Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

LINDSTROM: Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Brett Lindstrom. I'm from Omaha and represent District 18. I'm honored to serve as Vice Chair of this committee. The committee will take up the bills in the order posted. Our hearing today is your part of the public legislative process. This is your opportunity to express your position on the proposed legislation before us today. Committee members may come and go during the hearing. We have to introduce bills in other committees and are sometimes called away. This is not an indication we are not interested in the bill being heard in this committee, it Is just part of the process. To better facilitate today's proceeding we ask that you bide by-- abide by the following procedures. Please silence or turn off your cell phone. Seating is limited, therefore, we ask that you only maintain a seat in the hearing room when you have an interest in the bill currently being heard. We will pause between bills to allow people to come and go. While exiting the hearing room, we ask that you use the east door. We request that you wear a face covering while in the hearing room. Testifiers may remove their face mask during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. Public hearings for which attendance reaches seating capacity will be monitored by a Sergeant of Arms who allow people to enter based upon seating availability. Persons waiting to enter the hearing room are asked to observe social distancing and wear face covering while waiting in the hallroom-- hallway or outside the building. The order of testimony will be the introducer, followed by proponents, opponents and neutral testifiers, and in the closing by the Introducing senator. Testifiers, please sign and fill out the pink sheet and turn it in at the box on the testifiers table when you come up to testify. As you begin your testimony, we will ask that you please spell your first and last name for the record. It is our request you limit your testimony to five minutes where we use the light system. The light will be green for four minutes. It'll turn yellow with one minute to go and then when it's red, please end your testimony. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white tablets at the entrance where you may leave your name and other pertinent information. The sign-in sheets will become exhibits in the permanent record at the end of today's hearing. We ask that you please limit or eliminate handouts. Written material may be handed to

the committee clerk while testimony is being offered. To my immediate left is committee counsel, Bill Marienau, and to my further left down at the end of the table is committee clerk, Natalie Schunk. We'll have the senators introduce them-- introduce themselves starting with Senator Pahls.

PAHLS: Rich Pahls from southwest Omaha.

McCOLLISTER: John McCollister, District 20, central Omaha.

FLOOD: Mike Flood from Norfolk, Madison and a little bit of Stanton County.

BOSTAR: Eliot Bostar, District 29, south central Lincoln.

LINDSTROM: Thank you. And now we will open the hearing on LB487 introduced by Senator Arch. Good morning, Senator Arch.

ARCH: Good morning, Senator Lindstrom, and members of the Banking, Commerce and Insurance Committee. For the record, my name is John Arch, J-o-h-n A -r-c-h, and I represent the 14th Legislative District in Sarpy County. And I'm here today to introduce LB487. LB487 would require commercial insurers to reimburse for the treatment of mental health conditions delivered using telehealth or telemarketing services at the same rate as a comparable treatment provided in person. During the interim, I conducted a study that focused on the impact of COVID pandemic has had on the utilization of telehealth to access health care services. Obviously, while people were isolating at the onset of the pandemic, telehealth usage skyrocketed. One area where it increased significantly was in behavioral health services. A survey I did for the study showed that in the first three months of the public health emergency, Nebraska's commercial insurers reported that nearly half of all outpatient telehealth visits were for behavioral health services. Fair Health, which tracks telehealth data, reports that mental health conditions accounted for 58.38 percent of all telehealth claims in the Midwest region for the month of October 2020. Clearly, the floodgates have been opened and telehealth will remain a major component in the delivery of health care services. During the pandemic, insurers have voluntarily restructured reimbursement rates to accommodate telehealth claims. And while I generally do not support mandates on the private market, I think ensuring payment parity going forward for behavioral health services specifically is worth putting

into statute. First, the cost of providing behavioral health services, whether in-person or through electronic means, should be fairly equal already. There's no need for large overhead costs, nursing and support staff, lab facilities, exam rooms, etcetera. It is also not necessary to have physical contact with a patient at every visit. There are no hands-on examinations performed. A licensed mental health practitioner can deliver services from almost anywhere, and because of the pandemic, we are learning the patients can effectively receive these services from almost anywhere. Second, providing behavioral health services via telehealth is effective. Numerous studies on the efficacy of treating mental health conditions through telehealth report that patients rate the treatment as therapeutic as meeting-- as therapeutic as meeting in person. Additionally, it has been found to be particularly effective in reaching patients with severe conditions that make them unable or unwilling to seek treatment outside their homes. Anecdotally, I've been told providers are reporting people appear more receptive to treatment provided from the comfort of their own home and that appointment, no-show rates, are down. Finally, and most importantly, telehealth increases access to behavioral health services. The Kaiser Foundation reports that over one million Nebraskans live in mental health care professional shortage areas. The shortage of behavioral health providers is particularly detrimental to our rural parts of the state. According to the CDC, the agriculture industry has one of the highest suicide rates among major industry and occupation groups. The ability to seek services through telehealth eliminates the need for long distance travel time and provides for greater confidentiality in smaller farming communities. Statewide being able to access services conveniently. Eliminating the costs associated with taking time off of work and traveling, makes important mental health services more available to many Nebraskans. Mental illness is debilitating to individuals. It's devastating to the children and families of those who suffer from mental illness, and it's costly to society. With a passage of LB487, we can assure effective, valuable services are adequately reimbursed and readily available to those who need it. I urge the committee to advance this bill to General File. Thank you.

LINDSTROM: Thank you, Senator. Any questions from the committee? Seeing none, thank you.

ARCH: Thank you.

LINDSTROM: First proponent. Wait one second, we're going to-- we'll spray this down here. Sorry. Good morning.

ANNE BUETTNER: Oh, good morning, Senator Lindstrom, and committee members and later I will be testifying for you all too. I'm so disappointed, my own senator is not here. I'm from Grand Island. OK. Anne, A-n-n-e, Buettner, B-u-e-t-t-n-e-r. I am Anne Buettner, I'm the legislative chair of Nebraska Association for Marriage and Family Therapy. The licensed Marriage and Family therapist has assumed under licensed mental health practitioners, and there are over 3,000 of us. And we all practice full-time or part-time telehealth, mental behavioral health, mental behavioral, interchangeable, those two words, and that's why we are here. It started with telepsychiatry in the 1970s and 1980s, and that is MDs specializing in psychiatry, prescribing psychotropic medication and so on. And then they find that the telepsychiatry is equivalent to in-person care in terms of diagnostic accuracy, treatment effectiveness and patient satisfaction. So it often saves time, money and other resources. The VA facilities practice it very broadly to this day. And then by the 1900s, its all over the world, particularly in Australia. And by the 2000s, we have enough outcome studies that platforms are developed to have practice guidelines and so on. And there is the emergence of telebehavioral mental health. By definition, it means that video or audio conferencing between the providers and the patients are clients, no matter where the patient or clients are located, wherever they are located and is always outside of the office, of course. So, and the terms can be telotherapy, virtual therapy online. Therapy you may hear different terms and they can be with individuals, couples or families. So needless to say, the demand for virtual mental health is soaring even before the pandemic. And when the pandemic came, of course, it's exponentially increase. And I will not provide you with the different sources which are already detailed in, you know, written testimonies. But our data show that it can increase the utilization rate-- can increase up to 302 percent for virtual therapy and psychiatry. OK. So, and then also the age groups that you said, we find that especially-- well, men use them more than women and especially people who are older than 65, but it cut across all age groups, including Generation Z, which means the age six to age 23. So it's all age groups. And we even have data, you know, people who use it. And we would ask them, do you want this to continue post-COVID? There will be such a day when the pandemic is over and 100 percent of people who use virtual psychiatry

said yes. And 62 percent of the consumers who are using it for teletherapy, psychotherapy, would say, yes, I would do it even when it is safe to go to a doctor's office. Now, we have provided to the committee a list of comparative studies by different disciplines, mental health disciplines, comparing the efficacy of telehealth, comparing telehealth, telemental behavioral health with inpatient care, and it points to the effectiveness scientifically, so this is not anecdotal. Now, when it comes to reimbursement, it is true that not long after the executive orders pertaining to emergency care came into effect, the insurance companies do and now they do reimburse the equivalent telehealth in person, in person care. However, the pervasive fear is that when the pandemic is over, the insurance company would still recognize the usage of telehealth, but the rate would go back to the way it was lower or much lower than in person. So and then another-- do we have time? I think-- I think I saved the most important reason last, which is what Senator Arch has brought up is about rural area, and telehealth has become more and more widespread. To be specific, with the data, 88 out of the 93 counties have been designated federal as well as by the state as mental health professional shortage. And 32 counties have absolutely no mental health providers. Doesn't matter what discipline the mental health practitioner or a psychologist or psychiatrist, no difference. So finally, just more data here is that all 50 states and the District of Columbia already recognize telehealth usage to remote technology. And so they have it for their Medicaid members. In Nebraska, I am proud to say that regardless of the pandemic, for Medicaid, it has been the equivalent, you know, telemental health where this in-person mental health. So seeking parity is ongoing legislative effort for the commercial insurers. So we hope that the committee would advance LB487. Any questions?

LINDSTROM: Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom, and thank you for coming today. Prior to the pandemic, what was the relationship between telehealth versus on-premise or in office, what percentage difference was it?

ANNE BUETTNER: With the commercial insurers? Well, that-- it varies. If I can name. Blue Cross Blue Shield has always been equivalent, but not the others. And some would be low, quite low, maybe less than half. But, so that is pre-COVID. Now when COVID started, at the

beginning some insurance companies did not change, but then upon protests and so on, eventually they reprocess the claims and then they now reimburse equivalency.

McCOLLISTER: Well, prior to the pandemic, what was the percentage discount for telehealth versus on-premise calls?

ANNE BUETTNER: Well, like I said, it varies. I-- from what I, you know, dollars and cents, I cannot tell you, but I have heard that some insurance company would reimburse half or less than half of-- only Blue Cross Blue Shield from what we gather, you know, reimburse the equivalency.

McCOLLISTER: So you're saying less than half in some cases?

ANNE BUETTNER: That's from what I heard. OK. I don't have it tabulated like the effectiveness of telehealth. I don't have it scientifically tabulated, but that's what I have.

McCOLLISTER: Thank you very much.

LINDSTROM: Any other questions from the committee? Seeing none, thank you.

ANNE BUETTNER: Thank you.

LINDSTROM: Wait one second. Can we get the chair spread down, please? Thank you. Good morning.

SCOTT JANSEN: Good morning. Senator Lindstrom, members of the committee, my name is Scott Jansen, S-c-o-t-t J-a-n-s-e-n. I'm the practice administrator at Complete Children's Health here in Lincoln. I'm testifying on behalf of the Nebraska Medical Association in support of LB487. Thank you very much for the opportunity to testify today. Private health care practices all across the state were forced to quickly adapt last year to meeting the needs of their patients as a result of the COVID-19 pandemic. One of the tools that proved especially valuable was the use of telemedicine. In our clinic, our patients were able to access their psychologists who work in our clinic while remaining in the safety of their homes. That was an advantage that telemedicine provided to us. In rural areas, many of the parents of our patients also began to appreciate the fact that they could access their care provider without having to take time off

from work due to drive time and then time spent in the clinic. One of the other advantages of telemedicine is that our psychologist could have teachers or outside resource professionals teleconference into a visit with the parents as part of the care provided when their involvement was important to the provision of care of the patients. Unfortunately, there's a myth that telehealth considerably lowers the costs for a practice, thereby justifying the historic fractional reimbursement rates that we've received compared to in-person services. This certainly couldn't be further from the truth. And in fact, many-- many practices may have closed across the state and in the country, if not for the temporary increases that we received in reimbursement from health insurers in 2020. There-- there's a considerable amount of fixed costs that a private practice bears, regardless of how care is provided or delivered. Insurers cannot simply the flip of a switch revert back to their old reimbursement policies. And certainly it would stifle our abilities to continue, I think, providing telehealth care, and that's why we believe that LB487 is needed. It really became a valuable tool for our psychologists during the pandemic, but it didn't decrease our costs of care either. We still had to schedule patients to see the psychologists. We still had to access and confirm their health insurance information via phone or fax or email instead of being able to do that in person. Our psychologists still had access to their offices. They would come into their offices and-- and have their telemedicine visit with the patient. They still had to maintain medical records as part of our electronic records. Our billing team still had to work to precertify visits, submit claims, mail statements to patients for any remaining balances. When patients have questions, we still have to explain to them what is and is not covered and why. Mental health and behavioral health has really come under focus in recent years, and rightfully so. As a society, we've been-- begun to recognize this important subset of health care and how it impacts overall health. In fact, the Nebraska State Chamber has a standing policy position that Nebraska should do what it can to increase access to behavioral health services because a healthy workforce is a valuable asset. LB487 is a policy that does just that, will permit Nebraskans to access mental health care without having to overcome other barriers such as transportation or taking time off from work. It also allows the patient's existing provider to meet the patient where they are and provide high quality care due to their existing relationship knowledge of a patient's history. High quality care ultimately leads to lower costs and better outcomes for

the patient and their families, which should be the aim of any health care policy change. Telehealth reimbursement equivalency for behavioral health will allow Nebraska providers to continue to provide high quality care to their patients. Telehealth should not be viewed by policymakers and insurers as a novelty service, but as a-- as a valuable and separate tool in the toolbox that allows the provider to deliver high quality care that Nebraskans deserve. Without reimbursement equivalency, however, nationwide tele-- telebehavioral health companies who can absorb lower reimbursement will siphon off patients from Nebraska providers, lowering the quality of care to Nebraskans, due to a lack of an existing relationship, patient knowledge. We've made strides in behavioral health and LB487 will prevent us from backsliding due to a lower quality of care. It will move behavioral health care forward by increasing access and utilization, signaling to Nebraskans that it's OK to reach out for help at any time. The Nebraska Medical Association respectfully request the committee to advance LB487 to General File. Thank you and I'm happy to answer any questions at this time.

LINDSTROM: Thank you. Senator Flood.

FLOOD: Thank you for your testimony today. I have a constituent who has a son that had a severe acne and there are no dermatologists that are taking appointments within the next three or four months--

SCOTT JANSEN: Sure.

FLOOD: --as you might imagine. And so this constituent went online to a online provider and saw a doctor by just sending pictures. The doctor responded over email and in this case, I don't think they took insurance. The reason I submit this is, could a patient start online and never go see the psychiatrist?

SCOTT JANSEN: I suppose the-- the answer to your question is probably yes, a patient could start online and never have an in-person visit occur. It might simply because of-- be because of the nature of the situation that the psychologist is treating. I think oftentimes, though, at least in our practice, that wouldn't occur. Our psychologist, as well as our-- as our physicians would always prefer to have an opportunity to see a patient in person. Certainly there are many things that can be done via telehealth and it is a valuable, valuable tool, but it shouldn't replace in all cases the ability of a

physician to sit down and actual-- or a provider to sit down and actually be with the patient. And so in our practice, we don't make a recommendation that there's never an in-person visit. But there certainly are times and I can share in-- in our practice as a result of the pandemic, the difference in-- in dollars was slightly over half a million dollars in actual revenue this year. That allowed us to keep eight-- eight and a half staff employed through the pandemic, which-- which I think was-- was certainly critical to us because it-- had we not been able to keep those people, our ability to climb out of that hole would have been all the more difficult.

