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COMMITTEE ON BANKING, COMMERCE AND INSURANCE
February 8, 2005
LB 389, 545, 589, 652

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 8, 2005, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB 389, LB 545, LB 589, and LB 652. Senators present: Mick Mines, Chairperson; Pam Redfield, Vice Chairperson; Jim Jensen; Joel Johnson; Chris Langemeier; LeRoy Louden; and Rich Pahls. Senators absent: Mike Flood.

SENATOR MINES: Ladies and gentlemen, good afternoon. I'd like to welcome you to the Banking, Commerce and Insurance Committee. My name is Mick Mines. I represent the 18th Legislative District and I'm glad that you are here. I'm the chairman of this committee. First and foremost, please turn off your cell phones because Rich and Bob, in the red coats, will be over and have their way with you if you don't turn them off. Let me today introduce, first of all, members of the committee that are with us. On your left, Rich Pahls from Omaha, Senator Rich Pahls, excuse me; Senator Jim Jensen from Omaha, and Senator Pam Redfield, Vice Chair of the committee from Ralston. On your right, Senator Chris Langemeier from Schuyler. Senator Flood is excused today and Senator Louden is introducing a bill in another committee. You may find that our committee members might come and go. It means no disrespect to you, but we are introducing bills this time of the year. The committee will take up the bills as listed in order and this is your part of the process so please feel free to engage. Please feel free to come up and offer your ideas and opinions. I might caution you today. We expect this to be quite a long session so we would sincerely appreciate you being brief in your presentations. Please pay attention to testifiers in front of you, try not to be repetitious. But if you're bringing new information, please be concise and if you have testimony, written testimony, offer that to our page, Jeff Armour. I forgot to introduce Jeff. Also, when you testify please fill out one of our sheets. They're located either on the desk in front of me or at the door. Our process is the senator will introduce the bill and then we will take testimony of those supporting this bill, those opposing the bill, and those in a neutral position. Senator then closes if he or she so wishes. And one of the most important things to do here is spell your name, both first and last so

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that not only Jan, but everyone else understands who you are. So with all of that, I will go to the sheet and we will open public hearing on LB 389 and I'll turn the chair over to Vice Chair Redfield.

SENATOR REDFIELD: Thank you. We've been joined by Senator LeRoy Louden from the beautiful western end of the state. Senator Mines will open the hearing on LB 389.

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SENATOR MINES: Senator Redfield, members of the Banking, Commerce and Insurance Committee, my name is Mick Mines, M-i-n-e-s. I represent the 18th Legislative District. I am here today as principal introducer of LB 389, the Health Care Prompt Pay Act. I will be brief. There will be many behind me on either side of the issue, I assume. But I'm bringing this bill on behalf of the Nebraska Medical Association. LB 389 requires that health insurers pay claims submitted by health care providers on a timely basis. Nebraska's hospitals, physicians, dentists, and other health care providers have experienced problems when some health insurers have failed to process and pay claims within a reasonable time after they've been submitted. This practice obviously adversely affects the provider's cash flow and overall business operations. Because of similar problems, other states have enacted prompt pay laws and Nebraska is one of the few states without such legislation. I thank you for consideration and would ask that questions be directed to those behind me.

SENATOR REDFIELD: All right, thank you, Senator Mines.

SENATOR MINES: Thank you.

SENATOR REDFIELD: Other proponents of the bill? Please state your name and spell it for the recording secretary.

DAVID FILIPI: Thank you. I'm Dr. David Filipi, F-i-l-i-p-i. I'm a family physician from Omaha and I chair the Insurance Committee of the Nebraska Medical Association. We ask for this bill to be introduced. Forty-six states...only Nebraska and a few others have not had similar bills introduced. Initially, I wanted to work with the

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insurance companies to see if we couldn't resolve this internally. And we had a tremendously good response from the domestic insurers within Nebraska, the Blue Crosses, the Mutual of Omahas, but poor response from insurance companies that really are domesticated outside of Nebraska because we're a very small part of their business and because we just don't consider or they don't consider ourselves very important to them. We worked very diligently with this issue. We also had some problems with something called a rental network which is a conduit between the physician's office and major players like Aetna or Cigna, that type of thing on a national basis. They are the people that process the claims that go to Aetna and Cigna, and the Department of Insurance currently does not have oversight on that particular issue. We like the bill and I think it's really tailored very nicely for Nebraska in several ways. First of all, it includes the protective umbrella for the physicians to include not only the insurance companies, but the networks which process claims for insurance companies. That's extremely important. Secondly, there's a fairly substantial punitive interest rate charged by the insurance company back to the physician if they violate those sorts of rules. And thirdly, what I like is that there's not a direct impact upon those people that are good payers, that the people who had a good track record, they are not burdened with unnecessary regulation. It's our goal to keep insurance as inexpensive as possible in Nebraska and unnecessary regulation would tend to increase the cost of that insurance. The question may be asked by some of you is, why don't we just not contract with these companies if they have not paid us? Well, there's some problems with that. First of all, we want to maintain insurance competition within Nebraska and if we were to drop some of these insurance companies, only one or two options of insurance companies for small towns in Nebraska may be available. So we want to enhance competition and by doing that we do want to contract with all the folks we can to encourage businesses to get insurance in Nebraska. And, secondly, the patient really gets left out of the loop in this situation because if we don't contract with a given carrier and that patient of ours is employed by a company who uses that carrier, that patient may have to go some distance away from their small community in order to receive care. So we don't want to leave patients in lurches. We want to provide good service and we want to promote

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insurance for the state of Nebraska. Thank you. Questions?

SENATOR REDFIELD: Thank you, Doctor. Are there questions? I don't see any. We want to thank you for your service this morning.

DAVID FILIPI: Thank you.

SENATOR REDFIELD: (Exhibit 1) Other proponents? While you're coming I want to read into the record a letter in support of LB 389 by the Nebraska Pharmacists Association, Inc.

KEITH SHUEY: (Exhibit 2) I'm Dr. Keith Shuey, Tecumseh, Nebraska, and I'm testifying in favor of the passage of this bill. I represent the NMA...I'm sorry, I didn't spell my last name, S-h-u-e-y. I'm representing the NMA, myself, and the Southeast Nebraska Rural Physicians Alliance who represents about 75 primary care physicians in the southeast quarter of the state. This is my third appearance before this committee on this bill, and it's been reworked and reworked a number of times. While it's not perfect, it certainly makes the insurance industry accountable for service rendered in a timely manner. I'm an independent business operator and a citizen of my town, and my state, and my country, and I have to pay my obligations in a timely manner and that includes paying my staff, my payroll, my suppliers, and even my state and federal taxes. You all know what happens when these payments are late. To keep cash flow going, my wife, who is my office manager, and I spend until about 9, 10 o'clock in the office at night going through these past due accounts. We go over these. The next morning I hand these to one of my staff members and after she has time to get her voice sharpened up, she starts calling insurance companies for these claims. And these claims may run from anywhere from 60 days to two years old. This goes on day after day and ties up a member of my staff for hours each day. She could probably write a book on some of the stories she's been given as to why claims aren't paid, everything but the dog ate my homework. Now, you may think my office is somewhat outdated and whatnot but I have the most sophisticated computer system to submit data. It's upgraded every three years. My software is upgraded. We've had company representatives come to my office to look at the processes and they've never found any big problems. And you

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wonder if I'm some sort of an outlier from other offices. And I did a quick survey of some other compatible offices. A small office like mine from Hastings told me they had (\$)75,000 out 45 days and older. One in Hebron (\$)70,000; one in Columbus (\$)50,000 and I probably have (\$)75 to \$100,000 out over 45 days. These are small offices, probably about ten doctors totally. You multiply this by 2,000 plus doctors in Nebraska and take a look at the figure. Go one step further and what would your Revenue Committee do with the tax money that would be paid in if some tooth fairy came along and paid all those accounts up? Specific examples, we had a local major employer that contracted with an insurance company in October of 2004 and as of this date, even though they have collected the money out of the paychecks, cards have not been issued to these people and so I cannot file insurance claims for these people because they have no numbers and no cards. So I'm basically carrying these accounts. We had another company who decided that any claim must be filed...claims have to be filed in 90 days or no good at all. Now we file electronically so every day so they can't be "lost in the mail." And after my staff member fights through the automated phone answering system, outsource to Lord knows where, we finally must refile again because the claims "got lost" so the process just drags on and on. Now someone from the industry may say that we can check the status of the claims on the Internet which is very true except that the Internet does not tell you why the claim is being held. It says it's there, but it does not say what is wrong with the claim. This must come from a real live person who can track this down and finding a real live person to talk to is getting harder and harder, by the way. You look at this from a humanistic standpoint. A good friend of mine I recently diagnosed with cancer and he's going to have to undergo a rigorous chemotherapy program. His one-day session which will go on about every two to four weeks will easily add up to about \$7,500 to \$10,000 in drugs for each session. Now, should I be forced to tell him that he must get his treatment in Lincoln or Omaha as they can better "absorb that expense" than my small office can? I can maybe carry one or two like this for a few months, but right now I have five people on this program so you can see how my numbers start to add up. If this were your wife, or your family member, or you, would you want me to tell you that the doctor who has cared for you for 38 years cannot afford

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to care for you? And you have to go someplace else because I cannot afford and carry the debt this long. This whole thing I think is an abuse of power. I think it should not go on. This bill has been worked and it spells out as to proper monitoring, proper enforcement, prompt enforcement, and punitive damage for violation. Because without this, the only recourse that I have is basically jaw boning and phone harassment to get prompt payment for services rendered. And I think that you and the citizens of the state of Nebraska want better. Thank you very much. If there are any questions I'd be happy to answer them.

SENATOR REDFIELD: Thank you, Doctor. Are there questions? I do have one. In your testimony you talked about an employer whose health carrier had not issued cards. How would the bill deal with that situation? I don't see that there's a remedy here since you can't file a claim on those yet.

KEITH SHUEY: There probably isn't. I think it just points up the problem with the industry in general. I mean, the cards have not been issued and we've talked to the company and we've talked to the...we talked to the insurance company and the employer and they each blame each other. And so consequently, the individuals basically have no health insurance, but the money for the premium is being taken out of their paycheck.

SENATOR REDFIELD: So the bill is limited to...

KEITH SHUEY: Right.

SENATOR REDFIELD: ...a claim that's been filed and the deadlines there.

KEITH SHUEY: Right, right.

SENATOR REDFIELD: Not seeing any other questions, thank you very much for your testimony.

KEITH SHUEY: Thank you.

SENATOR REDFIELD: Other proponents?

ROGER KEETLE: (Exhibit 3) Good afternoon. For the record,

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my name is Roger, R-o-g-e-r Keetle, K-e-e-t-l-e. I'm a registered lobbyist for the Nebraska Hospital Association and on behalf of our 85 members, the Nebraska Hospital Association supports LB 389 and urges the committee to support this bill. Nebraska is finally catching up, we hope, with the rest of the country in getting a prompt paid bill in law. Again, the hospitals and the providers basically accept the insurance card and provide the service, and then try and get paid later. That doesn't give us a lot of leverage as we provide the service first and then depend on the process to eventually pay our claim. One of the things that I think needs to be emphasized here is we now have what's called HIPAA, health insurance portability act (Health Insurance Portability and Accountability Act) of 1997 which means a lot of paperwork on keeping records confidential. But it did have a good point. And that was the ability to file claims electronically. And you'll see in this bill, LB 389, that it has provisions for filing electronically. And, again, we've appreciated working with the domestic insurance companies in the state, Blue Cross/Blue Shield and Mutual of Omaha have been a leader in this country to allow hospitals and physicians to file electronically. That's an excellent system, a model I think for the country and something that we highly would recommend that a lot of our outstate companies that, give us the most trouble here and where we have the least leverage, refuse to use the electronic system. So with that, I've enjoyed working with the domestic insurance agent industry in coming up with this bill over the last few years. It's something that needs to be done to get Nebraska into the swing of things. I would also say that I've been handed amendments today by Mr. Bill Peters and representatives of the Golden Rule Insurance Company. I have not had a chance to look at these amendments or put them in context. I am concerned about some of the language that's here and I certainly need more clarification before I would be able to give you any opinion on whether they're valid. I cringe at some things saying...one of the provisions is is, says something about lack of documentation and prevents timely...let's see, let's go through this. Any defect including lack of documentation and particular circumstances requiring particular treatment. I understand what that...prevents timely payment for being made and then it goes on to say the time period for the interest does not...is told, in other words, the interest doesn't start to accumulate until all of the requested

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information is received. Now normally what it says is information sufficient for the adjudication of the claim. We run into situations all the time where the insurance company asks for the kitchen sink and the refrigerator. And I'm very concerned about what that means in the proposed amendment. I'd like to find out more about what they're talking about on that particular suggestion that will be presented to you and, in general, you know, all of the insurance companies, including Golden Rule, are subject to HIPAA which says they have to take the HIPAA forms. They have to adjudicate on those forms so I want to learn more about the amendments before I am in a position to issue an opinion.

SENATOR REDFIELD: Thank you, Mr. Keetle, for clarification. Your objection to language is the amendment language...

ROGER KEETLE: An amendment that you will be seeing.

SENATOR REDFIELD: ...not the bill.

ROGER KEETLE: That's correct.

SENATOR REDFIELD: You've been through the wars on this bill and tell us why this version that we see this year is better than what we've seen before.

ROGER KEETLE: Well, I think the one thing that is important, as I mentioned, is Blue Cross has had an excellent system for years and has done...and what this does is it allows them to file a certification that they've been good actors, that gets them out of a computer programming problem they would have if that section wasn't in there and we don't want to see their costs increase. We believe the other thing that's important is we've worked with the insurance department to figure out how this all fits into the unfair trade act (Unfair Insurance Trade Practices Act). And I think that was another key point that has been sort of up in the air up until this year so, again, we would urge you to support the bill as drafted and go from there.

SENATOR REDFIELD: Are there questions for Roger? I don't see any. Thank you.

ROGER KEETLE: Thank you.

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SENATOR REDFIELD: Other proponents.

MICHAEL KASHER: (Exhibit 4) I do have testimony.

SENATOR REDFIELD: In lieu of the page we have a volunteer (laughter).

MICHAEL KASHER: Thank you for your time today, Senators. I appreciate the opportunity to offer testimony. I, too, was here a couple of years ago and presented some facts and figures. Dr. Filipi did a fine job, I think, of covering some of the history. My first paragraph on my written comments covers some of the history that we've been through and I won't cover that. I'll just kind of jump into catching you up on what I have seen in the past two years since last I was here. Two years ago, I...

SENATOR REDFIELD: Mr. Kasher,...

MICHAEL KASHER: Yes.

SENATOR REDFIELD: ...I'm sorry to interrupt you. Did you spell your name, please?...

