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Banking, Commerce and Insurance Committee
February 07, 2012

[LB810 LB882 LB1100 LB1129]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 7, 2012, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB882, LB1129, LB1100, and LB810. Senators present: Rich Pahls, Chairperson; Beau McCoy, Vice Chairperson; Mike Gloor; Pete Pirsch; Ken Schilz; and Paul Schumacher. Senators absent: Mark Christensen; Chris Langemeier.

SENATOR PAHLS: Good afternoon. I want to welcome you to the Banking, Commerce and Insurance Committee hearing. My name is Rich Pahls. I represent District 31, which is basically the Millard of Omaha. We will take up the bills as posted, that would be (LB)882, (LB)1129, (LB)1100, (LB)810, in that order. To better facilitate today's meeting I'd like to have you take a look at the chart, so I will not read it. Those are the procedures we'd like to have you follow. So again just read those. And today...I do not plan to use the lights today, so I want you to really adhere to the last one, to be concise. So if you have a feel, around five minutes, that will allow us to move through the hearing today. If you have written copies that you need to hand to the committee, we need ten of them. If you do not have ten and you want to distribute them to this committee, please wave them now and I'll have the page make some copies. Seeing no hands...all right, thank you for that. What I'll do is I'll have the senators introduce themselves.

SENATOR SCHILZ: Ken Schilz, District 47, Ogallala.

SENATOR SCHUMACHER: Paul Schumacher, District 22, Columbus.

SENATOR PIRSCH: Pete Pirsch, District 4, Omaha and Douglas County.

SENATOR McCOY: Beau McCoy, District 39, Omaha and western Douglas County.

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

SENATOR PAHLS: Okay. Our legal mind is Bill Marienau, and the person who keeps everything in order is Jan Foster, and over here we have two young gentlemen as pages, named Michael and Matt. And one thing I want to make sure everybody knows, if you testify today it is important that you fill this form out. If you don't have the forms right now and you will testify, we do have some on the sides. Okay. I think, Senator, we are ready.

SENATOR NORDQUIST: (Exhibits 1, 2, 3, 4, 5, 6, and 7) Good afternoon, Senator Pahls, members of the committee. For the record, my name is Jeremy Nordquist, representing District 7, which covers downtown and south Omaha. The intent of LB882 is to establish parity between oral chemotherapy medications and intravenous

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medications for cancer patients. The language for this bill was pulled directly from Texas's legislation, which was signed into law by Governor Perry last year. LB882 would ensure that patients and doctors can make decisions about the course of treatment that will provide the best care, not the treatment that insurance companies deem the most cost-effective. LB882 requires that any health insurance policy, except for specific disease or limited-benefit coverage, that provides coverage for cancer treatment shall provide coverage for a prescribed, orally administered anticancer medication based on a "no less favorable" than IV administered medications that are covered as medical benefits by the policy. Currently, many cancer patients are not able to afford oral chemotherapy medications because they typically fall under a different benefit plan than IV chemotherapy. Insurance policies typically cover most, if not all, costs associated with IV chemotherapy as a medical benefit. Oral chemotherapy is often classified as a prescription drug benefit and often requires a much larger copay. The lack of parity in coverage between IV and oral chemotherapy medications is relatively new, but a growing problem as more and more new cancer therapies are being developed at a rapid pace that can range in price from \$5,000 to \$10,000 a month. Research shows that when confronted with the reality of high out-of-pocket expenses, cancer patients forgo expensive therapies and often discontinue treatments, in part because they do not want to saddle their families with unmanageable debt. Additionally, because oncologists know how expensive oral medications can be, they do not prescribe them even when they are the best option, in their opinion. Some patients are not receiving the treatment that is most appropriate for their cancer care solely due to cost and insurance issues associated with it. Testifiers after me today can speak about their experiences with oral chemotherapy medications under our current laws. I'd like to be clear about a few things. First of all, this is not an insurance mandate. It does not mandate coverage of oral chemotherapy, oral therapies, chemotherapy, or other health plans as part of a pharmacy benefit. It simply establishes parity in patients' out-of-pocket costs and ensures that patients have real access to medications deemed most appropriate by their physicians. It allows the insurer to require prior authorization. It allows the requirement of copayment and coinsurance, but it shall exceed the copayment or coinsurance that's associated with IV or other cancer treatments. I'd like to be clear that despite what the opponents may tell you today, there's been no evidence in the 15 other states that have enacted this legislation that requiring this parity will send premiums soaring. It's a convenient argument, but the evidence is not there in these other states. I have provided a letter from the Indiana Department of Insurance which, in response to a couple legislators following up from the bill they passed in 2009 that was signed by Governor Daniels, says that they asked specifically about the additional costs. And the response was, "There were initial concerns raised by some carriers regarding the potential increase to accommodate this new mandate; however, no increase has materialized at this time." California produced an analysis in their state which showed the cost of between 5 cents for a large plan member, and 80 cents for individuals, per member per month. Vermont did an analysis which said the costs were negligible. And Milliman did a national study which shows that for most

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benefit plans the cost would be under 50 cents per member per month. Some may argue that oral cancer chemotherapies are more expensive than IV therapies; however, this definitely ranges from drug to drug. And when you take into account the costs of administering the IV chemotherapy in the health setting, whether that be a physician's office or a hospital, the costs of oral chemotherapy are not significantly more. Plus, I think it's also important to consider the costs of prevention. When doctors are prescribing oral chemotherapies or not prescribing the most effective care in their opinion, or they prescribe a medication that the patient doesn't think they can afford, we are going to see cancer patients continue to worsen and eventually get to higher stages of cancer and be more costly for insurance at that point. So this is about getting the best care, in the physician's opinion, at the right time. I believe fundamentally these decisions should lie with doctors and patients, as much as we can make them, and I think this bill will help us move in that direction. I have a few letters here I'll submit...I want to make sure. We have one from Susan Komen for the Cure in support; International Myeloma Foundation; Nebraska Hematology-Oncology out of Lincoln; Leukemia and Lymphoma Society; and Nebraska Oncology Society, letters in support for the committee. And with that I'd take any questions. Thank you. [LB882]

SENATOR PAHLS: I'll just ask you one direct question. You mentioned a few of the states. Do all of the states, do they come back and say that there's not really a significant cost? [LB882]

SENATOR NORDQUIST: Yes. The research that's been in those states has shown negligible if any. [LB882]

SENATOR PAHLS: Okay. Okay. [LB882]

SENATOR NORDQUIST: Yeah. [LB882]

SENATOR PAHLS: Senator. [LB882]

SENATOR GLOOR: Thank you, Senator Pahls. And thanks for bringing this bill forward, Senator Nordquist. If you can't answer this, I imagine there will be somebody behind you that can, and so my question, hopefully, will be a prompt to them, but given the nature of the drug we're talking about here, chemo drugs are in and of themselves poisons, this has to be a very small subset of patients that could have the type of medication that you could take home where children are around, or to the workplace where the workers might be exposed, so we can't be talking about a lot of medications that can be a substitute for direct IV chemo applications. [LB882]

SENATOR NORDQUIST: Yeah. I've talked to some of the folks from different...some of the pharmaceutical companies that are actually...and they say it's going to be a growing problem because this is where they're putting their research dollars, is into oral chemos.

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But right now, in the short...or at least in the next few years, you know, we're looking...the number I've seen is 20-25 percent, that potentially it could grow up to that, and... [LB882]

SENATOR GLOOR: Could potentially grow up to. [LB882]

SENATOR NORDQUIST: Yeah. Yeah. I don't know where it's at right now, but I know blood cancers tend to be the one, from my understanding, to be the most prevalent right now. [LB882]

SENATOR GLOOR: Okay, I would think the cost differentiation would also be...I mean, above and beyond the coverage issue, I would think a medication that you can take and administer to yourself is also going to be a lot less costly than going into an institution or an organization where its staff there, a number of credentialed people around who have to be paid for, yada-yada-yada, and expenses. [LB882]

SENATOR NORDQUIST: Yeah. I think the issue is that it's classified now under a pharmacy benefit. It's not classified as the same, so. But when you take into account the full cost of administering it, the IV chemo, the drug may not be as expensive, but the administration of it is what adds a lot of the cost onto that. [LB882]

SENATOR GLOOR: Well, I say that because it would seem to me that the insurers themselves would be incentivized to urge more self-administration rather than going through the elaborate and expensive process of clinical administration. But maybe somebody will come forward and argue that point. [LB882]

SENATOR NORDQUIST: Yeah, I would hope we can hear that. Yeah. [LB882]

SENATOR GLOOR: Thank you. [LB882]

SENATOR PAHLS: Senator Pirsch. [LB882]

SENATOR PIRSCH: I appreciate your testimony here today. And with respect to them, you kind of touched on the cost side of the equation which dealt with a number of states and their analysis, Indiana, California, etcetera. But on the benefit side of thing, and maybe you'll have those behind you testify to that a little bit, but has the...with respect to the difference between intravenous chemotherapy and oral chemotherapy, has there been demonstrated or is it generally accepted as materially better outcomes as a result of the...or is that kind of a new, such a new thing that it's a new type of treatment delivery system that there isn't really studies that have been done on those? [LB882]

SENATOR NORDQUIST: Well, I think that there can be people speak to me after that, but it is a...it's becoming more prevalent and more research is being put into oral

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chemo, so. But I do think there obviously has been extensive research done that in specific instances of cancer that oral chemos are the more appropriate treatment. And like I said, there's people behind me that can address that. And if you want more, we can certainly put you in touch with the experts that can talk about that. [LB882]

SENATOR PIRSCH: Yeah, and that would be great. And I'm trying to gather is the reason, is it easier for patients to tolerate as I see it listed in the memorandum of support, or is it becomes the outcomes are better insofar as it doesn't suppress the.... [LB882]

SENATOR NORDQUIST: I think it's a combination. It's my understanding that some of these people can take oral chemos and continue working, and so it doesn't...it's not as...it doesn't take such a toll as the IV chemo. But again there's people that can speak to that. [LB882]

SENATOR PIRSCH: Wonderful. I look forward to that. Thank you. [LB882]

SENATOR PAHLS: Seeing no more questions, thank you. I need to see a show of hands how many proponents do we have so I have a figure? I see...hold them up high. One, two...four. How many opponents? One, two. How many in the neutral? Okay, this is the procedure that we use here. When you are up to speak, we like to have you move to the front row so that way it gives me a feel of the flow. So we do have a couple seats up here. And we are ready now for the proponents. Good afternoon. [LB882]

SHELLY JACKSON: (Exhibit 8) Good afternoon, Chairman Pahls, members of the committee. I appreciate the opportunity to be able to speak in support of this bill. My name is Shelly Jackson. I am the mother of a leukemia patient here in Lincoln. My son Tyson was entering his senior of high school when he was diagnosed with a form of leukemia, chronic myelogenous leukemia. It's been four and a half years since his diagnosis, and it has been devastating on many levels. Medically he's had periods of successful treatment and multiple treatment failures. He has received multiple chemotherapy drug treatments since his diagnosis, all of which ultimately in the end, have failed to control his leukemia. He's currently participating in a FDA research study. He was found to have a genetic mutation that makes his particular leukemia potentially terminal and very difficult to treat. While we are very grateful for every day that he has survived with the leukemia, the thing that we failed to understand when he was diagnosed that perhaps the most difficult part of the disease was not going to be figuring out how to treat it; it was going to be figuring out how to pay for it. When he speaks of his leukemia, my son frequently says he sees it as a cage, and I can appreciate the analogy. It's a little heartbreaking for me because I think that I helped him build the cage, and it's made up of his access to medical services. At the time that he was diagnosed, I had good insurance. I had low deductible, low out-of-pocket maximum insurance with a reputable insurance company. I did not for one minute during his

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diagnosis think that paying for his care was going to be the issue that it turned out to be. My plan specifically covered chemotherapy. It was a listed benefit. Then I discovered the reality of treating with oral chemotherapy drugs was a lot different than I would have assumed, despite my plan which specifically covered the service. His initial chemotherapy copayments were around \$3,000 a month, an amount that did not apply to my out-of-pocket maximum or my coinsurance. The only reason for this is because it came in the form of a pill. He was prescribed this pill not because it was more convenient or because it was experimental; it is the only standard of care for the kind of cancer that he has. There isn't an intravenous substitute for the drug they prescribe for CML. It just wasn't covered because of its place on a formulary that meant our insurance would pay for 50 percent, and the drug is very expensive. Several months into his treatment this particular drug was moved to a place on our insurance formulary that dropped the copayment to \$35 a month, and we were ecstatic. Unfortunately, three months later when his chemotherapy needed to be switched to a different kind, the new drug was not covered at all by our insurance. At that time the retail price of that drug was around \$7,600. I worked an additional job. I used my savings. I cashed out my retirement funds to cover his treatment costs that weren't covered until that wasn't a viable option anymore. After multiple hospitalizations, he did reach the lifetime maximum benefit on our policy and was, for a time, without insurance. As soon as he was old enough and eligible, I encouraged him to and helped him apply for SSI and a combination of Medicare and Medicaid for insurance coverage. My objective at that time was to keep him in treatment, and I knew that that was really his only option. I didn't realize, or maybe I did and it wouldn't have changed my decision, but he's 22 years old now. He...I sent him to live alone in a 300-square-foot apartment that his SSI could cover, because he didn't qualify for Medicaid with my income. And it did keep him in treatment, but it creates a pretty bleak future for a 22-year-old. He doesn't have a lot of options now. The physical limitations of his disease might keep him from being able to work in a lot of careers, but he probably is capable of doing some kind of work. However, he has no postsecondary education. He has no job skills. He's not insurable under a traditional insurance policy. He has no real hope of finding an employer that's going to want to take on his insurance burden and provide him with affordable group health insurance. The types of jobs he might be able to get are not going to enable him to join the comprehensive health insurance pool and pay the premiums and the copays that would be required. And our family finances have been decimated by the impact of essentially being underinsured for this illness when he got sick. Our family is not alone in this situation. As of June 2011, there were 32 types of cancer that had oral chemotherapy with no IV equivalent available. Today, oral oncology comprises about 10 percent of available therapy. It's estimated that 25-35 percent of the medications in the oncology pipeline are oral however, this question came up earlier. I do know the answer to why it's going to oral. As they are able to more target chemotherapy, they are able to deliver it in a different method that provides fewer toxic side effects and treats more of just the cancer cell rather than poisoning the whole body. They are expensive drugs that a lot of research goes in behind them. There are no generic equivalents available. Most

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of them are very new. I know that there are a lot of competing interests in legislation like this, but I believe strongly that passage of this bill is in the best interests of the cancer patient, and I think it's in the best interest of the taxpayers. The current system allows health insurance companies to selectively disallow coverage for chemotherapy, and it creates a situation where at some point previously insured patients are going to have no choice but to go on social welfare programs to survive. Nobody can pay that kind of copay out of pocket forever. There's not a lot of options out there. And I do understand that I am very close to this situation. It might not be as black and white as it seems to me. There are a lot of industries and organizations that have a financial stake in this, and the costs are very high. Everybody wants to cut costs and we live in precarious economic times. I do understand all of that, but I can't help but ask: What are people in our situation supposed to do? I am a college-educated middle-class Nebraskan, and I had all of the appropriate insurance. I feel like this shouldn't have happened. I wasn't just living beyond my means leading to a situation where I thought that, you know, society should foot the bill if something happened and I wasn't going to pay for insurance. I did have catastrophic health insurance coverage. Although this bill comes too late to help my son, I do urge you to support it so that others are not faced with the same situation. I know our time is limited. I have included much additional information in my written testimony, so I hope that you will get a chance to look at that, and I'll be happy to answer your questions if I can. [LB882]

SENATOR PAHLS: Thank you. Do we have any questions? Seeing none, thank you for your testimony. [LB882]

SHELLY JACKSON: Thank you. [LB882]

SENATOR PAHLS: Next proponent. [LB882]

TESSA FOREMAN: (Exhibit 9) Hi. My name is Tessa Foreman; that's T-e-s-s-a F-o-r-e-m-a-n. I'm here today to speak in support of LB882. In April 2010, at the age of 47, I was diagnosed with stage III rectal cancer. I was told I would need to undergo six weeks of radiation and chemotherapy. I would then have surgery to remove the tumor, followed by an additional six months of chemotherapy. When I met my oncologist for the first time, he explained that there were two chemotherapy options used to treat this type of cancer: an oral medication called Xeloda and an intravenous drug called 5-FU. He informed me that studies had shown these two drugs to be equally effective. Xeloda, the oral medication, is believed to be better tolerated than the IV drug. My oncologist also discussed with me how the two drugs worked. In order to receive the IV drug, I would have to first undergo a surgical procedure to install a Port-a-Cath into my chest. This device is used to deliver the chemo drug directly into the blood stream. The chemo is administered through a pump that I would have to carry around 24/7 while it released a steady supply of the drug into my system. I would have to carry it with me everywhere I went. I would have to go to work with it, sleep with, and shower with it, making sure not

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to get it wet. On the other hand, in order to receive the oral chemotherapy drug, all I would need to do is pick up a prescription and take a couple pills twice a day. So considering that it was less invasive, would not require an otherwise unnecessary surgical procedure, would be less complicated to administer, would be less disruptive to my daily life, and could potentially cause less side effects, my oncologist determined the oral medication would be the best option for me. He made this decision based on his education, training, and experience as a medical professional specializing in the treatment of cancer. I agreed with his decision. That was when my insurance company stepped in, disregarding the wishes of both my oncologist and myself to select the treatment option they preferred. They refused to pay for the more expensive oral chemotherapy drug. I could have appealed their decision, but the appeal process would have taken months. I did not have months to wait. I was in a fight for my life and it had to start now. Having no other viable option, I proceeded with the process to undergo the IV chemotherapy, beginning with the surgery to install the Port-a-Cath. I developed complications from that surgery. When I started the IV chemotherapy, I developed very serious side effects that resulted in hospitalization. I have documented those experiences in the written version of my testimony for you to read. Those complications and side effects caused much additional pain, suffering, medical costs, and hours of lost work time for both me and my husband. Much if not all of that could have been avoided if the insurance company had allowed me to take the oral chemotherapy treatment. The irony here is that the insurance company undoubtedly declined to pay for the oral chemotherapy in order to save them money, but by the time they paid for all the medical costs that resulted from the complications and side effects, I doubt that they came out ahead. The decision as to what type of chemotherapy treatment I received should not have been made by anyone other than my oncologist. I was already facing a life-threatening disease, radiation treatments, and a major operation. The least my insurance company could have done was to allow me to take the easier chemotherapy treatment. Please pass LB882 out of your committee and into General File. This is important to me and to all Nebraskans who have faced or will someday face a cancer diagnosis. Thank you for your time. [LB882]

SENATOR PAHLS: Seeing no questions, thank you for your testimony, Tessa. Next proponent. [LB882]

DOUG BAUCH: (Exhibit 10) Good afternoon, Chairman and distinguished members of the committee. My name is Doug Bauch, D-o-u-g B-a-u-c-h. I live in Lincoln and I'm represented by Senator Colby Coash in District 27. I have contacted Senator Coash and his staff about LB882, even though he's not one of the sponsors or part of this committee, because I will be asking for his support when you move this out of committee into General File. I want to give a special thank-you to Senator Nordquist for his strong leadership in sponsoring this bill, and to Senators Howard and Wallman for also displaying leadership in their decision to cosponsor it. Senator Nordquist did an excellent job of outlining, at the introduction, the results that have been seen in other