FLOOD: I guess the reason I ask is if this committee did favorably consider sending this bill forward, wouldn't it make sense-- and because we're talking about behavioral health, that the first visit before you can-- before parity kicks in would have to be in person. And the reason I'd be interested then in that is that if you have somebody that's suicidal or is in crisis and we have some provider in Denver or Dallas that's treating one of our citizens and they do go into crisis and they're in Butler County, the provider in Nebraska would know who to call. They know where the nearest hospital with the behavioral health unit is. I just fear that if we were to do this and to make it more attractive, that you'll have some out-of-state provider come in and they'll be dealing with the Nebraska behavioral health crisis.

SCOTT JANSEN: Well, and quite candidly right now, we have that. All of-- anybody who's covered by Blue Cross and Blue Shield has access to their panel of telehealth providers. Blue Cross and Blue Shield touts it. And it's-- it's a very low cost option to the patient. However, that information, whatever is done during that visit, whatever is provided there, that information never gets communicated to the patient's physician unless the patient takes it upon themselves to do that.

FLOOD: Well, I think-- I think-- I'm just interested in the constituent that asked me about this dermatology-- dermatology issue said that it was very weird that they were just sending pictures. They never spoke or had any interaction. And at one point, the physician said, well, let's double your dose. And the parent said, I don't know if that's the right thing to be doing. And, you know, here we have a provider six states away. I don't-- you know, I think when you're treating a behavioral health patient, you want some connection to the

state of Nebraska because it's a very state oriented system. I don't-- I mean, the question about parity is one for the committee, but I would-- before I got into the parity discussion, I'd want to know that this physician was licensed to do business in Nebraska so that we don't open up this sea of providers from all over the United States. And when you're mentally ill and you go online to find a psychiatrist, I'm sure there's some nefarious actors that exist on the Internet and suddenly they're going to be thinking that they're going to get-- just pay a copay. I mean, you're dealing with the population that's vulnerable, so that is my question.

SCOTT JANSEN: I-- I certainly agree, yes.

LINDSTROM: Senator Bostar.

BOSTAR: Thank you, Senator Lindstrom. Thank you for your testimony. You mentioned that the overhead costs for these kind of providers is-- is low. And that was in line with justifying the fact that the-- the payments for services should be the same, whether it's telehealth or in-person. But, I would imagine that the overhead is zero to provide services in person. So let me-- let me-- let me, I guess, ask this question. Would this bill incentivize good providers who currently offer services in person? Would it incentivize them to stop offering services in person in order to avoid what overhead costs do exist and move to a-- a wholly teleprovider service?

SCOTT JANSEN: It's difficult for me to speak to the virtues of every physician who provides care in the state of Nebraska. Is it possible that there would be a provider that would believe that there's suddenly now an advantage to instead of having a medical office, essentially operating a television studio with a couple of really nice cameras and a computer at their desk? It's possible. Could it hap-- could it happen? Possibly. But the physicians that I know who truly want to provide, and we're talking about mental health, so even the psychologists, the mental health professionals that I know who want to provide care to patients want to do it in the best possible fashion. And most of them would prefer to do it in person. However, there are situations where the need to provide care through an alternative method like telehealth is very valuable. What-- what this bill allows us to do is make that decision without having to bring into consideration the financial impact that it would negatively pose on a practice if parity did not exist. Senator McCollister asked the person

who sat up here previous to me a question about the cost of-- or the amount of reimbursement prior. It was about 50 percent and it varies from payer to payer a little bit and contract to contract, and individual employers can weigh in on how much of this that they want to pay as well. So it goes clear down to that level. But we don't want providers to have to make that consideration when they're determining what is the best avenue to reach their patient at the time their patient needs care. We-- we had a pretty significant snow event here recently. Some have called it historic. We were able to, again, reach out to our patients who needed care that day via telehealth. Again, the-- the-- the pandemic is starting to wane a little bit. But we had a sudden situation where we had a number of patients who-- who we felt needed to have care and we were able to deliver it that way. We're a pediatric practice, so we have moms and infants who-- otherwise we would ask them to make a choice to get in a car and drive through conditions that were, quite frankly, in some cases very dangerous. But we were able to not worry about parity or costs and implement a number of telemedicine visits during the blizzard.

BOSTAR: So I just want to follow up. You mentioned that the providers that you know want to be able to provide services in person. And I understand that that's not always possible. It's not always convenient and for the patient, it may be beneficial to not be in person.

SCOTT JANSEN: Yes, absolutely.

BOSTAR: What I'm-- my concern is, is I think that's great, but I think that when it's-- when it's about what the patient wants, that makes sense to me. My concern is when it isn't necessarily what the patient wants, but it's what the provider wants, and I would be concerned about a situation where a patient who's receiving teleservices decided one day that they wanted to receive services in person because, for whatever reason, that was important or valuable to them within the-- within the course of their treatment and it being impossible. That's my hesitation around this. Would there-- is there anything in this that would ensure that a provider would need to be able to be available in person if a patient were to need that?

SCOTT JANSEN: I don't really have an answer to that question necessarily, and I think it's because something like that never, ever would have even occurred to me that-- that there would be a situation where a physician who was in practice would refuse to see a patient

because they were-- they were offering primarily a telehealth model. Other than-- certainly the product, the Amwell product that Blue Cross and Blue Shield touts for their patients, anybody who relies on that product for care does not have the ability to access a key physician provider because that model is not-- is not constructed that way. I believe that patients are made aware of that when they access the service. I don't know, I've never accessed it. And certainly in response to Senator Flood's question, you could set up various codes under a plan where a new patient wouldn't have to be paid at a level of parity. So you wouldn't have that first introductory sort of encounter, if you will. With-- with a provider via telehealth, but that it only-- that there would only be parity under an established patient relationship, that could certainly happen. But I-- it just doesn't-- I just can't imagine there would be a situation where a physician or a mental health provider currently in practice in the state of Nebraska would say no to seeing a patient in person and would insist on only seeing them via telehealth.

BOSTAR: Thank you.

LINDSTROM: Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom. Would it be fair to say that some medical practices like behavioral health lend themselves to telehealth kind of practices or mobility versus maybe a dermatologist or a OBGYN?

SCOTT JANSEN: Certainly. I think mental health services are probably most able to lend themselves to telehealth sort of situations. I think primary care is probably next. And then as you get into dermatology is one that, that lends itself well to telehealth as long as there is some-- some good video capabilities available as well. I would tell you, as well, through the pandemic, in my practice, there were a number of situations, and I hate to bounce back and forth between mental health and physical health, but I think they're-- they're very similar from the perspective of telehealth services. Oftentimes, we would start to see a patient via telehealth and then would ultimately end up having an in-person visit occur after anyway, because the physician simply didn't feel they could adequately treat the patient via telehealth. And so the visit was started that way, but it wasn't completed that way because generally, again, I like to believe that health care providers will make the decision that's in the best

interest of the patient under the circumstances and wouldn't game a system simply for financial gain.

McCOLLISTER: Thank you.

LINDSTROM: Any other questions from the committee? Seeing none, thank you.

SCOTT JANSEN: Thank you very much.

LINDSTROM: Good morning.

KORBY GILBERTSON: Good morning, Vice Chair Lindstrom, and members of the committee. For the record, my name is Korby Gilbertson. It's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as registered lobbyist on behalf of the Nebraska Psychiatric Society. Dr. Martin Wenzel is not able to be here today so I'm giving you a letter on his behalf, but I thought instead of repeating what prior testifiers have said, I'd try to address a couple of questions that were brought up by Senator Flood regarding whether or not there should be allowed for an initial visit with the patient. I would argue to be very careful about prohibiting that, because one of the issues that this bill helps-- helps alleviate and that telehealth helps alleviate is in issues where you need a psychiatrist or someone that can do prescribing to be able to talk to a patient in order to help another physician that doesn't feel comfortable prescribing those drugs or something like that, that that might need to be an initial visit or an evaluation that could be done via telehealth, which is especially important with our-- the rural nature of our state. So I just would caution being careful about that. And I would be happy to try to answer any other questions.

LINDSTROM: Any questions? Senator McCollister.

McCOLLISTER: Happy birthday.

KORBY GILBERTSON: Oh, thank you. [LAUGH]

LINDSTROM: Any other questions?

KORBY GILBERTSON: Nonquestions.

LINDSTROM: Seeing none.

Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

KORBY GILBERTSON: Thank you.

LINDSTROM: Good morning.

PAT CONNELL: Good morning, Senator Lindstrom, and members of the Banking, Commerce and Insurance Committee. My name is Pat Connell, P-a-t, Connell, C-o-n-n-e-l-l, and I serve as the health policy advocate for Boystown and Boystown National Research Hospital. I am here today as the legislative chair for the Nebraska Association of Behavioral Health Organizations, also known as Navajo, and providing testimony in support of LB487. And I appreciate Senator Arch introducing this-- this important piece of legislation. Navajo membership span across the state and consists of over 50 member organizations providing behavioral health services, substance abuse treatment services, hospital-based services and behavioral health regions. Our mission is to ensure that mental health and substance abuse disorder services are accessible across the state to everyone who needs them in Nebraska. I'm not going to repeat some of the same things that some of the other testifiers said, so I'm going to glance over on some items so I can address some of the other questions that came up from the previous questions. Telehealth is a really critical tool in behavioral health. And-- and the thing is, is that if you go to page 2, there are seven items and they're the same seven things that you do in person that you also do with telehealth. You've got to register the patient. No difference. You got to get consent forms. It's a little bit more difficult with telehealth, but-- when you do it in-person but you still got to get them. Three. The treatment services are-- many of the time, they are time-based, so there's not any difference. You do it either an hour in person or you do an hour and by telehealth. Coding or billing documentation requirements are the same. You just have to add on that you-- you're doing it by telehealth. Coding and billing requirements, use the same process. Patients have a choice between in-person versus telehealth. So there's still a need for a treatment office. And then there's slightly higher cost for telehealth because not only do you maintain an office, but you've got to maintain the software, the hardware and-- and sometimes your very first appointment with a new patient, sometimes the first, the staff spend maybe 15 minutes before the appointment getting the software on their system, getting in tune how to use them because it's still-- it's not just using Zoom or Webex. There's-- there's more sophisticated software out there to protect and do further encryption than what with those packages do. One of the major advantages to

telehealth has been the decline in no shows. So that could be weather, as one of the previous speakers have spoken to. As soon as the weather turns bad, even if you're a mile, mile and a half away, people will cancel appointments. Telehealth gives them the option of staying at home and as an option to an in-person visit. We-- some of our members have reported that our no-show rate has dropped to almost zero. Now, that may be just looked at from a purely economic financial reason that, well, that benefits a provider, but it also benefits the patient that dropping a no show. Because what it does is, is it increases continuity of care and access, because if you-- you cancel an appointment with a typical behavior health provider, it sometimes takes two to four to six weeks to get another appointment schedule. So we see it as a major advantage having that telehealth as an option. And so in addition to increasing clinical productivity, it really does increases the clinical effectiveness of treatment. So, I also serve on the National Association of Behavioral Health. This is a 1,100 member organization back in Washington. And we've been-- we've been spending a lot of time talking about telehealth and how it relates to behavioral health. And one of the things that's come out of this is that there's a-- there's a common agreement that the-- whenever possible see the patient in person as that's that's-- that's sort of the highest standard. And with that actually seeing a patient in a clinic setting or a rural setting, not necessarily from their home. Several years ago, Senator Flood alerted me to a patient that was up in Norfolk that was traveling, you know, from Norfolk to Omaha to see one of our psychiatrists. This was a-- and so with that, we-- we explored with behavioral specialists up in Norfolk and we've been providing telehealth services through that to the Norfolk community ever since then. We've had patients having to travel from Beatrice up to Omaha. So, again, whenever the weather starts going bad, people aren't going to want to travel it. Behavioral health as a industry is-- is-- the margins are so thin. So if-- if we're going to have rates for telehealth that are going to be less than what we-- for in-person visits, you're going to see some providers gravitate to saying, I'm only going to see patients in person. And I think that would be a disservice to the rural communities. And-- and again, it doesn't-- it doesn't improve anything. This bill gives you opportunity to maintain that kind of continuity of care and access. So I hope that is helpful, and I stand ready to answer any questions.

LINDSTROM: Thank you. Senator McCollister.

McCOLLISTER: Thank you, Senator Lindstrom. Just a quick question. What kind of special software does a doctor typically employ for this service? Plus, do you record the telehealth session?

PAT CONNELL: OK, I don't know what other providers do, I can speak to it. We do it at Boystown in our psychiatry clinic. We use Webex because we find that Webex has got better encryption than Zoom, although it seems like each week the software gets updated and changed. We are-- we have signed with Bryan Health to use InTouch, which is a much more user friendly software on both ends for the provider and for the-- for the patient. And so, like right now, we're doing this in-- we started this in St. Paul. We went to Norfork. We've done-- we're down in Superior, Nebraska. We're doing psychiatry services work for the YRTC. And, you know, I think before this pandemic, most psychiatrists did not want to see a patient by telehealth, they wanted to see the patient in person. And, of course, you get a lot of body language. You get a lot of cues from seeing him in person that are harder to get by-- by telehealth, but-- I don't know where I was going with that but--

McCOLLISTER: You record the calls?

PAT CONNELL: But we don't record the calls.

McCOLLISTER: All right. Thank you.

LINDSTROM: Senator Flood.

FLOOD: Thank you, Mr. Connell, for your testimony. I was just going to ask you about what kind of money we're talking about. So what would a-- assuming we don't intervene, the state doesn't intervene with a mandate, what would be pre-COVID the cost of a visit to like a licensed mental health practitioner, and what would the discounted rate be for a telehealth?

PAT CONNELL: I would-- I would answer that by saying it's plan by plan. And if you would like, I could pull our membership and gather some data for you to answer that question.

FLOOD: OK. Do you think if you had to guess, is it like a 50 percent reduction in fee-- 75-- you know 25 percent reduction?

PAT CONNELL: Well, you know, again, that-- that 50 percent reduction actually then creates a barrier. I, as a provider, could see this patient in person and I get paid 100 percent. Oh, but if I have to do it by telehealth, I'm going to have to take a cut in what I'm going to get reimbursed and I'm also going to have the added complications for doing a telehealth visit.

FLOOD: Do you think it's 50 percent reduction?

PAT CONNELL: I don't think it's 50. I-- I frankly, I don't have the answer, so I could get you the answer.

FLOOD: Something less than 100 percent--

PAT CONNELL: Yes.

FLOOD: --under the current contract, but the insurance companies right now are honoring during COVID the parity.

PAT CONNELL: Yes, it started with Medicaid. And, you know, that was driven by the federal government to increase the motivation for behavioral health providers to do telehealth.

FLOOD: Sure.

PAT CONNELL: And then I think Blue Cross came on. They saw that-- and we very much appreciate Blue Cross's leadership in this area of being able to say, yes, we are-- we support the use of telehealth and behavioral health, and--

FLOOD: Are other states mandating this parity?

