JACOBSON: [RECORDER MALFUNCTION] begin committee hearing today. I'd like to welcome you to the Banking, Commerce and Insurance Committee hearing. My name is Mike Jacobson. I'm from North Platte and represent the 42nd Legislative District. I serve as Vice Chair of the committee. The committee will take up the bills in the order posted. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. Committee members will come and go during the hearing. We have to introduce bills at other committees and we are called away. It is not an indication we are not interested in the bill that you-- being heard in this committee, just part of the process. To better facilitate today's proceedings. I'd like you to abide by the following procedures. First, please silence your phones or turn them to vibrate. Move to the front row when you're ready to testify. Our order of testimony will be the introducer, the proponents, opponents, neutral testimony, and closing. Hand your green sign in sheet to the committee clerk when you come up to testify. Spell your name for the record before you testify. Be concise. It is my request that you limit your testimony to three minutes. If your testimony goes beyond three minutes, I will ask you to conclude your remarks. And there's very likely that if the committee members want you to finish, they'll ask you a question that may be-- while you do finish that comment. If you, if you will not be testifying at the microphone but want to go on the record as having a position on a bill being heard today, there are gold sheets at each entrance where you may leave your name and 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 while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We need ten copies. If you have written testimony but do not have ten copies, please raise your hand now so the page can make copies for you. To my immediate, I guess to my immediate left in the empty chair is Senator, our Chairman, Chairman, Julie Slama, who will be gone today. Thus you have me, and I will start on my extreme left with Senator Bostar, and have each senator introduce themselves.

BOSTAR: Eliot Bostar, District 29.

VON GILLERN: Brad von Gillern, District 9.

AGUILAR: Ray Aguilar District 35.

KAUTH: Kathleen Kauth, District 31.

BALLARD: Beau Ballard, District 21.

DUNGAN: George Dungan, District 26.

JACOBSON: To my immediate left is committee counsel Joshua Christolear. And to the end of the table is our committee clerk, Natalie Schunk. The committee members have, of course, introduced themselves. And we also have-- we will have two pages today. We have one right now, Mattie [PHONETIC]and Mia. So with that, we're ready to begin. And since I have the first bill up, I'm going to turn the Chair over to Senator Bostar, while I testify.

BOSTAR: Thank you. So we'll open the hearing on LB852. Welcome, Senator.

JACOBSON: Well good af-- good afternoon, Senator Bostarr and members of the Banking, Commerce and Insurance Committee. My name is Mike Jacobson, spelled M-i-k-e J-a-c-o-b-s-o-n. I represent Legislative District 42. I am here today to introduce LB852. LB852 solves an issue that was brought to my attention by the members of the Nebraska insurance industry while discussing other Medicare insurance issues. Medicare, as a reminder, is the federal health insurance program for seniors and, and certain disabled individuals. Specifically, the issue relates to a loophole in federal Medicare law exploited by a small number of durable medical equipment suppliers to the detriment of Medicare beneficiaries in Nebraska and Medicare supplement issuers-- insurers. Under current federal guidelines, nonparticipating Medicare providers are health care providers who do not accept assignment of a claim, which means that they do not have to file the claim with Medicare on the beneficiaries behalf. But a nonparticipating provider does accept the Medicare approved rate for most services. Such nonparticipating providers are of-- are prohibited from charging more than 15% higher than the Medicare rate. Other tops-- types of health care providers are those who accept assignment and work directly with Medicare, and those who opted out of Medicare altogether. Durable medical equipment, or DME, suppliers are businesses that supply home health equipment that is reusable, such as wheelchairs, home oxygen equipment, prosthetics, etc. while the cap on nonparticipating providers of 15% higher than the Medicare reimbursement rate applies to all other types of medical services, such as physician services and hospital services, the federal government has not applied this rule to DME suppliers. This has led to some DME suppliers to charge both

beneficiaries and Medicare supplement insurers rates, significantly higher than the Medicare rates, to the level that the insurers believe that that the levels are abusive. And I know they will testify behind me, to some-- to provide some examples. These charges over the Medicare rates are paid by both insurer and the beneficiary. When the beneficiary pays the difference between what Medicare paid and the bills charge, this is known as balance billing. When the insurer pays the excess payments, that leads to higher premiums to all senior citizens. LB852 simply closes this loophole to protect Nebraskans by simply applying the 15% cap that applies to all other health providers, to DME suppliers as well. With that, I would stop and ask for any questions.

BOSTAR: Thank you, Senator. Any questions from the committee? Seeing none. Thank you very much. First proponent. Welcome.

JEREMIAH BLAKE: Thank you, Senator. Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B as in boy l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in support of LB852. I want to express my sincere appreciation to Senator Jacobson for introducing this bill. LB852 would close a loophole in federal law to protect seniors from excessive charges for durable medical equipment. Specifically, LB852 would apply the same federal limit to DME suppliers that is currently in place for all other medical providers. Under federal law, Medicare providers who choose not to accept Medicare assignment can charge a Medicare beneficiary no more than 115% of the Medicare approved amount. LB852 would apply the same cap of 115% to DME suppliers. The vast majority of DME suppliers in Nebraska are honest businesses providing an important service to seniors. However, we receive claims from a very, very small number of DME suppliers who are exploiting a loophole in federal law and submitting claims that we are-- that we believe, at the very least, are waste and abuse because of the exorbitant prices. A common example of these types of claims we receive are for power wheelchairs. If you look at one DME supplier's website, the most expensive power wheelchair they offer costs about $7,000. Yet, we receive claims from suppliers in the range from $28,000 to $36,000 for these power wheelchairs. Unfortunately, we have no legal recourse to contest or deny the claims, since Medicare supplement plans are required to pay the excess-- pay all excess charges for our members. In effect, we were paying for new cars, not power wheelchairs. These claims are coming from a very small number of DME suppliers, but they are having a significant impact on claims

costs, which are ultimately are passed on to seniors in the forms of premiums. Over the last several years, we have tried different avenues to put an end to these abusive claims. We worked with our colleagues at Mutual of Omaha and mutu-- other Medicare supplement carriers to raise this issue with the Nebrask-- or the National Association of Insurance Commissioners. The NAIC, as a result, asked the federal government to clarify that the federal cap on the amount a medical provider can charge Medicare beneficiaries also applies to DME suppliers. We also worked with the Blue Cross and Blue Shield Association to ask Medicare to investigate these claims as fraud, waste and abuse. Unfortunately, those efforts have been unsuccessful, which leads us to LB852. This bill will have no impact on those DME suppliers who accept Medicare assignment. However, LB852 will put an end to the abusive claims that we are currently seeing from a very small number of DME suppliers. I encourage you to advance this bill to general file to protect seniors from excessive claims and higher Medicare supplement premiums. Again, I want to thank Senator Jacobson. I'd be happy to answer any questions you have.

BOSTAR: Thank you, Mr. Blake. Questions from the committee. Senator Kauth.

KAUTH: Mr. Blake, thank you. OK. I have a couple of questions. My first thought on this is that we're limiting private businesses to charge what they will, and people can choose to buy it or not. But you said something about the Medicare supplement plans. Can you go into that more detail for me?

JEREMIAH BLAKE: Yes. So right now there is a federal law that prohibits all other Medicare providers from essentially balance billing Medicare beneficiaries. If-- that law applies to hospitals, doctors, any other provider. CMS has interpreted that federal law does not apply to DME suppliers. Right? So that's the first issue we have is that there isn't a cap on what they can charge. And then we have a, a requirement under state regulations to play-- to-- let me back up. As Medicare supplement plans, we are obligated to pay any excess charges that our members see from providers. So we get a claim from a DME supplier for an amount, we have to pay that claim. We have no ability to negotiate, deny or anything else. We just have to accept whatever they, they charge.

