistance program. So all three are tied together. All told, you're looking at probably about $45,000.

McCOLLISTER: OK. And if folks have insurance, are you able to-- able to utilize--

JASON BUCKINGHAM: Yep.

McCOLLISTER: --insurance for those-- that coverage?

JASON BUCKINGHAM: Yep. Yep. And that's where they can go beyond the-- the services that pro-- the services that we provide for off-site aren't-- aren't unlimited. We pay for the first three sessions that they visit. Then after that it's up to the-- the parent to see if there's a way that they can use that through their own insurance, or if they're Medicare or Medicaid eligible, there also is a possibility that they can claim that as well.

McCOLLISTER: Thanks for coming.

JASON BUCKINGHAM: You bet.

WILLIAMS: Senator Kolterman.

KOLTERMAN: Thank you again, Senator Williams. When-- when you're-- when you're dealing with kids and you're spending that kind of money, do some of those-- those-- like you're going to pay for the three--

JASON BUCKINGHAM: Um-hum.

KOLTERMAN: --first three visits.

JASON BUCKINGHAM: Yep.

KOLTERMAN: Does that money then get counted towards their deductible, do you know?

JASON BUCKINGHAM: No. Nope, that's dollars that we've already expended at the start of the year.

KOLTERMAN: And then-- and one final question--

JASON BUCKINGHAM: Sure.

KOLTERMAN: --and this is just for understanding. Back in the stone ages when I went to high school with like Williams and McCollister here, we had counselors,--

JASON BUCKINGHAM: Um-hum.

KOLTERMAN: --but they weren't psychologists.

JASON BUCKINGHAM: Correct.

KOLTERMAN: Is there a difference between a guidance counselor in the schools today, and-- and you say you have four psychologists--

JASON BUCKINGHAM: Um-hum.

KOLTERMAN: --on-- on the payroll?

JASON BUCKINGHAM: Yep.

KOLTERMAN: But they're not your guidance counselors?

JASON BUCKINGHAM: No, we have guidance counselors in addition to that.

KOLTERMAN: So that's in addition to?

JASON BUCKINGHAM: Um-hum.

KOLTERMAN: Thank you.

JASON BUCKINGHAM: You bet.

WILLIAMS: Any additional questions? Thank you--

JASON BUCKINGHAM: Thank you for your time.

WILLIAMS: --Mr. Buckingham. Invite the next proponent? Welcome.

DEBRA ANDERSON: Thank you. I feel short.

WILLIAMS: It's a big chair.

DEBRA ANDERSON: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Debra Anderson, it's D-e-b-r-a, oop, sorry, A-n-d-e-r-s-o-n. I am the senior director of early intervention and training at Project Harmony, Child Advocacy Center in Omaha, and today I'm representing Nebraska Child Health and Education Alliance. I appear before you today in support of LB619 to require coverage for mental health services delivered in a school or other educational setting. Research shows that children who have suffered four or more adverse childhood experiences are twice as likely to experience learning and behavior problems as children who have not suffered from those adverse experiences. So since January of 2015 Project Harmony has operated a program called Connections. It's an early intervention mental health program. We work with four public school districts in the Omaha area. We work with OPS, Millard, Bellevue, and Papillion, and school social workers refer students to

us that have mental health needs. We match them with a licensed mental health practitioner who has expertise in addressing their needs, both the students and families. Some of the most common adverse experiences we see children struggling with are separation or divorce of their parents, children strug-- struggling with the loss of a loved one, and children that are struggling with a parent's substance abuse or mental health problem. As a result, the children that are referred to Connections display symptoms at school that range from hopelessness and despair to anger and aggressiveness. Since we opened our doors 4 years ago, we've increased access to mental health services for 5,000 students. Last year, we served over 1,600 students, grades K through 8. And notably, over 500, or more than a third, were able to get individual or group therapy in their own school. School principals regularly tell us if you don't place a therapist in my building, my students won't be able to get to therapy. Families are challenged by transportation issues, lack of child care, long workdays, and other things that you've heard. By allowing therapy to be-- to be delivered in school, students do not go without needed services, and they have access when they need it. Families have to consent, so parents consent to our service. They thank us for being able to provide the therapy in the schools, so they know their child is getting the help they need. And providers tell us that not only does it help the child-- child they're seeing, but the school staff benefit as well because therapists help them understand trauma and other mental health issues. Addressing mental health concerns as early as possible builds resiliency and prevents long-term consequences, which is really why we got into it. However, providing behavioral health services in school is not feasible for providers or programs like mine unless insurance covers the cost of the service. When private insurance denies a claim simply because the place of service is coded as a school, we cannot arrange for school-based mental health services, and that means students and families lose, providers lose, and schools lose. I urge you to support LB619 as this bill would ensure that insurance covers mental health services delivered to students in schools across the state of Nebraska. Thank you for this opportunity, and I will try to answer any questions you have.

WILLIAMS: Thank you, Ms. Anderson. Questions? Seeing none, thank you for your testimony. Invite the next proponent? Welcome, Mr. Kohout.

JOE KOHOUT: Chairman Williams, members of the Banking, Commerce and Insurance Committee, my name is Joe Kohout, J-o-e K-o-h-o-u-t, appearing today-- before you today on behalf of our client, the

Nebraska Association of Regional Administrators, an association comprised of the administrators of Nebraska's six behavioral health regions. Behavioral health regions are local units of government that partner with the state of Nebraska the planning and development of mental health and substance abuse needs within specific geographic areas. Each region is governed by a board which is comprised of a county commissioner from each of the counties comprising that region. Our members understand that this hearing has drawn quite a bit of testimony today, but felt it was important to go on the record in support of LB619 and to thank Senator Kolowski for introducing it. Our members believe that by passing LB619 that those seeking behavioral health services will be greatly benefited by access to those services based in a school setting, a setting that is very familiar to them. Coverage of these services in-- in school buildings will allow parents seeking services for their children to save in both time away from work to travel to provider locations as well as savings to their household income by knowing that necessary behavioral health services their child needs will be covered by their health insurance. In addition, students will be less disrupted in their routines by being able to stay in the classroom longer, providing important stability to-- in a young person's life. The bottom line is LB619 is legislation that will help our young people to get the behavioral health services in a place-- in a setting in which they are comfortable in. We appreciate the opportunity to testify before you today in support of LB619 and ask for your support moving this legislation to the full body for their consideration. I would be happy to try to answer any questions that you might have.

WILLIAMS: Thank you, Mr. Kohout. Questions? Seeing none, thank you--

JOE KOHOUT: Thank you.

WILLIAMS: --for your testimony. Would invite the next supporter? Welcome, Mr. Dunning.

ERIC DUNNING: Good afternoon, Mr. Chairman, members of the Bank and Commerce and Insurance Committee. For the record, my name is Eric Dunning, E-r-i-c D-u-n-n-i-n-g. I appear today as a registered lobbyist for Blue Cross and Blue Shield of Nebraska in support of LB619 as would be reflected in proposed AM287. AM287, if adopted, would more accurately reflect the original intent as we understood it, the sponsor, and would limit a fairly standard place-of-service exclusion found in most insurance-- health insurance policies. The amendment is consistent with our current insurance policies starting

1/1/19 which do not exclude mental health services provided in a school setting if the services are otherwise covered under the contract and delivered by an approved provider. This policy change expands member access to covered mental health services. AM287 balances this expanded access to the services with allowing insurers to continue to maintain the other provisions and protections in insurance contracts, such as medical necessity and requirements that services be delivered by qualified and credentialed providers. With that, I'd be happy to answer questions.

WILLIAMS: Questions? Senator Kolterman.

KOLTERMAN: Thank you. Thank you for coming today. Do your policies today provide equal coverage for mental health? At one time, there were limitations, like a $50,000 minimum.

ERIC DUNNING: What-- there are extensive provisions on mental-- on mental health coverage found in both state and federal law, and we're in-- we're in compliance with those.

KOLTERMAN: OK.

ERIC DUNNING: That coverage is really-- has really morphed over the years and is significantly broader than it was before.

KOLTERMAN: But-- but there-- do you still have limited amount-- a limited number of trips to the doctor?

ERIC DUNNING: Well remember, we're subject to the-- to the standards in mental health parity, so--

KOLTERMAN: OK, that answers my question.

ERIC DUNNING: --broadly speaking mental and physical are treated similarly.