PAT CONNELL: What-- actually this is a good question, because I just asked that question on Friday trying to get an answer. And this is a-- this is a question in process, I guess, that would be the best way to do it. Massachusetts, a couple of weeks ago passed a law that said behavioral health rates would be falling with Senator Arch's bill does and then mandates on the physical health in a couple of years. But I would say that what we're getting is positive feedback from other states about the-- the benefit of maintaining telehealth, because really a cat's out of the box, the bag or whatever the expression is, or the horse is out of the barn. It's-- it's proven its effectiveness and it's going to be very difficult to go back to the old ways.

FLOOD: Thank you.

LINDSTROM: Senator Bostar.

BOSTAR: Thank you, Senator Lindstrom. Thank you, Mr. Connell, for your testimony. Just kind of a follow up to Senator McCollister's question related to the software. Are there-- are there minimum requirements for security, for encryption that a provider has to use or could they just use SOU?

PAT CONNELL: Well, you know that the HIPAA laws apply to, you know, the privacy between the clinician and the provider, and most providers actually kind of carry that through to what they do with telehealth services trying to preserve those-- those privacy rights.

BOSTAR: Is that a requirement or are they doing that voluntarily?

PAT CONNELL: I'm not sure. I just know that when this first came up within our provider group, we-- we just said, well, we're going to do it. I mean, trying to make the same experience, whether in person or through telehealth. And, you know, that speaks to another question was asked if I could answer, is that you want to-- you want to see that patient, you-- you need this. It's different. It's difficult to say there's a farmhouse in Fremont-- there's not a farmhouse in Fremont, but I mean, some other rural, Elgin, Nebraska, etcetera. And so what provider-- a lot of providers like Boystown is they're partnering with the rural hospitals. So they're the rural hospitals patients. And so we-- we have records. We know who they are. We can-- that just seems to create better continuity of care and understanding of the patient's needs.

BOSTAR: Thank you very much.

LINDSTROM: Any other questions? Seeing none, thank you.

PAT CONNELL: Thank you. Appreciate it.

LINDSTROM: Good morning.

ROBIN CONYERS: Good morning, Vice Chair Lindstrom, and members of the Banking and Insurance Committee. My name is Robin Conyers, R-o-b-i-n C-o-n-y-e-r-s. I'm the division vice president of Behavioral Health Services at CHI Health. CHI Health is a regional network consisting of

14 hospitals, 2 standalone behavioral health facilities, a freestanding emergency department and more than 150 employed physician practice locations, and more than 12,000 employees in Nebraska and southwest Iowa serving communities from Corning, Iowa, to Kearney, Nebraska. CHI Health is also the largest provider of behavioral health services in the state of Nebraska. I appreciate the opportunity to speak with you today in support of LB487 on behalf of CHI Health and the Nebraska Hospital Association. We thank Senator Arch for his leadership on the Health and Humanity Services Committee and for recognizing the importance of telehealth to the future of health care delivery in Nebraska, and we'd like to recognize Senator Pahls as well since we support his LB314. And I'd like to thank all of you for your support of our health care providers during this pandemic as I know, we have CHI Health facilities in many of your districts. It was truly a remarkable-- it was truly remarkable in the first few weeks of the pandemic how many legislative and regulatory barriers were removed to allow for the rapid expansion of telehealth services across the country. And while we've always believed the expansion of telehealth is the key to rural access and affordability in the states like Nebraska, we do believe the genie is out of the bottle as they say, and as a result, these innovations and the demand for them by the general public, which will only increase over time. And with an acute and ever-increasing shortage of behavioral health care providers in our state, it provides access for patients that would otherwise be very difficult to provide. One in every seven families in Nebraska is impacted by behavioral health issues, and we saw tremendous growth in the total number of behavioral health virtual visits throughout our system in the last year. Our system had 43 outpatient behavioral health virtual visits between March and May of 2019 and 17,640 virtual visits between March and May of 2020. So virtual visits went from less than 1 percent up to 66 percent of all behavioral health outpatient visits in this initial stage of the pandemic. This seems to have peaked at about 82 percent last summer, but we still have 52 percent of all outpatient visits are happening virtually. We think this is for a few reasons, obviously COVID concerns and a reluctance or an inability to visit providers in person, but also because folks have become familiar with the virtual technology and in many cases are preferring to use virtual visits for their behavioral health care needs, and we believe we are achieving as good, if not better, outcomes. And here are a couple of real life examples I'd like to share with you. The CHI health doctor in small town in Nebraska that

typically makes rounds to nursing homes and assisted living patients was able to establish telehealth visits to continue to provide needed care for her patients without having to do in-person and/or require her patients to venture out and be quarantined then for 14 days upon their return. This was critical for their mental health and their stability. A 16-year-old female who had been a behavioral health patient for over a year had been attending biweekly in-person sessions, but really struggled finding words or processing therapeutic needs and the capability of telehealth to help break a barrier with her, and that she was much more comfortable receiving care from her home than in person and she is now doing very active therapeutic work with her provider. And she's not alone. Behavioral health in-person appointments traditionally suffer from high cancelation rates. Those cancelation rates in our system have been reduced by over 50 percent via the telehealth platform, which has encouraged more folks to get the help they need in a setting that they prefer. I could go on and on with additional examples, but respecting your time, I would simply say that none of our telehealth success stories would have been possible without the recent Medicare 1135 waivers and flexibilities that allowed in the federal and state public health emergency orders that are still in effect at the moment. And while they're all important, reimbursing providers the same amount as if the services were being provided in person has been critical to our ability to provide increased coverage. This is currently happening in Medicare and Medicaid and as a result of the public health emergencies, and it's happening in some instances within the private insurance. But providers and patients need to know it won't go-- just go away when public health emergency orders are lifted or that private insurance will no longer cover this option. And it's not about behavioral health providers being able to make more money. CHI Health alone loses approximately $12 million per year just providing behavioral health services. We view this as part of our mission that will never change. It's more about helping providers meet increasing demand for a badly needed service and making it accessible and affordable to all Nebraskans. And this makes perfect sense at a time when federal COVID Appropriations and Governor Ricketts are making broadband expansion through the state a reality. I'd like to close by saying I think two of the most difficult lines of business over this last year have probably been health care and public service, so I thank you all for your service. And I'd be pleased to answer any questions.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

KAITLIN REECE: Good morning, Vice Chair Lindstrom, and members of the Banking, Commerce and Insurance Committee. My name is Kaitlin Reece, K-a-i-t-l-i-n R-e-e-c-e, appearing today as the registered lobbyist for Lutheran Family Services of Nebraska in support of LB487. As one of the state's largest nonprofit providers of mental health services, Lutheran Family Services, or LFS, is grateful for Senator Arch's leadership and the committee's attention to this important issue. In 2020, the world changed overnight. I don't have to tell you that. The pandemic radically altered LFS's operational status. Within 24 hours of LFS's March 15th decision to launch its emergency telecommunications plan, the agency achieved 90 percent workforce connectivity. Three days later, the agency in its statewide locations accomplish 100 percent connectivity. For its part, LFS broadcasted COVID-19 information in 14 different languages via YouTube. The staff continues to guide refugees and immigrants in submitting pandemic-related unemployment claims and provides interpretive services for all telehealth clients as needed. LFS is also under contract for interpretation and translation services for Governor Ricketts' office. The emergency telecommunications plan included serving clients virtually through telehealth and shifting to telecommunications to deliver behavioral health therapy, support groups, classes and staff training beyond online platforms. Training staff and the use of telehealth and the application of best practices for this new model of service delivery was essential. Pre-pandemic, LFS utilized five private virtual telehealth rooms to serve clients across the agency. Staff and client safety in March 2020 dictated that LFS move it's service line into telehealth services and we're now using more than 65 private virtual rooms to service clients across the state. Since moving to its emergency telecommuting procedure, LFS has conducted almost 50,000 behavioral health appointments utilizing these virtual telehealth rooms. These virtual rooms include a new program model in which LFS partners with churches to provide safe, secure, confidential satellite telehealth treatment rooms, resulting in a network where individuals who were previously geographically removed from services can visit a local church and have access to the full network of LFS's human care professional. In the state of Nebraska, 88 out of 93 counties pro-- report a provider shortage. The satellite treatment program is one step in addressing this critical need in our

state. Included in my testimony is a packet of information that LFS provides partner churches and clients as part of this program. Even after the current COVID pandemic is over, the need for more flexibility in terms of access to mental health services will persist. Rural Nebraskans, Nebraskans with limited mobility or limited access to transportation all faced barriers before the pandemic. We know from experience that timely and appropriate access to mental health services is effective in treating mental illness and avoiding deeper and more expensive treatment options, such as inpatient treatment and the inappropriate use of the emergency room for treatment. These front-end investments in our behavioral health system can help repair lives and lower the cost of health care for everyone, payers and those insured. For these reasons, we are grateful to Senator Arch for recognizing this need and ensuring that these access points to our health care system that we've achieved during the pandemic do not disappear or deteriorate once we've reached widespread immunity to COVID-19 through vaccines. Thank you for your time and happy to answer any questions you may have.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

KAITLIN REECE: Thank you.

LINDSTROM: Any other proponent-- proponents? OK. We do have testifiers that dropped off letters: Katie Zulkoski, Nebraska Academy of Physician Assistants; Jeremy Nordquist, Nebraska Medicine; Brennen Miller with Nebraska Association of Regional Officials; Andy Hale, Nebraska Hospital Association; Matt Schaefer with Nebraska Methodist Health System; Cora Schrader with Nebraska Nurse Practitioners and Jason Hayes with NSEA. We will move to opponents. Good morning.

ERIC DUNNING: Good morning, Mr. Vice Chairman, members of the Banking, Commerce and Insurance Committee. Oh, good, I get to-- I get to get rid of this thing. My name is Eric Dunning. For the record, that's spelled E-r-i-c D-u-n-n-i-n-g. I'm here today as a registered lobbyist for Blue Cross and Blue Shield of Nebraska. And we're here very briefly in opposition LB47-- LB487. During the COVID emergency, as you've heard from previous testifiers, Blue Cross and Blue Shield of Nebraska expanded reimbursement levels for telehealth services at two levels. We went beyond the federal requirements that were tied to the pandemic. And then-- and until July, we waive all cost sharing for

telehealth services, copayments, coinsurance, everything. And we did all of this because we focused on the safety and well-being of our community, both our members and our provider partners. And we've been trying to make sure that members have access to the care that they need, at the same time easing that burden to the providers. We have no plans to pull back from our current telehealth payment parity position because we believe that currently it meets the needs of the market and that the market itself will punish insurers who pull back from similar positions. And with that, I'd be happy to answer any questions.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

ROBERT BELL: Vice Chairman Lindstrom, and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell, last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation. The Nebraska Insurance Federation is a state trade organization representing the domestic insurance industry in Nebraska. I am here today to testify in opposition to LB487. First, I would like to thank Senator Arch for all of his hard work over the interim looking at the issues surrounding telehealth. I think he has recognized that the COVID-19 pandemic has changed consumer and provider activity related to telehealth. Just as we all have, policyholders have now become more accustomed to utilizing video for a variety of needs, including telehealth visits. Insurers have done their best to meet the challenge of the epidemic to provide telehealth parity during these trying times. LB487-- LB487, excuse me, focuses on behavioral health tele-- telehealth visits, excuse me, in providing parity payment with in-person visits. As opposed to more expansive telehealth mandates, LB487 stands out as a proposal that is more limited in its application, with a stronger correlation between the medical provider time and actual cost. More expansive propos-- proposals fail to take into account the great amount of overhead or fixed costs, as we heard earlier, in providing medical care in person such as assistants, nurses, equipment, parking lots, building costs, etcetera. Yet LB487 does remain a mandate. Historically, the federation has opposed all health insurance mandates for numerous reasons. First, simply, it is the cost of a payment parity mandate. The increased cost occurs in two ways. First, by the simple act of adding to the benefit package if the mandate is not already covered, but also because mandates impair the ability of the health insurer to effectively negotiate-- negotiate a fair price with

the provider of the medical service. The second reason is the hidden cost of insurance mandates and also heard earlier that employers were mentioned. And I would state for the record, and I need to point out to the committee, the limited reach of legislation such as a state mandated benefits have no reach to most self-insured employer plans covered by the federal ERISA law. And according to research that I've reviewed, ERISA plans cover about 50 percent of actual insured Nebraskans. For these reasons, the Nebraska Insurance Federation respectfully opposes the passage of LB487, and I thank you for the opportunity to testify.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

ROBERT BELL: You're welcome.

LINDSTROM: Any other opponents? Seeing none, any neutral testifiers? Seeing none, Senator Arch, would you like to close?

ARCH: Well, thank you for hearing this bill today. I want to-- I want to respond, first of all, to a couple of the questions that were raised. Senator Flood asked, you know, should that first visit be required to be in person? And Korby Gilbertson responded to that question. I-- I would also add that one of the benefits you have with telehealth is the immediacy of-- of-- of-- of-- of having a-- a visit with that patient and-- and particularly if the patient is in crisis. I did counseling early in my career. That was-- that was my-- that was my-- when I first got out of grad school, I did family counseling and I realized the-- the benefit of talking to a family member or a patient when they're ready to talk. And-- and what we're-- what we're seeing right now is sometimes the scheduling of visits are out weeks or sometimes months to get in to see a practitioner. And the immediacy of being able to have that first visit when the patient is in crisis is of great benefit. So I would-- I would be hesitant to put that requirement in. That being said, as part of my preparation for this bill as well, I spoke to psychiatrists. And there is within-- within the practice of medicine, there's something called professional judgment. And that is-- that-- that is something that every practitioner uses every day. They use professional judgment. One of the psychiatrists that I spoke to said, you know, I-- there would be patients that I would use telehealth with and there would be patients that I would not. In particular knowing-- knowing that perhaps the

conversation could put the patient in crisis and you need somebody in the room with them at that time, and so that professional judgment-- telehealth is not going to-- I don't think anybody envisions is replacing face to face completely, 100 percent, but rather as a-- rather as an option. One other question. Senator Bostar, you mentioned, you asked about encryption, and in my-- what I'm-- what I'm seeing right now is encryption was waived during the pandemic and-- and I believe still is waived. Requirement to have encryption, and that was to get health care out as quickly as possible. But I see encryption coming back as a-- as a requirement that waive-- that waiving dropped. Frankly, most of the-- most of the software now is developing encryption because it's necessary not just for health care, but really for all of our communication. And so encryption is becoming much more available to-- to providers as well as-- as-- as well as all of us. I would also-- I would add one other thing that a comment about telehealth not completely replacing face to face because some may not choose, some providers may not choose not being willing to do telehealth visits, period. And that is a choice based on professional judgment. But there's also involved with prescribing of psychotropic meds, the-- the requirement for vital signs. So you may-- that patient may need to be in a facility where a nurse could take vital signs and before-- before a psychiatrist would be willing or a physician would be willing to prescribe psychotropic meds. So, again, not-- not going to be replacing all of it. I have another bill in Health and Human Services Committee, LB400 that I want to make sure it harmonizes with LB487. You might-- you might see some tweaking to LB487 and some clarification. I've had some questions recently raised on exactly how that-- how that relates to LB400. So you might see a-- you might see an amendment come as well to the committee with some tweaking of that. Last comment I would make is I really wrestled with this issue and some in the room know that I wrestled with this issue because we had-- we had a number of conversations. I-- I personally am not a strong proponent of mandates, but in this particular case there were two things that brought me to this point. One-- one being the serious issue we have with access for mental health care in our state. We know that. We've heard it this morning, the number of counties-- the number of counties, 88 out of 93 counties are designated as a mental health shortage area. And we know that telehealth and we've seen it be effective in that. And I felt as though the opening up of access and making sure that that's available is one of the drivers. But the other thing that brought me to this was-- was my-- was my issue with cost.

