[LR109 LR111]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Friday, September 21, 2007, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR109 and LR111. Senators present: Rich Pahls, Chairperson; Chris Langemeier, Vice Chairperson; Mark Christensen; Tim Gay; Tom Hansen; Dave Pankonin; and Pete Pirsch. Senators absent: Tom Carlson. []

SENATOR PAHLS: Good afternoon. We'd like to get started with today's hearing. Thank you. Welcome to the Banking, Commerce and Insurance Committee. My name is Rich Pahls. I represent District 31, which is the Millard of Omaha. We have two resolutions that we will be discussing today, LR109 and LR111. And I'm asking you, to better facilitate our meeting, just to look at some of the directions we have on the board over there. Typical, many of you have been here before so this is old stuff to you. Cell phones; if you're following somebody else who has already given some testimony, please try not to duplicate that. We do have an on-deck chair. Also, if you are going to speak we would like to have you fill out the sheet and put it in the box up here. Begin your testimony by spelling your first and last names. That will help people when they are looking at the transcript. If you have written material, we need, it looks like...well, typically we need ten copies. I don't think we...yeah, I guess we would. We need ten copies. If you do not have ten copies, hold your hand up and we'll have the page run them off. Okay. We'll introduce some of the individuals who are up here. To my...the guy I'm hitting right on the shoulder, many of you know Bill Marienau. Jan Foster is over here, she is our committee clerk. And what I'm going to have you do today, we have one senator who cannot be here, so we'll start off with you, Senator Pirsch, and we'll have you introduce yourself. []

SENATOR PIRSCH: I'm Senator Pete Pirsch, represent the 4th Legislative District in west Omaha. []

SENATOR LANGEMEIER: Senator Chris Langemeier from Schuyler. [LR109]

SENATOR PANKONIN: Senator Dave Pankonin, Louisville, District 2. []

SENATOR GAY: Tim Gay, Papillion-LaVista. []

SENATOR CHRISTENSEN: Mark Christensen, Imperial, District 44. []

SENATOR HANSEN: Tom Hansen, District 42, home of the most honorable son, Ben Kuroki, first tail-gunner that was a Japanese-American, Hershey, Nebraska. []

SENATOR PAHLS: (Exhibits 1-3) Good. If you do not know, this senator is our historian. (Laughter) So in every session he brings a little history, which we do appreciate. And our page today is Kim Weber. She is from Lincoln, Nebraska. The first resolution is LR109 and I'm just going to read a very brief part of that. The purpose of this resolution is to study issues relating or regarding the Comprehensive Health Insurance Pool, commonly called CHIP, and consider whether amendments should be recommended to the CHIP Act. And to get us started, I think we will have Bill give us some information, give us a little history, make everything clear to all of us. Bill, would you mind? Bill, just a second before you begin. We did receive some information. I just want to get this up front. We received a number of e-mails which we will note. Also we received some information from the American Heart Association, and also from one of the people who testified this morning, Sheri Smith. Those will be entered into the record. Okay, Bill, the floor is yours. [LR109]

BILL MARIENAU: (Exhibit 4) Mr. Chairman and members of the committee, my name is Bill Marienau, B-i-l-l M-a-r-i-e-n-a-u, legal counsel to this, the Banking, Commerce and Insurance Committee. I appear here today at the request of Chairman Pahls to provide an overview of Nebraska's CHIP, the Comprehensive Health Insurance Pool, the subject of this interim study. And I'll pause for a moment to remind everyone we're

talking about CHIP, not CHiPs. (Laughter) There's no S. CHiPs was a show about motorcycle cops in the California Highway Patrol in the late 70s and early 80s. (Laughter) So that will help everyone remember that. This study is conducted pursuant to interim study resolution LR109, which was introduced by Chairman Pahls on May 4 of this year and which calls for an examination of the funding of the net loss of CHIP, the determination of annual premium rates, the extent of CHIP policy coverage, provider reimbursement methodology, eligibility for pool coverage, and cost containment strategies. And I perhaps forgot to mention that my statement is in your committee book. CHIP is what is known as a high-risk health insurance plan or high-risk health insurance pool. The first of these entities appeared in the late 1970s in Connecticut and Minnesota. At last count, about 33 states have high-risk health insurance pools or similar state plans that provide access to health insurance coverage for individuals who have been denied health insurance coverage because of a preexisting medical condition. A risk pool typically is a state-created nonprofit entity that offers comprehensive health insurance policies to individuals with preexisting health problems; that is, people who have been denied coverage in the private market due to a chronic illness or condition who have found they can only access restricted coverage or have found other coverage that costs more than what is available from the pool. Risk pool insurance typically costs more than standard insurance coverage, but by law has a cap on premiums that can be charged in order to provide cost protection for policyholders. As a result, each risk pool inherently loses money. As a practical matter, it is not feasible to pool a group of individuals known to have major health problems and expect their premium contributions to cover the entire cost of the pool without pricing coverage beyond the reach of most applicants. Each pool needs some form of subsidy, often an assessment made against health insurers doing business in the state on a proportional basis or through some other state funding mechanism. The pools are overseen by an appointed board of directors and often have some supervision by the state's insurance department, typically a private third party administrator or administering insurer handles day-to-day operations. Risk pools are largely a temporary stopping point for many individuals. While some people enroll in state risk pools for extended periods, many

people enroll for a limited time and then disenroll when they become eligible for coverage elsewhere. Risk pools largely serve small businesspersons, employees of small businesses that don't health insurance, and the self-employed and other workers who are not part of a large employer plan. In fact, much of the initial push for the formation of risk pools in the 1970s and 1980s came from farmers and ranchers who had been relying on the individual health insurance market. Nebraska's Comprehensive Health Insurance Pool Act was enacted in 1985. CHIP became operational in November of 1986. Nebraska was one of the first states to create a high-risk insurance pool. The CHIP Act states that it is the intent of the Legislature that adequate levels of health insurance coverage be made available to residents of Nebraska who are otherwise considered uninsurable or who are underinsured due to a medical condition creating a high risk. As of the end of July of this year, CHIP had an enrollment of 5,203 individuals. In 1997, Nebraska designated CHIP under the requirements of the federal Health Insurance Portability and Accountability Act of 1996, HIPAA, as an alternative mechanism to provide health insurance portability in the individual market to individuals who have lost their employer group coverage and have no other alternative to obtain coverage. CHIP is a nonprofit entity created by state law. CHIP is not an insurance company, but has powers of an insurance company. CHIP is managed by a board of directors which is required to select an insurer through a competitive bidding process to administer the pool subject to approve of the Director of Insurance. Blue Cross Blue Shield of Nebraska has always served as the Nebraska CHIP's administering insurer. CHIP is required to offer major medical expense coverage to every eligible individual and the pool coverage, its schedule of benefits, and exclusions and other limitations are to be established by the Director of Insurance through rules and regulations. In establishing the pool coverage, the director is required to take into consideration the level of individual health coverage provided in the state and such medical economic factors as may be deemed appropriate and shall determine benefit levels, deductibles, coinsurance, and stop-loss factors, exclusions, and limitations determined to be generally reflective of and commensurate with individual health insurance coverage provided by the five insurers writing the largest amount of individual health insurance

coverage in the state. CHIP policy premiums are established annually by the CHIP board of directors and submitted to the Director of Insurance for approval. The CHIP board of directors determines the standard risk rate by calculating the average individual rate charged by the five insurers writing the largest amount of individual health insurance coverage in the state actuarially adjusted to be comparable with the pool coverage. Then the annual premium rate established for pool coverage shall be 135 percent of rates established as applicable for individual standard rates, except that the annual premium rate established for pool coverage for children under 18 years of age shall be 67 5/10 percent of rates established as applicable for individual standard rates. As is the case in other states with high-risk pools, premiums paid by CHIP policyholders pay for only about 60 percent of the incurred claims and expenses of CHIP. As CHIP was originally set up, the net loss was made up by assessments made against health insurers on the basis of the proportion of health insurance annually written by each insurer in Nebraska. Self-insured plans under ERISA were not subject to CHIP assessments because federal law shields them from the reach of this kind of state law. Insurers were allowed to offset their CHIP assessments against their premium tax liability. Insurers were not subject to CHIP assessments in excess of their premium tax liability and were entitled to refunds of such assessments made. By the late 1990s, concerns were expressed that the CHIP funding mechanism of assessments and refunds had become unnecessarily cumbersome. Legislation was enacted accordingly in 2000 which changed the funding for CHIP beginning in 2001. The assessment mechanism and premium tax offset were repealed and the Director of Insurance was authorized to approve funding for CHIP from a newly created CHIP Distributive Fund. Under this restructured system, which remains our current system, all premium taxes paid by insurers writing health insurance in this state are deposited in the distributive fund. The distributive fund is used to operate and pay claims against the pool. The CHIP board of directors estimates the amount needed from the distributive fund and the Director of Insurance approves withdrawals. Any funds remaining in the distributive fund after operating costs and claims of the pool are funded are transmitted according to existing law with each dollar being distributed as follows: 40 cents to the General Fund;

10 cents to the Mutual Finance Assistance Fund, which goes to rural and suburban fire protection; and 50 cents to the Insurance Tax Fund. And that 50 cents further breaks down: 5 cents to counties; 15 cents to municipalities; and 30 cents to school districts. Thus, in order to fund its net loss, CHIP taps into premium taxes after they are paid. That means there is a reduction of funds otherwise bound for the General Fund and other state aid destinations. CHIP's net loss in 2006 was almost $23 million. The size of the CHIP board of directors is seven members. All members of the board are appointed by the Director of Insurance. The composition of the board is as follows: four representatives of domestic insurers; one representative of health agencies which are involved in advocating for individuals with special healthcare needs; one representative of individuals eligible for pool coverage; and one representative of the general public. Why is there a need for an interim study at this time? Well, there is concern that the trends in both premium tax receipts and the net loss of CHIP suggests that at some point in the not too distant future the CHIP deficit may outstrip the existing available funding source. This past session, this committee, at the request of the Director of Insurance, Tim Wagner, introduced LB118, which contained proposals regarding CHIP. At the committee's public hearing on LB118, Director Wagner said, and I'll quote, CHIP is a plan that is heavily subsidized by the state. Last year we subsidized it through the premium taxes that the department collected in an amount of roughly $24 million. And this amount has been increasing due to increased medical costs. The concern that the department has is that we only have so many available funds within the premium tax pool that would apply. End quote. In addition to considering the provisions of LB118, Director Wagner urged the committee to conduct an interim study on a broader range of issues related to CHIP funding concerns. The committee held LB118 for further review. By way of review, LB118 contained three proposals. First, the bill would provide that an individual not otherwise HIPAA-eligible is not eligible for CHIP coverage if he or she is also eligible for coverage under a group health plan. This proposal is an effort to counter dumping, a practice whereby, for example, an insurance producer quotes an employer a group rate without a particular high-risk employee who is then dumped into CHIP coverage. "Group health plan" is already a defined term in the CHIP Act used with

regard to eligibility under the HIPAA portability provisions. Second, the bill would provide that an individual is not eligible for CHIP coverage if the premium for his or her CHIP coverage is paid by any person not related to him or her by blood, marriage, or adoption. This proposal is an effort to discourage persons, such as healthcare providers, from paying for CHIP coverage for high-risk individuals who otherwise quality for Medicaid payments in order to instead take advantage of the higher CHIP reimbursement rates. And third, the bill would provide that an individual is not eligible for CHIP coverage of he or she fails to provide information requested by the administering insurer to determine continuing CHIP eligibility and also that the administering insurer would be provided with explicit authority to collect information to determine CHIP eligibility. This is an overview of CHIP, a bit of history, and some recent developments. I'm pleased to say that Director Wagner will be following to offer his testimony and exhibits. His presentation will include information on trend lines for such things as premium tax availability, net losses of the pool, policyholder enrollment, etcetera. And his presentation will also include recommendations for the committee. I would also mention that I've included two exhibits, as it were, that would follow my statement. One is a memorandum that I update every year or every other year that deals with the subject of the CHIP premium cap. And I have borrowed from a national publication that shows what the cap on CHIP premium rates are in all the other states that have a comparable plan to ours. I would point out that in some regards, this memo is more accurate than it's useful because it will identify in many cases what is the maximum risk pool rate that can be established in a given state. And what I found through further research is that generally most states do not establish their CHIP premiums at the maximum rate. They are somewhere below the stated max. So you'll see maximums a lot of times of 150, 200 percent of standard risk rate. And in most cases, those states have not quite gone as high as the max they're allowed to go to. Nebraska's system is a straight 135 percent of standard risk rate, is the benchmark for CHIP premium rates. There's no ceiling, there's no floor, it's a straight 135 percent. And then I also created a little chart where I tried to in one page describe CHIP eligibility in a sort of decision tree or whatever one might call it of what it takes to be eligible and to remain eligible for