KOLTERMAN: OK.

ERIC DUNNING: One question, Mr. Chairman, that I heard you ask earlier that I'd like to-- to address, I-- we don't believe that there's anything in AM287 which would limit the ability of the use of telehealth in this setting.

WILLIAMS: Additional questions? Seeing none, thank you for your testimony. Invite the next proponent? Welcome.

BRIAN HALSTEAD: Welcome. Thank you, Senator Williams and members of the Banking, Insurance and Commerce Committee. For the record, my name is Brian Halstead, B-r-i-a-n- H-a-l-s-t-e-a-d. I'm with the Nebraska Department of Education, here to tell you that the State Board of Education voted to support this bill. The State Board supports and advocates for a system to ensure a solid system of behavioral and mental healthcare is developed statewide that coordinates these services between and among partners that breaks down the barriers for families and children. As you're all well aware, the Department has the general supervision and administration of the school system of this state, which this year encompasses just under 364,000 children. Thirty-six thousand, almost 37,000, are in private schools that are also part of our jurisdiction. So from the State Board's perspective, we want to support families' and children's having access to services that meet their needs. And if there is any ambiguity in state law about policies being offered that can limit it to not-- to school settings, that we think that should be something that the family should have access to. So I'll stop there and take any questions.

WILLIAMS: Thank you, Mr. Halstead. Questions? Seeing none, thank you for your testimony. Invite the next proponent? Welcome, Mr. Tabor.

NOAH TABOR: Thank you, Mr. Chairman, members of the committee. My name is Noah Tabor, N-o-a-h T-a-b-o-r. I'm the government relations manager from Medica Health Plan. I just want to echo what Mr. Dunning said earlier. Medica is in support of the amended language before you. I want to thank Blue Cross and the others that are involved in coming to this good compromise language that reflects the original intent. I also wanted to hit lightly, Senate author mentioned that the amended language before you would likely help to address the fiscal note. Because we are the offerer on the health exchange, that fiscal note come-- came from our actuaries and the Department of Insurance. I would agree with the Senate author's assumption that the fiscal note would likely be significantly reduced with the amended language. I am certainly not a fiscal analyst. I'm not an actuary. But the amended language proposed today certainly would greatly reduce that number, I am sure. So with that, I'd be happy to answer questions.

WILLIAMS: I'll ask a question on that. Significantly reduced or eliminated, which do you think?

NOAH TABOR: Again, Mr. Chairman, I'm not an actuary, not a fiscal analyst. I would think, because the amended language helps to clarify, this is not expansion of benefits or services. This is dealing with where the services are provided. I think it would eliminate.

WILLIAMS: Thank you. Questions? Seeing none, thank you, Mr. Tabor. We would invite any additional supporters? Seeing none, is there anyone here that would like to testify in opposition? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Kolowski, you're welcome to come close.

KOLOWSKI: Thank you, Mr. Chairman and committee. I also want to thank every one of the testifiers for their time and effort today to bring those-- those statements forward, to give us the information they were able to share with us. I think it's really important in the sense that we understand where we are and what the end result would be with successful legislation like this. I had a very difficult bill about three or four years ago that we-- we spent considerable hours on as staff and in support of getting-- getting the spaghetti line out of the bowl because it was just so complicated. And it had to do with the health insurance situation. And it had to do with insurance and all the rest. We got that solved. It was a tremendous opportunity to get that taken care of in our state, and many shared accolades with us because we were able to do something that had not been done or taken on by anyone. And we are-- we think that's-- that was a good success sign, and we're doing it again. We're trying to do it again with this particular situation. Many of the-- those who spoke today talked about the mental health in the schools and the student bodies that we are working with. I started-- I started teaching in 1967. That was a different time, different place, different world, different families, different everything compared to the world that we're in today. My last years in the middle schools, 15 years as principal of Millard West High School, I had the opportunity to work with Mr. Lindstrom as a student, in fact. So it's good to see him, of course. And I worked with Mr. Buckingham and others in Ralston schools as we were doing some consulting there with the directions they were going in their district. In both cases, either building opportunity that I had of constructing-- helping to construct and then operate Millard West High School for 15 years, or Ralston High School, or any other school in any location, it's a different world today. And what we do and how we get that done is so wrapped up in the total milieu of-- of the school, the support services that are available through counseling and psychol-- psychological help, the advisor-advisee programs that exist

in-- in those schools. And-- and how the climate, how kids feel about being in that school on a daily basis, pays such a remarkable dividend when it's done-- done correctly and the kids care about-- and know that people care about them. And they-- they love their school. And they're-- they're ready to help you as a teacher with the job that you're doing because they-- they feel so good about it. It's a goal that everyone has as they start a school year, a goal that every district has as they begin their work on a yearly basis. Yet, we have challenges all through our society. I hope in our case, with this particular issue of services being delivered at a school will be a step forward in a mental-- mental health side of things that might lead to other options in the future that would also be very good for us. We live in a society that has many needs. We live in a society that has many challenges for us. And I hope we'll be able to put together the services and the nurturing aspect of a kind of place where kids can know and grow in their future. To be healthy in mind and body is the goal of our schools. And I hope with the assistance of something like this particular bill, this will be impactful upon that goal and upon the lives of those schools and the families that are served by those schools. Thank you very much.

WILLIAMS: Thank you, Senator Kolowski. Questions? Senator Kolterman.

KOLTERMAN: Senator Kolowski,--

KOLOWSKI: Sure.

KOLTERMAN: --thanks for bringing the bill, it's good legislation, and getting the amendment taken care of. I only have one question.

KOLOWSKI: Sure.

KOLTERMAN: You alluded to Senator Lindstrom. Was he as bad an actor there as he is here?

KOLOWSKI: I'll talk to you at 7:00 tonight, OK?

KOLTERMAN: All right. Thank you. [LAUGHTER]

KOLOWSKI: He was a star, believe me. Any other questions for me?

WILLIAMS: I'm just glad you left my daughter-in-law out of it.

KOLOWSKI: And your daughter-in-law also, I didn't want to bring her up. There was a marriage there, I understand.

WILLIAMS: That will close the public hearing on LB619. The committee will take a short break, and we will begin in ten minutes.

KOLOWSKI: Thank you, Senator.

[BREAK]

WILLIAMS: All righty. We will get started again, and we will open the public hearing on LB569 with Senator Morfeld to adopt the Out-of-Network Consumer Protection, Transparency, and Accountability Act. Welcome, Senator Morfeld.

MORFELD: Thank you, Chairman Williams, members of the Banking Committee. For the record, my name is Adam Morfeld, A-d-a-m M-o-r-f-e-l-d, representing the fighting 46th Legislative District, here today to introduce LB569. Imagine for a moment that you or your significant other has a medical situation which requires you to go to the emergency room. You quickly look up your health insurance on your health insurance app on-line or call them to make sure the hospital is covered. You show up, see several providers, perhaps an ER doctor, radiologist, maybe even an anesthesiologist. A few months later you get a bill for thousands of dollars and the realization that, while maybe the hospital is in-network, but the radiologist or anesthesiologist is out-of-network. This is often known as what is commonly referred to as a surprise bill. This happens more often than you think. It happens to my constituents, people I know, and even a few of our fellow senators, as I found out after I introduced this legislation. LB569 will add transparency and accountability for insured individuals in cases of inadvertent out-of-network billing for healthcare services. It sets up a framework for notification for consumers from healthcare facilities, physicians, and healthcare providers on network status and lays out a process for consumers to check the network status of all the above whether it's in-network or out-of-network. The purpose of this bill is to eliminate billing surprises. I introduced this bill after I'd heard from several constituents and people close to me that has experienced this or received a bill from an out-of-network healthcare provider, facility, or services. The surprise comes because the patient assumes if the facility is in-network, such as a hospital or emergency room, the physician treating the patient will also be in-network as long as the lab where the tests are sent. This always isn't the case, and they're