KAUTH: And is that-- so our DMEs providers, are they automatically just anybody who provides this equipment can be considered a DME provider, or do they already have to be established within the

Medicare or Medicaid framework? Are they accepting Medicare payments for other things, and so that qualifies them? I guess, at what point do you say, OK, this is just someone with a couple extra wheelchairs who's renting them out?

JEREMIAH BLAKE: Yeah. So a DME supplier can choose a couple of different things. They can choose to participate in Medicare. And under that situation they would see a Medicare beneficiary, they would bill Medicare directly, and Medicare would pay them whatever the fee schedule allows. There's also an option for a DME supplier to accept assignment, which is basically the same thing, it's just they do it on a, as I understand it, kind of a claim by claim basis. And they can also choose not to accept assignment, which is at that point it becomes the seniors responsibility to pay whatever charge the DME supplier determines is appropriate. If they have a Medicare supplement plan, whether or not they have a Medicare supplement plan, the member is responsible for that cost. If they have a Medicare supplement plan that cost transfers to the Medicare supplement plan.

KAUTH: OK. So--

JEREMIAH BLAKE: Does that makes sense?

KAUTH: A little bit. Let me walk--

JEREMIAH BLAKE: It's a lot.

KAUTH: So so if, if-- so my dad needs a motorized wheelchair--

JEREMIAH BLAKE: Yes.

KAUTH: And so he goes and says, hey, this is the one I want. And I pull some up. There's some really cool power wheelchairs out there. So he says this is the one I want. It costs $18,000. Medicare has said we think you should only get a $7,000 one. So if he goes to someplace that has chosen to participate, they would say, we can give you the $7,000 one. Would they then say you have to pay anything else if you want it?

JEREMIAH BLAKE: It has to be a Medicare covered piece of equipment, right.

KAUTH: So it already has to be-- medicare has already had to look at it and say, okay, we won't pay for anything that's not already Medicare covered. So even with the supplemental. So if somebody has a

supplemental, they say yeah but I really, really, really want this one. Unless Medicare has said these are the ones that we cover--

JEREMIAH BLAKE: I'm going to defer that to the testifier behind me. I think she'll have a little more expertise into that kind of detail.

KAUTH: OK. OK. Thank you.

JEREMIAH BLAKE: Thank you.

KAUTH: That's just some noodling I'm doing.

BOSTAR: Senator Dungan.

DUNGAN: Thank you. And thank you for being here. I'm also trying to wrap my head, I think, around a little bit of the process, but I do appreciate you kind of explaining that. That makes more sense. Is it just to make sure I understand, too, when you're talking about these, like $28,000, $30,000 claims, do you, based on your experience and your sort of knowledge of this field, see any rational connection between the amount that you're being asked to pay and the actual DME that the person's purchasing? Because it sounds like to me that the $28,000, $30,000 is astronomically high, right? That that's not even a rational connection to even the more expensive $18,000, $10,000 wheelchair. Is there any rational connection between that dollar amount? Or do you think that legitimately it's just an overcharge to get extra money that you then have to pay?

JEREMIAH BLAKE: I would say those claims are an anomaly in what we see for other durable medical equipment from other suppliers.

DUNGAN: OK. Thank you.

JEREMIAH BLAKE: They stand out. Yeah.

BOSTAR: Thank you, Senator Dungan. Any other questions from the committee? Thank you, Mr. Blake.

JEREMIAH BLAKE: Thank you.

BOSTAR: Next proponent. Welcome.

KELLIE HARRY: Hi. Good afternoon, Senator Bostar, members of the committee. My name is Kellie Harry. K-e-l-l-i-e H-a-r-r-y. I'm a senior associate counsel with Mutual of Omaha, here today to testify

in support of LB852. I'd also like to start by thanking Senator Jacobson and his staff for their work on this important bill, and to thank the committee for your consideration of this matter today. Mutual of Omaha Insurance Company is headquartered in Nebraska, and at present is the third largest carrier of Medicare supplement plans in the nation. Medicare supplement, Medsup, Medigap, it's known by a lot of names. Those policies are designed to cover the out-of-pocket expenses that are incurred by traditional Medicare beneficiaries. LB852 is before you today to address abuse of claims that we're seeing from certain suppliers of durable medical equipment. And I, I did hear some of the questions that were posed, and I'm hopeful that, that some of my comments will, will address those questions and, and to maybe pull back and expand on some of the earlier testimony. Durable medical equipment is an example of a Part B benefit under Medicare. And there are three types of providers that generally issue benefits for Part B covered services. There are the opt out providers that you heard about. Those are providers for services that do not engage in the Medicare system. They don't submit a bill to Medicare. They don't receive payments or approvals for those. Then there are the participating providers which accept Medicare and those Medicare assignments in all cases. So to, to really simplify this, a participating provider will submit a bill for its services to Medicare of $150. Medicare will approve $100 of that. They accept that in full satisfaction. That-- there's no further excess charge. A nonparticipating provider, which is who we're here to talk about today, will submit a $150 bill. Medicare will approve $100. And if they have not accepted assignment, then they're limited to a 15% overage of that. So $15 will then be passed on to the Medicare beneficiary. Or if they have a Medsup policy to the Medsup policy to cover. The issue that is really taking place is with these nonparticipating DME providers who are not captured by that excess limit. So there is essentially no cap on what they can provide in excess. So what we see in that example is a DME provider sends that same $150 bill to Medicare. Medicare approves that $100. And now that-- they can send the full $50 back to the insured, or if they have a Medsup policy to the Medsup insurer. That's great if that $150 represents a reasonable and appropriate charge. However, the next week, same Medicare insurer sends now same equipment, $500 bill. Medicare approves $100, and that $400 remaining goes on to the Medicare supplement insurer or the Medicare beneficiary. The week after that, it's $2,000. The week after that, it's $5,000. So there's no cap and there's no mechanism in place. And I do see, I'm at time, so I want to ensure that I provide an opportunity for any questions.

BOSTAR: Let me see if if any of the members of the committee have any questions. Thank you for your testimony. Questions from the committee. Senator Kauth.

KAUTH: Would you like to finish what you were going to say?

KELLIE HARRY: Certainly. Thank you so much. So I, I, I, I think in short, the, the ultimate point here is that Medicare supplement insurers are ready, willing and able to pay all qualifying charges. What we need here, though, is a mechanism to prevent untenable and completely unreasonable charges. We are seeing examples of 800% over what Medicare approves. So we need a mechanism to be able to say what is a reasonable and customary charge, or a, a process in place that caps it in the same way that a doctor, a hospital or anything else would be. We think this bill is a key step in that direction. We are seeing other states take these approaches. There are eight states that already have legislation in place that address balance billing. And we think this, is a reasonable approach that follows suit.

BOSTAR: Senator Kauth.

KAUTH: Sorry. I'm having-- I'm having a hard time wrapping my head around. If this is a private business and they've opted out, they've said we don't want to participate with Medicare prices. So there's two parts to that. If they're getting some reimbursement from Medicare, then are-- aren't they automatically kind of participating.

KELLIE HARRY: So--

KAUTH: Is that the assumption?

KELLIE HARRY: Yes. So, so there are providers that will-- and it's a bit of a misnomer, right? Because a participating provider is someone who accepts Medicare and and that's it. They accept that as full satisfaction. That's what you see for most hospitals and physicians who accept Me-- they're, they're usually participating providers. Nonparticipating providers will accept Medicare payments. But, generally speaking, I'm trying-- a good example of a non participating medical provider would be, a psychiatrist. They will often not accept an assignment. So Medicare approves $100 of their bill. They take that and then they have an overage. They're limited to 15% over that amount. The DME providers do not have that limitation.

KAUTH: So this would not apply to just a business who says, look, I don't take any payments from Medicare. I will bill straight to the

individual. And however the individual chooses a handle payment is up to them.

KELLIE HARRY: Correct.

KAUTH: It does not apply to them.