CHIP. And I went to one of the third pages, I couldn't make it any shorter than that. But that also follows my statement. Thank you. [LR109]

SENATOR PAHLS: Pretty comprehensive. Yes, Senator Langemeier. [LR109]

SENATOR LANGEMEIER: Thank you, Chairman Pahls. Bill, in your exhibits here you give us all these states and you talked about Nebraska being at 135 percent and it's really no max, it's no minimum, it's kind of a fixed number. [LR109]

BILL MARIENAU: Yes. [LR109]

SENATOR LANGEMEIER: And then earlier you said that the board, the CHIP board meets annually to set the rate. [LR109]

BILL MARIENAU: I said...I think they set the structure of the rates. But the 135 is the max that's set, it's the cap, as it were. But they establish, you know, a rather sophisticated rate structure. And they have authority to set different deductible levels and that sort of thing. [LR109]

SENATOR LANGEMEIER: So that's some other rates that they... [LR109]

BILL MARIENAU: Yeah. [LR109]

SENATOR LANGEMEIER: Okay, thank you. Thank you, Chairman. [LR109]

BILL MARIENAU: Yes, thank you. [LR109]

SENATOR PAHLS: Senator Pirsch. [LR109]

SENATOR PIRSCH: I'll go ahead and waive the question for now and wait until a

different... [LR109]

SENATOR PAHLS: Any other questions? This is the time to ask, a lot of good information here. One thing that I have after looking at this and some of the past testimony in the past years, there's always been the issue of what affordability means. Can you help me clear that up, what the means when we're dealing with CHIP? [LR109]

BILL MARIENAU: I don't know if I can really make it clearer. I think that I'd probably say that if I had a lick of sense, I would defer this question. So now I'll go ahead and try to answer it. (Laughter) When one talks about affordability with regard to CHIP and CHIP premiums, that becomes a hard issue to get one's arms around. You start out with certain basic bedrock principles. Healthcare is expensive, therefore health insurance is expensive. And one always follows the other. SO when you talk about affordability of CHIP premiums, one asks, well, what is it that we're talking about here? Affordability, when one reads literature and reports and things over the years on risk pools, it always comes up in the context of the premium cap. And there are major common elements with regard to risk pools in the states where they have them. You start out, you have a creation of a pool of medically uninsurable people. The policyholders pay a premium that's above the market rate for individual health insurance. But the premiums are capped at a percentage of standard risk rates so that there is some protection there for the policyholders. And that's where the concept of affordability comes in, although that is always a bit subjective. I think what's affordable is different in the eyes of the buyer and in the eyes of the seller of something. And then the...we know the premiums are capped, but then the arrangement is always subsidized, generally through maybe the other insurance-buying public, but usually ultimately by the taxpayers. And frequently at the hearings on this topic over the years people will look to the intent section of the CHIP Act. And the way it was originally written in 1985, there are two places in the intent section that say it's the intent of the Legislature that the premiums be affordable. But then there's never any other discussion, as it were, in the statutes in terms of what that affordable means. We know it means affordable in the context of the cap on the

premiums. And it's interesting to note that the language in the intent section sometimes is a two-edged sword because in 1985 when the Legislature said the premiums are to be affordable, the Legislature then said that the initial rate for the premium structure for CHIP was to be 135 percent of standard risk rate. That was kind of the pump-priming cap at the time, or rate at the time. But the rates could subsequently be established up to but not to exceed 165 percent of the standard risk rate. So what conclusion does one draw from that? Well, some might say, well, that means that the same Legislature that said in 1985 that premiums are to be affordable was the same Legislature that said the premiums could go as high as 165 percent of standard risk rate. So does that mean 165 percent is not unaffordable in terms of intent? And I think people can only draw their own conclusions from that. But affordability in terms of the CHIP premiums can't be viewed in isolation or in a vacuum. The premiums we know in risk pools are always set at some point above the market going rate for individual health insurance, and even that is not cheap. I think if CHIP premiums were set at 105 percent or 100 percent of standard risk rate, there would still be people saying, we're finding this not affordable. So it has always been a very hard issue to grapple with for this committee and for the Legislature in terms of CHIP premiums. [LR109]

SENATOR PAHLS: Senator Pirsch. [LR109]

SENATOR PIRSCH: I'll just ask it. What is it...you said 135 percent was what it was set at when it originated there in the 1980s. [LR109]

BILL MARIENAU: It kind of moved a little bit. The way the law was written in '85, it was to be...135 was the initial rate. And then there was discretion with the board and the director for a few years of where to set, to let it move, but it couldn't go above 165. Then in 1990 it was decided through legislation to provide a floor and a ceiling. So there was a range of 125 would be the lowest, 155 would be the highest. But then what happened was there was what you would expect the inevitable pressing of the Director of Insurance by those who said you can't let the cost of this get out of hand, you better

have the premiums at 155. Well, the policyholders are saying this is expensive, we would like the premiums to be at 125. And the then Director of Insurance, Bill McCartney, said to make a decision of the premium somewhere within that range was really a public policy decision and perhaps was one not appropriate to be made by an agency director. And he then asked the Legislature in 1991 to just, in a sense, pick a number. And the decision was made to set it at 135 percent. So there is no floor or ceiling anymore in terms of the standard risk rate. [LR109]

SENATOR PIRSCH: And that's where it stands right now? [LR109]

BILL MARIENAU: And that's where it is now. In addition...and then there's the children's rate, but it's been at 135 since 1991. [LR109]

SENATOR PIRSCH: And in the last few years, have the numbers of participants in the CHIP program decreased? [LR109]

BILL MARIENAU: Throughout this decade, it's been above 5,000. I think in 2003, it got as high as about 6,400. And now it's back down to whatever that number was I had written in my statement, I forgot. The low five. [LR109]

SENATOR GAY: 5,203. [LR109]

BILL MARIENAU: 52-something, yeah. So that's reasonably constant, I think. In 1985, somebody asked at the initial hearing on the first...on the bill to create the CHIP Act, the introducer of the bill said, well, it will probably only be a few hundred people that will ever enroll in this. So we at least exceeded that estimate. [LR109]

SENATOR PIRSCH: So we don't think that there is a downward trend from 6,400 and 5,200 that will continue in the future in sufficient enough numbers that the costs of the overall program are going to go down? [LR109]

BILL MARIENAU: It's held between 5,000 and 6,000 for about 7 years or so. [LR109]

SENATOR PIRSCH: Okay. And how much then with these individuals, the 5,203 paying 135 percent, how much is the current shortfall then again? What did you say that the number was then, that it's being subsidized by the... [LR109]

BILL MARIENAU: I think last year the number came in at just under $24 million. [LR109]

SENATOR PIRSCH: Okay. And the pool, the insurance premium pool, the pool from which these funds are taken and paid towards this, the $24 million is taken from, what's the total amount of that, those insurance premium pools just in general, kind of round numbers? Do you know? [LR109]

BILL MARIENAU: You know, I forget. And I heard from the Department of Insurance within the past couple of days. I think they said it was a bit over $30 million. I hope I remember that right. I think the director may have that in his comments. [LR109]

SENATOR PIRSCH: Okay. So it's the narrowness of the margin there that's giving concern and why we're addressing it here. Well, that's all the questions I have for now. I appreciate it. [LR109]

PRESIDENT SHEEHY: Senator Gay. [LR109]

SENATOR GAY: Yeah, I've got one. Bill, those 5,203 that are on the program now, you said people enter and they may go for a year. But how many just stay on it and don't get off until maybe they qualify for Medicare or something like that? [LR109]

BILL MARIENAU: I'm not sure. I've never seen numbers in that regard. I hear nationally, people will say in national reports there's a two- or three-year average. But I don't know

if we are at that average or not. Sometimes that research was done before there was the HIPAA eligibility. And I don't know if that has changed that. Because when it started out, we were dealing strictly with people who were medically uninsurable that came on and then had to go through their waiting period. But then with HIPAA people had the portability to come straight into the program. And I don't know if they come in sufficiently different in what causes them to go into the pool, that that's altered that set of numbers. I'm not sure. [LR109]

SENATOR GAY: So what you're saying is two to three years, and then they'll go get normal insurance, just regular health insurance. [LR109]

BILL MARIENAU: And that's the national average. But I'm... [LR109]

SENATOR GAY: So you don't just get on it and stay on it, you can't do that? [LR109]

BILL MARIENAU: One could. [LR109]

SENATOR GAY: And how many do that? We don't know. [LR109]

BILL MARIENAU: I don't know, I don't know. [LR109]

SENATOR GAY: Okay. But that would be interesting to see if they're just using this to...thank you. [LR109]

SENATOR PAHLS: Senator Pirsch. [LR109]

SENATOR PIRSCH: Just briefly, has any estimations or projections been done with respect to LB118, which carries with it three components, one of which is providing information, one of which is requiring...third parties could not pay the cost to get on CHIP, and then the...let's see, the third component... [LR109]

BILL MARIENAU: Was dumping. [LR109]

SENATOR PIRSCH: Yeah, yeah. With those three items in place, is there any kind of cost-saving projections with those? Does that make a margin? We're about six million...the margin right now is six million. Is there a kind of feeling that that might free up significant type of savings or... [LR109]

BILL MARIENAU: I'm not aware of anybody trying to make that determination or to estimate what savings would be involved if there would be cracking down on dumping or the third party paying the premiums. I don't know if the third party paying the premiums is a major large ticket item now or whether it's something that has kind of appeared as an issue and there's fear that it may grow. I think it's hard to know always how much dumping actually may be going on, by its nature. [LR109]

SENATOR PIRSCH: Thank you. [LR109]

SENATOR PAHLS: When you raise your hand like that, I thought...thank you, Bill. As usual, job well done. And to help us build more on our base of knowledge, the next person I would like to have would be the Director of the Department of Insurance, and then following him would be the chairman of the CHIP board of directors. And then we'll go with the rest of the individuals. But the next person would be...Director. [LR109]