MICHAEL KASHER: I'm sorry, I didn't tell you who I was. Kasher. It's K-a-s-h-e-r. And I am representing the Nebraska Medical Group Management Association.

SENATOR REDFIELD: Thank you.

MICHAEL KASHER: I'm practice administrator with Complete Children's Health here in Lincoln. I'm sorry, now back to catching up in what's happened the last two years. Two years ago when I was here I related some stories about some of the problems we were having with a repreciser here in the state. And I'm happy to say that that repreciser has improved their performance significantly in the past two years. I believe that these hearings and the potential passage of this legislation had a part in that improvement. Unfortunately, while this repreciser has improved their performance, I have seen a decline in the turn-around time from other third-party payers. Recently, we received payment, reimbursement on a number of clean claims that we had first submitted in January and March of 2004 just about

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a year ago. I realize my time is limited here and there are a lot of other people who have things to say and so I won't go into great detail other than to tell you that my billing staff literally went round and round with the payers, calling the support people, filing and refiling the claims until finally almost a year later we were paid. Sometimes I do feel like I'm playing that arcade game that I'm sure you've seen where you have the big foam bat and you've got this board with the holes in front of you and the little gophers pop up and you're trying to jump like this and hit them. And that's sometimes exactly what I feel like when we're filing claims. And you get one piece taken care of and then another bad player pops up over here. While the definition of penalties for noncompliant payers in the bill is an important part of this legislation I do believe that the key provision is in giving health care professionals the right to file the complaint about the unfair practices with the director of insurance. Currently, as Dr. Shuey indicated, only the insured can lodge a complaint with the director of insurance and rarely, if ever, are those insured aware of some of the things that I've described here, the hoops we have to jump through to try and get a claim paid. What LB 389 does give us is it's a tool much stronger than that foam bat to deal with the problem of prompt payment. I really don't think that you'll see the director of insurance being inundated with complaints because the mere existence of this bill is going to encourage payers to work with us in a timely manner for the prompt payment of clean claims. The presence of this tool in our tool belt will help us run our small businesses more efficiently and effectively, thereby allowing us to do even more in helping to keep down the pressure of the rising health costs. I do thank you for your time. Any questions?

SENATOR REDFIELD: Thank you, Mr. Kasher. Are there questions? I don't see any. Thank you. Other proponents?

JAMES CAVANAUGH: Senator Redfield, members of the Banking, Commerce and Insurance Committee, my name is James Cavanaugh, J-a-m-e-s C-a-v-a-n-a-u-g-h. I'm representing the Creighton University Medical Center-Tenet Healthcare in support of LB 389. And we commend Senator Mines for bringing this matter to you. I don't want to rehash a lot of the testimony that's gone before. Suffice it to say that as a tax paying hospital, we don't get additional time to

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pay our taxes. We pay payroll every two weeks. We pay our vendors every 30 days and this is a long-established policy in a hospital that's been here serving Nebraska for over a hundred years. A large part of our patient base is what you would call charity care. These are people who have no insurance and have no way of paying their medical bill and we treat them anyhow. That in mind, we think that it's only fair and equitable that insurers who cover patients that come to our hospital should, in a timely fashion, pay their bills. That's what this bill is about, fairness and equity. I commend the domestic insurers, particularly United, and Mutual, and Blue Cross who have worked with us and the department, and Senator Mines and his staff on many, many drafts of this to get a broad consensus of what is the fair way to go forward. This is it. As Mr. Keetle mentioned, I saw an amendment just moments ago that will be presented to you by some following testimony, having had a chance to review it. But I would say this bill in this form enjoys broad support among the affected parties and it would be a fair and equitable thing to put forward to the full floor of the Legislature. Be happy to answer any questions you might have.

SENATOR REDFIELD: Are there any questions? I don't see any. Thank you.

JAMES CAVANAUGH: Thank you.

SENATOR REDFIELD: Other proponents. We have a page.

BILL PETERS: (Exhibit 5) Senator Redfield, members of the committee, my name is Bill Peters, B-i-l-l P-e-t-e-r-s. My appearance, I suppose, is sort of anticlimactic since you've been advised of what I have to present. Let me say I'm representing Golden Rule Health Insurance Company in support of this bill with modifications which I'll explain. There's one point that I would like to make. I'm not apologizing for just showing people amendments. Yes, I am, earlier just before the hearing. We're a foreign company. We would have been glad to participate in drafting this bill since we're in support of this concept. It's hard to participate when we're not invited. That wouldn't have bothered me. If I'd even known about it I would have crashed the party, but I did not even know about it. So it's not all foreign companies that are shirking any responsibility. I would

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distribute an amendment. There's two things here that are of concern to us in the bill. First is the section regarding forms, the definition of a clean claim. This bill is drafted that the claim will be filed on a form prescribed by the insurer's standard printed or electronic transaction form. We're not a large company (laugh), we don't have one. This would require us to prescribe a form. We rely upon the HIPAA and the other Medicare type forms that are rather uniformly recognized. In looking at this amendment, I thought about drafting an amendment to say that if you don't have your own form then you may use these others. But then the examination became, are we worried about the forms or are we worried about the information? So, coming to the conclusion that we're more concerned about a clean claim having the necessary information, I've drafted the provision that I've supplied you. Also, related to clean claims, on page five, line one. It sets out what elements are part of a clean claim. There are many other elements that are also important in making a determination. So rather than trying to...I don't believe it was the intent to limit the information, but instead of adding on more examples and trying to think up all the examples. One I think of real readily is that of whether the person is covered. At twenty-two years old, covered if they're a full-time college student. Well, it might be of interest, you know, the company might want to make a query as far as this person entitled to the insurance? That would be one example that an inquiry that would be made before the form could be paid. It was our reading of the statute, the second point is that it was the intent that when information was being required, and if you have up to 30 days that you not be able to defeat the 30-day clause by just withholding the information and just filing it when needed. And that the statute should be told. Our concern was, was how do you start counting the time on the statute being told? And so that is the purpose of the amendment relating to section 4. The last point is one relating on section 8 that's not a particular big concern but it seemed to me that we have an Unfair (Insurance) Trade Practices Act. This bill, starting on page six, copied the provisions of the Unfair (Insurance) Trade Practices Act. And my thought was that wouldn't it be simpler just to refer to the Unfair (Insurance) Trade Practices Act, make sure that failure to pay a claim on time was an unfair trade practice, the pattern, and cut down the length of the bill. This also, down the road, will avoid

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the situation of having to amend two statutes if you want to keep the two consistent. With that, that is the two points that we would like to see that would make this bill improved, a tolling of the statute while the information is coming in and then secondly, that the definition of a clean claim be broader.

SENATOR REDFIELD: Mr. Peters, I have a question on your clean claim language. You use the illustration of a query to see whether a person is entitled to that coverage. Now I'm assuming that your company, Golden Rule, that you represent, is receiving an application from someone. They take their check and they agree to cover them, so why would it be the hospital or the medical provider's responsibility to satisfy whether, in fact, that person was...

BILL PETERS: Insured?

SENATOR REDFIELD: Yes. Why isn't that your responsibility? I mean, you know if you have them on the roles or not and you know whether they're a college student before you sign them up. Correct?

BILL PETERS: Not necessarily.

SENATOR REDFIELD: I mean, if that's the qualification for that product?

BILL PETERS: Well, I believe under a plan that you could have...the plan could be insuring all of the children until age whatever it is, I don't recall, or until they've graduated from college but not to exceed age 25.

SENATOR REDFIELD: Right.

BILL PETERS: As a matter of practice, we don't routinely ask the insured to keep telling us every time they have a child that quits being in college. I don't think they would hide it but it's just...

SENATOR REDFIELD: So, currently, is that practiced that the hospital or the medical provider would have to give a birthdate to you on that form?

BILL PETERS: That I don't know. I couldn't answer that on

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what information that they would supply.

SENATOR REDFIELD: So if the birth date is on that form, you know, in fact, whether they have exceeded the age limit.

BILL PETERS: The 25. We wouldn't know whether or not they're still a college student.

SENATOR REDFIELD: I see. Okay, thank you. Are there other questions? Senator Langemeier.

SENATOR LANGEMEIER: I have one question, Bill. So your testimony is that you're in support of this bill with this amendment that you have handed us today. Correct?

BILL PETERS: That's correct.

SENATOR LANGEMEIER: Without this amendment, where do you go on this bill?

BILL PETERS: Our enthusiasm probably wanes but we're probably still in support...we're still in support of the general concept. It will be up to the director of the insurance to decide whether or not we are compelled to provide a form. There will be problems down the road regarding what is included in a clean claim. But that's...there will also be a problem on whether or not the statute is told. We get a claim in, on the tenth day we see if there's a medical necessity, or we ask for a health record for a pre-existing condition, and that doesn't get in for 20 days. By the time we open the mail we're in default unless the statute is told. That does present a problem. We think it will work much better, even though we're a foreign insurance company, that if we had this opportunity.

SENATOR LANGEMEIER: Thank you very much.

SENATOR REDFIELD: Okay. Other questions? Thank you very much.

BILL PETERS: Thank you.

SENATOR REDFIELD: Other proponents.

DAVE McBRIDE: Good afternoon, members of the committee. My

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name is Dave McBride. That's D-a-v-e M-c-B-r-i-d-e. I'm the executive vice president and registered lobbyist for the Nebraska Association of Insurance and Financial Advisers. I'll be brief and not, try not to reiterate the testimony previously. But our group was before this committee two years ago in support of a similar piece of legislation on the same concept, still are in favor of the concept of this. The details may not be perfect. Our experience is that most insurance companies are probably already meeting or exceeding the standards proposed in this bill, but we believe that it is appropriate for Nebraska to join the other 46 states around the country that have similar legislation and would encourage your support. And, again, I have not seen the specific details of the amendment you just heard about, but we're certainly in support of the concept of this bill.

SENATOR REDFIELD: All right. Are there questions? I don't see any. Thank you, Mr. McBride. Proponents. Are there opponents? Any neutral testimony? We'll close the hearing on LB 389. Senator Mines, are you ready for LB 545?

SENATOR MINES: Let me close on this one.

SENATOR REDFIELD: Oh, I'm sorry. I apologize. Senator Mines to close on LB 389. I apologize.

SENATOR MINES: Thank you, Senator Redfield. Members of the committee, you heard many proponents and you heard that there are some questions yet that many need answered, and certainly the amendment that was passed out today indicates that not everyone is dancing to the same song. If I can propose to the committee that perhaps now that we have seen the amendment, that those interested parties have seen the amendment, that we come together, that we allow everyone to look it over, think about it and we'll come together later with perhaps an amendment, or not. So I would just ask you to hold this bill in committee, if you would. With that I would close on LB 389.

SENATOR REDFIELD: Thank you. Again, I apologize.

SENATOR MINES: That's okay.

SENATOR REDFIELD: LB 545.

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SENATOR MINES: Senator Redfield, members of the committee, my name is Mick Mines, M-i-n-e-s, representing the 18th Legislative District. I am the principal introducer of LB 545 that would change subrogation rights for health insurance and workers' compensation insurance. I'm bringing LB 545 on behalf of the Nebraskans for Workers' Compensation Equity and Blue Cross/Blue Shield Nebraska. This bill would recognize the right of a health insurance or workers' compensation insurance carrier to recover under its right of subrogation, in the same proportion as the amount received by a claimant or an injured employee, from all sources other than the health insurance or workers' compensation insurance coverage payments, bear to the total loss suffered by the claimant. The bill would also provide that any settlement or judgment received by the claimant or injured employee that is less than the applicable liability insurance coverage policy limits should be conclusively presumed to constitute complete recovery of total loss. As before, there are testifiers following me and I would ask that questions be directed to them.

SENATOR REDFIELD: Thank you, Senator Mines.

SENATOR MINES: Thank you, Senator.

SENATOR REDFIELD: Proponents. Do you want to close on this one?

SENATOR MINES: No, thank you. I'll waive.

SENATOR REDFIELD: Thank you (laugh).

TOM JENKINS: (Exhibits 1 and 2) This is testimony. If you could pass those out I'd appreciate it. There is...I gave the page a rough copy of my testimony but I won't follow that exactly. So this bill is about subrogation. I'm sorry, I'm Thomas Jenkins, Blue Cross/Blue Shield of Nebraska.

SENATOR REDFIELD: Would you spell your last name?

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TOM JENKINS: J-e-n-k-i-n-s. This bill is about subrogation and some of you may well say, what is that? And really I don't blame you for saying that. It is a legal concept that goes back many years and the idea is that...that when one party has paid a debt that really should have been paid by another, then the party who made the payment should be able to later recover. In reality, it works like this. Let's say a person, Joe Goodguy is injured in an automobile accident caused by Clyde Careless. And Joe incurs medical bills of \$10,000 which are paid by his health insurer, Blue Cross...promptly paid, I should add (laughter). Okay, Joe sues Clyde Careless. Clyde's auto insurer, Ranch Mutual, promptly settles for \$25,000. Now all parties, let's say, can agree the case was worth \$50,000 due to pain and suffering, and other expenses other than the medical expenses. But the Ranch Mutual policy limits were \$25,000, a very common limit in this state, as you know, because that's the statutory minimum. Therefore, Joe Goodguy is not made whole in the terms of this new case that we have that came down in October and I'll mention more about that. Okay. The case that was decided in October by our Supreme Court was Blue Cross v. Dailey. The facts were something like this. Mr. Dailey was badly injured. The numbers were much bigger than the ones I'll give you here, but in the example with Joe Goodguy, Mr. Dailey actually had the medical expenses paid by Blue Cross on behalf of his employer. He was a county employee and we've got that county group. The medical expenses were in the neighborhood of \$800,000 and Mr. Dailey negotiated a settlement with Union Pacific Railroad. The burns that he had suffered came, it is thought, from a Union Pacific train starting a range fire. So the bills are paid at \$800,000. The Union Pacific came in and settled with him for \$1.2 million up front and another \$10,000 per month so another \$1.2 million; \$10,000 per month for the next ten years. And the Union Pacific provided that if it turned out that he had to pay Blue Cross anything they would reimburse that. So Blue Cross on behalf of the county group which is, by the way, it is a very much experience-rated group. That is, their experience sets their rates, made demand for the \$800,000 and eventually negotiated down. Their final offer was in the neighborhood, I think, of about \$725,000. Union Pacific refused to pay that. We sued them in district court in Douglas County, got a summary judgment so a favorable ruling without having to go to a full trial. It was appealed to

