[LB11 LB79 LB124]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Monday, March 2, 2015, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB11, LB79, and LB124. Senators present: Jim Scheer, Chairperson; Matt Williams, Vice Chairperson; Kathy Campbell; Joni Craighead; Mike Gloor; Sara Howard; Brett Lindstrom; and Paul Schumacher. Senators absent: None.

SENATOR SCHEER: Good afternoon. It is a little past the appointed time. Welcome to the Banking, Commerce and Insurance Committee hearings. My name is Jim Scheer, I'm from Norfolk, I represent the 19th Legislative District and I'll serve as the Chair this year, of the committee. The committee will take up the bills in the posted order. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposals of legislation that we'll have before us today. Committee members will be coming and going during the hearing. We have to introduce bills in other committees and are called away. It's not an indication we're not interested in the bill being heard at that time, it's just part of our process. To better facilitate today's proceeding, I would ask you to abide by a couple of the following suggestions: Please either turn your phone off or turn it on silent so we don't have ringing going on. If you are going to be testifying, if you could move towards the front chairs so that we know how many people might be testifying yet. The order of the testimony will go: the senator will introduce, we will have proponents, opponents, neutral, and then closing by the senator. Testifiers will sign in. You will need to fill out this pink sheet in its entirety and please give it to Jan on the end there as you come up so that she has the correct information. As well, when you start to testify, if you'd be so kind as to spell your first and last name at the very beginning so that the transcribers have that as they start to type the official minutes of the hearing. I would ask you to be concise. If somebody else has already said what you plan to say, it's okay to say that I am just trying to reiterate what others have said before me. That's perfectly fine, we will get that. If you're going to be testifying at the microphone, please make sure you're speaking into the microphone. And as well to my fellow senators, make sure that you don't have something in front of your microphone as you are talking as well. If you have written material and you would like the senators to have that, you will need ten copies. If you do not have 10 copies, Jake, our page, will be glad to make those for you. Just make sure you do that before you testify. It would be better to have that in front of us while you're testifying rather than later. If you wish not to testify, but you would like to express your interest as either a supporter or in opposition of a bill, in the back there are these white sign-in sheets. If you'd put your name and the bill that you're interested in and either supporting or opposing, that will go on the official records as well. Our committee counsel is Bill Marienau, to my right. And our committee clerk is Jan Foster, to my far left. And I will let the committee introduce themselves and we'll start with Senator Gloor this time.

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

SENATOR CAMPBELL: Kathy Campbell, District 25, Lincoln.

SENATOR CRAIGHEAD: Joni Craighead, District 6, Omaha.

SENATOR WILLIAMS: Matt Williams, District 36, Gothenburg.

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

SENATOR HOWARD: Sara Howard, District 9, midtown Omaha.

SENATOR SCHUMACHER: Paul Schumacher, District 22, Platte and parts of Colfax and Stanton Counties.

SENATOR SCHEER: And our page that's passing out stuff right now is Jake Kawamoto from Omaha and he's here to assist you as well. So having said that, we'll go ahead and start today's hearings with LB11. Senator Krist. [LB11]

SENATOR KRIST: (Exhibits 1, 2, 3, and 4) Thank you, Senator Scheer and members of the Banking, Commerce and Insurance Committee. For the record, my name is Bob Krist, B-o-b K-r-i-s-t, and I represent the 10th Legislative District in northwest Omaha along with north-central portions of Douglas County, which includes the city of Bennington. I appear before you today in introduction and support of LB11 and I want to preface by noting the pages are distributing some articles that I'd like to talk to, as well as an amendment which replaces the green copy. The amendment replaces the green copy. In all fairness, as we got to this point and arrived at this amendment, it's moving the bill from chapter 44 to chapter 68. So there are several of you who have experience or are currently sitting on Health and Human Services and are also on the referencing portion and you will understand that that means that this bill potentially could have gone to HHS for its subject matter because of the chapter that it actually covers. The hearing notice was scheduled. I think I'll get just as good a hearing here as I will in HHS because I know you all understand the subject matter that we will be talking about. The bill addresses a situation with managed care plans and reimbursement of services provided by family members as providers. AM563 strikes the original section that amended insurance provisions relating to managed care and provides an exception to the Medicaid reimbursement provisions under managed care plans, stating that the requirements under Medicaid must not prohibit reimbursement of providers solely based on a family relationship between the patient and the provider. I'd ask you to look first at the article dated...from the Lincoln Journal Star, dated

December 2, 2012. And as you might peruse that, and I'll highlight the section for you here before I finish my introduction, and then we'll move to the next. Senator "Cap" Dierks, whose intentions were well served in this body, served for many years with great distinction, had an issue with the Shaffer family of Brian and Dee. Brian, as they refer to him--the boy in the bubble--Dee, his mother, who has provided the care that she has for years and years. And the article by itself will confront you with a little bit of emotion and tear, but it's good. And the article was a good one. Joanne Young wrote it very well. "Cap" went to the Department of Health and Human Services--Senator Dierks, I'm sorry--went to the Department of Health and Human Services and tried to negotiate with them as though they had a moral conscience and compass. And they agreed that they would provide those services for the Shaffer family, kind of a handshake. Senator Dierks did something that we all do occasionally. We trusted, and he pulled back his bill. The department then later...the department administrator reneged on the contract and the agreement that was made with the Shaffer family. And what you see here is the results of that. On page 3 of that article, after Senator Dierks pulled back and years of this happening and Senator Bloomfield became involved with it, and Senator Bloomfield and I were sharing an office at the time. He pulled back from the situation and said, you're on Health and Human Services, you need to deal with this. I tried to negotiate with the Department of Health and Human Services. I tried to make that contractual deal. I tried to make them understand that this is a mother who is dedicated to now her adult son and had given everything to that adult son. And they had contracted and were paying for those services in accordance with that agreement and then had basically reneged again on it and I wanted them to reconsider. I met with a stone wall. At that point it became obvious...and, by the way, I think Senator Campbell, Senator Gloor, and Senator Howard, to some extent, were involved with that discussion. As painful as it is to realize that you are one of 49 and we don't have the power to tell the department what they can and cannot do or should and should not do, it became obvious to me that this needed to go to legal. And I made a personal appeal to Mr. Alan Peterson, whose ability and his professional reputation is impeccable, to try to intervene in this process and carry it forward. The second article is written with reference to the kinds of things that had been done and how Senator Dierks was there. Again, I'll leave you to read that one. But in the first one, on that third page, it said that I did intervene on the Shaffers' behalf. And to that end, Dee and Brian Shaffer then I thought were in pretty good hands with Mr. Peterson. The third article, dated January 24, 2014, said that the ruling, in fact, was in favor of the Shaffers' claim and indeed something was going to be done legally to make sure that those services would be provided. Unfortunately, there was a technicality in the fact that the law firm that was representing...legal that was representing the Shaffers did not include Coventry as a provider in the negotiation. That's my layman's interpretation and I'm sure Mr. Peterson can correct me if I'm wrong. But at the present time, even the legal system has failed this family. So I'm not backing off of this bill. I'm going to bring this with all haste, if you'll allow me to, to make sure that if a mother wants to take care of her son and if she is indeed qualified to do that at home--which I think by the articles you will see that there is a compelling reason to keep Brian in his home with his mother as a primary care

provider who is qualified to do that--that we need to keep him there rather than institutionalizing him because I don't...I believe and I think the medical field will tell you, the doctors will tell you, there isn't another alternative besides institutionalizing the child or the young man now. I would save the rest of my comments for closing. I'll tell you that this has been an arduous journey for Senator Dierks, Senator Bloomfield, Senator Krist. But just imagine what this mother is going through, having the ability to take care of her child at home, building a home around his needs, trying to make sure that every waking moment of her time is spent with her son. Knowing that she has that kind of support from the state and then the rug is pulled out from underneath you. Imagine that you've spent all of your money and getting close to a point where the money is going to run out; and there's a technicality here; and there's a broken promise there; and the state of Nebraska is not there for you when you need them most. Thank you. [LB11]

SENATOR SCHEER: Thank you, Senator Krist. Any questions? Senator Craighead. [LB11]

SENATOR CRAIGHEAD: Thank you, Mr. Chairman. Hi, Senator Krist, just a question. This mother who is the care provider is not receiving any kind of assistance on this. Is the son receiving some assistance from the state? [LB11]

SENATOR KRIST: What we have negotiated in the past--and I can't speak to the exact amount right now--but there were some avenues to try to fund certain silos of activity, not the total care, certainly. And, again, it's...they came forward and made some concession, but not nearly what was initially contracted with the state. [LB11]

SENATOR CRAIGHEAD: Thank you. [LB11]

SENATOR SCHEER: Any other questions? Seeing none, thank you. I now open it to proponents of LB11. Good afternoon. [LB11]

ALAN PETERSON: (Exhibit 5) Good afternoon, Senator Scheer and members of the Banking, Commerce and Insurance Committee. I'm Alan Peterson, A-l-a-n P-e-t-e-r-s-o-n, I appear in behalf of myself. I am the lawyer for Ms. Shaffer and her handicapped son, Brian, also, but I'm not their lobbyist. I'm here as a lawyer trying to seek justice. This bill, LB11, would close off one escape mechanism that the state has used in the past to keep from having Mrs. Shaffer being the private duty nurse for her son. This bill would prevent what I call the excuse. Oh, well, she's a member of the family. And, therefore, under the managed care rules that...Coventry Care is the managed care contractor to the state has...under those rules they said, we can't have family members being a provider. This has kind of a long history. It goes back to 2007 when Senator "Cap" Dierks believed, at least, he had negotiated a solution which seemed so simple. Mrs. Shaffer is a licensed practical nurse, qualified, licensed then, licensed now. Her son has multiple

handicaps, not only autism and retardation, but also an extreme form of hyperallergenic condition so that this guy is allergic to all kinds of very ordinary things and cannot be around pets, perfumes, various deodorants, that sort of thing or anybody who's wearing them. Okay? That's the background. Are we on...do we have three minutes or five minutes? [LB11]

SENATOR SCHEER: Five. [LB11]

ALAN PETERSON: Thank you very much, I'll really try to do that. So Senator Dierks first, back in 2007, entered into what he considered an agreement with HHS to hire her as Brian's private-duty nurse, full-time for a fair pay. Brian has extreme medical costs and she, Mrs. Shaffer, Dee Shaffer she's called, took on responsibility to buy everything needed. She used her salary, in part, to build a home in Ashland that is built to avoid many of the allergies from, well, insulation and all kinds of stuff. And she has...and they still live there. She's broke. You want to know why? Because after keeping the arrangement to hire her for five years, in 2011 HHS simply told her and Brian, well, we're going to drop your waiver position whereby you work for us on a fee basis, Mrs. Shaffer and Brian. We're going to turn you over to managed care. Within a very short time, the managed care company, Coventry, said, oh, well, we don't think Brian really has the medical necessity for this service. And furthermore, even if he did, Mrs. Shaffer, we wouldn't hire you because you're a member of the family and we have a rule against that. HHS had no such rule, but they turned her over to somebody who did have the rule. She hasn't had a dime of income from work since then, 2011, and she's expended everything. You can't pass a law just for one person or family, I know that. But there would be many others in the same position if this excuse--so call it--is allowed to stand. That no...even though you're a nurse, you're qualified, you have an extremely unusual situation where your own family needs constant care, you can't be hired because you're a member of the family. All this bill does--and it's directed only toward the managed care contractor of HHS under the amendment that Senator Krist is offering in place of the bill--it only applies to the managed care companies who work for HHS to fill those needs under Medicaid and it would wipe out that excuse. That's all it does. I need to bring you up to date and in order to do that, I handed out the history of this situation that is shown in the committee hearing two years, three years ago in 2012, when Senator Bloomfield brought a bill which he thought would shut off this excuse. And Senator Campbell, Senator Gloor, and a number of you, I believe were...well, some of you were on that committee at the time. And Mrs. Shaffer came in at that time, frankly, very emotionally. I didn't ask her to come in this time. At any rate, another lawyer had the case for her, proved there was medical necessity in court in Lancaster County. However, he made a fatal flaw. He failed to name the insurance company, Coventry, as a separate defendant and that's what Senator Krist referred to. The Supreme Court, a month or two ago, reversed that finding, dismissed the case. There's another case that I'm handling separately at Ms. Shaffer's request and Brian's and others who requested me. I'm suing on contract. That case is coming up for trial in May. I think there was a contract, partly oral and partly written, between HHS and the Shaffers. This bill has nothing to do with that lawsuit, just

to clarify. I'm not trying to improve my hold with legislation as to that lawsuit. However, this is the third try to get HHS to deal in good faith with the poor little Shaffer family. They're broke, they're out of money, they're living on charity. She's qualified, she's a nurse, and our concern is that either HHS or the managed care company--now owned by Aetna, by the way--will pull the same excuse out again and say, no deal, we won't hire you. That shouldn't happen. I would ask that you advance LB11. It's a decent bill. It was too broad as originally written because we only mean to cover the managed care contractor for the state, not other insurance companies. Thank you very much. [LB11]