not informed it is the case until after they receive the bill. I've heard of it happening to several people. In fact, I heard from University of Nebraska students who contacted me, one particular with her story and fairly detailed documentation of what happened. She experienced an emergency health issue, needed to go the emergency room for care. She actually checked to see if the hospital was in-network, so doing the things that a good consumer would, and that her student insurance policy was-- was covered under it before going. She thought all is well, but, lo and behold, several weeks later, the student received an expensive bill, thousands of dollars, from the emergency room physician that was not in-network. This isn't right. And as you know, a majority of bankruptcy now, personal bankruptcies, are from expect-- unexpected medical bills. And this is another way that insured Nebraskans aren't treated fairly when they do-- even when they do their due diligence. A recent survey from NORC, a nonpartisan research group at the University of Chicago, surveyed 1,002 individuals and found that 57 percent of adults have experienced surprise billing with regard to medical bills. Among those surveyed, 53 percent were most often for physician services, followed closely by laboratory tests, 51 percent. Other common sources of surprise bills were hospitals or healthcare facility charges, 43 percent imaging, 35 percent for prescription drugs. The survey also states that the public holds insurers and hospitals most accountable-- accountable for surprise medical bills. This is why I introduced LB569, in the interest of transparency and fairness to our citizens. This bill is based in part on a bill that was passed in New Jersey several years ago. And according to NCSL, at least 89 bills have been introduced in 28 states since 2016 related to this bipartisan issue. Nine of these have been enacted or adopted in seven legislatures. The bills range in purpose from encouraging greater transparency to banning the use of balance or surprise billing practices altogether. Louisiana just enacted a law requiring hospitals to inform patients prior to receiving care that out-of-network providers may be used during the course of care. Given the lack of federal law to sort-- to address these sorts of billing practices, states are leading the way to ensure America's health system is more affordable, accessible, and transparent. We as states have many options to protect consumers while ensuring providers receive fair compensation for their services. So what LB569 does is set up a process of disclosure for insured per-- persons with the following information. First, prior to scheduling a non-emergency procedure, a healthcare facility must inform that their facility is out-of-network for the covered person's insurance carrier and must advise the patient to check to see if physicians or

providers, reasonably anticipated to provide certain services for them, are in- or out-of-network with the patient's insurance plan. If in-network, they must inform the patient that they'll be required to pay deductible, coinsurance, and coin-- excuse me, deductible, coinsurance, and copayment as provided in the covered person's health benefit plan. And unless the covered individual at the time of disclosure voluntarily selects an out-of-network provider, they will not incur any unexpected out-of-pocket costs in excess of the charges that applicable-- charges applicable to an in-network procedure. If out-of-network, they have to advise covered individuals that they'll be obliged to pay in excess of the amount allowed by their healthcare insurance provider. Healthcare facilities shall maintain the information on their Web site outlining which health benefit plans they participate, and state all physician services that are not included in their costs and will be billed separately, and that healthcare providers "may or may not participate with the same health benefit plans." The healthcare provider also shall disclose which health benefit plans they participate in and which facilities in which they are affiliated. This is only fair and allows Nebraskans to be informed consumers and make informed financial de--decisions. In the case of medical necessity and emergency services, the patient's inadvertent use of-- of out-of-network provider's costs that exceed the patient's health benefit plan deductible, coinsurance, and copay will not be billed to the patient. The out-of-network provider facility may bill the patient's carrier. And if the carrier deceive-- deems the costs excessive and notifies the provider or facility, they have 30 days to negotiate. LB569 provides much-needed transparency and will help consumers from going bankrupt or experiencing unnecessary financial hardship. This is important to all Nebraskans, and I urge your favorable consideration of the bill. I'm happy to work with the committee and any interested parties on needed changes to the bill. I'm happy to answer any questions, and I'm looking forward to everyone's favorable testimony behind me.

WILLIAMS: Thank you, Senator Morfeld. Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. You spoke of some constituents that were surprised with out-of-network bills. Did any of those constituents receive compensation for the unanticipated costs?

MORFELD: So no, with the exception of one, and it was only after I contacted the CEO of the hospital. And they got that person in touch with the-- the physician group to-- to work on the issue. I actually

don't know if that issue was resolved or not, but my understanding is the hospital CEO had-- had tried to work something out, so.

McCOLLISTER: Thank you.

MORFELD: But that was only after contacting your state senator and me contacting the hospital CEO and all that.

McCOLLISTER: So under this bill, would the hospital be obligated to pay for those unanticipated charges?

MORFELD: Well, the hospitals can come up and talk about this a little bit more, but it's the provider. The provider-- so right now, the provider would receive the-- would basically be the person that would be responsible for receiving the fund-- the amount that the insurance company would normally pay and then also negotiating with the insurance carrier the additional amount that they feel is-- is fair and necessary for treatment.

McCOLLISTER: So when you say provider, are you talking about the outside group that may be in a particular--

MORFELD: Yeah, so the physician-- the physician, you know, the radiologist, the lab that was out-of-network.

McCOLLISTER: I see. And so they would be obligated to negotiate a--

MORFELD: Well, they're not obligated to negotiate, but if they-- if they feel as though they're owed more than what was considered reasonable comp-- compensation by the insurance carrier, they-- it would be up to them to negotiate that.

McCOLLISTER: Well, failing that, the consumers out, correct?

MORFELD: Well, no, I mean so it depends on the situation. So if it's an emergency medical situation, then the consumer will not be billed any more than what their in-network insurance coverage would-- would provide for. And then the rest is between the provider and the insurance to negotiate. If it's a nonemergency medical procedure, then-- if it's a nonemergency medical procedure, then it's either the-- if the-- if the person was unaware and the hospital did not make them aware, then they only owe up to the amount of their deductible or copay. If the hospital made them aware and said, hey, listen, this is going to be out-of-network, and here's some other options, and then they choose knowingly, that's-- that's the term used in here,

"knowingly", to use an out-of-network provider, then, yeah, they are [INAUDIBLE]. But they have to knowingly make that-- that choice.

McCOLLISTER: Isn't that an unrealistic solution? Because if you go to the hospital, whether you have notice or not and, let's say, the radiologist is out-of-network--

MORFELD: Um-hum.

McCOLLISTER: --so you're-- here you are sitting in the ER of a hospital and they say, well, you know that-- that broken arm that you have? Radiologists are out-of-network.

MORFELD: So let me just stop you right there, Senator. So if it's an emergency room situation, it's medical nec-- that there's medical necessity, an emergency situation, it doesn't matter. Like that-- it's only covered-- so that's a different thing. So there's two-- there's two decision trees here if you-- if you want to look at it that way: nonmedic-- nonmedical emergencies where you go in and they have to give you notice and you can make the decision to choose the out-of-network provider or not choose it; or, if you're in an emergency room, a medically-- medical necessity, in which case all those services would be provided to you for just your in-network costs in the emergency room.

McCOLLISTER: So can we say that anybody that goes into an ER is a med-- is-- is an emergency situation?

MORFELD: I would think so in most cases but not always. I mean I suppose they could refer you to, say, just a reg-- a reg-- I don't know. You-- you should ask the people behind me.

McCOLLISTER: OK.

MORFELD: I would hate to guess on this one.

McCOLLISTER: Thank you, Senator.

MORFELD: I think most of the time, when you go into the emergency room, it's usually an emergency situation. But there are people that go into the emergency room for what many of us could be-- would consider nonemergency situation too.

McCOLLISTER: Thank you.

WILLIAMS: Senator Gragert

GRAGERT: Thank you, Senator Williams. I just have a quick question on the nonemergency.

MORFELD: Um-hum.

GRAGERT: You just said, oh, OK, if the patient wasn't informed that they're getting an out-of-network provider.

MORFELD: Yep.

GRAGERT: In a nonemergency, you know, they-- they can plan it and-- and think they're getting this, but they get something else. And they weren't informed they were getting it.

MORFELD: Um-hum.

GRAGERT: How does that-- how do-- how will that work?

MORFELD: Well, if they weren't informed-- so if they were not-- I think I'm getting your question. If they were not informed that, that person was out-of-network or that that service was going to be out-of-network,--

GRAGERT: Right.

MORFELD: --then they're only obligated to pay for the in-network deductible and copay. Now, if they were informed, said: Say, listen, we've got this phlebotomist or this anesthesiologist, and, you know, this is definitely going to be something that you need for this nonemergency condition, and it's out-of-network; and then that person goes, Well, listen, we've got to get it done, I want to go here, I don't want to shop around or look anywhere else; then they are obligated to pay for the out-of-- and I'm sure that there's probably going to be a procedure that the hospital--where you got to sign something saying, I was informed that this person's out-of-network, you know?

GRAGERT: I guess, you know, let's just stay with, I wasn't informed.

