**JACOBSON:** Welcome to the Banking, Commerce and Insurance Committee. I'm Senator Mike Jacobson from North Platte, representing the 42nd Legislative District, and I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. When it is your turn to come forward to testify, give the testifier sheet to the page or to the committee clerk. If you do not wish to testify but would like to indicate your position on the bill, there are also yellow test-- yell-- yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. If you come up to testify, please speak clearly into the microphone. Tell us your name and spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally, by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to get one. We will be using a 3-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining, and the red light indicates you need to wrap up your final thought and stop. Questions from the committee may follow. I might just add that if you're not near the end of your testimony and the red light is on, I would still ask you to stop. There's high likelihood that a committee member will ask you a question, potentially let you finish, but I'm hopeful that your-- you would hold the comments to 3 minutes. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It's just part of the process, as senators may have bills to introduce in other committees. A few final items to facil-- facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Please silence and turn off your cell phones. Verbal outbursts or applause are not, not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, the committee procedure for all committees state that written position comments on the bill to be included in the record must be submitted by 8:00 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website, at

nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. I will now have the committee members with us today introduce themselves, starting at my left.

**RIEPE:** Thank you. I'm Merv Riepe. I represent District 12, which is the southwest Omaha and the fine town of Ralston.

**von GILLERN:** Brad von Gillern, District 4, west Omaha and Elkhorn.

**BOSTAR:** Eliot Bostar, District 29.

**HALLSTROM:** Bob Hallstrom, Legislative District 1, covering Otoe, Johnson, Nemaha, Pawnee, and Richardson Counties.

**HARDIN:** Brian Hardin, District 48. Go as far west as you can and stop.

**WORDEKEMPER:** Dave Wordekemper, District 15, Dodge County, western Douglas County.

**JACOBSON:** Also assisting the committee today to my right is our legal counsel, Joshua Christolear, and to my far left is our committee clerk, Natalie Schunk. Our pages for the day are here, as well. And I'm going to ask them to go ahead and stand and, and introduce themselves. Tell us a little bit about yourself.

**AYDEN TOPPING:** Hi, I'm Ayden. I'm a junior psychology student at UNL.

**KATHRYN SINGH:** Hi, I'm Kathryn, and I'm a junior environmental studies student at UNL.

**JACOBSON:** OK. With that said, let's begin the hearing. We'll open up the hearing on LB315. Senator Sorrentino.

**SORRENTINO:** Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Tony Sorrentino, T-o-n-y S-o-r-r-e-n-t-i-n-o, and I represent Legislative District 39, which is Elkhorn and Waterloo in Douglas County. I bring you today, LB315. Nebraskans in all parts of the state feel that taxes are too high. As state senators, we routinely hear about the state's high property taxes. As a longtime member of Nebraska's business community, I understand that there is room for improvement when it comes to the taxes we impose on our state's businesses. It's important to have a business tax climate that aims to keep currently established

businesses from leaving the state, while signaling to businesses wanting to establish operations here that Nebraska wants to welcome their businesses. In 2023, the Legislature passed historic income tax reforms, bringing Nebraska's corporate income tax rate down to a flat 3.99% by 2027. In 2024, the Legislature passed LB1023 to lock Nebraska in at 60% full expensing of machinery and equipment expenses, a component of the 2017 Tax Cuts and Jobs Act that is currently on its way to phaseout unless there's action by Congress. Today, I'd like to talk about a lesser known tax that is imposed, and it's a tax known as the capital stock tax credit, or Nebraska's-- Nebraska corporate occupation-- corporation occupation tax. Simply put, a capital stock tax is a tax on a business' net worth. In Nebraska, it is paid each even-numbered year with the corporation's biennial filing with the Secretary of State. It is particularly harmful because it is imposed regardless of the profitability of a business. The tax itself is not a large tax, but this tax works against incentive programs that are in place that seek to draw businesses' investment into the state. Despite offering tax credits for jobs or investments in our state, those incentives are partially offset by the capital stock tax, which penalizes some of those investments. LB315 proposes to repeal, repeal Nebraska's biennial occupation tax on domestic and foreign tax corporations. I would be re-- remiss to not mention the fact that there is a fiscal note on this bill. It's a substantial fiscal note. In even years and odd years, it differs slightly. If you look at-- if you have the binder, it would be $400,000 in the odd years, but $10 million in even years. Knowing the certain situation that we have going on in the Legislature, I least want to bring this tax forward for your recognition. My intent with this bill is to add another dimension to the con-- conversation about ways to improve Nebraska's business tax friendliness and competitiveness. I thank you, and I'm happy to answer any questions that you may have.

**JACOBSON:** Questions for Senator Sorrentino? Yes, Senator Riepe.

**RIEPE:** Thank you, Chairman. You note in your statement at least, that it's via a sunset provision. Was this you were trying to relieve, relieve it of the sunset provision?

**SORRENTINO:** No. We're basically just trying to do away with the tax going forward, period.

**RIEPE:** OK.

**SORRENTINO:** Not really sunset it.

**RIEPE:** So then the $10 million, is that projected forever?

**SORRENTINO:** It would be $10 million every other year.

**RIEPE:** Every other year?

**SORRENTINO:** Now, granted, that's going to change with the number of corporations in the state, but give or take, yeah, about $10 million.

**RIEPE:** OK.

**SORRENTINO:** Thank you.

**RIEPE:** Thank you. Thank you, Chairman.

**JACOBSON:** Senator Bostar.

**BOSTAR:** Thank you, Chair. Thank you, Senator. For, for this amount of money, you know, we've-- as we try to look toward being competitive, we could get some-- I mean, not a, not a lot, but we could get some additional reduction in our income tax rates, which from-- you know, when we pursued that a couple of years ago in, in getting that number down, a lot of the discussion was, is that that's the number that a lot of businesses look at when they're looking at where to locate, where to move. Should some of these-- would we be better served with some of these efforts going toward continuously trying to get that number down, or is there a unique sort of a competitive advantage going in this specific direction? I'm just-- all things being equal, taking this pot of money, where are we best served by putting it?

**SORRENTINO:** If I was asked to prioritize it, I would go with the income tax relief over this one.

**BOSTAR:** Thank you.

**SORRENTINO:** It's an important tax, but I think in the order of priority, if I was going to relocate to Nebraska, I'd look at the income tax before this one.

**BOSTAR:** I appreciate that. Thank you.

**SORRENTINO:** Thank you.

**JACOBSON:** Other committee questions? Let me clear up a couple things, I guess, questions I've got in my own mind. The-- number one, you, you

said this is on the corporation's net worth, but really, effectively, it's really on their capital stock. Right?

**SORRENTINO:** Technically, yes.

**JACOBSON:** So capital stock usually is pretty low.

**SORRENTINO:** Right.

**JACOBSON:** And, and you have it there almost-- because of this?

**SORRENTINO:** Yeah. You have to have that. Yeah.

**JACOBSON:** So you have your capital stock low and then your other forms of capital are really the rest of your net worth.

**SORRENTINO:** Exactly.

**JACOBSON:** The other thing, is this the same filing where you update officers and directors of a corporation?

**SORRENTINO:** I believe it is-- the directors, presidents, et cetera.

**JACOBSON:** So would that go away or not?

**SORRENTINO:** It would, it would specifically not go away, from the standpoint I think it would need to be picked up somewhere else. There's a federal bill that's being batted back and forth now. I always get-- it's BOI or business owner-- where you identify-- you probably just filed it.

**JACOBSON:** Oh, yes. Yeah.

**SORRENTINO:** Yeah. There's that out there already. This is a little bit duplicative of that, frankly. So it could go away that you're already reporting that, but that other tax at the federal level is being held up in district courts. And it was supposed to be done by January 1, January 13, and it's still on delay. It is important to record in one of the two places. I guess we'll think about that.

**JACOBSON:** Yeah. And I guess I'm raising that and I'm familiar with that because I did file that.

**SORRENTINO:** I did, too.

**JACOBSON:** And, and not very happy about it. Then they said, oh, just kidding. You don't have to do it. And it's like, well, I already filed it. And then it came back again, so-- and then it might be going away again. But one of the things I look at from a banking perspective, is that we're always wanting to confirm that customers that we might be financing, we kind of know that they've not changed, you know, officers and we need to have a source-- reliable source to go to to confirm that information. And Secretary of State's Office has been the go-to place. I don't know if we're going into a black hole with this other information the federal government is collecting or not.

**SORRENTINO:** I would concur that whether it's federal or it's state, it does need to be known. If I remember right, on the federal side, the legislative intent was that-- I think, had to do with foreign ownership, and they wanted to be able to identify who it was and wasn't.

**JACOBSON:** Exactly.

**SORRENTINO:** I can't speak for the banking industry if that's the same concern or not.

**JACOBSON:** I, I think our primary concern, it would be with any customer, if we've got a corporate customer. Have there been changes to the ownership and, and the officers-- or not-- more the officers and directors that we weren't aware of.

**SORRENTINO:** OK. There is someone from the-- that will be speaking to the technicalities of the way-- you may want to re-ask that question.

**JACOBSON:** Perfect.

**SORRENTINO:** Thank you.

**JACOBSON:** And then just to be clear, this is $16?

**SORRENTINO:** I think it's $26.

**JACOBSON:** $26.

**SORRENTINO:** Yes.

**JACOBSON:** OK. Inflation is [INAUDIBLE]. $26--

**SORRENTINO:** Yes.

**JACOBSON:** --every 2 years.

**SORRENTINO:** Yes.

**JACOBSON:** Yeah. So I guess it gets back a little bit to Senator Bostar's question then, you know, if I were-- I'm, I'm one who feels like sales tax is fine but property tax is not, income tax is not. So income and property taxes are my concern. The smaller ones, if we could use that to feed the beast, if you will, I get, I get less concerned, but taxes in general are not, not attractive, but somehow we gotta pay for government.

**SORRENTINO:** Yep. I appreciate that.

**JACOBSON:** Yeah, but thank you for, for bringing the bill and raising the, raising the question. Any other questions? Yes, Senator Dungan.

**DUNGAN:** Thank you, Chair Jacobson. I appreciate this. I'm looking at the statute here, and I think Senator Jacobson might have just answered my question, but I just wanted to double check. So the statute is very unwieldy in how it's laid out. And it looks like there's a minimum of-- the occupation tax being $26. But then depending on your paid up capital stock, it can go up to a very high amount.

**SORRENTINO:** It can go up to the--

**DUNGAN:** I'm curious, what is the-- in your experience, what's--

**SORRENTINO:** I don't have the rates in front of me, unfortunately.

**DUNGAN:** Oh, it's--

**SORRENTINO:** Yeah, it's, it's big.

**DUNGAN:** Is $26 then, the, the amount that most people pay, kind of based on what Senator Jacobson was saying with regards to the capital stock that's being--

**SORRENTINO:** I can tell you that if you're a-- [INAUDIBLE] little LLC, you're protecting your personal assets and you own apartments, the number is 26. As far as what percentage of the people who pay this tax are paying $26, I honestly don't know that. There may be a subsequent witness who could. But I'll bet you it's the preponderance of it.