SENATOR SCHEER: Thank you, Mr. Peterson. Any questions? Senator Craighead. [LB11]

SENATOR CRAIGHEAD: Thank you, Mr. Chair. Thank you, Mr. Peterson, for being here. [LB11]

ALAN PETERSON: Yes. [LB11]

SENATOR CRAIGHEAD: Do you have any idea how many cases there might be like Brian's and Dee's in the state aid? I mean, maybe you do, maybe you don't. I'm just curious. [LB11]

ALAN PETERSON: I asked that question in an interrogatory in court and really never did get an answer. There would be a few, but I don't know how many. And, of course, that stuff is pretty private, you can't really get at it. [LB11]

SENATOR CRAIGHEAD: Thank you. [LB11]

ALAN PETERSON: Yes, thank you. [LB11]

SENATOR SCHEER: But there would be more than just the singular case that you've discussed. [LB11]

ALAN PETERSON: Oh, yes. Oh, yes. [LB11]

SENATOR SCHEER: So we're not looking at it as any type of special legislation. [LB11]

ALAN PETERSON: Absolutely. [LB11]

SENATOR SCHEER: Okay. Any other questions? Senator Campbell. [LB11]

SENATOR CAMPBELL: Yes, thank you, Chairman Scheer. Mr. Peterson, is Coventry still the managed care company that...or...and that's turned into Aetna? Is that what you're saying? [LB11]

ALAN PETERSON: Yes. I believe...I don't know if they did it by a merger or what. And I do think they still use the name, at least in some states. But it was...Coventry was purchased by Aetna, which is one of the five largest insurance companies in the world. [LB11]

SENATOR CAMPBELL: Which I think would mean now that Aetna has the managed care company that would service... [LB11]

ALAN PETERSON: Yes. Yes, that's correct. And there are three other companies that have some of their managed care contract. I guess they're spread across the state. Yes. [LB11]

SENATOR CAMPBELL: So it's because in the contract...in the managed care contract there's no requirement. And therefore, they can hire who they wish to take care of the individual. Is that the thrust of this? [LB11]

ALAN PETERSON: Yes, that's correct. They said, well, we have our own rules. We don't care what Senator Bloomfield's bill said. We're not going to hire any member of the family as a provider. [LB11]

SENATOR CAMPBELL: Mr. Peterson, just for the record, when did the managed care company start...came into the picture versus when the department...maybe we should make sure we clarify that. [LB11]

ALAN PETERSON: And my understanding is, the managed care company or a managed care company has been involved for many years, at least back ten or so, perhaps even longer. In this case, they came on the scene in 2011 when HHS decided to withdraw its waiver treatment of the Shaffers and turned her over to managed care without much, if any, explanation. [LB11]

SENATOR CAMPBELL: Because we have managed care in the state. We started out with five counties, I think, three counties and then we expanded that. And then we went statewide in managed care for physical health. We just recently added behavioral health. So my guess is that part of the time, if I remember well enough, when we were all on the Health Committee seeing this, at that point the department had some responsibility and was paying and then said, no. And I think they said no prior to the managed contractor even saying no. And that's what I recall, for the record. [LB11]

ALAN PETERSON: They might have, but not to Ms. Shaffer. They paid her for five years under the contract. Then, as far as I'm concerned, breached it. So that's what the lawsuit...and I'm not trying to win a lawsuit over here, but that's our position. [LB11]

SENATOR CAMPBELL: No, I understand. Okay. Thank you, Mr. Peterson. [LB11]

ALAN PETERSON: Thank you very much. [LB11]

SENATOR SCHEER: Thank you, Senator Campbell. Anything else? Senator Schumacher. [LB11]

SENATOR SCHUMACHER: Thank you, Senator Scheer. Thank you for your testimony. [LB11]

ALAN PETERSON: Yes. [LB11]

SENATOR SCHUMACHER: As a practical matter, wouldn't it be a lot more economical to pay the mother than to pay somebody else? I mean,... [LB11]

ALAN PETERSON: Yes. HHS did a careful study before they entered into that contract in 2007; and I have the itemization. They spent much more in 2006 on the Shaffers than they did under the contract. So from a financial standpoint, it doesn't seem to have made any sense. But there was some sort of a cutback philosophy in 2011, perhaps under a new director of part of the department. I don't know. But there were a number of cutbacks Mrs. Shaffer was caught by the reaper and her contract was disrespected, at the very least. And I will say, breached, in court. [LB11]

SENATOR SCHUMACHER: Thank you. [LB11]

ALAN PETERSON: Yes. [LB11]

SENATOR SCHEER: Any other questions? Thank you, Mr. Peterson. [LB11]

ALAN PETERSON: Thank you, Senator. [LB11]

SENATOR SCHEER: The next proponent. Seeing none, are there any opponents to LB11? Seeing none, are there any in a neutral capacity that would wish to testify? Seeing none, again, Senator Krist. [LB11]

SENATOR KRIST: Just to be clear--and I don't want to mess this up--Dee Shaffer...in the HHS review, Dee Shaffer...and the Coventry denial, they found that Brian did not have a medical necessity. And if why we're pleading this in front of HHS, that would have been the hardest or the most hard-core of my testimony here today. And in Exec, I'm sure you can have the Chair of HHS and her Vice Chair explain that medical necessity, which is going to be an interesting conversation. The district judge in Lancaster court disagreed, finding that medical necessity for at least 18 hours a day was needed given all the compelling testimony that came before him. That opinion was vacated, as you heard from Mr. Peterson, on the grounds that Coventry wasn't involved. To your point, Senator Schumacher, she was only being paid for 18 hours a day for private-duty nursing. If this young man has to go to a facility with over 90 individual allergies to anything he breathes and anything he feels...I mean they go to the point...you can read it in the articles. She goes to the point where she has to wash her clothes with lye and the floor has to be cleaned and vacuumed almost daily. Those kinds of things, I'm not sure that he would receive that kind of care in a facility. And we'd be paying full-time in a facility 24 hours a day. I don't think the economic interests alone warrants the kind of behavior on the part of the state and the treatment of the Shaffer family. So I would ask you, please, to kick this one out and let's get another attempt to try to make sure that people like Brian can be taken care of by people in their homes who are, potentially, family members and others and we can keep our families together. [LB11]

SENATOR SCHEER: Any questions? Senator Campbell. [LB11]

SENATOR CAMPBELL: Thank you, Senator Scheer. Senator Krist--and you may not know the answer to this--but even though if you say, well, there's a facility, in all of the discussions of this, has anyone ever asked if there even is a facility with all of the allergies that you've just described? [LB11]

SENATOR KRIST: If you recall back to some testimony from Ms. Chaumont during one of these hearings, there would have to be special provisions within an existing facility, but that first there would have to be identified a medical necessity that would move him out of there. So the conversation was kind of circuitous in terms of, do we have a facility? Yes, but we'd have to do this. And, but there really isn't a need for. And so it went round and round. [LB11]

SENATOR CAMPBELL: Thank you. [LB11]

SENATOR KRIST: You bet. [LB11]

SENATOR SCHEER: Any other questions? Senator Krist, just wanted to clarify that the bill is for the state of Nebraska. And I'm assuming you're using the example you brought forward today

just simply as an example of those things that could happen to an individual. It's not necessarily because of that that we're bringing the bill. [LB11]

SENATOR KRIST: Absolutely. And to that point, Senator Scheer, there's been legislative intent on the floor of debate where I've highlighted a couple that, again, he is a doctor and she I think is a lawyer or a nurse. But they have two children that they keep at home and they were restricted from doing the same thing. There was another example of a young man, almost violent in nature, autistic, who they are taking care of at home and they were denied that payment. In those other two cases that I just referenced to you, there was wherewithal with the parents to be able to do something and they were not about to give up their children. But we had a specific example in Health and Human Services of a family that basically had to put their children...a child up for adoption because they couldn't handle it. And the other three or four kids in the family were going to suffer unless they did something with that one child. So it's not an anomaly, it's not special legislation. And to that point, the department can do what the department will do. Magellan does exactly what the department tells them to do, either in terms of contract or in their authority, and then the managed care companies also can have regulatory. And my whole point in this since I started this effort was, they're Nebraska citizens first and they're business clients or customers of that managed care company last. It's our responsibility, just as it is in foster care, case management, and a few other of those things that we have a responsibility to those citizens that needs to be carried out. [LB11]

SENATOR SCHEER: Thank you very much. [LB11]

SENATOR KRIST: Thank you, Senator. Thank you for your attention. [LB11]

SENATOR SCHEER: And with that, that ends the hearing on LB11. And the next hearing will be LB79, Senator Gloor. And while the senator is taking his position, I neglected to state that we do use the light system. There...you have five minutes for your testimony. The green light will be on for the first four minutes. If your yellow light comes on, that means you have one minute left. The red light comes on, that means your time is up and I would appreciate it if you would curtail your comments. And if you don't then we'll help you. So with that being said, Senator Gloor. [LB11 LB79]

SENATOR GLOOR: (Exhibit 1) Thank you, Chairman Scheer. And good afternoon, fellow committee members. I've got a bill that's not very technical. At least it's something we can all relate to if we've ever tried to put eye drops in. LB79 was brought to me by the Nebraska Academy of Eye Physicians and Surgeons. LB79 is meant to help patients who rely on eye drops for treatment of glaucoma and other degenerative eye diseases. Unlike a pill or a closely measured injection, eye drops can be a bit tricky to measure precisely. Squeeze too hard and you

get two drops rather than one. Bump your arm while you're trying to put a drop in your eye, it ends up on your cheek or in your ear or, if you're especially clumsy like I am, maybe in your mouth. But my point is, unlike a dropped pill which you can recover, once you've squeezed that eye drop, you can't put it back in the little bottle, and it's not recoverable. And therein lies the problems. That means a person with eye drops might run out of the product before the prescription time frame has been met. The effectiveness of prescription eye drops relies heavily upon continuity of treatment, specifically consistent daily usage by the patient. LB79 was drafted to make sure that persons using eye drop treatments would be able to get their treatment in a timely manner with insurance coverage even if they run out of the product a little before the refill date because of the problems I just identified. I've handed out an amendment. The green copy of the bill only states that a refill can be obtained before the 6...30, 60, or 90 days of the prescription. What...AM479, which replaces the green copy of the bill, points out or restates that refill time frames are plugged into a window of time that equates approximately to one-quarter of the prescription so that on a 30-day prescription, they could get a refill beginning day 23. On a 60-day prescription, a refill would be given starting day 45. And a 90-day prescription could be refilled starting on day 60. This window of time frame, and it's an important piece, mirrors language used by Medicare since 2010. Nebraska Medicaid, which always falls in line behind Medicare, also covers eye drops just like Medicare in the same window of time we've plugged into the green copy. When I first saw this I thought, well--and this was one of my learnings--why not just prescribe a larger dose to compensate for this or two bottles rather than one bottle? What I didn't realize is that insurers are actually the ones who determined what we're given in terms of eye drops. And they measure out or at least do the calculation of how many drops in a vial and...or a bottle, and that's how the bottles are, in fact, distributed to us. So there really is not that option available for the practitioner or pharmacist. Nothing in this bill, by the way, would prevent copays/deductibles appropriately being charged as relates to this. I'd be glad to answer any questions. There will be some testifiers who are practitioners who I think can handle the more technical aspects of this. And with that, I'd ask for your approval of LB79 and then the AM479. [LB79]

SENATOR SCHEER: Thank you, Senator Gloor. Senator Campbell. [LB79]

SENATOR CAMPBELL: Thank you, Chairman Scheer. I'm probably paying a closer attention to this bill in the sense that I started taking a look at it in depth over the noon hour because, as many of you know, I just recently had eye surgery. And so I am daily working with eye drops. Senator Gloor, one of the questions that was posed to me by someone who visited with me this morning is that this covers medication that is very difficult to get into the eye. What specific medications does your bill cover? [LB79]

SENATOR GLOOR: I'd leave it to the practitioners to answer, but it allows me to make a...make note that we're not talking about, in this bill, if you go in and you...we all get blepharitis or pink

eye or something where we get a single prescription and we're supposed to take that until it's finished. This really only relates to those more elaborate diseases for which you're going to get multiple refills. So for this to take effect, it has to be something that you may get a 30-day script, but it's one that you have refills on. So if you get a script that doesn't have refills, this bill does not apply. It only applies to the glaucomas and some of the other more degenerative and disabling diseases that are out there. And that's the reason this bill is important. It isn't for just every little eye infection that you may get a one-time script. It's for the ones for which there is probably going to be long...there's going to be long-term usage. I think the practitioners can give you more specific examples of that. But that's why it caught my attention. To cut somebody off after...especially somebody who maybe suffers from some other debilitating disease, has a hard time keeping their hand steady, now we're talking about maybe they have to wait eight or nine days before they're taking treatments until they can get it refilled. Unlike your, you know, little eye infections that if it hasn't cleared up by that third week, you probably should be going back to your doctor anyway. In this case, the diagnosis has been made, there is an expectation that you're going to be taking this for a prolonged period of time. Yet you have to go through a period of time to wait to get it refilled. And that's a little scary with some of the eye diseases we're talking about. And that's why this bill caught my attention. [LB79]