KELLIE HARRY: Correct. They're-- they-- they're, they're for, for any individual who's operating in that space, and does not accept Medicare, there are other rules and things that apply to them. But the, the situation that I'm referencing today are those individuals who do accept Medicare payments and, and then excess bill and excess charge the remainder, without any basis for a reasonable and customary charge. As, as you heard in the prior testimony, we're seeing charges for, you know, a $46,000 scooter when you know that, that's truly nowhere to be found.

KAUTH: That clears it up. Thank you.

BOSTAR: Thank you, Senator Kauth. Additional questions? Senator Ballard.

BALLARD: Thank you, Senator, Bostar. So can you tell me what happens? So a senior purchases a scooter and you get the bill. Does a senior not go with the scooter, or is that just wrapped into a premium in the next go around?

KELLIE HARRY: So the scooter does seem to be kind of a, a simple example. And we do see that that in-- a great deal. They, they choose a scooter. Medicare will approve its amount. They can choose whatever scooter they like, whatever scooter is supported by their physician or recommended for their, for their needs. And, Medicare has its own fee system set up for durable medical equipment suppliers. So they're making a decision about what is reasonable and customary and approving that amount. But there's no mechanism for that individual to limit the excess bill that they receive. So that individual may get a bill. I, I will, I will tell you what we see as it's pulled back, generally speaking, and we'll see different bills if it's being sent to an individual without a Medicare supplement policy versus someone with a Medicare supplement policy. But we're left with the choice as the Medicare supplement insurer to say we think this is unreasonable price gouging, and we have no mechanism to challenge it based on the language of our policy, and we're forced to either pay it or reject it

and risk it being sent on to our insured, which is something that we're not satisfied with.

BALLARD: Okay, I see, thank you.

BOSTAR: Thank you, Senator Ballard. Additional questions from the committee. Seeing none. Thank you very much.

KELLIE HARRY: Thank you.

BOSTAR: Additional proponents. Welcome, Mr. Bell.

ROBERT BELL: Good afternoon, Senator Bostar and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell. Last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, and I am here today in support of LB852. I would like to publicly thank Senator Jacobson for introducing LB852 on Federation's behalf. As you know, the Nebraska Insurance Federation is the state trade association of insurance companies. Nebraska insurance companies, excuse me. Numerous member companies of the federation write Medicare supplement insurance, including a number of Nebraska domiciled insurance companies such as Mutual of Omaha, Blue Cross Blue Shield of Nebraska, Physicians Mutual Insurance Company, Central States Life and Health Company of Omaha, and Globe Life Insurance Company. According to the National Association of Insurance Commissioners, Federation member UnitedHealthCare is the largest writer of Medicare supplement insurance in the nation. The Blue Association plans, when you pool them all together, are number two, and then Mutual of Omaha is number three. In Nebraska itself, Blue Cross Blue Shield is the largest writer of Medicare supplement by a significant margin. And I tell you these stats just kind of inform the committee of the importance of LB852 to the federation members. And so I'll let you know that you-- both Mutual of Omaha and Blue Cross Blue Shield are experts in their-- in paying Medicare claims, and they see this experience kind of across the spectrum. I'm not going to reiterate what has already been said by both Ms. Harry and Mr. Blake. I know Ms. Harry did hand out some documents, including a presentation that was given to the NAIC by the Nebraska Department of Insurance a couple of years ago kind of highlighting some of the claims that we're seeing. You'll see the prosthetic nose document, in particular, which is pretty eye opening on the costs related to that. And again, this is-- we believe this will only apply-- what-- how this bill is drafted. We're, we're only worried about a small number of durable medical equipment suppliers

who seem to be abusive in their pricing practices. We know the vast majority of DME suppliers are good business partners to do business with for Nebraska seniors. But we are worried about balance billing as it relates to Medicare beneficiaries if they don't have Medicare supplement policies. If they do, we worried about, we're worried about increased premiums of Nebraska seniors for these, policies. That kind of seems like it's the Wild West. So we wish the federal government would make more reasonable, rulings from CMS on DME, but they have been unwilling to do. You also have, information in your packet there from Mutual Omaha related to the NAIC reaching out to CMS to challenge their, their decision and that response back from CMS. But with that, appreciate the opportunity to testify. Thank you.

BOSTAR: Thank you, Mr. Bell. Questions from the committee. I have one.

ROBERT BELL: Sure.

BOSTAR: So you talked about how it's your assessment that it's a small number of these suppliers that are, what, I guess characterizing it, you know, operating in bad faith. What-- can you try to quantify that? What share of these providers would you say?

ROBERT BELL: Oh, so I saw some information. There's a large number of DME suppliers that sell to Nebraskans, right? I-- you know, we're talking in the thousands. We were laughing, you know, wondering how the DME economy might change in the future with, you know, the prevalence of Amazon and other online retailers and whatnot, and how will they integrate into this whole supply chain. But we believe it's a very small number, probably less than 100 or so, maybe even a smaller number than that. I'm not in the in the bowels of the, claims, so I don't know. But I do know that the companies have identified a number of businesses, small number, relatively so, but that they do exist.

BOSTAR: Thank you, Mr. Bell. Additional questions? Thank you for your testimony.

ROBERT BELL: You're welcome.

BOSTAR: Additional proponents. Afternoon, Ms. Ragland.

JINA RAGLAND: Good afternoon, Chair Bostar, 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, here today testifying in support of LB852 on behalf of AARP Nebraska. When you're trying to navigate aging in

place, managing an illness, or coping with a disability, it can be hard to keep up with all the moving parts associated with your care, and especially can be difficult in acquiring a durable medical device. Older adults, who are more likely to have a chronic illness or mobility difficulties, need durable medical equipment more than any other group. Maneuvering the system can be long and confusing and can create a financial hardship for consumers, especially those on fixed incomes a July 2022 Kaiser Health tracking poll shows that unexpected medical bills are near the top of the list of people's financial worries, with about two thirds or 64% of the public saying they are at least somewhat worried about affording unexpected medical bills for themselves and their family. About 4 in 10 adults, or 41%, report having debt due to medical bills, including debts owed to credit cards, collection agencies, family and friends, banks and other lenders to pay for their health care costs. Additionally, about half of adults say they would be unable to pay an unexpected medical bill of even just $500 in full without going into debt. When someone undergoes a major medical procedure, has a major medical setback, is diagnosed with a life changing illness or disability, they need medical equipment to support and focus on their recovery. Like most things, medical equipment is expensive. Parent-- Patients depend on durable medical equipment to function independently or age in place in their homes and their communities. These items are intended to help consumers complete their daily activities, and are medically necessary due to a medical condition or recent procedure. The last thing people need in these situations is to get a bill in the hundreds, or maybe even thousands of dollars from a nonparticipating provider for equipment that is vital for them to live. Our health care system is already complicated, and consumers who do their best to navigate it in good faith deserve to be protected from costs that cannot always be predicted and therefore cannot be avoided. As you know, LB852 closes a necessary loophole in the federal CMS guidance and will provide a necessary consumer protection to halt possibilities of insurance nonpayment and result in balance billing for older Nebraskans. Thank you to Senator Jacobson for his leadership on this issue and for introducing the legislation. And thank you to the Committee for the opportunity to comment. We would ask you to support LB852 and advance it to the floor.

BOSTAR: Thank you, Ms. Ragland. Questions from the committee. Seeing none, thank you very much. Additional proponents. Seeing none, opponents. Seeing none, neutral? Seeing none. Senator Jacobson, would you like to close?

JACOBSON: I haven't been doing closes when there's no opposition testimony. But I didn't want you guys to think that I was always going to do that.

BOSTAR: I think you're missing an opportunity.