TIM WAGNER: (Exhibits 5 and 6) Thank you, Senator. This testimony that I'm about to give...I'm Tim Wagner, I'm the Nebraska Director of Insurance, and that's T-i-m W-a-g-n-e-r. And because it is pretty complex and comprehensive, I'm going to basically do a little more reading than I usually do. This, clearly it's something that...Bill did an excellent job in reviewing with you a number of the issues regarding CHIPs. And he did indicate that we would be making, quote, recommendations. I would temper that a little bit by saying we will be outlining options rather than making recommendations. We

believe that...clearly, I believe very strongly in the CHIP pool and what it has done, commend the director, the board of directors, those that have been involved because it does serve, clearly, a very important role to people in need. And I'd like to first thank Senator Pahls for introducing the interim study so that we've had a chance to work outside the context of specific legislation. Because quite frankly, specific legislation at this point might be a little premature before its studied. Hopefully this study will give us the ability to get a handle on the challenges posed to the program. CHIP financing, as you have heard, has been a matter of consistent concern with the department since its inception. The department is here today because of the nature of the program involves an important and significant public subsidy. But more importantly, that we need to assure that we are going to be able to maintain the promises to the people that are members of the pool that we can pay their claims. We want to inform you of a number of things today, with a view towards keeping the program within its existing funding sources for foreseeable future, as well to provide you with information about the size of the program. Before I begin, I want you to know the department is currently in the process of working with the CHIP board and the administrator and consulting actuaries to bring the levels of coverage in line with the coverage offered by the top five writers of individual health insurance that's currently required by law. And what happened here as a result of our public hearing, which we have annually to set the rates, we became aware that the levels of coverage that our CHIP policyholders were receiving were, in perhaps most instances, superior to those that you and I can buy in the marketplace. As the cost of insurance has increased, what has happened is there's been a general process by which individuals are asked to pay higher copays and deductibles and limitations on certain coverages. So we're undertaking that process. Currently the amount of the subsidy last year was actually $22.8 million. Through the CHIP Distributive Fund, theoretically CHIP has available to it between $34 million and $35 million. Because of the accounting issues caused by the quarterly collection of premium taxes and the relatively brief window of opportunity for CHIP to assess money in the fourth quarter, I am concerned that we may see a situation in which CHIP will have issues meeting its obligations. In addition, given rates of medical inflation and trends

within the healthcare financing system within the foreseeable future, CHIP will need more money to sustain itself as a program. Consideration of what Nebraska will do when this day arises needs to begin so that we can prepare for the day that will be coming, maybe not 2008, but someday soon. Rather than continue on until there is an immediate crisis, we need to begin to consider what our options are, keeping in mind that every dollar spent in increasing CHIP funding is a dollar that has to replace elsewhere in our state budget. Last year's LB118 included a brief list of changes. Bill went through those. They are still on the table. We do not have estimates of the cost savings associated with those three changes. But we do continue to believe that they are important changes and changes that should remain under consideration. I do not believe that the first source, the state of Nebraska is a realistic source of new funds from existing state revenues. The state subsidy for CHIP is already a hefty $22.6 million in 2006. That's up $12.2 million at the beginning of the decade. The number has arisen steadily, but not in a smooth and predictable fashion. In other words, we've seen spikes. Many...at some point there will be the day when CHIP absolutely runs out of money. It will be down the road, but we need to avoid, we need to avoid making changes to reign in spending or perhaps even reduce rates. Yet every dollar in the CHIP Distributive Fund is already spoken for. Dollars remaining in the CHIP Distributive Fund are dollars, state dollars that are distributed pursuant to the way Bill had outlined. There are other sources of funds. In order to minimize a current growth of the state subsidy, there is some further room for increased premium revenue from policyholders. Under current statute, the amount of premium charged is set at 135 percent of the amount charged at the top five writers of the state. If the Legislature decides to limit the increases in the state subsidy, we may want to consider increasing the amount of the multiplier; that is, from 135 to 150, the multiplier used by most other states. The maximum permissible under the federal law is 200 percent. In addition, it would encourage those policyholders who would be otherwise eligible for Medicaid to apply for Medicaid. This will allow the state to realize the benefit of the federal contribution to the program. We currently receive a minimal subsidy for CHIP, one that is not dependent upon the amount spent by the state. And by that, I mean there have been several small federal grants that have

been dispensed over the last few years to help us address and grapple with this unfunded mandate. As a last resort, the state could contemplate an enrollment cap. We do not really embrace nor do we believe that you should contemplate an enrollment cap. How you decided who gets in and who gets out would simply be a very difficult task indeed. But we could have higher per capita numbers of...we do have higher per capita enrollees in our CHIP plan in Nebraska than many other states. There are significant limits on how much additional funding can be contributed by policyholders. HIPAA requires that we maintain certain features of the plan to keep CHIP as an alternative mechanism. Without CHIP, insurers will have to accept business for all applicants and will undoubtedly leave the market. And although this is a plan of last resort, as mentioned, we do benefit from the participation by people who are relatively healthy. Those people will leave the pool, taking their subsidy with them as rates increase and coverage decreases. Last, the cost of premium is currently high and people simply just cannot afford it. While most of my testimony today doesn't discuss this point, it's a very important point to consider. Many of your constituents will have real difficulty paying the premium in years when there are significant increases. And I worry about those that can't afford the increase. Same, unfortunately, is true with all health insurance in general with employers. One area to which the Legislature should give close attention is the statutorily set rate for coverage for children. The rates paid for a child are currently set at 67.5 percent of the adult rate. The rate for children should be set at a rate adequately reflects their cost to the pool. The SCHIP program has been established to address the very real need for coverage for children whose families are below the 185 percent poverty level. At a minimum, children who are eligible for coverage under the SCHIP for which there is a federal subsidy should be ineligible for CHIP for which there is a minimum federal subsidy. More significantly, however, the Legislature should consider statutorily set rate for children so that the rate is set in the same was as for adults, at 135 percent of the rate for the top five writers in the state. It is important to understand that the rate for children is lower than the rate paid in the voluntary market. In 1998, the estimated cost in the hearing before the committee for this discount was $133,000. According to an estimate from the department actuary, setting the children's

rate in the same way the adult rates would yield an additional $2 million a year to the program. Because this is premium income, it would directly offset the state's subsidy of the program, thereby giving CHIP more room for operations. The third source of potential revenue should be explored is to try to find some other method to allocate the costs of CHIP. CHIP is a safety valve for the private sector insurance health...healthcare finance system. Without this safety valve, the instances where people cannot purchase health insurance at any price would become commonplace and really create a moral challenge to the way we finance healthcare in the country, to both the individual insurers regulated by the state, but even more so to the employer-based system regulated by the federal government. To meet this problem, Nebraska created CHIP. As the federal government has required that we either require that all regulated insurers to write all applicants or provide an alternative mechanism where people have a guaranteed source of insurance, Nebraska had CHIP available. Unfortunately, however, this has taken the form of an unfunded mandate. So in 2006, the state contributed, again, $22.6 million subsidy to provide a safeguard for both the state-regulated and the federal-regulated marketplace. What did the federal government contribute in the form of a grant last year? Less than $1,270,000. This grant is unsteady at best. Congress continues to grapple with the issue of increasing this subsidy but clearly there are no guarantees. Other states have used some other unique funding mechanisms. We don't necessarily recommend it, but there are tobacco settlement proceeds that are going to subsidize CHIP. Some have unclaimed property sources and some actually have a tax on hospitals. I've described a whole series of painful measures that will be need to be contemplated in the near future to assure that there are no cash flow issues involved in the way we fund CHIP. I've outlined the very possible painful options for the state and policyholders. The one remaining party left out of this is the solution of the...is medical providers. CHIP provides a reasonable, a reliable source of payment for providers. Without it, they can expect large increases in the amount of charity care they provide and increased uncollectable receivables. In addition, CHIP provides a generous private-sector levels of reimbursement to medical providers. This is a problem on two levels. First, the reimbursement is generous enough that some providers have gamed

the system by paying CHIP premium for the very sick rather than accept Medicaid levels of reimbursement. This does not appear widespread phenomena, but it occurs and it is both offensive and expensive. It is a good indication that the provider reimbursement rates are out of line. If such patients were covered by Medicaid in Nebraska, would at least benefit from the 60 percent federal contribution for Medicaid funding. Second, CHIP is a program of last resort and so there should be sacrifices. The state is sacrificing to avoid the bankruptcy of thousands of our citizens. Goodness knows the policyholders are sacrificing. However, the provides are paid the full rate negotiated by Blue Cross Blue Shield. Another option for assuring the long-term solvency of the program would be to look at reimbursement rates. Other states have done so. Wisconsin moved their administration of its pool to allow reimbursement at Medicaid rates. South Dakota requires providers being reimbursed at 115 percent of Medicaid rates. Florida recently considered requiring providers to accept reimbursement rates at Medicaid rates. Ultimately, reducing provider reimbursements would reduce claims paid and therefore reduce the taxpayer subsidy to CHIP. Some have argued that this will reduce the available network of providers who are willing to see CHIP patients. Before actually implementing the changes, a discussion of the impact with the plan administrator about the scope of this problem is in order. However, provider discounts are a significant way to create a broader sharing base of the funding of the program, so that all parties who benefit from the program will pay for the program. This is not the case today. We then ask that you reconsider or continue to consider the proposals that we had included in the original legislation. And with that, I'd answer any questions that you may have. I know this has been very long and arduous. I apologize for that. [LR109]

SENATOR PAHLS: It's good information. Senator Langemeier. [LR109]

SENATOR LANGEMEIER: Thank you, Senator Pahls. And Director Wagner, thank you for your testimony. And I think this little chart you handed out...I think that came from you, correct? And you put years of data on here, and I appreciate that. And if you go through, your claims insured against basically in eight years has doubled. Claims paid

has doubled. Losses have doubled. But operation costs have tripled. What are some of the challenges in providing this program that would make your operations cost increase at a rate triple that of everything else? [LR109]

TIM WAGNER: I'm not sure that...I need to...there was a doubling of the population. At 12-31 of '99, there were 3,000 people in the fund. It went up and then it went down. And I think you're seeing a little of that, because the fee charged has remained stable as a percentage of the premium. So that is something that clearly should be looked at. I would agree with that. [LR109]

SENATOR LANGEMEIER: And you do have that enrollment column on here that says in '99 you had 4,600 participants. And in 2006, you have 5,200 and it's bounced give or take 300, 400 every year in between with the 4,653 being the lowest. I'm just curious, and not so much why that doubled. I don't want to dwell on that. But I guess I was looking for some of the challenges from your department implementing this program. [LR109]

TIM WAGNER: Yeah. One of the things, Senator, bear in mind, we have a little bit of oversight. We're really not, aside from appointing the board, the board is really the manager. We do approve the contracts. And one of the reasons that the, as I look at the operating cost change, it is a percentage of the claims paid. And the claims paid have more than doubled as well. [LR109]

SENATOR LANGEMEIER: Yeah, exactly doubled. [LR109]

TIM WAGNER: And that's really kind of how that has occurred, whether or not the Blue Cross Blue Shield is making more money today on this program than it did in the past. It may or may not, I don't know. [LR109]

SENATOR LANGEMEIER: Thank you. [LR109]

TIM WAGNER: Thank you. [LR109]

SENATOR PAHLS: I see no more hands up. Thank you, Director. [LR109]

TIM WAGNER: Thank gosh. Okay, thank you very much. [LR109]

SENATOR PAHLS: Appreciate the information, as usual. [LR109]

VICTOR KENSLER: (Exhibit 7) Senator Pahls, fellow committee members, good afternoon. My name is Victor Kensler, spelled V-i-c-t-o-r K-e-n-s-l-e-r. I'm the chairperson of the Nebraska Comprehensive Health Insurance Pool, CHIP, here today to reinforce the CHIP board's support of the issues that have been brought before this committee by Insurance Director Wagner and to offer assistance wherever and whenever possible as this interim study progresses. I want to thank you, Senator Pahls, for introducing the interim study resolution, which we are confident will be the impetus towards positive change to ensure the continued success of CHIP in Nebraska. Last year, the Nebraska CHIP board of directors submitted to Insurance Director Wagner a list of proposed changes the board determined would improve the long-term outlook for CHIP coverage in Nebraska. Some of these were included in LB118. And in addition, testimony and support of that bill and this interim study was given by me on behalf of the board of directors. Since that time, the board of directors has worked with consulting actuaries, the administrator, and the Insurance Department to develop levels of coverage that are commensurate with that being offered by the top five carriers who write individual insurances in Nebraska. These efforts are in keeping with current requirements of the law and have previously been mentioned by Director Wagner today. We are very aware that while the high-risk pool is a valuable mechanism for the portion of the uninsured population that can afford the premiums, it can present barriers to others. And states with pools have adopted, and you heard that earlier, states have adopted a wide range of approaches to subsidizing their high-risk pools. At present, the

currently mechanism in place for Nebraska CHIP is working. However, we firmly believe that our attention should be on the future as well as the present. We therefore encourage the committee to include in this interim study a strong look into the development of a truly broad-based funding mechanism, perhaps one in which all Nebraska citizens help pay for covering uninsurable citizens. I will answer any questions that you may have for me. [LR109]