**DUNGAN:** OK. And that was my question.

**SORRENTINO:** All right.

**DUNGAN:** Thank you.

**SORRENTINO:** Thank you.

**JACOBSON:** Other questions from the committee? If not, will you be sticking around for close?

**SORRENTINO:** I will be.

**JACOBSON:** All right. Thank you.

**SORRENTINO:** Thank you.

**JACOBSON:** Proponents of LB315. Welcome.

**NICOLE FOX:** Afternoon, Chairman Jacobson and members of the Banking Committee. Nicole Fox, N-i-c-o-l-e F-o-x, representing Platte Institute. I'd like to thank Senator Sorrentino for his willingness to carry this bill on our behalf, because we would like to start a conversation on Nebraska's capital stock tax, also known as Nebraska's corporation occupation tax. Nebraska's property tax ranks 45th in the nation overall for competitiveness, according to the Tax Foundation state competitive-- competitiveness rankings. There are 2 primary factors which caused our system to be ranked so low. First is that Nebraska has an overall heavy property tax burden, and second is that Nebraska levies a property tax on types of property that should be exempt from property taxation, including business capital. Only 15 states current lev-- currently levy a capital stock tax and we should expect that number to decrease, as there have been proposals in other states in recent years. Connecticut just phased out their capital stock tax at the end of 2024. Mississippi is currently phasing theirs out, and it will be eliminated as of 2028. In November or December of '24, Louisiana just passed a bill to effectively repeal theirs as of January of 2026, and the only neighboring state that does levy a similar tax is Wyoming, at a rate of 0.02%. Nebraska's corporation occupation tax is levied upon a business' net worth rather than its profitability, and is calculated based on the value of capital within the state. The tax is paid to the Secretary of State and goes to our General Fund. Capital stock taxes hinder the virtuous cycle of capital formation and, and economic growth. It directly disincentivizes capital formation and investment in Nebraska by taxing capital

formation and investment. Because businesses pay regardless of prof-- profab-- I can't talk today-- profitability, this is bad tax policy for companies in low- or no-profit years. Taxing business capital works directly against other Nebraska state incentive programs that seek to draw business investment into our state. Perhaps the best argument for-- against the capital stock tax is to simply look at the structure of the tax. There are 43 different tax rates imposed and I have included a chart in your handout. There is 20-- there-- starts at $26, going up to $23,990. This, this type of tax simply does not belong in a modern tax code. It predates Nebraska's corporate income tax. The capital stock tax should ideally be eliminated and done so. But realistically, we understand the state's current revenue picture. It could be phased out gradually, instead. Gradual phase out could either be lower the tax imposed at each valuation level or exempt the first $50,000-100,000 of paid-in capital stock while progressively exempting more and more, or some combination of rate reduction and exemption. If some element of revenue replacement is desired because the state is providing a specific service for businesses paying this tax, a simple flat fee commensurate with the cost of providing the government service should instead be considered. Nebraska's property tax is the least competitive component of its tax code. The corporate occupation tax is an especially uncompetitive and archaic component and is essentially a business physical wealth tax. I asked this committee to consider its repeal or phaseout to make the tax code simpler, more transparent, and more competitive. And with that, I conclude my testimony.

**JACOBSON:** Questions from the committee? Yes, Senator Bostar.

**BOSTAR:** Thank you, Chair. Thank you for your testimony. Do you have a sense of what the revenue loss would be to eliminate just that first tier of under $10,000? It-- the $26 for under $10,000? I mean, it feels like for a lot of small businesses that are just there, it's--

**NICOLE FOX:** Yeah.

**BOSTAR:** I'm curious, like if it's worth the money or can we eliminate a hassle--

**NICOLE FOX:** Yeah.

**BOSTAR:** --that businesses are facing and what that would cost.

**NICOLE FOX:** No. Unfortunately, I don't. That's something I-- you know, if there's a way that we can get that to you, I'm happy to try and find that out. And I agree with you, which is why we threw out there the idea of maybe trying to at least simplify these 43 brackets and look at, you know, should we maybe, you know, do some elimination, particularly for some of those businesses that are smaller.

**BOSTAR:** Because it does feel like that first bracket should effectively be zero just because it's-- anyway, thank you very much.

**NICOLE FOX:** Yeah.

**JACOBSON:** Other questions? Senator Hallstrom.

**HALLSTROM:** Similar issue, different committee, personal property tax.

**NICOLE FOX:** Correct.

**HALLSTROM:** Would you-- would your organization support eliminating the tax on a certain level of property?

**NICOLE FOX:** Senator Hallstrom, that is a very good question. And in fact, Senator Sorrentino carried a bill for us in Revenue Committee to do just that. So yes, we are-- Platte Institute is very interested in-- we'd love to see complete elimination of the-- of TPP but at this point, our initial goal is to reinstate the $10,000 de minimis that was repealed in 2020.

**HALLSTROM:** I was hoping you would give a, give a shoutout to Senator Sorrentino.

**NICOLE FOX:** Yeah. Any time.

**JACOBSON:** Other questions? Maybe just to follow up. And, and I'm guessing that you're not sure of the number that are under $10,000. And I'm going to probably ask you the question on the larger ones. I'm, I'm trying to figure out-- because, again, this is paid in capital stock. And so you talk about capital formation, but really most C Corps are started with capital stock and surplus. And then you're going to grow your undivided profits over time, but you're not going to grow your surplus unless you do more capital-- unless you issue more stock. So, you know, if you're relying upon really, undivided profits to build the capital, you know, I don't know that we're seeing this tax go up. And, and I think most companies are going to probably keep their surplus or their capital stock at a minimum. So

I'm-- I, I guess I'd be curious to know where-- how many companies are paying on the higher end, and, and really, how many are really on down a ways. I mean, we're, we're talking about $10 million statewide, so there-- I just-- I'm just curious if you have any kind of breakdown of who fits in what category.

**NICOLE FOX:** No. I mean, essentially, Senator, we just-- we brought this because we want to start a conversation. And just--

**JACOBSON:** Sure.

**NICOLE FOX:** --knowing that our goal is to tackle a lot of the, you know, business taxes, the layers of business taxes that businesses throughout our state pay, and try and simplify our tax code. So-- but we're happy to, to look more into that.

**JACOBSON:** I'm, I'm intrigued by your--

**NICOLE FOX:** Is that being question that's being posed. Yeah.

**JACOBSON:** Well, I'm intrigued by your thoughts that there probably ought to be a cap and there probably ought to be a floor. And, and maybe there's even-- if some of this comes back to what does it cost to deliver the service, I, I do believe that one way to hold down income and property taxes is to do more fees for services, as opposed to tax.

**NICOLE FOX:** Yes. Fees commensurate with services.

**JACOBSON:** Yes. Fees commensurate with services, as opposed to everybody pays a tax to pay for things you don't even use.

**NICOLE FOX:** Correct.

**JACOBSON:** You know, so, so I, I do like that thought, and I like the spirit in which this was brought, so thank you.

**NICOLE FOX:** Thank you.

**JACOBSON:** All right. No other questions, we'll ask for another proponent. Welcome back to the committee.

**RYAN McINTOSH:** Thank you, Senator Jacobson, members of the committee. My name is Ryan McIntosh, M-c-I-n-t-o-s-h, testifying in support of LB315 on behalf of the National Federation of Independent Business. I

don't have a whole lot else to add other than to note that the-- NFIB does view this as somewhat of an arbitrary tax, in that we don't have something similar for other corporate structures such as LLCs and partnerships. This only applies to corporations, so we do think it's arbitrary in that regard. And we appreciate the Platte Institute and Senator Sorrentino for bringing this forward to look at the way that we're taxing our business entities in Nebraska. And with that, I'd be happy to answer any questions.

**JACOBSON:** Questions? Now if I'm not mistaken, LLCs are also filing a biennial report, and there's a fee for that. But maybe that's the lower number fee and it's not capital stock related, obviously, because they don't have capital stock. So-- and I, I don't know that that-- again, I'm just looking at-- I'm, I'm kind of curious to how many-- the smaller corporations, I'm convinced nobody's going to have more than $10,000 of capital, so they're going to start there and, and any other capital structure is going to be in a different form of capital. But, but-- so what I'm hearing you say, though, is that it's-- many of those members are C Corps and are subject to the tax. And do you have any idea where-- what level some of those would be?

**RYAN McINTOSH:** I, I do not have any data on, on, on what people are reporting. You know, perhaps if you have a registered agent or a-- or an accountant that gets your, your annual yellow postcard-- it changes colors. I think this year, they're yellow-- from the Secretary of State's Office. You know, you, you-- if you have a small business owner, they're not going to know the difference between what paid up capital stock is and perhaps what their stock is worth, and so they're looking at their balance sheet. And perhaps-- and I've seen this in my own personal experience, with clients coming in to, to get me to file these. They say, well, you know, our stock is worth, you know, X because that's what our accountant says. It's like no, it's paid up capital stock, so I do think you have a lot of people overpaying on this. There, there is a, there is a, a similar fee for limited liability companies. It's a-- I believe, just a couple dollars lower. But again, it could be a huge limited liability company or a small, and you're paying the same fee.

**JACOBSON:** But there's probably not a lot of them with $100 million in capital stock.

**RYAN McINTOSH:** Probably not a whole lot in Nebraska. No.

**JACOBSON:** Yeah. OK. And I don't know whether somebody from the Secretary of State is going to testify, but-- and I don't know whether they would have this information, but I'd be kind of curious to know what that is.

**RYAN McINTOSH:** I was very surprised with the $10 million number.

**JACOBSON:** Yeah. Yeah. All right.

**RYAN McINTOSH:** Thank you.

**JACOBSON:** Thank you. Further proponents? Proponents? OK. How about opponents for LB315? Wow. OK. No opponents. Let's go to neutral testifiers. Hello.