Cost in health care, we know is a very serious issue right now, how to reduce cost and-- and the weighing of cost for the provision of behavioral health services, whether that be face to face or whether that be via telehealth. And when I-- when I consider the cost structure, because typically the cost structure of a-- of a behavioral health provider is-- is very simple. It's a room. It's a desk. It's a chair. It's a computer. And within that environment, large enough perhaps to have a family in the room. But it is-- it is truly-- it is face to face across the desk or it's face to face on the computer. And that's different than-- that's different than many medical professions, but in behavioral health, that's-- that is the cost structure. Yes, you have-- yes, you have check-in. Yes, you have billing. Yes, you have that. But whether it's face to face or whether it's on the-- on the computer, very little difference in cost structure. So between-- between the access issue and the-- and the cost structure analysis, I felt as though that this was a-- that this was a worthwhile bill, and so I brought this to your attention today. And with that, I would close.

LINDSTROM: Thank you, Senator Arch. Any questions from the committee?Seeing none, thank you.

ARCH: Thank you.

LINDSTROM: We did have letters for the record, 11 proponents, zero opponents and zero neutral. And that will close the hearing on LB487. OK, we will open the hearing on LB337 introduced by Senator Kolterman.

TYLER MAHOOD: Ready?

LINDSTROM: We're ready to go, Mr. Mahood.

TYLER MAHOOD: Awesome. Good morning, Vice Chair Lindstrom, and members of the Banking, Commerce and Insurance Committee. My name is Tyler Mahood and I am Senator Kolterman's Legislative Aide. Unfortunately, due to COVID protocol, Senator Kolterman is unable to attend today, so I am honored to have the opportunity to introduce this bill on his behalf. Step-therapy, also known as fail first, is a program commonly used by insurers to control the order in which a patient takes certain therapies approved for a given condition. Under step-therapy, a patient may be required to try one or more alternative prescription drugs chosen by their insurer before coverage is granted for the

prescription drug prescribed by that patient's health care provider. Step-therapy programs require patients to try one or several medications before being covered for the drugs selected by the provider. Because of this, the patient may have delayed access to the best therapy for their condition. Senator Kolterman and our supporters believe this legislation will help remedy issues that currently limits a patient's access to life-changing treatment in a timely manner. More than two dozen other states, including Iowa and South Dakota, have adopted similar language-- legislation to the language we are proposing here today and this bill is directly modeled after Iowa's law. Today, you will hear from providers and patient advocates, including a constituent of Senator Kolterman's, who has been directly affected by step-therapy protocols. The testifiers who will follow will share the impact of step-therapy on patient care. We have built a large coalition here in Nebraska with over 45 patient advocacy groups and provider organizations represented. These groups and provider organizations are all committed to seeing some common sense guardrails put into place for the patients of Nebraska. Senator Kolterman has worked diligently with stakeholders, including Chairman Williams, to come to a consensus on this language. Due to the unique challenges COVID presents, we conducted multiple Zoom meetings to allow us to come kind of-- before this hearing to allow us to come to this compromise agreement. As this negotiation-- as these negotiations carried into the legislative session, I am introducing AM20 on behalf of Senator Kolterman that we respectfully ask the committee to adopt. By adopting this amendment, the committee would provide Senator Kolterman and the stakeholders the updated language that has been agreed to between the bill's introduction and this hearing. I am proud we were able to get this work done before the hearing, and I guarantee you, Senator Kolterman feels the same way. Thank you. And on behalf of Senator Kolterman, we ask for your support on this bill, and I would open it up for any questions, but I would prefer that you ask the people following me who are more versed in this issue.

LINDSTROM: Thank you, Mr. Mahood. Any questions from the committee? Seeing none, thanks.

TYLER MAHOOD: Thank you.

LINDSTROM: Good morning.

Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

KRISTEN STIFFLER: Good morning, Vice Chairman Lindstrom, and members of the Banking, Commerce Insurance Committee. My name is Kristen Stiffler, spelled K-r-i-s-t-e-n S-t-i-f-f-l-e-r, and I am the state government relations manager for the National Psoriasis Foundation. The National Psoriasis Foundation represents 8.3 million Americans and over 45,000 Nebraskans living with psoriatic disease. I'm also proud to represent a coalition of almost 50 patient and provider advocacy organizations known as the Nebraskans for Step Therapy Reform Coalition. The patients and providers we represent have been impacted by the practice of step-therapy and will directly benefit from the protections of LB337. Step-therapy can be detrimental for patients facing chronic, progressive and complex conditions such as psoriasis and psoriatic arthritis, and as it can lead to patients inability to access appropriate treatments. Step-therapy when it's not medically appropriate can result in weeks, months or even years before a patient can get the medication originally prescribed by their doctor. I'd like to emphasize that step-therapy can be an appropriate utilization tool. However, it can be particularly difficult to apply towards complicated-- complicated diseases such as psoriasis. That is why LB337 does not ban the practice of step-therapy. Instead, it outlines an exceptions process for patients to bypass steps that are not medically appropriate. When step-therapy fails to take into consideration the unique nature of a disease like psoriasis, it can be detrimental for patients and it can lead to disease progression, higher overall costs of care, irreversible damage and development of other comorbidities. It is likely an individual with psoriasis will have at least one, if not multiple, significant comorbidities, including arthritis, cardiovascular disease, metabolic syndrome, inflammatory bowel disease or depression. Diseases that on their own frequently encounter step-therapy and are also represented by our coalition. These associated comorbidities emphasize the importance of tailored and efficacious treatment plans. Having a clear process for providers and patients to request an exception to a step-therapy protocol will ensure that the doctor-patient relationship remains at the core of how medicine is practiced, allowing patients to access the right medication in a timely fashion. So LB337 specifically requires a clear process for a doctor or a patient to request an exception to the step-therapy protocol if one of the following criteria are met. If the step-therapy drug is contraindicated or will likely cause an adverse reaction of physical or mental harm, if the step-therapy drug is expected to be ineffective, if the step-therapy drug is previously

tried and discontinued due to a lack of effectiveness, if the step-therapy drug could worsen a comorbid condition, be ineffective to the patient's medical adherence or compliance, if the step-therapy drug decreases the ability to achieve or maintain functional ability in performing daily activities, or if the patient is currently receiving a positive therapeutic outcome on a medication while under the patient's current or previous health plan. LB337 also includes a clear and timely process to receive a response from an insurance company for the exception request. That's 72 hours for an emergency situation and five calendar days for nonemergency situations. Due to the precautions of COVID, we have requested our coalition members to provide written testimony or submit testimony early this morning. However, we do have a doctor who will-- who will describe the common sense guardrails that are needed to help his patients who have experienced complications with the current step-therapy exception process, and from two mothers whose children were delayed treatment for their-- from their doctors originally prescribed plan due to the difficulties with the step-therapy protocol. Finally, I want to give a special thank you to Senator Kolterman, Tyler as well, for their leadership and Chairman Williams, who's not here, both for their guidance as they have brought all stakeholders together, including the provider community, the health plans, pharmacy benefit managers and patient organizations to work on this really important piece of legislation. Through our discussions, we made changes and we compromised on language. I want to personally thank all of the stakeholders who helped make this the best bill for Nebraskans. The National Psoriasis Foundation and the Nebraskans for Step Therapy Reform Coalition respectfully request you vote LB337 out of committee. Thank you for the opportunity to provide testimony and happy to answer any questions.

LINDSTROM: Thank you. Any questions? Senator Bostar.

BOSTAR: Thank you, Senator Lindstrom. Thank you, ma'am, for your testimony. I apologize, there was a bit of a distraction as you were going through the list of the situations in which this bill would address regarding step-therapy. Could you just read that list again?

KRISTEN STIFFLER: Sure. So when a doctor requests an exception to the step-therapy protocol, the bill requires that there are certain criteria that need to be met for that exception to bypass that certain step. And so that would include if it's contraindicated or likely to

cause an adverse reaction of physical or mental harm, if the drug is expected to be ineffective for the patient, if it's been previously tried and discontinued due to lack of effectiveness, if the step-therapy drug could worsen a comorbid condition, be ineffective to the patient's medical adherence or compliance, would decrease the ability to achieve or maintain functional ability in performing daily activities, or if the patient is currently receiving a positive therapeutic outcome on their current treatment.

BOSTAR: Thank you so much.

LINDSTROM: Thank you. Any other questions? Seeing none, thank you.

KRISTEN STIFFLER: All right, thank you.

LINDSTROM: Good morning.

LESLIE SPRY: The-- Vice Chair Lindstrom, Senator Pahls, my name is Les Spry and I am-- been practicing medicine here in Lincoln for about 43 years.

LINDSTROM: Could you spell your name for the record, please?

LESLIE SPRY: Oh, my-- Leslie, L-e-s-l-i-e, last name is Spry, S-p-r-y, and I'm at 7576 Crystal Court here in Lincoln.

LINDSTROM: Thank you.

LESLIE SPRY: So as a physician, I have been involved in patient education for the National Kidney Foundation since 1985. It turns out that I also do some-- somewhat progressive stuff. I write informational blogs both for the National Kidney Foundation as well as for the Huffington Post. So I feel it's important that I add my voice in support of LB337. This legislation will help put much needed commonsense guide rails-- guardrails on step-therapy in Nebraska. Every day I help my patients navigate step-therapy protocols. One of my patients, turns out a constituent of Senator Kolterman, is a 40-year-old male who was from York and was diagnosed with bladder cancer and also newly-diagnosed kidney disease. His insurance company required step-therapy for the kidney disease. Instead of giving the drug that I prescribed, the insurer-- insurers required him to take a drug which is known to cause bladder cancer. I fought the step-protocol, which took many months of back and forth with his

insurance company. It is my belief that that delay resulted in progressive kidney failure and dialysis. Turns out the patient was just recently transplanted in November. I believe that that drug therapy that I originally recommended was appropriate for the patient and it turns out that that is now a standard of care for his type of kidney disease today, although it wasn't at the time. I support LB337 because it will ensure something like this does not happen again. It will require step-therapy protocols to be based on widely accepted medical and clinical practice guidelines. The constant back and forth with insurance companies can be frustrating, labor intensive and time consuming for my staff and patients as well. LB337 will create a clear and expeditious process to request a medical exception and require a response by the patient's health plan within five calendar days for nonemergency and three days for emergency situation. I support LB337 because it is not-- it does not prohibit step-therapy, but puts much needed guardrails around the practice. It also allows for common sense exceptions so my patients and others with chronic diseases can get access to life-saving and pain-relieving medications in a timely manner. I ask that you vote favorably on this bill. Thank you for your consideration.

LINDSTROM: Thank you. Any questions from the committee? Senator McCollister.

McCOLLISTER: Yeah, thank you, Vice Chairman Lindstrom. Health care in the United States currently is at 18 percent of gross national product, higher than most any industrial country in the world, at least a third higher than most countries. You know, the step-therapy program was a device that insurance companies used to save money. What other place can we save money if we can't do such-- use such mechanisms like step-therapy to save money?

LESLIE SPRY: Well, so if you want my opinion, I would say that one of the things that was recently done which was to allow reimportation of drugs, would be the most effective way of doing that. Turns out that the sale of drugs overseas are usually at a percentage of what we pay here in the U.S.. And so if we were to allow reimportation of drugs and then utilization, prices would come down. In other words, we have no way to put pressure on prices of drugs in this country because we don't bargain for them. Second issue, I would say, would be the step-therapy I do think is a good process. I think it's the proper process. In my case, what I was-- was happening was I was dealing with

someone who did not have any medical training in nephrology that I was working in, and I could not convince this-- this chief medical officer for this insurance company that I knew what I was talking about. He just would read UpToDate. He would quote me UpToDate, which is a common medical textbook but does not contain anything current. It has to be-- it takes about two years for that kind of literature to make it in UpToDate. So my problem was, is that I had no way to put pressure on this chief medical officer. Now, second, again, my own opinion, this is not the opinion of the Psoriasis Society, but my own opinion would be, make these chief medical officers have licensure in the state so that my medical board can review their activities. That would be another way to get their attention, because right now I don't have any pressure to put on chief medical officers for insurance companies.

McCOLLISTER: Thank you.

LINDSTROM: Thank you. Any other questions? Seeing none, thank you.

LESLIE SPRY: Thank you.

LINDSTROM: Good morning.

NIKKI PERRY: Good morning. So dear members of the Banking, Commerce and Insurance Committee, my name is Nikki Perry, N-i-k-k-i P-e-r-r-y. I am a resident of Lincoln District 25. My senator is Suzanne Geist and I'm here today in support of LB337 for my 11-year-old son. I call him Maxi Pooh, but now that he's eleven, he says, no, mom, it's just Max. So our lives changed forever when Max was diagnosed with epilepsy at the age of five. He has refractory epilepsy, which means that the drugs that he takes will not stop his seizures completely, but they will help reduce the incidence of his-- of the severity of the seizures. I was so happy when I heard about this legislation because Max would benefit. For the first several years, we struggled to find the right therapy for Max. When his neurologist would prescribe a drug, we would show up at the pharmacy only to be told that our insurance provider was requiring Max to try and fail on other drugs before getting the drug his doctor prescribed. The first drug that Max took gave him debilitating side effects. He had mood instability, nausea, vomiting, diarrhea, and that's just to name a few. The side effects differed with each drug that we were given, self-injury, dizziness, changes in appetite, sensitivity to sound and light,

changes to smell and so on. And this is no way for a child to live or a parent. It was heartbreaking. He was barely surviving, and yet there was a medication out there that could help him. This process is requiring a patient to fail on medications before receiving the medication their doctor prescribed, which is called step-therapy or fail first. Step-therapy can delay access to needed medication, which Max faced those delays and it's heartbreaking to watch your child go through such pain. After several years of trying an array of medications, Max is now stable on the medication his doctor prescribed. That is why I am here today to support LB337 which will put common sense guardrails around step-therapy protocols. One of those guard-- guardrails that will protect Max includes a provision that states if a patient is stable on a medication, the patient can stay on that medication. This bill does not ban step-therapy. It simply creates a path for patients to appeal to step-therapy requirements when medically necessary. It has been a long, hard fight for Max to find and be successful with the medication his doctor prescribed. Please take favorable action on LB337. This legislation will help ensure that moving forward, patients with epilepsy and other chronic diseases will be able to access the therapy their doctors believe is best for them. Help us keep these important medical decisions in the hands of the doctors. Thank you for listening to my testimony in support of LB337, and thank you to the sponsors of this legislation for encouraging all stakeholders across the entire health care system to work together to improve the step-therapy process for Nebraska patients like Max.