SENATOR PAHLS: Senator Pirsch. [LR109]

SENATOR PIRSCH: I guess just a...you mention here at present, the current mechanism in place for CHIP is working. It's the future you're concerned about. How pressing is the problem? What type of a time line are you looking at? The next few years, next five, is it hard to predict based upon the changes that were kind of experienced in the past? [LR109]

VICTOR KENSLER: It is hard to predict but it, as we've seen geometric growth in the expenditures, we felt it was extremely important to deal with it now. [LR109]

SENATOR PIRSCH: Okay. Thank you. [LR109]

SENATOR PAHLS: Senator Gay. [LR109]

SENATOR GAY: Victor, when it comes to the cost and the way insurance is working, earlier this morning we talked about some insurers who are developing, you know, if you start living a healthier lifestyle we can cut your premiums, call it what you will. But basically they do a risk assessment or health assessment. Obviously these are high risk and I don't completely understand every detail of this. But is there...have you looked at anything where, for those that are on here longer term, and I guess that's why I asked the question prior. Who's on this that this is just their insurance policy, they aren't getting off, that we could try to get them off? Are you looking for proactive ways to

improve their health and get them off the pool into the mainstream insurance, I guess? [LR109]

VICTOR KENSLER: Yes. We have put into place, using federal grant money, for a one-year period, for the length of that grant money, a disease management program. And that disease management program would and is expected to do the kinds of things that you are suggesting. Those people who have long-term conditions, I don't know about getting them off of the, you know, getting them out of the pool and into regular coverage. But it would certainly help them take care of themselves and thus reduce their claim expenses. [LR109]

SENATOR GAY: So I guess a follow-up on that. So you had a one-year pilot program, or what's going on with it? You said you got the grant, one-year pilot program. But would it be...I guess if they did this and said, hey, I will abide by this healthier lifestyle, that we could...I know we have a funding problem, but to encourage them to use less. That would help on this column of the claims paid. We could lower that if they were healthier. [LR109]

VICTOR KENSLER: We would be looking for monies to continue that. [LR109]

SENATOR GAY: So we aren't doing anything is what you're saying? [LR109]

VICTOR KENSLER: No, we're not...beyond that one-year period, there are no plans to continue the disease management program at this time. [LR109]

SENATOR GAY: Okay. Could I get information at some other time more on that program? [LR109]

VICTOR KENSLER: Yes. [LR109]

SENATOR GAY: All right, thanks. [LR109]

SENATOR PAHLS: Senator Pirsch. [LR109]

SENATOR PIRSCH: Just a few quick questions. Just to get my arms around it more, 135 percent of the top five written policies, what does that come out to be in just hard dollar terms, so I can get an idea or equivocate that in actual money terms, either what's 100 percent or what's 135 percent say for this year? [LR109]

VICTOR KENSLER: Well, Senator, it varies by age and sex of the insured, as you know. [LR109]

SENATOR PIRSCH: Okay. So the...I guess, is there a range or does it vary? [LR109]

VICTOR KENSLER: I don't have those premiums in front of me. I have them here with me today but I don't have them in front of me right now. [LR109]

SENATOR PIRSCH: That's fine. [LR109]

VICTOR KENSLER: But I can certainly make that available for you. [LR109]

SENATOR PIRSCH: I'd just like to kind of get an idea of what...one of the proposals was that it increase from 135 percent to 150 percent. And so I wonder, just in, you know, ballpark terms how much that equivocates out in hard dollar terms. But I'd be...I can certainly get in touch with you. I understand there's some different factors that go into determining that. And so I'm just trying to get a ballpark estimation. So I can contact you, I guess, and get that information. What are the primary types of, I guess, factors that...obviously it's a high-risk pool, right? Is there...can you categorize the type of individuals within this pool, why they're there, what types of maladies or diseases they have that make them high risk? Is there...I guess that kind of feeds into Senator Gay's

question. [LR109]

VICTOR KENSLER: The kinds of conditions that would make someone uninsurable: diabetes is a big one; you know, somebody in need of a transplant; cardiovascular disease. It runs the whole gamut. And that information, in terms of the most serious diseases and where the claims are being spent, we can get that information as well. [LR109]

SENATOR PIRSCH: Okay, yeah. I would appreciate that. I guess it feeds, to a certain extent, to Senator Gay's, which is, are some the reasons why people are in this pool preventable, not caused by, you know, birth defects but things that if we could, through encouragement, you know, I guess is the sense that I think Senator Gay was interested in pursuing. You know, help encourage people to take the right action there. [LR109]

SENATOR PAHLS: Senator Gay. [LR109]

SENATOR GAY: One more thing, just what Senator Pirsch was talking about. That one-year study, it's exactly why I was asking because the one-year study, if you're doing the study, diabetes management is a...if we could manage that, you could manage the longer term cost. So I'd be interested to see how that one-year study or program went to see if it's successful. Maybe we should put some money, our own money into that instead of federal money and control some of these costs. Senator Langemeier asked earlier about the operating costs going up. I assume that's with the claims incurred. But are you doing anything to control those costs or you internally look at your cost of processing claims or anything like that? Ten percent has been...what we're hearing is it costs us 10 percent just to manage these claims. Is that what you find? [LR109]

VICTOR KENSLER: Right. I don't know the exact answer to, you know, to that. I think the director indicated that as the claims go up, the administrative fee is tied to that, and therefore higher claims are going to have a higher administrative fee to that. I believe

that was the correct answer for that. [LR109]

SENATOR GAY: Yeah. He had talked about the premium. I think it's the claim, I don't know. Something to look into. Thank you. [LR109]

SENATOR PAHLS: Any...okay, thank you. Appreciate it. [LR109]

VICTOR KENSLER: You're welcome. [LR109]

SENATOR PAHLS: Can I just have a show of hands to see how many people that we have yet to testify, just so I get a feel? Do I see two, three? Okay, thank you. We are ready when you are. [LR109]

DICK NETLEY: (Exhibits 8-12) Mr. Chairman, members of the committee, my name is Dick Netley. That's spelled D-i-c-k N-e-t-l-e-y. I serve on the board of directors of CHIP, also known as NECHIP, as the public representative. I'm here today not as a representative of the board, but as a consumer advocate and a concerned citizen addressing several issues relating to CHIP. For the record, I am not a CHIP policyholder. Nearly 18 years ago, I sat in this chair for the first time and asked for what became the first waiver of the six-month waiting period. Over the years, the Legislature has seen fit to add several more waivers. Today, I am here asking for another. Private individual health insurance plans that are no longer marketed but guaranteed renewable are squeezing some policyholders in a premium death spiral. As premiums rise, healthy individuals opt off these sinking ships for more affordable policies. Those with preexisting conditions are trapped in a progressively sicker plan. Like a combine separating wheat from the chaff, this process is in effect culling high-risk individuals from the healthy population. High-risk individuals can find themselves isolated and trapped in a private market that is legally allowed to raise premiums to cover costs from a captive market while selling new and less expensive policies to the healthy individuals that are allowed to shop around. As an example of the scenario I just described, I

submitted to you the transcript of a news story broadcast by an Omaha TV station a couple of years ago. I won't read the entire transcript but just the highlights. This individual's name was Tom Moriarty. Mr. Moriarty was a heart transplant patient. His premiums jumped more than $1,000 a month. His attorney said, looking at the documents it appears they're involved, the insurer is involved in a pattern where they're trying to make it very difficult for Mr. Moriarty to continue with his insurance. The company says, the rates are necessary to provide comprehensive coverage to all policyholders. The insurer, Prudential, says increases meet state requirements. But Mr. Moriarty says, I think it's out of line; I think it's beyond the expectations of most people. The state Department of Insurance says Prudential filed a report that shows losses to justify premium increases in major medical plans like Tom Moriarty's. Any policyholder who can no longer afford these kind of rates can apply to the Nebraska Comprehensive Health Insurance Pool. These high-risk individuals are technically eligible for CHIP because their rates are greater than CHIP rates. However, CHIP will not cover their "pre-ex" for six months. In order to access more affordable health insurance through CHIP, they are faced with two choices: either pay both the private policy and their CHIP premium to get through the waiting period, or go without coverage on their preexisting condition for six months. These are not choices we should be giving Nebraska citizens. According to the preamble to the CHIP Act, it is the purpose and intent of the Legislature to provide access to health insurance coverage and affordable premium to all residents of Nebraska. To this end, if private coverage is offered at a rate exceeding the CHIP rate, the individual is eligible for CHIP. To impose a waiting period on someone who has already satisfied it under these circumstances is inconsistent with the intent of the CHIP Act. It is illegal for small groups to carve out and dump high-risk employees. But it is legal for insurers to squeeze high-risks out of their policies. Allowing this practice to continue is to embrace a very dubious cost-saving maneuver. Health insurance portability laws under HIPAA allow credit for time served when coming off a group policy. We need to extend this same path to those qualified individuals coming off private individual plans. I hereby ask you to either cap the rates that insurers can charge or provide a waiver of the six-month waiting period to qualified individuals in this

situation. Let me offer a little more history on the current adult rate of 135 percent. In 1990, the CHIP board proposed a 58 percent rate increase that would have taken CHIP rates to the limit of the discretionary range that existed at that time, which was 155 percent of the standard risk rate. After a very contentious public hearing, the Director of Insurance, with the approval of Governor Kay Orr, rejected the proposed increase in favor of a 30 percent increase. To avoid such future clashes, the Legislature in 1991 set the CHIP rates at 135 percent of the standard risk rate. Let me quote state Senator Don Wesely as he presented this bill on the floor of the Legislature. Last year, 1990, there was a proposal to have the rate set at 155 percent, which had the policyholders enraged and eventually the rates were set at about 130 percent, which had the insurance industry enraged. So we sought a compromise and struck upon 135 percent. When comparing Nebraska rates to those of other states, please keep in mind that the statutory rate cap that other states have is not necessarily where their rates are currently set. In fact, most rates are actually below their state statutory cap. Some states have even established low income subsidy programs for their pools. The current child rates were set by the Legislature in 1998 in conjunction with the SCHIP, or the Kids Connection bill. At that time, child rates for CHIP were substantially more than 35 percent above the standard risk rate. These programs stood in stark contrast to each other. Free healthcare for some families while other families with sick kids were paying twice the market rate. I'll try to explain why the kids' rates got so high. Over the years, the average of all CHIP rates remained at 135 percent of the standard risk rate. However, the age rate slope did not keep up with the private sector. This resulted in rates for older CHIP policyholders being below 135 percent and rates for younger policyholders being more than 135 percent. The rates were cut in half to essentially bring on par with the standard risk rate. In 2005 and 2006, actuarial adjustments were made to more closely parallel the industry age rate slope. This resulted in child rates being below the market in some cases. It was not the intent of the 1998 legislation to create child rates below the market rate. To retain the intent of the child rate of 1998, the child rate would need to be revised from 67.5 percent to 100 percent of the standard risk rate. Since 2003, CHIP has seen a steady decline in enrollment from a peak of