**COLLEEN BYELICK:** Hi. Good afternoon. My name is Colleen Byelick. It's C-o-l-l-e-e-n B-y-e-l-i-c-k. I'm the general counsel and chief deputy for the Secretary of State's Office. So hopefully I can answer some of your questions-- at least wanted to give you some background information on this filing and, and on this tax. So currently, we have 46,000 active corporations on record in Nebraska. This bill only addresses corporations. So we heard a little bit about LLCs. This bill does not touch on LLCs or other entity types. Corporate registration, just to kind of go back to basics, does provide the entity with limited liability protection, so the officers and the directors of the corporation are not personally liable for the acts of the corporation. And corporations are created by complying with state corporate law, so you have to file articles of incorporation with the Secretary of State. Minimum information is required to maintain the corporate record and provide information to the public regarding the corporation. This tax is filed in the even years. So essentially, in 2024, corporations filed. LLCs and nonprofits file in the odd years. The fee for the domestic corporation is based on the par value of their paid up capital stock. So in 90% of the cases, corporations are paying $26. So I think that was one of the main questions. From what we're seeing, 90% of domestic corporations are paying the $26 fee every other year. For foreign corporations, the fee is based on the value of their property owned or used in the state, and their fee is twice the fee of the domestic corporations. But again, we're seeing 90% are paying that fee, which is $52 every other year. The report contains the name of the corporation, the registered agent information, the address of their principal office, the names and addresses of their corporation directors and officers, and their nature of business. And then we take that information and we provide

that to the public for free. It's available on our website and it's used by the lending community, the legal community, the law enforcement community, and the general public to learn basic corporate information. So if this report ceases to be filed, we will no longer have accurate information for any of those items. There are separate processes to update your agent, but we want to have accurate officer/director information. 3 notices are sent to the corporation regarding filing this report. So they get an initial notice, they get a reminder notice if they haven't filed it, and they get a dissolution notice, if they fail to file the report on time. Essentially, the Secretary of State's Office dissolves corporations that do not file this report. It's called administrative dissolution, and that helps keep our acc-- our office's records accurate between active and inactive corporations in the state. So if this passes and that filing goes away, we would no longer kind of have that distinction. Couple of things mentioned, in 2021, we did a very comprehensive review of our fees. We did not touch this fee. However, we did look at other filing fees and we did compare those filing fees with other state fees. So I think that our fees are fairly similar to what other states are charging or potentially even lower. I'll just stop there.

**JACOBSON:** Questions from the committee? Senator Hallstrom.

**HALLSTROM:** Did the fiscal note take into consideration anything for not having to give the 3 notices or file the dissolution?

**COLLEEN BYELICK:** Yes, I believe it did.

**HALLSTROM:** Thank you.

**COLLEEN BYELICK:** Yes.

**JACOBSON:** Is there something else you want to tell us in your opening that we probably should know?

**COLLEEN BYELICK:** I was just going to mention the beneficial ownership report, which is the federal report that's a fairly new report that's been tied up in litigation. That's asking for beneficial ownership information. It's not necessarily asking for officer or director information. And the federal government has to create rules and decide who's going to get access to that information, so I don't know that those 2 things are really comparable. So just kind of wanted to mention that that's kind of a separate thing from this filing that's required.

**JACOBSON:** I, I appreciate it. I think that's valuable information.

**COLLEEN BYELICK:** Yeah.

**JACOBSON:** Well, I, I appreciate what you've, what you've brought for the-- in fact, I'm, I'm just impressed that they actually were prepared to give us some answers that we-- you had no way to know that we were going to be asking about. But-- so basically, a large, overwhelming number of people are paying the 26 bucks.

**COLLEEN BYELICK:** Yes.

**JACOBSON:** So if we were to look at fee for service-- I'm just taking a wild guess that you're going to be about 26 bucks, aren't you?

**COLLEEN BYELICK:** Right. And I was going to say, like the LLC, this is-- so the corporates pay this corporate tax. LLCs pay a biennial report-- biennial report fee. That fee is $25 if you file it online or $30 if you file it in-house or send it in the mail. So this fee is very similar to what other entity types are paying.

**JACOBSON:** I'd just be curious to what the Fiscal Office would, would put this on if we were bringing this as a new bill-- to bring this, and whether they would come up with $10 million or whether it would be $50 million, and--

**COLLEEN BYELICK:** Yeah.

**JACOBSON:** --whether it would be 6 employees and--

**COLLEEN BYELICK:** Yeah. All-- I mean, all of our secretary fees, most-- this fee goes completely to the general fund. But most of our Secretary of State fees that we collect, 60% goes to the General Fund and 40% goes to the Secretary of State Cash Fund. So I think within this fee scheme, there's a thought process that some of this money needs to go to the general state operations for, you know, allowing businesses to operate in the state. So.

**JACOBSON:** Yeah. Thank you. Questions from the committee-- further?

**HALLSTROM:** One question was raised about looking at whether the bill did away with both the occupation tax and the report. I believe it does from my reading--

**COLLEEN BYELICK:** Yes.

**HALLSTROM:** --but we could easily keep the report if the committee was inclined to want to do away with the tax.

**COLLEEN BYELICK:** Correct.

**HALLSTROM:** Thank you.

**COLLEEN BYELICK:** Yep.

**JACOBSON:** And then you handle that for free.

**COLLEEN BYELICK:** Yeah. I mean, essentially, our office does not currently derive any revenue. You know, this part of our office is paid for using that Secretary of State Cash Fund. We currently do not receive any funding into that cash fund for this filing. This fee goes all to the state General Fund.

**HALLSTROM:** But you currently charge $25 or $30 for LLCs.

**COLLEEN BYELICK:** Yes,.

**HALLSTROM:** You could do the same thing on a fee basis, as opposed to this tax basis.

**COLLEEN BYELICK:** Yes. I think that there would be some revenue difference to the General Fund there, because some entities are paying more than the minimum, so I don't know how that would fully flesh out, but--

**HALLSTROM:** Thank you.

**JACOBSON:** Other questions? If not, thank you for bringing the information and for testifying. Other neutral testifiers? All right. Seeing none, Senator Sorrentino, you're welcome to close.

**SORRENTINO:** Thank you.

**JACOBSON:** And I might add that there were zero proponent let-- letters, one opponent letter, no neutral testifiers, and we did not receive any written ADA testimony regarding this bill.

**SORRENTINO:** Members of the committee, I appreciate the opportunity to bring LB15 and at least start the conversation on repealing or scaling back the capital stock tax. I think the topic is appropriate to consider, if not necessarily ready quite for prime time. But I appreciate your time today. Thank you.

**JACOBSON:** Questions for Senator Sorrentino? Thank you very much for bringing the bill and for being here.

**SORRENTINO:** Thank you.

**JACOBSON:** All right. That closes our hearing on LB315. And we'll move on to our hearing on LB293, Senator Beau Ballard.

**BALLARD:** It's good to be back.

**JACOBSON:** It's good to have you here.

**BALLARD:** Yes. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Senator Beau Ballard. For the record, that is B-e-a-u B-a-l-l-a-r-d, and I represent, represent District 21 in northwest Lincoln and northern Lancaster County. Today I'm here to introduce LB293, a bill designated to give professional employee organizations greater flexibility in their health benefit plan offerings. PEOs provide comprehensive human resources service, including payroll, benefit, tax administration, and regulatory compliance assistance for employers. They allow businesses to access benefits such as retirement plans, health insurance, dental coverage, and other employee benefits that might otherwise be difficult to provide independently. In Nebraska, PEOs are regulated through the Nebraska Professional Employer Organization Registration Act, the PEO Act. Under the PEO Act, the PEO is authorized to offer this covered employees a health benefit plan that is either fully insured or self-insured. However, PEOs seeking to sponsor a self-insured plan must comply with certain provisions of the Nebraska Multiple Employer Welfare Arrangement Act. LB93 [SIC] makes changes to the PEO Act to provide PEOs greater flexibility and incorporate additional consumer protections. The changes would require written notice to covered employees when health benefit is self-funded and mandate a filing of a financial report to the Department of Labor certifying sufficient reserves to pay claims. If the PEO does not have sufficient funds to cover obligations, the hearing procedure, procedure commenced. The hearing would then results in an adverse determination. The PEO must be compliant within 30 days to avoid registration revocation. These provisions are tailored to the PEO structure, ensuring both flexibility and strong consumer protection against abuse or fraud in the context of self-insured plans. I also have-- if the page wants to come up real quick. I also have an amendment from the department. AM148 will make 3 changes. The first is a very small change brought by the committee legal counsel. It would

just replace the word director with department, a very small technical change to conform the bill that refers-- making sure it's compliant with existing statute. The next 2 changes were brought by the Department of Labor. The amendment would change the frequency of the report from annual to quarterly. The other changes in the department were brought to set a stop-loss requirement. I believe there is a representative from the department that's testifying later to explain the, the reasoning. With that, I would be happy to answer any questions.

**JACOBSON:** Questions for Senator Ballard? All right. Seeing none, thanks.

**BALLARD:** Thank you.

**JACOBSON:** You sticking around for close?

**BALLARD:** I will.

**JACOBSON:** All right. Thank you. Proponents for LB293. Welcome.

**AMY KNOBBE:** Welcome. Good afternoon, Chairman Jacobson and members of the committee. My name is Amy Knobbe, A-m-y K-n-o-b-b-e, co-founder and managing partner at Pando PEO. My business partner and I founded Pando in July of 2022, the only Nebraska-born PEO. We currently service 240 clients equating to 5,000 worksite employees across 46 states, ultimately processing $230 million in wages. Small business runs in our veins. It's deep-rooted passion. I come from a long line of small business owners and cattle feeders, giving me first-hand experience of the challenges and rewards that come with being an entrepreneur. Dealing with compliance regulations and the constant quest to attract and retain talented individuals can be demanding. However, having spent 2 decades in the PEO industry, I observed firsthand how PEOs can alleviate the weight of these responsibilities. By partnering with a PEO, businesses can offload these tasks and concentrate their efforts on their core operations, unlocking greater potential for success. PEOs offer a wide range of HR services to businesses, including payroll administration, benefits management, tax administration, and assistance with regulatory compliance. By partnering with Pando, our clients can gain access to comprehensive HR services that may not have the resources or expertise to handle on their own. This includes offering benefits such as retirement plans, health insurance, dental coverage, and other employee benefits. PEOs leverage their collective purchasing power to negotiate better rates

and coverage options, making it more affordable for small businesses to provide these benefits to their employees. Health insurance premiums can be a substantial expense for small businesses, especially those with limited resources. Rising healthcare costs and increasing premiums constrain the financial resources of small businesses, potentially impacting their profitability and ability to invest in other areas of their business. In many cases, this requires employees to contribute a portion of their health insurance premiums. High premium costs may lead to increased employee contributions, which could impact employee take-home pay and potentially impact their financial well-being. To tackle these challenges, the design of insurance plans becomes crucial. Under the PEO Act, a PEO is authorized to offer its covered employees a health benefit plan that is either fully insured or self-insured. PEOs that seek to sponsored self-insured plan must comply with certain requirements set forth in Nebraska's Multiple Employer Welfare Arrangement Act, the MEWA Act. The application of these MEWA Act provisions do not fell-- fit well with the PEO structure. As Senator Ballard stated, LB293 makes changes to the PEO Act to provide PEOs greater flexibility and incorporate additional consumer protections. The changes would require that a PEO plan that is self-insured utilizes a third-party administrator licensed to conduct business in the state, hold plan assets in a trust, and provide for sound reserves. In additions-- in addition, PEOs sponsoring a self-insured plan will be required to file a yearly financial report to the Nebraska Department of Labor that will include a financial statement, a statement from a qualified actuary certifying sufficient reserves to pay claims, and a certificate of compliance. All of these requirements provide protections for the consumers and assist to ensure that participants in a PEO plan are offered a high caliber of coverage.