JACOBSON: I think I probably am. But let me just say this, and I-- Senator Kauth, I appreciate the questions that you asked because I spent most of this last summer working with the health insurers on my Medigap policy, which, of course, was, was heard in this committee last session. And we reached a compromise. And through that whole process, I learned a lot more about some of the issues that they're facing. And as we work through a compromise on the Medigap plan, one of the things we continue to focus on is affordability of insurance and making sure that any moves that we made were not going to negatively impact the affordability to those who are already on Medicare or in this case, Medicaid supplement program, or Medicare supplement plans, or, or going to be negatively impacted from a premium adjustment because of things that we bring into the bill to require them to do. That became very clear when you look at that this durable medical equipment that-- and I want to reiterate one of the things I think that Senator, or Mr. Blake mentioned in his testimony and alluded to was, think about you pull up the website and you look at one of those $17,000 scooters and your insured purchases, that scooter, the bill gets sent to Medicaid and-- or, or Medicare, and they, say, pay $12,000. So instead of-- and so at that point in time, they turn around and send the bill to the Medsup policy, provider for $30,000. Well, that, that same scooter was advertised on their website at $17,000. Where'd that number come from? And you also heard it alluded to that both the individual, they may not have charged him that much, but when they see that they're covered with a Medsup plan, hey, here's our opportunity to go stick it to the insurance company. But when you stick it to the insurance company, you stick it to all of us. We all pay. We all pay those premiums. So what this bill is really designed to do is to get everybody on the same, same plane. You can upcharge 15% above what, what is provided by Medicare, you can be in that business if you want to be in this, it's a captive business, you're going to-- you're going to know you're going to get paid. I can tell you from a number of the businesses I finance, they don't always get paid. In this case, you do. You've got a pretty good provider out there between Medicare and the insurance plans. So I think the bill is reasonable. It closes a good loophole that needs to be closed up. And ultimately it saves us all. And it also prevents those uninsured clients, patients out there from balance billing, which could come

back as the last testifier mentioned, and really hit them at a time when they've got all these other costs involved. So, again, I would encourage you to vote in favor and move this, this particular bill out of committee to the floor. So thank you.

BOSTAR: Thank you, Senator. Final questions from the committee. Thank you. And for the record, there was one proponent letter, two opponent letter, and zero neutral letters. And that concludes our hearing on LB852.

JACOBSON: OK. Thank you, Senator Bostar. And we're now going to move on to LB1 or LB1024. And, Senator Bostar, you're up.

BOSTAR: Thank you. Good afternoon, Senator Jacobson and fellow members of the Banking Commerce Insurance Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29. Today I am presenting LB1024, which proposes to bar any documents or information solely related to costs from being provided during the external review process of an adverse determination by a health carrier. An adverse determination is any decision to deny or reduce a claim by a health carrier on the grounds of medical necessity, appropriateness, health care setting, level of care, or effectiveness. Nebraska law, the Health Care Grievance Procedures Act, and the Utilization Review Act provides for the appeals of adverse determinations and sets up the processes, standards of review and timeliness for an internal review, which is essentially the review process of an adverse termination by a health carrier. If the carrier does not reverse its initial decision and the adverse determination becomes final, the covered person can file an external review via the Health Carrier External Review Act. For state regulated plans, when a covered person, subject to final adverse determination, has exhausted internal appeals within the health carrier, the covered person can file an external review with the Nebraska Department of Insurance. Once filed, the department will pass along the information to a nationally accredited, independent review organization. The processes, timeliness, and standards of review utilized by the independent review organization are included in the Health Carrier External Review Act, including expedited processes when medically necessary. LB1024 amends the provision of the Health Care External Review Act, which enumerates the information that the Independent review organization would receive from the health carrier that made the final adverse determination by making it clear that documents or other information solely related to cost shall not be provided. I introduced this legislation after meeting with a stage four cancer

patient from Lincoln. You will hear from her this afternoon in her struggle to acquire the medication that she was prescribed for her cancer diagnosis, medication which was covered by her insurance provider for two years. A stage four cancer diagnosis is something I hope none of us ever have to experience, whether it be ourselves or a loved one. Fighting a health carrier's adverse determination adds even more stress to an already difficult situation, especially when you or a loved one is denied a treatment that was keeping your condition in check. LB1024 makes clear that information solely related to costs shall not be part of the external review process, and that these decisions should be based on medical necessity. I urge the committee to support LB1024. Thank you for your time, and I'd be happy to answer any questions you might have.

JACOBSON: Thank you, Senator Bostar. Questions for Senator Bostar? Okay. Seeing none, thank you.

BOSTAR: Thank you.

JACOBSON: Now, I ask for any proponents of LB1024?

CATHY MARTINEZ: Good afternoon, senators. My name is Cathy Martinez, C-a-t-h-y M-a-r-t-i-n-e-z. I'm a sixth generation Nebraskan. I'm 52 years old, married with eight children. I'm a small business owner running a child care center for nearly 31 years. Our youngest child has severe autism, and over the past 20 years, I've become an advocate for people with disabilities as well. Until August of 2020, I was the picture of health. I worked out every morning. I've never smoked. I ate healthy. No family history of cancer. I was living a great life. I developed some lower abdominal pain and assumed I pulled a muscle during a workout. I went to see my doctor and he found nothing wrong with me. I went back two more times and still nothing was found. On September 27th of 2020, the pain was so intense I went to Saint Elizabeth's E.R. One scan and one hour later my life had changed forever. The doctor came in and bluntly told me I had stage four kidney cancer. She showed me the images of my torso full of tumors. The largest tumor was five and a half inches, sitting on my left kidney, and had sprouted tentacles into my abdominal wall. I had two tumors in my lungs, one under my heart, and the cancer had spread into my lymph nodes. She estimated by their size, the tumors had been growing for approximately 18 months. I was diagnosed with advanced stage renal cell carcinoma, sarcomatoid cell type with rhabdoid features, essentially the worst of the worst. I was given 8 to 30 months to live. My daughter had just announced she was expecting my

first grandchild, and I wasn't even sure I would live to meet her. My husband Caesar [PHONETIC] and I cried until we could cry no more. We began to make plans for my death: funeral plans, purchasing cemetery lots, financial planning for our son with disabilities. My family encouraged me to find a new medical team that would treat my cancer more aggressively. They found an oncologist and surgeon they wanted me to see. My new team was unanimous on how to proceed. Immediate removal of the left kidney and surrounding lymph nodes, followed by relative-- relatively newer immunotherapy chemo drugs, Inlyta and Keytruda. One is fast acting to shrink the tumors near my heart and lungs, and the other was long acting to keep the cancerous tumors from coming back. It was a very difficult time for my family. I was hospitalized five times between September 27th and November 30th of 2020. My skin began to slough off. I lost all my hair. I couldn't walk or eat. I had given birth to 9 pound babies that didn't compare to the pain that cancer was wreaking on my body. It was excruciating. By January of 2020, my medical team had me stabilized. The Inlyta did its job. It shrank tumors within three months. The Keytruda has been doing its job for nearly three years now, keeping my cancer in check. My insurance company, Medica, decided in June of 2023 it would no longer cost the cover-- cost-- or cover the cost of my drugs. They gave me lots of excuses, but I believe the reason was the cost of the medication. In a three day span, Medica gave me three different rulings for drug coverage. Nine more treatments, no more treatments, and then ultimately gave me one more treatment when I pointed out that they must cover the cost of my drug during the appeal process. They gave me that additional treatment and then promptly denied my appeal. I applied for an external review of this decision to the Nebraska Insurance Review Board, as my entire case had been mishandled. Ultimately, the review board decided that since I have stage four cancer, I'm incurable and merely treatable, and the judge [SIC] would only prolong my life. That was their words, not mine. My oncologist has had terminal cancer patients who have been on Keytruda for 7 to 10 years. He said that given my relative youth and fitness at the time of diagnosis, 20-- 15- to 20-year remission would be very possible for me. Insurers and the review process have not kept pace with the advancements in immunotherapy that transforms deadly cancers into chronic conditions. I'd like to ask the review board what they think about insulin for diabetics, or medicine for heart or thyroid conditions. They're not curable, just treatable chronic conditions. Where will they draw the line with determinations such as this? They sided with the decision to deny me a drug that's saving my life for the last three years. I'm OK with merely prolonging my life. Aren't we