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states, the positive effects of the bill. I'd also like to note that Senator Gloor had some excellent questions about the costs and some other aspects that go along with that. And Senator Pirsch, your question on treatments being in oral form only, I hope that's been addressed for you that in some cases this is the only option; there is not an IV or radiation or what have you. If you want to keep that cancer in check or hopefully keep it in check, it's going to be a pill in 10-30 percent of the opportunities that are there--or you're just not going to be here anymore, and that sounds pretty doom and gloom, but I'm a friend of Ms. Jackson. I've know her son and her since '03, and to say the last four and a half years has been difficult is a major understatement. It's a roller coaster. If any of you have had terminal illness in your family or friends, you know exactly what I'm talking about when I say roller coaster. You get the good news that this is working or we've found something new, and then something happens and it's not working anymore. I lost an uncle to leukemia about four or five years ago. He was in his seventies. He had beat it. It came back. He had no options, and they just sent him home to die with dignity. Now he had led a full life. He had served his country in World War II and made his contribution to society, but it was still heartbreaking. And here we have a gentleman in his early twenties that doesn't have the opportunities that you and I had, for most cases, or your children have or you'd like your children to have. Employers are hesitant to hire him. If they do, they get upset and disappointed at his inability to continue showing up to work on a regular basis, being sick, leaving early. The same with college. You have to be there to get the credits and pass the class. And when you're having bone marrow biopsies where they drill into your hip and remove your bone marrow, and you're bleeding for two days, it can be pretty tough to get there. So his life is really shattered, and this experimental drug that he is on right now is a godsend--and it came around Christmastime, ironically. It's a drug trial; it's phase II. It is working, it's expensive, it has side effects, but it's only available in pill form, and Ms. Jackson has had to tap significant financial resources that she put away when the insurance companies were changing or not paying what people expected. So LB882 is an excellent opportunity for Nebraska to be on the forefront. There is at least 14 or 15 states, plus the District of Columbia, that have this. Another personal side of this: My aunt has multiple myeloma which is a form of bone cancer. She lives out in Colorado. She's a Nebraska native, grew up in the Sandhills out in Sparks. They beat it with intravenous. It came back, and the only option she has is oral, and she's facing the same situation. Three hundred-plus dollars for a pill you have to take every day. She's retired, close to 70, on Medicaid. Colorado just recently passed a similar bill to (LB)882, and I'm hoping that's going to be helpful for her. But the only thing that is keeping her alive is this oral treatment, and it's the only thing that's available to her. She's exhausted everything else, similar to Tyson's situation. I have left significant testimony in here for you to look over. I just again want to commend Senator Nordquist and Wallman and Howard for their leadership, and the committee for considering this bill and hosting today's hearing and hearing both sides of the story. I believe Senator Nordquist stated the gist of this situation very well in his January 9 press release. It is on his web page and I highly recommend you go there and see the entire press release. It's not that

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lengthy, but one paragraph here alone is very telling. "Ultimately, LB882 would ensure that patients battling cancer can afford the drugs that best suit their course of treatment--a decision best made by a physician and their patient, not an insurance company." You have the opportunity to move this bill forward, put Nebraska at the forefront with some other states, and have a positive impact on all Nebraskans, especially those that are affected by cancer, and alleviate some of the financial burden that's being put on Medicaid by those that are being forced onto public assistance, which is a direct cost to all taxpayers. I again thank you for your time this afternoon, and I'll be willing to take any questions if there are any from the floor. [LB882]

SENATOR PAHLS: Seeing no questions, Doug, thank you for your testimony. [LB882]

DOUG BAUCH: Thank you again. [LB882]

SENATOR PAHLS: Next proponent. [LB882]

DAVID HOLMQUIST: (Exhibit 11) Good afternoon, Chairman Pahls, members of the Banking, Commerce and Insurance Committee. My name is David Holmquist; that's D-a-v-i-d H-o-l-m-q-u-i-s-t. I am a registered lobbyist. I appear on behalf of the American Cancer Society and the American Cancer Society Cancer Action Network. I am here in support of LB882, with thanks to Senator Nordquist and the cosponsors for introducing this legislation. I have made available to the committee copies of the report mentioned earlier that was prepared by the highly trusted research firm Milliman. The report outlines the issue of chemo parity for you. You'll notice the first couple of pages of the executive summary, I've highlighted some areas for you as well. At the beginning is the word cancer. It's a bummer. There's no surprise there. Then on top of hearing the "C" word from your doctor, you hear some other things that you have to consider. As you're probably well aware, treatments for cancer can wreak havoc on cancer patients, physically, emotionally, and financially. They can also wreak havoc on the families of those cancer patients, as we've heard in previous testimony. Usually first, there's surgery and then recovery from surgery, and then there might be radiation treatment or there might be chemotherapy or there might be a combination of these. Then there are patients who must travel long distances over many weeks or months to have intravenous or injected drugs that may experience undue financial and/or emotional hardships when an equivalent oral therapy could be taken at home. For example, if a Nebraskan lives in, let's say, Valentine and can't have any infusion done there but has to travel to Kearney for infusion. What is that, 150 miles each way? And if they have to go three days a week, that's 300 miles a day, three times a week: 900 miles. We all buy gasoline everyday. We know it just went up again. That's going to be a financial burden, not to mention the travel burden of having to travel back and forth from your home to an infusion center. And then there are other issues to consider. On top of the travel, imagine for a moment sitting in a chair for hours on end while your treatment is being dripped into you through an IV. It's not unlike you all sitting here every afternoon

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listening to testimony, some of it interminable, I think. But you have the option to be able to get up and move around or go and introduce a bill in another committee. Cancer patients don't have that. They are pretty much stuck in that recliner for hours on end while a chemotherapy poison is dripped into their veins. Now on the positive side of the scale, infused medications are covered as a medical benefit in most health plans, and these medical benefits often bring relatively low-cost burdens to patients. Now there is an alternative and it's called oral chemotherapy, and sometimes there's a combination of therapies both oral and infused. I'm not a medical expert; I can't tell you all those details. A patient on oral chemotherapy, however, can continue treatment without leaving work or home, and the side effects are generally much lower. The inability for patients to access oral chemotherapy drugs due to financial burdens places yet another layer of challenges and stress on patients and families. Currently, oral chemotherapy is usually covered by a patient's prescription plan. Pharmacy benefits can make high-cost oral cancer medications unaffordable, as you've also heard. By contrast, only an office visit with an oncologist may be necessary to put a patient on the oral chemotherapy regimen at a low cost to the patient and to the insured...the insurance companies. Medically, oral chemo drugs run a lower risk of complications compared to IV counterparts, and have fewer side effects and higher rates of adherence. In other words, patients who are on oral drugs take them every day, there's not a problem with them underdosing themselves as there may be missing appointments for infusion. The problem is, of course, financial. The majority of new chemo drugs in the research and development pipeline are being designed for oral administration, so we're going to have to face this sooner or later. The cost-sharing inequity in some plan designs between intravenous and oral chemo products is becoming more apparent as high-cost oral products come to the market. For most benefit plans, parity will cost under 50 cents per member per month. In other words, if I have an option to pay 50 cents and get an oral chemotherapy as opposed to saving 50 cents a month, I think I want to spend the 50 cents instead of \$3,000 a month. It just seems to me common sense. Insurers suggest that this legislation will only cover the 30 percent of insureds who are not in large, employee-based plans. Now whatever the percentage, cancer patients should have the affordable alternative to the stress of infusion and the medical...the side effects and the possible complications. Also many of the major self-insured plans will cover oral chemotherapy. In fact, the state employees' plan in Nebraska covers oral chemotherapy. Medicare covers oral chemotherapy. It is not a part of Part D. Medicare covers oral chemotherapy as part of your Part B coverage. That...I think some parity between the working stiffs among us and those who have managed to be able to retire in this economy would be a good thing as well. I think there's much more that could probably be said. I'm not an expert in it by any means, but I think we need to consider the cost of treating cancer, as it has been brought up by a previous witness. She had to undergo medical procedures that were, frankly, unnecessary and that caused complications and perhaps cost her insurance company as much as the oral product would have cost. I will...I think the insurance companies will tell you that they don't want you or me telling them how to run their business, and yet it seems to me that insurance

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companies over and over again tell doctors how to run their business, by making decisions about a patient's care that should be best left between the doctor and the patient. Finally, Senator Pirsch, you mentioned targeted therapies, and I think we've heard from previous testifiers that there are 32 cancers currently being treated by this. Among those are breast cancer, prostate cancer, lung cancer, and blood cancers. And there seems to be materially better outcomes because of the targeted therapy. In other words, we're not opening a port in an arm and dripping chemicals into your body to kill every cell in sight. Instead, a pill can be targeted to attack only the cancer cells in a particular portion of the body, therefore, thereby saving long-range costs both to the patient and the healthcare systems and the insurance companies and, thereby, saving suffering and saving lives in the long run. And really what it's all about is saving lives. So I urge you to pass this bill. I have to say Kansas passed it last year. We had this conversation for many years about covering colon cancer screening. Kansas has never been able to cover colon cancer screening, but they got this bill passed and signed by the governor; same thing in Texas, in Colorado; last week, I think in New Jersey. It's happened in more than 15 states and the District of Columbia, and will continue to do so, and I think Nebraska needs to take ownership and pass this bill. And with that I'll close, and I encourage you to read the Milliman study, and I'd entertain any questions you might have. [LB882]

SENATOR PAHLS: Senator Gloor. [LB882]

SENATOR GLOOR: Thank you, Senator Pahls. Thank you, Mr. Holmquist. I'm guessing that you helped kind of work with Senator Nordquist to line up some of the testifiers today. So is there going to be a clinician that comes up after you at some point in time? [LB882]

DAVID HOLMQUIST: No, to my knowledge there will not. [LB882]

SENATOR GLOOR: Okay. [LB882]

DAVID HOLMQUIST: But we would be happy to get more information to you from a clinician. I know one oncologist who I think would like to have testified is in Washington for another meeting and not able to be here. [LB882]

SENATOR GLOOR: I would. I mean I've got some questions. They're not highly technical. They're coming from me--they're not highly technical, but it would be helpful. You did make mention of something though that I wondered, and that is that you're saying an increasing number of ERISA plans are providing this as part of it. [LB882]

DAVID HOLMQUIST: That's my understanding, yes. I don't have data. [LB882]

SENATOR GLOOR: And Medicaid? And Medicaid is covering it? [LB882]

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DAVID HOLMQUIST: Medicare is covering it. I don't have an answer on Medicaid, but I could certainly get that. [LB882]

SENATOR GLOOR: Yeah, I think that would be good information to have. Thank you. [LB882]

DAVID HOLMQUIST: Thank you. [LB882]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LB882]

DAVID HOLMQUIST: Thank you. [LB882]

SENATOR PAHLS: Any more proponents? Again, if we have any more proponents, it would be possible that front seats are available. Okay. Any opponents? I did see two hands. Going once. If you would move to the front, that would give me a feel, because I know some of you are regular lobbyists. [LB882]

ROBERT HALLSTROM: (Exhibit 12) Chairman Pahls, members of the committee, my name is Robert J. Hallstrom. I appear before you today as a registered lobbyist for the National Federation of Independent Business to testify in opposition to LB882. For those of you who have been on the committee for some extended period of time, there are various and sundry forms of mandated benefit proposals that come before the committee, all of which in their own merits may...in their own respect, may have merits. They may not be budget busters in and of themselves, but small businesses have consistently opposed these types of measures for the potential aggregate effect that they may have on their ability to provide insurance coverage to their employees. We survey our members on a regular basis and find that those things that reduce the cost of insurance are favored; those things that can serve to increase the cost of insurance are opposed, and LB882 in some small measure will increase the cost of health insurance. One additional thing that I think is on the radar screen from issues that have been raised in the past is the potential implementation of the federal health care act. We're seeing with the recent dictate that the states are going to be given flexibility to develop their own essential health benefits package, that mandated benefits will obviously become a part of that. So to consider additional mandated benefits that would be part of that package going forward into whatever new environment for healthcare provision that we may encounter would place even greater pressure on small businesses. So we believe that these types of issues should be...remain voluntary, negotiated between employer and employee, taken as a part of the entire benefits package that can be provided, because obviously things that increase the cost of providing insurance coverage will have an adverse impact on other perks and benefits and salaries that the employers may provide for their employees. I'd be happy to address any questions that the committee may have. [LB882]

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SENATOR PAHLS: Seeing none, thank you for your testimony. [LB882]

ROBERT HALLSTROM: Thank you, Senator. [LB882]

SENATOR PAHLS: Next opponent. [LB882]

RON SEDLACEK: Chairman Pahls, members of the Banking, Commerce and Insurance Committee, for the record my name is Ron Sedlacek. That's spelled S-e-d-l-a-c-e-k. I'm here on behalf of the Nebraska Chamber of Commerce. Echoing Mr. Hallstrom's comments, the State Chamber has consistently been opposed to further mandates, particularly on targeted to our group and individual policies. We have a number of local chambers in our membership who do offer or had offered such plans, as well as other trade associations who may be in that particular market. And as employers have consistently, continually migrate to ERISA-type programs, we find less and less of our membership part of the group market or individual market, but those who are, are small businesses, are individual entrepreneurs. And again, it's the aggregate effect. Every mandate that has been before this committee is a well-intentioned mandate. However, the aggregate effect is going to increase those costs and drive employers either out of that particular market. If they're fortunate enough to get into an ERISA plan, that's fine. However, they may also increase, of course, the costs of...due to the costs of the insurance, there is a risk of affordability and availability of that product to their employees. And for this reason that is why we are in opposition to further mandates. [LB882]

SENATOR PAHLS: Seeing no...oops, Senator Schumacher. [LB882]

SENATOR SCHUMACHER: Thank you, Senator Pahls. Has the chamber done any research in those countries that offer single-payer universal healthcare as to whether or not...how they handle this issue of oral medication for cancer? [LB882]

RON SEDLACEK: Not for that specific purpose. No, Senator. [LB882]

SENATOR SCHUMACHER: Thank you. [LB882]

SENATOR PAHLS: Senator Gloor. [LB882]

SENATOR GLOOR: Thank you, Senator Pahls. Mr. Sedlacek, if insurers came to business leaders and said, you know, this is beginning to fall in the category of mammographies and colorectal screenings and a number of other things that we think make sense to pay for up front because it saves so much money on the back end, do you think the chamber and other business leaders would look at this differently? I mean, is this an insurance decision or is this an individual employer decision, I guess is my

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question? Do we have to work on the insurers on this or do we have to work on the business leaders? [LB882]

RON SEDLACEK: Not the business owner. I mean, certainly they may have some...most of the people that we deal with are small businesses and they probably do not have the negotiating power to do so. It would be something that would probably have to be worked out with the insurance companies themselves. [LB882]

SENATOR GLOOR: Okay. I'm asking it more from the standpoint of... [LB882]

RON SEDLACEK: Because we're essentially the consumer. We're buying the product from the insurance company,... [LB882]

SENATOR GLOOR: I think that answers the question. [LB882]

RON SEDLACEK: ...and the question is, is it affordable? Yeah. [LB882]

SENATOR GLOOR: Well, yeah. I mean there's that part of it, but somewhere along the line we, from a societal standpoint, made a decision that we should provide some coverage on things that in the long run made more sense. In other words, there shouldn't be any copays or deductibles as it relates to certain screening exams because they pay for themselves, and then some, in the long run. And I've never been able to figure out whether that was driven by the insurers educating us as consumers, because I used to be a consumer for my employees, or whether it's one that we ourselves took the insurers to the table and said we want to do this because we think it makes more sense in the long run. And so I'm really asking it from an education standpoint I guess. And it's a guess. [LB882]

RON SEDLACEK: Thank you. [LB882]

SENATOR PAHLS: Am I to assume then all the states that have already passed similar legislation, the chamber probably was opposed to it in those states also? Would that... [LB882]

RON SEDLACEK: I don't have any idea what the local chambers... [LB882]

SENATOR PAHLS: Well, what would be your perception? [LB882]

RON SEDLACEK: More than likely. [LB882]

SENATOR PAHLS: Okay. Any questions? Thank you for your testimony. [LB882]

RON SEDLACEK: Um-hum. [LB882]

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SENATOR PAHLS: Good afternoon. [LB882]

JAN MCKENZIE: (Exhibit 13) Good afternoon. Senator Pahls, 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, testifying in opposition to LB882 as executive director and registered lobbyist for the Nebraska Insurance Federation. As usual, we as an industry, my companies who are in the business of selling health products, are opposed to mandates that make what is available in the market to the consumer more one size fits all than flexible and available to meet many people's needs. You all were, except for Senator Schumacher, I believe, privy to a report that the department gave you in their interim study hearing on the health exchange efforts. And it was one that was commissioned as a part of their study grant. I took the liberty of pulling a few pieces out of there to highlight what the state of insureds is in Nebraska. And I think as policymakers that's where you're going to be focused for the next couple of years. Regardless of the issue, whether it's cancer or oral screening or oral treatment for cancer or any of the numerous different things we've heard in the past few years, we have more than 50 percent of Nebraskans in an ERISA plan. Those plans are not touched by mandates. And now with the federal health reform efforts of essential benefit plans that the states are going to have to determine, you are more and more going to be in the hot seat as policymakers to decide what Nebraskans can afford, as you heard yesterday: if they're buying their own policy or what the state can afford to supplement if you choose to add it to the essential benefits list. My point in particular is, if you look at the last part about deductible levels in Nebraska, Nebraska is a small employer state. Seventy-six percent of Nebraska employees...or 76 percent of Nebraska businesses have less than 50 employees. Of those businesses, if you look at the bottom, compared to large group, which are most likely going to be ERISA, if you'll notice the difference between those folks who are already paying a deductible of \$1,500 or less, in the small group it's 45 percent; in the large group it's 85 percent. Small employers, people in small businesses, are already at much, much higher deductible levels than are folks who are provided insurance in a large group. And I think that is something that in Nebraska we have to be concerned about. More than half of the employees working in small firms in Nebraska are not offered insurance compared to the 1.6 percent in large businesses. These are the facts that came from the study. Ninety-five percent of large employers in Nebraska offer health insurance. Many of those are exempt from mandates, and large employers represent only 24 percent of the business in Nebraska. And we currently have an uninsured rate of 11.5 percent. Now I put those things on the table for this bill and for the next bill for your consideration. It is an issue that it is harder and harder for self-employed people and small employers to be able to purchase and provide insurance. We want to make sure Nebraska's market is such that there are many choices out there for people. Businesses offer and develop many different types of products in competition with each other to try to meet the needs of the consumers. In some cases, employee groups can work with their employers to modify and change and

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add benefits, and in some cases employers do that as Mr. Holmquist said, and in some cases they quite honestly feel they can't afford to do that. It is a business and it is an important business and we want to make sure that the market is healthy and competitive for Nebraska consumers. With that, I would answer any questions you might have. [LB882]

SENATOR PAHLS: Senator Schumacher. [LB882]

SENATOR SCHUMACHER: If we...thank you, Senator Pahls. Thank you for your testimony today. If we accept the notion that the idea behind insurance is to spread the risk of a calamity of some kind and if we accept the notion that cancer probably is apt to strike any of us, and so any of us could find ourselves in the shoes that were described today and have to make a choice between apparently a little better stuff with the oral, at least that's what the testimony seems to indicate, or the more grueling kind of treatment that might even end up being as expensive or more expensive, what policy reason is there for not just saying this is one...this like a heart attack, like a clogged artery, like anything else, is a reasonable cost and it should be insured, and if the insurance companies don't want to do it, we mandate it? [LB882]

JAN MCKENZIE: Well, I'm going to tell you that I believe they do all cover oral chemo drugs, or at least most of...as I'm familiar with, my Nebraska companies. But the difference is, they are in a formulary and there's a copay versus a medical treatment which is met by your deductible, and that's probably what's created the difference. Plus the fact that formularies put drugs that are very expensive in different tiers, and they do that in an effort to try to spread the risk across the prescription drug pools so that a majority of drugs that are most often prescribed are more affordable. But it is, yes, very much about spreading risk, and not so much about whether it's covered, but how it's covered, does that make sense? [LB882]