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the Supreme Court. Supreme Court said no, sent it back to the district court for a decision on this question. Was Mr. Dailey made whole? Is the \$1.2 plus the \$10,000 enough to make him whole? Because if it's not and here's the new rule, if it's not then Blue Cross doesn't get anything to the extent he's not made whole. So, let me go back to my simpler example. And, by the way, let me tell you, that case is on remand now. In other words, it's down in the district court again for a decision by the trial court as to whether Mr. Dailey was made whole. And that could be a rather extensive proceeding so we don't have the final on that. No matter how it comes out, the rule is there. Under my example, I said Blue Cross pays \$10,000...actually, I've got some more copies of this. If you wouldn't mind...could I have a page here? I'll just pass them. I didn't make enough for everybody but there's a few there. Under the Dailey rule, in my example, with \$10,000 of medical expenses paid by Blue Cross and an assumed value of the case of \$50,000 settlement proceeds, again, the \$25,000. Blue Cross under Dailey recovers nothing. And Joe keeps the whole \$25,000. Under this bill, under (LB) 545 we'd go back to something that really was the way we operated previously and I think a lot of insurers did. Under this bill, Blue Cross would reduce its claim of \$10,000 by half. Why half? Because his \$25,000 that he got is half of what the case is thought to be worth. Now that concept of what a case is worth is actually a pretty complicated endeavor and it usually would go something like this. His lawyer would say, this case is worth a half million dollars and we'd say, no, it's worth \$12,000 and you negotiate and you might land on a number about like \$10,000 or \$50,000 rather. But subrogation is a valid cost avoidance technique and it says, that all or part of the payment by health insurer should be repaid if I recover from another source. It is the approach typically taken by private insurers and actually is a softer approach than that taken by the government payers. For Medicare and Medicaid, the first option instead is something called cost avoidance. And under this method, just by way of contrast, Medicaid or Medicare will actually reject the claim for the \$10,000 in my example and say, because it appears that a third party may be liable. In other words, the auto insurer pays the medical expenses in the first instance. Now private payers like Blue Cross, instead, will typically pay in the first instance, but by contractual provision will require a repayment if the patient also

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recovers from the auto insurance company. And it's a part of the covenant between the insurer and the insured person. The payer's part is to say, I'll be there for you, I'll pay in the first instance; and the patient's part is to say, if I later get something back I will return it, or at least a portion of it, to you. And I'd like to present just a few technical points. First, subrogation really does affect rates and I think it's important to mention this because I have heard intelligent, sophisticated people question that. It doesn't really matter to rates. Well, at some level, actuarial sciences is beyond the comprehension of us mere mortals, but the easy part of it is this: The key building block of next year's premiums are last year's claims. And let me clarify that. Unlike auto insurance, this adjustment of the rates, based on experience, doesn't occur at the level of the individual insured. In other words, if I get in an auto accident my rates will go up, but if I get sick my rates don't go up. The whole block goes up, but not mine in particular, so just with that clarifying point. Still at the group level, if it's a big enough group their experience is totally rated. In the example I gave, it's the counties and their experience is totally dependent on their claims experience. And if it's not a big enough group or if it's an individual policy then it's our whole block of business. So this year's aggregate claims determine next year's aggregate rates, but not just gross aggregate claims, rather net aggregate claims. That's the amount paid out minus the recoveries that we get back from subrogation, coordination of benefits, a few other tactics. And then from there, okay, that's the easy part. Then the actuaries take over with the hard part and factor in things like health care trend, the aging of the population, our increasing obesity, new technologies and other things. But, again, the starting point is net claims. Second technical point, medical expenses are always the first thing, in a sense, to be recovered when there is a claim against an auto insurer or any other...I'm saying auto insurer but it could be a liability insurer for medical malpractice. It could be a slip and fall case or something, but it's a bit disingenuous to do as Dailey later did to say, though, that the medical expenses weren't recovered. And the building block of any settlement for personal injuries is the medical expenses and plaintiffs' lawyers earn their keep, and the harder part is proving that there should be some compensations for things like pain, suffering, loss of quality of life. But before

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those hard parts even start, the medical expenses are figured into the settlement. And due to some legal rules that some find odd, in fact, the award includes the hospital or doctors' usual and customary fee, not the discounted amounts the provider might have actually taken. And furthermore, due to something called the collateral source rule, the defendant is not even allowed to show, as a mitigating factor, that there even was health insurance. But then under this new made-whole rule pronounced by the Supreme Court in October, the first shall be last in the health plan despite its subrogation provision, can be told that it should recover nothing. So the medical expenses which played a critical part in building up the value of the case are marched to the back of the line once the money comes in. Third, I feel it's valuable to remember that in most cases of illness or injury there is no third party to recover and that's okay. That's what your health insurance is for. What we are discussing here today is only what should happen in those cases where there is a recovery from another source. Fourth, let me just head off one thing that I think we're likely to hear, and I say we might hear this today, but at least the Dailey case made mention of this in citing another court and I see it all the time, and I just about want to pull my hair out. And it's this. That this person paid a premium for their health insurance and they're entitled to keep it. And what they paid a premium for is what is in the four corners of the contract document. And if they wanted an insurance policy without a subrogation clause they'd pay more, but people are really interested in lower premiums and so the value of subrogation is something that matters to all of us. This Blue Cross v. Dailey case, really kind of fixed something that wasn't broken. This is something, subrogation, yes, it's kind of complicated, but it's worked out every day by professionals on both sides. The plaintiff's attorneys on the one and the insurers on the other and negotiations are made and settlements have always gone forward. But Dailey created a rule that says as long as the smallest part of the most imaginative element of damages is unrecovered, nothing should be returned to the pool called health insurance so as to remediate rising costs paid by others. Not surprising because the court and the plaintiff's attorneys are looking only at the parties in front of them. That's their job. You, as policymakers, have to worry not only about those parties but about all the parties not present, those who pay the premiums. And I

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should say after saying that, in fairness, two of the judges in the Dailey case did recognize the impact or the importance of thinking about the others and in that case that I handed out, if you look at the last page, the highlighted language they talk about, there could be unfairness from this made whole rule and the Legislature could well think about a proration rule which is why we're here today. So we're not here to say that payers should be first in line or that they should take everything. Rather, that the community interests should be recognized and that a pro-rated portion returned if that is what the contract said. And I'll be glad to take any questions.

SENATOR REDFIELD: Thank you, Mr. Jenkins. I do have a question. If Joe...no, Joe, the good guy, decided not to sue Clyde Careless, would you have gotten anything or would you have sued?

TOM JENKINS: We, as a practice, do not. Some insurers are more aggressive in that behalf. We just have never...we've talked about whether we should do that in a case where there's clearly a wrongdoer and clearly a lot of injuries. We just haven't but it's not out of the question.

SENATOR REDFIELD: So, if you wouldn't have, he did you a favor. Do you share his attorney costs?

TOM JENKINS: As a practice, we do that, yes, we do. And, you know, we have debates about the amount and we'll sometimes try and pay, you know, try and pay an attorney fee of say, 25 percent if we think it's out, you know, if it's too high. And I will say that, you know, plaintiff's attorneys credit. They will sometimes voluntarily reduce when there's not enough there either. Not always. But yeah, we do...we have a practice of paying it. Again, that might vary by payer but there is actually a rule, though, in Nebraska on an insured case, this would be necessitated. It's called the common fund doctrine and pretty much an insurer would have to pay that.

SENATOR REDFIELD: Okay, one last question. You said this had been remanded so should we be waiting to see what happens or we need to...?

TOM JENKINS: I would say no and here's why. The rule is

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the rule. It's a new rule in Nebraska. How it gets applied in the Dailey case remains to be seen. In other words, the district court could say, okay, now I've considered this new thing and I find Mr. Dailey was made whole or it may say, he wasn't made whole. And so Blue Cross doesn't get anything. Whatever they decide there, will only apply to that one case but this rule goes forward for all the cases from now on. And we've noticed a real...in cases that we could have settled easier and earlier with the parties involved, it's getting tougher now and there are cases where we're basically just told, no, we don't have to pay anything. And that is happening as we speak.

SENATOR REDFIELD: All right, thank you. Are there questions? I don't see any others. I need all the proponents to come forward. We're talking about health. We were just informed that our insurance rates are going to go up if the obesity increases so I need all the proponents to come up in the front row. We're going to do some up and down so that we can move faster, get a little aerobic activity going. Are you the only proponent? All right, thank you. And how many opponents do I have out there? And how much neutral testimony? All right, we have two more. We can probably call Senator Beutler soon. Thank you.

DALLAS JONES: (Exhibit 3) Thank you. Chair and members of the committee, my name is Dallas Jones and I'm an attorney here in Lincoln. And I practice with the law firm of Baylor, Evnen. My specialty is workers' compensation so I'm here to discuss that part of LB 545 that relates to the workers' compensation subrogation interest. What I'd like to do is give you a quick history lesson where things were on the workers' compensation side with regard to subrogation interests. Prior to 1994, we had a Nebraska...what was generally referred to as a dollar for dollar rite of recovery that an employer and its workers' compensation carrier had to recoup any payments it made for workers' compensation injuries from the settlement or the verdict proceeds that were received in the tort claim. Someone drives along, crashes into an employee, causes injury to that employee, the employer pays benefits. The employer had the right to get dollar for dollar recovery of whatever benefits it paid because of the workers' compensation claim that came out of that accident. In 1994, (section) 48-118 was amended and it was amended because when you look back at

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the legislative history it provides a very good example of what was happening. The dollar for dollar recovery was causing problems in those cases where there were questions of liability so the individual who was injured would want to take some reduction to settle the case because of the contingencies of litigation and the worry that they would not recover anything at trial so they would settle for less than their whole recovery. Because there would oftentimes be a very large workers' compensation subrogation interest because of lots of benefits paid, sometimes it would even exceed the amount of the settlement of the tort claim. It made it very difficult to resolve that case because in those situations the employer or the carrier had the ability to basically hold up the settlement and recoup sometimes all of the settlement proceeds. A case developed in Omaha along those lines, and what happened is a district judge saw the inequities of that, and made a rather unique and what we would call a fair and equitable decision, and held a hearing. Even though he didn't have authority to do so under the statute, basically said all right, I'm going to split the proceeds of this settlement. It means that the claimant is not going to be made whole certainly, and it certainly means that the employer and the carrier won't be made whole, but I'm going to split it up and he did so on a 50/50 basis. There was some threat that that was going to be appealed. In the end it was not but what came out of it is the realization that the statute needed to be changed to avoid that circumstance and allow district judges, when the parties couldn't agree on how to divide those settlement proceeds, to do it for them on a fair and equitable basis. So that gets us to the past ten years after that amendment was made. In this particular field, what's been happening is district judges, at least of those decisions I'm aware of, have followed generally a proportionality rule where they've interpreted a fair and equitable distribution which was the language added in the 1994 amendment, to mean basically they would look at how much of a percentage of the claimant's loss was compensated by the tort. If they got 60 cents on the dollar from the tort proceeds then basically after some attorneys' fees and whatnot were dealt with the employer and the carrier wasn't allowed to usually recoup more of a percentage of its subrogation interest than the injured employee got from its subrogation interest, and it worked. That's not to say there wasn't litigation where the parties fought about what amount does it take to make the

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employee whole, where they fought about what percentage is fair and equitable. But it worked, generally, and in the end over the past ten years, we were able to work through that much as the testimony indicated was occurring on the health side. Then along came Dailey and even though Dailey was decided in the context, of course, of a health insurance contract, what is occurring now is the claim is being made that the same principles that Dailey adopted for the health insurance contract side of things should apply to workers' compensation. Because we don't have a good definition in the statute of what a fair and equitable distribution means, the claim is being made that, in fact, until the claimant, the injured employee has received full recovery or made whole from that tort case, the employer and the workers' compensation carrier are entitled to nothing. I have one case, I can't talk about the details of it because it's ongoing but by way of example to illustrate the problem, we were negotiating what amount of the subrogation interest should be satisfied by a settlement and we're getting closer, I suspect, and I believe to resolving that. Dailey was decided and all of a sudden the game changed, if you will, and now the claim is this individual had not received 100 percent of his damages in the accident and therefore the workers' compensation carrier and the employer, the argument goes, should not receive anything because the principles of Dailey should also apply in comp as they do in health insurance. I am aware of one decision that has been decided by a district court judge now that has specifically adopted the principles of Dailey and applied those to the workers' compensation subrogation statute. That's presently on appeal, in the very early stages of appeal. But therein lies the problem. What the comp portion of LB 545 does is essentially take us back to where we were the past ten years. In a workable solution where the end result is, we have some definition of what fair and equitable means, in other words, the proportionality rule that was essentially being applied across the board and is, specifically by statute, directing the court and the parties that that's how we should address these types of problems where we can't agree upon the distribution. There shall be a proportionality approach lent to that. And for that reason, I should have said I'm here on behalf of the Nebraskans for Workers' Compensation Equity. On their behalf, I'm proposing that you move the bill out of committee and I'll be happy to take questions.

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SENATOR REDFIELD: Thank you, Mr. Jones. Did you spell your name?

DALLAS JONES: J-o-n-e-s. My apology, Senator.

SENATOR REDFIELD: Are there questions? Senator Jensen.

SENATOR JENSEN: Yeah, when you refer and what it is referred to, made whole. I can understand that in dollars but when it goes beyond that, is that whatever a court should decide that may be or are there guidelines on that?

DALLAS JONES: There are no guidelines on that, Senator. In the workers' compensation field, it is a brand new concept at least in this state so there are no rules that the statute or that Dailey necessarily says to workers' compensation matters held in front of district judges are to follow. So it's very much up in the air, I would say, as to what exactly that means. You know, there is some guidance certainly from outside of the workers' compensation and other jurisdictions I think we can look to, but we do not have anything from any higher court that tells us here is how you shall determine that, here are what monies, whether it's tort or otherwise, that shall be considered, we don't know.

SENATOR REDFIELD: Thank you. Other questions? I don't see any. Thank you.

DALLAS JONES: Thank you.

SENATOR REDFIELD: Next proponent. I saw the front row get crowded. How many more of you are proponents? Okay, thank you.