SENATOR SCHEER: Thank you, Senator Campbell. Senator Howard and then Senator Williams. [LB79]

SENATOR HOWARD: Thank you, Senator Scheer. I...just to clarify, the refill time frames that are outlined in the amendment, those follow time lines that are already used by Nebraska Medicaid and Medicare? [LB79]

SENATOR GLOOR: Yeah, exactly. [LB79]

SENATOR HOWARD: Okay. And then how many other states have implemented this type of legislation? [LB79]

SENATOR GLOOR: I believe, in reading through my material, it's a dozen, 15, something like that. [LB79]

SENATOR HOWARD: Okay. [LB79]

SENATOR GLOOR: I'm not sure what that the final count was in. But it seemed to me that that's a rough count...maybe one-third of the states. [LB79]

SENATOR HOWARD: And just...it...my thought is that the purpose is for individuals with chronic illnesses or degenerative illnesses...and if their supply runs out early, that could exacerbate their condition, leading to increased claims to the insurance company. [LB79]

SENATOR GLOOR: Exactly. [LB79]

SENATOR HOWARD: Is that kind of your thought? [LB79]

SENATOR GLOOR: Sure, exactly. [LB79]

SENATOR HOWARD: Perfect. Thank you. [LB79]

SENATOR SCHEER: Senator Williams. [LB79]

SENATOR WILLIAMS: Thank you, Senator Scheer. Senator Gloor, I just had a question about your testimony to just be sure I understood what you said. I think you indicated in your testimony that the insurer actually has some say in the volume of the medication that goes into the little eye dropper thing. They're determining that, not the manufacturer? [LB79]

SENATOR GLOOR: Yeah, there is a...I mean, I...my understanding of how it works is that manufacturers are, in fact, standardized to packaging based upon the number of drops that they know will be paid for: 30, 60, 90 days. So if you're supposed to put two drops in each eye, the amount that you would get would relate to two drops in each eye or four drops per application whenever that is. But that...and that makes sense to me because when you look at pill vials and the times...or, excuse me, eye drop dispensers, when you look at the bench time that pharmacists have to spend doing a lot of things to measure out or titrate out a certain amount in a little vial and then close it up and maintain sterile procedure and all this, I can understand why what the manufacturers try and do is come up with dosages that fit what the insurers will pay for, so. [LB79]

SENATOR WILLIAMS: Okay. My question was, who was setting that level? And your testimony is, it's the insurer. Thank you. [LB79]

SENATOR SCHEER: Any other questions? Seeing none, thank you, Senator Gloor. [LB79]

SENATOR GLOOR: Thank you. [LB79]

SENATOR SCHEER: I'm assuming you're going to stick around to close. [LB79]

SENATOR GLOOR: I plan to. [LB79]

SENATOR SCHEER: And now open the testimony to proponents. And again, if you're going to be testifying, if you could move towards the front so that we can expedite the movement between testifiers, that would be great. [LB79]

MICHAEL FEILMEIER: (Exhibits 3 and 4) Okay. Good afternoon. Thank you, Chairman Scheer, and thank you to the rest of the committee. My name is Michael Feilmeier. That's F-e-i-l-m-e-i-e-r. I am an ophthalmologist in Omaha, Nebraska. I am the current president of the Nebraska Academy of Eye Physicians and Surgeons. I am speaking to you today in favor of LB79, a bill that would require insurance coverage of early refills of prescription eye drop medications. Many of the eye diseases that we see and treat are chronic conditions that need to be treated with prescription eye drop medications. In most cases, these eye drops are administered daily, sometimes several times per day, often over a period of several months and, in some cases, years. Patients treated with eye drop medications are instructed to administer only one drop at a time to their eye. If you have ever administered eye drops to yourself, this seemingly simple task is actually quite difficult. Now imagine patients with other complicated medical conditions such as Parkinson's disease, Alzheimer's disease, severe arthritis, a tremor or other musculoskeletal problem trying to precisely squeeze the bottle to administer a single drop to their eye. Furthermore, as you can imagine, many of our patients have poor vision from glaucoma and coexisting eye diseases such as cataracts and macular degeneration, making it even more difficult for them. Even the most experienced patients without these confounding conditions will commonly miss their eye with the drop or administer more than one drop at a time. As a result, many patients are running out of medications early. And due to current legislation, they are not able to get their prescription refills covered. Most patients will simply wait the few extra days for the medication refill without administering their drops. This is an issue that we face and have to address on a weekly, if not daily, basis in our practice. Patients who go untreated, even for short periods of time, risk permanent vision loss and increased likelihood of failed medical treatment and the necessity of surgical intervention. Currently, early refills prior to the predicted days of use are not permitted by insurance companies. However, because of the difficulty for patients administering these drugs and the poor outcomes that are made possible by these treatment delays, a different standard is needed for eye drop medicines. It is important to note that other states across the country are beginning to address the same problem as evidenced by the map that is included in your information. And the first entity to put regulations in place was CMS, the Centers for Medicare and Medicaid services, directing early prescription refills at 21 days for a 30-day supply for Part D participants. LB79, as introduced by Senator Gloor, reflected the language that four states are currently using, directing refill coverage when needed. Senator Gloor's suggested amendment proposes an even more limited requirement

matching the language of New Mexico and Alaska. Passage of LB79 would ensure that our patients and the citizens of Nebraska have continuous access to eye drop medicines by ensuring early refills can be obtained with the consent of their prescriber prior to the end of the intended period of use. I thank you for your time and welcome any questions. [LB79]

SENATOR SCHEER: Senator Craighead. [LB79]

SENATOR CRAIGHEAD: Thank you, Mr. Chairman. Hi, Dr. Feilmeier. [LB79]

MICHAEL FEILMEIER: Hi. [LB79]

SENATOR CRAIGHEAD: Thank you for being here today. Obviously I understand this in having dealt with an elderly parent, but has anyone ever considered going to the manufacturers and saying, can we do a different eye drop bottle, something like an eyewash cup or something that would allow patients with glaucoma or maybe some type of palsy or just old who, you know, have difficulty applying these drops...has it been...has this issue been looked at from that aspect as well? [LB79]

MICHAEL FEILMEIER: Sure. That's a great question. And I think there's a lot of research and money that goes into developing delivery systems that are easy. And maybe there are also devices that can facilitate drop application. But the technology isn't perfect and so I think that the manufacturer's response to that at this point in time is to put a few extra drops in the bottle. But still, we have patients that are running out routinely. So this bill is, you know, really to, you know, give them a little bit more wiggle room. Okay. [LB79]

SENATOR CRAIGHEAD: Thank you. [LB79]

MICHAEL FEILMEIER: You're welcome. Thank you. [LB79]

SENATOR SCHEER: Senator Howard. [LB79]

SENATOR HOWARD: Thank you, Senator Scheer. Thank you, Doctor, for your testimony today. What happens when a patient doesn't get their eye drops? [LB79]

MICHAEL FEILMEIER: Well, it certainly depends on the condition that's treated. You know, the majority of conditions addressed in this bill are chronic conditions such as glaucoma or chronic inflammatory conditions of the eye or infections of the eye. So it certainly depends on

which condition you're treating. But if patients go for, you know, any period of time, even short periods of time, untreated, there certainly can be permanent vision loss in those patients with these conditions that we're talking about. [LB79]

SENATOR HOWARD: Thank you. [LB79]

SENATOR SCHEER: Senator Schumacher. [LB79]

SENATOR SCHUMACHER: Thank you, Senator Scheer. Is...my mother is in a retirement center. And she has the same problem that you guys described here today. And the...and she...when she drops the drops, she misses often. But as...they used to have one of the aides or CNAs that was in the retirement center do it. And recently they've stopped doing it, saying that it was causing a malpractice issue or something like that. Is...are these things dangerous if you don't put them in right? [LB79]

MICHAEL FEILMEIER: You know, that's a good question. Not to my knowledge. I mean, you know, obviously there's danger in missing with the drops. But I think that, for many of these patients, they need to have their drops put in by someone else, many nursing home patients, because they don't have the ability, you know, to put the drops in at all. But from a malpractice standpoint, I don't think that there's a risk in somebody else applying the drops. Does that answer your question? [LB79]

SENATOR SCHUMACHER: I think it does. What I'm getting at is that a lot of these drops are being missed because people just are shaking or whatever when they're dropping them and if there is a malpractice issue or some kind of issue then maybe that's the place we should address, too. But if that really shouldn't be an issue then I guess there's nothing we can do about that part of it. [LB79]

MICHAEL FEILMEIER: I think that the people who do have somebody who can administer the drops or help administer the drops are really blessed because there are, you know, a lot of my patients who still live at home and live by themselves. And they're the ones that are really affected by this bill, you know, patients who put in maybe three or four different drops one, two, or three times a day and they have a great deal of difficulty in doing so even though they're doing it so many, you know, so many times per day. And those are the patients really that are impacted by this bill. [LB79]

SENATOR SCHUMACHER: Are the drops all the same chemicals or are there different kinds of drops? [LB79]

MICHAEL FEILMEIER: You know, there's...yes, so I don't know...I don't have an exact number for you. But there's, you know, several different types of medicated eye drops that work to treat different eye conditions. So I don't know an exact number for you, yeah, but they're all different in composition. [LB79]

SENATOR SCHUMACHER: Thank you. Thank you. [LB79]

MICHAEL FEILMEIER: Sure. [LB79]

SENATOR SCHEER: Dr. Feilmeier, the Part D, based on Senator Gloor's testimony or somebody's--I can't remember, maybe it was yours--that provides the refill at 21 days, this is at 23. Are most insurance companies already providing this at 23? Is there just a problem with part of the industry or, you know, what part of it is not working properly? [LB79]

MICHAEL FEILMEIER: To my knowledge, Medicare and Medicaid are the only ones who are, at this point in time, allowing early refills beyond...or before the 30-day or 60-day or 90-day if that's the way the prescription is written. They're the only ones who currently allow for early refills. So I think that, you know, this bill addresses all the insurance providers outside of Medicare and Medicaid to allow patients to get their refill...their prescriptions refilled early. And what we're shooting for here is one week for the 30-day refill, two weeks for the 60-day refill, and three weeks early for the 90-day refill. [LB79]

SENATOR SCHEER: So to your knowledge, the only participants that are able to do this early are those that would be under Part D? Is that...regurgitating what you just said? [LB79]

MICHAEL FEILMEIER: Right, with the current legislation. [LB79]

SENATOR SCHEER: Under the current legislation, yes, okay. [LB79]

MICHAEL FEILMEIER: Yes. [LB79]

SENATOR SCHEER: Any other questions? Thank you very much, Dr. Feilmeier, for coming down. [LB79]

MICHAEL FEILMEIER: (Exhibit 5) Okay, thank you. And I also have a letter in support of this bill from the Nebraska Medical Association. [LB79]

SENATOR SCHEER: Okay, thank you very much. The next proponent? Good afternoon and welcome. [LB79]

JOHN PETERS: (Exhibit 6) Thank you. Good afternoon, ladies and gentlemen, Senator Scheer, Senators. My name is John Peters. I'm an ophthalmologist. I practice in Omaha, Nebraska. I am here testifying in support of LB79. In daily practice, my colleagues and I ask our patients to instill eye drops to treat various conditions: infections, inflammation, glaucoma, and even eye pain. And we do this because of the restraints of human anatomy and the physiology which limit the effects of drugs administered by other routes. And I'm sure you're wondering, why all this discussion of eye drops? Can't we use another method to get the drug to the site? But if we can get eye drops in the eye, for many conditions, it's actually much more effective and it can lower the chance of systemic side effects which might occur with an oral medication or an infusion. And so that's why all the fuss about using an eye drop versus another medication. On the other hand, the downside is, of course, the issue of dexterity and practice with our patients. And particularly our elderly patients may be unable to accomplish this task reliably or consistently. The eye drop bottles and dispensing tips can also present design flaws which lead to waste or inadvertent excess use despite the patient's best efforts. Multiple studies in the literature have shown that even patients experienced at self-administering their eye drops 50 percent or more of the time can deliver more than one drop or miss the eye entirely, leading to wastage of a portion of their given volume of medication. In these circumstances, our patients or their pharmacist may notify us that the patient has run out of their eye drop. And unfortunately, some are refused a refill until their insurance coverage permits. Of course, they may pay out of pocket, but for some of them that is simply prohibitive. Other times, our patients will simply go without the medication and we will know nothing of it until they arrive for their next appointment and we are alarmed to find out that they have not been taking their glaucoma medication for X number of days. This leaves our patients exposed to progression of their glaucoma, worsening of the inflammation or infection that they may have, as well as eye pain and, of course, potentially loss of sight. Also, this can lead to a situation where, let's say, their glaucoma progresses and they're not able to get their refills. We as the clinicians are then forced to make other decisions. Well, do we then move to something more invasive such as performing laser treatment or performing surgery to try to control or fix the patients's condition? Of course, we can sometimes give them samples, but that's not a very reliable option. We run out of samples quickly and sometimes we don't have the right medication for them. To address the situation and assist our patients, we are requesting passage of this legislation. The amendment offered, as noted, is a different number of days. And I would say that, on average, it's two, three, four times per week that I run into this with my patients. Take that times maybe, oh, say 100 ophthalmologists in the state and then optometrists who prescribe this, 300 or 400 of them, you get an idea of how many patients this concerns. In my opinion, LB79 is a step to serve the well-being of our citizens, improve the quality of their lives, increase their ability to function productively at home and work, and decrease the number of incidents whereby a patient who is willing to follow their proper

treatment plan is denied access to the proper medication. For that reason, I ask you to advance LB79 to General File. And I would be happy to answer any questions you might have. [LB79]