SENATOR SCHUMACHER: But yes. Yes and no. I mean, if this is a trend in the development of treatment and if it...all of us are exposed to the same risk, then, you know, the reasoning, subreasoning, and subreasoning of subreasoning, you know, that gets into why this in some cases is denied or you have to pay \$700 for a pill or whatever some of that testimony was, it would seem to me that maybe we need to say as a society, you know, we're not going to take this subcategory. This is between the medical profession and the insurance company should cover it then, if there's a cost, it's a cost, since we're all equally exposed, we should buy. I mean where's...? [LB882]

JAN MCKENZIE: Well, in many cases, as to Senator Gloor's question as procedures and treatments become proven and, in fact, do save money for the group of people investing against the risk together for their healthcare needs, those kinds of changes have been made. But they've made...different plans have different kinds of medicine formularies, prescription drug formularies. For instance, I helped my mother shop for her

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new med sup prescription this year, and we worked with the pharmacist and the doctor to determine which of the ones were best to meet her drug needs. So there are a lot of different choices out there, and it's not always based on everybody has to pay everything for every drug. Does it make sense? No? [LB882]

SENATOR SCHUMACHER: Well, a little. In those countries that have universal coverage healthcare systems, how do they address this issue? Do they segregate it out? [LB882]

JAN MCKENZIE: I don't know, Senator. [LB882]

SENATOR SCHUMACHER: You haven't researched that. [LB882]

JAN MCKENZIE: No, I haven't. [LB882]

SENATOR SCHUMACHER: Okay. Thank you. [LB882]

SENATOR PAHLS: I have a question not for you, but actually maybe Senator Nordquist could give this information to us. But I'm curious, I'm sitting and listening to some of the testimony. And maybe...I'm taking medication. I do not have cancer, but I take chemo drugs, at a relatively, I think, inexpensive. That's probably because of my plan or because it's an old drug, an old chemo drug. I'm trying to figure that out. That's not a question for you. It's just to make a statement while you're up here so maybe Senator Nordquist could get that information. That's why I wish we would have had a, you know, somebody in the medical field also talking to us. [LB882]

JAN MCKENZIE: Yeah. And I think one of the proponents mentioned that a particular drug they had been on was expensive, and then it went...it was moved down to a less expensive. And that may or may not be because it was moved into a generic mode so it was made by a different manufacturer and was more generic, or it may be that the manufacturer chose...I mean, one of the problems we sometimes have in this world is that the pharmaceutical companies choose not to provide or produce that particular prescription anymore and/or they choose to change the price, and the insurer does not have anything to say about that, the prescription drug plan. That's completely based on what the pharmaceutical company wants to charge for that drug. So lots and lots of strings attached to lots and lots of parts on these issues. [LB882]

SENATOR PAHLS: And I appreciate that response because I'm hoping Senator Nordquist is listening and to provide that. I mean, apparently I'm one of the fortunate ones who has a...I mean I'm not on Medicare, I'm on another private... [LB882]

JAN MCKENZIE: Right. And years ago all of this was included, everything was under your medical. And then there was an effort, because as prescription drugs became

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more and more a key piece of good treatment, the two became separate types of systems. And most health insurers work with a pharmacy benefit manager to develop the plans that match their medical plans, and so there are various combinations of those out there available for employers to look at or for consumers to consider. [LB882]

SENATOR PAHLS: Again, I thank you for your helping educate me. [LB882]

JAN MCKENZIE: Thank you. [LB882]

SENATOR PAHLS: Any more opponents? Anyone in the neutral? Senator. [LB882]

SENATOR NORDQUIST: Thank you again, members, for your attention to this issue. I just want to address just a couple of the issues that came up, real quick. Senator Gloor, I just whispered to Ms. Jackson with her son in the situation that he's in, he's on a part...an SSI, part Medicaid, part Medicare. And Medicaid does cover this, does have parity for it. And also as far as the clinician, my brother was intending to be here and he got called out of town. He's part of a government affairs, for now, lobbying team for American Society of Clinical Oncologists, and he's in D.C. actually lobbying on a congressional bill that would do the same thing. But as I told him, I don't anticipate Congress is going to be doing anything related to healthcare for some time, so. And then Senator Pahls, I guess I don't have a great answer for you. I would assume that if it's because of when that drug was developed and maybe the costs being ratcheted down since then. But the basics of this, I think actually Jan maybe said it best, is not whether it's covered; it's about how it's covered. And that's the crux of the bill. It's not a mandate. We're not saying you have to cover. It's saying that if you do provide other cancer treatments, that we put this on par. That should be our new business model. The way we have it now is an outdated business model. New drugs that are coming out, the pharmaceutical companies are putting their dollars in research on oral and on targeted chemotherapies, and that's what Nebraskans are going to need going forward. You know, I grew up in a house where my parents were both public servants, and my dad was diagnosed with cancer and ultimately passed away with cancer when I was a senior in high school. There is no way if we were in the situation of any of these families, our family...my dad could get the treatment he needed should it have been an oral treatment, without bankrupting our family. I mean I think that's the position a lot of Nebraska families would be in. So I encourage you to take a hard look at this. The dollars associated are small. You can look at the Milliman report. We can get data from all the other states that have conducted analyses on this to show you that the costs that are passed along are minimal. And on the part of the small businesses, I think, you know, not in all situations, oral, you know, oral may be the only alternative in all situations, but in some situations it is an alternative. And if you have a small business that only has a handful of employees, keeping that employee on the job would have a big impact to your small business, and I think it would be worth the 28 cents a month per member to keep employees on the job and not taking three days a week to get

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chemo and then obviously all the side effects that come with that too, so thank you. [LB882]

SENATOR PAHLS: Any questions for the senator? Senator Gloor. [LB882]

SENATOR GLOOR: Thank you, Senator Pahls. Senator Nordquist, is it your brother that's the clinician that will probably get back in touch with you? [LB882]

SENATOR NORDQUIST: Yeah, and I would be happy to give you his cell number. I'll make sure he gets in touch with you. [LB882]

SENATOR GLOOR: Oh, I would love to have it. [LB882]

SENATOR NORDQUIST: We can coordinate that with anybody. [LB882]

SENATOR GLOOR: We'll spend some of our time at your expense talking about you and.... [LB882]

SENATOR NORDQUIST: (Laugh) All right. I would be happy...and really, this bill came about from he has a cancer center he just opened in west Omaha, and he has over a half-dozen patients that are directly impacted by this. And, you know, as I told him on the phone when he was talking about going to lobby Congress, clinicians like him are the ones that actually...you know, he administers IV chemo in his clinic, and it's a big source of revenue and, you know, but they're still willing to step out and say this is what's best for our patients even though it could hit our bottom line, so. [LB882]

SENATOR GLOOR: Thank you. [LB882]

SENATOR NORDQUIST: Yeah. [LB882]

SENATOR PAHLS: Seeing no more questions, thank you. [LB882]

SENATOR NORDQUIST: Thank you. [LB882]

SENATOR PAHLS: Thank you, Senator. That will close the hearing on LB882. We are now ready for LB1129, Senator Coash. And before you begin, I'd just like to see the number of hands who plans to testify as proponents. Okay, I just want to keep this in mind. I see one, two, three, four, five six, seven, eight. I think I will ask Mike Wasmer, Cynthia Ellis, and Rebecca Olander to come to the front. I think you are going to be our first testifiers after the good senator is finished. Senator. [LB882 LB1129]

SENATOR COASH: Thank you. Thank you, Senator Pahls and member of the Banking, Commerce and Insurance Committee. This is my first bill in front of your committee. And

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for the record, I'm Colby Coash, C-o-l-b-y C-o-a-s-h, and I represent District 27 right here in Lincoln, and I appreciate the opportunity to introduce LB1129. LB1129 requires health insurance policies, including self-funded employee benefit plans and the Nebraska state employee plan, to cover screening, diagnosis, and treatment of autism spectrum disorders for people up to the age of 21. The language in LB1129 mandates coverage of up to \$70,000 per year for persons 9 years and younger, and up to \$20,000 per year for persons age 10 to 21. If we move forward in the future, we should amend this language to require \$70,000 per year for the first three years of treatment so that it kicks in when you start to get treatment, not depending on your age, and up to \$20,000 after that per year, until the child reaches the age of 21. The language in this bill ensures that no matter the age of diagnosis, a person with autism spectrum disorder can get the intensive therapies he or she may need in the first three years of treatment. We know now that the first years of intervention are critical. After those first three years of intervention, a person with autism spectrum disorder will likely need less treatment, if any at all, in the coming years. Members of the committee, you all know better than I what a hot-button issue insurance mandates can be, and I decided to carry this bill as a result of findings in LR219 that you heard this last summer and after meeting with autism advocates right here in our state. You will recall the compelling testimony of the LR219 hearings on November 30 of last year. You heard oral testimony from eight advocates, including parents of children with autism, psychologists who treat them, Autism Speaks, the Autism Family Network, and the Center for Autism at the University of Nebraska Medical Center. The case was definitively made that we lawmakers must acknowledge the profound needs of Nebraska families. In response to this need, I met with representatives from the Autism Action Partnership and Autism Speaks earlier this year. Autism Speaks offered to do an actuarial study on the costs of autism coverage insurance mandates. However, in order to conduct the study, they needed an actual piece of legislation in order to assess it. LB1129 is that legislation, and I am pleased to welcome Autism Speaks here today to share with you the results of that actuarial study. I will note that in order to save a little paper I did not print out the appendix that includes the text of LB1129, as you already have that in front of you. Upon introduction of the bill I was contacted by several provider groups, including the Nebraska Association for Marriage and Family Therapy, the Nebraska Psychologists Association, the Nebraska Counselors (sic: Counseling) Association, and the Nebraska Association of Social Workers. I thank them for reaching out to me and I look forward to including them in continued discussion of autism services coverage. It is critical that providers in our state are ready, willing, and able to provide the services mandated in this bill, and I thank them for their continued input. It is my hope that this relatively extensive and most importantly Nebraska-specific data contained in the actuarial study--and one of the testifiers behind me is going to share with you that actuarial study--will guide you and I as we work together towards a policy that serves our Nebraska families well. Colleagues, I may be one of the least likely senators to carry an insurance mandate bill, but I'm not afraid, however, of data. Data should drive our decisions. There was a time when colon cancer screenings, for example, were vehemently opposed as coverage.

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Times change and people began to realize that colon cancer screenings actually saved lives and saved money. I believe that soon we will realize that treatment for autism will also save money. I will tell you that I've worked with people with autism throughout my career, some of whom have had the advantage of this treatment and some who did not have the advantage of this treatment, and I want to illustrate the differences between the two. I used to work with a young man named Chris. His diagnosis of autism was not until he was in his mid-teenage years, and by the time he was properly diagnosed his education was nearing completion. Although he is a capable young man, he does not work, does not live independently, and relies 100 percent on state funds and Social Security in order to meet his needs. In contrast to that, I also used to work with a young man, who is now an adult, named Ed. Ed was diagnosed early in another state. In that state, he received intensive therapy and he now lives independent and holds down a job. His diagnosis was considered to be more severe than Chris, and I am absolutely convinced that the early diagnosis and the resulting intensive therapy was key to his success as an adult. And I know there are many other Eds and Chrises here in our state, and I see LB1129 as the beginning of a longer policy discussion that we should not let go away. At the heart of this discussion, and something I think you learned, is the divisive approach that has dominated this discussion between the educators and the medical and insurance community. Until these entities stop passing the buck between them and start working together for children, we will continue to spend money in inappropriate ways. So where do we go from here? Here's what I would ask the committee: Please look at the data that is going to be provided to you today. We should not be afraid of this actuarial study that came as a result of this bill. I would ask that you listen to the families, as you always have. Read the letters of support from them, from those families who are struggling with their children. And please know that I will work with the stakeholders on this issue to bring them together and to continue to engage them and this committee, as this represents a policy decision for the state, and I ask you if you would stay engaged in this discussion as well. And thank you for your time. [LB1129]

SENATOR PAHLS: Seeing no questions, will you be here for the closing? [LB1129]

SENATOR COASH: (Exhibits 1, 2, 3, and 4) I'm going to...I'm running the boat across the hall. But I will be in and out, and I will be available. I do have some letters of support just to be passed out to the committee. If you would take care of that. Thank you. [LB1129]

SENATOR PAHLS: Thank you, Senator. Okay, we are now ready for proponents, and my last hand count we had eight, and I'm not going to use the lights so I'm asking you to keep that in mind. [LB1129]

MICHAEL WASMER: (Exhibits 5, 6, and 7) Good afternoon. I am...thank you for the opportunity today to speak in strong support of LB1129. My name is Michael Wasmer,

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W-a-s-m-e-r, and I'm the associate director of state government affairs for Autism Speaks. I'm also the parent of a child with autism, and your neighbor to the south in Kansas, who enacted similar legislation in 2010. Autism Speaks is the world's largest science and advocacy organization, and we have been involved in most of the now 29 states that have enacted similar legislation. At the interim hearing on this issue in November, the committee heard testimony on the importance of early intervention and the effectiveness of behavioral health treatments such as applied behavior analysis. You also heard compelling testimony from Nebraska families who despite having health insurance are denied coverage for these medically necessary treatments and forced to pay out of pocket or go without. Without effective treatment, the lifetime costs to the state has been estimated \$3.2 million over the life span of every child with autism. The impact on the affected child and their family is immeasurable. Also at the November hearing I shared with this committee actual claims data from states that have preceded Nebraska enacting autism insurance reform. Although the terms of coverage vary somewhat between states, the average first-year cost of implementation is 15 cents per member per month. We've received new information since that hearing that I will share with you today, including first-year claims data from Kansas, which demonstrate a per member per month cost of 13 cents. Missouri also enacted legislation that went into effect January of last year. The Missouri Department of Insurance released a detailed report of their first-year experience last week, which has also been distributed to the committee members. Almost 4,000 Missouri children with autism were able to access treatment as a result of this law. The cost per member per month was 25 cents, and this equates to one-tenth of 1 percent of total claims. The average monthly cost of ABA per individual with autism was \$35, or 6 cents per member per month. While the first-year cost of implementation in Missouri is higher than the average of 15 cents, I suspect this is largely due to a very aggressive implementation process initiated by the Department of Insurance of Missouri. Prior to implementing their law, the Missouri DOI held statewide meetings for consumers and service providers in the insurance industry to answer questions about the available coverage and how to facilitate the claims process. The Missouri DOI also maintains an extensive on-line resource for consumers and providers. Because of their proactive approach, the first-year claims data is consistent with a more mature benefit. Claims data from five states show that the average second-year cost to the implementation of autism insurance reform to be 31 cents per member per month. The Missouri report concludes by acknowledging that although claims costs are expected to grow somewhat in the future, it seems very unlikely that costs for autism treatment will have an appreciable impact on insurance premiums. The fiscal note that's been filed for this bill would seem to conflict with actual claims data in other states. The total number of covered lives in the state health insurance plan and the University of Nebraska health insurance plan weren't reported, so it's not possible to compare results on a per member per month basis. However, several inaccurate assumptions were made in the fiscal note that I'd like to address because they may result in a significant overestimate of treatment costs. First, the fiscal note incorrectly assumed that 100 percent of children with autism inaccurately assumes 100 percent

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treatment prevalence of autism. For a variety of reasons, not every individual with autism will be diagnosed. Additionally, not every individual who is diagnosed with autism will receive treatment for autism. While the CDC reports the prevalence of autism is 1 in 110, treated prevalence of autism is approximately 1 in 150. The fiscal note also did not consider treatment utilization by age or by the range of severity of subtypes of autism spectrum disorder. One of the handouts that I distributed, slide number 20, you'll find a diagram that shows the umbrella term "autism spectrum disorder" actually includes three subtypes: autistic disorder, which is on the more severe end of the spectrum; Asperger's syndrome; and PDD-NOS on the less severe end. A 4-year-old with autistic disorder is much more likely to be prescribed an intensive treatment plan than an 18-year-old with PDD-NOS. Failure to consider that autism presents a spectrum of severity will make it difficult to prepare an accurate cost projection. A review of fiscal notes that were prepared in states where actual claims data is now available overestimated actual cost of coverage by 300 to 1,200 percent. As Senator Coash referred, an independent analysis of LB1129 was prepared by Oliver Wyman Actuarial Consulting, which is one of the largest actuarial firms in North America. This has been passed out to you as well. In addition to considering the treated prevalence of autism, the age of the affected individual, and the subtype of autism spectrum disorder, the Wyman analysis also factored in demographics and insurance market information specific to the state of Nebraska. Three different scenarios were tested based on different rates of treatment utilization. The middle scenario was based on a 65 percent utilization rate, and the long-term annual claims costs were estimated to be \$14.50 or \$1.21 per member per month. The resulting long-term premium increase was estimated to be 0.44 percent. The short-term premium increase could be as low as 0.09 percent until the benefit matures over several years. Although beyond the scope of most fiscal notes or actuarial analyses, it's important to consider not only the cost of the proposed coverage, but the return on investment. Virginia's independent Joint Legislative Audit and Review Commission issued a report on this topic in 2009, and found that the commonwealth could save approximately \$137,000 in special ed costs per student with autism if early intensive behavioral treatment was consistently provided. Research demonstrates that children with autism also have significantly higher medical expenses for issues unrelated to their developmental delay than children without autism. The Wyman analysis states that the cost of ABA treatments covered by LB1129 could be covered through reductions in educational and medical expenditures alone. Autism is treatable. While financially devastating to individual families if these treatments are paid for out of pocket, the growing body of actual claims data from multiple sources demonstrates that enacting autism insurance reform legislation is cost-effective and the right thing to do for Nebraskans. I urge this committee's support of LB1129. I'd be happy to answer any questions. [LB1129]

SENATOR PAHLS: Senator McCoy. [LB1129]

SENATOR McCOY: Thank you, Chairman Pahls. And is it Dr. Wasmer? [LB1129]

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MICHAEL WASMER: Yes. [LB1129]

SENATOR McCOY: Thank you for being here, Dr. Wasmer, this afternoon, and very much appreciate the thoroughness of the information that you've given us, and it's...I'm sure we'll have a great deal of time to go over this in further detail after this afternoon. I would like to give you the opportunity, one, because I believe it's your or your president of the advocacy...or I should say your national president, is it Mark Roithmayr... [LB1129]

MICHAEL WASMER: Roithmayr. [LB1129]

SENATOR McCOY: ...is your president. There's a New York Times article from January 19, and if you didn't reference this in your testimony, I apologize if maybe I missed it in some your handouts, but... [LB1129]

MICHAEL WASMER: That's okay. [LB1129]

SENATOR McCOY: ...that talk about a proposed new definition of autism and autism spectrum. [LB1129]

MICHAEL WASMER: Right. [LB1129]

SENATOR McCOY: And I imagine it may get touched upon this afternoon. But briefly, would you...do you mind commenting on that piece? [LB1129]

MICHAEL WASMER: Not at all. And again, if you'll refer back to the one page, I think it was 20...the slide 21 where we show that umbrella term "autism spectrum disorder," and then the three subtypes: autistic disorder, Asperger's syndrome, and PDD-NOS. Those terms are the definitions based on the DSM-IV, which is the current edition of the Diagnostic...I can't think what the acronym is for...but it's the book, it's put out by the psychologists that define how a child with autism is diagnosed. What is being proposed in the forthcoming edition of the DSM is combining all of the specific subtypes into one name, simply calling them autism spectrum disorder. They are not broadening the definition. They are simply combining those into one term, and then within autism spectrum disorder they're going to refer to them...or they are proposing, at least, that they're refer to as category 1, 2, and 3, based on severity. If you look at the left-hand side of that diagram, there is childhood disintegrative disorder. That is actually being brought into the umbrella of autism spectrum disorder, but as you can see on there, that is incredibly rare. That diagnosis is incredibly rare on the order of 1 to 50,000, I believe, relative to 1 in 110 of autism spectrum disorder. So the addition of that subtype isn't going to do anything to broaden the diagnostic criteria. Autism Speaks is actively pursuing studying the implications of the proposed changes because the fear is that it's