BOB HALLSTROM: Senator Redfield, members of the committee, my name is Robert J. Hallstrom. I appear before you today as a registered lobbyist for the National Federation of Independent Business in support of LB 545. I am also registered as a lobbyist on this issue for Blue Cross/Blue Shield of Nebraska and for the Nebraskans For Workers' Compensation Equity, but you've already heard from representatives of those groups. Take a little bit different approach from the small business community

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perspective, and that is one of the items that Mr. Jenkins referred to, is that it's a simple fact of life, particularly if you belong to a group policy type of situation, that the monies that come in to pay premiums are compared to the amount of claims that you have and the difference is going to adjust or affect your group rates, their experienced rating the next year. Health insurance problems are a primary concern for small businesses and the fact that you have either the potential to eliminate or drastically curtail the right to subrogation recoveries for insurance companies will undoubtedly have an impact on insurance rates for businesses. So from that perspective, I'd make that point. I think I also want to make a point, for the record, that the concepts, at least in the abstract of LB 545, were not dreamed up out of the clear blue sky. There is a current statute under Nebraska Revised Statute 44-3128.01 that provides a similar type of proportionality concept, if you will, in the property casualty arena. That particular statute also has provisions relating to the establishment of a conclusive presumption if the plaintiff has settled for less than the policy limits. So we have a concept that is in statute. We have a concept that I think, in fact, the legislative record will show that some that did not support the conclusive presumption came back to the Legislature to try and overturn that, and were unsuccessful in doing so. So we at least have some measure of public policy in a similar fashion, not identical, but a similar fashion that the conclusive presumption provisions that are set forth in LB 545 should be upheld. And, again, I think in closing, I think the key thing to look at is particularly when you look at the negotiation. Mr. Jones started to talk about the negotiation impact that it had on a pending case. It's not uncommon for a plaintiff's attorney and I've done some myself to determine that you've not been made whole without going to court to get the determination. I think, Senator Jensen, if you went into court and had a jury determination then you clearly would say that was the final determination and it was deemed by the jury that "X" amount of an award was full recovery and that you were therefore made whole and that then you could have some issues to deal with. If you don't go to court and you settle the matter on a daily basis routinely, the plaintiff's attorneys are contacting either the insurance company or the medical providers saying, I really don't think my client got a hundred percent of the recovery to

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which they were entitled. In fact, we maybe only got 50 percent. Would you accept a 50 percent or more haircut on the amount that you're entitled to under your subrogation provisions of your contract? LB 545, we believe, will take us back to that particular arena where those types of negotiations can fairly and freely be undertaken by the parties concerned.

SENATOR REDFIELD: (Exhibit 4) Thank you, Mr. Hallstrom. Are there questions? Next proponent.

GALEN ULLSTROM: Senator Redfield, members of the committee, for the record my name is Galen Ullstrom. That's G-a-l-e-n U-l-l-s-t-r-o-m. I'm senior vice president, registered lobbyist for Mutual of Omaha Insurance Company, appearing today in support of LB 545. I won't repeat what the previous testifiers have said regarding the reason for this bill but, again, it comes from the Dailey case. The attempt of this bill is to put the state of law in Nebraska back to where we were prior to the Dailey case, where we believe we had negotiations between the plaintiff's attorneys and defense attorneys about appropriate subrogation rights. As we've stated, the pot of money that we recover on subrogation goes back into the pot of money that would otherwise be considered claims cost and experienced-rated employers, that pot of money paid out as Mr. Jenkins stated, is the basis for setting the premiums for the future years. So with all the concern that we have regarding the cost of health care coverage in this state, I think...what this is is to try to be equitable, not allow double recovery, but provide a proportionate recovery by the health insurer. And I think that's a fair and equitable result so we would urge support of LB 545.

SENATOR REDFIELD: Thank you. Other questions? I don't see any. Did you spell your name?

GALEN ULLSTROM: Yes, I did. Yes. Thanks.

SENATOR REDFIELD: Thank you. Next proponent. I think this is our final proponent.

JAN MCKENZIE: I think so. Senator Redfield, members of the committee, for the record, my name is Jan McKenzie spelled M-c-K-e-n-z-i-e, representing the Nebraska Insurance

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Federation as a registered lobbyist and executive director. I too lend my support to LB 545 on behalf of the Nebraska domestic industry. You've heard all the good arguments here today on the proponent side as to why this bill is important and, in general, for the industry as we, in particular, in health are concerned about keeping insurance affordable and available to Nebraska citizens. We would like to see LB 545 advanced from the committee and, hopefully, signed into law by the end of session. Thank you.

SENATOR REDFIELD: Thank you, Jan. Other questions? I don't see any. Are there any other proponents we missed? Opponents.

BOB MOODIE: Senator Redfield, members of the committee, my name is Bob Moodie, M-o-o-d-i-e. I'm an attorney here in Lincoln and I'm testifying on behalf of the Nebraska Association of Trial Attorneys in opposition to LB 545. Basically, ladies and gentlemen, what I think this case is about, at least with regard to section 1 and not the workers' compensation section, but with regard to section 1 of the bill is the question of who bears the risk of incomplete recovery in a particular case? Using the example that Mr. Jenkins gave to you which is a nice, clear example and very well crafted, may not be particularly likely to occur because very seldom are you going to find one in which everybody agrees with the ultimate value of the case is. But for the purpose of an example, you have the Clyde Careless who has caused an accident because of his negligence. He has caused \$50,000 of damage to Mr. Friendly who, through no fault of his own, has suffered medical bills, pain and suffering, lost wages, perhaps permanent impairment. Because of a Mr. Careless is carrying only minimal insurance coverage there's only \$25,000 of insurance available. Therefore, only \$25,000 of a \$50,000 claim can possibly be recovered in that particular scenario. So the question is, which party in this scenario are we going to say bears the risk of nonrecovery? Mr. Friendly, who is the only person that has not really accepted any risk prior to this, is the one that LB 545 is going to place a predominant share of the risk on. And whether it drives Mr. Jenkins crazy or not, the fact remains that the insurance company that paid \$10,000 of medical bills on this case has been paid to accept a risk. They have been paid to accept the risk that their policyholder is going to be injured or take

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ill in some manner, and that they are going to then be called upon to pay for medical bills under those circumstances. And is it most appropriate to place the risk of nonrecovery on the entity which has already been paid to accept a risk or is it more appropriate to place the risk of nonrecovery on the completely innocent individual who was involved in the accident through no fault of his own. I suspect that negotiations are still going to occur in these types of cases. I think it's been suggested to you that because of the decision in Blue Cross v. Dailey suddenly there will be no more negotiations between the plaintiffs, their attorneys, and the health insurance companies. And I don't believe that's entirely true because, of course, we still have these questions over exactly what is full recovery in the case? And unless a jury has actually rendered that decision, that is a hotly debated discussion in almost every case. So if, in fact, the settlement has rendered a full recovery, you may certainly have the situation where the health insurance company is going to be entitled to its subrogation. If there is dispute, is going to be entitled to subrogation or if the combination of the recovery in the case and the amount that has been paid under the health insurance exceeds full recovery, then under the current law the health insurance company can still collect back to the extent that the settlement, the combined payments have exceeded about what would be full recovery. LB 545 provides for a conclusive presumption that if the plaintiff settles for less than the liability policy limits that settlement represents a full compensation. That theory might make sense if the amount...the only issue in dispute were the extent of the person's damages and how much money was necessary to fully compensate him for those damages. However, there are other reasons why people agree to compromise settlements. Disputes in liability. The expense of litigation. Any one of those could motivate a potential claimant to accept a compromise settlement which is less than full value, and it would be our position that in those cases the health insurance should still bear the risk of nonrecovery because they have been paid to bear a risk in those particular situations. Now, part two of the bill dealing with the amendment of section 48-118, I would argue to the committee, quite frankly, is premature. I have read and reread, myself, the Dailey decision and find really very little, if any, reference in that decision which could apply to a workers' compensation case. The Supreme Court in that

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case is interpreting the subrogation language of that particular policy and then applying public policy arguments to it, but in a workers' compensation case we already have a statute which calls for fair and equitable distribution. The made-whole doctrine does not apply and I would argue that the Blue Cross v. Dailey decision does not apply to workers' compensation. What the change in LB 545 would do is instead of allowing the court to make an equitable distribution, the court is going to be given a formula that must be followed, thereby eliminating any discretion at all that the court would have in evaluating what is equitable in any particular situation. And there's a couple of points, a couple of things that I think the court needs to be paying attention to in workers' compensation situations that are not necessarily accounted for in this proportionality formula that's included in there. Number one is the question of attorneys' fees. Because (section) 48-118 already establishes and deals with the questions of under what circumstances the workers' compensation insurance carrier should or ought to contribute towards the attorneys' fees of the claimant when the third party claim, when he had to hire a lawyer to pursue the third party claim on his behalf. Section 48-118 already talks about that. It's there. It's still going to be there if you adopt this amendment to (section) 48-118 and (LB) 545, but no longer is the judge going to be able to use...pay attention to that in one of his criteria in establishing what is fair and equitable in this particular situation. The other issue that has me confused is the question of future medical expense. Now I've looked at the proposed language in section 2 of LB 545 and the language on page three appears to assume that the compensation insurance carrier and its subrogation interest includes estimated future benefits. Now, the way (section) 48-118 is already structured, I propose that it doesn't necessarily include future benefits to the extent that the third party recovery exceeds the amount of workers' compensation payments that has been made to date in that part of the case. It constitutes a credit against future payments. Therefore, an estimated amount of future medical expenses estimating the amount of future medical expenses is necessary in establishing what a fair and equitable distribution is. I would suggest that very clearly the second section of LB 545 is unnecessary at this time. Section 48-118 already allows the court to make fair and equitable distributions. We have, by definition, in

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that statute essentially established the made-whole doctrine does not apply. It may be that in one of Mr. Jones' cases, eventually, the Supreme Court will give us further instruction, but I don't believe it's necessary to anticipate that at this point. Thank you. Oh, one other thing. I would say, that being said and despite my voiced objections to the bill, I will indicate to the committee and to those on the other sides of this bill that our organization will be willing to meet and, in fact, I think they have made the offers to us and we haven't quite yet, within the last couple of days, been able to arrange that meeting but we are willing to do that to discuss our differences.

SENATOR REDFIELD: Thank you. Are there questions? Senator Louden.

SENATOR LOUDEN: Yeah, Mr. Moodie, I understand you're a trial lawyer. When you talk about Joe and Clyde and all here, why doesn't Blue Cross sue Ranch Mutual for their cost of Joe's medical bills?

BOB MOODIE: Well, they might and they might be able to or they might be able to work out some other means of pursuing it, but the fact is going to remain that Ranch Mutual has a policy that basically says, we're only going to have to pay up to \$25,000 on this claim. And whether we pay it to Joe Friendly or we pay it to Blue Cross and Blue Shield, we're only paying \$25,000. So whether Joe pursues the claim on his own...now, clearly, if Joe chooses not to pursue the claim then I guess he's made the decision that he is not going to seek full compensation because of that. But if he is pursuing the claim and if he is seeking full compensation the problem remains, how do you split up the available funds?

SENATOR LOUDEN: True. The Ranch Mutual had...they were only liable up to \$25,000 but on the other hand, Blue Cross is liable for Joe's medical bills.

BOB MOODIE: That's true.

SENATOR LOUDEN: And, so when they pay his medical bills and whatever else is different there, why it'd be the \$15,000 or something like that and it looks like to me that they could

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be someplace in there that Joe did the suffering but he's the one that's going to foot all the bills.

BOB MOODIE: Well, remember, Senator, that we are assuming that for the purpose of this example we have assumed that his full claim is worth \$50,000 and that \$50,000 figure may have come about by the fact that he has suffered \$25,000 of wage loss. In addition to the \$10,000 of medical bills that he has suffered and the fact that he now has a back that is going to make it difficult for him to play golf, or hunt, or fish, or do other things that give his life enjoyment. So, yes, you certainly can look at it and say, well, Joe's still getting \$15,000 and he looks like he's still making a good recovery on this case. But unless we really know what the facts of the case are, if in fact, he suffered \$25,000 in wage loss then it comes down much more clear that he is being the one that is making a sacrifice.

SENATOR LOUDEN: Yeah. But why should Blue Cross be the one that when they've agreed to pay for his medical bills be able to recover all of their medical bills at Joe's expense, I guess, is what I'm kind of wondering?

BOB MOODIE: Well, I don't think they should and I don't think that the way the decision in the Supreme Court in Dailey says that they should either. That under those circumstances, Blue Cross can collect their money back if the money that Joe collects from his settlement fully compensates him for his loss because the idea is, Joe shouldn't be allowed to do a double recovery. He shouldn't collect full compensation from Clyde and his insurance company and then also be allowed to keep the benefit of \$10,000 of medical payments. So if he's been fully compensated he shouldn't be allowed to keep the whole thing and that's when the complete subrogation to Blue Cross would occur.

SENATOR LOUDEN: Thank you.

SENATOR REDFIELD: Are there other questions? You referred to Joe Friendly. We actually don't know if he's friendly or not. His name is Joe Goodguy...

BOB MOODIE: Okay.

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SENATOR REDFIELD: ...which means we don't even know if he is a good guy. It's just his name is Goodguy (laughter). But I do have one question about how the attorney fees work here. Sometimes I understand attorneys would take a case on contingency. Their fee would be hinged upon the settlement.

BOB MOODIE: Yes, ma'am.

SENATOR REDFIELD: How would that be affected in the subrogation of these funds? Would, in fact, the attorney lose part of that or would that all come out of Joe's pocket?

BOB MOODIE: Well, I don't think this bill addresses that issue. I don't think whether LB 545 is passed or rejected is going to make a difference. There are a line of cases that the Supreme Court has handed down that dictate to us under what circumstances the subrogation carrier, whether it's a health insurance subrogation or a auto liability med pay coverage subrogation, under what types of circumstances the subrogation holder should contribute to the attorney's fee. It does not appear to me that LB 545 is attempting that, to change that. So I don't see this as a bill which is affecting the attorneys' fees issues.

SENATOR REDFIELD: (Exhibit 5) All right. Thank you. Thank you. Are there any other testifiers? And, Senator Mines, you did not want to close. I would read into the record one other letter from the Nebraska Association of County Officials in support of LB 545 and that closes the hearing on LB 545.

LB 589

SENATOR MINES: Thank you, Senator Redfield. I'll take the chair back. It's been a while (laugh). Nice job. I will now open the public hearing on LB 589 and this will be introduced by Senator Beutler from the Legislative Performance Audit Committee. Senator Beutler, welcome.

SENATOR BEUTLER: (Exhibits 1, 2) Mr. Chairman, good afternoon.

SENATOR MINES: Good afterncon.

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SENATOR BEUTLER: Sounds like you have some easy topics today.

SENATOR MINES: We're screaming right along, aren't we (laugh)?