SENATOR SCHEER: Thank you. Dr. Williams...or, (Laughter) Senator Williams. [LB79]

SENATOR WILLIAMS: I jumped right in there. (Laugh) [LB79]

SENATOR SCHEER: Well, doctor of law, I guess. [LB79]

SENATOR WILLIAMS: Thank you, Senator Scheer. Dr. Peters, a couple of questions: How expensive are these drugs that we're talking about here? [LB79]

JOHN PETERS: The expense will vary for different reasons. Some medications will run, for the patient, maybe $30 to $40. Other will $100 to...I've had some of my patients say upwards to $120, $130 for a bottle. [LB79]

SENATOR WILLIAMS: So they're not inexpensive. [LB79]

JOHN PETERS: And to our patients, they can be very expensive. And I hear about that quite often. And mind you, it is important for the senators to understand that the option of prescribing generic medications is no longer always a distinctly less expensive option to our patients. The pharmaceutical industry is changing, and many of our patients, and actually many of our providers, are still of the thinking that the generics will come to the rescue and provide a less expensive option. That is not always the case. [LB79]

SENATOR WILLIAMS: You're lucky my wife is not in the room or she'd be doing jump twirls for you right now. She's experiencing that. Okay. So they're not inexpensive and they happen and the pure bottom line of this is, somebody is going to have to pay. If these are going on the cheek or off to the side and not getting in the eye, it's either going to be the insurance company that will have to readjust underwriting costs and premiums will be adjusted in some form...do you have any thoughts about that? [LB79]

JOHN PETERS: There are a number of obstacles in this situation. The issue we are trying to address is, of course, getting the medication in the patient's hands because if they don't get it in their hands, they can't get it in their eyes. This has been going on for decades, is trying to find mechanisms to more efficiently and accurately administer the drops. And many mechanisms, many tools, attachments, etcetera, have been attempted, some of which do slightly better, some of which have proven to do substantially worse. And obviously we don't have a great solution for

this. Otherwise we wouldn't probably be here. So I don't know the solution. I know the problem and I'm happy to talk with everybody involved about how we might accomplish this, be it more drops per bottle, for example, or there are many different ways to approach solutions. [LB79]

SENATOR WILLIAMS: Thank you. [LB79]

SENATOR SCHEER: Other questions? Senator Craighead. [LB79]

SENATOR CRAIGHEAD: Thank you, Mr. Chairman. Hi, Dr. Peters. [LB79]

JOHN PETERS: Hello. [LB79]

SENATOR CRAIGHEAD: Thanks for being here. [LB79]

JOHN PETERS: Sure. [LB79]

SENATOR CRAIGHEAD: For these eye drops that we're talking about, are they usually covered by Medicare or Medicaid insurance or are they paid for out of pocket? [LB79]

JOHN PETERS: The majority of them will be covered by insurance to varying degrees. And depending upon the insurance plan an individual has, they are typically set up in various tiers where some may be preferentially provided if there are several options. [LB79]

SENATOR CRAIGHEAD: Okay, thank you. [LB79]

SENATOR SCHEER: Senator Schumacher. [LB79]

SENATOR SCHUMACHER: Thank you, Senator Scheer, and thank you, Doctor. Are usually both eyes involved with these medications or do people need them in both eyes? [LB79]

JOHN PETERS: That's a good question. And it really depends upon the condition involved. So conditions that are treated long term such as glaucoma most commonly is a condition that occurs in both eyes and requires the patient to instill one or several different types of eye drops one to four times a day. And so that patient will be treating their disease indefinitely unless they progress to needing laser treatment or having surgery performed. Other conditions such as I see commonly which are serious eye infections on the surface of the eye are typically just one eye. But the situation I run into is, I have to use antibiotic drops to stop an infection on the surface of

the eye. And when we begin these eye drops for serious infections, the patient is often using them every one to two hours while they're awake. You can imagine they go through more than a standard quota of bottles to treat their infection which is serious. So those patients in my practice can run into this obstacle fairly quickly. They go back to the pharmacy for their refill and they say, no, you've used up a one-month supply already, not knowing what the patient's condition is. They've hit some quota. [LB79]

SENATOR SCHUMACHER: And no one has been able to come up with some gizmo that...to administer these things? [LB79]

JOHN PETERS: It's not for lack of effort, trust me. There are some interesting contraptions that are being developed, actually, all around the world. And probably the best devices would have to do with something that actually separates the eyelids which then, of course, can lead to trauma in the eye and then you have yet a new problem. And that's really the situation we have. And then there's the patient's stability and dexterity that comes into play. [LB79]

SENATOR SCHUMACHER: Thank you, Doctor. [LB79]

JOHN PETERS: Yes. [LB79]

SENATOR SCHEER: Senator Howard. [LB79]

SENATOR HOWARD: Thank you, Senator Scheer. Thank you, Doctor, for your testimony today. [LB79]

JOHN PETERS: Sure. [LB79]

SENATOR HOWARD: What's the role of the manufacturer in deciding how much a month's supply is? [LB79]

JOHN PETERS: It's my understanding from speaking to some of the representatives from the manufacturing companies that, particularly in regard to glaucoma medications, there is typically what's called an overfill amount. I cannot speak to the amount that that is, but a number of them tell us that there is an overfill amount so that there are more than 30 drops, for example, in a one-month supply. I'm not aware of the numbers and so I'm not going to make a comment to that. I have no idea what the quota is for, let's say, an antibiotic drop or an anti-inflammatory drop or a steroid drop which we will sometimes use much more often. [LB79]

SENATOR HOWARD: Thank you. [LB79]

SENATOR SCHEER: Other questions? I suspect if you could develop that new super-duper dropper that you would no longer be an ophthalmologist, you'd be deep-sea fishing in the Caribbean. (Laughter) [LB79]

JOHN PETERS: That is right. You are correct. [LB79]

SENATOR SCHEER: Having said that, I ask you the same question. Because Medicare and Medicaid provides the 21-day, to your knowledge, other insurers do not provide any type of early renewal or is it more isolated to certain parts of the insurance segment? [LB79]

JOHN PETERS: And I'm unaware and so I won't make any comment. [LB79]

SENATOR SCHEER: Okay. Fair enough. [LB79]

JOHN PETERS: I'd be happy to provide that. I can look it up and provide you guys with that information. [LB79]

SENATOR SCHEER: Okay. Thank you. [LB79]

JOHN PETERS: Yes. [LB79]

SENATOR SCHEER: Thank you for coming, Mr....Dr. Peters. [LB79]

JOHN PETERS: Thank you very much. [LB79]

SENATOR SCHEER: Next proponent? Seeing none, are there any opponents to LB79? Good afternoon. [LB79]

ERIC DUNNING: Good afternoon, Mr. Chairman. Members of the 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 and the director of government affairs for Blue Cross and Blue Shield of Nebraska, here today to testify in opposition to the mandate which would be imposed under LB79. The introducer statement for LB79 states that even using the most...the utmost care in storing and using the eye drops finds it nearly impossible to ration the medication to last for the period of intended use. We've heard additional testimony to that effect today. We've also heard that there is some overage built into

the bottles. But if, after having been counseled on the use of the prescription and using the utmost care it is nearly impossible to ration the medication, maybe this problem goes beyond a problem for the payers, but also goes to the manufacturers as some of the questions today have elicited. Insurers already have procedures in place to deal with the situation of spilled medications including Blue Cross and Blue Shield of Nebraska. Prescribers already have the ability to indicate what to dispense and how long it will last. Our providers are allowed to prescribe whatever quantity is needed for a 30- or 90-day supply or a 60-day supply, for that matter. When a refill has been prescribed by the prescription, insurers typically limit when a refill can be filled to a percentage of the duration of the prescription. In Blue Cross and Blue Shield's case, in the case of a 30-day prescription, our current policies allow our members to request the refill after 22 days. If the member needs a refill before that time, we do have a process in place to help us determine if the early refill is appropriate because of a problem with inappropriate handling or the medication has been lost or is stolen. It could be argued that because our current policy already complies with the amendment that's in front of you today then it wouldn't be a problem to adopt the mandate. Our bottom line, however, is that Blue Cross and Blue Shield of Nebraska opposes mandates. Aside from the cost of the service, additional requirements pose additional administrative costs. Compliance adds costs. Those costs are paid by our members. And in the past, we have worked with mandate proponents who have identified a significant need that was not being met in the marketplace to develop an industrywide standard when the need was significant. But we don't believe that the need for a uniform standard outweighs the compliance burden imposed by the bill and ask that the bill not be advanced. And I would love to answer any questions. [LB79]

SENATOR SCHEER: Thank you. Any questions? Senator Williams. [LB79]

SENATOR WILLIAMS: Thank you, Senator Scheer. Thank you, Mr. Dunning, for being here. I want to go back to your comment about what Blue Cross Blue Shield of Nebraska does. You mentioned, I think, in your testimony the 22 days. Are you aware of what other providers of insurance for prescription drugs would offer? [LB79]

ERIC DUNNING: I do not believe that we are out of the norm here. I don't believe that we are particularly more generous than other insurers. [LB79]

SENATOR WILLIAMS: Okay. I'm sure you heard my question to Dr. Peters about looking at the cost of this, what these prescriptions cost. What do you...what would you project...since you are doing this already without a mandate, would there be any increased cost to purchases or...we don't know what causes that in here, by the way. It's somebody's microphone. (Laughter) [LB79]

ERIC DUNNING: Oh, good. I thought it was my heartbeat. [LB79]

SENATOR WILLIAMS: You just have an electric personality. Would there be any increased cost to the insurance companies for providing this? [LB79]

ERIC DUNNING: Senator, we have not been able to identify any increased cost for the additional services for the bill. [LB79]

SENATOR WILLIAMS: Thank you. [LB79]

ERIC DUNNING: Thank you, sir. [LB79]

SENATOR SCHEER: Any other questions? You know, I think it's just basically picking up your pacemaker, Eric, but that... [LB79]

ERIC DUNNING: Probably, probably. [LB79]

SENATOR SCHEER: So it's good to know that it's still ticking and working. Thank you. [LB79]

ERIC DUNNING: Thank you, sir. [LB79]

SENATOR SCHEER: Any other opponents for LB79? Good afternoon. [LB79]

JAN McKENZIE: Good afternoon. I do know what causes that microphone to act like that. [LB79]

SENATOR SCHEER: Well, please, tell us. [LB79]

JAN McKENZIE: Senator Scheer and members of the committee, actually I was informed by Chuck that it's a discrepancy between a new system being used for broadcast through the NET system and the old analog systems that exist here in the microphones, so. [LB79]

SENATOR SCHEER: Well, thank you for sharing. (Laughter) [LB79]

JAN McKENZIE: I'm just happy I could bring you an interesting tidbit. [LB79]

SENATOR WILLIAMS: Well, tell them to cut it out. (Laughter) [LB79]

JAN McKENZIE: I know. It's quite annoying, isn't it? Members of the committee, for the record, my name is Jan McKenzie, spelled J-a-n M-c-K-e-n-z-i-e. I'm executive director and registered lobbyist for the Nebraska Insurance Federation. As to Senator...or, excuse me, Eric Dunning's testimony, we, too, are always in opposition to mandates. And just for new members of the committee's sake, you haven't heard my speech before about who gets a mandate when you look at a bill that mandates something in health insurance. Now, between ERISA, health exchanges, a lot of these folks are going to be under Medicare because glaucoma and aging patients are already going to be under Medicare. If it's an individual policy, and I'm not certain about what the amendment says, having not seen that, but the green copy, in many cases, the mandates don't go to an individual policy which is what I have, not a family policy. And in many cases, we're talking now about 20 percent of Nebraskans who are in small groups who buy their own insurance or individuals who buy their own insurance who already are buying very high-deductible plans. That's the group who gets the mandate. And that's become our concern over the years as ERISA has allowed self-funding to take place and more and more large employers have moved into those kinds of plans. So when we talk mandates, we're really talking about a very small portion of population who would get the benefit. And the second concern is that when people see in the paper that this will be covered now on your health insurance policy and you're getting your policy or your health insurance through an employer, not, you know, buying it yourself, you may not get that in your plan because they are an ERISA plan, a self-funded plan. And so it confuses the public into believing in many cases that they're going to get something covered under their health plan. And then when they find out it's not, and often it's after the fact, then there's more distrust and upset customers and clients, you know, in regard to their insurance. So I would just bring those to points to the attention of the committee and hope that my explanation of the microphone was a nice balance to my negative comments. (Laughter) We are in opposition to LB79 as written in the green form. I will have distributed copies of the amendment to my members for their review, so. [LB79]