LINDSTROM: Thank you. Any questions from the committee? Senator Bostar.

BOSTAR: Thank you, Senator Lindstrom. Thank you, ma'am, for your testimony. What was the time period between diagnosis and Max receiving medication that was-- that was good.

NIKKI PERRY: Well, so he's stable now and he's 11 and he was diagnosed at the age of five. He's actually been on 12 different medications and-- oh, sorry.

BOSTAR: No, no, please.

NIKKI PERRY: So it's-- it's-- it's been that long.

BOSTAR: In that entire time was failing on different medications along the way.

NIKKI PERRY: Uh-huh.

BOSTAR: The medication that Max is on now was-- was that the initial medication that was prescribed?

NIKKI PERRY: One of them. So he's on three seizure medications and three or four behavior medications right now. And one of the seizure medications that he's on now was prescribed originally, but we received the generic. What the-- we received the lowest, the cheapest form of that medication. And now he is on the more expensive brand medication because he has less side effects on this medication. Does that make sense?

BOSTAR: Yeah, thank you very much.

NIKKI PERRY: Yeah.

LINDSTROM: Thank you. Any other questions? Seeing none, thank you.

NIKKI PERRY: Thank you.

LINDSTROM: Good morning.

LISA RHODES: Good morning. Vice Chair Lindstrom, and members of the committee, imagine knowing that your child's life will be cut short by a disease that there are few treatments for and no cure. Your natural instinct would be to make the most of the time that you have with your child and make every day as good as it possibly can be for them. My oldest child, Lane, as you can see here, was diagnosed with muscular dystrophy in 2014 when he was just two years old. The disease is a genetic disorder that is characterized by the progressive loss of muscle. It impacts every muscle in the body. The disease primarily affects boys. One in 5,000 will be born with Duchenne. Life expectancy for those living with Duchenne is 30 years old, but not without difficulties. The established treatment for Duchenne includes steroids to slow the muscle decline. But the side effects of long-term steroid use can be significant, including weight gain, bone fragility, immune suppression and behavioral issues. When Lane was on a particular steroid for a period of time, he experienced extreme behavioral issues. My happy kid became a different person. He suffered through

uncontrollable rage and aggression. He had a trigger temper and we would never know what could set him off. Our son was suddenly a stranger to us, and his behavioral issues from the steroid affected our entire family. So when in 2016, another steroid that offers fewer side effects hit the U.S. market, I was excited. This medication could slow the progression of the disease and offer less side effects, improving his quality of life. However, due to a protocol known as step-therapy, our health plan required Lane to fail on the traditional steroid before being granted coverage of the newly available steroid. It took over a month for our doctor to go back and forth with the health plan to appeal the decision. That is why I support LB337. This legislation requires a response by the patient's health plan within five days for nonemergency and within three days for emergency situations. It allows Lane's doctor to request an exemption to the step-therapy protocol because Lane had previously tried and discontinued the traditional steroid due to the debilitating side effects. For Lane and other boys living with Duchenne, having the right medicine is giving them time until more treatments are found. Being on the right medication gives me more quality time with my sweet boy keeping his muscles as strong as possible. So when I hug my son, I can feel his arms squeezing me back. I want to thank my Senator, Senator Kolterman, and Tyler, for introducing this bill, and I ask that you please vote favorably on LB337. And I think I forgot to say-- did I spell my name and everything at the beginning. OK, I'm sorry. I couldn't remember if I did or not.

LINDSTROM: Oh, could you just state your name again?

LISA RHODES: Sure. Lisa Rhodes.

LINDSTROM: OK, can you spell it real quick?

LISA RHODES: Yes. L-i-s-a R-h-o-d-e-s.

LINDSTROM: Thank you very much.

LISA RHODES: Sorry.

LINDSTROM: No, you're fine. Any questions from the committee? Seeing none, thank you for coming today.

LISA RHODES: Thank you.

LINDSTROM: Any other proponents? We do have letters that were dropped off for testifiers for proponents: Dexter Schrodt with Nebraska Rheumatology Society; Katie Zulkoski with Bio Nebraska; Andy Hale, Nebraska Hospital-- Hospital Association; Matt Schafer with Nebraska Oncology Society; Jina Ragland with AARP of Nebraska; Jason Hayes with the NSEA; Michelle Weber, Nebraska Academy of Physicians Assistants; Bob Hallstrom, Nebraska Pharmacists Association. And now we'll move to opponents of LB337. Any other opponents, seeing none. We'll move to neutral testifier. Sorry to make you sit down there.

ROBERT BELL: I deserve that. That was just for Senator Kolterman, in case he was watching. [LAUGHTER] I'm sorry about that. Vice Chairman Lindstrom, and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today to testify in a neutral position on LB337. And-- and as you know, the Nebraska Insurance Federations Primary State Trade Association-- Association of Insurers domiciled and/or with significant economic presence in Nebraska. I want to first point out our appreciation to both Senator Kolterman and Senator Williams, who were involved in the negotiations related to LB337, and to the advocates of the legislation to-- for listening to the concerns of the insurance industry related to this legislation, and Tyler as well, so thank you very much. As way of explanation, step-therapy is a tool that insurance companies use to keep prescription drug costs down for policyholders. In some cases, other treatments can be just as effective as name drug medication that has been marketed by pharmaceutical companies to either the medical provider or directly to the consumer. Step-therapy is a tool utilized by companies to keep these costs down. LB337 will be in addition to existing Nebraska law that already provides the opportunity for policyholders to challenge an insurance company decision. Both the Health Care, your grievance procedure act, and the Health Care external review act, so one-- kind of informal way to reference those is internal review and external review of decisions provide the current statutory scheme of internal and external review. According to the Nebraska Department of Insurance, there have been a number of external review requests made. So the Department of Insurance reviews and passes along external review requests, you know, as way of explanation. An internal review is a review that is done by the insurance company. An external review is one after a decision has been made by the insurance company that

the provider, the medical provider and the policyholder disagree with. That is made to the Department of Insurance who passes it along to a health utilization review organization to make a determination on whether that-- that treatment should be provided or it should go a different route or paid for-- excuse me. There have been-- step-therapy has been challenged both internally through internal review and external review, and some of those decisions have been overturned by those health utilization organizations and some of them have not. It would appear to be about 50-50 in the last three years. It is important to note-- I just want to note that if LB337 passes, the internal time frame is 10 working days faster for under step-therapy. So this legislation would speed up the decisions related to step-therapy as opposed to other medical decisions that a health carrier might make. From 15 working days under the internal review act to five days under the step-therapy review law. For these reasons, the Nebraska Insurance Federation is neutral in the passage of LB337. We think that the changes that have been made by Senator Kolterman and advocates, provide for. One of our greatest concerns was consumer confusion with the initial draft. We believe this clears that confusion up and I appreciate the opportunity to testify. Thank you.

LINDSTROM: Thank you. Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom. Thank you, Mr. Bell, for your testimony.

ROBERT BELL: You're welcome.

McCOLLISTER: How often do these treatment appeals occur?

ROBERT BELL: According to the Department of Insurance from some information I received from them, in the last three years there were 72 external review requests directly related to step-therapy.

McCOLLISTER: Thank you.

ROBERT BELL: Yep.

LINDSTROM: Any other--

McCOLLISTER: And you gave statistics on how many were successful or not?

ROBERT BELL: It's about 50 percent. I mean, it's every year-- it's thereabouts. It's approximately, so.

McCOLLISTER: OK, thank you.

ROBERT BELL: Yes.

LINDSTROM: Any other questions? Seeing none, thank you.

ROBERT BELL: You're welcome.

LINDSTROM: Good morning.

ERIC DUNNING: Good morning, Mr. Vice Chairman, members of Banking, Commerce and Insurance Committee. For the record my name is E-r-i-c, Eric, last name D-u-n-n-i-n-g, Dunning. I'm a registered lobbyist, appearing today on behalf of Blue Cross and Blue Shield of Nebraska. And just very quickly, Mr. Bell handled most of the points that I think would be worth raising from a payer standpoint. So I just want to again thank Senator Kolterman as well as Senator Williams for working through some of the issues related to a very technical bill. In addition to some of the safeguards under existing processes contained in Nebraska law, I think it's worth noting for the committee's use that insurance companies also get to make these decisions in the context of a very significant accreditation requirements from URAC, who come in every few years to review whether or not we are making science-based decisions that are in the best interests of our members. Those URAC requirements will remain in place and will remain standards that we have to abide by as well as we go ahead and implement the new standards found in LB337. So for those reasons, Blue Cross and Blue Shield is here in a neutral capacity on LB337.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

ERIC DUNNING: Thank you, sir.

LINDSTROM: Any other neutral testifiers? Seeing none. We did have letters for the record, 38 in support. It looks like zero opposed and zero neutral. Mr. Mahood. Mr. Mahood waives closing and that will end the hearing on LB337. We will now move to LB314 introduced by Senator Pahls. Good morning.

Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

PAHLS: Good morning, Vice Chairman Lindstrom, and the members of the Banking, Commerce and Insurance Committee. My name is Rich Pahls, R-i-c-h P-a-h-l-s. I want to thank you for the opportunity to present LB314. LB314 creates full parity of reimbursement for telehealth and in-person medical services. I'm going to stop there because like Yogi Berra said, it's deja vu all over again. Earlier you heard on LB487, lots of the things that I was going to talk about. So they took away all my talking points to speak of. And I'm sure some of the proponents and opponents will probably say some of the same things. But what I want to just make sure everybody understands, this is full parity for all telehealth. I see this bill as sort of like the umbrella. Everything would fall under this. Right now we have Medicaid, which was, I think in 1999 by this Legislature that was established full parity. I heard earlier this morning want to talk about behavioral health. Do we want to go down through each section of health and say, OK, this qualifies or this does not? I think that is what this committee needs to think about. It's that simple, because right now we do have one that-- and if we go health and I'm not saying no, I'm just saying we need to take a look at, do we want to do this piece at a time or the-- or the whole picture of all of the thing-- services that could qualify for the utilization of telehealth. And I think we have to look at the spectrum is what we have to look at. And that is-- that's basically as simple as that. I mean, I could talk about how the committees have met. I can re-- like say regurgitate how this is needed out in rural Nebraska and how the telehealth, the cost and the savings. But I think I will let the people following me go in more detail of what was stated probably earlier.

LINDSTROM: Thank you, Senator Pahls. Any questions from the committee? Senator McCollister.

McCOLLISTER: Yeah, thank you for your opening, Senator. Did it really follow in terms of the drafting, what we heard this morning from-- you know, before you said it.

PAHLS: Well, what I'm saying, they-- the parity is what I'm looking at.

McCOLLISTER: OK.

PAHLS: I was just basically saying, if we do the parity for that-- for behaviorial health, that would be just one subsection.

McCOLLISTER: So you're saying the provisions are basically the same.

PAHLS: Yeah.

McCOLLISTER: OK, thank you.

LINDSTROM: Any other questions? Seeing none, thank you. First, proponent.

ANNE BUETTNER: OK. Hello again. Tell me, do not just say ditto.Oh, by the way, Anne, for the record, Anne, A-n-n-e, Buettner, B-u-e-t-t-n-e-r, legislative chair for Nebraska Association for Marriage and Family Therapy. And for the record, again, state that the licensed Marriage and Family Therapy-- therapists subsumed under the umbrella of licensed mental health practitioners. And there are over 3,000 of us. And to give you a little bit more details, is an omnibus structure. As the licensed mental health practitioners we have licensed Marriage and Family therapist. We have licensed professional counselors and we have licensed social workers. That's why there's an army of us. OK. And like I said earlier, we either practice full-time or part-time or very part-time telehealth, but this is very important. It is our livelihood. And also when you benefit consumers, you benefit providers and providers can become consumers too. So it's just you benefit all. I would like to address some of the questions that were raised, especially by the committee earlier for LB487. First of all, there is this concern about-- about would telehealth pays in-person health. The answer is a resounding no. It's not mutually exclusive. These bills would have to enhance the flexibility for the providers and the consumers. It's not a replacement of one for the other. There is some-- and Senator Flood, you brought up that wonderful example of dermatologists and so on, so on. And it is on everybody's mind, the power of presence, the power of bonding and so on, so on. And what if the consumer would like in-person? Well, for the license and I can-- I-- the other profession can speak for themselves, but for mental health, licensed mental health practitioners, we have code of ethics and the code of ethics and actually under professional conduct, have a section called referral. And if it is not the best care and certainly when the patient can ask for it and he wants it and not make a referral, we will be committing unprofessional conduct. So-- so there are different-- different structure to govern this. And also the question about we will be attracting anybody, just pick up the phone and then surprise Nebraskans, that will never happen. There is the

Nebraska Telehealth Act and then also within our mental health practice act and so on, there is reciprocity and they are-- in the statutes and regulation is stated that the practitioner has to be licensed where the patient is located-- has to be licensed where the patient is located. Now, with the executive order from Governor Ricketts and so on, it sort of waives it a bit-- with just a bit, but still have to have clearance from the credentialing department. By the way, being it just speed up the process. It doesn't mean waive the requirements or the practitioners has to be licensed and the disciplinary background has to be clean and clear and so on. And that is the same for reciprocity. And we have laws on that, too, already in place. OK, I-- and I want to address more in detail about the concern about the in-person. There is no denial that, of course, especially for telehealth, you will wonder how do you reach out to the-- to the Kayan, you know, when everything is a one dimensional screen and bust through a wire and all that? Well, interestingly, believe it or not, for those who practice telehealth, those therapists, and we have so many studies to document that, they-- if they want to practice telehealth, they want to give the best care, it is required by ethics and they want clients to get well so that word by mouth, they have more clients. And, so they often report that, yes, they have to be super present, super focus. It be a telephone or video, and it raises a higher level or deeper level of concentration. And it's-- it's to bring each client's emotions and thoughts into the foreground, mirror them and move into empathy. So you can say those who practice telehealth are the heightened therapists. Of course, just like any professions, there are always bad apples. That-- bad physician, good physician, bad mental health, professional-- good mental health professional. But-- but if you practice it, you know, you want to-- you want your consumers to come back. So this is how they practice. Now, there was a question about how--

LINDSTROM: Sorry to interrupt, we're at the red light, but we'll see if we have a question.

ANNE BUETTNER: Oh, sorry. I'm already-- when I do not have a script, I just--

LINDSTROM: No, that's OK.

ANNE BUETTNER: -- go on, free associating. I was just about to address when you ask how many states have parity-- seven.

LINDSTROM: Any-- any questions from the committee? Seeing none, thank you.

ANNE BUETTNER: Good. Thank you.

LINDSTROM: Good morning.

LESLIE EILAND: Hi, good morning.

LINDSTROM: Whenever you're ready.