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actually going to exclude some higher-functioning children and adults where they would not be considered autism spectrum disorder anymore. So if anything, if these proposed changes go through, the concern is that it would lessen the number of individuals diagnosed than increasing the number of individuals diagnosed. [LB1129]

SENATOR McCOY: Thank you. [LB1129]

SENATOR PAHLS: Seeing no more questions, again thank you for your information here. Next proponent. Good afternoon. [LB1129]

CYNTHIA ELLIS: (Exhibit 8) Hello. My name is Cynthia Ellis, C-y-n-t-h-i-a E-l-l-i-s. I'm a pediatrician and I'm director of developmental medicine for the Department of Pediatrics and the Munroe-Meyer Institute at UNMC. I've been working in this field for 23 years and I've been practicing in Nebraska for the past 13 years. I am one of four board-certified developmental behavioral pediatricians in Nebraska, and I'm the only physician in Nebraska with board certification in neurodevelopmental disabilities. And today I'm testifying as a private citizen. I have a couple of points that I would like to make today. One is that autism spectrum disorders are biologically based neurodevelopmental disorders. They're medical disorders that are diagnosed by medical professionals. There's a variety of professionals who work with children who are qualified and skilled to evaluate children and identify children who are at risk for autism spectrum disorders, but the diagnosis is made by medical professionals using what we just talked about, the DSM-IV criteria which specifically outlined what it takes to be get the diagnosis of autism. And autism is fairly common. It is estimated to be in about 1 in 110 children. My next point, which empathizes what Mike just said, is that autism is treatable. The evidence is clear that early and appropriate treatment for young children has a very positive influence on their outcome. The improved outcome is exemplified by the fact that if you intervene with young children, about 50 percent of them will be able to be mainstreamed into early elementary school classrooms. Furthermore, we know that autism treatment benefits many individuals with autism across their life span. There's a number of different treatment approaches that have evolved over time, and behavioral interventions continue to be the mainstay of treatment and they have the most evidence for their benefit in treating autism. In fact, there was a report by the National Autism Center called the "National Standards Report" which came out in 2009, which concluded that there were 11 behavioral treatments for autism that they called well-established. This means they had "sufficient evidence available to confidently determine that a treatment produces favorable outcomes for individuals on the spectrum." There are also two medications, risperidone and aripiprazole, which have been approved by the FDA for use in children and adolescents with autism, and they are specifically indicated to treat irritability. We use these medications frequently to treat comorbid psychiatric disorders and also to help manage the behavioral manifestations of autism, however, these drugs don't change behavior. They simply alter the neuronal activity in the brain by altering neurotransmitter functioning. That means they affect how

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the brain chemicals in the brain work to facilitate all the transmission of information between the brain neurons. Furthermore, these medications are significantly limited by a number of side effects, some which can be potentially severe. We frequently see children will have weight gain, sleep disturbance, hormone and endocrine dysfunction. Furthermore, they can also have some very serious side effects. One is tardive dyskinesia, which is a permanent abnormal movement disorder, and another is neuroleptic malignant syndrome, which is a life-threatening syndrome where the vital signs and temperature regulation become unstable and patients can have cardiovascular collapse. Although many children with autism are provided services through their school, the goal of these interventions is to accommodate their disability and facilitate their education, and this is very important for all children with autism. However, these interventions do not treat autism and the associated problems, and they're not designed to do so. They're not intended to do that. There are many children with autism who require treatments that are above and beyond what is provided to them through their schools. In my medical practice I see a large number of children with autism. Private insurance and Medicaid will pay for almost any medication that I prescribe for these children regardless or not of whether they're FDA approved or there's any evidence of their safety in autism or even in children. However, when I prescribe a behavioral intervention which has good evidence for its use in autism, those are rarely covered by private insurance or Medicaid. In my experience, when a child does not receive or can't access those nonmedical treatments that I prescribe, their only choice left is medical treatments, and this is almost always medication. And I believe that this leads to the problem we have with overmedication of children with autism, but as a physician, we're in a bind. We need to do something and we have a treatment that we can provide that has some benefit, but it also has great cost and it's frequently not the best treatment or even a very good treatment for what we're using it for. And I'm very concerned about the problem of overmedicating children with autism. There was a study in 2002 that showed that 57 percent of the children with a diagnosis of autism received psychotropic medication. And if you looked at those 8 years old and older, it was up to 70 percent. Another study in 2006-07 found that 58 percent of children with a diagnosis of autism received medication. Sixty-eight percent were prescribed one drug; 18 percent were prescribed two drugs; and 14 percent were prescribed three or more drugs. I frequently see children in my office that are prescribed even up to five or six different medications. So in summary, I feel that the treatment of autism should be based on matching the individual needs of the child with available evidence-based treatments. And when we determine what treatments should be provided, what should be the primary consideration is the evidence and the science that the treatments that I'm prescribing are safe, effective, and appropriate. We shouldn't be determining what treatments will be provided based on what is covered by insurance and what the children have access to. [LB1129]

SENATOR PAHLS: Senator Schumacher. [LB1129]

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SENATOR SCHUMACHER: Thank you, Senator Pahls. Thank you for your testimony today. If I recall the interim hearing we had, there was some testimony that the early and strong behavioral intervention had fairly good, in fact, real good return on investment, in a large number of the children, but then at a...it did work and there was a point of diminishing returns in which if it didn't provide the result that was wanted, the expenditures didn't seem to produce the results over those... [LB1129]

CYNTHIA ELLIS: That's true. There's a number of children that early intensive intervention doesn't provide the same degree of benefit that it does for other children. And, you know, there's still research looking into which children respond best to which treatments, which is again part of what this whole thing is about is being able to use what works best for individual children. But those are children that either have a different...you know, maybe a different genetic form of autism. We don't really know why, but there's some children that don't respond to the same therapies as other children, so we need to be able to have a range of things that we can offer them. [LB1129]

SENATOR SCHUMACHER: But to the extent that cost is a factor--and I assume since insurance companies oppose this, cost is a factor--at what particular point would you say we hit a point of diminishing returns in some children? Is it a year? Is it two years of treatment, five years of treatment, six months of treatment? [LB1129]

CYNTHIA ELLIS: Well, I don't think we know the answer to that specifically, but usually we would use the same thinking that we would use for almost any disease that we were treating, and we would look at the trend of benefit and are they making some progress versus no progress, how fast is that moving, and what would be the kind of expectation for those treatments. And I'm not a specialist in some of those early intervention fields; I recommend them, but I don't actually do them. And so usually we would look at are they making progress as we would expect, and if not, then our logical thought would be to change track and try something different. [LB1129]

SENATOR SCHUMACHER: Okay. Thank you for your testimony. [LB1129]

SENATOR PAHLS: Senator McCoy. [LB1129]

SENATOR McCOY: Thank you, Chairman Pahls, and thank you, Dr. Ellis, for being here this afternoon. I have a couple of quick questions for you, if I may, and I mentioned this to Dr. Wasmer, and I'll give you an opportunity to weigh in on it, as well, if you would. These proposed...the proposed revision to the DSM in The New York Times piece that I mentioned, if you care to comment, is that...will that be...how will that affect your practice as you deal with your patients? Is that a positive change do you see in what you deal with? A negative change? I know it's proposed at this point, so... [LB1129]

CYNTHIA ELLIS: Well, I think that those criteria that have been kind of published, now are proposed, and it looks pretty much like that's close to the direction that they will go. I think these will be...are anticipated to be enacted in May of 2013. I think that initially it's going to be a big problem for me, because a lot of the things that I use to diagnose kids and the kids that we have that are currently diagnosed, some of that may change a bit. But overall I think that we need to follow the science, and the science is what really drives the DSM, which is the Diagnostic and Statistical Manual, and it's really based on looking at evidence of what kind of symptoms kind of fall together to make certain disorders. And autism right now, autism spectrum disorders and Asperger's, it's all very broad. And so the goal is to really look at this scientifically and group the children together diagnostically to those that go together. So eventually I think this will be a very good thing to move along according to science. There's a lot of concerns about if children will still meet the diagnosis of autism or not. There are still going to be the same children. They're still going to have the same problems and we're still going to need to look at treating them, but the concern is that if without that diagnosis of autism, are they going to lose a lot of their services? And that will be up to us to make sure that we continue to advocate for what they need--not just by what they have, but by what they need. [LB1129]

SENATOR McCOY: Thank you. And would you see those proposed changes affecting...if we were to move forward with this legislation, would you see those proposed changes...? Let me rephrase this. Would those proposed changes affect how you would do things and other practitioners in this arena going forward? [LB1129]

CYNTHIA ELLIS: No, because it's really still the same kids with the same needs. And it doesn't matter what we call them, we usually treat them by what they need, and so I don't see that the DSM is going to change what we recommend for those children. It may make some things difficult at first to realign services or to reacquaint ourselves with the different names for things, but I don't think that it's going to affect the services that these kids need or what we need to provide. [LB1129]

SENATOR McCOY: It may, though, change, if I'm understanding correctly, what's being talked about in this piece. It may change though as far as, and you mentioned this, which children would then be technically determined in the spectrum. [LB1129]

CYNTHIA ELLIS: Right. [LB1129]

SENATOR McCOY: Therefore it could change how an insurance provider would cover that. [LB1129]

CYNTHIA ELLIS: Right. And so actually what it may do is narrow the diagnosis of autism, so less children will get that diagnosis, so these insurance coverages will then

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cover fewer children. Then we're going to have to eventually look at this and see if that's the case and are there other children that are slipping through the cracks and what do we need to do for them. But in the meantime, those most severely affected children, we don't anticipate they will be, they will fall through with this. So I don't think it's going to make a big change in that regard, at least initially. [LB1129]

SENATOR McCOY: Thank you. [LB1129]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony, Doctor. Next proponent. [LB1129]

CATHY CLARK-MARTINEZ: Senators, my name is Cathy Clark-Martinez, C-a-t-h-y C-l-a-r-k hyphen M-a-r-t-i-n-e-z. I have been a local business owner in Lincoln for nearly 20 years. I'm the president of AFN, which is the local support group, a past board member of Autism Society, and the 2008 and 2009 Autism Walk chair. Today, I'm a parent of a child with autism. I have been married for 11 years. We have four children. Our youngest child is on the autism spectrum. He's 8 years old. In June of 2003, Jacob, a healthy baby boy joined our family. In March of 2005, we started noticing distinct changes in Jacob's behavior. He lost language, he began banging his head, he lost eye contact, and he also engaged in repetitive behaviors. In July of 2005, he was diagnosed with autism. In August of 2005, we began three hours of speech therapy per week. In October of 2005, we added two hours of OT to that three hours of speech therapy. We had done everything recommended thus far by our pediatrician, but we weren't seeing the changes we had hoped for. We began researching other intervention techniques, including ABA. With an annual household income of less than \$80,000 and four children, we hesitated for a few months to begin ABA, not knowing how we were going to pay for it. In December of 2006, we made the heartrending decision to begin ABA therapy for Jacob. ABA gave Jacob 45 hours a week of direct one-on-one therapy at an annual cost to our family of \$62,000. We began to see changes almost immediately. Over the course of the past six years, we saw our child go from banging his head on the wall, hidden in a corner of our house, to being potty trained, eating with utensils, signing, counting, playing games with his siblings and peers, and dressing himself independently. Although Jake hasn't yet learned to speak, he is now typing words on his assistive communication device. All of this can be attributed to his ABA therapy. Over the course of the past six years our family has patiently waited for insurance reform legislation to be passed in this state. We have debated about relocating to another state that has coverage for children with autism. We had to file bankruptcy last year still waiting for this insurance coverage for our child. We had a choice to make: Give our severely autistic son treatment that he so desperately needed, or save ourselves from financial ruins. We chose our son. I refuse to envision his future reduced to a life of being institutionalized. Because of ABA, our son is still able to live at home with his family instead of being made a ward of the state or put in foster care as so many of our children have been. With insurance coverage, many families would be able to continue

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the day-to-day care of their children. This would save the state the cost of providing the permanent lifelong care for many of these individuals. Ending the insurance discrimination is essential to the livelihoods of families affected by autism in the state of Nebraska. Any questions? [LB1129]

SENATOR PAHLS: Senator Schumacher. [LB1129]

SENATOR SCHUMACHER: Thank you, Senator Pahls. Two different lines of questions. The first one: Do you feel when you first noticed these unusual behaviors emerging, if there would have been real rapid and intense intervention that it would have changed the course of things, or was it something that just has to evolve? [LB1129]

CATHY CLARK-MARTINEZ: Knowing that the brain is very plastic in the first few years of life, I think we missed a valuable year of opportunity debating on how we were going to provide that coverage. So I believe he would have made better gains had we started at the age of two than at three and a half. Yes. [LB1129]

SENATOR SCHUMACHER: Were finances part of that decision? [LB1129]

CATHY CLARK-MARTINEZ: Finances were the only reason we didn't do ABA because we didn't know how we would come up with that money. And then we took out all of the equity in our house. We cashed out our 401(k)'s. We cashed out our other children's college funds. We borrowed money from the bank, and ultimately filed bankruptcy on that debt. [LB1129]

SENATOR SCHUMACHER: Now on the other line of questioning, you mentioned it was \$62,000 a year? [LB1129]

CATHY CLARK-MARTINEZ: That was before he entered school. The cost decreased significantly once he entered kindergarten. [LB1129]

SENATOR SCHUMACHER: Was he getting help through the school system then? [LB1129]

CATHY CLARK-MARTINEZ: Yes. He did receive help through the schools, their home-based therapy before he entered school, and then he entered the preschool program and then we did ABA after preschool every day. [LB1129]

SENATOR SCHUMACHER: How...during this \$62,000-a-year time, how many hours a week was he involved with the therapist? [LB1129]

CATHY CLARK-MARTINEZ: He had 45 hours of one-on-one treatment weekly. [LB1129]

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SENATOR SCHUMACHER: And how many therapists are involved in the one-on-one...is it just the one person? [LB1129]

CATHY CLARK-MARTINEZ: No. We hired probably five to six that came in, in three-hour shifts. [LB1129]

SENATOR SCHUMACHER: And that's how the 45 hours... [LB1129]

CATHY CLARK-MARTINEZ: Correct. [LB1129]

SENATOR SCHUMACHER: Thank you for your testimony. [LB1129]

SENATOR PAHLS: Senator Pirsch. [LB1129]

SENATOR PIRSCH: Just to...interested. Now, and did you go to Munroe-Meyer, is that where you...? [LB1129]

CATHY CLARK-MARTINEZ: We did not use Munroe-Meyer. We used the Lovaas Institute from Minneapolis. [LB1129]

SENATOR PIRSCH: Oh, I see. Okay. Thank you. [LB1129]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. Next proponent. [LB1129]

REBECCA OLANDER: Go ahead? [LB1129]

SENATOR PAHLS: Go ahead. [LB1129]

REBECCA OLANDER: (Exhibit 9) Okay. Hi, my name is Rebecca Olander. Rebecca is R-e-b-e-c-c-a, Olander, O-l-a-n-d-e-r. Thank you for letting me come here today. I'm the mother of a 19-year-old son with autism. He was diagnosed in the 1990s when there was not a lot to offer as far as services and, even if services were available, insurance did not cover them. Over the last 15 years, things have changed in that there's now good evidence-based treatment options available as you've heard about. However, nothing has changed in the fact that insurance still does not cover the treatment of autism. When my son was diagnosed we found the best evidence-based treatment available and found a way to get those services for him. I could not stand by knowing that there were treatment options available that could improve his life significantly and do nothing about it. So we took out personal loans, we took out second and third mortgages on our home, and I stepped away from my career in order to get him the services that he needed, and we're still paying off those loans now. Was it worth it?

Absolutely. But I do not want other families to have to go through what we've gone through to get services for a child with autism. I've also been actively involved in the Autism Society of Nebraska as a past board member and president, and FEAT of Nebraska--Families for Effective Autism Treatment--as a board member for many years. And I've seen, firsthand, numerous children with autism that have had their lives transformed and that are doing fantastic now because their parents were able to afford or to find a way to get the services that their child needed, and sometimes, as you've heard, to the point of significant hardship and bankruptcy. Those children are very fortunate that they got those services. I have also seen firsthand many, many more children who do not receive the proper treatment for autism because insurance would not cover it and their parents absolutely could not afford the treatment, and they are still struggling today and will continue to struggle for the rest of their lives. I can't imagine if things such as childhood cancer were not covered by insurance. That's the kind of thing that we're dealing with now with our children with autism. Our parents are faced with that decision. There's also been discussion in place about autism therapy and board-certified behavioral analysts and licensed practicing psychologists. I'd like to address that issue. As someone who works with Ph.D. psychologists and who has received intensive behavioral services with board-certified behavioral analysts, I believe that both psychologists and BCBA's play an important role in helping children with autism. BCBA's specialize in providing the intense one-to-one therapy in teaching new language skills and behavior shaping. Their expertise is in this intense 25-plus hours per week of therapy that is vital to the success of the child. Psychologists also play a vital role in providing therapy to the entire family as well as consultative and hands-on behavior therapy. And although their therapy is less intensive, the psychologists' services are incredibly beneficial to both the family and the child. And I am pleased to see that LB1129 allows for reimbursement for both of these specialties and would encourage the committee to support both licensed psychologists as well as BCBA's in Nebraska. I'm now working as a mental health nurse practitioner and I work with a lot of families with children on the autism spectrum. When parents come in to us, desperate for help, it kills me to know that there's good evidence-based treatment out there, but these children will not receive that treatment even though their parents have been paying their insurance premiums that they've trusted would cover their family's healthcare needs. This has got to change. This injustice is just unacceptable for these children. Their lives could be so much better if they could only receive the proper treatment. On a bigger picture, we need to think about the tremendous costs to society when these children without treatment become adults and are unable to care for themselves. I have heard estimates that nationwide over 800,000 individuals on the autism spectrum will be entering adulthood in the next 10-15 years. If we cannot pay for their treatment when they're young, how can we even begin to pay for those services when they're left untreated and we need to care for them for their entire lifetime. I know our country is stretched thin and I know we have a lot of difficult choices to make, but we cannot ignore these children any longer. Many cannot speak for themselves, but they desperately need to be heard. Thank you. Any questions? [LB1129]

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SENATOR PAHLS: Seeing any questions, thank you for your testimony. [LB1129]

REBECCA OLANDER: All right. And I turned in some individual letters of support over there, too. [LB1129]

SENATOR PAHLS: Any more proponents? Proponents, come forth. I think...how many more do I see? Two, three? Okay. [LB1129]