MORFELD: You were uninformed.

GRAGERT: And-- and now the insurance company is paying their share.

MORFELD: Um-hum.

GRAGERT: Is anybody going to come at me now for that additional monies? Is that-- is that doctor going to be coming at me, you know, as a patient that-

MORFELD: So under this law, Senator, they can't do that. Now that-- that provider can, I believe that they can try to go after the-- the insurance carrier and negotiate with them--

GRAGERT: OK.

MORFELD: --only if they're not informed.

GRAGERT: Right.

MORFELD: And this is-- you know, I'll be honest with you guys. I've-- I've learned a lot about this subject. I've read my legislation and other states' legislation multiple times, you know? And so I won't pretend to be an expert. And-- and that's one of the problems that we're facing is it's a really complex system. And it's tough for people who are even well-informed to be able to wrap their head around this and be in a position to make decisions, financial decisions, with-- with all the knowledge. And I'll tell you, I remember I had to get a vaccination because of potential exposure to something at one point, and I called my insurance. This is a separate issue. But I called my insurance company ahead of time and said, is this covered? And they said, yes, it's covered. Got the $2,000 bill several months later. Called them back up again and said, hey, you said it was covered. They looked at it and said, yeah, you're right. We did say it was covered, but it's actually not covered. So we're still not going to cover it. I mean so, you know-- and that's a different-- this doesn't cover that, but I'm just saying it's really tough, even if you're an informed individual, to be able-- be able to participate fairly in the marketplace.

GRAGERT: Um-hum.

WILLIAMS: Additional questions? Seeing none.

MORFELD: I promise my closing will be shorter. Thank you.

WILLIAMS: We would invite the first supporter to testify? Welcome.

JINA RAGLAND: Welcome. Chair Williams and members of the Banking, Commerce and Insurance Committee, my name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I'm here today in support of LB569 testifying on behalf of AARP Nebraska. AARP is a nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to families and those 50 years of age and older. It is the policy of the AARP that policymakers should enact safeguards to protect consumers against surprise bills from nonnetwork providers who provided services without the consumer's knowledge or consent in an otherwise in-network set-- setting, such-- safeguards such as creating new dispute resolution processes that hold consumers harmless, limiting consumer responsibility for out-of-network, cost-sharing amounts, improving accuracy of provider directories, and requiring insurers and providers to provide consumers with meaningful disclosures of out-of-network providers. Surprise balance billing happens when an individual seeks medical care from providers and facilities they believe are in their health insurance plan's network but unknowingly receives a service from an out-of-network provider. At some later point, the consumer receives a surprise bill from the out-of-network provider for which, depending on their insurance plan's out-of-network benefit, they will be responsible for paying a large portion if not all of the costs. Consumers receive surprise balance billings much more frequent-- frequently than one would think. According to a February 2018 Kaiser Family Foundation analysis, nearly one in five inpatient admissions includes a claim from an out-of-network provider. In the same analysis, Kaiser noted that patients using in-network facilities still face claims from out-of-network providers, particularly for inpatient admissions. The percentage of inpatient admissions with a claim from an out-of-network provider remains significant, 15.4 percent in fact, even when enrollees use in-network facilities. We often hear from consumers across the state that have done their research before a procedure admission and thought the providers and facilities they receive care from were in-network only to find that despite their efforts, they received unexpected and upsetting bills. This is because somewhere in their treatment an out-of-network facility was used or an out-of-network provider participated in their care. Surprise balance billing bills may also occur when a patient and-- a consumer has outpatient services. This may happen, for example, when they go to their in-network provider for services and their-- get their blood drawn or an X-ray taken down the hall only to have the blood sample sent to an out-of-network lab or the X-ray read by an out-of-network radiologist. While the dollar amounts may not be as traumatic as when

the patient is hospitalized and subjected to surprise out-of-network services, it is nonetheless troubling and may be financially devastating for a consumer who does not have a savings cushion often resulting in bankruptcies and credit rating downgrades. According to the Kaiser 2018 health tracking poll, healthcare costs continue to be an important issue. When given a list of possible worries, unexpected medical bills tops the list that includes other healthcare costs, such as premiums, deductibles, and even drug costs as well as other household expenses. Four in ten insured adults, age 18 to 64, say they have been-- there had been a time in the past twelve months that they had received an unexpected medical bill. And one in ten say they received a surprise medical bill from an out-of-network provider in the past year. Our healthcare system is already complicated, and consumers who do their best to navigate it in good faith deserve to be protected from costs that cannot be predicted and therefore cannot be avoided. When someone undergoes a major medical procedure, they need to focus on their recovery. When they and their families have taken the time to research and use providers and facilities that are in their insurer's network, the last thing people need is to get a bill in the hundreds or thousands of dollars from an out-of-network provider facility that the consumer may not have even known was involved in their care. Thank you to Senator Morfeld for introducing the bill, and thank you for the opportunity to comment on this legislation. I would be happy to answer any questions.

WILLIAMS: Thank you, Ms. Ragland. Senator McCollister.

McCOLLISTER: Thank you, Senator Williams. When a hospital employs an outside group inside the facilities, don't you think it ought to be the obligation of the hospital to equalize the charges?

JINA RAGLAND: Yes. Again, from the consumer perspective, I think that that's part of what the problem is.

McCOLLISTER: Thank you.

WILLIAMS: Additional questions? Thank you for your testimony. Would invite the next proponent? Welcome.

MOLLY McCLEERY: Hello. Chairman Williams, members of the committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm the director of the healthcare access program at Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans, and I testify today in support of

LB569. LB569 addresses a top concern-- consumer concern. I think that the data presented by both Senator Morfeld and Ms. Ragland is really compelling when we look at the concern around surprise medical bills in comparison to things that we commonly consider to be top consumer concerns in healthcare, like meeting your deductible, premiums, costs, or prescription drugs. The fact that a surprise or unexpected medical bill tops that list is really telling that this is a problem for consumers that needs to be addressed. Under our current system, consumers can exercise due diligence in an attempt to choose affordable healthcare services but still end up with unexpected, expensive bills. As others have mentioned, consumers are often unaware that they may be treated by an out-of-network provider at an in-network facility. This bill helps provide clarity for consumers through increased notice to aid and inform decision making, which is something we always ask of consumers to-- to engage in. LB569 also protects consumers financially in emergency situations when they are not able, or should not reasonably be expected to Senator McCollister's hypothetical, to shop around for an in-network provider. LB569 is a huge step forward in protecting consumers, and accordingly, we respectfully ask that the committee advance this bill. I'd be happy to take any questions.

WILLIAMS: Thank you, Ms. McCleery. Questions? Senator Gragert.

GRAGERT: Thank you, Senator Williams. I'm going to-- trying to piggyback on what Senator McCollister asked earlier-- earlier, but why isn't it if we're in a program-- network program facility that a-- and an out-of-network provider comes into that facility, aren't they agreeing for the same amount of money that a network provider would get?

MOLLY McCLEERY: So I would let providers and insurers that I'm sure will come up after me discuss that contractual relationship. I'm not entirely sure all of the motivations that they would have for entering into a-- a relationship with having a provider be an independent contractor or something like that. I think the real concern here is that this is a nearly impossible situation for a consumer to navigate. That if we-- if we are grappling with these questions and have all the resources to-- to try to figure them out, it's really difficult for a consumer who is facing a medical issue to have to parse out these questions.

GRAGERT: I was just wondering though, you know, if I'm-- if I'm a consumer or if I'm a patient trying to figure this out and I go to a

network facility, everybody in there ought to be network, or if he isn't, he's going to be willing to charge what-- what that fac-- network facility and providers charge in that facility.

MOLLY McCLEERY: I think you're pointing out the problem. You know, I think that's kind of why we all can agree that this is an issue. That is what-- that is what a consumer would expect.

GRAGERT: All right. Thank you.

WILLIAMS: Additional questions?

MOLLY McCLEERY: Thank you.

WILLIAMS: Thank you for your testimony. Invite the next proponent? Welcome, Ms. Gilbertson.