LESLIE EILAND: OK, thank you so much for the opportunity to speak today at this committee hearing. My name is Dr. Leslie Eiland. It's E-i-l-a-n-d. I'm an endocrinologist at the University of Nebraska Medical Center and the medical director of our Endocrine Telehealth Program. We started our program in 2013 at Mary Lanning in Hastings, Nebraska, and have since expanded to nine community hospitals in Nebraska and Iowa. Prior to COVID, our program performed about 2,000 telehealth visits per year, but with the changes due to the COVID-19 pandemic, our endocrine division is now doing about 700 telehealth visits per month. My colleagues and I believe that your health should not-- your health outcomes should not be dictated by where you choose to live, but unfortunately, that's currently the case. The prevalence of diabetes is higher in rural areas, and people with diabetes living in rural areas have higher rates of diabetes-related deaths than those in urban areas. My patients are elementary school teachers from Platte County with Type 1 diabetes who now get to connect with me through their phone in their classroom at the end of the day, instead of taking time off of work to drive in for a visit. There are women in western Nebraska with hypothyroidism who are homeschooling their three children and they now get to see me from home during rest time to review labs, adjust meds, and they don't need to drive hours to see me and bring their children to their appointment. While I am so grateful that these home-based telehealth visits have allowed my patients to address their health in ways less disruptive to their daily life, I want you to understand that in order to make these virtual visits successful, it takes multiple steps, both before and after the visit, to ensure a successful visit and provide the highest level of care. I have focused the majority of my clinical time on telemedicine the last seven years not because it's easier, but because I'm from rural Nebraska and I love being able to provide a service that's never before been available to a community and improve access to specialty

care. There are a few misconceptions about telehealth that I would really like to address this morning. The first is that you cannot provide effective, quality physical health care via telehealth. I presented data at the American Diabetes Association annual meeting last year showing improved outcomes in people with Type 1 diabetes seen in our telehealth clinics. There's now a large amount of evidence in the literature showing that managing diabetes with telehealth is not inferior to an in-person model. The second misconception is that providing telehealth services is easier and saves time for the provider and their practice. As you know, many clinic visits require something to be obtained prior to the visit. Right? Like some lab work or an imaging study, like a CT or an MRI. And the whole purpose of that visit is to review the data, see how the patient is feeling and formulate a plan. So when I see patients in person, labs and imaging are ordered in-house and I'm easily able to retrieve and review results with the patient during their appointment. But now let's say I'm doing a home telehealth visit with a patient with diabetes in Broken Bow. In order to have results prior to the visit, our clinic staff reviews the schedule one to two weeks prior, contacts the patient, asks where they want to get labs drawn, prints off paper orders, either mails them to their home or faxes them to the local lab. Then hopefully, hopefully, when results are available, they're faxed to my clinic. Someone then must retrieve the fax, look up the responsible provider, scan and email the results, which then need to be manually entered into my medical record. It's a similar situation for patients who need imaging. Paper orders are sent, there-- there are several steps of coordination involved between my clinic and the local radiology departments to ensure that the report and images are available for my review prior to the appointment. If you want to do telemedicine well, which we do, it requires not less work, but additional work and coordination to ensure that the visit is an appropriate use of everyone's time. The final misconception is that telehealth will continue to expand without payment parity. If there is not payment parity for these services, health systems will not be interested in investing the time, money and resources needed for the additional staff for these visits to be successful. We will continue with the primarily in-person model that requires patients to drive long distances and will take significant time off of work in school. When we start a telehealth clinic in a new location, we're not seeing established Nebraska medicine patients, we're seeing brand new patients who have never before seen specialists. There are many

reasons for this, but often it's a personal or economic barrier that's prevented them from seeking care. They have no one to drive them. They have-- they can't take time off of work or away from their families that are hundreds of miles away. Since the ramping up of telehealth earlier in the pandemic, our patient surveys consistently show that patients are more likely to recommend telehealth than in-person visits, and they say that staff gets to know them better through telehealth than in person. It's clear that patients want telehealth to stay. It's also clear to me that telehealth is a much needed resource in our state and has the ability to narrow the disparities that currently exist in rural areas. So in closing, I ask your committee-- your committee to consider, at minimum, enacting telehealth payment parity for the next 18 to 24 months, which will allow our patients and providers to transition out of the COVID-19 pandemic without facing a major disruption in needed care. Thank you.

LINDSTROM: Any questions? Senator Flood.

FLOOD: So where are you from in rural Nebraska?

LESLIE EILAND: I'm from Columbus.

FLOOD: Very nice. You did a wonderful job.

LESLIE EILAND: Thank you.

FLOOD: With those-- with the faxes, what would happen if the whole state got on the same medical records platform? Because I know some patients in Norfolk, they're-- our hospital is with Epic, and all that stuff is already there, their medications and stuff--

LESLIE EILAND: Sure.

FLOOD: --so when you go to Broken Bow, you're still doing faxes, what's going on with that?

LESLIE EILAND: We're still doing faxes. So our one clinic at Mary Lanning in Hastings is also on Epic through a program called Community Connect. So Hastings, Norfolk, Beatrice, and North Platte are all on the same system, which is great. But you still, you know, I'm still seeing patients that live three hours from one of those Community Connect sites, so there's no transparency.

FLOOD: Is faxing the most-- is faxing the most secure way to transmit that?

LESLIE EILAND: That's my understanding, yes. Most of the local community hospitals are not set up to do secure confidential, like scanning and emailing.

FLOOD: OK.

LESLIE EILAND: They rely on fax.

FLOOD: Interesting. Thank you.

LINDSTROM: Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom. Isn't NEHI working to harmonize most of those systems?

LESLIE EILAND: That's-- that's my understanding, but I have not found it to be applicable for most of the small community hospitals that my patients are getting their-- their labs drawn in.

McCOLLISTER: Thank you.

LINDSTROM: And the other questions? Seeing none, thank you.

LESLIE EILAND: Thank you.

SCOTT JANSEN: Vice Chairman Lindstrom, members of the committee, my name is Scott Jansen, S-c-o-t-t J-a-n-s-e-n. I'm the practice administrator at Complete Children's Health here in Lincoln. I'm testifying on behalf of the Nebraska Medical Association in support of LB314. I want to thank you for the opportunity to testify today. I am going to sort through my notes and try and avoid repeating testimony from LB487, but I do want to make a couple of important points and distinctions as we consider what I also agree is a bit of an overarching bill for telemedicine. I think it's very valuable for private practice physicians to have this tool available to them to reach out to their patients, especially those patients in rural areas. As a pediatrics practice, we see a number of patients who will-- will regularly drive a significant distance to see us, and the ability to have those visits via telemedicine is-- is a valuable service to be able to offer patients who are in rural communities. Additionally, we

do have the ability to, when necessary, pull in a specialist into a telemedicine exam or conference with a patient, thereby saving them a significant amount of time and in some cases repeat visits to-- to receive care. I want to share a little bit about our practice specifically. In-- in March of 2020, before the pandemic hit, we were seeing about 1,300 patients in our office on a weekly basis. By the end of March, that number had dropped to about 700 patients. Of those 700 patients, at that time 30 percent of those patients were receiving visits via telehealth. During 2020, our clinic provided 3,200 telehealth visits to our patients. And those occurred primarily because at that time, parents felt comfortable and confident that their children were able to be treated safely. We still had patients come into our office and we took many of the same measures that are being taken here today to assure that guests into our office were-- were safe. But had we not had telehealth parity, had that been eliminated, it would have simply exacerbated an already difficult situation for us, seeing a-- what would have been then a greater than 60 percent drop in patient volumes. Would have been very difficult for us to recover and we have still not yet recovered. We have not had a week where we have matched our 2019 patient volumes. Sima Verma, CMS administrator for the Trump administration, said the genie, if out of the bottle on telehealth, it's fair to say that you can't put it back in, and I think that comment was made a couple of times previously. The Nebraska Medical Association agrees with that and agrees with her CMS policy change that provides telehealth reimbursement equivalent-- equivalency for Medicare plans. So Medicare plans has equivalency, Medicaid has parity as well. One thing that private practice providers do fear is because the genie has been out of the bottle with telehealth, that there might be nationwide services that spring up and look to fulfill patient demand in this space. I think due to economies of scale, these telehealth companies could absorb lower reimbursement. It's simply a room with a cell phone and it's much less costly to construct than a physician's clinic, however these companies do not have a personal relationship with Nebraska patients, which can lead to very fragmented care, patient confusion over medications or plans of care. Ultimately a rise in fragmented care leads to a rise in costs to the health care system due to duplicity-- duplicity and inefficiency. Telehealth utilizing the patient's existing physicians allows the physician to meet the patient where they are, provide high quality care due to the existing relationship and knowledge of the patient's history. High quality care can ultimately lead to lower costs for

patients and their families, which should be the aim of any health care policy change. Telehealth reimbursement equivalency will allow Nebraska physicians to continue to provide this high quality care for their patients. It should not be viewed by policymakers and insurers as a novelty service again, but another tool in the physician's toolbox to provide the kind of high quality care that Nebraskans deserve. Recent Center for Connected Health Policy reports finding that private payer telehealth laws have been one of the most common legislative reforms made by state Legislatures in the last five years. I do believe that it is worth pointing out that Minnesota, which is a corporate home to several health insurers operating in Nebraska, one of which is a United Health Care--

LINDSTROM: I apologize. We're at the five minute mark, is it--

SCOTT JANSEN: I'm sorry.

LINDSTROM: You're fine. Just trying to keep it level playing field here. Any questions? Senator Bostar.

BOSTAR: Thank you, Senator Lindstrom. Thank you again for your testimony. You talked about the concern being over a provider, providing services at scale, just a room and a cell phone and that parity would help to reduce the risk of that occurrence. And am I understanding that, correctly?

SCOTT JANSEN: Yes.

BOSTAR: I guess-- I guess my question is, why-- why would that reduce-- because that's what I'm worried about. Why would that reduce the risk of a large scale provider coming in trying to just maximize their profit and with little potential regard to the results of the services they provided.

SCOTT JANSEN: So if-- if I, as a practicing physician, don't have essentially the same opportunity to enter in, because I-- I'm operating a full-fledged, full-blown practice. If I don't-- if I don't have the ability to offer telemedicine, telehealth services that I believe I can do within my overhead and my business model, patients-- if patients need that service, if I'm not available as an option, they only have unlimited other option available. In years past, we, as a practice have reached out to Blue Cross and Blue Shield and asked them

to consider allowing us to provide telehealth services to our patients and they indicated that they would allow that if we wanted to become providers under their Amwell model, which simply opens us up to calls from anybody across their-- their policy holders to telehealth calls. We wanted to, as our patients' medical home, we wanted to be able to provide those services to our patients, not patients that are simply the general public who need that health care service. But if we're unable to do that under-- under a competitive cost model, I don't have an incentive to do that within my operation, so I can't do it. So patients who need that service are forced to go to an outside provider and their care gets fragmented.

BOSTAR: So, thank you. I-- I think I'm still concerned, um. You know, if we have two providers, you and then a pop-up provider who is looking to kind of take advantage of the system, and you're both getting full parity for telehealth services. You also have to pay for all of your overhead, all of your, your support, whereas this other provider maybe takes what that-- what those expenses would be for you and puts them into marketing and tries to take some of the market. And then we are in the same situation again. Do you think that it would make sense to have 100 percent parity for telehealth services conducted by a service provider that can and does do some services not for every patient, but is able to do services in person and not 100 percent parity for a service-- for a service provider that, say, has no in-person capabilities whatsoever.

SCOTT JANSEN: From my preference, I would think that that would be a positive situation, I believe. I'm not sure what all of the ramifications would be on the scenario, but just on the surface, I think that helps to eliminate one of the concerns that you would have, and that would be these pop-up providers that may simply take advantage of the situation.

BOSTAR: Thank you.

LINDSTROM: Senator McCollister.

McCOLLISTER: A related question. Thank you for your testimony. We're all familiar with the online solicitations for legal services, you see it on TV as well. What would-- would licensing preclude somebody from out of state? Would soliciting business in Nebraska or is-- do you have to have a license to actually handle patients in Nebraska that

would preclude somebody from out of state just a-- and the term was used pop-up, a pop-up operation.

SCOTT JANSEN: I don't know if it would preclude that necessarily because it is not difficult to get a license if you are a qualified practitioner, you simply live out of state. There's an economic cost to that. But if you're qualified, there's nothing that would prohibit you as a physician from getting a license in the state of Nebraska that I'm aware of.

McCOLLISTER: So if you have a license in Minnesota, New Mexico or whatever else, you can practice in Nebraska as well?

SCOTT JANSEN: I believe that you can provide telehealth services, yes.

McCOLLISTER: OK, thank you.

SCOTT JANSEN: I did want to address one of the questions that you had regarding NISA. NISA right now is simply a data repository. It's not super effective if you're looking for specific information in a patient's chart, for example, to provide them care that's needed during an exam.

McCOLLISTER: OK. Thank you.

LINDSTROM: Any other questions? Seeing none.

SCOTT JANSEN: Thank you very much.

LINDSTROM: Good morning.

BRIAN BOSSARD: Good morning, Vice Chairman Lindstrom, and members of the Banking, Commerce and Insurance Committee. My name is Brian Bossard, Dr. Bossard. I'm an internal medicine physician. My name is spelled B-r-i-a-n B-o-s-s-a-r-d. As a lifelong Nebraskan, I have practiced medicine for over three decades and I practice in a traditional medicine practice. Sadly, I'm old enough to say, I'm the first hospital medicine doctor in the state. And I've created multiple hospital medicine practices throughout the state, including here in Lincoln, Bryan Health; in Columbus at Columbus Community Hospital; in North Platte at Great Plains Health, and I continue to oversee those practices. I've also supported the development of hospital medicine practices in multiple additional communities around the state. And

while providing oversight for those hospital medicine programs, I've been responsible for the care of literally tens of thousands of patients over those 30 years. Patients who have been referred from essentially every rural community around the state. And during that experience, those experiences over the years, I realize there are profound gaps in access to essential lifesaving services in many communities, most communities in Nebraska, and that clinical care needs, needed to be delivered differently and better. And there are lots of reasons for these gaps. I think the primary one is the shortage in every clinical service line for physicians. We've talked about mental health. That's clear. 14 counties don't have a primary care physician in the state. And you can go on down the line in terms of specialty services. Bryan Telemedicine was founded in 2014 to address these issues of clinical access. The current public health emergency has created a broad awareness of a new paradigm in telehealth offerings, including direct to consumer care and direct to patient care, have been obvious.These home-based services have experienced dramatic growth during the height of the pandemic and have served for many as the face of telehealth.That's what we all think about when we think about telehealth. However, telehealth offers much more than that. Complex acute care clinical offerings such as neurology care, stroke care, pulmonary intensivists care, hospitalist care being offered in communities around the state. We currently offer programs in the majority of hospitals in Nebraska, including 60 percent of critical access hospitals. We do this through expensive, sophisticated, HIPAA compliant, high-tech compliant equipment, and we do it after a lengthy implementation process is followed. It takes a lot of time to set these up. These patients are sick, they're precious lives, and we take seriously the opportunity to develop the programs. Many outpatient telehealth clinics are also offered. Endocrinology is a great example. Patients can, in the comfort of their hospitals located in their own communities, receive care. We have oncology clinics 200 miles away. Patients can either travel 200 miles for a 15-minute visit and travel back 200 miles, or use telehealth for those visits, saving family and patients' time and trouble and expense. Rural health care is experiencing a financial crisis throughout Nebraska. As a leading employer, the crisis created in a rural community when the hospital closes, transcends health care. The personal economic impact of a rural hospital closure to affected communities is disastrous. Telehealth enables rural hospitals to reduce patient outmigration, treat patients in their local facilities

and prevent the loss of substantial revenue. Telehealth offers solutions for these seemingly unsolvable problems for access, and in so doing provides a lifeline for the economic health of these rural communities. Avoidance of patient transfers from rural communities eliminates the high cost of medical transportation and dramatically reduces the overall cost of care. Telehealth also provides for clinical staffing models at a fraction of the cost of in-person care. Rural communities are required to bring in physicians at high expense, locums physicians. Telehealth can offer that at a fraction of the cost. Studies consistently show an increase in cost of care as patients move through the care continuum with the inpatient care and care in emergency departments offering the highest cost alternatives. And on the other end of the spectrum, costs are reduced due to access to timely health care through the lowest cost option of telehealth. Ultimately, improved access to care through telehealth supports the Institute for Healthcare Improvement, IHI, quality initiative known as the quadruple aim of health care, improve patient experience, improve clinical experience, improve outcomes and lower costs. Telehealth supports the goal of broad access to preventative health measures. LB314 will ensure the sustainability of efficient and lower cost models of care offered through telehealth by reimbursing services at the same rate as an in-person visit. I appreciate your time. Thank you for your support of LB314.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

BRIAN BOSSARD: Thank you.