all hoping for long lives? Isn't that the goal of modern medicine? It's tragic that these two entities put a dollar value on my life. If they're doing this to me, they're doing this to other Nebraskans. My life has value. I'm a contributing member of the community. I'm currently receiving my drug supplied from Merck on a compassionate waiver based on income. The drug is working for me. So why would I ever stop taking a drug that's saving my life? I'm happy to report that since February of 2021, my scans have been stable with no new growth. I'm still employed full time. I'm still running an advocacy nonprofit for people with disabilities on the side. I found an excellent medical team who believe in me and give me hope. I've outlived my original prognosis. I am now at the 40 month mark since diagnosis. I believe in the power of prayer, and it's nothing short of a miracle that I'm still alive today. I've been able to not only witness my granddaughter's birth, but we're now planning her third birthday party, and we've since welcomed an additional granddaughter. I'd like to thank Senator Bostar for his leadership on this initiative, and I'd like to thank you all for your time this afternoon.

JACOBSON: Thank you for your testimony. And you may be going a little over the three minutes, but there's no way, after all you've been through, that I could even begin to ask you to stop your testimony. So thank you.

CATHY MARTINEZ: Thank you.

JACOBSON: Questions from the committee. Senator Dungan.

DUNGAN: Thank you, Senator Jacobson, and thank you for being here. And I guess I just want to start by saying I'm very happy you're here. Thank you very much. What was it like for you to have to deal with that entire external review process while simultaneously dealing with your diagnosis, and also going through the process of taking the drugs? What was that like from a more personal level? Because I, I don't think we know what that probably feels like to actually be in that sort of struggle. So if you could go into a little more detail about that, I'd appreciate it.

CATHY MARTINEZ: Sure. My life is already challenging enough. I have a child, an adult child with disabilities, and I have stage four cancer, and I'm trying to maintain employment so I can pay my bills and not lose my home and then it caught me completely off guard that they were going to deny that-- the coverage from the drug. I had no, no idea

that they were going to do that. So it just complicated my life and made it more difficult. And I felt like all my energy should be put into trying to recover. But now my, my energy had to be focused on getting access to the drug that's saving my life, which obviously created a lot of stress.

DUNGAN: How long was that entire process that you had to go through from the time that the, the decision was made to no longer cover that medication to the final external review decision being made.

CATHY MARTINEZ: About 60 days.

DUNGAN: Thank you.

JACOBSON: Senator Kauth.

KAUTH: Thank you for being here, Ms. Martinez. When we look at the way this bill is written, do you-- that maybe this is the question for Senator Bostar. Documents solely related to costs shall not be provided. Do you feel like that's just a way of saying, we're going to set the cost over here and look at just the success of the drug and the recommendations that they have health outcome?

CATHY MARTINEZ: I would like to think that my physician would be able to determine the medication that I'm able to receive and not my insurance company.

KAUTH: Thank you.

JACOBSON: Other questions? If not, I truly appreciate you being here today and thank you for your courage.

CATHY MARTINEZ: Thank you.

JACOBSON: Proponents.

ROXANN HOLLIDAY: Good afternoon. Thank you for having me here. My name is Roxann Holliday. R-o-x-a-n-n H-o-l-l-i-d-a-y. Bear with me. I thought I had five minutes, so I will try to shorten this. On July 18th--

JACOBSON: I will stop you shortly after three.

ROXANN HOLLIDAY: July 18th of this past year, essentially six months ago to date, I received MRI results that changed my world and

confirmed my worst fear. I learned the cause of my persistent back pain was, in fact, the return of my breast cancer. After 17 years, it was back, stage four, for which there is currently no known cure, only treatments to prolong my life. The doctor said the cancer was in the lymph nodes in my neck, in my hips, and in my spine where it caused a fracture. I was referred to one of the best oncologists around, and after two weeks of more tests and consultations, we could discuss treatment options. The oncologist recommended a treatment regimen of a daily pill and an injection every three weeks of a new targeted therapy drug. So to step back 17 years ago, I was 37 when I was first diagnosed with stage three breast cancer. Every three weeks, I took treatments for 18 weeks. Each treatment caused my white count to drop to zero and would put me in the hospital. I required blood transfusions, I lost my hair, I got miserably sick, and I had to be careful around my young kids, eight, six, and two at the time because chemotherapy kills good and bad cells, so I was at risk of getting very sick. In addition, I needed a double mastectomy, a hysterectomy, and 14 lymph nodes removed from under my arm. All necessary parts of my treatment. So you can imagine the relief I felt in July when my doctor recommended a treatment plan that did not include chemotherapy. After careful study of the most recent research and case studies, my oncologist confirmed that the genetic makeup of my cancer would be best and most effectively treated with a daily hormone blocker, and once every three weeks, an injection of an innovated-- innovative and targeted drug, Phesgo. This treatment would directly and most effectively treat the estrogen positive, HER2 positive genetic makeup of my cancer. He knew chemotherapy was not the right choice for my cancer's specific genetic makeup, and that this treatment would give me the best chance of longer term survival. But my relief was shattered when my insurance company returned with a denial for this treatment. The only way they would cover the treatment is if I would add chemotherapy to it. I could revert to the recommended plan only when the chemo proved to be too toxic for me, and we knew it would prove to be too toxic for me. So essentially, they wanted me to take a treatment that killed all cells, good and bad, versus the targeted treatment that would just address the cancer cells. I'm a marketing professor. I'm around college kids all the time. College kids are notoriously sick. So I worried about how much work I would have to miss, not just to keep myself safe, but also for those days when the chemotherapy would make me too sick to work. My doctor's office appealed the decision, which again was denied. Then the doctor conducted a peer to peer review with the insurance company and again I was denied. Thankfully, I was-- I-- the, the oncologist reached out to

the drug company, and after submitting my tax documents to prove the financial need, I was able to get this covered for a year through the drug company. I've had a scan since then, and I'm happy to report that this treatment plan of Phesgo without chemotherapy is working. There are signs of cancer shrinking, signs of bone regrowth, and less intensity on the spots that do have cancer. I'm able to continue working every day without fear of getting sick from my college students, and I have amazing quality of life under this treatment plan.

JACOBSON: If I could have you just hold on there, I think there's going to be a question for you. So are there any questions? Senator Kauth.

KAUTH: Would you like to continue your story?

ROXANN HOLLIDAY: Thank you. But my success is in no thanks to the insurance company. I can't imagine how a third party completely removed from my individual situation would have a better idea of the right treatment for me than a top oncologist. So if I can do anything at all to help change the landscape and paradigm under which the insurance industry operates, I'm happy and eager to do it. I know I'm not the only one that's been denied recommended treatment plans, and if nothing is done, there will be too many more people like me. Thank you.

JACOBSON: Thank you very much for your testimony today. Further questions? If not, thank you again for being here.

ROXANN HOLLIDAY: Thank you.

JACOBSON: Further proponents? Proponents? If not, we'll take opponent testimony. Any opponents to the bill? OK. Neutral testimony. Mr. Bell.

ROBERT BELL: May I?

JACOBSON: Go ahead.