**JACOBSON:** Probably need to have you just wrap up if you can.

**AMY KNOBBE:** OK. The proposed changes outlined in LB293 represent a significant step towards enhancing the operational flexibility of PEOs while simultaneously safeguarding the interests of consumers. By streamlining the regulatory framework, we can empower PEOs like Pando to provide an even more valuable service to small businesses throughout Nebraska. This not only alleviates the burden of compliance and administrative challenges for business owners, but also facilitates improved access to essential employee benefits, making it easier for small businesses to attract and retain the talent they need to thrive in today's competitive market.

**JACOBSON:** Thank you. Questions? Yes, Senator Hardin.

**HARDIN:** What happens if we don't do this?

**AMY KNOBBE:** What happens if we don't do this?

**HARDIN:** Paint a picture for us.

**AMY KNOBBE:** Sure. What happens if we don't do this-- and Michelle Sitorius, our legal representative who's going to testify next, would be able to provide more of a technical, technical piece to it. But with the-- number one, with the MEWA regulation, PEOs are considered a single employer, not a multiple employer, so we don't necessarily fit into all of those requirements.

**HARDIN:** And a MEWA is a wonderful relic of insurance days gone by, so. Thank you.

**JACOBSON:** Other questions? All right. Seeing none, thank you for your testimony. And I would like to ask for the next proponent, who I'm guessing is going to answer the rest of the questions. Welcome.

**MICHELLE SITORIUS:** Thanks. My name is-- well, good afternoon, Chairperson Jacobson, and members of the committee. My name is Michelle Sitorius, S-i-t-o-r-i-u-s. I'm an attorney at Cline Williams law firm here in Lincoln, and my practice focuses exclusively on employee benefits. Our client, Pando, LLC, has already testified today in relation to the proposed legislation amending Nebraska's Professional Employer Organization Registration Act. As Amy indicated, Pando is a homegrown, Nebraska-headquartered PEO looking to grow its business both here in Nebraska and regionally. PEOs are unique, as Amy just set out. Under the current Nebraska PEO Act, a PEO is a co-employer with each of its clients. Thus, both the PEO and the client are the employer. This co-employer relationship has been recognized not only under Nebraska statutes, but also by federal agencies, including the Department of Labor. The PEO Act currently provides that PEOs headquartered in Nebraska have the option to structure their health benefits plan as either fully insured or self-insured. For PEOs electing to provide self-insured-- a self-insured plan to their employees, the plan must follow the registration requirements under the MEWA Act, as Senator Hardin set out there. The proposed revisions to the PEO Act, pursuant to this legislation, move the requirements for a PE-- PEO to sponsor a self-insured plan to the PEO Act. The rationale is twofold here.

First, applying the MEWA Act provisions to PEOs, there are certain impediments in the statutory language of the MEWA Act that do not fit the structure of PEOs. In addition, since the regulatory agency for PEOs is the Nebraska Department of Labor, not the Nebraska Department of Insurance like the MEWA Act, these proposed changes assist the Department of Labor in evaluating PEOs' compliance with Nebraska law. The proposed revisions also make several useful changes, of which Amy articulated a few. For example, in order to sponsor a self-funded plan, a PEO will need to provide for reserves sufficient to make-- to meet actuarial standards. This reserve, as you note in the language, is specifically tied to the language of ERISA's standards of, of prudence and loyalty. These are standards that are applicable to every employer sponsoring a plan, including a PEO. Those standards are the highest standard of care, for those of you who love ERISA, meaning that the employer must think first and foremost about the participants in the plan, not its own interests. While this proposed revisions of the act hold PEOs to specific requirements, the implementation of practical fraud prevention protections have also been included. So if you look at this specifically, the PEOs-- a PEO sponsoring a self-funded plan will be required to file a quarterly report in relation to the plan, providing all the information set out in 48-2706(8)(b). Outside of the quarterly process, there's also a compliance hearing by the dar-- department, if there are issues that arise from review of those, those quarterly reports. Notably, I would, I would note that the proposed revisions bring the Nebraska PEO Act further in line with the Model National Association PEO Act utilized in other states and, and supported by the national organization, so our language more closely mirror other-- this national language that is-- obviously brings us some uniformity.

**JACOBSON:** I'm going to ask you to wrap up. We've got-- both testifiers are going way over, so I'm going to need to conclude your comments, if you would.

**MICHELLE SITORIUS:** I am concluded.

**JACOBSON:** All right. Thank you.

**MICHELLE SITORIUS:** You can ask questions. How's that?

**JACOBSON:** I'll ask for questions from the committee. Senator Hardin.

**MICHELLE SITORIUS:** Sure. Hardin.

**HARDIN:** How are reinsurers responding to this? Have they seen it? Have you talked with any reinsurers?

**MICHELLE SITORIUS:** We have not talked to any reinsurers. But the-- kind of the notion here is that-- I mean, they would make their decision of whether or not they think it's a good risk. And normally, what reinsurers do is they take a look and say like, what is the, the risk profile, and here's what we'll charge you to provide reinsurance at a certain level. The stop-loss piece in the amendment talks about the level of reinsurance you would need in order to sponsor this type of plan, which makes, I think, good sense. And that's a similar provision that's in the MEWA statute as well. Actually, it's copied word for word.

**HARDIN:** For a PEO, I think, with this kind of thing, we, we were looking at MEWA and trying to put a PEO into a MEWA, it's like a bad suit. It touches them everywhere, fits them nowhere. And so I would think this would be a better fit.

**MICHELLE SITORIUS:** That's exactly our thoughts.

**HARDIN:** Thank you.

**JACOBSON:** Further questions from the committee? All right. Oh, you have Senator Hallstrom.

**HALLSTROM:** You mentioned that the PEO and the employer are both considered the employer. Are there any notices that are provided by the insurer in connection with the policy? And if there are, who do they go to, one or both?

**MICHELLE SITORIUS:** Sure. So if a, if a PEO is fully insured, then obviously, the insurance company has taken on that risk, and they're the ones who handle if everyone gets colon cancer. Right. If the PEO decides and-- to get a self-insured plan, the statute does require-- these revisions do require notice to participants to say, like, hello. Your-- you are covered by a self-insured plan, not a fully insured plan. So it's it-- obviously, each of the clients of the PEO know this. And then, we are required to tell specifically-- and this is the same thing as in the MEWA statute-- specifically tell participants, you are self in-- this is a self-insured product, not a fully insured product, so they're aware of that.

**HALLSTROM:** And would the, would the PPO and/or the insure-- and/or the employer get any notices from the insurance company?

**MICHELLE SITORIUS:** Well, certainly, the PEO will, will know that they have a self-insured plan because they're the plan sponsor. And then as far as the insurer providing notice-- is that what you're asking?

**HALLSTROM:** Yeah.

**MICHELLE SITORIUS:** The insurer in that context-- when you have a self-insured plan, what the insurer essentially transforms into is a third-party administrator. So the-- so for example, if we take-- I'm not going to use a example here in the state. If you take an insurer in this state, they have fully insured plans which they support. And if they are doing a self-insured plan for one of our bigger employers, let's say, they transform into a third-party administrator. So we're still using the network of a Medica, Blue Cross Blue Shield, United, et cetera, but now they're-- that insurer is acting-- and they know that, because we have a service agreement with that entity, Blue Cross, Medicaid United, that says specifically we're providing third-party administrative services, not a fully insured product.

**HALLSTROM:** And the reason I ask the question is in your amendment, I-- I'm assuming the insurance industry has reviewed the amendment on stop-loss coverage?

**MICHELLE SITORIUS:** In regards to-- I don't know if the specific stop-loss carriers have looked at it. I do know that we have talked to the insurance people in regard to this, this bill, and I do not think there was any concerns.

**HALLSTROM:** Because there's a requirement in there that prior to termination, there must be a notice sent to--

**MICHELLE SITORIUS:** You would have to notify.

**HALLSTROM:** --both the PEO and the commissioner of labor. It that--

**MICHELLE SITORIUS:** Yes, there is. And my notion with that is, is if they were going to terminate, they would definitely tell us it's a contractual part of the reinsurance contract that would say, if we're terminating this, we will tell you. And then there's obviously a notion that we need to tell the Department of Labor, as well.

**HALLSTROM:** So when, when they terminate a contract or a policy, they should give some form of notice to all of the interested parties.

**MICHELLE SITORIUS:** Correct.

**HALLSTROM:** Thank you.

**JACOBSON:** Senator Hardin.

**HARDIN:** I'm curious, how small can the companies be that sign up with your PEO? How many employees?

**MICHELLE SITORIUS:** I do not know that answer. That is an Amy question.

**HARDIN:** If they're little companies--

**MICHELLE SITORIUS:** 2.

**HARDIN:** OK. I'm just saying, if they're little companies, this gives them a lot more flexibility--

**MICHELLE SITORIUS:** Yeah.

**HARDIN:** --for the ability to participate in a partial self-funded situation that they could never access as a little company on their own.

**MICHELLE SITORIUS:** Correct. When I am counseling clients often-- and often-- obviously, this is a broker question, as well. But when you're counseling employers, there is a-- kind of a point where it becomes feasible to be self-insured, and that point is somewhere usually between 100 and 300. So anything smaller than that, it's very difficult, for the simple reason if the 2 people get colon cancer, you got a problem. So if you have a bigger group, obviously that spreads the risk across the, the employees.

**JACOBSON:** Other questions from the committee? All right. Seeing none, thank you for your testimony. Other proponents? Other proponents? OK, seeing none, how about opponents? Any opponent testimony? If you're planning to testify, there are 3 empty seats up here in the front. You might want to slip into those. How are you doing?