SENATOR BEUTLER: Mr. Chairman, members of the committee, last year the performance audit unit of your Legislature completed an audit over at the Health and Human Services programs trying to determine, in a general sense, in a broader sense at the beginning, whether they were maximizing their resources by minimizing improper health care payments and collecting back on overpayments. And, in short, working the billing processes properly to see that we've recovered as much money as we could to replenish the Medicaid program to the extent possible. The performance audit, one of the focuses of that review was the Medicaid collection program. That is, to what extent was the Medicaid program collecting from private insurance companies or recovering from private insurance companies in the case where Medicaid recipients were covered by private insurance. The performance audit, in reviewing the program over at Health and Human Services revealed a number of deficiencies related to staffing and organizational structure and recordkeeping. But the staff, itself, at the health department also identified another cause of inefficiency from their perspective, and that was the difficulty that they perceived in collecting appropriate reimbursements from private insurance companies. The program staff indicated that some, but not all by any means, private insurance companies made it difficult for them to determine whether one of their recipients also had private insurance coverage. They described a noncooperative attitude on the part of, again, some but not all insurance companies. As indicated by one of the performance audit staff members that this is a problem at all is a cause for serious concern considering that several hundred thousand dollars annually, maybe even millions of dollars annually, are at issue here. Not only does the state lose money when an insurance company successfully avoids its obligation to pay for services, but also an inordinate amount of time is expended by the Medicaid reimbursement staff, the state staff, attempting to attain the necessary information upon which to make billing decisions. To solve this problem, the Health and Human Services System, itself, suggested to the

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committee LB 589. The basic purpose of the bill is capsulized in section 3 on page 3 and applies in similar fashion to the other parts of the system and other parts of the bill. But in section 3 it says upon request of the Department of Health and Human Services or the Department of Health and Human Services Finance and Support a licensed insurer shall provide health information to the requesting department without an individual's authorization for purposes of determining an individual's eligibility for state program benefits. Such information shall be provided within 30 days after the date of request unless good cause is shown. And then it empowers the director of insurance to impose and collect a civil penalty of not less than \$1,000, no more than \$10,000 for failure to comply with a request under this subsection. It goes on and requires the coordination of benefits in the same fashion in cooperation, similar cooperation with respect to the coordination of benefits. And, again, allows for a civil penalty in the event that that cooperation is not forthcoming. What they mean by coordinating benefits, I passed out to you a section of federal law that describes some of the requirements for state plans for medical assistance. And this particular section describes what a state plan must do and the idea of coordinating benefits is based on this document and the obligation of the insurance companies to cooperate in fulfilling the federal requirements as illustrated in this particular document, as described in that particular document. I also passed out to you, just in case you're interested, the overall findings and recommendations of the performance audit committee on that audit and you can see that this item was one of the items that was identified in that audit. Finally I would just point out to you, and the department will testify next and describe and be able to answer for you, I think, any questions you may have about the details of the bill. But I also just wanted to point out finally the fiscal note on the bill. Health and Human Services and the governor's budget this year predicted that if we can get this system straightened out and get this particular provision in place, that we ought to be able to collect \$2.5 million in the first year that this is in effect and \$5 million the second year, that being \$1 million of General Funds and \$2 million of General Funds. So I just quote that to indicate to you that it's a good chunk of money that we're talking about here and we ought to try to collect it as best we can. Thank you, Mr. Chairman.

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SENATOR MINES: Thank you, Senator Beutler. Is there question...anyone have a question for the senator? I have one, Senator Beutler. And not understanding...this is far from my element of expertise. However, where you have a penalty, a civil penalty of not less than a \$1,000 or more than \$10,000. That seems like a lot or is in the normal course of this type of infraction, is that normal?

SENATOR BEUTLER: Well, this provision, as I understand it, was taken by the department from a similar provision that they have in other parts of their law. But I also understand they've been working with at least the Blue Cross/Blue Shield representative who suggested that an alternative penalty was more appropriate and would be just as effective. And I believe the department is going to recommend that change to you.

SENATOR MINES: I see. Okay. Thank you, thanks for your testimony. May I see a show of hands, those that wish to testify in support of LB 589? I see one. A show of hands of those in opposition to LB 589? I see none. Those that wish to testify in a neutral capacity? I see two. Very good. Welcome. Spell your name for the record, please.

DICK NELSON: (Exhibits 3 and 4) Good afternoon, Senator Mines and members of the committee. My name is Dick Nelson, N-e-l-s-o-n. I am the director of the Department of Health and Human Services Finance and Support. I might add, Senator Mines, I think this is the first time I've had the pleasure of appearing before your committee...

SENATOR MINES: Well, wonderful, nice to have you here.

DICK NELSON: (laugh) I do want to thank the Legislative Performance Audit Committee for introducing this bill on behalf of the Health and Human Services System and, of course, I am here today to testify in support of LB 589. Under federal law, Medicaid is designated as the payor of last resort. That means with limited exceptions. If there is another source of payment for a person's medical care, that payment should be tapped first before taxpayer-funded Medicaid dollars are paid out. When a person is Medicaid eligible they own few resources. Therefore, it may be surprising to you to learn that approximately 10 percent of

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Nebraska's Medicaid population carry private health insurance policies either through an employer, a noncustodial parent, or occasionally purchased by the client themselves. Medicaid has been experiencing increasing difficulty with some health insurers obtaining information regarding whether a Medicaid eligible person is insured, the terms of the policy, and the status of any payment under that policy. Some insurers have told Medicaid that they believe the privacy provisions of the federal HIPAA law, the Health Insurance Portability and Accountability Act, either prevent them from sharing information or at least don't require them to share that information. Whatever the reason, the result is increased costs for the Medicaid program. The federal patient confidentiality law, the HIPAA law, provides at a subsection that I've cited here, 164.512 which describes the uses and disclosures for which consent or authorization, or an opportunity to agree or object is not required. And that means the opportunity for the patient to agree or object, and under the standard there are...it allows use and disclosure for health oversight activities. I'm not going to read this whole section of the law to the committee, Senators. Suffice it to say that when Medicaid is paying out state and federal dollars, we are entitled to determine whether the patient is eligible under our program and whether we should be paying or not. When read together, HIPAA and the Medicaid, the federal law under Medicaid, which Senator Beutler has shared with you on the payor-of-last-resort issue, clearly place an obligation on insurers to coordinate benefits with the Nebraska Medicaid program. However, many of the state's insurers have recognized that there are no consequences if they refuse to coordinate benefits. This legislation will close this loophole and compel insurers to abide by the terms of their policies and pay the coverage that was purchased, instead of shifting the cost to state and federal taxpayers. There are two types of health insurance policies prevalent in Nebraska. The first is health insurance purchased from a risk-bearing or a licensed insurance company and under the jurisdiction of the Nebraska Department of Insurance. The other type of policy is one which is funded by an employer, but is only administered by an insurance company. The employer-funded/self-insured plans are governed by the federal ERISA law and are not subject to the jurisdiction of the Nebraska Department of Insurance. For those insurance companies under the Department of Insurance jurisdiction,

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this legislation proposes that the Department of Insurance impose fines and other actions for failure to coordinate benefits with tax-funded benefit programs. For ERISA programs not under the Department of Insurance jurisdiction, this legislation permits the Health and Human Services Finance and Support agency to impose penalties. I would say at this point, Senators, if I may, as Senator Beutler indicated, we have prepared an amendment, at the suggestion of one of the insurance companies, which we would offer today. And I would just state just very briefly what this does is move the penalties for the licensed insurance companies under, I believe it's called the Unfair Insurance (Claims) Settlement Practices Act, an existing law regulating insurance companies with existing penalties. And I would offer that.

SENATOR MINES: Okay, want to hand that to our page, please?

DICK NELSON: There have also been questions about the need for coverage information and coordination of benefits from certain insurance plans such as indemnity policies. An example, for example, would be a cancer plan which would pay a lump sum to a patient upon a cancer diagnosis. Nebraska provides Medicaid coverage or eligibility to individuals who are disabled with resources to be applied with the cost of care. This is also referred to as "spenddown." Aged or disabled persons whose medical expenses exceed their income are allowed to spend down to...I'm sorry, their income and their resources, are allowed to spend down and still qualify for Medicaid. An indemnity policy payment would trigger that spenddown eligibility and computation. Though the client does have an obligation to report this to us they often do not. And notification from the insurance company will provide timely, important notice to allow correct eligibility determinations and application of lump sum payments to medical services. We have not requested this legislation and come to your committee as our first solution to this problem. Last year we enlisted the assistance of the Department of Insurance to obtain voluntary compliance. After the Department of Insurance published a bulletin for insurers, we began attaching copies of that bulletin to our requests for coordination of benefits. It has had little effect. A copy of the bulletin is attached for your information. There has been no appreciable improvement in the cooperation Medicaid has received from insurers. Given

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the current climate of fiscal constraint, it is imperative that the state plug all leaks and close all loopholes through which state dollars are being inappropriately bled. This legislation does not shift costs to private carriers, but instead compels them to abide by the terms and conditions of their purchased policies and federal law. I thank you for the opportunity to testify and I would be happy to respond to any questions you may have.

SENATOR MINES: Thank you, Dick. Do you have questions, committee? Anyone want a question, no questions? Seeing none, thanks for your testimony. You did a nice job.

DICK NELSON: Thank you.

SENATOR MINES: Anyone else in support of LB 589? Seeing none, those in opposition? And finally, I see none. Mr. Ullstrom, you are a neutral guy. Please step forward.

GALEN ULLSTROM: I am a neutral guy.

SENATOR JENSEN: Did we get a copy of that amendment?

SENATOR MINES: It's coming.

SENATOR JENSEN: Oh, thank you.

SENATOR MINES: Yeah, the page is making copies.

GALEN ULLSTROM: Senator Mines, members of the committee, for the record my name is Galen Ullstrom. That's G-a-l-e-n U-1-l-s-t-r-o-m. I am senior vice president of Mutual of Omaha Insurance Company, again appearing today in a neutral capacity. First of all, I want to say that we are in support of the concepts proposed here. I, over the years, have participated in some studies of Medicaid. We know that we have a problem with Medicaid. We think that all appropriate sources of revenue to Medicaid should be exhausted so we are in support of it and I think when...we did meet with the Department of Health and Human Services just over a year ago on this issue, we were told at that time that we were not one of the companies they were going after. We honor requests directly from Medicaid and we recognize that Medicaid should be the payor-of-last-resort. We should be the primary payor. So it's not an issue from

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that perspective. I did have some concerns with the language of the green copy of the bill. Mr. Nelson, one of the concerns I had was the penalty sections. I think I would much more prefer to have these penalty sections go pursuant to the Unfair (Insurance) Claims Settlement Practice Act which already exists in Nebraska and I do understand that that's...I haven't seen the amendment but that's an amendment maybe being offered by Health and Human Services. And so that goes a long way to alleviating my concerns with regard to that. In the process side, there's also a little bit of a concern. On page 4, section 6, talks about when there's a violation and it basically says that if the Department of Insurance is going to fine you they send you the fine and then you can request a hearing. I think the normal practice of the Administrative Procedure Act that they would send you a notice of a charge. You would have then the opportunity to go to a hearing before they would assess the penalty so they'd get facts on both sides. So I guess I would like to see the Administrative Procedure Act followed here so if there is a case in controversy that both parties be able to say whether they agree or disagree before there's a fine levied. And then we would have the right to go to a hearing to discuss the possibility of a fine so those are just...those are technical issues again. We thought and we were hopeful that based on our meeting a year ago and based on the department sending out a bulletin clarifying insurers' responsibilities that the need for legislation was not needed. We felt that there currently was legislation, at least from an insurer's perspective, allowing compliance or providing compliance. And, again, I'm surprised that I don't know whether the department has been contacted back again about companies that weren't complying. But we always felt that you ought to get the bad guys and not necessarily don't need a statute to enforce what most of the companies in Nebraska, or at least the ones that I know, are already doing. So that was the concern and if we're going to have a statute, and we feel we need a statute, then we'd like to see it...make sure that it's drafted appropriately so it doesn't cause any undue harm.

SENATOR MINES: All right, Galen. Thank you.

GALEN ULLSTROM: Thank you.

SENATOR MINES: Questions for Mr. Ullstrom? You have not

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seen the proposed amendment.

GALEN ULLSTROM: I have not seen the amendment.

SENATOR MINES: We will make sure that we get you one.

GALEN ULLSTROM: Okay, great. Thank you.

SENATOR MINES: Thank you very much. Anyone else wishing to testify in a neutral capacity? Ted?

TED FRAIZER: Please.

SENATOR MINES: Nice to see you.

TED FRAIZER: (Exhibits 5 and 6) I'm Ted Fraizer, a lawyer in Lincoln, a registered lobbyist for AFLAC. AFLAC is a Nebraska domestic insurance company and has been pleased to have its presence noted in Nebraska. Indirectly, Dick was making reference, I guess, to AFLAC because it is well known as a cancer specialty company. We, of course, were aware of the activities of Health and Human Services even before the department issued its bulletin in January a year ago and looked at it, recognized that what it was requesting. But since we're already complying as far as we knew, why, of course, there was no response to the department bulletin. I would like to hand out to committee members the form which AFLAC receives from HHS asking AFLAC to acknowledge by a deemer that named insurers have coverage. Relying on this notice to AFLAC, they found no need to respond to it when they can verify that the coverage does exist and consider that they're fully compliant with the request of the department. Now if there's additional information or additional failure certainly by AFLAC, they would like to have better acknowledgement or more extensive acknowledgement by HHS. There are the other technical aspects to the bill which we believe could be coordinated a little bit better if all of us, many of us, had seen this bill prior to the day that it was introduced. And as Mr. Ullstrom has indicated, some parties were aware of a situation many months ago, but there had been no further efforts to develop a bill which would satisfy any deficiencies. Just for the information of the committee, I'll also hand out a section of the Nebraska statutes which clearly points out the lien rights of the department when

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there are...well, when a person signs up for Medicaid and there are a couple of other statutes in addition. Those statutes really are noted right on this notice form that the department sends out. It lists all the sections of the Nebraska code which apply to assignments, to liens, and those are all recognized. Now it does require a line of communication, shall we say, between HHS and an insurance company to apply a lien for the lien to be collectable, shall we say. The insurance industry prides itself, in general, on the prompt payment of claims. Certainly AFLAC does and very often, I presume, that by the time that a notice, even such as this is received, why, the company has received a claim and made a payment...

SENATOR MINES: I see.

TED FRAIZER: ...so if there's anything it's an after the fact matter and there are other provisions in the laws pertaining to medical assistance for HHS and one of its entities to go back at somebody that may have double-dipped, shall we say. I just received this...just been handed a copy of this amendment dated today. I had a long discussion with HHS yesterday and we visited about many issues and I'm sure that there can be further discussions, and we're certainly willing if the chairman and the introducer are...I won't say inclined but (laugh), would sit down with representatives and see if we can work out a more workable bill within all the sections of the insurance code which pertain to prompt payment of the claims, unfair trade practices, and the diligence which the insurance industry attempts to apply to have good relations with the public, certainly with state government and its several entities. And maybe that's where this bill should go within the next few hours (laugh) not...and we're not asking there to be...well, we're certainly not asking that it be sent out, but not asking that it be killed either which is the reason for coming before you in a neutral capacity.

SENATOR MINES: Great. So AFLAC is open to discussions if Senator Beutler and HHS...

TED FRAIZER: Sure.

SENATOR MINES: ...everyone is amenable. Okay.

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TED FRAIZER: Yes, yeah.

SENATOR MINES: Any questions for Ted? Seeing none, thanks for your testimony.

TED FRAIZER: Yeah, thank you very much.

SENATOR MINES: Anyone else wishing to testify in a neutral capacity? Seeing none, Senator Beutler to close.