SENATOR SCHEER: Thank you. Questions? Senator Williams. [LB79]

SENATOR WILLIAMS: Thank you, Senator Scheer. Ms. McKenzie, I have a question just following up on Mr. Dunning's testimony and also the ophthalmologists that we heard. The ophthalmologists are testifying that they have patients regularly coming in that have, you know, used up the prescription that they have and it's early and yet now we have testimony that insurance companies allow early renewals or early writing of the prescriptions, 22 days. Can you explain why that can happen then? [LB79]

JAN McKENZIE: Well, I think I testified before that different companies do have different policies and they put together their formularies for their insurance plans in different ways. I'm not certain what my other members do, but I know in my particularly instance, no matter what prescription I have, if I run out of lose some or...I'm traveling back and forth between Lincoln

and Omaha so I'll...or Lincoln and home so I'll get home and realize I've left my prescriptions up here for the weekend, I've been...in some cases, I can call my pharmacy and they will do an early fill for me or when I went on vacation, they did a vacation fill. So I think there are...I don't know how many cases there are, but I know my experience has been that there is an early fill for monthly prescriptions. And it may be that these are the ones that are only for 30 days. I don't think the mike is...the mike didn't like my explanation. (Laughter) So I'm sorry, Senator, I can't completely answer your question, but I can find out. [LB79]

SENATOR WILLIAMS: It would certainly be helpful for me if I had an answer to that question. [LB79]

JAN McKENZIE: Okay. [LB79]

SENATOR WILLIAMS: Thank you. [LB79]

JAN McKENZIE: We'll see if we can do that for you. [LB79]

SENATOR SCHEER: Any other questions? If not, thank you, Ms. McKenzie. [LB79]

JAN McKENZIE: Thank you. [LB79]

SENATOR SCHEER: Any other opponents for LB79? Are there any in a neutral position for LB79? Good afternoon. [LB79]

STEVEN ROBINO: Good afternoon. Senator Scheer, members of the committee, my name is Steven Robino. That's S-t-e-v-e-n R-o-b-i-n-o. And I'm with Aetna. I wasn't planning to testify today, but just listening to the questions that have been raised, want to at least provide information to the committee. Aetna does follow the standard 21-day rule that Medicare has set. We apply that across our commercial business as well. We do want our members to get eye drops and their refills. We also have programs in place where we track early refills for eye drops in case there is some patient education that's required that we can help them or reach out to their physician to help them better manage putting the eye drops into their eyes. So it is something that's very important to us. I just wanted the committee to know that we do have that policy in place where we allow refills at 21 days. Senator Williams, you know, some of the examples that you may be hearing about could be policies under self-funded plans that can follow different rules. I don't...they don't...I don't know the answer to that, but that may be an issue there. So I just wanted the committee to know that that is our policy. We do follow the 21-day rule for eye

drops just in line with Medicare. It's...it makes sense and it's consistent. And I'd be glad to answer any questions that you may have. [LB79]

SENATOR SCHEER: Senator Schumacher. [LB79]

SENATOR SCHUMACHER: Thank you, Senator Scheer. And thank you for your testimony today. [LB79]

STEVEN ROBINO: Sure. [LB79]

SENATOR SCHUMACHER: Do you know if Aetna or anybody else has done any type of research to determine what makes the stuff that expensive? Or is this just a high-price profit center for a manufacturer? [LB79]

STEVEN ROBINO: Senator, I don't know. I can ask our pharmacy team if they have any information on that and then provide that to you, but I'm not sure. [LB79]

SENATOR SCHUMACHER: That would be interesting... [LB79]

STEVEN ROBINO: Sure. [LB79]

SENATOR SCHUMACHER: ...because you would think this...whatever it is and whatever is in there, it could be made in fairly large batches and the equipment will bottle a little bit in a little bottle and...isn't adding up, in my mind at least. [LB79]

STEVEN ROBINO: Yeah, I'll ask the question and see what information I can find. And I would also...to let the committee know that, you know, we've seen this bill in other states. This is not the first time that I've come across this bill. And what I do hear from my colleagues at other health plans is they do, too, have policies in place for early refills. That is a fairly common practice across the industry. [LB79]

SENATOR SCHUMACHER: Thank you. [LB79]

STEVEN ROBINO: Thank you. [LB79]

SENATOR SCHEER: Any other questions? Seeing none, thank you, Mr. Robino. [LB79]

STEVEN ROBINO: You're welcome. Thanks. [LB79]

SENATOR SCHEER: (Exhibits 7, 8, 9, 10, 11, and 12) Any others in a neutral capacity? Seeing none, while Senator Gloor comes up, I'd like to read into the record that we have two letters of support from the Nebraska Optometric Association and the Nebraska Hospital Association. And we have the following in opposition...is CVS Health, Express Scripts, and the Nebraska State Chamber in opposition to LB79. Senator Gloor. [LB79]

SENATOR GLOOR: Thank you, Chairman Scheer. Just a couple of clarifications, a couple of follow-up comments: To Senator Howard's question about numbers of states, I've got... [LB79]

SENATOR SCHEER: (Exhibit 2) Oh, excuse me just a moment, Senator Gloor...and one letter of neutral position from the state of Nebraska Department of Insurance. Excuse me, and back to you. [LB79]

SENATOR GLOOR: Sure...each state's adopted LB79 which is more permissive: Two states adopted what basically is the amended version that I am proposing that is more restrictive. That would be a ten...total of ten. I think I said eleven but...or thereabouts. It's ten. I also misstated, and I want to clarify this for the record, that the refill time for the 90-day was 60. It's not. It's 68 days. I mentioned that this was in place for Medicare and Medicaid. We've now heard from Blue Cross and another insurer that it's in place for theirs. It's also in the state employee health plans. The state employee health plan provides that window for refills, but I would remind the committee, we've not heard from every insurer out there. There is at least one larger insurer, private insurer, that we've not heard from. There must be...there is a problem. Otherwise it wouldn't have been brought to me and I have a couple of personal friends who are pharmacists...when I mentioned this bill to them and said, great, we're glad somebody is dealing with this problem. So they apparently...obviously when somebody walks in and asks for a refill early, the person who gets to break the news to them most of the time is the pharmacist. And so the pharmacists that I've walked with identified this as a problem they deal with on a pretty regular basis. And then the issue of added cost to the insurer, remember this is just for multiple use scripts, not the one-time script that you'd get to treat an eye disease for 30 days. These are ones for which a refill is out there. And it's certainly possible that somebody will come in, get their script filled early, but that doesn't mean that they're going to come in and get additional scripts every month. I can see where, with a certain number of patients once or twice a year, they may end up with the script early if their prescription is an ongoing one, not just for 90 days. But I would think the roll up on that with patients who have that kind of disease across the state of Nebraska is still going to be such a small number that it's not likely to affect rates at all. I can't imagine that would affect rates at all. And again, we're back to the...identifying this issue of being pound wise and...or penny wise and pound foolish. These are the people who have eye

afflictions that we want to continue to get treated so that they don't get worse in their condition with a far more expensive treatment option in the future. And with that, I'd be glad to answer any final questions. [LB79]

SENATOR SCHEER: Any questions? Senator Howard. [LB79]

SENATOR HOWARD: I frequently heard from some of the testifiers that it was 21 days versus 23 days that's as written in the amendment. [LB79]

SENATOR GLOOR: I think that was for their treatment plans so their insurers... [LB79]

SENATOR HOWARD: Oh, I thought that was for Medicaid. [LB79]

SENATOR GLOOR: No, we follow...yeah, ours is a little different. [LB79]

SENATOR HOWARD: Okay. [LB79]

SENATOR GLOOR: We dealt with a percentage. Or we dealt with an actual number of days, I think, rather than percentage, so ours doesn't match up with Medicaid exactly, but it's close. We could certainly do that, but I think ours is a little less permissive than Medicaid. [LB79]

SENATOR HOWARD: Would it make sense to align it with Medicaid because we have the managed care insurance companies doing the work? [LB79]

SENATOR GLOOR: It might. We'll think about that. It's a good suggestion. Thank you. [LB79]

SENATOR HOWARD: Thank you. [LB79]

SENATOR SCHEER: Any other questions? Hearing none, that will end the hearing on LB79. And as printed, we will take a five-minute break and we will reconvene at 2:55. [LB79]

BREAK

SENATOR SCHEER: Okay, we are past the appointed time so we will go ahead and reconvene and we will now take up LB124. Senator Nordquist. [LB124]

SENATOR NORDQUIST: Good afternoon. Senator Scheer, members of the Banking, Insurance...or Banking, Commerce, and Insurance Committee, my name is Jeremy Nordquist. I represent District 7 in downtown and south Omaha, here to introduce LB124 which is a bill to provide parity in cost-sharing requirements between care sought from a medical doctor acting as a primary care physician and services rendered by physical therapists, occupational therapists, audiologists, speech-language pathologists, and chiropractors or chiropractic physicians. Essentially, it would allow patients to pay the same for these therapies as when they go to see their family doctor. Currently in many health plans, these medical professionals are classified under special...the specialist designation where the specialist designation is...when it's utilized, the classification is often accompanied by higher copayments for the consumer. Most other health care specialists are seen at less frequent intervals than those...than when you go to seek treatment from a physical therapist or an occupational therapist or a chiropractor. This results in the patient paying higher copays for each specialist visit. These higher cost-sharing requirements are multiplied then by the number of treatments that a patient needs to seek during an episode of care to...and it often creates a disincentive for them to finish the full recommended course of treatment and thus hinders getting to the outcome that we would want them to get to and that is full rehabilitation. Nationally, the copayment for primary care visits averages about $22 while specialists...specialty visits is about $32 according to an employer survey by the Kaiser Foundation. And in our state's wellness plan for employees, primary care office visits have a copay of $20 as do outpatient rehabilitation. So in our state wellness program there is parity. I believe this is a recognition in our state wellness program that we understand the preventative benefits of these types of therapies in preventing more costly services, the need for more costly services down the road such as surgery when you're talking about physical therapy, for example. However, in our regular plan, state plan, which is the choice plan, they charge a 20 percent copay, 20 percent after deductibles have been met for the therapies while there is a $20 copayment for primary care visits. I think there's a real public policy question here as to whether physical therapy sessions should cost as much as a visit to a neurosurgeon, for example. Obviously you would visit a neurosurgeon much less likely than you would a physical therapist. You're not going to go to a neurosurgeon several times a week for multiple weeks on end to get to the point of full rehabilitation. There are significant long-term costs with patients not completing their therapies whether it's from a physical therapist, occupational therapist, chiropractor, etcetera. If patients don't get the appropriate course that they need and are dissuaded because of high copayments, it very well...we could lead to them even not regaining their full capacity and, as I said early, facing surgery or other costs or prescription drug treatment, etcetera. So as we look at just reforms to health care in general, obviously investing in prevention, removing disincentives for seeking preventative care are the smart things to do. And that's what we're attempting to do with this bill. I certainly think that the cost of it, of creating parity, certainly could be offset by the savings in the long term. Thank you. [LB124]

SENATOR SCHEER: Thank you, Senator Nordquist. Any questions? I don't see any right now. Are you staying or do you... [LB124]

SENATOR NORDQUIST: All right. I intend to, but I might sneak back to Appropriations for a little bit, too. We'll see. [LB124]

SENATOR SCHEER: Okay. We will now open it to proponents of LB124. Good afternoon. [LB124]

JULIE PETERSON: (Exhibit 1) Good afternoon. Senator Scheer and members of the Banking, Commerce, and Insurance Committee, I want to thank you for allowing me to testify today in support of LB124. My name is Julie Peterson, J-u-l-i-e P-e-t-e-r-s-o-n. I currently serve as the chapter president for the Nebraska Physical Therapy Association. I am speaking on behalf of the NPTA in support of LB124. It has been brought to our attention by patients as well as members that there has been an increasingly significant financial burden assumed by many patients in Nebraska when seeking physical, occupational, and speech therapy services which ultimately limits access to care. Patients are encountering copays that range from $45 to $75 per visit and this occurs after a calendar year deductible has already been met. Many insurance companies are putting rehab services under a category of specialist care rather than primary care visits as a cost-shifting strategy. Rehabilitation services are often provided two to three times per week for a period of several weeks. Or in the case of stroke or traumatic brain injury, these services may carry on for months. Necessary rehabilitative services are often not received due to high copays. Let's take, for example, a patient who has undergone a total knee arthroplasty. It is imperative that these patients achieve functional range of motion following their surgery. Critical pathways are moving patients through inpatient stays quicker, relying on subacute transitional care facilities and outpatient facilities to complete postsurgical care. However, if a patient is faced with a high deductible followed by a $45 copay or higher and is to receive physical therapy three times per week, the patient may choose not to receive skilled services at the right time or at all. Research indicates that over half of the reoperations following a joint revision are due to stiffness in the knee. This stiffness can be properly addressed or prevented with physical therapy provided at the right time following surgery thus avoiding further costly medical or surgical interventions. Unfortunately, specialist copays are intended for specialized medical services or specialties such as seeing an oncologist or cardiologist. Patients generally do not visit these practitioners on multiple occasions unlike a provider of rehab such as PT, OT, or speech who often require several visits to achieve functional goals. High specialist copays are a barrier for patients to access appropriate rehabilitative care. If copays were reduced from $50 to $30, the patient may view the reduction as an increased access to rehab services when appropriately needed at a lower cost. The provider's view would be that the cost of the service remains the same, but that there may be an increase in utilization due to the lower copay. The insurance company's view may be a small cost shifting to the premium and a potential increase in the utilization of rehab services.