ROBERT BELL: Good afternoon, Vice Chairman Jacobson 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 in a neutral position on LB1024. As you know, the Nebraska Insurance Federation is the state trade association of the Nebraska insurance companies. The federation membership includes most of the

major medical health plans writing business in Nebraska that are subject to the Health Care External Review Act, which is being amended by this bill. External review, as you've heard today, is a creat-- well, as we know it today is a creature of the federal Patient Protection and Affordable Care Act. External review is an independent review of an adverse determination by a health carrier. Before being able to access external rev-- the external review process, a covered individual must first access-- exhaust, excuse me, all appeals internal to the health carrier, which is called an internal review. So the process goes, you go through all of your internal review of the adverse determination. Then application is made for an external review. If the adverse determination continues, and I would say and note that if the-- if it's a state regulated plan that ,that appeal goes to the Department of Insurance, who then forwards it on to an independent review organization. If it's a federally regulated plan that will go to the US Department of Labor, and that will go again to the same group of independent review organizations. These aren't decisions that are made by either the Department of Insurance or the US Department of Labor. Once they receive that application, it goes to the IRO, or Independent Review Organization, which is a nationally accredited organization meeting the standards set forth in statute, in the External Review Act. The IRL-- IRO will receive all sorts of information from both the health provider and the health carrier, the covered person, etc. and then they will make a determination of whether or not to override the decision of the health carrier based on the cris-- the criteria set forth in the act. And it does provide what an IRO should consider in rendering the decision. One of the factors that is not included-- one of the factors that is not to be included is the cost of service, procedure, or the medical supply. So LB1024 would expressly prohibit that those documents that are solely related to cost. So the health carrier wouldn't be able to provide a document that says this drug costs $50,000 a dose. But there's another drug that only costs $500 a dose, right? Under, under the provisions of LB1024. We believe that the external review process is actually working quite well. I-- oh, I'm sorry. I'm over time, I will end my testimony. Thank you.

JACOBSON: All right. Thank you, Mr. Bell. Questions for Mr. Bell? Thank you very much for your testimony.

ROBERT BELL: You're welcome.

JACOBSON: Any other neutral testimony? All right, seeing none, Senator Bostar, you are welcome to close.

BOSTAR: Thank you, Vice Chair Jacobson and members of the committee. You know, we, we introduce a lot of bills, and we hear a lot of bills in this committee. And a lot of them relate to insurance, particularly health insurance. And we consider all of this policy at a fairly macro level. And so I, think it's important in this case to just really evaluate the fact that we are talking about individuals who came in here today. And what we do here, not just on this bill, but what we do here in general has direct impacts on the health of others, the ability for others to even be here with us. And it's-- when, when you spend as much time as we all do dealing with the very high level policy, I think it is important to be able to view what's happening on the ground with, with our systems, our practices and our policy. I hope this bill helps. This is an important issue. It's a serious problem we have. When you're dealing with serious medical challenges. And you're fortunate enough, fortunate enough to find a treatment that won't cure you, but will help you. We'll let you live your life. Will let you recover to a great extent. That's, that's-- you're incredibly fortunate if you get to-- if you get that opportunity. Most don't get that opportunity. And so what we're talking about here is individuals who were faced with some, some-- what would be considered, I think, probably unbearable health challenges and then finding, through the work of, of their health care teams and their physicians, finding treatments that genuinely help them. And then, after some period of time, in the first testifiers case after two years, having that cut off. It does seem cruel. The drug manufacturer is currently supplying that medication, that treatment, at no cost because the insurance provider will not cover it, covered it for two years and then stopped. At this point, our system is relying on the generosity of a pharmaceutical company to, frankly, keep someone alive. Well, I appreciate the fact that right now that medication, that treatment, is being provided, that has an end date from, the from the pharmaceutical manufacturer. Hopefully we-- you know, it can keep getting pushed out as long as possible, but there's no guarantee. I don't like a system that relies on big pharma giving away medication. There's a problem there, and we can do better than that. Sometimes drugs that are prescribed and then covered-- so a doctor says you should get it and your health insurer concurs. But then you stop having it covered. That can happen for a number of reasons. One reason is, is that sometimes medication is, is, unsafe, right, after a certain amount of time. Other times, that's just simply how long the clinical trial was. When it's sought approval. So drugs were submitted for, for testing and trials by the FDA. And they go through that process and they submit trials that lasted, let's say, for example, two years. And they can

demonstrate efficacy, they can demonstrate some level of safety that they can get the dosing figured out. The system we currently have in place allows, allows insurance covers to follow guidelines that say, well, the only-- the trial initially was only two years long, so who knows if it would work for two and a half years? We don't have to cover it. Well, to be clear, we're, we're looking at an individual that is on the drug for longer than what the insurance provider, thought was appropriate. And I don't know, in this drugs case, whether it's because the clinical trial was only for two years, or because they thought that somehow it wouldn't be safe after two years. I don't know, and frankly, it doesn't matter. This person is still coming before us. Living a life. Contributing to our great state. And so, whatever the reason, it was wrong. We can see that with our own eyes. So, like I said, I thank you for your time and attention. I hope that this legislation helps. It's part of the conversation we need to have and certainly should continue to have. With that, I would be happy to answer any final questions.

JACOBSON: Senator von Gillern.

VON GILLERN: Thank you, Senator Bostar. We heard two very compelling testimonies today. How many others are a-- do we have any way of knowing how many other individuals are out there? What, what's the prevalence of this problem? Any idea on numbers?

BOSTAR: Not really. But, but perhaps there are some ways to find out, and we should try to look into it. But, yeah, that's a good question. I mean-- and there's a couple of issues here. One is just denials of treatments outright, and then there's denials of treatment that you were already getting. And, and both of those have, have potential serious consequences. And so it would be interesting to see what-- how to, how to kind of figure out how big the, the challenges that we're facing.

VON GILLERN: In your bill does it do anything to address the, or challenge the current proc-- external review process. Correct?

BOSTAR: It's, it would-- when the documentation and information is submitted for the external review-- to the external review organization. It would be prohibited to submit information that was solely related to cost.

VON GILLERN: OK. Thank you.

JACOBSON: Other questions? If not, I do want to mention there were two proponent letters received, no opponents, and no neutral bill-- letters received. With that. That concludes a hearing on LB1024. Thank you. Let's just take a brief break, as I think there may be some leaving the room, and we'll go to Senator Dungan next. Okay, let's, let's reconvene. Our hearing will now begin the hearing on LB989. Senator Dungan, you're welcome to proceed.

DUNGAN: Thank you. Good afternoon, Vice Chair Jacobson and fellow members of the Banking, Commerce and Insurance Committee. I'm Senator George Dungan, G-e-o-r-g-e D-u-n-g-a-n. I represent Legislative District 26 in northeast Lincoln, and today I'm introducing LB989. The purpose of LB989 is to update the Nebraska Appraisal Management Company Registration Act. First I want to briefly overview what an appraisal management company or AMC does. In Nebraska, we have 75 AMCs and about 650 to 700 appraisers. Appraisal management companies are entities that act as intermediaries between real estate appraisers and lenders or financial institutions. Their primary function is to facilitate the appraisal process for real estate transactions, ensuring that appraisals are conducted impartially and in compliance with relevant regulations. AMCs play a crucial role in the real estate and mortgage industries by helping to maintain independence and objectivity in the appraisal process. This separation is essential to avoid conflicts of interest and ensure that property valuations are conducted fairly. Additionally, using AMCs can help streamline the appraisal process, improve efficiency, and enhance the overall quality of appraisals. The purpose of LB989 is to update the Nebraska Appraisal Management Company Registration Act to implement the recommendations of the Appraisal Subcommittee of the Federal Financial Institutions Examination Council, as identified during its 2022 State Off Site Assessment, or SOA. These changes are required for the board, the board's continued compliance with Title XI of the Federal Financial Institutions Reform, Recovery, and Enforcement Act of 1989 and Appraisal Subcommittee Policy Statements 1, 7 through 9, and 10 through 12. Title XI, as amended by the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, expanded the Appraisal Subcommittee's core functions to include monitoring the requirements established by states that register and supervise the operations and activities of appraisal management companies. If the state of Nebraska is found to be non-compliant with Title XI by the appraisal subcommittee, it-- the appraisal subcommittee may then remove all Nebraska registered appraisal management companies from the AMC registry, resulting in no appraisal management companies authorized to

provide appraisal management services in connection with federally related transactions. Such an action would substantially negatively impact the mortgage loan activity in Nebraska. Along with the changes to the appraisal subcommittee's SOA recommendations, LB989 includes a small upward change from $1,500 to $2,000 for the renewal of registration. To sum it all up, this is a bill that harmonizes our statutes with federal requirements. As I stated earlier, we risk our AMCs being removed from the national registry if we don't do this. Testifying after me is Tyler Kohtz. Tyler is the executive director of the Nebraska Real Property Appraiser Board. He is an expert in this field and can walk us through the details of the legislation far better than I probably can. That being said, I'm happy to answer questions from the committee at this time.