SENATOR BEUTLER: Just a couple of things, Mr. Chairman. One, I was negligent in not indicating to you at the very beginning basically two things. One, I meant to thank Dick Nelson for his great cooperation since he's come on board and I know he's trying to make things work right over there as far as their obligations are concerned in terms of this reimbursement and billing process. And we're trying to be helpful to him with this legislation and whatever else is needed to be sure the taxpayer is getting all the money back that they should get back. Secondly, the way the performance audit process worked and then into the fall and brushing up against the session, it would be a fair criticism that the insurers did not have an adequate opportunity before it was filed to weigh in on this a little bit more. And so I don't think Ted's suggestion is all that bad. If you'd give us a week or two to sit down with the insurers and be sure we picked up all their ideas, all their...

SENATOR MINES: That will be great.

SENATOR BEUTLER: ...ideas that would be...I'd be grateful for that and I think we could offer you something that probably is a consensus sort of piece of legislation.

SENATOR MINES: Sounds like a good idea. I think Senator Jensen has a question.

SENATOR JENSEN: It would sound like you and Director Nelson could get together with the insurance companies and get their ducks in a row and proceed from this time forward. (laughter)

SENATOR BEUTLER: Well, at least one (laughter) AFLAC (laughter).

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SENATOR MINES: Any other questions or witty comments from...Chris, before I close this hearing, the work you do with the performance audit committee is really under the radar. A lot of people don't see or appreciate what goes on. We appreciate what you're doing and thanks for putting this together and bringing it to our attention. Thanks.

SENATOR BEUTLER: Well, thank you, appreciate that.

SENATOR MINES: With that, we will close public hearing on LB 589 and let's open the public hearing on LB 652 and talk about provisions for motor vehicle service contracts. And this will be introduced by Senator Beutler. Welcome again.

LB 652

SENATOR BEUTLER: (Exhibits 1, 2, 3, and 4) Mr. Chairman, this is a follow-up on some discussions we actually had this summer on the National Warranty situation and...

SENATOR MINES: That's right.

SENATOR BEUTLER: ...I'm trying to remember which members of the committee were in on that discussion. Several were, I think.

SENATOR MINES: Joel and Mick (laugh).

SENATOR BEUTLER: Pardon me?

SENATOR MINES: Joel and Mick is sitting...LeRoy as well, I'm sorry.

SENATOR BEUTLER: Just...LeRoy.

SENATOR MINES: Senator, I could take this graph home and study it for a week and I'm just not sure where I'd end up with it.

SENATOR BEUTLER: You know, the real challenge for me today, Mr. Chairman, is to try to simplify this matter but not oversimplify it for you and try to illustrate the different approaches here. The central question before you is whether

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we need to change the structure of the law, regulating automobile service contracts in order to better protect consumers. In light of National Warranty's collapse in the summer of 2003, everyone agrees that some changes to the structure of the law are needed and I want to emphasize that, that this is a situation where everybody agrees some changes are necessary. We don't agree yet anyway although we're working hard on it on what the correct approach should be. There are currently three main lines of thought on the direction of change. One idea is to return to the origin so the automobile service contract law, and this would basically require that the car dealer be a party to the contract. In other words, the obligor to the consumer. This way the dealer would be primarily responsible to the consumer. There wouldn't be any insurance. This is the way it was handled at the beginning. Car dealer deals with consumer. However, the car dealers, at this point in time, do not want to return to this system for tax reasons, and possibly for other reasons, and no one involved in this discussion is suggesting that start to change. And it would be a dramatic change from what has occurred in the last 15 years. So that's not the avenue that's being discussed. What's being discussed are two other lines of thought. The second line of thought suggests that the automobile service contracts be treated more like a straight insurance contract and be regulated like an insurance product. This is the direction of the amended version of (LB) 652 which has been passed out to you and which is the version that will be discussed and presented to you by Mr. Tim Wagner, the director of the Department of Insurance. The third line of thought comes from industry representatives who are agreeable to building a more responsible system. The current structure involves a more or less elaborate system of middle men between the consumer and the insurer, a system that failed miserably in the case of National Warranty leaving thousands of consumers without their money and with no meaningful legal recourse. Let me say, however, that Nebraska victims of this particular collapse were largely, although not entirely, made whole by the automobile dealers of this state. Notwithstanding the fact that as a group they were not technically liable on the service contracts. Many of them did, in fact, maybe most of them did, in fact, come forward and protect their own customers, the consumers. Let's talk a little bit about the second and third avenues of reform. I want to attempt to relate those ideas a little

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closer to the current structure of the automobile service contract relationships. And I want to do this in as simple as form as possible and I hope I'm able to give you a basic understanding. But the entire situation is extremely complex and I think, though, that if I can just orient you to the basic question, that's really practically before you, then Mr. Wagner and, in turn, those who would propose the other alternative solution can both describe to you then in more detail their suggestions. And before I start, I want to indicate that in this case we have had some ongoing discussions and we are, I think, moving closer to an agreement on how to deal with the situation overall. But let me go back right now and just try to use these charts a little bit. First, take a look at this draft structure chart of National Warranty. As you can see, it's extremely complex and I don't think it's necessary to go into all of these complexities of National Warranty to give you an idea of the three basic groups that are involved. If you look at this National Warranty, this was overall on this big rectangular chart, it was a risk retention group. And there was the insurer, National Warranty Risk Retention Group, and then it had these members, and then it had some other entities that were involved in types of activities that may have related to marketing, may have related to holding reserves and a number of other functions. But, basically, the business of dealing with automobile insurance contracts, it can be by a risk retention group, but it can be by another organization that doesn't involve a risk retention group. So what we're looking at is a solution to the overall problem, not just in the context of a risk retention group. But in this group you have basically the insurer and then you have a group of people that are performing a number of other functions; some of them marketing, some of them serving as the obligor on the contracts with the consumers. That is, the consumer wouldn't enter into a contract with the dealer as you might expect, but would enter into a contract with one of these administrative organizations. And the reason that they like to do this is because there is a tax advantage to the car dealers if they are not the obligors on the contract. So these different units in National Warranty can serve to show you how many of these entities, other than the insurer, are involved in an organization and stand between the insurer and the consumer. Okay? Now, look at the simpler chart. This oversimplifies and brings it down to the things I think we want to talk

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about. Up at the top you have the insurer. And then under the insurer you have, under the current structure, these administrative obligors. These are the units that have the functions that are described down below there on the chart. They may actually market the automobile insurance contracts. They may allocate contract payments between parties. They may negotiate claims. Instead of the claim adjuster being with the insurance company it could be with one of these organizations. They could pay claims and, finally, they could actually hold some of the reserves, some of the premium money that is there for the payment of claims should that ever be necessary. So the original impetus of the Department of Insurance was to eliminate that category of administrative obligors because they felt that overall it made it an impossible situation to regulate, and that they could never really guarantee that the consumer would have a modest degree of security. But what we're trying to do is to retain the function of the administrative obligor or at least allow them to retain functions one, two, three, and four on your list. Okay? The one that's problematic is that fifth one, holding reserves. What we're working towards is a solution whereby administrative obligors, under the current framework, no longer hold reserves. These administrator obligors under current law are not insurers and are not regulated by the Department of Insurance, and yet they have been holding a portion of the reserves that are relied upon to pay claims in the event that there's a problem with the insurance company and therein lies a large part of the problem. The Department of Insurance can't identify because it can't control those administrative obligors, cannot identify how much in reserves they have, whether they're adequate overall when added to the reserves that the insurer keeps, the portion of the reserves that the insurer keeps. There's competition with regard to holding reserves. And so the whole situation is problematic as long as these administrative obligors are going to hold reserves. What we would like to do, we're trying to figure out a way whereby they do not hold the reserves, that the insurer holds all the reserves, that the insurer has certain obligations with regard to capital and ratios, that the insurer's records, overall, can be reviewed so that a regulator can know whether the system taking as a whole is safe or is not safe. And requiring...and a mechanism for requiring that is to require first dollar coverage by the insurer. That is, the insurer is obligated for the whole

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claim and then can look to the administrative obligor, or not look to the administrative obligor but is responsible for the whole claim. So that's the basic system. I hope that's given you some idea of what we're working with here. Keep in mind that these administrative obligors in any one system may be multiple in numbers and can do a whole number of functions. But the holding of reserves is the big problem item. I'm sure that I've both oversimplified and forgotten to tell you maybe one or more key things but, hopefully, with that starting point as you listen to Mr. Wagner and as you listen to representatives of the industry, and we're trying to listen to each other, we're working through this pretty handily lately. I hope you get a very clear idea of what the problem is here and what we need to address.

SENATOR MINES: Thank you, Senator Beutler.

SENATOR BEUTLER: Thank you.

SENATOR MINES: Are there questions for the senator? I might just make a comment that in looking at the chart that shows the insurer administrative obligors and consumer, it felt restrictive at the administrative level but you've explained that it really can be multiple entities and can be fashioned in whatever way works for the insurer, but for holding of reserves.

SENATOR BEUTLER: Um-hum.

SENATOR MINES: Okay. I'm on board. Thank you. Could I see a show of hands, those that support the bill, please? I see two hands. May I see a show of hands of those that will testify in opposition? I see one, two, three, four, five. And those that will testify in a neutral capacity. I see none. Mr. Wagner, welcome.

TIM WAGNER: Thank you.

SENATOR MINES: Director Wagner I should say, I'm sorry.

TIM WAGNER: No. My name is Tim Wagner, W-a-g-n-e-r. I'm the Nebraska Director of Insurance and I first want to acknowledge to you, Mr. Chairman and Senators that this clearly is an issue that there are many sides to. I think,

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Senator Beutler, I really appreciate and acknowledge his help and his presentation. I think he presented that more formally and more concisely than I could have in my rambling. I also acknowledge that there is opposition. It's excellent opposition. There are different philosophies involved here in this and we have to be cognizant that, however, we do need a system that will protect our citizens because we have had not one failure, but historically there have been a number of failures. The first and foremost recently is the National Warranty situation. At first we thought, well, it's a command company, you know, what do you expect? And then we got into it and well, it was a risk retention group. Well, that was a problem, but we have analyzed and re-analyzed and the problem is much deeper. And it's a systemic problem. There have been failures in the past, same systems, General Warranty, American Warranty, Universal Dealer Services, are just some of them. The most sophisticated company in commercial lines insurance, or purported to be, is American International Group. International...American International Group just disclosed, or it was reported, they lost approximately half a billion dollars in the owner warranty business over the past several years. And I believe that the model doesn't work because of its flaws and band-aids won't fix that. It's going to take some major change to create security. In fact, we adopted fairly close to what was the then model in 1990 and our citizens would have been better off without it because what we created was the administrative obligor so there was no place in the event of the failure of the insurer for these people to go. And I also would like to acknowledge that the car dealers stepped up to the plate in Nebraska, in most instances, and paid those claims. There were only a few instances in Nebraska that I'm aware of where they didn't perform as if it were a dealer warranty. In my estimation, administrators of warranty service companies have been given too much power. Now that doesn't mean that every one of them is exercising that power or restraint. Their relationship with the underwriters is clear and it's negotiated. But we have situations where they have set the price or how much the reserve will be. They actually maybe don't...may hold the reserve or they may have a turnkey operation where the reserves are held by, we call them POICs which are produced-owned insurance companies. There is no regulation of these companies. They can invest in anything. They can be day traders. There's no limit on how much can

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be marketed and yet we're relying on those reserves to pay these claims. So that is an issue that I'm concerned about. There's competition on the amount of the reserves and the fees that are charged to the dealer because the competition in essence is related to the relationship between the administrator and the selling dealer. To that the dealer adds a margin for selling to the reserves to get the ultimate cost to the customer. And there's been enough money paid to handle these claims but, unfortunately, for some reason there have been just too many failures. Dealers are incented to take the deal that has the lowest reserves because it's the most profitable, but yet the dealers become victims, as well as our citizens, when the thing collapses. The department doesn't regulate the administrators for solvency and we have absolutely no idea what the reserves are. And we have no way of knowing what they're invested in. Once an insurer gets into these deals and they are deals. I mean, there are very substantial firms and excellent administrators. But there are, I guess, for want of a better word, a few high binders out there. Unfortunately, National Warranty ran into some of them. But...and so it isn't a universal, but we can't craft regulation in such a way that we can carve out the good guys. We have to create a system. All insurance company managers are not geniuses and there's even some that have a great penchant for what they feel are risk-free fees. And it gets the best of their judgment and they're basically led down a path, if you will. They enter into these deals and then when it hits the fan they can't get out. They try to underwrite, they try to write their way out and that just exacerbates the problem. What we're trying to do is take that money away from the administrator and put those reserves, those first dollar reserves on these warranties, with the insurance company so they're subject to the insurance company, therefore, can look at loss payout patterns, can test reserving, can do investing in accordance with the investment code that we require. That's...by putting it on the income statements and the balance sheets of the insurers, the regulator can get some idea of how the company is leveraged. The way this system worked and the way, in the instance of National Warranty, and I believe in other cases but not all again, the money for what would be the expected losses sat with the administrator or in these POICs. The insurance company just gets its fee, in this case in the case of National Warranty that fee was about

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\$50. And they just simply guaranteed the risk. They weren't looking. They weren't studying. They didn't understand what that risk was. We looked at the National Warranty statements and I showed you in the summer hearing what is called a statutory blank. It's about this big. We have a rather sophisticated manner in which we monitor the solvency of insurers, but when the premiums are not booked, when the premiums that would have been charged for the exposure the company had are down at the administrator level the company looks pretty good because it doesn't look leveraged at all. Its risk-based capital ratios would look good. National Warranty, I believe, was an A- rated company about six months after, before its demise and as we reviewed the statements I even reviewed them in retrospect. And I had no idea. You couldn't have told from that statement the risk that this company had assumed and to me that is a major problem. The amendments...this is an ongoing process. It's a very complex process. And what we're trying to do is simplify it. We're trying to say the administrators, they can administrate, they can market, they can pay claims, but certain functions have to rest with the insurance company. The holding of reserves while not in the bill, the pricing of the product, and the investing of those reserves. And that...it's basically saying, we want to keep it simple. We want to keep it within an existing regulatory framework that we have. We don't want have to establish a separate regulatory framework to regulate warranty service contracts. That's expensive to us, it's cumbersome and would take a lot of ideas and a lot of time. One thing I would like to say that even though is a step and we're one state, and I must caution you on this point because we could have another failure or two. And you may come back to me and say, well, we enacted some protections. Why didn't that work? Why do we have these unpaid claims of our Nebraska citizens? And I want to say that the reserves in the process and it's a complicated process, but even though we require reserves to be held on our business in our state doesn't mean the company will hold reserves in similar other states. There's only one other state that requires the holding of these reserves. I mean that...that's true but the issue is when a company goes insolvent we're going to prorate with everybody so there could be some damage. And we're working to try to see if we can create some system to give Nebraskans a preference and some reserves are held under our statutes. But those are the basic...that's really what we're trying to

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do and I'd be more than happy to entertain any questions. It's pretty complicated (laugh).