6,400 to the current level of 5,200. And I might point out to you in your packet of information that I made available to you is a rather crude chart that I have prepared that shows, amongst other things, the enrollment over the years since the beginning of CHIP. And you will see that in 2003, the peak enrollment of 6,400 occurred and we've had a steady decline since then. The most likely explanation is that CHIP is becoming less affordable for more and more of the middle class. By far and away, the most frequent complaint I hear from policyholders is about how expensive this insurance is. This complaint is becoming louder, especially from those over 50 and those with multiple family members in the pool. In response to the cry for more affordable options for CHIP...for more affordable options, the CHIP board has added higher deductibles. As the rates have risen, more policyholders have gravitated to the $5,000 and $10,000 deductible. Approximately 22 percent of our policyholders have deductibles of $5,000 or higher. It is likely that raising rates to generate more funds could exacerbate the decline, possibly driving off low users who subsidize the pool. If he isn't even meeting his deductible, a 60-year-old policyholder is thinking he can buy a lot of healthcare with $12,000 he is paying in premiums every year. As I mentioned earlier, several other states are establishing low income subsidy programs to expand coverage to more of their citizens. For the year, as of July 31, policyholder premiums are covering 67.5 percent and the state 32.5 percent of the total cost of the pool. For the entire life of the program, the total is 62-38. The national average is 60-40. The premium tax rate in Nebraska is one half of 1 percent for groups and 1 percent for individuals, which happens to be the lowest in the country. Prior to the year 2000, CHIP deficits were funded by assessments against insurers. This was and still is the typical funding mechanism in most states. Insurers in turn were allowed an offset against their premium tax liability. In 1992, the Legislature capped the industry's liability for funding CHIP but included a sunset provision in the legislation. In 2000, the state terminated the assessment funding mechanism and established the CHIP Distributive Fund, a repository for premium taxes. To provide a different perspective on potential supplemental funding mechanisms, let's look at the cost impact of two scenarios on those affected: a 10 percent increase in policyholders' premiums versus a supplemental

assessment on insurers equal to 10 percent of their premium tax. For a CHIP policyholder paying $12,000 a year in premiums, this would be a $1,200 increase. For a private-sector policyholder paying $9,000 a year in premiums, this would be an increase of $9 per year. If an insurance broker could offer a safety net benefit like this that wasn't otherwise available to the public, I think most people would say, I'll take it. This is just an example. I am not necessarily advocating a return to assessing insurers. The point is this: CHIP is a small but vital component of our healthcare system. Its cost needs to be incorporated into the entire system and borne by those who benefit from it in a way that can serve more people for the greater good. Who benefits from CHIP besides the policyholders and their families? The insurance industry and their clients benefit from a more stable and competitive market. The insured population benefits by having a safety net under them. Healthcare providers benefit by being compensated for their services and their patients benefit from less cost shifting to cover uncompensated care. Businesses and other entities benefit by avoiding the trickle-down consequences of medical bankruptcies. Taxpayers benefit from having fewer people rescued by Medicaid after they have become seriously ill with complications that could have been avoided. Who benefits? We all benefit, directly or indirectly. In conclusion, as Yogi Berra once said, this is deja vu all over again. I'd like to provide you with a copy of the 1991 study of the Nebraska Comprehensive Health Insurance Pool. This study was commissioned by the Legislature in 1991 because of concern for the increased costs of operating CHIP and to investigate methods to provide for adequate funding for CHIP. Other specific issues that were included, that the study included, were feasibility of a needs-based premium rate structure, alternate funding sources for CHIP, how the annual premium rate is established and implemented, provider reimbursement methodology, cost containment strategies, strategies to address the practice of intentional separation of employees from their employer's group health coverage in order to place into CHIP. Some things never change. By the way, this study included a survey of the policyholders and an actuarial report. Also for the record, I would like to restate my opposition to LB118 by resubmitting my testimony for that bill. I won't bother to reread it at this time. If there are any other questions... [LR109]

SENATOR PAHLS: Do I see any questions? If not, thank you for your information. Appreciate that. [LR109]

JENNIFER HERSH: (Exhibit 13) I'm a little bit shorter than this microphone here. Good afternoon, Mr. Chairperson and members of the committee. My name is Jennifer Hersh, H-e-r-s-h, and I am director of policy and strategic alliances at the American Diabetes Association. I appreciate this opportunity to illustrate the importance of high-risk pools to individuals with chronic diseases, particularly diabetes. According to the Centers for Disease Control, over 90,000 Nebraskans are currently diagnosed with diabetes and it is on their behalf that I speak to you today. ADA is the nation's leading voluntary nonprofit health organization providing diabetes research, information, and advocacy for all Americans, including Nebraskans, affected by diabetes. It is the association's mission to prevent and cure diabetes and to improve the lives of all people with this chronic and often deadly disease. One of the many approaches ADA employs to further advance its mission is by advocating to improve and protect access, affordability, and adequacy of health coverage for all people with diabetes. To date, 33 states have created high-risk pools to guarantee coverage availability to uninsurable state residents who require individual health insurance. Purchasing health insurance in Nebraska is extremely difficult for people with diabetes. These individuals continue to face many obstacles in obtaining access to affordable and adequate healthcare coverage. Nebraska insurers are not subject to guaranteed issue provisions and therefore are not required to offer individual health insurance policies to all who apply. Most importantly, insurers are permitted to refuse individual coverage based on health status. Thus, people with diabetes and other chronic diseases are commonly denied individual health insurance policies, rendering health coverage through the Nebraska Comprehensive Health Insurance Pool, or CHIP, critical for sick people in the state as individual health insurance for this population is essentially inaccessible. Unfortunately, high-risk pool policies in Nebraska are not exactly affordable for uninsurable residents, as evidenced by substantial decreases in pool enrollment. For example, CHIP enrollment peaked at

approximately 6,400 individuals. In 2007, program enrollment declined to 5,200 individuals. Seemingly ever-increasing premiums are most likely responsible for this downward trend and will only continue as premiums increase. CHIP is quickly becoming unaffordable for the people who need it most. People forced out of the individual market and into high-risk pools are not looking for handouts and do want to pay for their healthcare. However, Nebraska will eventually pay for their care, for the care of these individuals as they are no longer to afford CHIP except at a much higher cost to both the state and ultimately the patient. The association applauds the Legislature for mandating coverage for diabetes-related care for items including but not limited to blood glucose monitors, insulin, insulin pumps, and diabetes self-management training. However, these coverage mandates are of absolutely no benefit to people with diabetes unable to afford CHIP coverage. For example, according to CHIP's premium calculator, a 52-year-old nonsmoking female facing a $1,000 yearly deductible must pay an estimated monthly premium of $784.27, not to mention cost containment measures including copays. A 58-year-old nonsmoking female with diabetes subject to a $4,000 deductible pays an estimated monthly premium of $531.70. In 2006, the median household income in the state for a family of three was $58,055. For a person with diabetes requiring daily care, medication, and self blood glucose monitoring, all subject to a six-month preexisting condition exclusion period, this amounts to an almost impossible situation placing the lives of sick Nebraskans in jeopardy. As enrollment continues to steadily decline, the CHIP board is again seeking to increase the statutory cap from 135 to 150 percent. This increase will create an even more significant barrier to high-risk coverage for individuals with diabetes. While the association believes it is the responsibility of all relevant parties to bear increased costs to maintain pool solvency, the brunt of these costs cannot fall on the individuals the pool is intended to serve. Alternative funding mechanisms must be considered. For example, in 2005 Nebraska's high-risk pool sustained a loss of approximately $23 million. Currently there are approximately 138,000 state residents in the individual health insurance market in Nebraska with average monthly premiums of $165. If the state were to spread the CHIP loss to these individuals at an additional cost of $13 per month, rendering their

premiums at $178 per month, the pool could remain solvent without placing additional undue financial burden on high-risk pool enrollees whose lives depend on this coverage. The purpose of health insurance coverage is to protect individuals when they are sick, not to make it substantially more difficult to obtain the medications and care essential to their health and well-being. As health plans and public coverage programs place increased financial burdens on people with diabetes, enrollees will be forced to make decisions as to which treatments, medications, and supplies they can afford and which they must go out. People with diabetes must not be forced into such situations which can result in negative and debilitating, yet preventable health outcomes, including but not limited to cardiovascular disease, neurovascular complications, and even death. While diabetes is a manageable chronic disease, the ability to effectively manage it is directly tied to the ability to access affordable and adequate medical care and management tools. Without affordable and adequate coverage, the rates of diabetes-related complications will continue to rise. Furthermore, the sick will seek care in emergency rooms and through programs such as hospital charity care programs. However, through the CHIP program, Nebraska taxpayers with diabetes can obtain the medical treatment they need to remain healthy and productive members of the community. All Nebraska taxpayers benefit when there are fewer uninsured patients requiring expensive emergency treatment arriving at Nebraska hospitals. ADA is concerned with the rising costs of healthcare, the rapidly escalating number of Americans with diabetes, and the ability of individuals with diabetes to access quality health services. The association is committed to finding legitimate and comprehensive solutions to health insurance issues facing people with the disease throughout Nebraska and the rest of the country. Providing funding beyond and/or in addition to premium increases to deem high-risk pools accessible, affordable, and adequate is an important step toward improving the overall health and lives of Nebraskans with diabetes and to stem the tide of this deadly disease. The American Diabetes Association strongly yet respectfully urges this committee to reject the proposed premium increases while exploring alternative funding mechanisms to maintain the viability of the high-risk pool. One in four Americans will at some point find themselves

navigating the individual health insurance market, many of whom have preexisting conditions, will be denied coverage and will be forced to seek alternative means of care. In effect, many of us here today may at some point need to face the situation analogous to a game of musical chairs. Unfortunately, we may have that chair pulled out from under us. Again, on behalf of vulnerable Nebraskans with diabetes, the association truly appreciates this opportunity to advocate for these individuals who oftentimes are too ill to speak for themselves. Thank you, and I welcome any questions. [LR109]

SENATOR PAHLS: Do I see any questions? Senator Pirsch. [LR109]

SENATOR PIRSCH: Do you know how many...I think the testimony was there's about, this year about 5,200 people who are enrolled in the CHIP program. Do you know...you said diabetes is a major reason why people are there. Do you know approximately how many of those 5,200 people suffer from that ailment? Is it one of the larger reasons? [LR109]

JENNIFER HERSH: Unfortunately I don't. One of the reasons, and we've had this problem both at state and federal levels, is because oftentimes, and this has to do with how physicians code diseases when they bill for diseases, they miscode diabetes. So a lot of times most people with diabetes have other complications, including cardiovascular disease. So a lot of times they will be admitted for cardiovascular disease with diabetes as a secondary diagnosis and therefore their reason for enrolling in a program such as CHIP will be because of their history of cardiovascular disease and not of diabetes. So therefore those numbers are quite ambiguous and we've even worked with CDC to try to parse that out and we haven't been able to do that just yet at this time. [LR109]

SENATOR PIRSCH: Thank you. [LR109]

SENATOR PAHLS: No more questions? Thank you, Jennifer, for your information and

testimony. [LR109]

JENNIFER HERSH: Okay. Thank you very much. [LR109]