**MIKE MAPES:** Good.

**JACOBSON:** Good.

**MIKE MAPES:** Good afternoon. Thank you for having me. My name is Mike Mapes. And my experience with PEOs began in 19--

**JACOBSON:** I need you to spell your name.

**MIKE MAPES:** Mike Mapes, M-i-k-e, Mapes, M-a-p-e-s. My experience with PEOs began in 1995. In 1997, I started a PEO called the Alliance Group. And probably before today, you guys had never heard of a PEO. A lot of people haven't. But I owned and operated that business until 2000-- 2022, when it was sold to one of the larger PEOs in the United States. And to give you a perspective, 5,000 employees that Pando has now is big, don't get me wrong, but Vensure Employer Services has 700,000 employees. There's-- the top 20 PEOs in the United States have 90% of the market. So 3,000 sounds big. 5,000 sounds big. It's just not big in the PEO world. While I was the owner of the Alliance Group, I worked with our National Trade Association in 2010 to pass this PEO recognition bill that we're talking about today. While I'm no longer an owner of the PEO, the industry is still near and dear to my heart and is an incredibly important outsourcing option for many small businesses, just like you've heard today. The work we did at our PEO and what PEOs do today is extremely valuable to its clients. Allowing a PEO to self-insure its health insurance plan is unnecessary, it's misleading, and it's also bad public policy. The reason is-- and the, the proof I can give you for it being unnecessary is for 25 years, we ran the Alliance group. We had close to 4,000 employees. 80, 90% of our clients had health insurance plans. We did not have a self-funded-- self-insured health plan. We were able to provide our services. I think the question that was asked is what happens if we do nothing on this? Nothing changes. The PEO still exists. The PEOs that operate in Nebraska, they still provide their services. The only difference is now there's no risk involved. The reason why this is misleading is, again, when a company has 2,000 or 3,000 employees, it sounds like a large company. And I'll give you an example. Hudl, here in Lincoln, has 2,200 employees. They have revenue of $600 million. If they were off on their health insurance plan by 10% and they had to take a hit, out of $600 million in revenue, you can take that hit. A PEO with 3,000, 4,000, 5,000 employees, their revenue is probably $4 million, $5 million at most. And if you're off on $45 or $50 million of premium, if you're off by 10%, there goes all your revenue. That's why it's misleading. They're not as big as they sound. And bad public policy is prior to 2010, PEOs in Nebraska were allowed to self-insure. Three of them, Strategic Staff Management out of Omaha, The Resource Company out of Omaha, and there was a small one here in Lincoln, they all had self-insured plans. And the reason I know that is because I had to compete against them. All 3 of them went out of business. Hundreds of people had healthcare bills not paid. And it's bad public policy, which is why you see the wording that's in the 2010 PEO registration bill the way it is now, because the Department of

Insurance at the time said we want fully insured health plans. As I've said, PEOs are wonderful. Small businesses who utilize the services would never go back to doing those functions on their own. Believe me. Let's keep PEOS alive and well in Nebraska. They do not need to offer self-insured health plans. It is unnecessary, it's deceptive, and history has shown it's bad public policy. Please keep this in mind as you consider LB293. Thank you.

**JACOBSON:** Thank you. Question? Senator Hardin.

**MIKE MAPES:** Yes?

**HARDIN:** Is there a difference in Nebraska as far as you know, between the way the spec and the ag would work on a traditional business versus a PTO? Because at the end of the day, it's still up to the reinsurer in terms of no one's putting a gun to their head in terms of whether they take on that risk or not. So we're still dealing with, with spec and ag in a similar way that we would be with a traditional big business. Is that correct?

**MIKE MAPES:** Well, I think so. Right. Just like there's probably-- I don't know-- 100, 150 work comp carriers licensed to do business in the state of Nebraska. Maybe only 2 will deal with a work comp policy for a PEO. Very few reinsurance people will like the PEO industry. The other thing is like, say, at Hudl, 2,000 employees-- very homogenous group, everyone is the same. A PEO with 2,000, 3,000 employees, they'll have anywhere from a doctor's office to people working on a ranch. I mean, it's not a homogeneous group. Insurers don't like that. It's hard to underwrite. It's-- I lived it for 25 years. It's-- they're not going to like it.

**HARDIN:** Well, and, and to your point, that does end up making the cost of the insurance more expensive.

**MIKE MAPES:** Yeah, well--

**HARDIN:** PE-- PEPM, right?

**MIKE MAPES:** Right. Exactly.

**HARDIN:** So it is-- even if it passes, it's still up to the individual insurers whether they want to take on that risk or not.

**MIKE MAPES:** Correct.

**HARDIN:** There's nothing in Obamacare that says thou shall.

**MIKE MAPES:** Correct.

**HARDIN:** It's-- you can accept or reject a whole group for any or no reason whatsoever.

**MIKE MAPES:** Correct.

**HARDIN:** Right. And so it's kind of no harm, no foul, if we-- because it's up to the insurer whether they want to take on that risk or not. And to your point, they're rare as hens teeth to find them.

**MIKE MAPES:** Right. Assuming, I guess, what, what level that the P-- what level of risk the PEO, PEO is going to take, whether or not they can financially handle that portion of the risk.

**HARDIN:** Right.

**MIKE MAPES:** Not the reinsurance people.

**HARDIN:** So you're, you're saying we, we could pass this, but you still have to deal with the pragmatics of can, can you find a partner in the risk world who's willing to underwrite it?

**MIKE MAPES:** Right. So what's the, what's the deductible for the PEO? Is it going to be $0.5 million? $1 million? $2 million? $5 million?

**HARDIN:** And that's, to your point, a very important piece that-- does it make it sustainable or not.

**MIKE MAPES:** Right. Right.

**HARDIN:** Thank you.

**JACOBSON:** Other questions? Yes.

**von GILLERN:** Thank you, Mr. Mapes. A quick question. There was an amendment that-- and forgive me. I had a hearing in another committee. I had to present, so I'm a little late to the game. Looks like there was an amendment that was presented to the committee here, and you probably haven't even seen it, that calls for a stop-loss insurance policy for coverage in excess of 125,000-- 125% of the health benefit plans expected health claims costs. Does that change your thoughts at all for their stop-loss cov-- limits previously, in your experiences?

**MIKE MAPES:** Not really. I mean, if you have one PEO here in Nebraska doing 100% of the work, and then you just have one PEtO watch, that's great. But there's 700 PEOs in the United States, and if they have a couple employees here, they're going to be reporting quarterly, possibly, maybe. And the other thing, too, if the notice goes out to the employee, what-- if I'm an employee of a 10- or 15-person shop and I go to the owner and say I'm uncomfortable having-- being under a self-insured health plan, what's the owner going to do? I mean, so what difference does it make if you give a notice to an employee? The employee's not going to go to the owner and the owner is just going to go, you're right, we need to be fully insured. So I think that notice is, is misleading, also. The employee has no power to change that. They're not going to go to another job because their employer is stuck with this self-insured plan.

**von GILLERN:** And then one other quick question. You mentioned 3 companies that failed that were-- that did have self-insurance plans. Were, were their failed-- were the fail-- failures of those companies directly attributed to--

**MIKE MAPES:** Yes.

**von GILLERN:** --to health insurance losses-- self-Insurance losses?

**MIKE MAPES:** Yes. Strategic, Strategic Staff Management and The Resource Company, yes. And then the, the one in Lincoln, they just, they just kind of fizzled away, but it was because their health insurance plan was in trouble. But the other 2 was--

**von GILLERN:** The one in Omaha was pretty public, as I recall.

**MIKE MAPES:** Yeah, it was. But 2 of them are, yeah.

**von GILLERN:** 2 of them? Yeah. OK. Thank you.

**MIKE MAPES:** OK.

**JACOBSON:** Yes, Senator Hardin.

**HARDIN:** More of a comment, but react to this comment. Most of what we're seeing now in partial self-funding is level funding, and so-- or, or max funding, if you will. And that being the case, it really does function like a fully insured plan. You have the benefit of not having to pay many of the fees that are associated with the Affordable Care Act. And so that's obviously--

**MIKE MAPES:** That's nice.

**HARDIN:** --one of the, the big reasons Nebraska happens to be good for Nebraska, probably one of the top 3 states in the country when it comes to the employ-- or the use of partial self-funding.

**MIKE MAPES:** Right.

**HARDIN:** And that's one of the big pieces to it. In the days when these others failed, I think that was probably before-- I don't know how long ago it was, but the level funding thing just really became wildly popular in about the last 4 or 5 years.

**MIKE MAPES:** Yeah, it was the late '90s, early 2000s when-- the other time it happened. But I was a fan of the, the level funding one, too.

**HARDIN:** Yeah.

**MIKE MAPES:** That was nice.

**HARDIN:** So anyway, just saying that we're, we're kind of in different waters from what's practical and what's found out there, as opposed to kind of how things looked even a half a dozen years ago, when it comes to self-funding.

**MIKE MAPES:** Possibly.

**HARDIN:** Yeah.

**JACOBSON:** Other questions from the committee? All right. Seeing none, thank you for your testimony.

**MIKE MAPES:** Thank you.

**JACOBSON:** Further opponent testimony. Any other wishing, wishing to speak in opposition? Seeing none, any neutral testifiers? Welcome.

**KATIE THURBER:** Thank you. Good afternoon, Chairman Jacobson and members of the committee. My name is Katie Thurber. K-a-t-i-e T-h-u-r-b-e-r, and I am the interim Commissioner of Labor. I would like to thank Senator Ballard for being agreeable to the amendment we have proposed. I don't really have planned testimony other than to be here to answer any questions you may have. The whole goal of the amendment was to make sure that we put into the law the level set requirement for the stop-loss provision, and to require more

reporting. So instead of annual, it will be on a quarterly basis to the department. Now with that, I would answer any questions.

**JACOBSON:** Thank you. Senator Hardin, would you possibly have a question?

**HARDIN:** Yeah. What's the potential upside and downside of this from your neutral perspective?

**KATIE THURBER:** I was going to say we're neutral for a reason. But it expands potential business. This was brought by a PEO, is my understanding. And so, I believe there is an interest in that business community and they see a benefit to that. The risk was discussed in the opponent testimony, as if the business does go under-- health insurance, as you all know, is a bit of a gamble. You have lots of people with cancer that your plan is suddenly a lot more expensive. That is why it was critical to us to make sure that we outlined a reasonable stop-loss provision. We didn't create that. We stole it from MEWA. So thank you, MEWA.

**JACOBSON:** Further questions? Senator Hallstrom.

**HALLSTROM:** Congratulations on your new position.

**KATIE THURBER:** Thank you. It's good to see you in your capacity as senator, as well.

**HALLSTROM:** Let's withhold judgment.

**JACOBSON:** Other questions from the committee? All right. Seeing none, thank you for being here today and for your testimony.

**KATIE THURBER:** Thank you.

**JACOBSON:** Are there any other neutral testifiers? Hold your horses there, Beau. All right. All right. Seeing none, Senator Ballard, you're welcome to close. And there are-- we did receive 2 proponent letters, zero opponent letters, zero neutral letters, and the committee did not receive any written ADA testimony regarding this bill. You're welcome to close.

**BALLARD:** Thank you, committee. I'll be brief. I just want to say thank you to the committee for their, their attention today. I know this is a very exciting issue, but I appreciate it. I'll just briefly say I appreciate Mr. Mapes and his, his concern. I share them with the risk

of PEOs, but that's not quite what we're getting after today in LB293. That was dealing more with LB1227, which I introduced in front of this committee last year. That's where that-- we-- the committee unanimously passed that to the floor, and that's when we're dealing with that self-insured risk. So I, I appreciate it, but that's not quite what we're dealing with today. But I do want to briefly mention the fiscal note. Willing to work with the department-- we did get a revised fiscal note for an actuarial employee, so willing to work with the committee or the department on that to try to-- I know we are in constraints as those on Revenue know. And so, I'm trying to be sensitive to expensive actuarial employees. So with that, I will close and answer any questions.

**JACOBSON:** Questions for Senator Ballard? All right. Seeing none, thank you for bringing the bill today.

**BALLARD:** Thank you. Appreciate it.

**JACOBSON:** And that concludes-- this concludes our test-- or our hearing on LB293. And at this time, I'm going to turn the chairmanship over to Vice Chair Hallstrom, because I'm next up on bill Introduction.