LINDSTROM: Any other proponents?

PAT CONNELL: Good morning, Senator Lindstrom, and members of the Banking, Commerce and Insurance Commission-- Committee. My name is Pat Connell, P-a-t C-o-n-n-e-l-l. I serve as a health policy advocate for Boys Town and Boys Town National Research Hospital. I'm here today as legislative chair for the Nebraska Association of Behavioral Health Organizations, also known as NABHO, and providing testimony in support of LB314. In light of the time and the-- the generous amount of time we had for questions and answers on the previous bill, I think it would be redundant for me to talk about a lot of those things. But they also-- we just want to be on record that we support parity for

behavioral services. With that, if there's any questions that-- that would conclude by testimony.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

PAT CONNELL: Thank you.

LINDSTROM: Any other proponents? We do have letters that were dropped off who would be testifiers. Proponents: Brennen Miller, Nebraska Association of Regional Administrators; Katie Zulkoski, Nebraska Academy of Physicians Assistants; Andy Hale, Nebraska Hospital Association; Cora Schrader, Nebraska Nurse Practitioners, and Bob Hallstrom, Nebraska Pharmacists Association. We will now move to opponents.

JAY McLAREN: Good morning, Vice Chair of Lindstrom, and members of the committee. My name is Jay McLaren, J-a-y, last name, M-c-L-a-r-e-n, and I'm the vice president of Public Policy and Government Relations for Medica, which is a nonprofit health insurance company offering coverage in Nebraska as individual group and Medicare markets. We cover about 100,000 lives in the state of Nebraska. I'm here testifying in opposition to LB314. First, I'd like to start with how my company has responded to COVID-19, particularly in the realm of telemedicine. First, we changed our coverage policies at the beginning of the pandemic so that we're coving-- covering more services. We're aligning the services that we cover via telehealth to mirror those of Medicare, which has expanded dramatically throughout the course of the pandemic. And we are paying a parity for all those services today. So we are paying a parity now. That policy is running through the end of April. We have every intent of offering that through the extent of the national pandemic. And we extend those policies from time to time, but again, we intend to pay at parity through the remainder of the national pandemic. And so we have adjusted our policies from time to time so that it allows providers and provide-- and reduces barriers to our members to be able to receive the care that they need during the pandemic. However, it's a much different conversation when you talk about placing a permanent requirement in state law that we pay for those services at the same rate as in-person services. Their services that have a lower cost affiliated with them. And as a reminder for the committee, if we're required to pay a higher reimbursement for these things, our members will have to pay that price. Most of our members

aren't HSA compliant plans where they have to pay all of the costs up to the deductible. And so they are going to be the ones that pay more for these services if this law goes into place. So-- so actually, they're the ones that will ultimately pay the price.The market has not had an opportunity to respond. So in a lot of these in Nebraska, in working with the Legislature here for a number of years, there is a need and you identify areas to intervene where the market has not had an opportunity to respond. This is an instance where it has not even had an opportunity to respond. As previous testifiers have spoken on the care system side, telehealth is here to stay. Before this year, it composed a really small percentage of the health care services that were delivered to members in Nebraska and elsewhere. In the future as previous testifiers have said, it is going to be a larger percentage of those services and of those-- that revenue for those care systems. Previously, providers have not prioritized being paid more for telehealth services. In the future, they obviously will, as it will represent a different mix of the-- of the services they're providing to their members. My ask is to allow the private sector to respond to this in our contract negotiations with the providers so that they have an opportunity to negotiate this and not just enact a bill that requires us to pay more before that has even happened. So members, I will conclude on a personal note by saying, I-- some of you who have heard me testify last year know that some of you who are new have not, I'm a native of the Omaha media market. I grew up just about an hour, 15 minutes east of here. I have constituents in multiple legislative-- or I have relatives who are constituents in multiple legislative districts in Nebraska. I received care at Clarkson Hospital growing up. I have two sinus surgeries I got there, got great care at UMC. It's a state of the art facility. They provide state of the art services. My belief on this bill, however, is that they should not be paid more for a lower level of service that's provided through telehealth. It is not in-person care. It is not the same thing. Thank you, Mr. Vice Chair and members.

LINDSTROM: Thank you. Senator Bostar.

BOSTAR: Thank you, Senator Lindstrom. Thank you, sir, for coming in today. Uh, so you talked about how telehealth services from a provider standpoint cost less and therefore shouldn't be reimbursed at the same rate as in-person care. Is that correct?

JAY McLAREN: Mr. Chair and Senator, I'm saying that it does have a lower cost structure affiliated with it. The private sector should be able to negotiate what price is paid for that moving forward and that enacting legislation to require us to pay at parity, yes, does not reflect the underlying cost of that-- of that service.

BOSTAR: So we heard in the proponent-phase several providers talk about how it actually costs more to provide telehealth services. So, I guess how-- how do you think I should evaluate those two conflicting pieces of information?

JAY McLAREN: Well, Senator-- Mr. Vice Chairman, Senator, and members, I can't answer for the previous testimony. I myself was confused by it. There was testimony saying that telehealth is here to stay, but they may not offer it if there's not payment parity. So to be quite frank, I didn't understand some of the previous arguments as well. So it's hard for me to answer that question. I apologize.

BOSTAR: Thank you, sir.

LINDSTROM: Any other questions? Seeing none, thank you.

JAY McLAREN: Thank you, Mr. Chair, and members.

ROBERT BELL: Vice Chairman Lindstrom, and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell. Last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation. As you know, the Insurance Federation is a state trade organization representing the domestic insurance industry in Nebraska, and I am here to testify in opposition to LB314. I'm going to be extremely brief. I think Jay covered, and Metica is one of my member companies, the basis of the opposition of the insurance industry. Let's-- let's have the market. Let's have-- let's give it a little bit of time and see what the market happen. What happens after COVID-19 actually passes by. I have my own personal experience for both my wife and I were diagnosed with shingles over the summer and I had to go to urgent care and she did not. It was very interesting. She did a telehealth visit, took 10 minutes, got her vital drugs. I had to go into urgent care for a lot of reasons. But one, I had to, you know, I had to sit in their lobby. I had to park in their parking lot. I had to-- I had to interact with the nurse. They had to put the thing on my fingers. They had to take

my blood pressure. I had to go back to the examination room and wait for the PA to examine me. Because it was on my face, I had to have a stroke test related to that. And as I later learned in the year, they also have an X-ray machine back there at that same urgent care center with a radiologist tech ready to go for people that come in. But because we were in the time of COVID, what we both paid out of pocket was exactly the same. So my 2-hour visit was the same cost as a 15-minute video for my wife. So anyway, I've just-- my own personal experience. I wanted to share that with the committee. Thank you for the opportunity to testify.

LINDSTROM: Thank you. Any questions?

PAHLS: Mr. Bell, I don't know your wife, but I can see why they'd take longer with you. [LAUGHTER] Here's the question. I did hear Jay say that the negotiation phase is-- since you represent multiple companies--

ROBERT BELL: Correct.

PAHLS: --is that's what's happening with all these companies right now they're negotiating-phase with both sides getting together is that--

ROBERT BELL: That phase is never over. It's a constant state of neg-- I mean, the insurers are in a constant state of negotiation with the medical providers and medical providers are in constant state of negotiation with the insurance companies. It's really-- it's never ending. And that's OK, I mean, that's kind of both what we both signed up for.

PAHLS: So he said-- is he right now though, I mean--

ROBERT BELL: Well, I mean, so COVID has changed it, right? Because there are different rules that apply during the pandemic as-- as we have tried to-- there's executive orders. There is reasons that we don't want policyholders in medical offices if they don't have to be. And I'm sure medical writers don't want people in their office if they don't need to be, right? So because of the pandemic, but whether or not that will stay the same post-pandemic, we'll see, so.

PAHLS: Thank you.

ROBERT BELL: You're welcome.

LINDSTROM: Senator Flood.

FLOOD: Thank you, Senator Lindstrom. Mr. Bell, what is-- maybe this was already answered and I stepped out for a second, but what is the discount for the same visit approximately from in-person to virtual?

ROBERT BELL: Well, you're getting me nervous, Senator Flood, with the Department of Justice. I don't know, and that would be prohibited, I mean, from even inquiring with my members because of antitrust reasons from a trade association standpoint. So a member might be able to tell you that, but I cannot.

FLOOD: We had one testifier that said it was an $800,000 difference to his or-- $500,000 difference in revenue to his practice.

ROBERT BELL: And that could be. I wouldn't dispute that. I have no reason to dispute that. I would say it might depend on the type of care you're providing, right. So if, if you're a primary care physician, it might be very different than if you're providing high end diabetes care, you know, and-- but that would be speculation on my part.

FLOOD: Well, it would be helpful to know as a policymaker what kind of-- you know if we're asked to bring parity up, how off are these two numbers?

ROBERT BELL: Yeah, I understand completely. And it could be volume too. There could be some volume.

FLOOD: Right.

ROBERT BELL: So, on that.

FLOOD: OK, thank you.

ROBERT BELL: You're welcome.

LINDSTROM: Any other questions? Seeing none, thank you.

ROBERT BELL: You're welcome.

LINDSTROM: Good afternoon.

Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

ERIC DUNNING: Good afternoon, Vice Chairman Lindstrom, and members of the Banking, Commerce and Insurance Committee. My name is Eric Dunning. For the record, that spelled E-r-i-c D-u-n-n-i-n-g. I appear before you today as the registered lobbyist for Blue Cross and Blue Shield of Nebraska here today to testify in opposition to LB314. Blue Cross and Blue Shield of Nebraska has worked with telehealth proponents for several years to advance the use of telehealth for our members across the state. We in no way believe that it is a less than optimal solution for our members, whether they live in Omaha or out in Sioux County. We think telehealth as it has advanced over the last several years, has been a really important component of our health care delivery system. You'll find that over the years we have supported or been neutral on legislation that repeals outdated requirements for the delivery of health-- telehealth, and that requires insurers to provide detailed descriptions of our telehealth payment policy to providers and legislation that requires insurers not to deny coverage solely on the basis that service is provided through telehealth. Payment parity is a long standing request of providers and seems to be a solution that keeps coming back to the table. Now that we're in COVID, again, we're going to see telehealth payment parity as a potential solution. But I want to say that during the telehealth emergency and during the-- excuse me, during the COVID emergency, Blue Cross and Blue Shield in Nebraska took significant steps to encourage our members to use telehealth services. We went beyond federal requirements tied to the pandemic until July. We waived cost sharing. That's copayments and deductible for people who would use telehealth services in an effort to get them over the hump to try to use telehealth services. Because, again, there was some reluctance, as we all felt, going into tel-- into the pandemic for the use of new technologies such as Zoom or Teams Remote meetings. So we did what we could to encourage people to get over that hump. We did all of this because we focused on the safety and well-being of our community, making sure our members have access to the care that they need and at the same time easing the burden on Nebraska's providers. We are also concerned about numbers that we hear, Senator Flood, about practices that are seeing a decline in revenue. And so that was certainly driving some of our decision making in the early phases of the pandemic. As a result of these decisions, though, we saw a real increase in telehealth use. Telehealth claims among our members were up 963 percent in March. In July, it was still up by more than 1,900 percent. Over half of those visits, 53 percent were for behavioral

health. Anecdotally, we believe that this expansion of telehealth allowed our members who may have been reluctant to try telehealth to give it a shot. We believe many of them liked what they saw. And some of this increase will be permanent. Telehealth is here to stay. We believe that's driven by member demand and not by payment parity. Although we have reimposed cost sharing requirements for our members using telehealth, we have continued to reimburse providers for telehealth services at parity. We do not have a current plan to change that policy, but we will be doing what we always try to do to meet the needs of our members. We believe the market requires this of us and it will require this for providers. Parity wasn't in place, and yet programs still opened in rural hospitals across our state and we're glad they did. We're looking forward to continuing to encourage the use of telehealth for our members. We're looking to continue use for primary care, urgent visits, chronic care visits, dermatology, ophthalmology, behavioral health and radiology. We're looking toward the development of new tools that will make telehealth work better, including otoscopes with cameras, stethoscope adapters and ton-- tongue depressors with cameras. These are just a few of the things that our physicians tell me is on the horizon. Ultimately, we plan to use what we've learned to improve access in places with specialties where access for our members is a challenge. Rural health and mental health services in particular. We're excited for the future of telehealth, but do not believe that having statutes tying new technology and new ways of doing things to old ways will encourage the uptake of telehealth or allow cost driven innovation in the health care delivery space. And as I close, I'd like to observe that about 15 states as of '19-- or 2019 report from Foley and Lardner had adopted some form of telehealth parity. So with that, Mr. Vice Chairman, and members of the committee, I'd be happy to answer questions.

LINDSTROM: Thank you, Mr. Dunning. Any questions? Seeing none, thank you.

ERIC DUNNING: Thank you.

LINDSTROM: Any other opponents? Seeing none, any neutral testifiers? Also seeing none, we did have letters for the record, 30 proponents and one in opposition. With that, Senator Pahls, would you like to close?

PAHLS: The words I like that I heard is, we're negotiating. So I see this as something I would say to be continued. Thank you.

LINDSTROM: Any final questions? Seeing none, that will close the hearing on LB314 and the morning hearings. We'll see you at 1:30.