DAVID HOLMQUIST: (Exhibit 14) I have copies of my testimony. My name is David Holmquist, a registered lobbyist and director of legislative government relations for the American Cancer Society in Nebraska. Senator Pahls and members of the committee, thank you for the opportunity to offer comments on LR109 and the important issues of high-risk pools and access to care. I appear today to offer this testimony prepared by and on behalf of our national government relations office in Washington, D.C. I'm going to try to pare it down a little bit so I'm not repeating numbers that you've already heard before. The American Cancer Society has set ambitious goals for significantly reducing the rates of cancer incidence and mortality, along with measurably improving the quality of life for all people with cancer. Let me explain the American Cancer Society's interest and commitment to access to care issues. On Monday, the American Cancer Society launched an unprecedented media campaign focused on the issue of access to care. The ad campaign is the culmination of extensive debate and discussion within the society about the direction of healthcare in this country. In 1990, the society adopted goals for 2015 that included 50 percent reduction in age-adjusted cancer mortality rates and a 25 percent reduction in age-adjusted cancer incidence rates. Although we have made significant progress in achieving these goals, the society has come to the conclusion that we will not be able to fully achieve them without broader reform of the healthcare system. Thus, we made the decision to actively join the healthcare reform debate. Earlier this year, the American Cancer Society adopted a statement of principles on what constitutes meaningful health insurance. Meaningful health insurance is adequate, affordable, available, and administratively simple. Adequate health insurance means: timely access and coverage of the complete continuum of evidence-based healthcare services, including prevention and early detection, diagnosis, and treatment; supportive services should be available as appropriate, including access to clinical trials, chronic disease management, and palliative care; and

coverage with sufficient annual and lifetime limits to cover catastrophic expenditures. Available means: coverage will be available regardless of health status or claims history; and that policies are renewable. Affordable health insurance means: costs, including premiums, deductibles, copays, and total out-of-pocket expenditure limits are not excessive and are based on the family's or individual's ability to pay; and premium pricing is not based on health status or claims experience. Administratively simple health insurance means: covered benefits, financial liability, billing procedures, and processes for filing claims, grievances, and appeals are easily understood and timely, and required forms are readily comprehensible; consumers can compare and contrast the different health insurance plans available, and can navigate health insurance transactions and transitions easily. Unfortunately, health insurance often fails to meet these criteria. Treating cancer can be very expensive, and not surprisingly, private health insurance companies seek to minimize enrollment by cancer patients or those at risk of developing cancer. The costs of diagnosis, surgery, chemotherapy, and other drugs and follow-up care can run into the tens of thousands of dollars. Insurers, especially in the individual market, often impose preexisting condition restrictions or riders that restrict benefits for the term of coverage, impose high deductibles and copays, limit benefit coverage, charge high premiums, or simply reject applicants with cancer and those with other chronic conditions. The result is that those who need the most meaningful health insurance often cannot obtain it. One way we monitor how well our health insurance system actually provides health coverage to cancer patients that is affordable, available, adequate, and simple is through our national call center. The National Cancer Information Center provides information about cancer treatment and support services to callers across the U.S. Beginning in 2005, NCIC also began to collect and analyze information about callers with cancer who had health insurance problems. To date, we have analyzed data from more than 12,000 case studies. More than half of those have been collected in the last year alone and they involve people living in 29 states. High-risk pools are often described as the solution to these problems in the private health insurance market. The high-risk pool is portrayed as a vital safety net for cancer patients and people with other serious chronic conditions, a place where

they can have access to adequate and affordable coverage. While the National Cancer Information Center has not yet begun collecting data from Nebraska, we have analyzed case data from 17 other states that operate high-risk pools. Time and again in those states we find that high-risk pool coverage is not sufficiently available, affordable, adequate, or administratively simple. In fact, in 1,689 instances during the last year we talked to cancer patients and survivors who needed individual health insurance and who considered the high-risk pool option in their state. Only 40, or about 2 percent, were able to actually obtain high-risk pool coverage. The rest were discouraged because of eligibility imposed by the state, because premiums were beyond their reach, or because of onerous cost-sharing requirements and preexisting condition exclusions which rendered coverage inadequate and so not worth pursuing. Let's take a brief look at how the Nebraska health insurance pool measures up. Is it available? It does not appear that it is fulfilling the need for which it was intended. This is...I'll let you read this for yourselves. This goes over the number of people who are in the pool, what the decreases have been. You've heard those numbers. Is it affordable? The insurance in the state high-risk pool is already expensive and now may become more expensive. I will make a disclaimer on the next statement. I can't give you answers on this. But according to our national office, last year in a bureaucratic sleight of hand, the state redefined "standard risk rate," the basis for premium rates. The rates had been 135 percent of the standard rate. But by redefining the basis for the rate, they were able to say the rate was still 135 percent of standard rate, but in fact, the rate under the old definition was adjusted to over 150 percent. Why I make a disclaimer, I can't cite any more than that. Now the board is again seeking to raise premiums. We're concerned that further premium increases will virtually eliminate the high-risk pool as a meaningful safety net. Is coverage adequate? Although the benefits are generally reasonable, the high deductibles and copays of the pool plans represent a serious concern. Over 70 percent of plan participants are in plans with a deductible of $2,000 or more and 247 people have a deductible of $10,000. While they often offer lower premiums, for cancer patients the expenses are additive. Any cancer patient will likely have to pay the entire deductible out of pocket. Moreover, there are copays. For example, the NECHIP

prescription drug benefit has a tiered system with copays ranging from $10 for generics to $40 for brand-name nonformulary. They appear to be nominal, but the reality is that cancer patients often take many drugs for extended periods and therefore the cumulative expense of the drug copays could become significant for a cancer patient. The next area is about the preexisting condition exclusion. I will skip over that; that's been discussed. Finally, is the system simple? On this criterion, the high-risk pool rates reasonably well. People who have had cancer in the past four years can automatically qualify for coverage in the pool. More generally the application process and requirements appear reasonable. Health insurance is about protecting people when they get sick. It's about providing necessary medical care and providing it in a way that does not threaten that person's financial well-being. Many people in need of health insurance coverage cannot obtain it in Nebraska's individual market. They're either denied coverage because of a medical condition or quoted premium rates that are unaffordable. The NECHIP insurance pool was established to be an alternative for these people. It should be the safety net for those who cannot get access to the private insurance market. But the available evidence suggests that the pool is failing in its mission and the current proposal to increase premium rates means that it will be a bigger failure. The comprehensive pool cannot and should not be allowed to be a fig leaf. We cannot say that there is an alternative for people in need when in fact that option is unaffordable and therefore unavailable to so many. The proposal before the Legislature says, in effect, that those who are already in need should bear an even greater cost. Yet we know that cancer imposes enormous financial burdens. In the survey of cancer patients sponsored by the Kaiser Family Foundation, USA Today, and the Harvard School of Public Health: 46 percent of respondents said they had used up all or most of their savings; 41 percent said they were unable to pay for basic necessities like food, heat, or housing; 35 percent sought the aid of charity or public assistance; and 45 percent borrowed money from relatives or got another loan or mortgage. If we continue to increase the financial burden on those who are most in need, the result will be a health insurance system in our state where those who are healthy get coverage but those in need because of medical or financial reasons go

without. This is wrong and it must stop. We strongly recommend that you not only reject the proposed premium increases, but that you also begin a serious review of the high-risk pool with the intent of restructuring it and adequately funding it so that it does truly meet the needs of the people of Nebraska who have no other viable insurance coverage. Thank you again for the opportunity. [LR109]

SENATOR PAHLS: Do we have any questions for David? Senator Pirsch. [LR109]

SENATOR PIRSCH: Just briefly, do you have a position on LB118 as introduced? I know that the previous testifier said that he opposed that. Do you also oppose LB118? [LR109]

DAVID HOLMQUIST: I have not personally looked at LB118. I will do so and will do so and will discuss it with our national government relations office and get you an answer, Senator Pirsch. [LR109]

SENATOR PIRSCH: Okay. Thank you. [LR109]

SENATOR PAHLS: Any other questions? Senator. [LR109]

SENATOR CHRISTENSEN: Do you have suggestions how we make it financially strong and yet include more people to it? [LR109]

DAVID HOLMQUIST: Once again, as I stated, I'm appearing on behalf of our national office. I, however, will be in Washington Monday. I will visit with a couple of the people and see if we can...if we have come up with some solutions and I will get you an answer, either with solutions or that no, we don't have those solutions. I suspect that we have come up with some ideas. But I can't guarantee that at this point. [LR109]

SENATOR CHRISTENSEN: Okay, thank you. [LR109]

SENATOR PAHLS: No more questions? Thank you. Appreciate the information. [LR109]

DAVID HOLMQUIST: Thank you. [LR109]

SENATOR PAHLS: Any other testifiers? If not, that concludes this hearing on LR109. Thank you. We are getting ready for LR111. I think we are getting ready to do...Senators. I'm just going to give you a brief analysis of this resolution. The purpose of this resolution is to study issues regarding the provisions of the Burial Pre-Need Sale Act, to determine whether the interests of the preneeds purchasers are adequately safeguarded by the act. I think our first person up will be from the Department of Insurance. [LR109 LR111]

ERIC DUNNING: Thank you. I have to apologize for a late-moment replacement. Director Wagner has been called out to some other things that he needs to attend to at the moment. So bear with me, as regards LR111. My name is Eric Dunning, D-u-n-n-i-n-g. I'm an attorney for the Nebraska Department of Insurance, here to bring to your attention, as the general oversight committee of this department, some of the issues that we see as regulator of preneed burial trusts established under the Burial Pre-Need Sale Act, which is in Chapter 12, unlike most of the statutes that we administer. The department has several responsibilities outside of what might be described as core insurance regulation, including this act. Originally adopted in 1986, the act has not been subject to significant legislative attention since that time. Generally speaking, we think that's a great sign, that the vast majority of preneed sellers are people who are doing the right thing and that are trying to abide by the law as it's written. However, there are some features of the act adopted in '86 which reflect policy decisions made at that time that may or may no longer be valid. And you know, worse comes to worse, every 21 years or so, whether you need it or not, maybe you just need to look at the acts. Legislature made some decisions in '86 that we'd like to bring to your

attention, not as part of proposed legislation--we don't have legislation up our sleeves that we'll be talking to you about in January at this point--but rather as part of an interim study resolution process. First, preneed sellers are entitled under the law to immediately take off the top of a contract 15 percent of the money that comes in and is given to them in trust to pay for funeral services at some point in the future. From the original bill transcript, it looks like this was a deliberate attempt on the part of the Legislature to give sellers an incentive to engage in the business. And the department has taken questions from the purchasers of these products throughout the years over the fairness of this provision to purchasers. And we want to bring this back to your attention and make sure that it continues to reflect the Legislature's intent. Nationally, the department has seen well-publicized instances where preneed sellers, after taking their 15 percent, seek to move the trust over into a new...to a new vehicle, such as insurance, which is the offer common means under which these are structured, merely to generate additional commissions, although we do not believe at this point that this is a significant issue in Nebraska, or to move it from insurance to a trust and then seek to recollect the 15 percent. The department has taken the position that the seller is no prohibited from making these transfers, but it does believe that the regulatory provisions on this subject could be clearer to make sure that we avoid these sorts of abuses. The department has been concerned for a number of years about the use of so-called master trusts by preneed sellers. Most of the smaller preneed sellers deposit individual trusts and individual certificates of deposit to fund funeral services with conservative, steady rates of capital accumulation instead of master trusts, which allow people to pull the money together for investment. We've had a number of inquiries over the years from persons whose money has been placed in master trusts that have pursued more aggressive investment strategies. For example, preneed purchasers have found it disconcerting to take losses in their accounts, as has happened during recent downturns in the equities markets. Funds exceeding the Consumer Price Index under the law can be taken by a preneed seller in years in which the investments make a profit. However, there's no obligation for the preneed seller to compensate the funds...to put money back when there have been losses in the trust. Perhaps if excess funds could not be taken out,

some of the investment, aggressive investment strategies might be mitigated. The department also questions whether retaining the earnings of the trust above the Consumer Price Index is warranted since preneed sellers can retain up to 15 percent of the trust amount up front. For example, recently the department received a complaint from an individual who, in '97, deposited 488 hundred dollars (sic) with a preneed seller to pay for their funeral services at some point in the future. After the preneed seller retained an initial amount of $400 as allowed under the law, $4,400 was placed into a master trust account. But after 10 years, the trust was recently valued at $4,700, $100 less than deposited 10 years ago, which obviously troubled that individual greatly. While the department was able to investigate the matter and help to the extent it could, a majority of the issues raised by the complainant appeared to stem from the lack of understanding of how that contract they had entered into was actually structured and how interest on that account would have been credited. We have received complaints that we believe could be best avoided if the purchaser were allowed to have a little more control over how his or her funds were invested as part of this trust arrangement. Among other miscellaneous changes that we think that you may wish consider would be to change the date of the annual reporting filing to March 1 instead of June 1 and add an automatic penalty provision for a failure to file reports to comply. We have similar authority over other licensees. We find that it works well to make sure that it keeps people on the ball and their compliance. Additionally, by the time that we receive the financial information from the previous year, the information is about six months old, which may be too late to address any potential problems before those get out of hand. Last, one other change that you may want to consider involves adoption of a statute like the one that's recently come to our attention from Ohio. Much of the preneed sales business has moved from a trust model, as we have under Nebraska law, to a system financed by insurance. While this change has been for the most part smooth, there are some holes that could be filled. Ohio's statute governs the taking of policy loans and preneed burial policy. It prohibits a provider of funeral goods from pledging, transferring, or otherwise assigning an insurance policy that was issued for the purpose of buying a funeral before the goods and services provided. Although there are other more narrow

issues created by the language of the act, these remain of concern as our examines go through and administer the act. We'd be happy to answer questions and we thank you for your time in bringing together...bringing to your attention a situation where the house is not on fire. So thank you very much. [LR111]