**HALLSTROM:** Next bill is LB527 Senator Jacobson. Welcome.

**JACOBSON:** Hey, thanks for the welcome. Well, good afternoon, Vice Chair Hallstrom and members of the committee. My name is Mike Jacobson, M-i-k-e J-a-c-o-b-s-o-n, and I represent District 42 in the Nebraska Legislature. I'm before you today to introduce LB527, the Medicaid Access and Quality Act. The bill is incredibly important to the future of, of healthcare in our state, especially in rural areas, and especially for pregnant women and Nebraska children. LB527 is important not just for folks on Medicaid, but for healthcare in Nebraska as a whole, and I'm going to tell you why. But first, I want to briefly cover the basics of what the bill is about. Many of you remember LB1087, which I introduced last year, and which passed with strong support from the body. That bill imposed an assessment on hospitals which brought in General Fund revenue that the state can use as matching dollars to qualify for additional federal Medicaid funding. That funding is direct-- is directed to enhance payments to the hospitals. LB1087 introduced a lot of us to the concept of a provider assessment. These types of assessments have become an integral source of financing for Medicaid across the country. LB527 is a different type of provider assessment. In this case, the providers

are the HMOs. LB527 imposes a 6% assessment or tax on premiums written under an HMO certificate of authority. That assessment is projected to generate approximately $246 million in general funds. Under LB527, all of that revenue will be credited to a new fund, the Medicaid Access and Quality Fund, to be used within Nebraska's Medicaid and CHIPs programs. Section 6 of the bill provides directions to DHHS for how this revenue can be used. $40 million annually shall be used to seek federal participants-- participation to enhance rates of nonhospital providers of physical health services. When combined with federal funds, this is projected to be a total of approximately $115 million annually to enhance rates for those providers, $5 million annual be-- annually shall be used to pay providers a monthly fee for serving as a primary care medical home, helping to coordinate care, and keep patients out of high cost, urgent, and emergency care. When combined with federal funds, this is projected to be a total of approximately $15 million to invest in primary care medical homes. Two, the remaining revenue will stay within the Medicaid and CHIPs programs. This is more than $100 million in new funds helping to pay for unfunded federal mandates in the Medicaid program and a reduction in the FMAP funding. So not only does LB527 do a tremendous good-- amount of good for healthcare in our state, but is also a tremendously valuable tool for paying for Medicaid costs that Nebraska is going to have to pay for one way or another. There's a lot more that I could go into with the details of the bill and how it works, but many of the testifiers behind me will answer these questions. But let me briefly touch on why the act is critically important. We know we have challenges with access to care in Nebraska, especially in rural Nebraska. We have primary care deserts and maternity care deserts. More than half of our counties are defined as maternity care deserts. These, these-- those access challenges are not strictly rural, rural. There are testifiers behind me who will speak to access challenges in urban areas, as well. If there are access problems to begin with, there's an even bigger problem if you're covered by Medicaid. That's more than 350,000 people in Nebraska, including about a third of pregnancies every year and one-third of Nebraska children. So this is one of the 3 moms, babies, and kids we're talking about. Now, before I wrap up, I'd like to hand out the, the- an amendment which has been distributed by the pages having-- on this bill. AM137 is a bill that clarifies the language and removes some, some unnecessary language. And these suggestions were brought to me by the office-- or Department of Insurance. The amendment basically lays out that the tax estimated by this section shall not apply to a premium received during calendar year 2025 that is attributable to an individual account or policy held

by an entity not offering the contract or policy in the calen-- calendar year 2026. Really has to do with payments being paid in arrears, so this would clean that piece up. So I would be offering the bill along with AM137. And I'll stop there and try to entertain any questions you might have.

**HALLSTROM:** Any questions of the committee? Senator Riepe.

**RIEPE:** Thank you, Chairman. Question of curiosity. I'm a free market kind of a guy, and it seems to me that this is-- this kind of legislation means that a-- an even greater reliance on expanded Medicaid and government insurance. I see it as a road to trouble--

**JACOBSON:** Well, I would tell you that--

**RIEPE:** --not only with the Medical Association, the Hospital Association, and with anyone else that's doing the double shift, as I cons-- consider it.

**JACOBSON:** I guess the way I would attack that is a little bit like LB1087. These are dollars we don't have today, and these are dollars that are going to help improve the processes and the care that's out there. When I look specifically at, at this particular bill, we need to keep in mind that Nebraska, through the FMAP program-- and, and FMAP is really the Medicaid dollars that we get from the federal government. That was significantly cut. And as we got our budget briefing, that number is going to grow to about $250 million a year that we lost in Medicare subsidy coming to the state of Nebraska from the FMAP program. So by applying for this program, we're going to recover some of the money that we lost from that program. None of the federal dollars are guaranteed. In fact, I would even tell you that LB1087, passed last year, has still not gotten final CMS approval. We expect that to happen. But obviously, the change in administration has brought some of that under scrutiny. And so, we're hopeful that that will indeed be approved. This would be looking at a 2026 approval period where those dollars could be available. It's always subject to what the federal government is doing. But I always think you can't lose what you don't already have. So if we get the funding, great, and if it continues to come, great. And if we lose the funding, we're back to where we are today.

**RIEPE:** I would simply say I was not a big supporter of LB1087 at the time.

**JACOBSON:** But I did get your vote.

**RIEPE:** I know you did, because I had assured the Hospital Association I would do that. But thank you very much. I appreciate it. Thank you, Chairman.

**JACOBSON:** Thank you.

**RIEPE:** Thank you.

**HALLSTROM:** Senator von Gillern.

**von GILLERN:** Thank you, Mr. Hallstrom. Senator Jacobson, if I just look at the fiscal note without any other context, it's money in, money out over this year and, and next, without a big delta. What-- what's the secret sauce that you don't get if you just look at the fiscal note?

**JACOBSON:** Well, I think what you're looking at is that, that these-- the dollars that are coming in, roughly $100 million is new money to the state that they're going to pay back out. But if they didn't take it from this fund, it'd be coming out of General Fund dollars. And that's-- and I, I can't--

**von GILLERN:** Federal funds versus cash funds-- general funds.

**JACOBSON:** Bingo. Yes.

**von GILLERN:** OK. Thank you.

**HALLSTROM:** Any other questions? Senator Bostar.

**BOSTAR:** Thank you. Thank you, Chair. Do you think we can-- just kind of following up on, on Senator von Gillern comment, it does feel like we're missing something. I mean, federal funds are represented on here as a, you know-- for example, in '25-26, there's a $117 million expenditure, $63 million in cash funds expenditures, $60 million in general funds coming in, and then $123 million on the cash funds on the revenue side. So it's, it's still-- I feel like we're-- it's not actually really well captured, because I, I-- like I kind of get what's happening and, and we've been down this road before. But there's, there's a piece missing here on the, I think on the federal funds line, because it isn't just $117 million in expenditures on the federal funds level. Right? There's, there's the federal funds on the

revenue side, as well. But that's-- I mean, I-- am I, am I thinking about this wrong or are we missing a federal funds revenue number?

**JACOBSON:** I'm going to let DHHS, who's going to testify behind me, give you that answer.

**BOSTAR:** OK.

**JACOBSON:** Because I will tell you that when you look at this type of program and how Fiscal accounts for it, it's starting to get beyond my mathematical skills. So.

**BOSTAR:** I, I look forward to it.

**JACOBSON:** All right. Thank you.

**HALLSTROM:** Senator Dungan.

**DUNGAN:** Thank you, Vice Chair Hallstrom. Thank you, Chair Jacobson. Just to clarify, I, I just want to make sure it's clear on the record. This department-- this bill allows the Department of Insurance to collect a 6% tax. Who-- who's paying that tax again?

**JACOBSON:** This, this would be the HMOs that are, that are participating. Yes.

**DUNGAN:** So this is not an increased tax on individuals who are utilizing various insurance?

**JACOBSON:** No, this is premium coming from the premiums. And then ultimately, you're getting additional Medicaid dollars being, being expended.

**DUNGAN:** I just had some questions about that based on, I think, the, the cursory glances people had had on this statement, so I just want to make sure. We're not talking about raising taxes on individuals necessarily, correct?

**JACOBSON:** Cert-- certainly not. That's correct.

**DUNGAN:** Thank you, Chair.

**HALLSTROM:** Anything else for Senator Jacobson? If not, thank you. Will you be closing?

**JACOBSON:** I'll stick around for the close. Thank you.

**HALLSTROM:** First testifier in support.

**JOHN MEALS:** Good afternoon, Vice Chair Hallstrom, Senator Jacobson and members of the committee. My name is John Meals, J-o-h-n M-e-a-l-s. I'm the chief financial officer for the Department of Health and Human Services, and I'm here to testify in support of LB527. LB527 creates a new tax on health maintenance organizations, or HMOs, as specified in the bill. And this tax would take effect in calendar year 2026. This tax would apply to all HMOs operating in Nebraska, which includes Medicaid's 3 contracted managed care organizations. Similar to other taxes that Medicaid levies, a portion of revenue received from the tax would be used as the nonfederal share to increase payments to Medicaid providers. Medicaid would have an obligation to ensure that any taxes the MCOs pay would need to be refunded or replaced in the capitation payments that they receive from the state. Medicaid currently operates similar taxes specific to certain provider types like nursing facilities, intermediate care facilities, and the program is currently in the process of standing up a similar tax specific to hospitals. That's the aforementioned LB1087. This bill specifies the purposes for which this federal funding can be used. The bill creates the Medicaid Access and Quality Fund. Revenue from the tax must be deposited. This funding will then be used to fund rate increases for Medicaid providers for outpatient services. About $40 million per year of the tax revenue, when matched with the federal funds, would result in an increase of approximately $115 million in total funds for certain provider rates. This funding then will also be used to fund a new per-member, per-month payment to primary care medical homes. This is the $5 million in tax revenue that, when coupled with the federal funds, would result in about $15 million in total funds, beginning in calendar year 2027. All remaining tax revenue will then be deposited into the department's Medicaid and CHIP aid programs, which is Programs 348 and 344. The Department would like to share with the committee practical benefits that we see this legislation offering. Members of the committee may be aware that Medicaid's federal medical assistance percentage, or the FMAP that's been referenced, decreased from 58.6% in federal year 2024. It is down to 57.52% in the current federal year, 2025. Our FMAP will further decrease to 55.94% in '26, and it is currently forecasted to reduce again to 54.36% in 2027. So in a 3-year period, it will drop over 4%. If unaddressed, this decrease can lead to program budget shortfalls. Medicaid anticipates that this new tax will help alleviate the potential budget deficits that the decrease in the FMAP will create. In addition to alleviating budget shortfalls, the department believes this bill has the potential

to positively impact healthcare access across the state. The program hopes the outpatient service rate increases that the bill affords will lead to more healthcare providers choosing to participate in the Medicaid program. This is good for beneficiaries across Nebraska, particularly in rural areas where there are notable healthcare provider shortages. Boosting these outpatient payment rates aligns with our current policy priorities, like improving maternal health outcomes. Many services related to maternal health are provided on an outpatient basis, and bolstering those outpatient rates will lead to both better healthcare access and better healthcare outcomes for expecting mothers. The department supports the adoption of this legislation. We respectfully request the committee advance the bill to General File. Thank you for your time, and I'm happy to answer any questions.