COLLEEN JANKOVICH: Hello. My name is Colleen Jankovich. The last name is J-a-n-k-o-v-i-c-h, and I am here to testify on behalf of my son, Matthew, who has autism. It's really difficult to know exactly what to say before all of you, and all I can say is it began June 19, 2002, when he was born. We had to have an emergency C-section because I was hemorrhaging during labor and there was a lot of birth trauma. I almost died; my son almost died, but he recovered. He passed his Apgar test, scored a 10. I recovered, went home, thought everything was going to be fine, but we were wrong. Matthew had delays and they weren't huge delays. He was just slightly behind his peers, sometimes only by a couple of weeks meeting his markers. At least that's what I told myself, but by the time he was about 21 months old and I was pregnant with my daughter, it was really apparent something was wrong; we just didn't know what to call it. He didn't play with other children. He parallel played, but would not engage with anyone other than his caretakers or adults. He didn't talk to people. He would say individual words like apple juice or cracker, and he could even sing "Happy Birthday" to my dad, but the words eventually disappeared, the songs stopped, and eventually Matthew started resorting to screams, tantrums, biting and pulling hair, to communicate. He still does that today. He did it today in the office, attacked me, and I thought I wasn't going to be able to be here because I was certain I was going to have bruises all over my face. Matthew received early intervention through the school district and was enrolled in a special education preschool. In spite of his teachers' efforts, they could not get him to speak, they couldn't toilet train him. He couldn't...he wouldn't cooperate or interact with other people, and so I eventually turned to the Munroe-Meyer Institute for help. Matthew was diagnosed as PDD-NOS in January of 2005, shortly after the birth of my daughter Ella. We were told about ABA therapy, but it was kind of up to us to find it at that time because there was no one currently in Omaha who would provide such therapy. But the doctor that diagnosed my son did mention that Dr. Wayne Fisher was coming soon to start a clinic at the Munroe-Meyer Institute. And once Dr. Fisher arrived, we met with him and he did indeed think that he could help Matthew. Matthew's behavior changed dramatically after the birth of my daughter. I went to the school district to see if there was any help available because we knew our insurance would not pay for any therapies. So eventually they agreed, the school district agreed to send Matthew to Munroe-Meyer for ABA, but they would only pay for 9 hours a week, and after six weeks they pulled the funding because they just didn't see any significant changes. It is recommended, from what I understand, that most children as severe as

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my son receive 40 hours of treatment per week, and my son was getting 9. About a year and a half later or so, things started really escalating at my house. Matthew was becoming more and more aggressive. He was destroying our furniture and putting holes in the walls. He was breaking windows. He was fecal smearing, and nobody likes to talk about it, but it's something that just happens with our kiddos if they're not toilet trained. They'll get into the diapers and we just kind of refer to them as "code browns." I don't know what else to call it. It's just, you know, a more pleasant term. I really, really thought I was going out of my mind. I still am not sure I'm back yet. And at that time I was pregnant with my fourth son--or my third son, my fourth child. So in May, about May 2007, we received a phone call from Munroe-Meyer saying that they did have an opening, would we still be interested? But it was only part time. So we jumped at it, and they were able to code things so that it would be covered by insurance. But, you know, we didn't dare say autism. We just didn't dare say that, because we knew that insurance would not cover that. So my poor kiddos--and mind you, I had a newborn at this time--spent the majority of the summer driving from 168th and Harrison to midtown for the Munroe-Meyer clinic for Matthew's treatment. And I'm going to show you some pictures just because I feel I have to. This is Matthew when he was diagnosed--cute little kid. This is Matthew now--still a handsome young man. This is what he did to my daughter that got him into therapy. He attacked her viciously. She's got bite marks all over her face as you can see. She was about a year and a half old. At that point we knew we had to do something; we just didn't know what to do. We took him into Munroe-Meyer. I was terrified he would do this again to the baby, my newborn. Our whole life was chaos. It was really hard to take what we were taught in the clinic and bring it home. We didn't have any in-home care. There are multiple issues with autism, but I keep thinking back. If we could have just said he had autism from day one, just said it--hey, he has autism--the doctors could all work together and work with the insurance companies immediately after he was diagnosed, not wait several years, but immediately after diagnosis, would he have retained more words? Would he have learned how to self-toilet? Would he be dressing himself? He would still be singing "Happy Birthday" to my dad. My son is a perfect example of what not to do. We need insurance coverage so that nobody ever has to go through this. My son is...we're looking at a group home. We're looking at removing my son from his home because he is too aggressive. He's too destructive to property. We don't know what to do with him. So I really implore you all to pass LB1129 so that no other child has to go through what my family has had to go through. It's not fair to anybody. It's just plain wrong. So thank you for listening today. [LB1129]

SENATOR PAHLS: Seeing no questions, thank you for your testimony. [LB1129]

COLLEEN JANKOVICH: Thank you. [LB1129]

VICKI DEPENBUSCH: Good afternoon. My name is Vicki Depenbusch; it's V-i-c-k-i D-e-p-e-n-b-u-s-c-h. I am a mother of a 13-year-old son with autism. I'm also a board

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member of the Autism Family Network, and that's what I'm here to talk about today. The Autism Family Network began in 2006 with a few moms around a kitchen table. After awhile we began with almost 30 families looking for support and understanding, and today we have over 300 needy families in Lincoln and Lancaster County. Each week we get e-mails and phone calls from families just diagnosed with autism, wondering what to do. They're told of this diagnosis. They're told we don't know the cause, there is no cure, and there is no insurance coverage in Nebraska. It's hard to promote early intervention when you have those against you. As a parent of a child with autism, you turn into a doctor when your child is ill and they don't know how to tell you that; you turn into a teacher when they're trying to communicate to you and you can't understand them; and you certainly turn into a lawyer when you're trying to fight for services for your child. Also as a parent during this time, you're learning to know about your child's education rights; you're learning what an IFSP is; an IEP; what are the possible education rights for my son. Then there's also the other problems that come that have been testified before such as seizures--my son has had seizures before as well--or GI problems. You become aware of their safety issues. Then you have to learn about language therapies, occupational therapies, behavioral therapies, and know that they're not covered by insurance. We hear so many stories of children that are in foster care because parents cannot take care of them anymore. Grandparents are calling us, wondering what to do, because they can't stand the thought of their grandchild being put in a foster care system, trying to adopt them, but knowing that they need the kind of care that insurance could maybe help cover. The hardships, the emotional, the marital, the financial hardships of these families come too often now. Helping families that are paying thousands a year of insurance to help gain ABA coverage would change our lives. Most states don't require private insurance companies to cover essential autism treatments and services. Our families are coming up to costs of almost \$50,000 a year on their own. Now 29 states have coverage for autism. It's time now that the Autism Family Network families to be heard and help our children so they can grow. Thank you. [LB1129]

SENATOR PAHLS: Senator Schumacher. [LB1129]

SENATOR SCHUMACHER: Thank you, Senator Pahls. Thank you for your testimony. How many cases of debilitating autism are there out, let's say, under 21 years old would you estimate there are in this state? Or is that number just not available? [LB1129]

VICKI DEPENBUSCH: At this point, I don't see it being available because the spectrum is so broad. When my son was first diagnosed, he lost the ability to speak. He would line up toys. He wouldn't make eye contact. That, at that point, he would become...he would go screaming if he heard the doorbell. That would be considered severe. Because we worked with him and learned about ABA, he has a private tutor that came in. We were able to get him to be able to become more educated so he's not as severe now. It's hard to get that...I wish we could get earlier treatment and an early diagnosis,

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which I think we are, but it's hard to put a number on the severity of that. [LB1129]

SENATOR SCHUMACHER: So was your experience similar to some of the other testimony we heard today, that there was a lag in the initial action taken because of financial considerations? [LB1129]

VICKI DEPENBUSCH: Yes. Yes, my husband and I put everything we could in making the decision to help find him a private tutor that knew about ABA therapies because we couldn't afford, like, Lovaas or Munroe-Meyer at the time, but we knew we had to do something. We made the choice not to have any more children so we could focus on Jacob. And... [LB1129]

SENATOR SCHUMACHER: For the cases that you've seen where there has been very early aggressive intervention, what's the outcomes and how long does the intervention last? I know it's hard...you know, we're talking in generalities... [LB1129]

VICKI DEPENBUSCH: Right. [LB1129]

SENATOR SCHUMACHER: ...but how long does the intervention last? Is the disease thwarted and are they able to function without a whole lot of additional intervention beyond a certain point? [LB1129]

VICKI DEPENBUSCH: A lot of times the families that I have spoken to that have tried ABA therapies have had huge success within a year. You'll know that there is going to be...they chart the progress. So even the parents know and the ABA therapists know where the gaps are that we need to be focusing on. If he's starting to make more eye contact, then we can start moving toward maybe sign language to say the word or a communication system. You start to see that that child is emerging. So whatever progression, we keep...it's logged so we know exactly where that child is at. We can take that next step and keep trying to promote that. So if you had a year of ABA, you're going to know whether or not that's the right direction to go. And typically it's before that you start seeing progress. [LB1129]

SENATOR SCHUMACHER: ABA. Is that kind of an alias for operant conditioning? [LB1129]

VICKI DEPENBUSCH: Applied behavioral analysis. That's the intense 40-hour-a-week treatment. Typically it's 40-45 hours a week, one-on-one. [LB1129]

SENATOR SCHUMACHER: Thank you. [LB1129]

SENATOR PAHLS: Senator Pirsch. [LB1129]

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SENATOR PIRSCH: And you're describing autism as you're encountering it through your health insurance, but. [LB1129]

VICKI DEPENBUSCH: Yes. [LB1129]

SENATOR PIRSCH: Are you familiar with the Medicaid coverage (inaudible)? [LB1129]

VICKI DEPENBUSCH: Yes. [LB1129]

SENATOR PIRSCH: Can you just briefly describe its application then? [LB1129]

VICKI DEPENBUSCH: A lot of times...for us as a family, we don't qualify for the coverage. We chose...both of us, my husband and I are both full-time working. We don't cover the...we're not qualified for the Medicaid coverage. [LB1129]

SENATOR PIRSCH: All right. But the Medicaid would cover certain... [LB1129]

VICKI DEPENBUSCH: Certain services, but when you're talking about 40-45 hours a week, that's not going to be covered... [LB1129]

SENATOR PIRSCH: More along the... [LB1129]

VICKI DEPENBUSCH: ...typically for the ABA therapy, which is typically what physicians will recommend. [LB1129]

SENATOR PIRSCH: Okay. Thank you very much. [LB1129]

VICKI DEPENBUSCH: Um-hum. [LB1129]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LB1129]

VICKI DEPENBUSCH: Thank you. [LB1129]

SENATOR PAHLS: Next proponent. [LB1129]

VICKI VINTON: (Exhibit 10) Good afternoon, Senator Pahls and members of the committee. My name is Vicki Vinton, V-i-c-k-i V-i-n-t-o-n. I am a registered nurse who resides in District 39. I am here representing myself and members of the Nebraska Nurses Association. We have chosen to support this bill because children with autism disorders have been discriminated against much too long and deserve insurance parity for the treatment of their disease. More children will be diagnosed this year with autism than those with cancer, diabetes, and AIDS combined. We ask that you take this opportunity to join 29 other states who have acted to ensure their citizens have autism

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insurance coverage. It is our moral obligation to provide appropriate healthcare for all of our citizens. I have a dual role as a mother and a nurse to my son who is now 20 years old and on the autism spectrum. His diagnosis was confusing because he was dealing with other comorbid psychiatric diagnoses, so it wasn't until about age 13 or 14, after I had kept saying to the doctor, are you sure he doesn't have autism, that we finally got a diagnosis. And so Zach did miss out on the early intervention. He is on five medications. Pharmacy bills are expensive. He also has ulcerative colitis, which is a common diagnosis and it is pretty severe. He requires Remicade I.V. infusions every two months for that. So nursing...his care is complex and I'm thankful for my nursing background so that I can help take care of him. We need to act to provide insurance benefits that are evidence-based. Appropriate care includes early treatment intervention using ABA therapy, parent training programs, speech and occupational therapies, counseling, and drug therapies. Treatment increases the chances of these individuals being contributing citizens rather than individuals who need state support. I think all Nebraska's citizens would agree that if it only cost...I'm...you're going to have to readjust my figures, something that I found was 50 cents to \$1.50 per member coverage per month. But what I was hearing Dr. Wasmer say was anywhere from 6 cents to, I believe, around \$1.20. So my figures are up around 300 percent of that, but that's certainly a sound investment in our fiscal future of Nebraska. The cost of autism care, as was stated before, is \$3.2 million over a lifetime, which includes lost productivity and adult care. Nearly 80 percent of adults with autism are unemployed and live at home with family members. My son is 20 and that looks like the direction we're headed. He's getting some help with vocational rehab and the Autism Center of Nebraska with job coaches, but it's going to be difficult to get employment for him. They are unemployed because they are often misunderstood; have processing difficulties, by which I mean they don't always understand instructions; and may have repetitive behaviors that are viewed as odd. People with autism don't look any different than you or I. This fact further complicates their ability to secure jobs and experience quality of life. Please support LB1129 and be a part of the solution in the lives of 1 of every 110 individuals in our state who are counting on you. Thank you. [LB1129]

SENATOR PAHLS: Seeing no questions, thank you for your testimony. [LB1129]

VICKI VINTON: Thank you. [LB1129]

SENATOR PAHLS: Next proponent. [LB1129]

CHRISSE McNAIR: Good afternoon. My name is Chrissy McNair, C-h-r-i-s-s-y M-c-N-a-i-r. Thank you to the committee for again hearing our testimony in November in the interim study, and again for hearing LB1129 today. I wanted to clear up a couple of issues if I can. First of all, there's been some question about Medicaid and what Medicaid covers, and I thought I might address that first. Medicaid does provide some waivers that will address some issues of children with autism. As you may remember, in

2007, we passed legislation prioritized by Senator Pahls that would allow for ABA therapy to be covered in Medicaid. As you may also know, that waiver was never funded. So as of right now, there's a waiting list with Medicaid that's about 1,200 to 1,600 to 2,000--depending on who you ask--people long; meaning that, for example, when I ask when my son would be up for Medicaid, I was told 20 years, so to give you some perspective. There are services available, but they are not funded. There are some families on Medicaid who can get things like respite care, who can get some medical treatment that they need. So Medicaid does cover some of that. But as far as behavior therapy evidence-based treatment goes, that is not currently covered by Medicaid. And I'm happy to take questions on that as well. Secondly, I thought I would give you some practical examples of what applied behavior analysis therapy is, and I'll give you two examples of that. One is in terms of teaching a child with autism, language. My son, for example, when he was young he loved to play with soccer balls and tennis balls and things like that, but he couldn't say the word "ball," nor could he say any word for that matter. So one of the ways that children with autism are taught in an intensive situation using applied behavior analysis might be to show them a picture of a ball and say, point to the ball. So if they can point to the ball they understand what a ball is. So the next thing you might do is you might put a picture of a ball next to a picture of a truck and say, point to the ball, and then you would get them to point to the ball. They are reinforced or rewarded for pointing to the ball, and you take that ability to understand what a ball is and build on that. So the next thing you might do is actually give them a ball, a 3-D ball and say, point to the ball. They point to the ball. Then you put in discriminators, so lots of different toys and distractors so that they you can make sure that they have generalized and understood what a ball is. But they still haven't said the word "ball." So you have to teach them what the feature and function of a ball is, so you could say something like, "Tell me something that you bounce; or what do you do with a ball?" You bounce it, you throw it, you catch it. You teach them what you do with a ball. And then if you know they like balls, you might hold up a ball and require them to say the word "ball," before they get the ball. Then you're reinforcing the child for using language. Now if you can imagine a child who doesn't really even understand what a ball is in terms of verbally what a ball is, take that across everything: crackers, toys, people. So you can understand why 40 hours a week is important because a lot of children with autism cannot generalize that skill across other types of material things if you will. Also some children can't even tell that a tennis ball is a ball and a soccer ball is a ball. So you may have to teach them the difference that the soccer ball is still a ball and so is a tennis ball--if that makes sense. Another way that applied behavior analysis is used is in terms of teaching a child skills, and I'll give you an example of how my child was potty trained. He would not go into a bathroom. I don't know if it was the flushing of the toilets or if it was the shiny porcelain or what it was, it scared him to death, and he would scream and yell--and he was in diapers when he was five. So we finally decided we couldn't have him continue to be in diapers, and so what we would do is take him to Target; stand out--because he loved Target--stand outside the bathroom; and just if he stood there without screaming, we gave him a reward; and then we left. And we just

kept building on that. Eventually we would take one foot and step it inside the door of Target. He would get a reward for standing there and not screaming. So eventually we got to the point where he would actually go into the bathroom, listen to the hand dryers, listen to people go to the bathroom, and tolerate that. We took that ability to tolerate those situations and built on it. So that's just some practical examples of how applied behavior analysis or intensive behavior therapy is used. I wanted to address the issue--I think, Senator Schumacher, you brought this up--about diminishing returns. And so there is a point where if you're doing, you know, 40-45 hours a week of therapy in terms of teaching language, that maybe a child has already gotten to the point where the reward is not as much as it used to be. But it doesn't mean that that type of therapy should stop. What it means is, like Dr. Ellis said, you adjust and you might tweak some things, but later in life that child may need intensive therapy again. My son is a perfect example of that. He...we kind of tapered off on the language development because he was able to generalize and he really...his language just exploded when we started doing the exact therapy I'm talking about. So we tapered off on applied behavior analysis, but then in a couple years his aggression became horrible, and so we had to go seek treatment in Baltimore for five months. And that's pretty intensive, about as intensive as it gets. So I caution you, or I guess I would advise you to think of diminishing returns in a different way. It might be one type of therapy maybe isn't effective anymore in terms of maybe language skills of something like that, but that doesn't mean that evidence-based practice can't be used in another area of that child's life and as the child continues to get older. I also wanted to address the issue of prevalence in the state of Nebraska. In 2007, when we estimated the number of children under the age of 9, we found that there were about 1,600 in the state of Nebraska under the age of 9. But it's very hard to get prevalence data because there are children who have an educational verification of autism which is not the same as a medical diagnosis of autism, and you have different sets of criteria and data that you're looking at. So really the best way to figure it out is to look at the census and trust the CDC has done their due diligence, and when they say the prevalence is 1 in 110, we can probably say the prevalence in Nebraska is 1 in 110 as well. I also wanted to address...and I apologize for not knowing which senator brought this up, but it might have been you, Senator Schumacher, but the issue of how effective is behavior therapy and do children eventually become mainstreamed. And the statistics out there say that 49 percent of children who get intensive intervention can actually lose their diagnosis. And I know there were some parents here in the audience today who that happened to their child. Forty-nine percent will no longer test on the autism spectrum, meaning that they will be mainstreamed into general education classrooms with no support. It doesn't mean that later in life they may not experience some issues. They are not cured from their autism, but it's manageable. And so varying degrees of intervention is important at various times, but that's basically the evidence that's out there in terms of recovery if you will. And I'm happy to answer any other questions that I can. [LB1129]

SENATOR PAHLS: Senator Pirsch. [LB1129]

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SENATOR PIRSCH: And you come from a medical background, is that right, or are you just...? [LB1129]

CHRISSEY McNAIR: No. [LB1129]

SENATOR PIRSCH: Okay. Thank you. You had spoken so authoritatively on that. [LB1129]

CHRISSEY McNAIR: No, I'm a parent. [LB1129]

SENATOR PIRSCH: Nothing further. Thank you. [LB1129]

SENATOR PAHLS: Thank you. [LB1129]

CHRISSEY McNAIR: Thank you. [LB1129]

SENATOR PAHLS: Any more proponents? Okay. Opponents? How many do I see? One, two. [LB1129]

ROBERT HALLSTROM: (Exhibit 11) Chairman Pahls, members of the committee, my name is Robert J. Hallstrom. I appear before you today as registered lobbyist for the National Federation of Independent Business to testify in opposition to LB1129. If Mr. Sedlacek does not make it back, he had asked me to also enter the opposition of the Nebraska Chamber of Commerce and Industry to this bill as well. Just to make the record, the same arguments that I made on the prior bill with regard to small business concerns, not over the merits of any particular type of treatment, medication, or protocol, but the potential aggregate impact from a cost perspective that each of these mandated benefits brings about is what small businesses are most concerned about. We would like to be able to provide an array of insurance coverage that's affordable for our employees. And with each potential new mandated benefit, that puts at risk our ability to do so. And for those reasons we consistently oppose mandated benefits. I'd be happy to address any questions of the committee. [LB1129]