KORBY GILBERTSON: Good afternoon, Chairman Williams, members of the Committee. For the record, my name is Korby Gilbertson, 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 Nebraska Association of Health Underwriters in support of LB569. I want to talk a little bit about the health underwriters and the work that they do with their national association. And a group of them just returned from D.C. where they spent the entire time there talking about this specific issue. And they came up with four different things in their decision to support legislation of this type. The first thing that they decided was patients should never-- should be protected from surprise medical bills. Obviously, we've covered that a lot already. Patients should be informed when care is going to come out of a network. And that is an issue that has had a lot of discussion as well, in their meetings here even, where they talk about the fact that the insured doesn't even know if that's going to be in-network or out-of-network until it happens. There are different services that are provided throughout the state that people will get preapproval for, show up for. And then someone stands in for someone else, or they have a provider in a certain area that is out-of-network. And no one knows that until it happens and the person gets billed. So that is a concern both for the insurer and the patient. Secondly, they believe that there should be a federal policy covering this, not done state by state because you look at the carriers and many of them do coverage in multiple states. And having piecemeal laws across the country might be an issue. However, I also understand, and I've talked to the senator. He's very interested in making sure something gets done and is not confident that something

will happen on the federal level. I think-- personally, I think it's something that is in the forefront of things going on there, so-- but I would never guess either way on that one. But they also-- part of their policy is that the federal policy should protect consumers while restraining the costs and ensuring quality network involvement. We don't want to disincentivize network participation by providers. And our fear is that if the only thing at the end of this bill that just says that they have to negotiate with the carrier for coverage, that doesn't tie anyone to what the payment will be. It doesn't bring in all of the parties. And for-- for example, the facility that has that provider there, that is contracting or giving privileges to that provider, seems to have no skin in the game. And that might be something else that needs to be considered. And then finally, payments need to be based on a federal standard. Looking at the fact that over 100 million Americans are enrolled in self-funded plans or ERISA plans, we need to make sure that these rules, whatever is decided on how the payments will work, will work both with the private carriers as well as ERISA plans. And finally, one of the biggest-- the biggest discussions we had when talking about this bill is that the focus on the provider and insurer might be misplaced, and it might need to be more focused again on the provider and in-network facility that employs them or gives them privileges. And for that reason, we think there needs to be some additional work on this legislation to make sure that there is a standard on how the payments will be made. We do have carriers in the state that automatically right now pay the provider in-network rates. But this bill-- or right now that-- that provider doesn't have to agree to it. There could be a standard or the contracted rate is $1,000, and the provider says, no, it's going to be $19,000. There's nothing in this bill that would control those costs or do anything if they failed to make an a-- make an agreement within those 30 days. So with that, I'd be happy to answer any questions.

WILLIAMS: Thank you, Ms. Gilbertson. Questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Can you tell me, Korby, is there anything going on? You say that there's federal legislation that's being proposed. Do you know where NAHU stands on that?

KORBY GILBERTSON: They support it.

KOLTERMAN: And-- and is it-- is it-- is it moving, or is it stalemated, or?

KORBY GILBERTSON: My understanding is that it's moving. I don't know. It has not been introduced yet, but that they're working on legislature-- legislation. There are a number of senators involved in it and who have been reaching out to providers and insurance companies to discuss the best way to deal with this.

KOLTERMAN: OK. Thank you.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. Are you suggesting this bill be modified in some way to resolve some of the issues that you raised?

KORBY GILBERTSON: I think so. I-- yes, we would argue that there needs to be some more specificity in regards to what the payment would actually be instead of kind of-- instead of just saying you need to negotiate it within 30 days because there's-- what happens if they don't come to an agreement? There's nothing left at that end. The-- the legislation that I have heard about has some definitive answers in it regarding what the payment will be. There's been discussions of whether or not it is the in-network payment or a percentage of Medicare or some other factor that can be used to say if you choose to provide services in this in-network facility and you're not in-network and you provide these services, then the payer is only responsible to pay you for those-- that set amount.

McCOLLISTER: Would you be willing to work with Senator Morfeld's staff?

KORBY GILBERTSON: I am very much willing to.

McCOLLISTER: Thank you.

WILLIAMS: What you're talking about is that-- that end game, so to speak. So there is some certainty with that at the end. Has your group that's worked on this-- one of the things that you said that intrigued me and has intrigued me on this whole thing is finding a way through legislation that could potentially incent people to be in-network, not create something that all of a sudden actually incents them to not be in-network, which could happen--

KORBY GILBERTSON: Right.

WILLIAMS: -- if we don't do this right. Did your group or has your group looked at language that would do that?

KORBY GILBERTSON: No, I think they were looking at more from the standpoint of making sure that this type of legislation doesn't disincentivize people from getting into a network because they say, wow if I can charge whatever I want and dig my heels in, I'm going to get more money than the people than-- in the network. And so that's what they're concerned with.

WILLIAMS: All right. Any additional questions? Seeing none, thank you--

KORBY GILBERTSON: Thank you.

WILLIAMS: --for your testimony. I would invite any additional proponents? Anybody else to testify in support? Seeing no one coming forward, I would ask anyone who would like to come up and testify in opposition? Seeing no opposition, I would invite anyone who would like to come up and testify in a neutral capacity? Good afternoon.

MICHAEL FEAGLER: Good afternoon, Senator. All right. Good afternoon, Senator Williams and members of the Banking, Commerce and Insurance Committee. My name is Michael Feagler, I am the vice president-- excuse me, M-i-c-h-a-e-l F-e-a-g-l-e-r. I am the vice president of finance for the Nebraska Hospital Association, and I am here today in a neutral position to LB569. Surprise bills can be the cause of patient stress and financial burden at a time of vulnerability when they're in need of medical care. Patients are at risk in incurring such bills during emergencies as well as when they're-- when they schedule care at an n-work-- in-network facility without knowing the network status of all the providers who may be involved in their care. We must work together to protect patients from surprise bills. The NHA supports the purpose of LB569, however, there are a few concerns. Initially, Section 15 addresses what information that a healthcare provider shall provide on its Web site regarding their health plan precipitate-- pre-- participation. What is missing is that any requirement for health plan-- plans to promptly update their network information when changes occur with providers enter-- entering and exiting the plan's network. Section 17 and 18 which allow for the healthcare facilities and providers to bill only the-- only bill the patients for in-network, out-of-pocket costs doesn't address the transaction between the healthcare provider and the health plan. In Section 19(4), the carrier must either pay the bill charges or notify

the healthcare provider that charges are excessive. The term "excessive" is concerned. Who determines what excessive is? We wonder if there couldn't be better terminology for that-- in that area. In Section 19(5), the parties have 30 days to reach settlement on the reimbursement of the claim. What occurs at the end of the 30 days if no settlement is reached? What is to prevent the health plan from slow "paying" the negotiation process such that a settlement can't be re-- reached? There are a few other items that also-- we would also like the committee to consider that are not addressed in LB569, such as self-funded health plans that are regulated at the federal level under ERISA. We need a federal solution to help-- assist with this issue. Network adequacy-- adequacy issues can impact this issue. LB569 does not address the issue of health plans denying services in emergency settings as unnecessary on a retrospective basis. It needs to incorporate a-- some sort of a prudent layperson standard to prevent this type of denial, which is another type of surprise bill that-- that individuals will-- can incur. We encourage Senator Morfeld and the Banking, Commerce and Insurance Committee to work with the NHA to address the issues of concern or to introduce an interim study to continue the discussion. This is too important of an issue not to ensure that we are considering all the aspects of the issue. We bring together the pertinent stakeholders to discuss the issue and find the most beneficial solution to protect all Nebraskans from surprise billings. Additionally, we feel it's important to ensure that any state and federal legislation work in concert to address the issue. The American Hospital Association and five other national healthcare organizations are working together with legislatures in Washington, D.C., to address this issue as well. The NHA and its members look forward to having the opportunity to discuss solutions and working together to achieve those solutions. Included in the information provided to you, there are some points that we believe are critical to consider in finding a solution to this issue. I thank you for the opportunity to speak with you today, and I'm willing to answer any questions you might have.

WILLIAMS: Thank you, Mr. Feagler. Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. Couple of questions. Are you suggesting that we should wait for a solution out of Washington before we find a solution in Nebraska?

MICHAEL FEAGLER: Not necessarily. What I'm saying is-- is that we need to be-- we-- what we need to make sure is that what we do in Nebraska

works in concert with whatever the federal government is going to do. The federal government is looking at this issue. Currently there are two bills that have been introduced into the Senate as well as another one that's been drafted for introduction. The NHA, along with these other five national hospital organizations, medical college organizations, have been working with these senators to fight-- to put together a solution that will help at the federal level. Now, like I said, ERISA plans, which are self-funded plans, they are-- they're regulated at a federal level. So how would this-- would this sort of legislation impact those? And will it-- what would-- what-- we might have crossover or things that might not be in congruency, you know, in terms of where the federal and state was.