**HALLSTROM:** Thank you, sir. Senator Bostar.

**BOSTAR:** Thank you, Senator. And thank you, sir. You seem like just the guy--

**JOHN MEALS:** Sure.

**BOSTAR:** --to talk to you about the fiscal note.

**JOHN MEALS:** Yes, sir.

**BOSTAR:** If you wouldn't mind--

**JOHN MEALS:** Yep.

**BOSTAR:** --what am I, what am I missing here?

**JOHN MEALS:** So the way it works, if, if-- look at 2027. The first year may be confusing because it only represents 6 months, OK. So let's look at 2027. The projected revenue that's going to come in is $246 million. Again, this-- if you look at the series of fiscal notes, I think the Department of Insurance is a little bit lower than ours on the revenue side. That's because we are forecasting the LB1087 hospital assessment revenue that has not happened yet. So DOI's fiscal note, historically, that's not included in there. We include it in ours going forward because the assumption is that it will be a part of the revenue when this begins in 2026. So you get $246 million in revenue. That's 6% of all HMOs' forecasted revenue.

**BOSTAR:** And that goes into the cash fund?

**JOHN MEALS:** That goes into the cash fund. Yes, sir. So you take the-- so the second paragraph of the fiscal note, the first thing that we have to do is make our managed care organizations whole. So $86 million of that 246 basically gets turned right back around and is included in the capitation payments that we pay the MCOs, and $160 million of the federal funds. So the-- so 86 of the 246 in revenue and then roughly 160 of the 239 in federal after the MCO-- or the HMOs rather, pay it in. We have to turn around and pay those amounts back to the MCOs in their capitation rates. And next paragraph down represents the amount that will be utilized, the third paragraph on the fiscal note-- on our fiscal note, rather, will-- that is the funding for the rate increases that we referenced. So $40 million of that cash fund will be grossed up with roughly $74 million in federal funds. So now of the 246 and revenue, you're using 80 of the-- 86, rather, of the revenue for the M-- for the MCOs, $40 million for the rate increases that first year. The next paragraph down then, is the other program that was referenced, the case management, the $5 million program, that becomes 15 with the federal funds. That first year, it'll-- that one begins January of '27. So it's only a 6-month period. So that first year, it's $2.5 million. So you take 86 plus 40 is 126, plus 2.5 is about 128. The remaining amount, or about $117 million, is the offset to the General Fund for the department.

**BOSTAR:** So in '26-27, I mean-- why don't, why don't we see the federal funds coming in?

**JOHN MEALS:** You, you, you do. So, so where they, where they are coming in is you take the $246 million in revenue--

**BOSTAR:** Sure.

**JOHN MEALS:** --you take out 117, because that is going to go to offset state General Fund expenditures. So then you have the remaining 86 for the MCOs, $40 million for the provider rate increases, and $2.5 million for the case management program. So you take that, roughly $117 million, gross that up with federal funds and that's your $240 million. All of-- those things combined then, are collectively paid out to the providers in their rate increases, for the new case management program,and to the MCOs.

**BOSTAR:** So the net on '26-27 is a loss of $3.5 million?

**JOHN MEALS:** It, it-- it's not a loss. What you're not seeing on here or what, what-- so let me----

**BOSTAR:** That's what I'm just trying to figure out.

**JOHN MEALS:** Yep. Let me--

**BOSTAR:** What am I not seeing on here?

**JOHN MEALS:** What you're not seeing is-- so the, the amount that offsets the state General Fund, anything that we utilize that for can be, can be matched against federal funds, and that's not going to show up on here.

**BOSTAR:** Why wouldn't it show-- I mean, why, if we're, if we're pulling down federal fu-- I guess this, this kind of goes to the root of what I'm asking. If we have this extra amount that we're pulling down in federal funds, which is sort of the whole point, why are we not-- why is the federal funds line on the revenue column blank?

**JOHN MEALS:** Because we're, we're not getting revenue from the federal funds. We-- it's, it's actually an expenditure. Because what happens is--

**BOSTAR:** You're killing me.

**JOHN MEALS:** I'm trying to be as clear, as clear as I can. The--

**BOSTAR:** Try harder.

**JOHN MEALS:** I mean, I'll see if I can say this a different way. When we get the revenue into the cash fund--

**BOSTAR:** Yeah.

**JOHN MEALS:** --the way that it is reflected is in payments that go out the door.

**BOSTAR:** Yes.

**JOHN MEALS:** Right? So we don't, we don't first draw the federal funds and then--

**BOSTAR:** Agree.

**JOHN MEALS:** --and then turn around and-- it just--

**BOSTAR:** Sure.

**JOHN MEALS:** So we, we change the, the capitated rate. We pay the MCOs, so it will-- it's all just going to be paid out to them at this higher rate, and then they turn around and use a portion of that to, to pay the tax to us.

**BOSTAR:** All right. So you were going to tell me what I'm not seeing on here. Because right now, we're at a net loss.

**JOHN MEALS:** We're not at a net loss. Right. A net gain to the state of $117 million.

**BOSTAR:** Understood. But I-- and I agree. But if you just look at the numbers that are being reported for the bill--

**JOHN MEALS:** Yep. I understand where you're going.

**BOSTAR:** --if you add them all up, we are losing.

**JOHN MEALS:** So--

**BOSTAR:** So what numbers are not here?

**JOHN MEALS:** The reason that it's not on here is because it's going to go to offset costs in Medicaid. It won't be reflected until we actually turn around and spend that dollar, and that will be on, I mean, a variety of things. If we, if we were to spend it on regular Medicaid services, then it's matched at the same, you know, 55-ish%, depending on the year. And so then you would get another $130 million from the federal government.

**BOSTAR:** So if we were to look at '27-28--

**JOHN MEALS:** Mm-hmm.

**BOSTAR:** --would we see that?

**JOHN MEALS:** It's never going to show up on here.

**BOSTAR:** See, this, this feels like a problem, though.

**JOHN MEALS:** It-- it's the difference between, I guess, the-- let me see how to best explain this.

**BOSTAR:** I kind of get what's happening. Right. Like, I, I understand the process. What, what I really-- what I'm failing to understand is

why we are utilizing a system that can't capture it in a way that's representative of the reality that the state is going to experience.

**JOHN MEALS:** So, so what is-- here-- here's a-- here's-- maybe this will help. These expenses are already happening within our Medicaid program. The, the federal share of costs are already occurring within Medicaid.

**BOSTAR:** Yes.

**JOHN MEALS:** And we're just using $117 million to offset the state's share of an already existing expense.

**BOSTAR:** Yeah.

**JOHN MEALS:** So it's not a new expense that would show up on here. It's an already existing expense that we are using this cash to offset the state's share of that original cost.

**BOSTAR:** I, I, I-- the fiscal note says we lose money. Are we going to lose money or are we going to gain money?

**JOHN MEALS:** We're going to gain $117 million.

**BOSTAR:** This is the problem. I, I-- that-- I, I-- that actually was really helpful to have you walk through it. I, I genuinely appreciate it. I don't think-- this feels more like a fiscal note issue than a--

**JOHN MEALS:** So let me give it-- I'll, I'll give it to you this way, too. You-- typically, the way that we write fiscal notes, this is what would go into an A bill. And if, and if I incorporated the other $130 or $140 million in federal funds that we're saying is missing from here, I would be asking for federal authority that I don't need, because I already have it. Like, HHS already has that federal authority-- or federal appropriation, rather. And so it's, it's an existing appropriation, and I'm just choosing to instead utilize this to offset the General Fund--

**BOSTAR:** OK.

**JOHN MEALS:** --cost of an existing appropriation.

**BOSTAR:** So I get-- that actually-- that makes a lot of sense.

**JOHN MEALS:** OK.

**BOSTAR:** But I-- so I think we need a, a process maybe, to where we can capture information for our own purposes, right? I mean, without necessarily having it need to be-- creating some new authorization that already exists in an A bill.

**JOHN MEALS:** That's fair.

**BOSTAR:** So, you know, on, let's say, our green sheet on the floor-- like, this is one of my concerns. Is this going to net out to a reduction on our green sheets? Like, this is what I'm worried about. If you just take the information from the fiscal note and we, we throw this bill up on General File, and then we go through and, you know, we're looking at all of our allocations of what's out, out on the floor, what's its impact, What do we have left to work with? Nothing. I'm worried that this is going to show a detrimental budgetary impact when-- that-- that's not true, right? I think--

**JOHN MEALS:** I would, I would describe it as we look at it in different buckets. When, if you-- when you look at the cash fund, obviously there's much more revenue than expenditures coming in, just on the cash fund, right. There's $246 million coming in. We're only going to spend 128 of it, right, in, in cash. There's going to be $117 million that is spent that offsets General Fund, right?

**BOSTAR:** Right.

**JOHN MEALS:** So the General Fund is going to show a $117 million benefit. The only place that you're going to show an increase is to the federal government. And that's the whole point of the program. Right? And so, yes, and if it shows a net loss, I mean, that, that would only serve to, I guess, prove the point that we are shifting costs from the state to the federal government.

**BOSTAR:** Well, that shouldn't be shown on our green sheet as a loss, right? I mean, taking, taking our costs and moving them externally, should, should advantage the fiscal position of the state.

**JOHN MEALS:** Depends which fiscal position you're looking at. If you just look at the General Fund position, it's going to benefit it by $117 million.

**BOSTAR:** I think the overall position of the funds that the state is sort of responsible, so general funds, cash funds.

**JOHN MEALS:** Can I give you this? I'll-- and we can work with Legislative Fiscal Office to see if there's a way we can revise this to maybe make it make more sense.

**BOSTAR:** You know, I mean, I think what I would like to do-- because I understand that we're now extending this conversation quite extensively. Why don't we, once this bill-- because I am really actually curious what this is going to look like. When the bill gets on General File, I want to see what it looks like on our green sheet. If, if this bill is represented in a way where, on the floor, its impact is detrimental to what we're able to do, or if it essentially is helpful. So why don't we, why don't we just look at what that turns out to be--

**JOHN MEALS:** Sure.

**BOSTAR:** --and then kind of go from there? Because that's more of what I'm worried about than this piece of paper, is how it gets combined, when we're only looking at aggregate stuff on a list and we don't have detail in front of us.

**JOHN MEALS:** Sure.

**BOSTAR:** I just want to see what that presents. Thank you very much.

**JOHN MEALS:** Yeah.

**HALLSTROM:** Any other questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. In the Health and Human Services Committee, we get a number of people who want to avoid mentioning the word General File or general funds out of fear that it's the road to a veto. And so, we get a lot of people and programs coming in there that refer to the excess profit funds. So we keep drawing from this balance of which we do not know exactly what it is. My question gets to be, with this tax going to the 3 managed care organizations, it's obviously going to increase their operating costs, which means their excess profit will decrease, so we will have fewer dollars. Correct me where I'm wrong. We will have fewer dollars to assign to bills that come through HHS that ask for, you know, excess Medicaid.