SENATOR MINES: Thank you, Director Wagner. Committee, any questions for the director? Senator Langemeier.

SENATOR LANGEMEIER: Director Wagner, if the repair business in the automotive industry is kind of unpredictable and you can't actuarial data determine that, how do we know any reserve level is truly enough or isn't enough? Would any reserve...let me rephrase that. Would any reserve have helped National Warranty and their customers?

TIM WAGNER: Well, certainly it would have, Senator. And you're right that when you're writing contracts that are five years long, you know, five years out, seven years out, new automobiles are coming out and there's no history associated with the repair costs. And we may or may not have an inflationary environment. There is no certainty. It is, at best, a risky business even regardless of where the reserves are held. And I would...I think the record is clear on that as the landscape is littered with failures in the ability to price the product. Initially, years ago, and to give you an example, the foreign automobiles had a much higher...a better, much better lower cost than the domestic produced cars in the United States. That I don't believe is no longer true, but I have personally attempted to reserve this type of business in my career measuring year of car, age of car, use of car, the terms, how long do you go out, you know, how many miles do you allow? It is a difficult business and I...there is certainly a lot of risk simply inherent. It is risky but it's better that the insurer have a...rather than a \$50 reserve on a fee, to have what might have been assumed to be, for instance, a \$400 a car reserve and have that available to pay those claims and identify changes in the business so they can adjust their reserve rates accordingly in future years or on future business.

SENATOR LANGEMEIER: Thank you very much.

TIM WAGNER: Yeah.

SENATOR MINES: Thank you. Any other questions? Tim, you had mentioned that only one other state, or there are two or

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three states...is this a...would this be a model that is used in many states around the country, the one that you're talking about? Or is this unusual and might it present problems for the industry?

TIM WAGNER: The one that we are proposing,...

SENATOR MINES: Right.

TIM WAGNER: ...we are pioneers and we can take some arrows.

SENATOR MINES: Okay.

TIM WAGNER: Okay. There is no doubt of that. But by the same token, the model act that we have, or very close to have, hasn't served us well and the model act that may be purported that's in 34 states didn't serve their citizens well when it came to National Warranty. I mean, so, you know, somebody's got to take a stand and we're trying to take that stand and do the right thing for our citizens...

SENATOR MINES: Thank you.

TIM WAGNER: ...and that's...

SENATOR MINES: Thank you, appreciate. Any other questions? Thanks for your testimony.

TIM WAGNER: Thank you.

SENATOR MINES: Next testifier. Welcome.

MARGARET BUCK: Thank you.

SENATOR MINES: Senator Aguilar is gone.

MARGARET BUCK: He's gone?

SENATOR MINES: Is he not gone?

MARGARET BUCK: No, he's in another committee but I'm not here on his behalf today.

SENATOR MINES: Oh, really? Oh, welcome.

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MARGARET BUCK: I'm here as a consumer.

SENATOR MINES: Welcome. I apologize.

MARGARET BUCK: Thank you. That's all right. I was going to address that.

SENATOR MINES: All right.

MARGARET BUCK: Chairman Mines and committee, my name is Margaret Buck spelled M-a-r-g-a-r-e-t B-u-c-k. And you do know me as Senator Aguilar's legislative aide but I'm not here as his employee but as a face on an issue. I'm here to give you a visual. I'd like to thank Senator Beutler for bringing this issue up because I was burned not once, but twice in this one. I consider myself a fairly savvy consumer and I'm not afraid to make inquiries or file complaints when I feel I've been wronged, but that didn't help in this issue. I'm kind of a poster child in more than one way here because one of the articles I read after the National Warranty articles came out said that single moms were many of the consumers who bought these purchases. And I think that's probably typical because we might worry about car repairs more than a guy would. And I'm a single mom, single income family, so I felt good when I had a contract that would take care of something like that and actually I had one that did work on the first contract that I had. It replaced several fairly expensive computer chips in a car that I had. When I traded that car in, I wanted another contract because the first one had worked. And I cancelled the first one on the car that was traded in, or at least I thought I had, but I never got the reimbursement and I never got the reimbursement. Finally, about ten months later I went to the car dealer where I had purchased the car originally and they were nice enough, they sat down and wrote me out a check right then and then they went back and argued with the other company about the reimbursement and thank you, Anderson Ford for that. The auto service policy on my current vehicle cost me \$1,415. I purchased it through a website of Warranty Gold, and it was less expensive that way so I thought I was going to be saving myself some money again. They even offered an interest-free year and a half long payment plan that I took advantage of, but I was somewhat nervous about buying it over the Internet. And I called and asked a lot of questions and

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kind of delayed my decision for awhile before I actually purchased it. One of the selling points they helped calm my nervousness on was that the administrator of the plan was right here in Lincoln, Nebraska so that helped me feel a little bit better about it. I recently went back and read the contract and nowhere in that contract does it mention anything about National Warranty, or any reinsurance group, or any risk retention groups. It doesn't say anything about any of that. That policy I never got to file a single claim on, never got to use it at all, 1,400 bucks down the drain because approximately eight months into it National Warranty went under. So I called Warranty Gold right away looking for assurance that they would be able to uphold my policy. And they told me that they were already in negotiations with a new risk retention group and my policy would simply be transferred to that so I'd be okay. At that point, I still had three months of payments to make on the policy. If they had been truthful to me, of course, I would have done what they expected and stopped those payments, but they weren't truthful with me on that. Eventually, I was e-mailed a bankruptcy notice from the Texas courts and Warranty Gold so my name is on some bankruptcy court list somewhere in Texas. I don't hold any hope of ever recovering any of that, but at least it's something compared to the other policy that I'll tell you about. I also went back to the website where I originally purchased it and even after the bankruptcy notice they were still selling policies. And I was just floored by that. The second policy that is involved here was on my daughter's car. She was in college and working two jobs, and Mom thought she'd be helpful and cosign for a car and get her an extended warranty because, goodness knows, she was terrible at taking care of cars. So we had a few minor repairs in the year that she owned the car and the policy did pay for a few of those minus the deductible, of course. But when her situation changed about a year later and she couldn't afford the car anymore, we sold the car. So I got this little form to fax in my cancellation which I did and I called to make sure the fax had come through okay and that everything was going to be all right. And they assured me that they would accept my cancellation request so the policy was cancelled, but they were not going to reimburse me for the unused portion. They stopped paying claims was the word she used and I said, what does that mean? And so the process went on and I started making a long list of phone calls and inquiries and what it amounted to was they owed me

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830 bucks and I had no way to try to collect it. Eventually I called the Department of Insurance and they were as clueless as I was, at that point, about it and said that they had no authority over what was going on there. I talked to an attorney but the attorney fees would have been exorbitant compared to the lousy 830 bucks so I just let it go. As far as the intricacies of all the things that Senator Beutler and Tim Wagner have told you about, I won't claim to understand any of that because I don't. All I know is that someone is getting out of their obligations and it cost me \$2,400, not happy about that. In closing, I'd just like to ask you to do whatever you can to prevent that from happening again. And if the Department of Insurance thinks their amendment will do that or greatly lessen the chance of that happening again, I'd ask you to support that. One of the articles I read, oh, I went over that. Sorry. I thought this was just insane because I never once thought that this was not somehow regulated. There wasn't somebody who had authority over it and I was, again, trying to be a good mom and trying to be a savvy consumer but none of those played out. So I thank you for your attention and for letting me put a local face to the situation.

SENATOR MINES: Thank you, Margaret. Committee, do you have any questions for Margaret? I'm sorry you had to testify today but...

MARGARET BUCK: So am I (laugh).

SENATOR MINES: ...but thank you for coming in.

MARGARET BUCK: You're welcome.

SENATOR MINES: Thank you, appreciate your testimony. Anyone else in support of the bill? Opponents, those in opposition, please come forward. Welcome.

TIM MEENAN: (Exhibits 5 and 6) Thank you, Mr. Chairman. My name is Tim Meenan, T-i-m M-e-e-n-a-n. We wanted to make it easy for you so you have a Tim proponent and a Tim opponent so it's easier to direct questions. I'm here today representing the Service Contract Industry Council which is the national trade association representing service contract providers. Includes insurers, includes retailers, it includes administrators, and others that are involved in

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this business. Our clients include companies like General Motors Acceptance Corp, Ford, Sears, and a number of other major insurers like Aon, AIG, and other providers of service contracts. I will first say that National Warranty, Warranty Gold, or any of the bad names you've heard today so far, none of them were members of our trade association, thankfully. We have worked over the past 15 years that I've been the general counsel for this association to work not only with the NAIC, but with regulators and legislatures across the country to try to bring some fair and balanced regulation to this industry. This is a product that started out with no regulation many, many years ago because it, in a way, emanates from two different theories of law. One is, is it a warranty which, of course, you can provide with a product and the warranties typically don't receive much regulation and are authorized under federal law or is it insurance? And, quite frankly, it has elements of both and I think that is why the NAIC in the early nineties, quite frankly, several years after Nebraska adopted its act, I believe, developed a model act. I will tell you that the current law in Nebraska contains a couple of pieces of the NAIC model act, but does not contain substantially the authority that that model act contains. We as an industry have taken that model act, in fact, thought of ways to add some enhancements to it and have spent ten years since it was adopted by the NAIC going around and working with commissioners and legislators to try to get this law adopted. While there are about 35 states that have laws and I include Nebraska in that regulating motor vehicle service contracts, about half of those laws were probably in existence before the NAIC model but we've gotten close to half of that number, a little less than half of that number, to go ahead and adopt it. States like New York, Illinois, and other states, Alabama, there have been a lot of states that have adopted some version of the model act with these enhancements I'm talking about. We're here today to tell you that, clearly, there has been a bad actor that acted incompetently or worse in Nebraska and elsewhere. It is a fluke of federal law that they could do that. We all know that they were a Cayman Island risk retention group that the federal law prevented insurance regulators from taking control of, and we're asking you to look at what are the chances of that happening again and tailor your response accordingly. We're not here to ask you to do nothing. We do think and, quite frankly, we welcome as an industry

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regulation. An NWIG is bad for all of us and I can tell you that, for example, the consumer that spoke earlier, had the NAIC model act been in effect here; it requires cancellation provisions, it requires you to promptly return them and you can fine the administrator, the insurer, whoever is obligated on the contract, if they don't step up. So there's those kind of provisions to all of them. It is a complex area and I will tell you that the chart that describes NWIG is in no way representative of how this industry works everywhere else and that is a complex chart. I will say that Senator Beutler's chart that he handed out is much more representative of how the industry operates. To a large extent, these administrators, that he calls them administrative obligors, that serve as obligors in the middle, many of them are owned by insurers like AIG or Aon or the car manufacturers. Some of those are independent. The insurance companies that stand behind them, they are on the hook for all claims. And if they're not charging enough then they've made a mistake. AIG was referenced by Commissioner Wagner, made a mistake and guess what? They paid \$500 million in claims for not pricing it right. The entire insurance industry mispriced asbestos claims and my role as general counsel for the Florida Guarantee Fund, you know, we're still dealing with some of those and there are a lot of insurers still around paying those claims. The system works, is what I guess I would say, to a large extent. What we would suggest today is is that you don't create a system that is unique to Nebraska and make it difficult for companies that operate in the other 49 states to have to change their business model to operate here. We would like to leave you with several ideas of enhancements to your law that we think will make it tougher for a thinly capitalized insurer to come in here and do harm to your consumers. And we've got several different options there. I will say that we appreciate...Commissioner Wagner has been working with us and we've committed to work in the coming weeks to try to find some common ground. We haven't reached that common ground yet but here's what we have. First and foremost, we have taken the current law to address this bill specifically and come up with a streamlined approach which preserves your current law and adds two very important concepts that if I was to say you had to do something fast and quick, this would make your law a lot better. The first concept on page 1 there, basically creates some solvency standards for the contractual liability insurers. You call

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them service contract reimbursement insurers here in Nebraska. I've been told that in Nebraska I guess it takes approximately a million dollars to start a property and casualty insurer. Every state has a different number. Florida, it's five. Michigan, it's seven. And there are states that are lower than Nebraska. What our view is is that if you want to be in this business and stand behind service contracts, we would like to see insurers that have more surplus. Our numbers are, give the industry a little flexibility. Either have \$15 million in surplus to even issue a service contract reimbursement policy or to add some flexibility. And, quite frankly, we worked this out before the California Legislature last year because there are different companies with different models. The second option would be have \$10 million, but maintain a writing ratio of a dollar for every three dollars in premium that you take in. So those are the two options that's in effect in California. We've actually got this wording pending in a New Jersey legislation contained within an NAIC type model right now that I think is going to work its way through. We've got it pending next door in Oklahoma in their existing law. We're making some changes and want to add this in. So it's an example of us trying to make it tougher and we think that's a good topic. The second concept in this amendment, that I think is paramount, is what we call in the business a cut-through and what this does is it puts a requirement on both the issuer of the service contract and their insurer and it works like this. If that obligor of that service contract and, quite frankly, there's a hundred programs; there's probably a hundred nuances. There are some dealer obligors. There are administrator obligors. There are administrators that are associated with the companies. Whoever that obligor is, they have to say in their contract with the customer, if we don't make good on your claim within 60 days, you have a direct right to go to the insurer. Here's who the insurer is and you can file that claim. It places the same responsibility to be placed in the service contract reimbursement policy that is issued by the insurance company to the obligor to say that, they have to open up their phone lines and their doors to take those if, for any reason, that claim is not satisfied. So it establishes this direct contract privity approach and it is contained in the overall model but we thought, of all the things that we could quickly offer to provide some extra safeguards, these would be, two. The second idea is what

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you've heard mentioned several times. This is an industry model act which, as I said, is basically the service contract, the NAIC service contract act with some enhancements. And you have heard the department is not embracing this approach right now. I would tell you that your current law in the model act that's being passed out to you are two totally different things. Your current law doesn't maintain a lot of the issues in the model act. The most notable is, it regulates, and requires registration and regulation of the administrators. We welcome that, we're fine with that. The fact is is that since insurance companies are so intertwined with this business, insurance companies are familiar with and used to and embrace regulation. And it will keep out some bad actors. If there are weaknesses in that law in light of it being drafted back in the nineties, we have pledged and listened to some of the things that Commissioner Wagner has suggested. And we're going to try to insert some things that aren't in any other states to give him more transparency so that he can find out where the reserves are, what the reserves are, keep the bad actor out, prevent someone who was with an insolvent company before from starting a new company and coming back in. Those are all good concepts that we think are good for the industry and will be good for Nebraskans. There's another concept that's not anywhere here, but it sort of came up in the last couple of days in talking with the senator and his staff, and the commissioner. In fact, it came up on Saturday. Senator Beutler likes to have you meet with him on Saturday and we're willing to do what it takes, even come from Tallahassee, Florida, up to snow-filled Nebraska as much as we need to, but this is the concept. The federal risk retention act says that if the state where the risk retention group is formed and, as I said, the Cayman Island thing is a fluke. They only let so many through the gate back in 1986. I think there were two left that met the offshore requirement. One is now gone. The other is not in this business. So the rest of the risk retention groups have a state regulator that the commissioner works with at the NAIC that could be in this business. Some of those are, quite frankly, members of our association as well. If that state is not doing their job, examining that company, the federal act allows a commissioner to go in and do an exam of that company. Many states, a number of states, have adopted a state corresponding provision to grant that authority to their commissioner. And we have not found where Nebraska