JACOBSON: Thank you, Senator Dungan. Questions from the committee? All right. Thank you. We'll now ask for proponents.

TYLER KOHTZ: Thank you, Senator Dungan. That was very thorough. He covered a whole lot of it, so he did an excellent job. My name is Tyler Kohtz, spelled T-y-l-e-r K-o-h-t-z. I'm the director for the Nebraska Real Property Appraiser Board. First off, I'd like to thank the committee for the opportunity to speak on behalf of the board in regards to LB989. I'll cover more of the technical aspects of what's in this bill. Specifically, "National" is stricken. Appraisers had to before registry to change the name from "National Registry" to "Appraiser Registry." This changes to harmonize the act with the language found in the Rural Property Appraiser Act. Definition of "AMC final rule" is replaced with "AMC rule." That is a recommendation that the Appraisal Subcommittee made during its 2022 SOA. "National Registry" is renamed to "AMC Registry" to incorporate the subcommittee's terminology as recommended during its 2022 SOA. There was some language that was stricken, such as who, who holds a credential. Because there's a defined term AMC appraiser which already has that language, so it's just repetitive to continue to have that language. Dates were updated where necessary, 2019 is updated to 2024. And, the definition of federally regulated appraisal management company. The definition of real property appraiser is added to harmonize the AMC act with the Real Property Appraiser Act. The term real property appraiser is used within the AMC act and is different than AMC appraiser, so we wanted to get that definition clarified. The AMC registration renewal fee limit is amended upwards by $500 from $1,500 to $2,000. Senator Dungan mentioned that one already. The criminal history record check requirements are amended for any owner of more than 10% of an AMC. If such owners previously committed a

criminal history record check for the purpose of AMC, AMC ownership, the CHRC is still required for any new owners of more than 10%. And this change meets the requirements of the ownership limitations in the state registered AMCs under the AMC rule. Section 11 is added to provide civil and criminal immunity for board members, board employees, and contractors. This language harmonizes the act with what's already existing in the Rural Property Appraiser Act. Sections 76-3209 and the 76-3211, or outright repealed as this language is duplicated under the appraisal panel requirements already found in the AMC Registration Act. LB989 updates the act for continued compliance with Title XI and the Appraisal Subcommittee policy statements. The subcommittee reviews each state's compliance with the requirements of Title XI, and is authorized to take action against noncomplying regulatory programs. IT policies, practices, procedures are inconsistent with the requirements of Title XI. If the state of Nebraska is found to be non-compliant with Title XI by the subcommittee, it may remove all Nebraska appraisers from the AMC subcommittee, which may have halt all mortgage loan activity within the state in which AMCs are utilized. The board supports LB989. Thank you.

JACOBSON: Thank you. Questions for Mr. Kohtz? All right. Seeing none. Thank you for your testimony.

TYLER KOHTZ: Thank you.

JACOBSON: Further proponent testimony.

ROBERT HALLSTROM: Vice Chair Jacobson, members of the Banking, Commerce and Insurance Committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m, here today as registered lobbyist for the Nebraska Bankers Association in support of LB989. I would note for the record that Senator Dungan was far too modest. He did an excellent job of highlighting the value that is added to the lending function by appraisal management companies, both in terms of underwriting loans and in maintaining compliance with the requirements of federal and state law relating to appraisals. I would just echo Mr. Kohtz's remarks that it is important for Nebraska to stay in conformity with the federal requirements, with regard to appraisal management companies. With that, I reserve whatever time I didn't use today for future hearings and would address any questions that you might have.

JACOBSON: If only it were. Questions for Mr. Hallstrom? All right, seeing none, thank you.

ROBERT HALLSTROM: Thank you.

JACOBSON: Further proponent testimony? Any opponent testimony, anyone speaking in opposition to the bill? OK. And finally, any neutral testimony? Would anyone like to testify in a neutral capacity? All right, seeing none, Senator Dungan, you're welcome to close. You're waiving closing. That concludes, our hearing on LB989. And there were no letters received on that particular bill. And with that, we're going to move on to LB992, also Senator Dungan. So, Senator Dungan, welcome back, and please proceed.

DUNGAN: Thank you. And good afternoon again, Vice Chair Jacobson and fellow members of the Banking, Commerce and Insurance Committee. I am Senator George Dungan, G-e-o-r-g-e D-u-n-g-a-n. I represent Legislative District 26 in northeast Lincoln. And today I'm introducing LB992. LB992 is the companion bill to the previous bill that we just heard. The purpose of LB992 is to update the Nebraska Real Property Appraiser Act to implement the Real Property Appraiser Qualifications criteria adopted by various subcommittees and boards at the national level. These changes are required for the board's continued compliance with Title XI of the Federal Financial Institutions Reform, Recovery and Enforcement Act of 1989, and the Appraisal Subcommittee Policy Statements 1 through 7 and 10 or 12. As stated previously, but to make clear for the record, Title XI requires each state to prescribe appropriate standards for the performance of real estate appraisals in connection with federally related transactions. In addition, real estate appraisals are to be performed in accordance with generally accepted uniform appraisal standards and are to be performed by an individual whose competency has been demonstrated and whose professional conduct is subject to adequate state supervision. Suppose the state of Nebraska does not comply with Title XI. In that case, the appraisal subcommittee may remove all Nebraska real property appraisers from the appraiser registry, resulting in no appraisers qualified to appraise real property concerning federally related transactions. Such action would substantially negatively impact the mortgage loan activity in Nebraska. LB992 includes changes to four fee limits, the credential application renewal fee, and temporary credential application, in addition to the temporary credentialing fee, which would be increased by $50 each. Once again, testifying after me is Tyler Kohtz, and possibly Bob Hallstrom. Tyler is the executive director of the Nebraska Real Property Appraiser Board. He's an expert in the field and can walk you through the details of the legislation. As was, evident in the last one, there's a number of changes that are

happening in here. I'm happy to talk with folks afterwards as well about each one of those. But similar to the last bill, this is harmonizing us with federal standards in order to make sure that our state law continues to be in accordance with that Title XI. So, without getting into all the details of what's in there, I'm happy to talk with folks if you have questions afterwards as well.

JACOBSON: Questions for Senator Dungan. I have to note, I really love your very attractive glasses, so.

DUNGAN: Thank you, Vice Chair. They, they match yours as well.

JACOBSON: Thank you. And we'll look for proponent testimony.

VON GILLERN: I miss Julie.

JACOBSON: You will.