McCOLLISTER: Well, it could well be this bill won't take care of every eventuality, but we do need to move something forward. You brought-- brought up the idea of denying claims on a retrospective basis. And why is that a new issue because I-- I would assume that that's been an issue of longstanding, correct?

MICHAEL FEAGLER: It is a been an issue of longstanding, and you know, we-- we've brought it up here-- part of this is because it is another type of surprise bill that, you know, the patient or the beneficiary would-- would see. But-- but-- you know, this type of legislation did not address it, so that's why we brought it forward as another issue that we need to be looking at.

McCOLLISTER: Why would a hospital, sir, be willing to contract with an outside group who is out-of-network inside the facility? I'm having a hard time understanding that-- that issue.

MICHAEL FEAGLER: In terms of that-- that issue, you know, I'm-- not being in the hospital, I can't answer that directly. But there are issues-- when you're-- when-- when a phys-- hospital and an independent physician are-- there are issues in terms of they-- when they're contracting with insurances, hospitals and independent physicians have to work separately in terms of that. You know, there's antitrust, there's collective bargaining issues, things like that, that play into that.

McCOLLISTER: Thank you.

WILLIAMS: Additional questions? Seeing none, thank you, Mr. Feagler,--

MICHAEL FEAGLER: Thank you.

WILLIAMS: --for your testimony. Invite the next neutral testifier? Good afternoon.

RUSS GRONEWOLD: Good afternoon, Chairperson Williams and members of the Banking, Commerce and Insurance Committee. I'm Russ Gronewold, R-u-s-s G-r-o-n-e-w-o-l-d, and I'm the CFO at Bryan Health and representing Bryan Health this afternoon. We are testify-- we're testifying specifically neutral on this, but we'd like to become supporters on this if we can get some underlying-- we support the underlying principles, specifically those that hold the patient harmless. But there are a few other things that we'd like to continue the bill to work on. So I'm just going to highlight a few points from my written testimony; I won't read it all to you. But surprise billing has been around for a long time as has already been mentioned. And to protect people from surprise bills and frankly, to help ourselves get a better chance at getting paid, we have 15 full-time people verifying insurance and preauthorizing procedures on an ongoing basis. We've had that for a long time. And with that-- even with all of those folks working on it full-time, we only get it right 88 percent of the time. You might say, well, how can you not get it right the other 12 percent of the time? If folks schedule ahead of time and we've got a couple of days to work on this, we get it right 100 percent of the time. It's just that that's not what always happens in a 24/7 operation. A lot of times we'll-- we see folks that need nonemergent care but it's-- it's nonemergent still, but they need to get that course of treatment going very quickly. So a mom picks up a kid at the end of the day, goes to the urgent care, and the doctor says, we need to start this course of treatment. However, I want to rule something out first. Go to Bryan. Go get this lab test and get this scan before I decide on that final course of treatment. That's all done after hours many times. Nobody is there for us to verify-- verify insurance. And so at that point, they're subject-- potentially subject to a surprise situation for themselves if we can't verify insurance. That's not the only reason. Other reasons we can't get it done, 1 out of 14 people come in giving us their insurance, and they've given us the wrong insurance, 1 out of 14. We have a 130,000 unique patients each year that we see, and 1 out of 14 is a lot of folks that have to have their insurance changed. They didn't do it on purpose. Mom or Dad's insurance changed, and they forgot to tell their son and daughter going back to college. Could be a spouse's insurance or partner's insurance has changed. So these things can-- it's not unusual for us to have literally thousands of

people each year that we're changing insurance on after they've given us their insurance. A lot's been talked about in terms of the nature of physician and hospital relationships. So in-- in Omaha, where I spent 25 years, many, many, if not most physicians are employed there. In Lincoln, small towns throughout Nebraska, 85 percent of our physicians are independent physicians. And so with that, we are not party to their negotiations nor can we be party to their negotiations with insurers. We do our best but-- but there-- at all times, little small practices, two and three people, partners leaving, new partners coming, they're going in and out of a network. They're going in and out of medical staffs. And so we don't know at any given time exactly who's on that-- that network. And we may look at the latest report, but it that may not have been updated yet. And so really there's only one source of truth when it comes to all of this. This only source of truth is the payer. They're the only one that knows exactly who's in the network at any given time no matter how hard we may try. And so a physician, while a person's in the hospital, maybe even an inpatient stay, is referring to a group that they're totally familiar with. But that group may have a new person coming on that they've applied for-- for credentials for the payer but may not have come through yet. And so I don't-- those providers, many of those physicians, wouldn't have any idea who's on the network in the middle of a very fast-moving, inpatient case. My point in all-- all of this is that while we think hospitals bear some responsibility and-- for the solution in this, it can't be the only responsibility. The legislation really puts a lot of responsibility on the hospital and providers. But we really think that the insurance companies really have a large part to play in the success of this. And without getting some of that responsibility in here, it really gives some very large insurance companies, really three or four very, very large insurance companies, a lot of leverage over very small practices such that we-- as we've seen already throughout the state, you'll see much-- many disparate payment relationships between Omaha and Lincoln and smaller towns because of the leverage they're able to bear. So somehow we have to get all of that together so we don't create all of those disparities. There's some other areas, that have already been talked about, that we think can also be cleared up a little bit. We'd like to work to help clear some of those things up, but-- but really that's where we'd like to do is-- is get the payers primarily responsible in concert with us to fix this problem.

WILLIAMS: Thank you. Questions for Mr. Gronewold? Senator McCollister.

McCOLLISTER: Yeah. Thank you, Mr. Gronewold, for being here. Capture some of the questions probably took a certain amount of courage. But doesn't a person walking into your facility make the implied assumption that all of the physicians inside that facility are in-network?

RUSS GRONEWOLD: So I think that they would have the assumption that certain physicians would be in-network, sort of standard ones that you might see in a procedure like an anesthesiologist or a radiologist and so forth. I think it's not-- that's not the case when it comes to, say, a surgeon who's on our medical staff. And all of these folks will apply to our medical staff, and they'll be on our medical staff and credentialed for that. But there may be a number of physicians that-- that they would be looking at in their narrow network and should know, if-- if they're completely informed by their employer or payer, that-- that-- that they may not be. So the answer is, I think, some yes, some no.

McCOLLISTER: What's-- re-- repeat that answer to me again, if you would.

RUSS GRONEWOLD: OK. When a narrow network is formed as an example-- and there are broad networks and there are narrow networks. And a narrow network is formed. They will go out, the insurer, and try to get a certain amount of adequacy that they believe that they can sell, something that will comply with the ACA regulations. But they don't have to have everybody, and it's not all willing comers. In fact, sometimes Bryan is left out of those networks. And people don't even know that Bryan's not in the network even though we might be the only, say, behavioral or trauma facility in the area. So people will show up not knowing that the network's not completely filled out either in physicians or in hospitals. But I think if they've looked-- if they've looked on their network and they see Bryan as an in-network facility, they should have an expectation that certain specialties that are-- that work only in hospitals, like the hospitalist and like the anesthesiologist for example, they-- they should have an expectation that they're-- that they would be included. And if not, if they wouldn't be included, we very much think that they should be held harmless in that process.

McCOLLISTER: So Bryan is a large hospital in Lincoln. You have a broad network, correct? And you make an effort to fill out the-- all the empty blanks in your network, I would assume.

RUSS GRONEWOLD: So we don't have any networks. We have a medical staff. But the networks are formed, not by Bryan, but by insurance companies. So the insurance companies-- I can think of two, for example, networks we're not-- insurance networks we're not in right now. We've not been either asked to be in or even allowed to be in even when we've asked to be in. So we can be out-of-network, and we're actually sort of on the surprise billing side too. We'll get people who come into our insurance-- our, excuse me, into our emergency department or into our behavioral health. We need to take them because they need to be treated there. And then we will be out-of-network not because we want to be, but because we are automatically. And so now we're in the negotiation process with the insurance company to get paid for those.

McCOLLISTER: How many networks are there that you attempt to work with?