Consider the actual cost of physical therapy services compared to other health care providers. According to OptumHealth, the cost of physical therapy service is $64 compared to a podiatrist at $67.89, a nurse midwife at $300.79, or an allergist at $67.68. The relatively low cost of physical therapy puts physical therapy in a necessary position to restore physical function and improve the quality of life for our patients. On a very personal note, as an owner of a private women's health physical therapy clinic, we focus on outcomes and performance. Our clinicians have taken personal ownership in providing evidence-based physical therapy services. In our personal practice, we are faced with competition from nurses who are providing the standard protocol to all urinary incontinence patients for six biofeedback services that cost the patient over $3,000 and are not covered by most insurances, thus being an out-of-pocket expense for the patient. If our office billed the insurance company for six similar visits, our bill would be roughly $600. The patient may be responsible for a $50 copay for each visit or $300 total. Physical therapy is more cost effective than many other health care providers and the insurance company should look favorably on this benefit for its beneficiaries. In conclusion, LB124 would protect patients against exceedingly high copays and coinsurances which limit their access to care and not materially increasing the health care cost to the insurance payers. Thank you. [LB124]

SENATOR SCHEER: Thank you. Are there questions? Seeing none, thank you very much, Ms. Peterson. Next proponent? Good afternoon. [LB124]

STEVE BOWEN: (Exhibit 2) Hello. Senators and committee members, my name is Steve Bowen. I'm an occupational therapist and I also represent the Nebraska Occupational Therapy Association in support of LB124. This bill is straightforward in both wording... [LB124]

SENATOR SCHEER: Excuse me, could you please spell your name first? [LB124]

STEVE BOWEN: I apologize. I had that even on here, spell, right there. (Laughter) [LB124]

SENATOR SCHEER: You just didn't read it, that's all. [LB124]

STEVE BOWEN: That's right. Steve Bowen, S-t-e-v-e B-o-w-e-n. [LB124]

SENATOR SCHEER: Thank you. [LB124]

STEVE BOWEN: This bill is straightforward in both wording and logic. Our view is that higher copays place an undue burden on individuals who seek or who are required skilled therapy or chiropractic care. It is in the best interest of the state of Nebraska to pass any legislation that will

improve the lives of its citizens. As therapists we are concerned with providing care that will allow individuals every opportunity to reach his or her highest level of independence. If there are stumbling blocks to reaching those goals, whether it be personal impairments, access to service, or insurance issues, it is our duty to advocate for those who cannot advocate for themselves. Furthermore, the high cost associated with health care in general places a significant financial burden on the good citizens of Nebraska. Many people are not seeking our services because it might be a good thing. Rather, many seek or are referred to skilled therapy due to complexity of disability or injury which limits the ability to live or perform tasks without assistance. Many people require services from all of the stated disciplines listed in LB124 in order to reach a level of independence necessary for a fulfilling life. The cost of copays based on a such situations could reach into the thousands of dollars per year thus placing an undue burden on someone who has little to no control over his or her situation in life. We advocate for the direct reduction in cost associated with our services so that people who forego care will have the opportunity to receive the care required for improved quality of life. The disparity in services can mean the difference between independence and a lifetime disability. Through recommended and necessary therapy services, patients are able to access avenues of treatment that would be otherwise closed. According to the fiscal note associated with this bill, implementing LB124 will have a minimal effect on the state's finances. It will, however, positively affect our...your constituents. As an example, I quickly discuss rehabilitation after a stroke. Current evidence suggests that possible return after a stroke is possible at any time, however the greatest returns can be between three and six months following the event. Return is often contingent, however, on skilled intervention to encourage return such that the person might perform life tasks with greater independence, return to his or her employment, and pursue other meaningful goals. Many people who experience a stroke require the unique skills of all three therapies. And as she stated in the previous discussion about costs, the person who receives all three of the services could pay upwards of $300 to $600 a week if copays are at $45 and their visits are three to five times a week. And this is after the person is required to pay medical expenses from hospital and inpatient rehabilitation. With the passage of LB124, these numbers would be between $180 and $260 a week, significantly reducing the financial burden. Of course, these are just estimates. The Nebraska OT Association is in combined efforts with the PT, speech, and chiropractic associations and we are unified in this effort because we see a loss of critical care associated with the required and excessive copays. Finally, the Nebraska occupational therapists would like to thank Senator Nordquist for introduction of LB124 and his constant, consistent efforts for bettering Nebraska. We hope that the committee will see a value of passing legislation to reduce the burden of care for the many good, hardworking citizens of Nebraska. Thank you. [LB124]

SENATOR SCHEER: Thank you. Any questions? Seeing none, thank you, Mr. Bowen. The next proponent? Good afternoon and welcome. [LB124]

MELISSA KIMMERLING: (Exhibit 3) Good afternoon. My name is Melissa Kimmerling, M-e-l-i-s-s-a K-i-m-m-e-r-l-i-n-g. So thank you, Chairman Scheer and members of the committee. And I apologize, I'm a little bit nervous and maybe a little bit emotional because I'm here speaking as a mother today. So in interest of full disclosure, I, myself, am an occupational therapist. But I am here as the mother of a handsome, intelligent, caring four-year-old boy with a developmental delay named Kaden. I was blessed to have a healthy pregnancy and a full-term delivery and I did everything by my doctor's orders, even giving up my beloved Diet Coke which I'm envying right across the room in a couple places here. (Laughter) [LB124]

SENATOR WILLIAMS: Sorry. [LB124]

MELISSA KIMMERLING: My son arrived on February 18, 2011 at a healthy 9 pound, 10 ounces and met every developmental delay (sic) until he was around two years old. This is when we began noticing that he wasn't talking like his peers. At first, I thought I was being too hard on him since I, myself, am a therapist. But when his daycare instructor brought it to my attention, the things that his classmates could do that he could not do, I knew I needed to pursue going through the appropriate avenues to have him tested. We went through all the appropriate procedures, having his hearing checked, having him assessed by the school system, and ultimately starting private speech therapy services. You see, the school system is limited in their ability to pick up children for early intervention. He scored below normal on the assessments that they administered, but not low enough to qualify for services. He's one of those children who fell into the gap. And they are limited in that capacity. We waited a couple of months, the school came back, same score, below normal, below average, but not low enough. Our only option was to pursue private therapies. We began receiving speech therapy services one time per week starting around his third birthday and it was his speech therapist who brought up the concern for autism and we moved forward with that testing. He has scored "very likely" on the Gilliam Autism Rating Scale and, of note, we are being evaluated at the developmental clinic at Children's Hospital in June. He then began receiving occupational therapy services two times a week in addition to his speech therapy one time per week. You may ask yourself why I'm just not able to treat my child to save on cost. And for me, the answer is kind of complex in that I'm not a pediatric therapist. That's never been my practice in my almost ten years of practice. And I don't feel like I could be objective and push him the way that he needs as his mother. My heart is too involved. So it's challenging to get permission to leave work three times a week, leave work three times a week, pick up a sometimes fussy child, and get him to therapy, let alone get him in there and in a good mood. So I started asking them to bill me for my copay because it was just very hard to write a check. They happily agreed and one day I received a very alarming bill, probably about three months later, for over $1,200 in back copays. And I do have a copy of that bill here. This is in addition to the $529 insurance premium in which I have to pay 100 percent as insurance is not provided by my...the place that I work. This is also in addition to other costs for my son such as day care. So really, just to give you a personal example, breaking that down I pay

$500 a month for day care, having moved down from a center that was $885, as we could no longer afford that. I pay $529 a month for my insurance premium. And unfortunately, my former insurance CoOpportunity Health, offered through the marketplace, did have to liquidate. So I am now with United Healthcare with a...nearly the same premium. So this already means that the base cost for caring for my beautiful son is $1,029 a month. So if you add in a $40 copay three times a week, that's $120 a week, bringing the cost up to $1,509 a month. This does not include any reduced income from the time that I have to take off work in order to be able to go to his therapies. So as an occupational therapist, I know the importance of these services. I have seen my son's abilities and skills grow dramatically over the last year and I am very proud of him. I know that the intensity of his services, as recommended by his highly skilled and educated therapist, is one of the reasons that he has made these gains. My family has done and made the sacrifices necessary in order to help him access services, but I know that this isn't possible for everyone. Some are working as hard as they can already just to make ends meet. Some have more than one child with a disability and some children require an even higher intensity of services. Keep in mind, this is a child still even without a formal diagnosis. So I'm asking for you to strongly consider the needs of the wonderful citizens of this state, those who do the right thing, you know? We have the jobs, we pay for our insurance, we pay our health care premiums. We just want the best for our children. And we make sacrifices to make that happen, but you know, sometimes the math just doesn't add up and people can't access services for their children. There's no reason for it to cost $20 to see a physician one time a year and $40 to $60--my new insurance, and I have the card here, my new cost is $60--for each discipline, so three times a week. So these high copays make services unattainable for those who need it most. Think of your breast cancer survivors with long-term lymphedema--lymphedema never goes away--or car accident victims with intractable back pain and our children with disabilities, just to name a few. Please consider supporting this initiative on behalf of my son, Kaden--I'm sorry--and all other children like him. Thank you. I don't know why I got so emotional. I'm sorry. [LB124]

SENATOR SCHEER: Thank you. Well, you're speaking from the heart, so that's very... [LB124]

MELISSA KIMMERLING: You're talking about your kids, yeah. Yeah, absolutely. [LB124]

SENATOR SCHEER: That's true. [LB124]

MELISSA KIMMERLING: Well, thank you for listening. [LB124]

SENATOR SCHEER: Well, thank you. Are there any questions? [LB124]

MELISSA KIMMERLING: I'm happy to answer them even though I'm emotional. [LB124]

SENATOR SCHEER: See, that's all you had to do is sort of start crying and no one's going to ask you anything. So a lot of people should learn that lesson, so, you know... (Laughter) [LB124]

MELISSA KIMMERLING: Right. I was, like, don't. Wait until the end. Yeah, no, so... [LB124]

SENATOR SCHEER: There are none, but thank you very much, Ms. Kimmerling. [LB124]

MELISSA KIMMERLING: Thank you very much. [LB124]

SENATOR SCHEER: The next proponent? Good afternoon. [LB124]

BRIAN BRUNKEN: (Exhibit 4) Good afternoon. Chairman Scheer, members of the Banking, Commerce, and Insurance Committee, my name is Brian Brunken, B-r-i-a-n B-r-u-n-k-e-n. I sincerely appreciate the opportunity to speak today. I am a lifelong Nebraska resident and have practiced physical therapy in our great state since 1997. In addition, I have been an outpatient physical therapy clinic owner since 2006. I obviously am here today in favor of LB124. In preparation for my testimony today, I have done some research on data from 2014 and discovered that copayments for my physical therapy services ranged from $25 to $60 per visit. I've had several patients cease physical therapy services secondary to the financial burden, as we've heard of from other wonderful testimony today. One patient with a diagnosis of multiple systems atrophy, which is a debilitating disease similar to Parkinson's, but they actually progress faster than Parkinson's patients, was only able to afford attending physical therapy on a one time per week basis. His copayment per session was $50. This is despite the fact that his neurologist had recommended that he attend formal physical therapy on a three times per week basis. His Medicare plan of care which I established and is required to be signed off by his physician was for him to receive physical therapy from August 26 of last year to November 11. He only used 11 visits during that time. I spoke with him a couple weeks ago and the patient stated that his condition continued to deteriorate as we would expect. His wife has not been able to obtain employment and thus they are unable to afford these copayments. Furthermore, a second patient whose diagnosis was a torn patellar tendon--I think former President Clinton did this--which he underwent reconstructive surgery and had a copayment of $60 per visit also ended his formal physical therapy secondary to the financial burden. His orthopedic surgeon prescribed two to three visits per week per his protocol. The protocol was established by his surgeon in Omaha, recommended formal therapy for 12 to 16 weeks which would provide a total of 36 to 48 visits...sounds like a lot. He was able to attend 20 sessions. However, unfortunately this patient fell just three weeks ago and tore his patella tendon again. He underwent a second patella tendon reconstructive surgery and is now attending physical therapy under a workmen's compensation claim which you know affects all of us here in our state. Finally, a third patient example I'd like to provide had a Medicare policy which required $45 per visit. She had a tibial plateau fracture,

fracture of the lower leg, with an ankle sprain. Once again, her physician prescribed two to three visits for two months. She discontinued physical therapy after 12 visits. I spoke to her last week and she stated that she was continuing to experience pain, stiffness, and difficulty walking. When we speak to patients about their copayments or coinsurances, a large number of them do not realize what their copayments or coinsurances are for the rehabilitative services. I completed an informal survey with some of my patients and none of them had been educated about these copayments or coinsurances by either their employer or their broker. Last week, I spoke with Bil Pearson, spelled B-i-l P-e-a-r-s-o-n, an insurance broker with Benefit Administrators in Omaha. And he informed me that no employers or individual policy purchasers inquired with him at the time of insurance plan selection about copayments or coinsurances for rehabilitative services. In addition, he stated that employers are only concerned about the cost of the plan and not about coinsurances or copayments for rehabilitation. Senator Scheer and members of the Banking, Commerce, and Insurance Committee, I urge you to support LB124 which will improve access to rehabilitative services and lessen the financial burden on patients. I believe that this would have a minimal effect on insurance companies in our state. I thank you again for your time and consideration in this matter. At this time, I will entertain any questions. Thank you. [LB124]