TYLER KOHTZ: Thank you, Senator Dungan. Once again, Tyler Kohtz, T-y-l-e-r K-o-h-t-z. And I'm the director for the Real Property Appraiser Board. I'll cut into the more technical aspect of it, but try to avoid where just definitions are updated, or where language is changed to reflect what's in USEPAP or what's in the criteria. So, moving through that, the high school education or equivalent requirement for trainee licensed classification is removed to not exceed the real property appraiser qualifications criteria. The 15 hour National Uniform Standards of Professional Appraisal Practice reference is stricken from qualifying education requirements, as it's the only one specifically mentioned by name. They're all in the regulations of the board by name, including the hours required for each. The exam completion requirements are updated for each classification to not exceed the criteria. The scopes of practice for licensed and Certified residential and certified general classifications are updated, to fall more in line with the criteria's classifications-- definitions. The random fingerprint audit program for the appraiser renewal applicants is removed. The Uniform Standards of Professional Appraisal Practice course is renamed as required by the 2026 criteria. The hour requirement is removed from the instructor recertification course, also required by the 2026 criteria. Continuing education awarded for completion of qualifying education is clarified. the valuation bias and fair housing laws course is added to the Continuing Education requirements for real property appraisers beginning on January 1, 2026, as required by the criteria. The valuation bias and fair housing laws course is also added to the

qualifying education course for all new credential holders. The credential application fee limit, renewal credential fee limit, temporary credential fee limit, and temporary credential application fee limits are amended upwards and the directory information requirements are updated to also include our real property appraisers credential, effective and expiration dates on the website listing. These changes are required for the board's continued compliance with Title XI and the ASC policy statements. The Appraisal Subcommittee is authorized by Title XI to take non-compling-- action against non-compliant state programs if policies, practices, and procedures are inconsistent with the requirements of Title XI. If the state of Nebraska is found to be non-compliant with Title XI, all credential appraisers may be removed from the appraiser registry, resulting in no real property appraisers qualified to appraise property in connection with federally regulated transactions. Such action would have a substantial negative impact on the mortgage loan activity in Nebraska. Once again, the board supports LB992.

JACOBSON: Thank you. Questions for Mr. Kohtz. Yes, Senator Kauth.

KAUTH: Real quick, Mr. Kohtz. What is the current credentialing fees? And you're increasing them each of those four by $50 each. What are they?

TYLER KOHTZ: Yeah, what, what you're looking at here is, is the application fee for credential. So that is currently $150. That'll be raised up to $200. The renewal fee, is set at $300. Will move up to $350. There's also an initial credentialing fee. We didn't change that at all. We just left it at the $300. And the other two are the temporary credential application and credentialing fee. The application fee will be moved up $50 from 100 to $150. And the, credentialing fee would be moved up $50 to $100, that you could look at as, as a whole picture. Typically when you file for an application or a temporary application, you just pay the $150. So it's the application fee and the credentialing fee. The, the federal limit is $250. So what we would be moving it up to is that federal maximum that we can charge for temporary credentials.

KAUTH: Thank you.

TYLER KOHTZ: You're welcome.

JACOBSON: Other questions? I do have a couple quick questions.

TYLER KOHTZ: Sure.

JACOBSON: I guess with regard to the fees, where do these fees go to and what are the fees used for?

TYLER KOHTZ: The fees would go into the the, the board's funds that are used for the operation purposes of the board.

JACOBSON: Is this a state level or federal level, those fees are being charged.

TYLER KOHTZ: State level. I, I guess I should clarify it. The ones we're talking about here are state level. We do have to collect federal fees that are transferred to the state program, but we just have a liability account for that. So that information never gets swept into our revenues. So it's just kept separate. But anything we're talking about here would be used for the board's operations and expenditures.

JACOBSON: And, and how are you sitting on reserves in that fund today?

TYLER KOHTZ: We're, we're actually sitting pretty good. And in fact, one of the things that, I would like to tell you is the board doesn't want to raise the fees. It's kind of one of those things that, it hasn't been done for at least 12 years. As long as I've been here, we've never raised one fee. And so that and, I went back and looked, and we average 2% increase in our budget a year, which is fairly modest. But after 12 years, those little increments start to build up. With the appraiser side, the numbers are pretty stable. They're around 700 every year. It doesn't increase. So, revenues are stable in terms of what they are. And so eventually those, those, expenditures will exceed the revenues. But the board's plan is to hold off as long as it can. And what it's going to start doing is drawing down the cash balance to its, its cash balance policy. Once it hits that point, then it'll start considering raising the fees. We're looking at it could depending on circumstances, it could be a year from now. It could be 6 or 7 years from now if revenues go good and the expenditures stay nice and low. But the bigger thing is the board wants to be prepared for when that time comes. It has that flexibility to be able to do so when it needs to do so, not that it intends to.

JACOBSON: I appreciate that, I would have one quick follow-up to that. And that is, obviously, appraisers, qualified appraisers is critically important, as you've outlined too.

TYLER KOHTZ: Yes.

JACOBSON: The mortgage industry and the banking industry, trends in appraisers, you've indicated the numbers that are out there. Are we trending higher or how many are moving towards retirement? Are we getting enough younger appraisers in, new appraisers? Are, are we, are we creating the right incentives to keep people in there so that we run into a situation where we're really short of appraisers?

TYLER KOHTZ: Yeah. That's a good question. You know, there's two sides to that. One, it's so controlled at the fedal-- federal level what the requirements are. And they are aware that there is a problem nationwide in terms of what the average age of an appraiser is. There's going to be a fall out some time. So they have been addressing that at the federal level. One of the things that they've started doing is there's a program now called PAREA where you can get your experience without having a supervisor. So that's going to bring more residential appraisers on board without having to go through that process of finding somebody to train you. So things like that are happening. Now, one phenomenon that's happening in the state here is as our older appraisers retire, they're being replaced with reciprocal appraisers that are coming in from other states. And so we look at those, we call them education, experience, and examination appraisers, those who are residents that go through the whole process. That number is slowly going down while the reciprocals are slowly going up. So our numbers are stable because they're being replaced by those coming in from out of state.

JACOBSON: Gotcha. All right. Well, thank you again for your testimony.

TYLER KOHTZ: You're welcome.

JACOBSON: All right. Other proponents. Mr. Hallstrom, we are still limited in three minutes, just in case you were wondering.

ROBERT HALLSTROM: Thank you, sir. Vice Chair Jacobson, members of the committee, my name is Robert J. Hallstrom. H-a-l-l-s-t-r-o-m, here before you today as a registered lobbyist for the Nebraska Bankers Association in support of LB89-- LB992. My testimony, very similar to what I said before, only with regard to appraisers being vitally important to the lending industry and the underwriting function in making loans. I will note that Mr. Kohtz did share this bill in advance of the session for which we were appreciative. We did ask him the same questions about the fee, and he gave us a consistent answer.

And he did, in fact, say that, it's up to an additional $50. And as he explained today, that may not happen for a while. So we think there's ample justification for those fees, in connection with your Senate-- your question, Senator Jacobson. Since the 1980s, when the appraisal requirements came into into play, we have pushed for registered and, and trainee appraisers to make sure that we've got that next generation of appraisers. The federal law or regulation that Mr. Kohtz noted is vitally important. As you might anticipate, what we've done over time is we've had the appraisers have to be trained and supervised by someone. And there's always the concern who wants to supervise someone that's going to get trained and then go put their shingle out across the street from them. So I think the new regulation will provide benefits in that regard. In closing, I just suggest that over the past 10 or 15 minutes, the three of us that have testified, have referred to PAREA, FDICIA, USPAP, AQB, Riegle-Neal Act, and federally regulated transactions. We apologize for the acronyms, but those are all part of the process. Be happy to address any questions.

JACOBSON: I would say I get sick to my stomach every time I hear those particular acronyms, just so you know. Questions for Mr. Hallstrom? OK, if not, thank you for your testimony.

ROBERT HALLSTROM: Thank you.

JACOBSON: Other proponent testimony? Seeing none, anyone wishing to speak in opposition to the bill? All right, seeing none, anyone wishing to speak in a neutral capacity? OK. Senator Dungan, you're welcome to close. Going to waive closing. I would note that there were no letters, either from proponents or opponents or neutral. With that, that concludes the testimony in our hearing today. And, so we will all declare the meeting adjourned.