RUSS GRONEWOLD: Oh, we must be in about, I would say, about a dozen organized networks, everything from Medicare networks, Medicaid networks, and commercial networks. And there would be about two or three that we would not be in.

McCOLLISTER: Wouldn't it be in your best interest to have relationships with all of the networks?

RUSS GRONEWOLD: We would love to be in all of the networks. They won't allow us to be in the networks. So networks-- so, again, there are narrow networks set up by the insurers with special relationships with our competition that have excluded us from the network.

McCOLLISTER: Thank you very much,--

RUSS GRONEWOLD: Um-hum.

McCOLLISTER: --Mr. Gronewold.

WILLIAMS: Additional questions? One question you might be able to help me with. We've heard some comments about ERISA plans?

RUSS GRONEWOLD: Yes.

WILLIAMS: From your customer base and seeing that number of patients come in, what percentage of them, could we at least have in the back of our mind, are covered by ERISA-type plans?

RUSS GRONEWOLD: That's a really good question that I won't know the answer to, but let me just give it a guess like this. If you think of what comes into Bryan, 60 percent Medicare and Medicaid, another 6 percent uninsured. So that's two-thirds of the patients right there. That leaves a third left, and of that third, about two-- about half of those, or maybe a little more, are by large-- are covered by large employers, typically many ERISA plans. So it-- it would be probably, you know, I'm going to guess 15 percent give or take a few percentage points would be my guess.

WILLIAMS: It's-- it's not an insignificant number.

RUSS GRONEWOLD: It is not an insignificant amount, right.

WILLIAMS: Any additional questions? Seeing none, thank you, Mr. Gronewold, for your--

GRAGERT: Real quick, are you related to--

WILLIAMS: Oop, excuse me, Mr. Gragert.

GRAGERT: -- Scott Gronewold?

WILLIAMS: Go ahead, Senator Gragert.

GRAGERT: Are you related to Scott Gronewold?

RUSS GRONEWOLD: Yes, he's what I-- well, if he were here, he would say that he is the taller, more handsome brother, but that's still debatable.

GRAGERT: OK. I just served with him in the military.

WILLIAMS: Invite the next neutral testifier? Welcome, Ms. Robak.

KIM ROBAK: Thank you, Senator Williams. Senator Williams and members of the committee, my name is Kim Robak, K-i-m R-o-b-a-k. I'm here today on behalf of the Nebraska Medical Association in a neutral position on LB569. I have to tell you that listening to this and the discussion, it's very evident that this is a complicated and very confusing issue. It's complicated for a number of reasons, but in large part because we want our healthcare and we want a lot of our healthcare. And we want good healthcare in the United States, and we're fortunate because we have it. What happens, however, and, Senator McCollister, to your comment about the assumption-- when you

go into a hospital, the assumption is that I'm going to get-- I always thought I'd get one bill, that I'd get one bill from the hospital, and it would have everything in it. Well, I found out, after having been in the hospital more than once, that you don't get one bill. You get a bill for the hospital facility. You might get a bill for the doctor. You might get a bill for the pathologist, or the radiologist, or somebody else who is not a-- an employee of the hospital but an outsourced service. And so you would get this number of bills that come in over a period of time. And some of those are surprise bills, meaning I didn't expect them. And some of them are bills that are a surprise because they're out-of-network, something that I wasn't considering. I didn't know that people who are providing these extra services weren't covered by my plan. What I believe Senator Morfeld is attempting to do, and what the NMA would like to help get done, is-- is provide more transparency and provide options to individuals who are going through this process so that I know that everybody's not in my plan and that I have some options with regard to that. There are-- there are two problems that I want to lay out for you and that we hope to be able to work with Senator Morfeld on. The first one deals with emergency services. What happens under the bill is, as it's-- as it's written today, is that-- that under this emergency services plan, you would-- you would be billed at the lowest-- or at the rate that the inpatient-- or the in-network cost is. So let's say, I have an out of-- I have an out-of-network physician. They bill at a higher rate. The-- the in-network costs would be substantially lower. And when you heard the last testifier talk about small networks, the reason that they're small networks is because they negotiate a really low rate. And they-- they-- so they want to get patients to go to that area, and they negotiate this really low rate. What can happen in that instance, if you pay only that low rate and not a rate that would be considered to be a rate that would be reasonable in the area for that service, then you would be undercompensating physicians. And you would be encouraging people not to be part of the network, Senator, as you've stated earlier. There are a number of databases. There is one called the FAIR Health, a database that is a database of physician charges, that's geographically specific. It's completely transparent, and it's independent of the control of the payers or the providers. And so you could use that as a standard to say, OK, if you-- if you don't-- if you're out-of-network, you have to be paid at this-- or 80 percent of this rate or 70 percent of that rate, so that you could have a-- a stable amount that would be paid for. So that's one thought. The second one has to do with knowing in advance and giving knowledge-- or telling you who this person is going to be that you're going to be

using, transparency piece. There is a concern that sometimes we don't know. Now you could say, how-- how could you possibly not know? Let's assume that you're in the middle of a procedure in an outpatient facility, and that you have now discovered something that needs to go to a pathologist. There is actually an incident where the physician sent out the sample or the-- the-- the tissue to four separate pathologists before it was discovered what the cancer was so that they could determine next-- the next scope of care. How much further do we need to take out? Do we need to go to the lymph nodes, etcetera? So there would be four instances, four separate pathology departments, many of-- many that may be in-network or could be out-of-network, but we wouldn't have been able to tell you that in advance. One of the things that we could do, however, is say there is the potential for out-of-network costs. You should be aware that there would be some costs. I don't know if that solves the problem, but it certainly gets you in the direction of giving more information to the consumer. Again, incredibly complicated. We want to work with Senator Morfeld. There is a problem that does need to get fixed. We just want to make sure we don't make the problem worse instead of making it better. I'd be happy to answer any questions.

WILLIAMS: Thank you, Ms. Robak. Questions? Seeing no questions, thank you for your testimony. Invite the next neutral testifier? Welcome back, Mr. Dunning.

ERIC DUNNING: Good afternoon, Mr. Chairman and members of the Banking, Commerce and Insurance Committee. My name is Eric Dunning. For the record, that's spelled E-r-i-c D-u-n-n-i-n-g. I'm a registered lobbyist hearing-- here today on behalf of Blue Cross and Blue Shield of Nebraska in a neutral capacity on LB569. Since 1939 Blue Cross and Blue Shield of Nebraska has worked hard to encourage the health and wellness of all Nebraskans of all ages. Our mission is to lead the way in supporting patient-focused care, to achieve a healthcare world without confusion that adds more good years to people's lives. This bill's focus on consumer empowerment is truly worthy of support and lines up really well with our mission. So any initiative that will increase consumer awareness about the services that they are buying is something that we can wholeheartedly support. We absolutely share Senator Morfeld's concerns on the subject and work hard in our contract negotiations and network design to avoid just these problems. That said, we believe that the Legislature needs to tread carefully in this area and to carefully consider proposed solutions because the situation, as you've heard today, is complicated. And a flawed

solution will only reward those who charge excessive amounts for their services. When hospitals hold themselves out to be in-network, we are concerned that certain core functions of the institution, such as the ER staff, radiology, anesthesiologists, and pathologists in particular can remain out-of-network, sometimes intentionally. While our members expect that outside specialists and others can be out-of-network and routinely check for that status when they're seeking medical care, they are not aware that a last-minute staffing shortfall at an in-network hospital can lead to an unaffordable balance bill for such things as anesthesiologists and radiologists and pathologists when they're released. This is an issue that can affect our members who are receiving emergency services in hospital emergency rooms as well as services made by out-of-network specialty providers that the hospital, and not the member, chooses. We've seen air ambulance providers, for example, that were labeled as being part of the hospital, on the air flight-- on the aircraft claim that they are not part of the negotiation and not part of the network to which their-- their hospital was a member. In an emergency setting, federal law already requires insurers to step up to provide insurers-- insureds with in-network cost-sharing even when the provider is out-of-network. That is, we impose any cost-sharing requirements as if the provider was in-network, and we-- and we make up that difference. However, because it's out-of-network care, the provider can still bill the member for the full amount of services provide-- received. And to counter this as much as possible, we maintain extensive tools to help our members understand which providers are and are not in-network so that they can plan accordingly. In other states, these bottlenecks in the delivery system have created some significant cost pressure with negative impacts on consumers. Nationally, according to a recent study published by the Brookings Institute, med-- and-- but again these are national numbers, median charges for an anesthesiologist is 5.5 times that-- the rate set by Medicare. And the top 20 percent of those charges is at about 11 percent-- or 11 times the Medicare rate. This is the most startling example, but in that context, the average-- to put that in context, the average for all physicians is a charge that's 2.4 times the Medicare rate, and at that upper 20 percent, 4.6 times the Medicare rate. Up till now, this is-- has-- this has been a relatively rare issue in Nebraska. Other states have more experience with this problem. The solutions they have developed, though, have in some cases created other problems which have increased costs for both consumers and hospitals. And we would urge caution as we sort through the issues in this area. The bill has some important features that should be included in any solution. The bill requires notice to