SENATOR PAHLS: Any questions? [LR111]

SENATOR CHRISTENSEN: Can you explain to me how one of these works? I just took a complaint from a constituent here. About two or three weeks ago they complained that this wasn't covered and that wasn't covered. I've never seen one. Is it laid out that they're prepaying the casket and the service and the help and this? Or how is this done? [LR111]

ERIC DUNNING: Senator, the department's primary role in this process is as a financial services regulator and making sure that the money is there to pay for the services that people have promised to render. As far as how the contracts are structured, I can't speak to that in any real depth. [LR111]

SENATOR CHRISTENSEN: Okay. [LR111]

SENATOR PANKONIN: I can. [LR111]

SENATOR PAHLS: Speaking of depth? [LR111]

SENATOR PANKONIN: Well, just to answer Senator Christensen's question, I was involved with these once for a person that I was kind of in a trust relationship for and she wanted, before her money ran out, wanted to get one of these things because, you know, it's protected. But you do make selections about how...what type of service you want and how extensive it is. I mean, there's a whole menu of things that she chose from. And it can be like any funeral. It can be pretty extensive or pretty basic. And we

made those choices. So some of that is...if people think they're getting...I mean, in this situation you made choices ahead of time. [LR111]

SENATOR CHRISTENSEN: Okay. Thanks. [LR111]

SENATOR PAHLS: Any other questions? Thank you for the information. [LR111]

ERIC DUNNING: Thank you, sir. [LR111]

SENATOR PAHLS: Just a show of hands, how many testifiers will we have? One, two. Okay. The floor is yours. [LR111]

BILL LAUBER: (Exhibit 1) Good afternoon, Senator, members of the committee. My name is Bill Lauber, L-a-u-b-e-r, legislative chairman for the Nebraska Funeral Directors Association, served as president of the association about four or five years ago and also served on the policy board of the National Funeral Directors Association, and currently on the examining board for the state of Nebraska Funeral Directors and Embalmers. Before I talk about the act itself, I want to just briefly give you a quick background on preplanning of funerals so that you kind of have an idea and then we'll talk about the act itself. Preplanning or prefunding of a funeral is certainly not new. It's been around now for 30, 40 years. It really caught on, I would say, in the 70s and 80s, especially when it comes to prefunding. Prefunding is unique in a way in the business world because, to give an example, if you went down to your new car dealership and you talked to your friend and you said, I want to give you $10,000 today and I want to buy a blue Cadillac and I want it in the 2012 model and I'll be back in 2012 to pick it up. Of course, the gentleman is going to laugh you right out of the office. He's going to say, you're out of your mind, we don't do those kinds of things. So it is rather unique. And over the years we've...the families actually came to us wanting those services years ago. And funeral directors have kind of enhanced their services and products to meet those families' needs when it comes to advance funeral planning. When we talk about prearranging,

that doesn't necessarily mean families have to prefund. In fact, I would say of my approximate 200 prearranged contracts that I have at my funeral homes, only about half, or about 50 percent of those, are prefunded. So we consult with each family and we discuss it. And not every family is a candidate for prefunding. So when we talk about prefunding, what are the advantages for a consumer to prefund a funeral in advance of need? Obviously there are several, but I'll just mention a few. One is, obviously they get their personal wishes met and it's paid for in advance. So they're paying for today's funeral at today's dollar. They're basically hedging against inflation. Another thing that is very important today, especially in my area that I serve...80 percent of the funeral homes, by the way, serve rural communities, say, under 50,000 people. So a majority of the funeral homes are not in metropolitan areas in our state. And the majority of my prefunding contracts are people who come in and they have mother or father in a nursing home. And mom or dad's resources are becoming depleted at a rapid rate. And when that happens, the social service worker, when it comes to applying for Medicaid, will say go say your local funeral director and prefund this money ahead of time so that when you do come back and we do an asset determination, this resource is excluded. So it is really important in regards to that. As far as advantages to the funeral provider, first of all, sometimes you are basically guaranteeing future business when you talk about prefunding and preneeding, especially in competitive markets in metropolitan areas. That's really crucial. Number two is that you are also meeting with families when emotions aren't as high. So it's a benefit to both of us when we're doing these kinds of things that you're meeting with people and the emotions are not as high as they are in an at-need situation. And finally, the proven peace of mind that comes from prefunding and preplanning, we hear this all the time. Children will come in and say, you know, I'm sure glad Mom or Dad purchased that market out at the cemetery, I don't know what they would have wanted if we had to have done it. When it comes to prearranging and prefunding funerals they'll say, boy, I'm glad that obituary was taken care of ahead of time, I didn't know Mom was born on the farm, I thought she was born in town, and those kinds of things. So it's a great lesson of the burden on them. Now as far as prefunding is concerned, now we get into how do people prefund their funerals. And I

wish, you know, sometimes that when people come in and they prefund their funeral, that the money goes right directly into our business checking account. We can't do that by law. It goes into basically two vehicles in funding. One is insurance, that Eric mentioned, and bank trusts. And that's pretty much nationwide, those two vehicles are used. Trusts are under the Burial Pre-Need Sales Act and we report all the interest and principal it accrues in these accounts. And we try to work with the Department of Insurance as best we can. I think we have done a real good job of working with the reporting of such trusts. He did mention separate trust accounts and master trust accounts. And most, I would say 80 percent of the funeral homes in the state of Nebraska do separate trust accounts in which 100 percent of the money of that family is put into an individual CD and that principal and interest grows and accumulates. And when the death occurs, we take out that interest and principal and use that to fund the funeral. The master trust accounts are generally used for...utilized by larger metropolitan firms where they have an aggressive preneed force and they do take advantage of that 15 percent clause in the Burial Pre-Need Sales Act. The 15 percent, I think when we look at this we have to understand that people are buying a funeral. They're not...when they come in and talk to the funeral director, they're not looking at it as an investment vehicle. So as long as the funeral home guarantees that the services and merchandise are provided when that time comes and the death occurs, no matter whether or not that account kept up with inflation or not, we have to keep that in mind that it's a different kind of concept when it comes to prefunding. I have no problem with that 85-15 law. We're in a 85-15 state and I would say probably there are 20-some states in the United States that do have a 15 percent in there. I know in my personal history, I only use the 15 percent clause when it comes to the trust, when it comes to cancellations. If I administer a particular prefunded account with a trust for seven years and then suddenly someone comes and says, we're going to move Mom to New Mexico because that's where she grew up and we're going to take the trust, if you don't mind, and take it to New Mexico. Well, I will take probably an administrative fee out of that. I won't sometimes use totally 15 percent that's allowed by law, but I might take, depending on how long I have administered that trust. Insurance is another vehicle we

use. That is insurance specifically designed for funeral planning alone, usually has a increasing death benefit to it. Unlike other insurance policies that may have a level death benefit, these have increasing death benefit riders attached so that it will offset any inflationary costs that we have. So the amount of the insurance policy is basically the amount of the funeral that the family decides upon. Let's see, I think most of the problems that we do see in our discussions with the DOI do involve cancellations and portabilities. You know, if someone does move a funeral that has been prearranged with me and they go to another funeral home, my prices at my funeral home may be higher or lower than that funeral home that they transferred to. So...and then also I think that we are continuing to work on, with my colleagues in my profession, is the fact that disclosures, when it comes to prearranging of the funeral, is crucial. They should be...you know, FAQs, frequently asked questions, the purchaser must have the opportunity to explore everything in that contract. And contracts when it comes to prearrangements are so important. Everything should be in writing. They should be...everything should be understood. And so...and when I was on the policy board on the national level, we made up a bill of rights. And if I could hand this out to the committee. And to end, it kind of just says that: we need to provide them a detailed price list; we need to, at the conclusion of the arrangement conference, should have a written statement listing all the goods and services you have purchased and the price; give you a written preneed funeral contract explaining, in plain language, your rights and obligations; guarantee in the contract that if any of the goods and services you ahve selected are not available at the time of need, the goods and services of equal and greater value will be substituted at no extra cost; explain in the contract the geographical boundaries of the funeral home service area and under what circumstances you can transfer the preneed contract to another funeral home if you were to relocate or if the death were to occur outside the area; state in the contract where and how much of the funds you pay will be deposited until the funeral is provided; explain in the contract who will be responsible for paying taxes on any income or interest; and inform you in the contract whether, to what extent the funeral will guarantee the price of goods and services you're purchasing, and if the prices are not

guaranteed, the contract will explain who is responsible for any additional amounts; and then finally, explain the contract whether and under what circumstances you may cancel your contract and how much of the funds you paid will be refunded. So it's really...disclosure is really crucial when it comes to preplanning. And in conclusion, I would just like to say that I have, over my years, met some wonderful people in funeral service. I really have. And I think if there is anything leaking in the roof we call the Burial Act, I know that a lot of my colleagues want to repair those leaks. And so I agree with Eric that now is the time to discuss the act, and if there is anything that we feel that we need to tighten the loopholes on so that we could try to eliminate or put pressure on the bad actors out there. We work so hard to build our reputations because reputations is a big thing in our line of work. And we don't want some event, some bad event to occur in our state. And I know you don't either, because it will just...it's a public relations issue for sure. And so we would want to make sure that we try to police that. Thank you. Any questions? [LR111]

SENATOR PAHLS: Yes, Senator Pankonin. [LR111]

SENATOR PANKONIN: Thank you, Senator Pahls. Appreciate your testimony and also in your concluding remarks about if we can head off any problems. We hopefully haven't had any serious ones and if we can head them off, I appreciate the industry's position on that. As I was trying to talk to my colleague, Senator Christensen, you know, you explained how it works somewhat, but just how...was I right in saying people have a menu of things to choose from when they do the prearrangement? It is right? [LR111]

BILL LAUBER: Yeah, certainly. Yeah, and again, you don't have to necessarily prefund. Some people will get a funeral cost estimate from us which will explain what they selected. And you have basically in a contract services of the funeral home, merchandise if any they select, and any miscellaneous items like obituary charges in the newspaper, grave opening costs, things like that. [LR111]