SENATOR SCHEER: Thank you. Any questions? Senator Williams. [LB124]

SENATOR WILLIAMS: Thank you, Senator Scheer. And thank you for being here. I just have one question because you brought it up. How is Medicare generally covered for physical therapy? Or how did physical therapy normally get covered by Medicare? [LB124]

BRIAN BRUNKEN: As far as what the patient is responsible for, I'm sorry? [LB124]

SENATOR WILLIAMS: Yeah. [LB124]

BRIAN BRUNKEN: They have a deductible that they have to meet for any physical...for any medical services. And once that deductible is met, they have to pay approximately 20 percent if they do not have a supplemental insurance plan. And that... [LB124]

SENATOR WILLIAMS: I'm assuming the supplemental plans would be all over the... [LB124]

BRIAN BRUNKEN: Correct, and I mentioned those in my testimony today. And I don't know how detailed you want me to be, but you know, with Medicare law, say a 30-minute session is $100 gross per session. With the write-offs that had been established by CMS, you might be reimbursed about $40. So maybe at that point their copayment would be approximately $8 if they did not have a supplemental policy. That answer your question? [LB124]

SENATOR WILLIAMS: Okay. Yes. Thank you. [LB124]

BRIAN BRUNKEN: Thank you. [LB124]

SENATOR SCHEER: Any other questions? Seeing none, thank you, Mr. Brunken. [LB124]

BRIAN BRUNKEN: Thank you for your time. [LB124]

SENATOR SCHEER: Next proponent? Good afternoon. [LB124]

JED DROGE: (Exhibit 5) Good afternoon. My name is Jed Droge, J-e-d D-r-o-g-e. I'm a Nebraska licensed physical therapist and currently serve as the director of rehabilitation for Johnson County Hospital in Tecumseh, Nebraska. I'm also currently holding the elected office of treasurer for the Nebraska Physical Therapy Association. I would like to start by extending my gratitude to Senator Scheer and this committee for allowing me to testify in support of LB124. In my capacity as director of rehabilitation at Johnson County Hospital, I am responsible for the oversight of physical, occupational, and speech therapies. It is possible for each of these disciplines to have their access restricted when patients' health care plans impose specialty copayments at a rate greater than that of routine health service copayment. Our patients often wonder why they can visit their primary care provider in the office next door for a copayment of $25, but are required to pay $40 to $75 per visit for our services. Specialty copayments are intended for specialized medical services or medical specialties, not routine health services like physical, occupational, and speech therapy. The practice of treating these professions as specialists has allowed health care providers to require consumers to pay nearly the entire cost of care in some circumstances. The excessive copay amounts often result in patients paying more out of pocket for these services than they would for a surgery, imaging, or pharmacy that they've had. All three of the therapy professionals that I supervise could be positively impacted with the passage of this bill. Unfortunately, my staff and I routinely see individuals who either significantly reduce their frequency or self-discharge from therapy due to high copayments. Currently, we have two patients who are paying $40 per visit as a copay and have, therefore, decided to become less...or come to physical therapy less frequently. A study published in the peer-reviewed journal, Spine, has shown that early referral to physical therapy for low back pain can lead to lower overall health care costs including less advanced imaging, less additional physician visits, less major surgery, less lumbar spine injections, and less opioid medication prescriptions. Using this study as a guide, we can expect that if our patients drop out of services due to copay cost restrictions, an increase in health care spending can be expected. Fair copays, however, lead to better outcomes and improved access. My wife, who is also a physical therapist, and I have decided to live and raise our family in rural Nebraska because of the many benefits a small community can provide. We routinely interact with our patients outside of work and have

seen the lasting effects that restricted access to routine health services can have. Nebraska's rural health care clinics place a very high value on providing quality services. In 2014, the National Rural Health Association ranked the hospital that I work at one of the top 20 critical access hospitals in the country for quality of care. My department takes great pride in the fact that we offer valued services to our community and ensuring patients can access each of us is of utmost importance. I would again like to thank this committee for the opportunity to be testifying in support of LB124. Any questions? [LB124]

SENATOR SCHEER: Thank you. Any questions? Don't see any. Jed, thank you very much. [LB124]

JED DROGE: Thank you, appreciate your time. [LB124]

SENATOR SCHEER: Any other proponents? Welcome. [LB124]

STEVE GRASZ: (Exhibit 6) Thank you, Chairman Scheer and members of the committee. My name is Steve Grasz, S-t-e-v-e G-r-a-s-z. I serve as legal counsel to the Nebraska Chiropractic Physicians Association and I am appearing in support of LB124. First of all, I would like to thank Senator Mello (sic: Nordquist) for sponsoring this bill and for Senator Howard for cosponsoring the bill. This bill addresses a serious problem that needs attention from the Legislature on behalf of consumers, health care providers, and taxpayers. When patients seek a service covered under their insurance plan from their physical therapist, doctor of chiropractic, or certain other health care service providers, they are often being charged insurance copayments that are higher than the copayments for the same covered services from other providers. The copayments are often so high they may equal the entire cost of the services provided even though the patient supposedly has insurance coverage. This is sometimes accomplished by charging two separate copays for the same office visit. This practice is not accidental. Rather, it is the result of actuarial and underwriting plans designed to shift additional costs to consumers. Perhaps this is obvious, but I want to emphasize to the committee that this bill would not in any way change the amount of money that the health care provider receives for his or her services. Rather, this bill addresses the hardship being placed on the patients. The practice of overcharging copays is unfair not only to consumers, but also to employers and taxpayers. The consumer is told their insurance policy covers the service, but the copayments make the coverage illusory, resulting in what is known as phantom benefits. In other words, the patient is told they have insurance coverage, but when they show up for the service, it turns out they must pay the cost out of pocket. The patient frequently blames the health care provider for what is really an actuarial gimmick. This deceptive practice creates a disincentive for people to even seek care. It is a shortsighted and improper cost shifting to patients. The practice is also harmful to employers who provide health benefits to their employees. That is because employees who could be treated

by physical therapists or chiropractors at relatively low cost decide not to get treatment since they must pay for the service out of pocket. The result is a less healthy work force. This eventually results in visits to more expensive providers for such things as MRIs and back surgery followed by disability claims and higher insurance premiums for the employers. That is why insurance companies normally try to encourage treatment by the lowest cost provider rather than discourage it. For much the same reasons, this practice is also harmful to taxpayers. When people don't go in for early, low-cost treatment, they may end up in emergency rooms for more serious complications where the hospitals and taxpayers end up footing the bill for some patients. Opponents of this bill may claim it would constitute a new mandate. However, I think it's important that this committee be aware of the fact that a very similar law has been on the books in Nebraska for literally decades. It's sometimes known as the insurance nondiscrimination law. Under section 44-513, it is already unlawful for an insurer to discriminate in coverage provided to policyholders in terms of whether the covered service is provided by a medical doctor or by an osteopathic physician, doctor of chiropractic, optometrist, or several other categories of providers. So why then is there a need for this bill? Well, first of all, some of the professions included in the present bill, such as physical therapists and occupational therapists, are not listed in the current statute. They should be afforded the same equal treatment. Second, some insurers and insurance plans are not complying with the current statute. We believe that LB124 would help bolster and enforce existing law. In sum, LB124 would help equalize the playing field for the benefit of consumers, businesses, and taxpayers, and ultimately even insurance companies because it would encourage patients to receive treatment in the most cost-effective care setting for lower overall cost and it would also eliminate any short-term underwriting disadvantages to those insurance companies who do not engage in this unfair practice. And I'd be happy to answer any questions for the committee. [LB124]

SENATOR SCHEER: Thank you. Any questions? Seeing none, thank you, Mr. Grasz. [LB124]

SENATOR WILLIAMS: Yes, I do have a question. [LB124]

SENATOR SCHEER: Oh, I'm sorry. Senator Williams. [LB124]

SENATOR WILLIAMS: I was thinking about that question for a second. [LB124]

SENATOR SCHEER: You got to be a little quicker. [LB124]

SENATOR WILLIAMS: Thank you, Senator Scheer. I'll be quicker next time. Since you're the attorney representing one of the disciplines that we're looking at here, I'm intrigued by whoever wrote this piece of legislation, why they chose the disciplines they chose and possibly left out

any that might not be in here. Are you aware of who actually drafted this and what went into that piece of this? [LB124]

STEVE GRASZ: Senator, not entirely. I do know that the Nebraska Chiropractic Physicians Association certainly offered their support and assistance in drafting it. I think the physical therapists played a key role in that. I do know that some of the professions were chosen because they were omitted from the current statute... [LB124]

SENATOR WILLIAMS: From the... [LB124]

STEVE GRASZ: ...some of the therapy occupations. [LB124]

SENATOR WILLIAMS: Okay, so no specific information on why an audiologist would be in here or a speech...well, we had a speech person. Is there anything on that? [LB124]

STEVE GRASZ: Senator, no, I do not. I think it has, probably, to do with a couple of things. I think that these are the professions that have been experiencing problems with patients being charged higher copays and treated as if they were going to a specialist like a neurosurgeon even though they are going for repetitive therapy. [LB124]

SENATOR WILLIAMS: Do you know if there were any disciplines left out... [LB124]

STEVE GRASZ: I do not. [LB124]

SENATOR WILLIAMS: ...that could have been included? Okay. Thank you. [LB124]

SENATOR SCHEER: (Exhibit 7) Any other questions? Seeing none, thank you, Mr. Grasz. Any other proponents? Seeing none, I would note that we have one letter of support from the Nebraska Speech-Language-Hearing Association in support of LB124. We now open to opponents of LB124. Good afternoon and welcome. [LB124]

RUSSELL COLLINS: Good afternoon. Chairman Scheer and members of the committee, my name is Russell Collins, R-u-s-s-e-l-l C-o-l-l-i-n-s. I'm general counsel with Blue Cross and Blue Shield of Nebraska and here to testify in opposition to the mandate which would be imposed by LB124. As you may know, Blue Cross Blue Shield of Nebraska is a mutual benefit company. We pay taxes, but exist as a not-for-profit entity. Over 75 years ago, we were founded to serve our members, not corporate shareholders. We continue operating under that principle today. I'm here

today and offer this testimony on behalf of our policyholders and our members. I want to be clear as I begin that the basis of our opposition is not to assert that the specialists covered by LB124 are unable or...to deliver cost-efficient or extremely high-quality care. In many instances, these specialists, many of which you've heard from today, may be the best provider for patients seeking treatment for certain conditions. However, requiring insurance coverage to provide cost sharing at the same level for specialists as for primary care physicians will increase the cost of health insurance products. Currently, insurers selling policies in Nebraska offer products that have higher cost sharing for physical therapists, occupational therapists, audiologists, speech-language therapists, and chiropractors than for primary care physicians. In addition, self-funded employer groups offer a great many benefit designs with regard to cost sharing elements. For example, the state of Nebraska...in the fiscal note, it was identified it currently offers several different types of plans, some of which do have copayments that are different for primary care and for specialists and some of which rely on coinsurance and deductible for cost-sharing differentials. This identifies and demonstrates the availability of a diverse number of benefit plans and designs to Nebraska citizens currently without the imposition of LB124. The inclusion of chiropractic providers, physical therapists, OTs, and speech-language pathologists and audiologists along with other speciality care providers such as neurologists, ENTs, endocrinologists, and orthopedists is appropriate because these specialists treat specific conditions and specific parts of the body. As such, insurers should have the flexibility in defining products and designing products to handle those services differently than primary care services. While chiropractors and PTs/OTs treat a wide variety of conditions, there are limits to what they can do. For example, chiropractors do not prescribe medications or perform surgery. Chiropractors aren't able to serve as coordinating physicians for nurse practitioners and are not able to inject substances into the human body including vaccines. Primary care physicians are trained to treat a wide range of conditions and to coordinate care with multiple providers, many of the specialists covered by the bill. Also, the movement toward supporting patient-centered medical homes may be inconsistent with equating specialty care providers with primary care providers. The focus of patient-centered medical homes, as many of you may know, is to achieve efficiency and increase the quality of care by having a single care provider deliver or be part of delivering the majority of a patient's care and to coordinate that care with other specialized care providers for more distinct services. LB124, in equating the cost sharing with primary care specialists and...primary care providers and specialists may be inconsistent with the goals of patient-centered medical homes. Advocates for bills and, as you've heard today, may indicate that the cost of health care overall will be reduced by reducing cost sharing to the specialists identified in LB124. Our analysis does not lead us to that same conclusion. While we have no specific data that would indicate the exact number or the exact impact to our policyholders or to other insurers, we can see circumstances where the overall number of covered health care visits would increase if LB124 is passed. For example, you could take a patient presenting with an earache and lower back pain. They could be treated by any number of the specialists that are identified in LB124. But if that patient required antibiotics or prescription pain medication, that

patient may need to seek care from a primary care provider to receive that...those services. If the patient saw an APRN, a physician's assistant, or a family practice physician, the patient could receive all of those services or treat all of those conditions in that way in one visit. In the example above where the member had insurance coverage with copayments equal for chiropractors and PTs, as a primary care provider, the member would pay two copayments possibly equal to less than a single specialty copay on products where there's a higher copay for specialists and the insurance provider would pay the balance of the charges for those two visits. Health care premiums are based on the cost of reimbursing health care providers for services and could increase in that scenario. In order to preserve the flexibility of product design by insurers and for the reasons discussed, Blue Cross Blue Shield of Nebraska opposes LB124. I'd be available for any questions. [LB124]