SENATOR PAHLS: Seeing no questions, thank you for your testimony. [LB1129]

ROBERT HALLSTROM: Thank you, Senator. [LB1129]

JAN McKENZIE: Senator Pahls, 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, testifying in opposition to LB1129. I just want to give you just a little bit of information, first of all, about why behavioral therapies would not have been covered under insurance and probably have not been in the past. Initially, health insurance only covered things that

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would be considered medically necessary as in a doctor's office, prescription, hospital. And that was pretty much the standard for a long time. And then there were some additional things added to it, like treatment by a chiropractor, but those folks have to be licensed, and in general that's the rule. If you're going to be covered as a professional under a health insurance policy, you must be licensed by the state. And in fact, last year, there was a bill, I believe, over in Health and Human Services talking about licensing and creating that scope of practice for ABA therapists. And that would have to be a critical piece of what also happens here. It is a fuzzy place. Many of you maybe know I was an educator and my background is early childhood education with a speciality in working with gifted and talented children. I worked with many very intellectually gifted children who had some sort of autism spectrum, so I'm not unaware of the frustration of these parents today. Special education doesn't view it as their problem and health insurance does not see it as a piece of what they define as medically necessary. I've visited with Senator Coash about it. I understand he wants to take a look at it as we're waiting to see what happens with everything that's happening with federal health reform through this year. I would be more than happy to work with him. In fact, I am personally intrigued by it and would urge the committee to hold the bill and to continue to look at the issue so that early and appropriate treatments, whether they be from coverage under health insurance or through our special education system for preschool and early interventions for educational purposes, can start to make some sense of this disorder. I would answer any questions if I could. [LB1129]

SENATOR PAHLS: I have a question. I heard you say special education does not... [LB1129]

JAN MCKENZIE: Well, I think there has been some disagreement about treatment approaches. [LB1129]

SENATOR PAHLS: Approaches. [LB1129]

JAN MCKENZIE: Approaches between...and often if you look across Nebraska where we have a pretty wide rural population that a lot of the treatments that I think parents today have talked about have not been available much outside of the Omaha area, and even for awhile not there. So I think what we have to look at is how we have approached speech therapy and issues for children diagnosed early in one of the special ed categories, and then are given occupational, or not...speech therapies or other kinds of appropriate programs. But I know that's been a part of the frustration, having listened to the interim study testimonies as well. If some of you recall, years ago it was sort of the same problem with TMJ treatment and the dental and medical coverages for TMJ treatment, where it's been hard to find which piece belongs where, so. [LB1129]

SENATOR PAHLS: But since you opened this up though, I'm curious, are not schools

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through an IEP... [LB1129]

JAN MCKENZIE: Yes, absolutely. [LB1129]

SENATOR PAHLS: ...aren't they...are they not held somewhat accountable to the best of their...? [LB1129]

JAN MCKENZIE: Yes. [LB1129]

SENATOR PAHLS: So something is happening in the schools, I'm assuming. [LB1129]

JAN MCKENZIE: Yes. [LB1129]

SENATOR PAHLS: Okay. Now have you told me in the past, some insurance plans...and I may be putting words in your mouth and I do not want to. Are there some insurance plans that cover this type of treatment that you know of? [LB1129]

JAN MCKENZIE: A...which treatment? ABA? [LB1129]

SENATOR PAHLS: Yes. [LB1129]

JAN MCKENZIE: I would have to double-check on that, Senator. [LB1129]

SENATOR PAHLS: Okay. I mean I'm not...yeah, I'm not trying to put words in your mouth. [LB1129]

JAN MCKENZIE: Yeah, I.. [LB1129]

SENATOR PAHLS: Okay. Senator Schumacher. [LB1129]

SENATOR SCHUMACHER: Thank you, Senator Pahls. Thank you for your testimony today. There is some testimony today that what we're looking at is an average cost per, I would take it, policy even though it does say members--I'm not sure if that means person or policy--of a buck a month. Is that number very far off? [LB1129]

JAN MCKENZIE: Senator, I was not provided a copy of the actuarial study prior to the hearing today. I would have to take a look at what sample...how the actuarial analysis that you were given today was put together. I honestly can't answer that. [LB1129]

SENATOR SCHUMACHER: Well, I mean, before they sent you in here to testify, certainly there was some discussion about how much they get...the insurance companies guesstimate that this would cost in premium increases. [LB1129]

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JAN MCKENZIE: Well, the best... [LB1129]

SENATOR SCHUMACHER: What's the guesstimate from the industry? [LB1129]

JAN MCKENZIE: The industry analysis based on the groups that they have coverage under is the fiscal note. It's in the fiscal note for the groups they cover: university, the state, those. [LB1129]

SENATOR SCHUMACHER: Right. But I mean, you know, for the average...you know, on the average policy if we were going to add this into the system, how much are we looking at? Because clearly we've got an issue here. There's people that are in a big crack. And, you know, is it a huge bill or a little bill? Is it \$10 a year for me or \$1,000 a year? [LB1129]

JAN MCKENZIE: I don't know. If you're in a small group maybe it's more than if you are in a large group. Honestly, I can't answer that without having looked at the actuarial analysis. [LB1129]

SENATOR SCHUMACHER: Okay. Thank you. [LB1129]

SENATOR PAHLS: Seeing no more questions, thank you for your testimony. [LB1129]

JAN MCKENZIE: Thank you. [LB1129]

SENATOR PAHLS: Any more opponents? Anyone in a neutral? Senator. [LB1129]

SENATOR COASH: Thank you, Chairman, and thank you to the members of the committee for your attention and your good questions. I want to just follow up with a few things. This is not new. We would not be the first state to say that this kind of coverage makes sense for its citizens. There's 29 other states that have done so. And this year, of the remaining states, all but five are looking at this. So this is where we're headed, in my opinion. As Dr. Wasmer mentioned, the estimated increase per that actuarial study...and I'll make sure I get that to Senator McKenzie. The increase on the premium cost per member is \$1.21. But I'll tell you that this is based on utilization estimates of 50 percent to 80 percent, and it's probably more likely that the utilization will be even less than that and more along the lines that they've seen in Missouri and Kansas which those increases were 25 cents and 13 cents per member per policy. So if we look at \$1.21 as the high end, I think 25 cents is the low end, we're probably somewhere in there. I wanted to repeat one of the reasons that I brought...agreed to carry this. I work in the field of developmental disabilities and I work with families who have made the decision that they can no longer be the primary caregiver for their children. The companies that I work with are the last line for these families. And a lot of times, by the time they find themselves into a service provider, they've gone broke, their families are

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fractured, and their child is in a safer place, but they're certainly not with their family and they become state wards. The kids who become adults become state wards, and we know who pays for that. This really for me is about return on investment and how much can we as a state save with that early intervention. And just to close, just one final thing, this really is...education doesn't think this is a part of their deal. They're working with kids but they're not providing applied behavioral analysis that would be provided in the medical realm. There's a fight here and it really does come down to money. And I'm going to continue to work with these groups, and I appreciate your support in that. Thank you, Senator. [LB1129]

SENATOR PAHLS: I just have one. Do you think the Affordable Care Act will have any play in this? [LB1129]

SENATOR COASH: Well, I...you know, it's interesting. The federal government sometimes takes the lead of the states, and we're...over 50 percent of the states have already said this makes sense, a long-term cost-savings for our country. And so it's very possible that the Affordable Care Act could sweep this up, but we don't even know if that's going to take effect at all. So, sure, it's going to be a player in that. Yes. [LB1129]

SENATOR PAHLS: Okay. Senator Pirsch. [LB1129]

SENATOR PIRSCH: And you spoke of these individuals once they have become adults, these individuals who have autism becoming wards of the state. [LB1129]

SENATOR COASH: Well, they start out as wards of the state as children. Now when they become adults, what happens is many of these children have become adults, and not all get swept up into the DD system, Developmental Disabilities System, and that is completely state-funded with Medicaid match as well. And these are adults...this is from my own personal experience. These are adults who are now getting services, that had they had this intervention early in their life, would not need it. If this were a pill rather than...if this were a pill rather than therapy, it would be a totally different discussion. But I found it fascinating, 49 percent, almost half of the children who get this can have that diagnosis removed from them, and then they go on. And it's about early intervention and that's what this bill is trying to address. [LB1129]

SENATOR PIRSCH: Are you aware of the frequency by which children, minors, access through the...to Medicaid program as a minor by accessing the child welfare... [LB1129]

SENATOR COASH: They don't access the type of treatment that is addressed here. [LB1129]

SENATOR PIRSCH: Sure. And I understood from a previous testifier that it's woefully inadequate. But, I mean, do you see even at that, there's some minimal amount of

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Medicaid coverage? Do you see individuals who are attempting to access through the child welfare system... [LB1129]

SENATOR COASH: The best we're offering them, Senator Pirsch, is a little respite here and there to try to keep these families together. That's the best we're seeing. [LB1129]

SENATOR PIRSCH: Thank you. [LB1129]

SENATOR PAHLS: You know, Senator, I would be interested if you can just give me some hard data on the starting at this, and then as adult, how they are...I mean if you do have that. [LB1129]

SENATOR COASH: You bet. [LB1129]

SENATOR PAHLS: I would appreciate it. That would help me out. [LB1129]

SENATOR COASH: I'd be glad to do that, Senator. [LB1129]

SENATOR PAHLS: (Exhibits 12, 13, 14, and 15) Okay. Seeing no more questions, thank you. That will close...oh, just a second before I close. The Nebraska Planning Council on Developmental Disabilities supports this bill; the National Association of Social Workers--these are letters that they...; the Voices for Children support...and also the Nebraska Psychological Association partly supports LB1129. Thank you. [LB1129]

SENATOR COASH: Thank you, Senator. [LB1129]

SENATOR PAHLS: We're going to have a short break. Good afternoon. Good afternoon. Thank you. Thank you. Senator. [LB1100]

SENATOR WIGHTMAN: Good afternoon, Senator Pahls, members of the Banking, Commerce and Insurance Committee. I am John Wightman, spelled W-i-g-h-t-m-a-n. I represent District 36. LB1100 was introduced on behalf of a constituent and the Nebraska Academy of Family Physicians. The reason for LB1100 is to start a discussion and encourage all providers of health insurance and administrators of health plans to participate in transforming medical practices into patient-centered medical homes. A patient-centered medical home means a team-based way to care for a patient led by a personal primary care physician who provides coordinated preventative care throughout the patient's life. Government payers of healthcare costs such as Medicare and Medicaid are moving to this system of care. Insurance plans need to share in the start-up costs and contribute to make the funding multi-payer for this transformation to take place. Senator Gloor started this process on the public side with his patient-centered medical home pilot program in Medicaid. He saw that the national push for reform was moving toward systems for managing the healthcare of patients.

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Medicare is moving in this direction also. Medicare has a nationwide program in which they have joined existing states...I'm trying to follow my notes; I'll do better. Medicare is moving in this direction also. Medicare has a nationwide pilot program in which they have joined existing statewide and regional multi-payer medical home systems. In order to encourage more states to build multi-payer system, the federal Center for Medicare and Medicaid Services is now announcing State Innovation Grant Program that will assist states in building multi-payer medical home systems. To take advantage of this opportunity and put Nebraska at the front of this reform, we need to get the private insurers to develop more patient-centered medical homes. There are three keys to transforming a medical practice and a medical system into a patient-centered medical home. Those keys are: information systems, such as a disease registry that allows physicians to track patients with high-risk health indicators or multiple diagnosis in order to be proactive about their healthcare; care coordinators that take that information and interact with high-need patients providing health education, follow-up care, and coordination of preventive care; reimbursement changes to pay for the coordination of care and information systems. One insurer in Nebraska has begun a disease registry pilot program and is already showing good success. Now we need the entire private side of health insurance to step up to the plate. In order for our state to make a transition to this more efficient way of providing healthcare, we need all the players on board. Some physicians in our state are trying to transform their practices to this new way of doing business, but they can't do it alone. Especially in a rural state like ours, it takes all stakeholders to make such a transformation successful. North Carolina is an example of a state that has been transforming to a patient-centered medical home system. They have saved millions of dollars in the process over the last decade. I believe Rhode Island, likewise, has done so and has collected some data on how much savings they've had. LB1100 does not mandate any benefit, but instead seeks to further this discussion through this bill and through a study resolution that will be introduced before session ends. We've got a great start in our state, but we need to build on that start. Nebraska's health insurance plans, Nebraska's medical community, and Nebraska businesses need to look at the evidence. Health insurers need to adopt proven strategies that improve the quality of medical care and reduce the cost of health insurance. I urge this committee to conduct a comprehensive interim study of the options and benefits of a patient-centered medical home for all Nebraskans. My personal physician, Joe Miller, from Lexington, is here to tell you about his practice transformation to a patient-centered medical home. I would urge you to advance this to General File and I think from the testimony you'll hear, you'll see the reason for this. Thank you. Any questions, I'll try to answer them. [LB1100]

SENATOR PAHLS: Well, I have a question. Now you're looking for a study... [LB1100]

SENATOR WIGHTMAN: Right. [LB1100]

SENATOR PAHLS: ...an interim study. [LB1100]

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SENATOR WIGHTMAN: Right. [LB1100]

SENATOR PAHLS: And that's your goal. [LB1100]

SENATOR WIGHTMAN: Right. That's correct. [LB1100]

SENATOR PAHLS: So in other words...and I'm just trying to be very up-front here. The information that will be given to us today will point us in the direction of an interim study. [LB1100]

SENATOR WIGHTMAN: That's correct. [LB1100]

SENATOR PAHLS: Okay. So lots of information will be collected during the interim study. [LB1100]

SENATOR WIGHTMAN: That would be the purpose of the interim study, yes. [LB1100]

SENATOR PAHLS: Okay. And I'm trying to get that point across today. [LB1100]

SENATOR WIGHTMAN: Right. [LB1100]

SENATOR PAHLS: If we support this, we're actually supporting an interim study. [LB1100]

SENATOR WIGHTMAN: That's correct. [LB1100]

SENATOR PAHLS: Okay. Okay. Any questions? [LB1100]

SENATOR WIGHTMAN: Any other questions? [LB1100]

SENATOR PAHLS: Thank you, Senator. Now I'm looking to see how many proponents we have. One, two, three, four. I see four, five, six. Now...and I'm speaking to you, if we're going to have an interim study, I want you to think about that, you know, in light of the amount of time. I'm not going to put on the lights, but if I can have you guys think in terms of that we will probably have an interim study. Okay. Proponents, you may start. [LB1100]

JOE MILLER: (Exhibit 1) Hello. I'm Joe Miller. I am a board-certified family physician in Lexington for the last 27 years. I presently am serving on the Nebraska Academy of Family Physicians board of directors and on the Nebraska Medical Association's ad hoc committee for patient-centered medical home, which I have been since its inception. I am the lead physician for the Medicaid and the Blue Cross and Blue Shield pilot project

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patient-centered medical homes with our practice here in the state. And I want to thank you, Senator Pahls, and the Banking (, Commerce) and Insurance Committee for this opportunity to testify. I also have a greater appreciation for you guys today after sitting here for the last several hours, and thank you for your time. Senator Gloor, I want to thank you for your leadership that you've given us with LB396 in 2009, and your continued leadership on the patient-centered medical home pilot project committee, and thank the entire Legislature in 2009 for their futuristic thinking with unanimously passing LB396, and to the Governor's commission that put together the pilot project a year earlier than dictated by law so we could proceed with this. And thank you very much, Senator Wightman, for your introducing this legislation. What is a patient-centered medical home? It is an individual's home for healthcare. It is a relationship between a primary care physician and that patient, whether that be a family physician, a general internist, or a general pediatrician. It gives them accessible, comprehensive, long-term care. This is care that is easily accessible by that patient either with that personal physician or someone that represents him so that they have an ongoing relationship with all the disease processes that they're dealing with. It is comprehensive. It doesn't deal with just an organ system, an organ, or even the whole body, but that whole human being, socially, medically, mentally, emotionally. It deals with all of those. And it coordinates their care, not just the care that they give there in that office, but the care with specialists, the care with physical therapies, maybe social workers, patient educators, whatever is needed for their care. It goes beyond disease care which is what we've been practicing in the United States for many, many decades now, and it goes to really looking at what can we do in both primary prevention and secondary prevention--primary prevention meaning preventing the diseases from even happening, and secondary prevention from taking diseases like diabetes and preventing what the complications may be down the road. Our practice has done two things, and I want to point out just recently one is an immunization nurse. And I had a fight with my partners here a few weeks ago to get this set up as a pilot project actually within the practice because they look on this as an extra FTE and they have to pay for it. But I see it as something that not only is this is a person that's going to be giving immunizations, but it's going to be looking at every individual that is coming in the next day or two and what are the immunizations that they need. We know that that's one of the greatest ways that we can prevent disease is through immunizations. That person is also going to be looking at every one of our well child...of our children, and seeing if they've made their well-child checks. Being a father of a child who had a cancer at age 7 months, I really understand why well-child checks are very important. We also put together a diabetes project and are working...we know that with our electronic medical record we are able to track and know that there are 1,400 diabetics in our practice of seven physicians out in central Nebraska. We also know that the recommended hemoglobin A1c of 7 or less, the blood pressure of 130 over 80 or less, and an LDL, or bad cholesterol, of 100 or less, all of those parameters being met by diabetics in the United States, only 7-10 percent meet all three of those. That really shows that we are not providing the healthcare that we really need. We are looking at the things on the backside. We're

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doing cardiac...coronary artery bypasses; we are putting people on dialysis that costs \$250,000 a year because we're not getting good care to those patients. Our goals are to improve that to 20, 30, 50 percent of people in our practice making those numbers will make a huge different. It takes time and a lot of money for physicians, first of all, to organize a plan, then having system managers and care coordinators to put this together, and then having the impact of the whole staff to really put together a patient-centered medical home. If we can get all of the payers together--right now, we're working with Medicaid and Blue Cross and Blue Shield--but we can get all the payers together, we can transform practices across the state to definitely decrease the cost of healthcare, but also to improve outcomes, and you're going to be hearing some testimony that shows that we can do that. I ask for you to go ahead and pass this so that we can have this interim study. Thank you very much for your time. Any questions? [LB1100]

SENATOR PAHLS: Okay. Senator Gloor. [LB1100]

SENATOR GLOOR: Thank you, Senator Pahls. And Dr. Miller, we would thank you for grabbing the bull by the horns and agreeing to be a practice site for the medical home pilots, and I know you've put an awful lot of time and effort into this. Let me ask you, you finished up talking about the challenges inherent in the fact that you have a practice that you're changing even though it's for a very small percentage of your overall patient load. How many of your patients, as a percentage of your patient load in your clinic, are we talking about are really covered by the pilot program? [LB1100]

JOE MILLER: We have about 25 percent of our patients are on Medicaid, and so that would be that. Our practice has a large portion of Blue Cross and Blue Shield, but it's of Illinois because of the Tyson plant. So we only had...when we were dealing with the diabetes project we only had, I think, 86 or 87 diabetics that really fit into that registry, though we were doing this for all our diabetic patients. [LB1100]

SENATOR GLOOR: So the nudge to get more insurers to begin looking at it and the same way the pilot is set up a little more comprehensively... [LB1100]

JOE MILLER: Right. [LB1100]

SENATOR GLOOR: ...would make it a lot easier for other practices to want to move in that direction clearly because... [LB1100]

JOE MILLER: Yes. [LB1100]

SENATOR GLOOR: ...because the dollars and cents that would make. [LB1100]