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has done that and I think the Nebraska law would be stronger if in its laws dealing with registering risk retention groups because they have to at least register and make their presence known, follow a number of the laws here. Giving that authority to your commissioner, I think, could have made a difference in that past debacle and will make a difference in the future as well. I can also tell you that a bunch of risk retention groups are not going to be able to write in this state if you adopt the 15, 10 million dollar surplus requirements and that's simply a fact. The way they operate and many of them, not all of them, the way many of them operate is they form shop for the cheapest state. You know, so it's no coincidence that when you look at the list of states where a lot of them seem to be domiciled they end up in the same couple of states and that's the state where it takes the least amount of money to form an insurance company. So you go there, form an insurance company, pronounce yourself an RRG, pounce on the other 49 states and there you are. This approach will survive federal challenge, you know, sadly the law on this has been set in federal court by NWIG (laugh). In fact, in a pretty big case in Oregon where Oregon tried to keep risk retention groups out there was a federal judge that construed the law and said, look, the federal law doesn't let you discriminate and say RRGs can't come in; admitted insurers can. And I think you all probably know that. But what it did say is that you can certainly put restrictions on a line of business as long as they apply to everybody. So the idea of the 15 and the 10 million, we're saying that the admitted carriers will do it. We'll step up to the plate and then they'll have to as well. And I do think you screen out start-ups and people that don't have significant capital on a significant investment in this business so that's another good concept that we want to talk about. You can, Senator Langemeier, if I may, you can project as well as an actuary can project anything, and actuaries for AFLAC and others, try to tell us how often we'll get sick, when we'll get sick based upon your age and your cigarette use. So it's at least as predictable to look at millions and hundreds and hundreds of millions of dollars of claims you can project actuarial science. The commissioner is right. New cars come in, new plasma screens come in, and there are adjustments and you have to be on top of it. But it's an actuarial science just like any other line of insurance. And I don't know what was going on at NWIG but, obviously,

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they forgot to talk to an actuary and that's a problem. And the companies I deal with, they're very conscious of price and they know where the reserves are and they have contracts locking in those reserves and making sure that they're only spent to pay claims. These are the major topics. We're for balance regulation. We would like to work with you to fix something up here that would work for your state. We have service contracts being provided by good companies that have paid every claim for years and are going to pay every claim for years to come. And we're asking not to take an approach that is so different that it will make it tougher to come in here and do it. And I think that ends my testimony and we thank you very much for the opportunity to appear here today.

SENATOR MINES: All right, Tim. Thank you. Questions for Tim? Tim, under your model contract, where are you at on the obligors holding any reserves? I mean, is that something...I obviously haven't seen this yet but?

TIM MEENAN: Sure. We like to have that flexibility. I can tell you that when one of my clients, one of the members of the trade association deals with a division, a nationwide, and they use an independent administrator which is the best example because I think we all recognize that when Ford Motor Credit owns their own warranty company, in a way, they do control their own reserves even though they may be in a different company.

SENATOR MINES: Sure.

TIM MEENAN: But in this case, this is a big national provider, probably one of the top five or six companies underwriting this, they have extremely strict requirements as to where those reserves can be. There's audit requirements. They come in and check audit manually, they can't remove those, so companies that do it right...

SENATOR MINES: But how, if I might interrupt. How might the department...Nebraska Department of Insurance understand where those reserves are?

TIM MEENAN: Okay. Here's our idea. If you require those administrators to register and, in fact, one of the places we're going to beef up this report, I mean this proposed

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bill, we don't mind giving financial reports. That's what these companies do in a lot of states. Make the administrators file financial reports. The model act itself actually gives companies that want to provide service contracts three options and the NAIC developed these three options to have solvency. One is insurance from an admitted authorized insurer. The second is establish your own self reserves and, quite frankly, 98 percent, probably or more, use the first option. There's very few self-reserving, but I will tell you I know of car dealers. I have one that's a client in Florida who has their own program and why do we want to force that guy who understands how to fix cars, he knows when they break down. He's got his own repair shop. The NAIC had testimony on allowing the smaller entities to businesses to have their own self-insurance option. The third option is and it sets the reserves, by the way, 40 percent of unearned premium has to stay on account and if it's not there you can be run out of the state. And then third is, there's an exemption for companies that are worth \$100 million. And I know, for example, Sears is a company that uses that on the brown and white goods side and the consumer goods warranty side. They're presumed to be big enough to be able to pay their claims. But we want to have transparency and let the financial information go to the regulators.

SENATOR MINES: Thank you. Any other questions? Great testimony. Thank you.

TIM MEENAN: Thank you, sir.

SENATOR MINES: That is our first opponent. Opponent number two. Mr. Todd, nice to have you here.

LOY TODD: Thank you. Senator Mines, members of the committee, my name is Loy Todd. That's L-o-y T-o-d-d. I'm the president and legal counsel for the Nebraska New Car and Truck Dealers Association, testifying in opposition to this legislation. First I do want to say this, that nobody felt worse about, you know, National Warranty than my dealers who were also victimized. And just to give you a very brief description of what that felt like for those dealers who did step up to the plate, there were at least a couple of dealers here in Lincoln, fewer than a dozen statewide, who were involved with this in any way. And they were relying a

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little bit on one section of Nebraska state law that's already in place that says, no service contract can be sold in this state unless it's insured by an admitted insurance carrier. Simply that. And so then this was an insured product. Now, unfortunately, they didn't realize they were dealing with a Hawaii corporation being regulated as a risk retention group out of the Cayman Islands and that it was totally untouchable. But they were victimized, too. And these dealers actually had monies they were holding in reserve. I had one dealer who had \$90,000. I had another dealer who had \$120,000, \$130,000. We find out National Warranty has gone down. They are somewhat relaxed anyhow because they...and I talked to them. And they called me and said, well, I'm going to be okay because I've got this \$90,000 or I've got this \$120,000 in reserves that we're holding because we take care of a lot of stuff. Guess what? These folks swept the accounts. When they checked their balances they were zero. Now, when you get citizen testimony that comes in here and starts talking about them being victimized and, you know, no one was more relieved in this room when Ms. Buck was testifying and I found out when she bought the policy from a car dealer, he wrote a check. When she bought them on-line she ended up holding the bag. Now, the fact is I hate to think that what's going to happen as a result of this legislation would be that the only place to buy these things is on-line from an anonymous source or from a postcard that you get in the mail, from some source that we know aren't even connected with the companies that they're purporting to do business with. We need to be in this business. Consumers want it. You don't want to trade in your \$40,000 car or 40,000 mile car and find out it has almost no resale value because we can't offer an extended service contract for the next purchaser. There's a comfort level there that makes sense. You know, our association endorses a service contract company, CNA Insurance marketed through CSO, Central States Omaha, never failed to pay a claim ever. And we want to continue to operate but the...and I think to quote...I won't quote them. But it's a very, very draconian method to going at this to say we are going to simply eliminate the warranty service providers. That's how the industry works. And to come out and try to do this on our own, is Nebraska being the new experiment? We're not big enough to get away with that. You know, the market will not move to us. We just simply aren't that big. There will be a vacuum here, but it will not be met by the

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large insurance companies suddenly getting into the service contract business. They're in the business of reinsuring or insuring risk measured by the dollars in, the dollars out, the actuarial approach. The warranty companies are the building block in this whole industry and they exist to, because they know transmissions and electrical systems and all those kinds of things and handle that. And whether they hold the money or whether the insurance company holds the money, we don't see that that's a real big difference as long as we are providing a system for the state to regulate that, if they're willing to do it. I don't know how we get past an impasse if the state is unwilling to regulate these people. Other states do it. I think that's why we have regulators. We're willing to come forward and say, here they are, make them register, make them file financials, make them jump through the hoops, and we can also make the risk retention groups and all the other people do it. I will say this. In our discussions I ask the question, would the \$15 million and the \$10 million and three to one ratio had stopped National Warranty from operating in Nebraska, and the answer was yes. And I think that's very telling. Now, there may be things to do. We're certainly working...and I really want to thank the department. They showed me initial drafts. I worked with these other folks, sent them back to the department. We've worked for weeks on this. Before the bill was introduced they gave us...really we have been working together to try to find this. But we are at an impasse and we're certainly working toward it. But, you know, our current law says, every service contract in this state must be insured by an admitted carrier. You know, so we don't have to be in too big a hurry to do that and please don't throw us out because of some operators that I can't believe that people are still trying to characterize them as victims of some other entity. They formed a corporation in Hawaii. They chose to be regulated as a risk retention group in the Cayman Islands. They structured this thing so they could sweep the accounts. They misrepresented this whole thing to my dealers who ended up in stepping forward. And I'm so proud of them for coming forward and saying, we're going to take care of our customers. So with that, I'd answer any questions.

SENATOR MINES: Thanks, Loy. Questions for Mr. Todd? Loy, one question, Internet, purchasing product on Internet. This won't stop it, will it?

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LOY TODD: No.

SENATOR MINES: I'm seeing nodding heads in the background so...

LOY TODD: Well,...

SENATOR MINES: ...I don't know, and that would be a concern.

LOY TODD: I don't know. I don't know how you stop anybody from buying anything on the Internet. I can gamble on the Internet...

SENATOR MINES: Yeah, I know, I know and that's a concern.

LOY TODD: ...I can buy. My, you know, children can buy booze on the Internet...

SENATOR MINES: Yeah, that's true.

LOY TODD: ...if somebody is telling you that they've got a way to figure it out here to stop somebody from buying a service contract on the Internet, I can't wait to hear it.

SENATOR MINES: Practically, I think you're right, but from a technicality or from technical standpoint I think the department may be right.

LOY TODD: It may be illegal (laugh).

SENATOR MINES: Yeah, it may be illegal, right?

LOY TODD: Yeah, great.

SENATOR MINES: Okay. Thank you.

LOY TODD: Thank you.

SENATOR MINES: Next opponent? Mr. O'Hara.

PAUL O'HARA: Thank you, Mr. Chairman, members of the banking committee. My name is Paul O'Hara. That's O-'H-'a-r-a. I'm a registered lobbyist appearing today on

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behalf of the Alliance of Automobile Manufacturers and more specifically, the captive companies that issue service contracts referenced by Mr. Meenan and Mr. Todd. And like Mr. Todd, I have spoken with Director Wagner and his very capable counsel, Eric Dunning, about this and they have been very, very easy to work with and we're looking forward to continuing to work with them. But we still need to address the bill before the committee and the amendments that were offered by Mr. Meenan. Section 44-3526 of Nebraska statute which is in section 7 of the bill would seem to indicate that the motor vehicle manufacturers or importers are exempt from the Service Contract Act and that used to be the case. But now GMAC issues service contracts for their GM vehicles for which they are exempt. But also a substantial portion of their business is the issuing of service contracts for other companies' vehicles, used cars, even rental cars so they have expanded into areas in which they would no longer be exempt under this section. They also use a third-party obligor, the General Motors Acceptance Corporation Service Agreement Company which is, again, a third-party obligor which they use to sell in 51 jurisdictions, including Nebraska, and they do want to continue to use this structure in all of the states. But this third-party obligor would not qualify for the exemption under section 7 and would have problems under the green copy of the act. I have seen the amendment that was offered by Mr. Meenan and would tell you that this would be acceptable to the automobile manufacturers. And if further discussions are to be taking place with the department, on behalf of the alliance, I am pleased to offer our services. So with that I'd be happy to answer any easy questions of the committee (laughter).

SENATOR MINES: Thanks, Paul, thank you. Any questions for Mr. O'Hara? Paul, have you been part of the discussions with the department and...?

PAUL O'HARA: I was brought in I would say a week ago and have spent a lot of the time just learning what the structure is about...

SENATOR MINES: It's unbelievable.

PAUL O'HARA: ...it is very complex. I have spoken with Mr. Dunning in the last several days and Director Wagner today.

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SENATOR MINES: And you would be willing to work with them in the future?

PAUL O'HARA: Absolutely, yes.

SENATOR MINES: Thanks so much.

PAUL O'HARA: Thank you.

SENATOR MINES: Mr. Rasmussen.

DENNIS RASMUSSEN: Thank you for the kind words...

SENATOR MINES: Nice to have you here. You're almost bringing up the rear.

DENNIS RASMUSSEN: Well, Mr. Chairman, some are first and some are last. Chairman Mines and committee, I'm Dennis Rasmussen, R-a-s-m-u-s-s-e-n, registered lobbyist for Nebraska Independent Auto Dealers which is the used car people. I'm not going to be here long. I don't think that I could improve any on what has been said here. I know it's complex. I know that any car dealer wants to do what's right and I'm going to agree with our king, Loy Todd (laughter). It would be difficult for Nebraska to be an island and not be able to do business as fluid as our society is today, Mr. Chairman. With that I'll close.

SENATOR MINES: Well, thank you. Thank you. Questions for Mr. Rasmussen? So you believe that competition might be restricted?

DENNIS RASMUSSEN: I would guess so because now I think with the proposed amendments and that they're working with Tim Wagner who I...and staff, his staff, which I respect greatly, that we could come up with probably a better solution with an option instead of the green copy.

SENATOR MINES: Got it. Thanks for your testimony.

DENNIS RASMUSSEN: Thank you.

SENATOR MINES: How many more are in opposition? Just Korby. Korby, welcome.

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KORBY GILBERTSON: Thank you. Chairman Mines, members of the committee, for the record my name is Korby Gilbertson. That's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as a registered lobbyist on behalf of the Property Casualty Insurers Association of America in opposition to LB 652. I think that instead of taking time restating things, I think it's very clear to the committee and all of us involved that this is a rather complicated issue and there are several members of PCI that have some concerns about (LB) 652 and would like to have the opportunity to continue working with Senator Beutler and Director Wagner to come to a mutually agreeable resolution to this. I, too, was brought in kind of late on this issue but would look forward to working with everyone on it.

SENATOR MINES: Great, great. Thank you. Questions for Korby? Nice testimony, thank you.

KORBY GILBERTSON: Thank you.

SENATOR MINES: Any other opposition? Anyone wishing to testify in a neutral capacity? Thank you very much. I do want to thank you all for being here today. It's great testimony, great information. I'll close the public hearing and that ends...