SENATOR SCHEER: Thank you, Mr. Collins. Questions? Senator Gloor. [LB124]

SENATOR GLOOR: Thank you, Chairman Scheer. Thank you for your testimony, Mr. Collins. Is it allowed anymore under the Affordable Care Act to set limits on the number of visits to therapists? Do insurance plans even attempt to do that? [LB124]

RUSSELL COLLINS: In general, no. [LB124]

SENATOR GLOOR: So is it safe to assume that part of the effort to try and control the number of visits is to establish copays? I mean, what's...I'm looking at the philosophy behind copays as opposed to, why not just say you get a maximum of 12 visits and that's it? [LB124]

RUSSELL COLLINS: I think the philosophy behind copays are, as you've heard in many examples today, is to involve the patient in paying for the services. And the diversity of benefit designs, if you would go shopping today for an insurance plan, you can see how, as premiums...in general, as premiums per month increase, the cost-sharing burden on the member may decrease. There is, in many ways, a relationship between the premiums that may be charged and the cost sharing that's available. So any cost...copayments are twofold in...it identifies and involves the member in the paying for services directly and it certainly does decrease the cost that the insurer would pay. [LB124]

SENATOR GLOOR: And is it usually the provider of the therapy services versus the primary care referer who says, that's enough? I mean, how does a patient know that they've completed their course of therapy, when they feel good enough to walk away or when the therapist says, you've had enough, or the primary care doc signs up and says, this is...should authorize them for ten treatments of whatever that treatment is? How does that work? [LB124]

RUSSELL COLLINS: I would think in most instances we would all hope that the patient would follow the advice of the medical professional, whoever that may be, managing the care. [LB124]

SENATOR GLOOR: Okay. Okay. Thank you. [LB124]

SENATOR SCHEER: Any other questions? Senator Williams. [LB124]

SENATOR WILLIAMS: Thank you, Senator Scheer. Mr. Collins, I think you started out your testimony by saying that LB124 would increase the cost of coverage. But then I sort of heard you say that you had not done an analysis to really be able to determine whether it would increase the cost in the long run. Did I hear both those statements? [LB124]

RUSSELL COLLINS: You did. And... (Laugh) [LB124]

SENATOR WILLIAMS: I thought I did. Would you like to explain the conflict between those statements a little more to me? [LB124]

RUSSELL COLLINS: Sure. I think our analysis relies in part on making assumptions about the impact of any change to benefits to utilization. So in many respects when you do analysis, when the actuaries perform an analysis to determine the impact of increasing covered services as this would, we make assumptions about what would be an additional impact by increasing the level of utilization, because as you've heard in testimony here, certainly there are plan designs out there where there are copayments for specialty services that are higher than those for primary care and there may be instances where individuals are impacted. So by lowering the copayments, you may increase the utilization of those services. So in many respects, the analysis is based on assumptions of what that change would make. So in doing the analysis, there's ranges built in and a lot of assumptions built in. [LB124]

SENATOR WILLIAMS: So you're recognizing that having higher copays probably does decrease the frequency or use of the services. Do you think that leads to a poorer outcome for the patient? [LB124]

RUSSELL COLLINS: I'm not sure whether...and I'm not asserting in any way that higher copays reduces treatment or leads to poor outcomes. Plan designs are diverse. If you shop for plans today, you can select plans with copayments at any...many different levels between specialists and primary care or plans with no copays relying on coinsurance and deductibles. And those plan designs are priced based on the amount that the insurers estimate it will take to cover the health care costs. As a nonprofit mutual company, that's how we price our products, to cover the

costs of the care. And so there's any number of results from any different plan designs that you could see, but certainly the impact of cost sharing to individuals in certain conditions is certainly a...could be an issue. [LB124]

SENATOR WILLIAMS: Knowing there are all those different plans, but focusing just on Blue Cross, you would still be saying if LB124 passed, premiums would increase? [LB124]

RUSSELL COLLINS: Yeah, we would estimate that premiums would increase, sir. [LB124]

SENATOR WILLIAMS: Thank you. [LB124]

SENATOR SCHEER: Any other questions? Seeing none, thank you, Mr. Collins. [LB124]

RUSSELL COLLINS: Thank you. [LB124]

SENATOR SCHEER: Any other opponents to LB124? Welcome back. [LB124]

STEVEN ROBINO: (Exhibit 8) Thank you. Senator Scheer, members of the committee, again my name is Steven Robino. That's S-t-e-v-e-n R-o-b-i-n-o, and I'm here representing Aetna. We're here to testify in opposition to LB124. I have a copy of a letter that's coming around with our written testimony. We wanted to kind of share...I think Blue Cross and Blue Shield did a good job on talking about, you know, some of the concerns of shifting to a copay or in some cases a lower copay for these services, but wanted to share with the committee some of the unintended consequences that we've seen in other states that have made some similar changes with...whether it be chiropractic services or physical therapy services. We've usually seen bills that addressed one or the other specialty not such a broad range of specialties all at the same time. But what we've experienced in other states is, in our plans we typically, for therapy services, charge a coinsurance. We know that the cost of their services can vary dramatically. Whether you're having...especially for physical therapy, if you're going in for, you know, a simple visit, one therapy, one modality, versus multiple therapies, multiple modalities, the cost of those visits can dramatically vary from one to the next. And so we typically charge a coinsurance that the member is paying a portion of the cost of those services regardless of what the eventual bill happens to be. In some states that have moved towards parity with primary care, which is almost always a flat copay, we've actually seen some services where the copay is actually higher than the coinsurance would have been for a simply therapy visit. That's one unintended consequence. The other thing that we've seen is, again, the cost shifting of capping the copay or capping the cost of the therapy services, you...we tend to see then more modalities, more therapies being done in a given service. It could impact the frequency of those services. That

ultimately could impact the cost of the premium in general. What we've also begun to see in a neighboring state is, especially with physical therapy, you know, in our benefit plans, we've always had a design that we try to encourage the member to go to the lowest cost setting. So we may have a lower cost share for a freestanding physical therapy center, a different cost share for an outpatient setting because it's more expensive in general, and so we have varying cost shares to try and encourage the member to go to the lower cost share setting. And what we're actually seeing in neighboring states in regards to physical therapy is a concerning shift now away from therapy services in a freestanding center where they tend to be more cost effective to more use of an outpatient facility setting where they tend to be higher in costs. That shift in charges really is not transparent to the consumer because their out of pocket is capped at a, you know, $20 copay, whatever it happens to be. And so, again, you're taking the consumer out of the equation. You're taking the ability of the consumer to really understand the cost of those services by having a capped or a flat copay for those services. And we think that that's not a good thing in the long run. As was also mentioned, we believe that, you know, our primary care visits should, in general, be the lowest cost service that a member would have a cost share on to encourage the use of primary care services, to encourage them to go back to their primary care and determine whether they need to continue therapies or maybe something different. So we run the risk of maybe having members not going back to their primary care physician if it's just as...a lower cost to continue going to a specialist or other services. So you run that risk as well. So those are some of the unintended consequences that we've seen in other states. And the other piece is, when you start to put some cost-share protections on one type of provider then others begin to say, well, what about me and I want that, too. And so we've seen that starting to play in in other states as well where you have this very type of parity for one specialty and others wanting the same thing. And at some point, where does it stop? That's the challenge. That's the difficulty. Be glad to answer any questions that you may have. [LB124]

SENATOR SCHEER: Thank you, Mr. Robino. Any questions? Seeing none, thank you very much. [LB124]

STEVEN ROBINO: Thank you. [LB124]

SENATOR SCHEER: Other opponents to LB124? [LB124]

JAN McKENZIE: Senator Scheer, members of the Banking, Commerce, and Insurance Committee, for the record, my name is Jan McKenzie, J-a-n M-c-K-e-n-z-i-e. I'm executive director and registered lobbyist for the Nebraska Insurance Federation. I'm here today testifying in opposition on behalf of the federation to LB124. And I will make it very short and sweet. I think this is the last time I get to talk to you in the chair this year. One standout point being: If any of you shopped around on the exchange just to see what it was like or you were actually

looking for something to purchase yourself or for your family, you could look at all the various different kinds of policies, copays, coinsurance, deductibles, and premium costs whether you were looking for a bronze or a silver or a gold. And I think that's the point that the companies are trying to make. The more choices consumers have and employers have in constructing what will work for them, the better the market is and the more competitive the market is. So any type of proposal to make a one size fits all and to make more and more plans look like each other, we are in opposition to that. [LB124]

SENATOR SCHEER: Thank you. Any questions? Seeing none, for the last time, thank you, Ms. McKenzie. [LB124]

JAN McKENZIE: It's been a lovely session. (Laugh) [LB124]

SENATOR SCHEER: (Exhibit 9) Any other opponents for LB124? Are there any that would like to speak in a neutral capacity for (LB)124? Seeing none, while Senator Nordquist comes up, I did receive a letter in a neutral capacity from the Nebraska Hospital Association. Senator Nordquist. [LB124]

SENATOR NORDQUIST: Great. Thank you. Senator Scheer, thanks to the committee members for your consideration of this legislation. I'll just...a few points that I wanted to make. First, as far as the medical home model, this bill does nothing to change the coordination of care or state where you can go to a physical therapy without a doctor's visit. But that is with the very unlikely...not a typical practice. Usually that care is coordinated through a physician and this bill obviously does nothing to change that. Matter of fact, I would think that when a physician is prescribing a course of treatment for rehabilitation that being able to utilize those services would actually help the care coordination and the management of care that a medical home model would put...be put forward. I know you guys have had to have several bills like this, this year, and this committee has heard many. I just...the bill that I had a few years back when we looked at parity between oral chemotherapy drugs and IV chemotherapy drugs and we mandated that as a state, we heard the same concern from insurance that this was going to drive up premiums. It was so detrimental to their businesses that two years later, when we took the sunset off the bill, they didn't even oppose it. So I think sometimes that is held out there as a red herring. I do think that maybe a little deeper analysis needs to be done, but I think the for...the public policy question is here that we have constituents who aren't able to afford the health care services that they need in this area. And when it comes to designing insurance, we have the right to set what those parameters are as state policymakers within the Affordable Care Act now. Certainly the federal government has taken a larger role in that. But within that design, we have the ability to say rehabilitation services is something that our constituents should be able to access on a regular

basis and it shouldn't be cost prohibitive because that is a basic service that is needed. So I would appreciate the committee's favorable consideration of this bill. [LB124]

SENATOR SCHEER: Senator Nordquist. Any final questions? Senator Williams. [LB124]

SENATOR WILLIAMS: Thank you, Senator Scheer. I just did have the question, Senator Nordquist, about the disciplines that were included in here and if you had any light to shine on that. [LB124]

SENATOR NORDQUIST: Right. Right. Well, we drafted this...actually it's a respin. We introduced it...I can't remember if it was last year or the year before. But we really looked at rehabilitative services and that's kind of what the focus is. So your question of what was left out, we can look. [LB124]

SENATOR WILLIAMS: If...was there anything left out? [LB124]

SENATOR NORDQUIST: I don't know. I don't know. These are the ones that came forward as kind of rehabilitation focused. But we can do an analysis of what licenses we prescribe as a state and what isn't in there and get that to you. [LB124]

SENATOR WILLIAMS: Thank you. [LB124]

SENATOR SCHEER: Any other questions? Seeing none, thank you, Senator Nordquist. [LB124]

SENATOR NORDQUIST: Thank you. [LB124]

SENATOR SCHEER: And that ends the hearing on LB124 and our hearings for today. Thank you all for coming. [LB124]