JOE MILLER: I have had several practices that have asked me to come speak to them

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regarding this. [LB1100]

SENATOR GLOOR: Okay. Thank you. [LB1100]

JOE MILLER: Yes, Senator. [LB1100]

SENATOR PAHLS: Senator Pirsch. [LB1100]

SENATOR PIRSCH: Yes. And thank you, Dr. Miller, for your testimony here today. So you talked about adding to your practice an FTE to deal strictly with vaccines, right, immunizations and whatnot, so. [LB1100]

JOE MILLER: Um-hum. [LB1100]

SENATOR PIRSCH: And there was concern amongst your partners that this would introduce somewhat more cost than without that. And what is the benefit then that your partners and you experienced then based upon this? Is it because of the way the pilot is structured then? Are you... [LB1100]

JOE MILLER: They agreed in that I told them we would probably be giving more vaccines and we would probably be getting more well-baby checks. I'm hoping that it will come that it looks like it might not be too much of a burden on the practice itself. But when they're looking at this, they're saying we understand it's best care, but to provide best care and not get reimbursed for it, if we continue to do that how do we stay in business as a business and if we just keep adding FTEs? This will be really our second care coordinator. The first care coordinator was actually paid for by the pilot. [LB1100]

SENATOR PIRSCH: The first care...you said the first employee was paid for by the pilot. [LB1100]

JOE MILLER: Well, you're going to be hearing from Chrystal next, but she was the care coordinator...the Medicaid pilot project involves one care coordinator, and she's done a whole lot of other things. But this was a way of getting basically a second care coordinator that we are going to pay for ourselves out of our own practice to just keep moving toward a better patient-centered medical home. [LB1100]

SENATOR PIRSCH: Okay. And it's maybe the concept of medical home that I'm still trying to understand all the necessary elements and how this is a change. Now you mentioned some factors: preventive care as opposed to addressing ailments on the back side after a full-blown manifestation, and utilizing, you know, the technology and keeping the database and you can have a seamless transition. But there's something more to just these elements to constitute a medical home, and you indicated it was the nature of your relationship with other physicians as fundamentally changed through this

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pilot program, or...? [LB1100]

JOE MILLER: I don't know that our relationships with other physicians has. I would say what we're trying to do is to better do what we can as physicians, particularly primary care physicians who have a relationship with those patients, use technology, use the other...use all of the avenues that we now have, we're able to look at things. Instead of having a paper chart and not know...I mean, I would have never guessed that I had 1,400 diabetics in our practice. But to be able to look at that and then plan care so that we can bring in all of those people who haven't been seen in the last year, trying to look at, okay, here's a group of people that are having hemoglobin A1c that's over 9; what do we need to do systemwise to address their care to try to get them under better control. What are the things...and we can look at all of those things as a system and therefore be able to improve healthcare and outcomes. [LB1100]

SENATOR PIRSCH: Is medical home then some sort of a greater sense of...as opposed to reacting to that which came through your door? Proactively going out and attempting to... [LB1100]

JOE MILLER: Much more. [LB1100]

SENATOR PIRSCH: ...segment the population...somehow carve off some certain...because they happen to have been a couple years ago been in your clinic or something? But somehow have responsibility over certain individuals and encourage them to get into a habit of coming back into you more regularly, or...? [LB1100]

JOE MILLER: It would look at what can we do to provide the best care possible using evidence-based medicine to all of our population. There are many patients who might come in for something small but they have hypertension and you try to get them to come back. We're trying to develop plans so that we can take care of chronic disease so that it doesn't go on to end up with complications such as dialysis and coronary artery bypass and those type of things that are very high, expensive things at the very end. [LB1100]

SENATOR PIRSCH: So medical home in your estimation is pretty synonymous with preventative care medicine, is that...or is it...? [LB1100]

JOE MILLER: No, it is whole care medicine. It's taking care of whatever the patient needs, but it's also...it adds a very strong preventative medicine component. [LB1100]

SENATOR PIRSCH: Okay. Thank you for...appreciate it. [LB1100]

SENATOR PAHLS: Thank you. Seeing no more questions, thank you for your testimony. [LB1100]

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JOE MILLER: Thank you. [LB1100]

SENATOR PAHLS: Could I have the senator come forth? I'd like to just...a question before we go. Senator, I just have a question. You want to do an interim study. That's your goal. [LB1100]

SENATOR WIGHTMAN: That's our goal. We'd like to have it in statute so that it would be...but we can live with just an interim study. [LB1100]

SENATOR PAHLS: Well, I mean if...I mean we would have an interim study. It's...as I'm listening to our first proponent, it sounds like we're getting...we're building...we're going to be, I'm going to use the word "regurgitate" this same information during interim study. [LB1100]

SENATOR WIGHTMAN: Well, I think it would be a lot more complete and probably more anecdotal and... [LB1100]

SENATOR PAHLS: Okay. I know it would be longer. But if you have eight or nine people speaking...I'm just looking for efficiency is... [LB1100]

SENATOR WIGHTMAN: Well, you're just looking as to whether that many need to testify is that one of your... [LB1100]

SENATOR PAHLS: Right, I mean, because it's very hard to... [LB1100]

SENATOR WIGHTMAN: ...and then...well, I'll let them decide that. That may be a possibility or maybe they can... [LB1100]

SENATOR PAHLS: Okay. Okay. Because I'm just thinking we will have our interim study if you so...if that's what you want. I mean we can even talk about how to write it, right up here. [LB1100]

SENATOR WIGHTMAN: Right. [LB1100]

SENATOR PAHLS: Okay? Okay, thank you. [LB1100]

SENATOR WIGHTMAN: Okay. [LB1100]

SENATOR PAHLS: Thank you. Next proponent. Good afternoon. [LB1100]

CHRYSTAL DOWLING: (Exhibit 2) Good afternoon, Senators. My name is Chrystal Dowling, C-h-r-y-s-t-a-l D-o-w-l-i-n-g. I'm the patient care coordinator at Plum Creek

Medical Group in Lexington, Nebraska. My role is coordinating care for our high-acuity patients. We've identified asthma, COPD, CHF, and diabetes as the disease processes that affect a majority of our patients and result in some of the highest financial costs affecting our nation's healthcare systems. Through our electronic health record, we developed patient registries to track these patients' outcomes. Physicians, nursing staff, and clerical staff help initiate care coordination by identifying high-acuity patients and bringing them to my attention as a care coordinator. Once the patients are identified they are followed to ensure they are treated according to our evidence-based standards of care. Reminders for needed labs, pulmonary tests, and immunizations are placed in the patient's electronic record for coordination of care prior to seeing the physician. As care coordinator, I also track patients seen in emergency departments, urgent care settings, and patients dismissed from inpatient hospital settings. Medications, immunizations, and all other pertinent history are updated in the patient's electronic health record to ensure consistent and quality care. Patients are then contacted by me and reminded of upcoming follow-up appointments, as well as answering any questions they may have regarding their condition or care. These contacts create teachable moments with the hopes of educating the patients and empowering them to become an active part of their medical team. Our goal is to increase knowledge by empowering the patient and creating healthy outcomes for the patient. One of our many success stories involves a child diagnosed with asthma. She had become a regular at the local emergency department, presenting several times over the span of a couple of months for her asthma. This included being admitted to the hospital on several of those occasions to simply manage her disease. She did not have a primary care physician to help her with her healthcare needs. This little girl missed so many days of school that she was no longer enrolled. I made contact with the mother and once the language barrier was addressed we were able to identify many critical roadblocks standing in the family's way and basically making it impossible. Her mother was a single mom working nights and relying on several different neighbors to help care for her child while she worked. The mother had missed so many days of work caring for her child that she was close to losing her job. She was using the emergency department for her primary care needs as that was the only care facility open during the hours that she could take her. As a care coordinator, I was able to connect her with services to help her with financial assistance to pay for day care, and worked with a primary care physician to get her letters that documented the need for her to be home in order to care for her child, thus returning her to a position of good standing with her employer. She was then ultimately allowed to switch to day shifts. Once a relationship was established with the patient, we worked together to identify a primary care physician, scheduled follow-up visits and physicals, thus eliminating ER visits and hospitalizations. Once educated on the disease process and enrolled in our asthma program, the child was able to reenroll in school, and her mother returned to work, ultimately changing the life of this family. The asthma program consists of education on the disease, the triggers of asthma, treatment plans to be followed by the patient, and medication use. The patients are placed on an asthma action plan that identifies what the patient needs to do to manage and control their

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disease based on their symptoms at the time. The asthma action plan is shared with the patient's caregiver, school nurse, athletic trainer, and coaches. Each patient is given a binder with information on their disease, references for them, information on the medications they are taking, and the means to communicate with their healthcare team. Thank you for allowing me to speak today. It's been a privilege. And if there are any questions I can answer in regards to my role. [LB1100]

SENATOR PAHLS: Senator Pirsch. [LB1100]

SENATOR PIRSCH: Thank you for your testimony. And you testified here today about a success story involving a child diagnosed with asthma. And was this...did this patient come to your attention because she had been treated at your medical group or was...or do you have some sort of a relationship with the emergency room at the hospital who kind of sort out characteristics of people coming to the ER and then shoot you the contact information of individuals who may meet certain characteristics that you screen for in terms of being able to take advantage of, you know, the information you provide? [LB1100]

CHRYSTAL DOWLING: It's a little bit of both. We have the ability with the electronic health records to...when I am...you're right in that I am issued a report on a daily basis of who was seen in the emergency department. If they are a patient of our clinic, then I make a follow-up call, make sure that there's no questions or concerns. And then at that point if it's a nonurgent, say, for a fever that they've had for three days, then I make the recommendation to use a primary care physician, you know, with the intention of decreasing the urgent care and emergency department use. There are certain things such as asthma that we know needs to be managed other times of the year besides when they're having an acute exacerbation. So the goal was to contact her, and she was then...we realized that we had issues with parenting; she was a single mom; there was no money for day care; she was in bad standing; was not able to pay for medicine. So once we got her set up with all the different services available, then we were able to get her back in better standings. [LB1100]

SENATOR PIRSCH: So is that a large part of your job duty or role then to...you provide through both your internal in-house, but also through the local ERs? I mean, is that what you do then, is you look at the fact patterns, is that... [LB1100]

CHRYSTAL DOWLING: Correct. [LB1100]

SENATOR PIRSCH: ...or is that all that you do? [LB1100]

CHRYSTAL DOWLING: No, I do...as we say, my job changes on a daily basis just depending on what our needs for the clinic are. But you're right in that we do look at all urgent care and all emergency rooms and look at those patients, and say, who could we

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manage, especially if they are patients of ours in the clinic. And again if it's a discharge report coming from an inpatient setting, we want to make sure that if there was a recommendation by the family physician to see, say, a pulmonologist or a different specialist, then we make sure that follow-up appointment was made, that the patient has the ability to get there and get back. So there's several different aspects to it. [LB1100]

SENATOR PIRSCH: And when you look around at the medical community as a whole, this doesn't...this has not typically taken place, right? Your activity of proactively looking out in the world trying to find that? [LB1100]

CHRYSTAL DOWLING: Correct. Correct. [LB1100]

SENATOR PIRSCH: Okay. So is that as you understand the term medical home or the evolution towards medical home, is that...is this a big part of that? Is that what we're seeing is there's a growing, I don't want to say responsibility, but a growing...the idea that the medical providers will not just simply react to patients coming in the door and treat the short-term needs, but proactively harness the technologies to go out and look for people who they have contact with through or become aware of through the medical records? [LB1100]

CHRYSTAL DOWLING: If what I understand is you're asking me if we're recruiting patients, the answer to that would be no. [LB1100]

SENATOR PIRSCH: Not recruiting, but I guess I'm trying to, in my mind, understand what the new term "medical home" means and certainly the concept of this technology and what it...but it seems to me that whatever medical means, there's a larger and more increased importance of the healthcare providers... [LB1100]

CHRYSTAL DOWLING: Right. [LB1100]

SENATOR PIRSCH: ...looking out to find things, essentially relationships that are financially broken or medical treatments. [LB1100]

CHRYSTAL DOWLING: And if I could just give you another example, and I'll just use diabetes as an example. If a patient is used to coming in once a year and they're a noncompliant diabetic and their lab values are elevated and they would happen to call in and catch the on-call physician to get a refill of their medications, we now have protocols and policies in place to where the nursing staff can only refill one time. At that point we then make that patient an appointment to come in to make sure that they're being screened as the, you know, evidence-based standards recommend. So we're catching these patients that are patients and, you know, we've managed over the past, but we're now looking forward in trying to better manage what their disease process is,

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what their needs are. [LB1100]

SENATOR PIRSCH: Okay. I was just trying to make sure I understood the word "medical home" and the home part of that. I was...you know. [LB1100]

CHRYSTAL DOWLING: Yes. [LB1100]

SENATOR PIRSCH: So thank you. [LB1100]

CHRYSTAL DOWLING: Any more questions? [LB1100]

SENATOR PAHLS: No more. Thank you for your testimony. [LB1100]

CHRYSTAL DOWLING: Thank you. [LB1100]

SENATOR PAHLS: Next proponent. Good afternoon. [LB1100]

CAROL FRIESEN: (Exhibits 3 and 4) Hello. I'm Carol Friesen. I represent the Crete Area Medical Center, and thank you for taking your time to listen to us today. We have a medical home in Crete which is just 20 miles from the city here. We have been in existence for about three years. So, you know, whatever questions you want to, you know, wheel at me, I'll try to answer that. Kind of my piece of this presentation is to talk about the investment and why it's a good investment. You know, really there's the value, and the outcomes speak for themselves, but really the barrier that is presenting itself still is that bridge from what we've passed than the practice of medicine or the delivery of medicine and the methods of reimbursement for that moving towards this more effective model and delivery of care which is paying for outcomes versus paying for collects which is what we've done in the process...or in the past. The Crete Area Medical Center made a strategic decision to do this for our community three years ago even though we weren't going to be paid for it under the current reimbursement systems, because we felt like it was the right thing to do. And really the medical home has several components to it. It really is about access and the continuity of care; it's about identifying and managing patient populations; it's about planning and managing care; it's about providing self-care options and community resources; it's about tracking and coordinating care; and lastly, it's about the measurement and the improvement of care. In our nation, we are spending buckets full of money hand over fist to no avail. When we have 50 percent of our adults have a chronic disease, 7 out of ever 10 deaths are related to chronic disease, 75 cents on every dollar is being spent on chronic disease. And at least 25 percent of all adults have at least one chronic illness that limits their activities on a daily basis. You know, we had a call to action. And so really the success and the burden of a medical home is really based on this robust, physician-led, performance quality improvement in which we're it, we're accountable. So we have 643 people that are diabetics that entrust us with their care, and as of today we have less

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than 7 percent of those diabetics are uncontrolled. But all of these things to deliver this model and this level of specificity so we know who they are, what the need, how can we respond, is built on top of a strong infrastructure of a high-functioning EMR, which most of you have probably heard a lot about the electronic medical record. This cost of initially installing and maintaining software and hardware, and then of course the people that support that and support the providers and the care teams to really utilize this to its fullest capabilities, for us was about an \$87,000 initial investment, and it costs us about \$21,000 a year annually to maintain that, as well as we have an IT resource that allows the physicians and the practitioners, as well as the care teams assistance in managing that. Secondly, there's a seamless and proactive communication like you were talking about earlier, with physicians, with care teams, with referring physicians, and mostly with our patients. And there's a substantial amount of time and effort that's spent taking care of people in between visits. And historically we're paid to take care of people when they're sick; we don't get paid to take care of them when they're healthy. So you have to be sick or you have to come in to draw a charge which derives a payment. And in a medical home, we spend a lot of time really on the in-between points in time coordinating complex care for chronic disease or coordinating preventative care outside the normal visits. We also have care teams that reach out to our patients with low-tech high-touch patient calls. And what we found this does, it eliminates readmissions. So every readmission that we have within 30 days to an acute setting for a person with just plain pneumonia, 25 percent of the nation's adults that are taken care of in a care setting will readmit to a hospital within 30 days. That's for a cost of about \$6,000 to \$8,000 an admission. So everyone that we prevent by making a simple phone call to check to see how people are doing saves money and taxpayer dollars. Additionally, there's amounts associated with reporting and analyzing and refining care protocols, being proactive, and benchmarking whether or not we're really providing outcomes to patients. A lot of people talk about how they're improving things, but they can't back that up. So some of the things that I sent around shows the results and how we're stacking up and how medical homes, or at least our medical home, is stacking up. All this takes time. We have two care team members that are dedicated to phone support. We have a leadership person that spends about 50 percent of her time on program compliance. These are the compliance regs with a patient-centered medical home, a true one that's recognized at a Level 3, which is the highest recognition that you can have for a medical home. These are the clinical outcome studies that physicians practice by if they decide they want to be a medical home. So you don't just go out and say, tomorrow, my practice of five different doctors are going to continue to practice the way they always have and they're just going to put a name tag that they're a medical home. That doesn't work. And so it's really saying for this population of patients or for this disease we're going to agree to practice medicine always this way. This is the best way to get care. And then lastly, we have a physician leader that dedicates three hours a week just to the practice and the evaluation of what evidence-based medicine is in our practice, and that's about a \$90,000 commitment. And lastly is access to care. A lot of clinics are an 8-to-5 gig Monday through Friday, or in the city here, Lincoln, a lot of times it's Monday

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through Thursday, half-day on Friday. So for us it means we're open every Saturday; we're open two evenings at night. We have a patient portal that you can access in your home that allows you to see what's my medication list; what do I need to have done; you know, what do my lab results look like; and I can send a note to my physician if I want to. That's access to care. And then some of that comes at a cost initially. For us we would say that that's mitigated. After three years into the process, we would believe that returns on its investment completely to our practice. So the true answer is really in linking reimbursement more closely to changing practices that get great outcomes for patients. So every person that has diabetes spends \$11,500 a year of their disposable income on their disease. And if we can help them be more controlled, we can put more money back into their pocket which they can keep more in their economy. Also for people that have hypertension or hyperlipidemia, once you have cardiovascular disease, it costs you about \$5,500 a year to sustain that disease process once it's going. And so we believe fundamentally that this is what's good for our community, but we need some change and bridging that gap between this medical home that we believe will revolutionize the practice of medicine and the cost of the practice of medicine, because now you're paying for something that's a deliverable versus just paying for a click, you know. And you can hold us accountable. If you're a diabetic in our clinic, we only...7 percent of the people that entrust us with their lives for diabetes today are uncontrolled. There's 43 people. I probably could tell you most of those people's names. So that's the level of accountability that a medical home is. It becomes personal. And bringing back to what maybe...maybe it was like when we were kids when we had a family physician that knew our family. They knew our mom, they knew our grandparents, they were invested in us. That's what medical home is about. So what we're asking for is this interim study that really allows us to establish a per-payment per-month coordination of care amount, and that's given to an individual once they've decided to be involved in your medical home. That's similar to what Blue Cross/Blue Shield has done with their pilot and lots of different programs throughout the nation with resounding results. And this payment also has to be accountable. You can't just give a payment to somebody...oh, sorry. You can't just give a payment to just anyone so you would have to make sure that they are indeed doing what they say they're going to do, so. In Nebraska...in closing, in Nebraska the ideal model, we have it. It's called rural healthcare, and they've been functioning like medical homes. And I think that given a little additional push and a little additional incentive, we would see this take off. Thank you for your time. [LB1100]

SENATOR PAHLS: No, no, no. I have a question. [LB1100]

CAROL FRIESEN: Yes. [LB1100]

SENATOR PAHLS: I appreciate your enthusiasm. [LB1100]

CAROL FRIESEN: Sorry. [LB1100]

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SENATOR PAHLS: No, I think it's great. [LB1100]