SENATOR PANKONIN: Now how do you, you know, if you pick out a potential range of costs for a casket...I mean, obviously you don't pick out a specific... [LR111]

BILL LAUBER: Oh, certainly. Yeah, you know... [LR111]

SENATOR PANKONIN: ...but there's a range of costs... [LR111]

BILL LAUBER: Right. We give the families a casket price list. And in my particular showroom, you have caskets that range in price from $595 up to $5,995. And so you have a broad range. But most people will choose in the medium price range, just like a lot of other things. Usually you won't have the high-priced ones sold and you won't have the real low ones, it's usually the ones in the middle that most people select. [LR111]

SENATOR PANKONIN: Thank you. [LR111]

SENATOR PAHLS: Any more questions for Bill? Thank you. Appreciate your testimony. [LR111]

GREG EASLEY: Senator, Senators, my name is Greg Easley, that's E-a-s-l-e-y. I'm the president of the Nebraska Cemetery Association. I'm also past president of the International Cemetery and Funeral Association, which represents cemeteries and funeral homes and crematories across the United States. I'm also in charge of the...chairman of the Nebraska Cemetery Consumer Council for complaints, if there would be any complaints concerning the cemeteries in Nebraska. Therefore I work with the...my name is on there with the Attorney General's Office. If there would be anything coming up, I would be advised and brought into the questions between the complaint of another cemetery and one of their customers. I become a third party to try to resolve the issue. Also with the Department of Insurance, they call me on any questions that might be, in case something pops up that I can help resolve that, I do that. And also all the channel news departments that are 7 Can Help or six can help or whatever the number

are, I get calls on that. We've been doing that since 1975 in the state of Nebraska. We were one of the first to join that national organization to help stem off problems that people might have so it didn't get to be a problem in your lap and become a legislative problem. In 1983, I was in the committee that put this act together, the cemeteries and the funeral directors and the people writing up at that time the statute. And we hammered this out. I'm very proud of this. We've, you know, we're at 85 percent, 15 percent. A lot of states are even lower than that, where they'd be 80 percent and the cemeteries or funeral homes keep 20 percent, even 75-25. Kansas is cost plus 10 or 15 percent for a long time. And we didn't want to go with that. We wanted to make sure that there was enough in there so that no matter where the fund went, it would still be a substantial amount to cover the costs of the materials. And to this date, I have not known any cemetery or funeral home that could not deliver...that had something in a preneed trust and could not deliver that to the family that was promised. And if...that's why I'm very proud of this legislation. It was put together in 1986. Took us three years to hammer it out. One of the things I notice in the policy where they talk about, and I'm all for this, if somebody...they want to move the filing date from like June 1 to April 1. One of the reasons why it was stated that way was because the banks doing a master trust of some of these cemeteries and funeral homes that have that, there's cemetery-funeral combinations, it's a very difficult program to get all that information out and spit out and put together. So that's why they asked for the six months. I mean, it could go up to May 1 possibly, but even before that they might have a tough time getting the information out so the cemetery and funeral home could then put it together and then mail it back to the department. So I wouldn't want to get that too close because it would just become...might be impossible to deliver on that date. But I think it could probably be moved up 30 days. The department has been doing an excellent job of overseeing everything. I'm just amazed at how they do their job and I commend the Insurance Department for what they've done over the years. When it talks about the people, and I've even have that said a couple times to me: well, wait a minute, you know, the policy went down, especially during 2001 and 2002, market took a dip. But whether that when down...like I said, it went down. This one person mentioned in here, it only went ahead

$400. Well, they could drop a third and they could still cover their costs and be all right. We've never had that situation like that. But there's never been anybody that hasn't been able to deliver. So the formula there is still a good formula and sometimes people don't understand it and they call us up and we say it doesn't make any difference if it went down, if it didn't make any interested. It doesn't make a difference whether you lost $500 or $600, you will get what you contracted with, and nobody has not delivered on that. So that's been good for 27 years, very good. Very proud of that, too. Moving from the trust to the insurance, back when we put this up, insurance was kind of starting back then. It was about, but most places had the trust. A lot of people are moving, would like to move their trust to insurance. And somebody says, well, you know they're redipping into their 15 percent. You know, as long as the family has been told, you know, we're going to be moving this to this type of vehicle and that we're going to be guaranteeing what you purchased, that's the important part. Second important part of when you go to insurance because the trust vehicle, they have to pay the income tax on the amount of growth every year, which upsets them. Insurance, that doesn't happen. That's not sent out to the public. So that's why I think a lot of the funeral homes are moving to that vehicle so that that isn't reported, sent out to them, having to pay this income tax on the growth of the fund. And so whether they make money on it or not, as long as that's been guaranteed, that's the important part of the whole scenario. Let's guarantee the costs, make sure that that family has been protected. And that's one thing we worked so diligently--the funeral homes, the cemeteries, and the crematories back in 1983, 1984, and 1985--was to make sure that consumer has been protected in the state of Nebraska. And I tell you what, they really are, and it's a great piece of legislation that's been put in there. Some of the complaints are really complaints of misunderstanding. And then once they find out, they say, well, you know, it's gone down but I'm protected, I'm fine with that. And once they find out what's an insurance policy and totally protected for the total amount they've been signed up for, they're okay with that. Some of the people that...like I said, I think I already mentioned, if they happen to be late with their funds, I'm all for the Insurance Department charging a fee, a late fee for not being on time. I think that's only right to do, especially if you've given us four months to get the

master trust put together. I use the master trust because that's a worst-case scenario, trying to get all that information put together on every individual person and then you put it in a master one and you get all this money put together and what was there last year and what was there this year. And that gives them about another 30 days, even if you moved it to May 1, to just fill in and go over it with the bank and then send it into the department. I think that would be more than enough time, and the penalty applied also. I also believe, just like in Ohio, I agree with the department, where if they are using insurance policies and borrow against them, that that should not be done in the state of Nebraska. I agree with that. I mean, I don't understand all his discussion here where they have...where they can't use it for...I don't know. I want make sure it just says if they move it from a trust to an insurance policy, the insurance policy itself can't be used to borrow against. They shouldn't be borrowing against the trust either, and they don't. We don't want that to happen, just because it might be legal to borrow against an insurance policy. That should not be allowed in the state of Nebraska. I agree with that 100 percent. Well, with all that, I'm pretty much in favor of working with the Insurance Department because they are a great group of people to work with over the last many...27 years I've had to work with them. And as long as we're kept in the loop in this, I would like what they are having to say. And Bill gave you an excellent scenario of everything concerning how preneed works and the policies. And the Nebraska funeral homes have done an excellent job in providing to their families and the families getting what they've asked for. And again, the problems they've had is probably mostly been in the realm of misunderstanding of what they might have gotten. But when they go over the contract with them, they understand it generally. But the funeral directors of Nebraska should be proud of what they provided and the Legislature has done a very good job with what they've done in '86 and the Insurance Department is doing a great job following up. So with that, I'd take any questions. [LR111]

SENATOR PAHLS: Do I see...Senator. [LR111]

SENATOR PIRSCH: Is there any requirements in existing law that on these burial

preneed contracts that there be some sort of written disclosure or something insofar as not...may not be an appropriate vehicle for a investment type of undertaking? In other words, is part of the... [LR111]

GREG EASLEY: They disclose where their investment is, like they have to go through a Nebraska institution. [LR111]

SENATOR PIRSCH: Okay. [LR111]

GREG EASLEY: Some places use out-of-state investors but they have to be a Nebraska institution and it has to be FDIC insured. And so it has all that protection. [LR111]

SENATOR PIRSCH: Okay. And does it say...is there a disclosure requirement that it indicates somewhere in the contracts that there's 15 percent? [LR111]

GREG EASLEY: Yes. [LR111]

SENATOR PIRSCH: Okay. So that's part of existing law? [LR111]

GREG EASLEY: Yes. It has to be disclosed. The 15 percent, 85 percent put in trust in a Nebraska institution and that it is...the services, the products and the services are guaranteed. [LR111]

SENATOR PIRSCH: Yeah. And it's not being, to your knowledge and your experience, is it ever used and marketed as some sort of an investment vehicle as opposed to a... [LR111]

GREG EASLEY: No. [LR111]

SENATOR PIRSCH: Just been marketed as a burial preneed and for... [LR111]

GREG EASLEY: Well, like Bill said, it's not a savings and loan, and it's not foreign investment of that type. If you want to call it investment in security in knowledge as you don't have to take care of this at a later date, and a lot of people are very grateful that they take care of it in the times when they have the economic wherewithal to do it, but later on they don't. [LR111]

SENATOR PIRSCH: Yeah. [LR111]

GREG EASLEY: But it's never said, hey, this is an investment tool. [LR111]

SENATOR PIRSCH: Yeah. Somebody had testified earlier that there was a complaint that someone had, was that they were upset that when they looked and checked in the account that after the 15 percent was taken off that they were actually $100 lower than, you know, after a few years and put in. But that's never marketed, to your knowledge? I mean it's kind of an odd... [LR111]

GREG EASLEY: Well, I tell you...yeah, not to be an investment tool. It might be an investment tool for the funeral home or the cemetery. Boy, after that 2000 where it took a dip, there were a lot of concerned people, we got a lot of telephone calls. But when we reassured them, as it says in the contract, that we would provide those services no matter what money is available there for us. Because it might be, you know, you still have the service of the funeral home, the funeral director and that sort of thing. Well, the only thing you really have to go buy is a casket and vault and the other things are the costs of running the...so they could take a hit and still provide everything for them. Now the funeral home may take a hit, not getting what they hope to get at that... [LR111]

SENATOR PIRSCH: Yeah, everything is prechosen, the quality of the casket and the service... [LR111]

GREG EASLEY: Has to be by FTI, FCI...FTC requires them to specify everything on that contract. In a full disclosure, prices have to be given out to everybody, too. So it's very well-regulated long before we this '86 law and it was regulated there. This only regulated the funds. [LR111]

SENATOR PIRSCH: Okay. [LR111]

SENATOR PAHLS: Senator Hansen. [LR111]

SENATOR HANSEN: Thank you, Senator Pahls. You mentioned the difference between a trust and buying the insurance. And the trend is going to buying the insurance rather than the trust because every year the trust...the income off the trust needs to be submitted as income. Where does the income tax come in if you do have it insurance? Because usually insurance proceeds are tax free. So when does a funeral home pay the income tax? [LR111]

GREG EASLEY: Well, like when the interest goes up in those particular accounts. [LR111]

SENATOR HANSEN: But in the insurance mode where you buy, where the family buys insurance. Where's...I mean, the money goes back to the funeral home at some time. [LR111]

GREG EASLEY: Time of delivery, of death. [LR111]

SENATOR HANSEN: Okay. Is that when they pay the insurance...the income tax? [LR111]

GREG EASLEY: Yes. That's when...yeah, but they can't touch it until there's a death

certificate. [LR111]

SENATOR HANSEN: Even though it's proceeds from insurance policy? [LR111]

GREG EASLEY: Um-hum. I believe that's the way it works. But I know they can't get the money until there's a death. So they can't get it out. Under this law, they take out the interest every year and put in the cost of living back in. And if there's a 5 percent earning, then the family has to pay 5 percent on that growth. I mean, they have to pay taxes on that 5 percent. And that, a lot of funeral homes just don't want to deal with that, saying, what a minute, what the hell am I paying this money for, you're going to get it all when I die. And so a lot of them are just saying, well, let's just go to insurance and we'll stop a lot of that. But that's why. [LR111]

SENATOR PAHLS: Anything else? Thank you. Appreciate it. [LR111]

GREG EASLEY: Thank you for your time. Appreciate it. [LR111]

SENATOR PAHLS: Any other testifiers, by chance? Looks like we are closing the hearing on LR111. Thank you. [LR111]