LINDSTROM: Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Brett Lindstrom, I'm from Omaha and represent District 18, and I'm honored to serve as Vice Chair of this committee. The committee will take up the bills in the order posted. Our hearing today is your part of the public legislative process. This is your opportunity to express your position on the proposed legislation before us today. Committee members may come and go during the hearing. We have to introduce bills in other committees and are sometimes called away. This is not an indication we are not interested in the bill being heard in this committee, it's just part of the process. To better facilitate today's proceedings, we ask that you abide by the following procedures. Please silence or turn off your cell phone. Seating is limited. Therefore, we ask that you only maintain a seat in the hearing room when you have an interest in the bill currently being heard. We will pause between bills to allow people to come and go. While exiting the hearing room, we ask that you use the east door over there. We request that you wear a face covering while in the hearing room. Testifiers may remove their face mask during the testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. Public hearings for which attendance reaches seating capacity will be monitored by a Sergeant at Arms who will allow people to enter based upon seating availability. Persons waiting to enter the hearing room are asked to observe social distancing and wear a face covering while waiting in the hallway or outside the building. The order of testimony will go as follows: introducer, followed by proponents, opponents, neutral and then the closing remarks by the senator. Testifiers, please sign in and fill out the pink sheet. Turn it in at the box up here when you come up to testify. As you begin your testimony, we ask that you please spell your first and last name for the record. It is our request that you limit your testimony to five minutes. We will use the light system. It will be green at five, one minutes to go you'll see yellow, and then when it's red, we'll just have you wrap it up. Doesn't look like we have too many people today, so not, not too worried about it. If you're not testifying at the microphone but want to go on record as having a

position on a bill being heard today, there are white tablets at the entrance where you may leave your name and other pertinent information. The sign-in sheets will become exhibits in the permanent record at the end of today's hearing. We ask that you please limit or eliminate handouts. Written materials may be handed to the committee clerk only while testimony is being offered. To my immediate left is committee counsel Bill Marienau, and at the end of the table is committee clerk Natalie Schunk. And with that, we will start the confirmation, confirmation hearing for Kelly Lammers. Good afternoon.

KELLY LAMMERS: Good to be here. Vice Chairman Lindstrom, members of the Banking Committee and-- Banking, Commerce and Insurance Committee, my name is Kelly Lammers, K-e-l-l-y L-a-m-m-e-r-s. I live near Milford, Nebraska. I'm seeking confirmation as the director of the Nebraska Department of Banking and Finance, a position I'm honored to serve, having been appointed on September 8, 2020, by Governor Pete Ricketts. For the past 37 years, I've had the opportunity of a lifetime. I've traveled the state of Nebraska working at all examiner levels with the Nebraska Department of Banking and Finance. I've worked with bankers, credit unions, trust companies and numerous other financial service providers watching the details of lending, exchange and the art of running a financial institution. I consider myself a lifelong student of banking and finance. I'm a fourth generation Nebraskan from Sherman County. I grew up on a farm outside of Hazard, Nebraska. During my senior year at Ravenna High School, thanks to a business class and the influences of a high school organization, the Future Business Leaders of America, I was a student intern at the Ravenna bank. Those skills learned as an intern stuck with me as I worked all four years of college with First National of Lincoln. Following college, I moved to Kearney to work for First Investment Company, a division of Platte Valley Bank of Kearney. By the time I joined the department in 1984, I'd worked for a state bank, a national bank, an industrial loan and investment company. As a field examiner for the department in the Kearney district, my larger education in financial institutions and community began. The field experience taught me the value of institution structure, management and their teams, to look at the community with the eyes of not only what it currently is, but what of it could be given the cash, given the credit and cash flow. Field work taught me every examiner relies on the department, and the eyes and ears of the department rests with each examiner. In the 1990s, I transferred to Lincoln as a review examiner

with the opportunity to supervise Lincoln field office and special projects. Over the years, I've also worked with specialty banks such as bankers banks, credit card bank and even a shelf charter. I served as deputy director of financial institutions divisions for the past five years, where I assisted in positioning the department to create examiner specialists in the areas of IT, accounting, trust, capital markets and BSA. I facilitated the 2018 reaccreditation of the department's banking division and worked as a lead in the mortgage division's 2020 accreditation, both granted by the Conference of State Bank Supervisors. I hold a bachelor's and MBA from the University of Nebraska, Lincoln. I'm a Colorado Graduate School of Banking alumni. I've held for more than a decade advanced certifications in information security and information systems auditing. I hold from the Conference of State Bank Supervisors the highest examiners designation, that being a certified examination manager. I am chair-elect on the Conference of State Bank Supervisors Education Foundation Board of Trustees. In 2019, I earned a UNL executive certificate and leadership sponsored through the Governor's leadership academy. Based upon my education and experience, I strongly believe that Nebraska's financial environment creates opportunity for Nebraska through responsible use of services, credit, financial expertise and innovation. I will support and enforce the banking and finance laws of the state of Nebraska, representing both the citizens of the state as well as the industries that provide liquidity, financing and a host of services from securities to money transmission. I will humbly offer my leadership to one of the most outstanding teams in state government, the team that daily strives to protect and maintain the confidence of Nebraska's financial services industries. Thank you, senators. Happy to answer any questions.

LINDSTROM: Thank you. Any questions? No questions. Thank you.

KELLY LAMMERS: Thank you.

LINDSTROM: Do we have any proponents? Seeing none, any opposition? Any neutral testifiers? OK. We're good to go with the confirmation. Senator Pahls would you mind--

PAHLS: Yes, thank you.

LINDSTROM: -- doing this next bill?

Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

PAHLS: Senator Lindstrom, LB509.

LINDSTROM: Good afternoon. Members of the committee, my name is Brett Lindstrom, B-r-e-t-t L-i-n-d-s-t-r-o-m, representing District 18 in northwest Omaha. Today I bring before you LB509 on behalf of the State Treasurer and his office. This is a simple cleanup bill to remove obsolete language, to update terminology reflecting our more modernized process and include necessary harmonization language-- excuse me, harmonizing language. Heidi Wallace, deputy director of treasury management from the State Treasurer's Office, is here to testify following my opening, so I would direct any specific questions to her. Thank you.

PAHLS: Any questions? We will have proponents.

HEIDI WALLACE: Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is Heidi Wallace, H-e-i-d-i W-a-l-l-a-c-e, deputy director of treasury management. I'm representing the State Treasurer's Office Treasury Management Division, and I'm here today in support of LB509. We requested the introduction of this bill to clean up obsolete language, update terminology that has become outdated over the years, better reflect processes as they have modernized and request changes to bring consistency to certain procedures. For example, in several sections we are requesting to remove references to draw warrants and replace it with "pay electronically" or similar language. I won't read each section, but they are included in the information we have provided digital copies of. We hope to update two sections that direct checks to be sent directly to the State Treasurer's Office rather than to the agency that is ultimately responsible for those funds. This change would be consistent with other processes allowing those agencies to prepare their own accounting of these fees. We are also requesting a change in Section 81-118 to coincide with Section 84-710 regarding the number of days an agency has to get funds into the State Treasurer's Office. This is being requested in cooperation with the Department of Administrative Services. Another example of Section 82-331 and 84-612, we are asking for obsolete transfer language to be removed. There are changes in three other sections that would harmonize language due to these changes. Again, I won't read those sections, but they're also noted in the information we provided digitally. In closing, I'd like to thank Senator Lindstrom for introducing the bill on the behalf of

the State Treasurer's Office, and thank you to the committee members for hearing my testimony.

PAHLS: Any questions? Seeing none, thank you. Any more proponents? Any opponents? Any neutral? Senator.

LINDSTROM: I waive.

PAHLS: The senator is waiving. That concludes LB509. You've done that before.

LINDSTROM: Let's just stand at ease here before-- is Senator Lowe, somebody--

SLAMA: He's just across the hallway, I'm guessing.

LINDSTROM: So we're just going to wait for Senator Lowe to get over here. All right, we will open the hearing on LB532, introduced by Senator Lowe.

LOWE: That's my-- hope mine is as quick. Thank you, Vice Chair Lindstrom and members of Banking, Commerce and Insurance Committee. My name is John Lowe, that's J-o-h-n L-o-w-e, and I represent the 37th District, which is made up of Kearney, Gibbon and Shelton. Today I am happy to introduce LB532. This is a cleanup bill for the unclaimed property division of the State Treasurer's Office. I'm going to keep this very short because I still haven't had lunch yet. So if there's any questions.

LINDSTROM: All right. Any questions for the senator? Seeing none.

McCOLLISTER: Do you waive?

LOWE: I will waive closing.

LINDSTROM: Waive closing? OK, thank you. First proponent. Good afternoon.

MEAGHAN AGUIRRE: Hi. My name is Meaghan Aguirre, that's M-e-a-g-h-a-n A-g-u-i-r-r-e, I'm the director of unclaimed property for State Treasurer John Murante, and I'm here to testify in favor of LB532. First, I would like to thank Senator Lowe for introducing this bill. And before I begin, I would be remiss if I did not acknowledge that

today is National Unclaimed Property Day. So happy National Unclaimed Property Day to all of you, and I encourage anyone hearing my testimony today to check our website and see if we're holding unclaimed property for you. Now, LB532, it removes the word escheat where it's listed in reference to the Unclaimed Property Trust Fund. The word escheat means reversion to the state, and unclaimed property is not a true escheat as the funds are held at the Treasurer's Office as custodian for the owners, where they always remain able to claim those funds. LB532 allows the Treasurer's Office some discretion on which items to maintain in safe deposit boxes, and so it would allow us the ability to destroy certain items with no commercial value. Really, what this is intended to do is to allow us to destroy items sometimes like empty envelopes or boxes, typically like cardboard boxes where they're taking up space, but would otherwise have no commercial or sentimental value to the owners. LB532 removes the aggregate reporting limit so holders currently can remit unclaimed property in-- like if it's smaller amounts due to an owner, they can remit it as a lump sum with no breakdown of the ownership. This bill would require companies to include the name and address and corresponding amount for every item so that we have a better ability to return all of the funds that are due to an owner back to them. LB532 also allows for the deferral of reporting of items under $50. So if a holder has less than $50 to report, they could hold that money and carry it over year after year until they have at least $50 to report, and then that property would be due. This just simply makes it more efficient for those holders so that if they-- they're not spending more time and effort to remit the money than the, than the properties were. And the same is true for our office. It can at times cost more resources for our staff to process those reports. LB532 adds the authorization for the Treasurer's Office to donate unclaimed property to a nonprofit organization when the claimant elects that option. Claimants from time to time may request this option, and so we are looking to add that in the future with this change in statute. And two years ago, the Landlord Tenant Act changed the dormancy period for security deposits to 30 days and required those funds to be reported as unclaimed property not later than 60 days after issuance. This resulted in many landlords having to remit almost monthly. The Unclaimed Property Act requires an annual remittance for all other property tights-- types with a specified reporting deadline. So LB532 streamlines the Landlord Tenant Act language so that the security deposits will have a one year dormancy period and remit in accordance

with the annual reporting deadline within the Unclaimed Property Act. With that, I'll take any questions.

LINDSTROM: Thank you. Any questions from the committee? Senator McCollister.

McCOLLISTER: Under the Tenant Landlord Act, does the landlord have a duty to report the surplus damage deposit, deposit to the tenant himself?

MEAGHAN AGUIRRE: To the best of my knowledge-- I'm more familiar with the unclaimed-- as it pertains to unclaimed property specifically, so I guess I don't want to wade too specifically into that. But I do believe if that's--

McCOLLISTER: It's probably a better question for the Judiciary Committee, I suppose.

MEAGHAN AGUIRRE: Yeah. I mean, I guess if that's who had-- I guess it would just depend on who was leasing that property. But I'm not really sure how that-- I guess I don't want to wade into something I don't have expertise on. Sorry.

McCOLLISTER: You're right. Thank you.

LINDSTROM: Any other questions? Seeing none, thank you.

MEAGHAN AGUIRRE: Thank you.

LINDSTROM: Next proponent.

KENT ROGERT: Senator Lindstrom, members of the Banking, Insurance and Commerce Committee, my name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I'm here today to testify in support of LB532 for the Statewide Property Owners Association, which is a coalition of rental property owners across the state. And apparently this is a day of note. The Treasurer thinks this is the first time in several, as long as he's been here, that I've ever come and testified in support of one of his bills. So a pretty exciting day for everybody. I don't know if it's true, but we'll take the thing so. The portion of the bill that we are testifying in support of is the, the-- on page 12, Section 7 that deals with Landlord Tenant Act. And this does help us out quite a bit, not having to send those in monthly and rather an annual fashion.

LINDSTROM: Very good. Any questions? Senator McCollister.

McCOLLISTER: I'll ask you my question.

KENT ROGERT: OK.

McCOLLISTER: Does the landlord have a duty to refund that money to a past tenant promptly?

KENT ROGERT: We do. It didn't used to be that way. But when we changed the law a couple of years ago, that's where the Treasurer got involved, by no fault of his own. We changed the duty back to the landlord to send the leftover security deposit to the last known address of the tenant, which unfortunately is the address of the place that they just moved out of most of the time. So if they don't call us and ask us to, with a new address, then it kind of comes back to our property that we own and we hold on to it for now a year so they have the chance to come find it.

McCOLLISTER: Then it goes to the State Treasurer.

KENT ROGERT: Then we send it to the State Treasurer.

McCOLLISTER: Thank you.

LINDSTROM: Thank you. Any other questions? Seeing none, thank you.

KENT ROGERT: Thank you.

LINDSTROM: Good afternoon.

RYAN NORMAN: Good afternoon, members of the Banking Committee. Thank you for allowing me to testify. My name is Ryan Norman, that's R-y-a-n N-o-r-m-a-n, I'm an attorney here in Lincoln, Nebraska. I represent the Residential Property Owners. I'm also here representing the Apartment Association of Nebraska in favor of LB532. You've already heard some testimony regarding why we're in favor of this bill, but I would-- I do want to highlight just a few things. The main reason that a lot of my clients are in favor of this bill and the apartment association is because when, when they have to send these in monthly to the, to the Treasurer, these return checks, what they end up having to do is cancel the check, the original check that they sent out to the former tenant. And so they're incurring lots of cancelation fees,

and that's a big deal for them. And then the other thing is this helps tenants, because, of course, if you're a tenant and your former owner tried to send you a damage deposit, you didn't get it, the first person you're going to call is not the State Treasurer's Office, it's going to be your former landlord. So it's just, it keeps them from having to make an extra call on their end, too. So it helps tenants, it helps landlords. And that's why the Apartment Association of Nebraska is in favor of this bill. I'm happy to answer any questions that you have.

LINDSTROM: Thank you. Any questions from the committee? Seeing none.

RYAN NORMAN: Thank you.

LINDSTROM: Thank you for testifying. Any other proponents? Seeing none, any opposition? Seeing none, any neutral? I do have dropped off-- or drop-off testimony from Jill Becker with Black Hills Energy and Walt Radcliffe with Woodmen of the World Life Insurance Society. And Senator Lowe waived closing, so that will end the hearing on LB532. Thank you for coming.

PAHLS: Vice Chair.

LINDSTROM: Yes, sir?

PAHLS: I have a-- I'm so rusty at it. On-- I was supposed to announce on your bill, LB509, that Bob Holstrom supported it. I neglected to do that.

LINDSTROM: That's all right.

PAHLS: [INAUDIBLE] being rusty.

LINDSTROM: Thank you.

FLOOD: That was easy.

LINDSTROM: Just in time. All right.