CAROL FRIESEN: (Laugh) I could take your whole interim study. (Laughter) More data to come. [LB1100]

SENATOR PAHLS: Well, and...okay, so let's talk about an interim study. [LB1100]

CAROL FRIESEN: Yeah. [LB1100]

SENATOR PAHLS: This, with your enthusiasm, this should be talked at several sites throughout the state... [LB1100]

CAROL FRIESEN: Um-hum. [LB1100]

SENATOR PAHLS: ...not just in Lincoln or in Omaha. Maybe a couple days, if this is that positive, throughout the state. [LB1100]

CAROL FRIESEN: Um-hum. [LB1100]

SENATOR PAHLS: How many associations are there like yours? [LB1100]

CAROL FRIESEN: Well, we are...we have two clinics in our location. We've been doing a lot of work. A lot of people have come to visit, so we've had in the last six or nine months we've probably had six or eight clinics come to visit what we're doing, trying to figure out how they transplant that in their community. And the reason, you know, the medical staff took this on is because people said we couldn't do it in Crete. And we said, well, I guess when we do it in Crete then you'll have to tell me why you can't do it in your place. But the reality is, is that we feel like this is something that really can make a meaningful difference even for employers. We're working with large employers to say: Large employer, you have a small town that you employ when you figure out your employees and your covered lives. How can we help you keep your healthcare affordable so you'll continue to give good benefits to your employees? Because what happens is when the cost of healthcare goes up, employers cut the ability, that they can, to fund benefits to the degree that they have; then they give it back to their employees in the way of larger deductibles, copays, and etcetera. And what happens is then 50 cents on every dollar that becomes patient due after insurance becomes charity care. And so we've went to employers saying, we want to help you figure out how you can control your healthcare costs, because I want you to continue to be able to provide the best benefits you can, and I know you can't do that unless we're in this together. And so that's why we say we're partners in innovation. You're a stakeholder and we're a stakeholder. And so I think that it's going to take off. I mean, we've got some good press in the Lincoln Journal Star about three months ago, and we got some good press also in

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the Omaha World-Herald. So I think it's just more or less getting the story out there. People in Nebraska are humble, and sometimes our humbleness gets in the way because we don't know what's great going on in Lexington or we don't know what's great going on in Crete, and then we don't get it out fast enough to other places. And it's because we're a humble bunch and, you know, we don't like to talk about ourselves. (Laugh) [LB1100]

SENATOR PAHLS: Thank you. [LB1100]

CAROL FRIESEN: We don't. [LB1100]

SENATOR PAHLS: And one thing that attracted my attention to your third thing that...and so in other words, if I am associated with you,... [LB1100]

CAROL FRIESEN: Yes. [LB1100]

SENATOR PAHLS: ...your organization,... [LB1100]

CAROL FRIESEN: Yes. [LB1100]

SENATOR PAHLS: ...I have access almost instantaneously. [LB1100]

CAROL FRIESEN: Yes. Yes. Yes, if you...if I had a laptop here, I'd just log on to myself and I could see all the things that...so I have my whole medical health maintenance records. So you would find out that in I think about seven days I'm due for my annual physical. So that thing will be red. If I'm past due, it will be red. It has all my medication lists. So if I was going to see a specialist, I would print out my medication list and be able to take it to my specialist. If I wanted to look at what was my last thyroid test or my last cholesterol test, I could just look it up, you know, or I could print that off for my specialist. So you wouldn't have duplication of tests. I mean, the whole problem with why our system is so broken is the right hand doesn't know what the left hand is doing. Everybody means well, but there's no coordination in it, you know. It's not anybody saying...I had a...we had an APRN when we were talking about doing this. She said we have a "tag, you're it" system, in which "tag," the healthcare provider is "it" when the patient makes the appointment. And then we see the patient and then we say, "tag, you're it, pharmacist"; and "tag, we're not it again until you call to make another appointment." And in a medical home, we're it. So if you've invested your life in us, we're invested in you and we're going to call you. If you're a diabetic, every six months you're going to get a call from us. We're going to make three attempts to make sure that you know that you're past due for an appointment. We're going to call you because we don't want...we want to be invested in you. And what we found is people respond well. There's a lot of people say, well, where's the personal responsibility in all this? You know what?--the relationship is gone. When you call a person and you're actually

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interested in it, it's amazing how much more compliant they'll be. People just don't care anymore. Like we have a diabetic, and he has had an A1c of 12. On an average, he was being seen in our ER, prior to the medical home, about every...about three times a month. He's a limited functioning adult. I suppose he's a DD guy that you were talking about earlier. And he has an A1c today of 7.2, and last time he was in our ER was about nine months ago. He has a personal relationship with the nurse at the acute. And so if he thinks his diabetes is out of control, he just calls her and says, hey, Mary, this is where I'm at; does that look all right? That looks all right, Joe--and you're done. And so it's that investment with patients that makes a big difference. But I think this could be reduplicated anywhere--anywhere. Sorry. [LB1100]

SENATOR PAHLS: Yes. Senator Gloor. [LB1100]

SENATOR GLOOR: Carol, thanks for your commitment to medical home. [LB1100]

CAROL FRIESEN: Yes. [LB1100]

SENATOR GLOOR: This will make you uncomfortable, but you're probably one of the senior administrators in the state when it comes to medical home initiatives. But unlike Dr. Miller's medical home, which is really his clinic, the difference in Crete is the physician practice in Crete is part of the hospital. It's an overall healthcare system. Am I correct in that? [LB1100]

CAROL FRIESEN: Yes. We call ourselves like a little mini Mayo. You know, you've got a medical home with wraparound services from a critical access hospital. [LB1100]

SENATOR GLOOR: But is that the reason that you can afford to make sure that your medical home is for every patient that walks in the door, whether they're Medicaid, Blue Cross, Medicare, because you do treat everybody like a medical home patient? [LB1100]

CAROL FRIESEN: Everyone. [LB1100]

SENATOR GLOOR: And you don't get paid anything additional for it. [LB1100]

CAROL FRIESEN: Nothing. Yeah, I think there's two...one main reason is that we're a rural health clinic in Crete and in Wilber, and then we're a critical access hospital. And so basically what that means is that we get payment assistance for Medicare and Medicaid. We're kind of held harmless a little bit, so to speak. And so really then we're only talking about the commercial insurance piece. So if we decide for our medical home it costs maybe \$8 a visit extra to do the care coordination, if we're willing to do that on 50 percent of our business to meet our mission, then that's something we can do because we're making it...something else is subsidizing that. When you're in private

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practice, clearly the only place that that subsidy would come from is their own pocket. [LB1100]

SENATOR GLOOR: Yes. I...the minute you pointed out you were a rural health clinic and I went critical access, I understand. Thank you very much. [LB1100]

CAROL FRIESEN: Yes. We're the only rural health clinic medical home in the state. There isn't any other...there isn't any other level...there aren't any other recognized medical homes, true medical homes, by the NCQA outside of Omaha other than us. [LB1100]

SENATOR PAHLS: And you would like to see more. [LB1100]

CAROL FRIESEN: Lots more. Just... [LB1100]

SENATOR PAHLS: Okay. Thank you for your testimony. [LB1100]

CAROL FRIESEN: Thank you. [LB1100]

BOB RAUNER: (Exhibit 5) Dr. Bob Rauner, R-a-u-n-e-r. I'll skip all the evidence stuff since you've got it and it's on my report, and I'll jump right to why we are here with this bill, okay? The problem is, is we're stuck with a 1980s-era reimbursement system that won't support twenty-first century healthcare, which is what we're trying to do here. You know, people like Dr. Miller, he's doing this because it's the Lord's work and he's a mission-oriented guy. It's not going to be systematic until all people pay for it. And what happens now is that you have the motivated people doing these things benefiting everybody, but others freeloading on the system. The evidence is there. It's...I mean, this is just a snapshot for those five, or within the last two months of studies, Medicaid and Medicare, you name it. We spent two years as the medical associations trying to get all the payers to come in willingly, look at the evidence, and say, yeah, this is the right thing to do; let's try to make this happen. After two years, we've gotten one plan to do anything, and that's Blue Cross/Blue Shield of Nebraska--and their pilot is actually working. I think Dr. Filipi is going to give you the summary of that here shortly. The problem is, how do you get the others to play ball? You know, I as a physician cannot treat only you in medical home and ignore the rest of you. It just doesn't work in a clinic logistically, yet our reimbursement is split up so that all of them compete against each other and don't want to cooperate with each other. And so, why this; why are we here? Well, because we tried the willing approach: Do it because it's the right reason and we've got the evidence. Now we need something stronger. As medical societies, we're limited to how hard we can push, because if we do it too hard we can run into antitrust issues, and that can be very large lawsuits and we're not willing to take that risk. So what a lot of states have done is try to figure out how do I bring...get around that. Well, we bring it in under a governmental umbrella--you guys--to get all the parties into the

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same room talking about it, seeing what will work. Several states have gone past that because it didn't work and they actually did an all-payer medical home requirements. That's what Rhode Island did. That's not the Nebraska way to have that mandated from above. So this is our way in-between to...short of going with the Rhode Island all-payer medical home bill, we wanted to try to get an interim study, get the right people in the right room including the payers, and say, look, this is what's good for Nebraska. We either do it because it's right, or if not, then we turn to legislation next year. And so part three of this bill, there is the suggestion of legislation if needed. And I think as we do this discussion we'll find out, well, is legislation needed or will people do it because it's the right thing and the evidence is there? So that's the shortest version I can give you, but I'll answer any questions. [LB1100]

SENATOR PAHLS: Yeah. Well, it was really interesting since you mentioned Rhode Island. I was there this summer, and this was on the conference, this is one of the topics that was covered. And I felt some of the same enthusiasm, although it was top down, but I felt some of the enthusiasm from the people. [LB1100]

BOB RAUNER: Yes. We actually have the Rhode Island health insurance coming to talk at our annual meeting two months from now, and I'm hoping to get some of you guys to come talk with Chris Koller because he's a very interesting guy. He may have been at that conference, so. [LB1100]

SENATOR PAHLS: Yes, there were a number of them. Seeing no questions, thank you for your testimony and your information. The next proponent. [LB1100]

DAVE FILIPI: (Exhibit 6) Good afternoon. I'm Dave Filipi. I'm a family physician, board-certified, and medical director of Blue Cross/Blue Shield of Nebraska. I'm not going to read my testimony. I'm going to...because it's been well-covered. I will say that we started two years ago with our pilot project in nine cities across Nebraska: Omaha, Lincoln, Auburn, Nebraska City, West Point, Geneva, Grand Island, Lexington. I think those are the nine. We started with diabetes. As I'm prone to say, we started with the medical cabin and we're moving up to a medical home. I think we are moving to probably to a medical bungalow at this point. We started with diabetes alone because that's where some of the low-hanging fruit was. What we found is we, in the practices that had the medical home, we saw decreased admissions, we saw decreased readmissions, we saw decreased emergency room visits, we saw increased use of laboratory, we saw increased patient visits, we saw increased use of medicine. All those things are good. Insurance companies like to pay medicines that are necessary, like to pay visits that are necessary. The other thing that we found from our physicians, even those that were only...were doing medical home for their entire patient population, not just Blue Cross/Blue Shield's, were they said we're seeing more patients; we're getting more laboratory work done; we're getting more important things done, and that's all generating profit for us. Laboratory is a source of...it's a profit center in most offices. And

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so you can get money by being a patient-centered medical home and by steering people in who need to get help. Where we're going right now is we're going to move on from diabetes to include diabetes, but also include pediatric asthma. We're going to take a look at heart failure. We're going to take a look at heart attacks and the risk for heart attacks, hypertension, and preventative measures such as immunizations. Are we getting immunizations done? Are we getting cancer screening done? If practices do a good job of that, they get money at the end of the year. If they don't do as well, they don't get the money. And then for their chronic patients we give them a kicker; we give them a certain amount of dollars per month for every Blue Cross/Blue Shield patient they have. We do have some challenges. We don't have all payers in. We'd like to have all payers in. Some say they are really not able to do that. Some say the market is not ready for it. I say, let's go in for it, and if you have a committee formed from this, I'd sure like to be on that committee to share the Blue Cross/Blue Shield experience and to share some of the data that we have, because our books are open to you. [LB1100]

SENATOR PAHLS: Okay. It sounds like you have...right now, you have nine sites? [LB1100]

DAVE FILIPI: We have nine sites and 170 doctors. [LB1100]

SENATOR PAHLS: One hundred seventy doctors. And one of your concerns is that you cannot meet the needs of everybody because of economics? [LB1100]

DAVE FILIPI: Well, we can't...all...well, at this point we ask for a practice to apply to be a patient-centered medical home, because not every practice is ready to be so. You heard from Crete. Crete wants to be a medical home. They are able to be a medical home. We'd love to have them in the program. We're having some legal problems with the contract that we hope to resolve. But we need practices that are ready to transform. Of all the practices that applied to us, we only turned down one practice because they really weren't ready and one solo doctor because he really didn't have the time to do what he needed to do. But everyone that's come to us, we've funded. [LB1100]

SENATOR PAHLS: Oh, okay. Okay. [LB1100]

DAVE FILIPI: But again this is not offered to everyone because people have to be ready to change. They...again it speaks to accountability. There's an accountability to their patient practice. They have to change the way of doing things. Well, doctors, and I can say that because I just turned 63, we don't like to change a whole lot. We've done things pretty much the same old way and, by golly, there's no reason to change. Well, we want to have doctors who are ready to change. [LB1100]

SENATOR PAHLS: Right. Well, with affordable health care in front of us I think there would be a lot of changes anyway. [LB1100]

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DAVE FILIPI: Absolutely. And this really changes that yield curve. People say, what's going to be on their curve? You know, is the accountable (sic--Affordable) Care Act going to be on the curve? No, not by itself. But we believe that patients that are medical home will change the yield curve, but we want to have a credible study within Nebraska to show that people that buy our insurance say we want to go to a company that has patients that are medical homes. If it's not Blue Cross, who is it going to be? We'd love to have competition...well, I guess some people would love to have competition. We'd like to have all the business, but. You know, we're offering patients that are medical home, and the market is demanding it, the other payers are going to have to go in. They just need to have credible verification that I think this legislative committee can give. [LB1100]

SENATOR PAHLS: Okay. Thank you. Seeing no questions, thank you for your testimony. [LB1100]

DAVE FILIPI: Thank you, sir. [LB1100]

SENATOR PAHLS: Proponent? How many proponents do we have? I see one. Okay. [LB1100]

MARK INTERMILL: (Exhibit 7) Senator Pahls, members of the committee, my name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, representing AARP. I have a short written statement that I will paraphrase and be very brief. The enthusiasm you heard from the Crete Area Medical Center, I can report to you is shared by their patients, at least the patients I talked to. One of the diabetics that Carol referred to is a member of AARP that I work with extensively, and he has seen improvements in his quality of life since the medical home has been established in Crete. He's also told me that readmissions in the hospital in Crete are down to zero, which for Medicare we're looking...that's one of the focuses of the Affordable Care Act is to try to reduce readmissions within 60 days to hospitals. Many hospitals are in the 15-20 percent range. When we have readmissions we have unnecessary costs. This is a way to address those costs, and AARP is very supportive of it and thinks it's a good thing that we need to be looking at to try to see if we can get insurance to cover it. [LB1100]

SENATOR PAHLS: Seeing no questions, thank you for your testimony. Any more proponents? Opponents? Neutral? Senator. [LB1100]

SENATOR WIGHTMAN: I wouldn't attempt to add any to the enthusiasm we've heard. [LB1100]

SENATOR PAHLS: Okay. Well, the senator waives. That closes the hearing. Now we are ready for Senator Gloor. Thank you. Senator Gloor, (LB)810. [LB1100]

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Banking, Commerce and Insurance Committee
February 07, 2012

SENATOR GLOOR: Is that the time of day? [LB810]

SENATOR PAHLS: No, it's not bad. You are chasing them out though, I will say that, for people who support you. [LB810]

SENATOR GLOOR: Nobody likes to go to the dentist. Want me to go ahead? [LB810]

SENATOR PAHLS: Yes, go ahead, Senator. [LB810]

SENATOR GLOOR: Thank you, Senator Pahls, members...fellow members of the Banking, Commerce and Insurance Committee. I'm Mike Gloor, G-I-o-o-r. In 2010, I introduced LB813 which you advanced, this committee advanced; the Legislature passed unanimously as I recall. That bill prohibited prepaid dental plans from forcing dentists to cap charges for a dental service not covered under the prepaid plan. It was my intention with that bill to prohibit this practice by any insurance policy that offers dental coverage. Since LB813 has passed, we found out that there are other types of insurance plans that provide dental services. LB810 will fulfill the original intention of including all insurance plans in the statute over the last year. I've asked the Department of Insurance to assist me with casting the net broad enough to cover all plans that offer dental services. With their guidance in insurance and this, the quote they give us, "terms of art," and terminology, (LB)810 was crafted. That does not mean the department endorses the bill. It only means that, as we're well aware, they don't do that sort of thing, but it means they answered the questions when asked and gave us quite a bit of help in making sure that we've closed this little gap in (LB)813, with (LB)810. I certainly understand the negotiation that goes on between an employer and an insurance company on what services should be covered and what level of reimbursement. However I don't understand how an insurer thinks they can force a dental provider to cap charges on services they don't even cover in the negotiated plan. You agreed with me two years ago when we advanced (LB)813. Today's bill, (LB)810, makes sure this prohibition covers all plans that offer dental service. I visited with the Nebraska Insurance Federation this morning. They don't oppose this bill. I'm not sure that anybody does given the fact that it actually already exists and we're doing a little cleanup with (LB)810. There is no fiscal impact. And I'd be glad to answer any questions. [LB810]

SENATOR PAHLS: Seeing none, are you going to stick around for closing? [LB810]

SENATOR GLOOR: You bet. (Laugh) I'll waive closing. [LB810]

SENATOR PAHLS: Proponents. A show of hands, how many proponents? I'm glad to see one up. Opponents? Twelve? (Laughter) [LB810]

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DAVID O'DOHERTY: (Exhibit 1) Thank you, Senator Pahls and members of the committee. My name is David O'Doherty, D-a-v-i-d O'D-o-h-e-r-t-y. I'm the executive director of the Nebraska Dental Association representing approximately 80 percent of the dentists in the state. We'd like to thank Senator Gloor for introducing LB813 back in 2010, and reintroducing or introducing (LB)810 to clean up what didn't occur back in 2010, and the Department of Insurance for assisting with the correct language and the correct placement of the language in whatever statutes that needed it to be placed in. This first handout, the handout that you just received is a summary of the 26 states that have passed the noncovered services legislation. I'd like to note two things about that map is that in those 26 states, that legislation passed in two years. When we came here in 2010, a handful of states had introduced this legislation. And so in two years, the 26, the yellow...it's about five yellow states, and they currently have 2012 legislation in place. I'd also like you to note the large majority of votes in favor, and many of those states passed them unanimously just like Nebraska did in 2010. Provider agreements are often unilaterally amended several years after the initial agreement has been signed, and that's what's going on with this noncovered services. They're appearing either in amendments that...or not even amendments. They're just on note to the reimbursement schedules. So it's not something that was anticipated by providers when they entered agreements, and it would actually cause them to disrupt years of patient relationships if they chose to now not go on with their provider agreement because of this type of situation occurring in the provider plans. We would just like to ask this committee to advance LB810 to General File, and I'd be happy to answer any questions. [LB810]

SENATOR PAHLS: I see no questions. Thank you for your testimony. [LB810]

DAVID O'DOHERTY: Thank you very much. [LB810]

SENATOR PAHLS: Any more proponents? Any opponents? People in neutral? Senator? That closes the hearing on (LB)810. Thank you. [LB810]