potential patients and prohibits providers from balance billing the patients. We think those are very strong features. We believe prohibiting balance billing really needs to be at the core of any solution. However, the bill limits an important patient protection in that it requires payment be made directly to the provider. That assignment-of-benefits provision limits an important tool in negotiations, that is, to allow the withholding of funds un-- until an agreement that is acceptable to all sides is-- is reached at. Bills in other states have gone beyond the provisions of LB569 to mandate the result of any dispute between the insurer and the provider which cannot be resolved. In many instances, this boils down to the insurer paying the higher of either the insurer's normal allowed amount or some sort of benchmark, either Medicare or some discount of-- off the bill charged. Other states have reported that these solutions have created distortions that drive the cost of higher-- healthcare higher or provide incentives-- incentives for specialty providers to deliberately sit out of network so they can obtain higher reimbursements. That doesn't seem like a good result for hospitals, insurers, or patients. To close, in response to inquiries from Congress, Blue Plans and other stakeholders have been asked to provide information on the proposed solutions to the issue. Working with our fellow Blue Plans around the country, we've developed a series of principles which I've asked to be distributed to the committee. We think they're a great resource as the process moves forward. National reports indicate that not only Blue Plans but others are developing principles on-- in this issue. As Congress moves forward to a federal solution, that solution which is still in the works as Senate Health Committee staff meet with patient groups-- excuse me-- and with that, I see I'm out of time.

WILLIAMS: Would you like to finish your-- your conclusion?

ERIC DUNNING: Thank you, sir. Senate Health Committee staff are meeting with patient groups and the spectrum of int-- interested parties. And we expect that-- that legislation to be introduced soon. In addition, at a one-- recent White House event, the president expressed a strong interest in getting this issue resolved in a way that benefits patients.

WILLIAMS: Thank you, Mr. Dunning. Questions? Seeing none, thank you for your testimony. Next neutral testifier? Welcome back, Mr. Tabor.

NOAH TABOR: Thank you, Mr. Chairman and members of the committee. Again, for the record, Noah Tabor, N-o-a-h T-a-b-o-r; I'm with Medica

Health Plan. I want to echo a lot of the commentary that's been raised today and applaud Senator Morfeld for bringing forward this legislation. Short of the price of prescription drugs, I would proffer that this is probably one of the most important national healthcare topics. Patients, insurers, hospitals, providers, we all have a vested interest in coming to a good solution, a solution that works for Nebraska. Medica operates in nine states currently. When states pursue solutions to complex problems like this, even good solutions, that causes us some pause, and it's certainly something that has operational considerations for us. We certainly commend the proposals espoused in the bill before us today, especially those regarding notice and efforts to curb surprise billing. However, as Ms. Gilbertson alluded to the end game, Mr. Chairman, how do we resolve those disputes at the end of the bill? The angels and the devil lie in those details. We would certainly like to see final consideration, the solution, have some considerations of what is that end game. Our national trade association, the American-- America's Health Insurance Plans, AHIP, is also very active on this issue at the federal level. We have some materials before you. I will say, to poke at our dear AHIP friends, anytime they put draft on watermarks, you know they're serious about moving things forward. They are very interested in working towards a federal solution that works for all groups. I will say while, Senator McCollister, the federal government at best lumbers about, this is an issue with some verve. This is an issue that, I would guess, all of the entities that came before us today, their national counterparts are working on. I am confident there will be a national solution. If a national solution stalls, a national solution isn't addressing the needs that need to be addressed. There is time for consideration. The individual market in Nebraska is very near and dear to Medica's heart. It's obviously where we serve our members. We love that market. That market, for many years now, has been held together with bubble gum and shoe strings, and it is in a status quo fashion right now. The bedrock of our ability to serve Nebraskans is our networks. We love the buyers we work with here. We are proud of the networks we have. The unintended consequences in the bill before us and what could this mean for networks is something that gives me pause. I am just a farm boy from Iowa. I leave it to more smarter folks than myself on what those unintended consequences could be. But it's really something worth consideration, deliberation and thought. As the city-- as the committee considers this bill and this issue broadly, we would encourage a measured approach. We certainly look forward to working with stakeholders, Senator Morfeld, and the committee this session, this summer, and in the sessions to come to

find something that works. And with that, I'm happy to answer questions.

WILLIAMS: Thank you, Mr. Tabor. Questions? Seeing none, thank you for your testimony. Any additional neutral testifiers? Seeing none, we would invite Senator Morfeld to close. Welcome back.

MORFELD: Thank you, Chairman Williams, members of the committee. I think if there's one thing that we can conclude on, it is that this is complicated, but that doesn't mean that we shouldn't take action. Also, I didn't see any opposition testimonies, so I'm thinking consent calendar. So we'll talk about that later. That will be the last time somebody doesn't oppose one of my bills in here. But in any case, in all seriousness, I-- I think that, you know, first off, while I appreciate folks on the federal level are finally taking this seriously after years of being a problem, I don't think that that should stop us from taking action. That's called a-- that's called a part of federalism. And if there's one thing I can guarantee you, it's that the federal solution will not be perfect nor will our solution be perfect. But the only thing that's even worse than being imperfect is not doing anything at all in this case. And I think we can be a leader in taking action on this and be a model for a federal solution. If that federal solution gets done this year and our solution somehow conflicts with that federal solution, well, that's why we have the supremacy clause. The federal solution will obviously trump in places that-- that the federal law and the state law directly conflicts. That being said, in addition, I-- I think that one of the things that's clear is that the person that is the least situated to be in the best position to understand these issues is the consumer. The insurers, the providers, and the hospitals have the most resources and the most information to be able to inform the consumer. And those are the people that should be responsible for informing the consumer of their options, and of solutions, and ways to move forward. I-- there's two aspects to this bill obviously, maybe three, depending on the way you look at it. First is the-- the transparency aspect, letting the consumer know, particularly in nonemergency situations, what their options are, what's-- what's covered and what's not covered, and letting them make a decision. And then there's obviously the emergency and nonemergency medical issues. The transparency part, I think, is important. But that being said, in certain circumstances not even transparency is going to be able to help that consumer, particularly in some of those emergency medical situations. And I think that-- I think that we need to put the hospitals, the insurers, and the

providers in the sit-- in the position where they're providing the most information and negotiating some of the details after-- after the fact. So that being said, I'm more than happy to work with the committee. This is a bill that is-- I'm not just introducing to introduce and learn some more and have a good discussion on. I want to get something across the finish line, preferably this year, but definitely by the-- by the end of next session. So I look forward to working with all the different stakeholders, and I've asked them to come to me with solutions sooner than later. And I'd be happy to answer any questions.

WILLIAMS: Thank you, Senator Morfeld. Any final questions for the senator?

MORFELD: I must be the last hearing of the day.

KOLTERMAN: You are.

MORFELD: Thank you.

WILLIAMS: Thank you very much. That will close the public hearing on LB569. I do need to go back, however, on the record for LB619. That was Senator Kolowski's bill. I forgot to read the letters that we received into the record. So on LB619, there were seven proponent letters from: Terry Werner from the National Association of Social Workers; Will Spaulding from the Nebraska Psychological Association; Julia Tse from Voices for Children; Beth Ann Brooks from the Nebraska Regional Council of American Academy of Child and Adolescent Psychiatry; Caroline Win-- Winchester, Superintendent, Chadron Public Schools; Mary Bahney, School Social Work Association of Nebraska; and, Joe Pittman from NAIFA Nebraska. There were no letters in opposition and no neutral testimony. Thank you. Now we are adjourned and we will not be--