**JOHN MEALS:** Thank you for the question, Senator. And it actually shouldn't have an effect on the amount--

**RIEPE:** Should not?

**JOHN MEALS:** --because, because one of the mandates of this program is that we have to make the MCOs whole. So any, any tax or assessment that they pay in, we have to turn right back around and, and ensure that their capitation payments are increased to where there's no-- they, they can't lose money. They also have it capped to where they can't make money. So there really should be no effect to the, the amount that's coming in.

**RIEPE:** So their excess profit fund is even going to grow because of this?

**JOHN MEALS:** It should, it should have a minimal effect in, in either direction, because it is, again, it's basically a net zero for them. They're going to, they're going to pay an assessment, and we're going to turn around and we're going to make them whole on the capitation payments that we pay them.

**RIEPE:** OK. Thank you. Thank you, Chairman.

**HALLSTROM:** I don't want to fall any further behind on this discussion, but I thought I heard you say we will realize revenue when we make an expenditure. Is that because of the federal match?

**JOHN MEALS:** Yes. So it's the-- that was just saying the Medicaid grant is a-- it's a reimbursement basis. So we have to-- there has to be an expenditure before we can draw on the grant. We don't-- it's not advanced to us.

**HALLSTROM:** Thank you. Thank you very much.

**JOHN MEALS:** Thank you.

**HALLSTROM:** Next proponent. Welcome.

**ROBERT WERGIN:** Thank you. Vice Chair Hallstrom, members of the committee, I am Robert Wergin, M.D. I'm a family medicine physician from Seward, Nebraska, and the president-elect of the Nebraska Medical Association, which represents over 3,000 physicians, residents, and medical students in Nebraska. I'm testifying on behalf of the Nebraska Medical Association and the Nebraska Academy of Family Physicians in support of LB527. First, I want to thank Senator Jacobson for introducing this important bill. The NMA has been grateful to partner with Senator Jacobson and the-- Governor Pillen's staff and administration to put together this proposal that strengthens Nebraska's Medicaid program and provides needed reimbursement rate

increases for physician practices and other providers, to ensure these clinics can continue to provide care. While the costs of operating physicians clinics have had significant increases, approximately 20%, over the past 5 years, net patient revenues have simply not kept up and in some cases, have decreased. These increasingly thinned or negative operating margin-- margins disproportionately affect small, independent, and rural physician practices. When reimbursement rates do not keep up, what you see is physicians limiting the number of Medicaid patients they can take in order to stay viable. It is common to hear about access to care issues for patient-- Medicaid patients for that very reason. As physicians' practices limit the number of Medicaid patients they see, we see an increased utilization of the ER for routine and minor healthcare, resulting in increased costs and further fragmentation of care. Finally, we see consolidation, private equity, and absorption of clinics by health systems as it becomes increasingly attractive to move on to an employed and salaried position. This helps some clinics stay viable, but also reduces competition and increases overall costs. In 2023, 21 out of 93 counties lack primary care physicians. When reimbursement rates are low, this makes it even more difficult for physicians to practice in these underserved areas. This is particularly important in rural Nebraska, where Medicaid is a major source of coverage. The results-- this results in individuals delaying care because they can't get appointments or can't make the time to travel to another county for their medical needs. As a family physician, I can tell you that, that delayed care inevitably leads to worse outcomes, higher costs, unhealthy patients. LB527 focuses resources where they are needed in primary care, including pediatrics and maternal care in rural areas. This bill takes a thoughtful approach to moving healthcare forward across Nebraska. The NMA and the NAFPs urges your support for this bill, and I'm here for answering questions as a rural family physician.

**HALLSTROM:** Thank you, Doctor. Could you please spell your name for the record?

**ROBERT WERGIN:** Oh, I did not do that. Robert, R-o-b-e-r-t, Wergin, W-e-r-g-i-n.

**HALLSTROM:** Thank you. Any questions of the committee? Seeing none, thank you for being with us today. Next proponent.

**RYAN BEETHE:** Senator Hallstrom, members of the committee, good afternoon. My name is Ryan Beethe, R-y-a-n B-e-e-t-h-e. I'm the

director of business operations at Maxim Healthcare Services in Omaha and serve on the Nebraska Home Care Association Board. Today, I'm testifying in support of LB527 on behalf of Nebraska Home Care Association membership. Thank you, Senator Jacobson, for introducing this legislation. We would respectfully request that LB527 includes reimbursement rate adjustments for Nebraskans who are medi-fit-- Medicaid beneficiaries and receive home health, skilled nursing, private duty nursing, occupational therapy, physical therapy, and speech language pathology services in their homes. In addit-- in addition to therapy, home health services include cardiac care, disease management, pain management, wound care, respiratory care, administering medications, medication reconciliation, and caring for patients in the home who have ventilators, trachs, and g tubes. A comprehensive review of home health reimbursement rates have not been conducted in at least 20 years. There are 10 home health agencies that have closed in our state over the past 5 years, most of these being in rural Nebraska, leaving large geographical areas where there are no home healthcare services available to keep our citizens safe, comfortable, and independent in their homes. Our, our home health agencies have stopped serving Medicaid beneficiaries or significantly reduced the number of Medicaid referrals they can accept because of low reimbursement rates. Home health saves our states thousands of dollars. Our members can help prevent avoidable emergencies, cost-- costly hospitalizations, and keeping Nebraskans in their homes. I've distributed a map of the Nebraska home healthcare agencies. You'll see that some counties only have one home, home health agency providing services in that county, but many of these agencies are only serving a 30-mile radius, not the entire county. When reimbursement rates do not keep pace with operating expenses, it means that home health agencies are unable to hire and retain adequate number of nurses, therapists, and aides and other staff to meet the needs for patient care. It is challenging to offer competitive wages and benefits for aides, nurses, and therapists compared to what they're being paid in other healthcare settings. Our home healthcare agencies serve Nebraskans from infants through the elderly. There, there are children here in facilities wanting to go home but home health agencies do not have the available staff to care for them. This is directly tied to low reimbursement. Home health agencies are also turning away referrals for our elderly patients because of low reimbursement and lack of staffing. Addressing the home health reimbursement rates will also support Nebraska's hospitals in reducing the number of rehospitalizations and to reduce the state's costs. It will also support residents in our state skilled nursing and assisted living facilities who also benefit from home

healthcare services. We appreciate your time today and would respectfully request your support of LB527 to help ensure that Nebraskans of all ages can receive healthcare services in their homes and remain, and remain in their local communities.

**HALLSTROM:** Thank you. Any questions for the committee? Seeing none, thank you. Next proponent.

**LIBBY CROCKETT:** Hello, my name is Dr. Libby, L-i-b-b-y, Crockett, C-r-o-c-k-e-t-t, and I am a board-certified OB-GYN at the Grand Island Clinic in Grand Island. I am here today representing the Grand Island Clinic. I'm also a member of the NMA. We are asking you to support LB527 and advance this bill out of committee, as it would provide critically necessary funds to help keep obstetrical, pediatric, and primary care services available in outstate Nebraska. The Grand Island Clinic was founded in 1922, yes, 103 years ago, and is owned by 15 physicians in 3 different specialties: Family medicine, pediatrics, and obstetrics and gynecology. We actively track our quality outcomes and we know we provide high-quality care that translates into improved health outcomes as well as cost savings for payers and employers who provide health insurance within our community. In total, we have 24 providers and we provide between 85,000 and 92,000 patient clinic visits annually. The Grand Island Clinic has always prided itself on serving a diverse patient population with a wide payor mix. Approximately 25% of our total patients are on Medicaid, with 40% of our OB patients on Medicaid and 45% of our pediatrics on Medicaid-- pediatric patients on Medicaid, Medicaid reimbursement rates do not cover the actual cost of providing care to those individuals. After factoring operational costs, we currently lose, on average, $90 for each Medicaid visit in our clinic. Consequently, in the past year, we have had to start limiting the number of new Medicaid patients we can accept. This is troubling to me as an obstetrician in greater Nebraska because I already see the distances that patients drive for maternal care, and our state cannot afford for these access challenges to grow worse. I do want to make it clear that we are continuing to see Medicaid patients and absorb these added costs. But the current substandard payment, substandard payment situation places an undue burden on our practice and our business. Our goal has always been to provide comprehensive care to as many patients as possible, but we also must ensure the sustainability of our clinic to keep our doors open for the entire community, so this decision was not made lightly. Substandard payment for obstetricians has been a significant contributing factor to rural health deserts. And while LB527 does not entirely close the gap in payer-- private payer reimbursement, the

sustainable increase it proposes would significantly help independent pra-- practices, as it specifically targets improving reimbursement for maternal and pediatric care in rural areas. LB527 would ensure that practices like mine in outstate Nebraska can continue to serve our most vulnerable populations while maintaining the financial viability of our practice for the next 100 years. Thank you for your time and consideration.

**HALLSTROM:** Thank you. Any questions from the committee? Seeing none, appreciate you being here today.

**LIBBY CROCKETT:** Thank you.

**HALLSTROM:** Next proponent.

**SIAN JONES-JOBST:** Vice Chair Hallstrom and members of the committee, thank you for the opportunity to testify in support of LB527. I'm Dr. Sian Jones-Jobst. That's S-i-a-n J-o-n-e-s-J-o-b-s-t. I'm a general pediatrician for the past 25 years and president of Complete Children's Health, which provides primary care to approximately 20,000 children and adolescents in Lincoln and the surrounding communities. Last year, we had over 100,000 visits to our clinic. As we all know, healthy infants, children, and adolescents become healthy and more successful adults. Healthy children are more likely to graduate from high school and become successfully employed adults. Children receiving appropriate preventive care become adults with less chronic disease, saving healthcare dollars 10, 20, and 50 years into the future, savings to be recouped by individuals, employers, commercial insurers, and public programs including Medicare. Public investment in pediatric, prenatal, and postnatal care is ethically, morally, and financially responsible. Private physician-owned practices like ours function without hospital system support, facility fees, charitable contributions or public grants. Despite the lack of alternative funding sources, independent practices have been shown to provide the highest quality, most cost-effective care. Our primary motivation is serving patients, yet we must remain financially solvent to pursue our missions. Over 30% of children under the age of 19 are covered by Medicaid and CHIP in Nebraska. Children with Medicaid coverage often face challenges, including transportation and financial insecurity, and complex chronic health conditions. This population often requires complex care coordination, longer visits, and access to social services, all of which increase practice costs. Serving patients with these needs is at the core of our mission as pediatricians. But to do so, we need adequate funding. Historically, practices balanced low

Medicaid payments with revenue from other sources, but this model is no longer sustainable. Rising practice costs, stagnant Medicaid reimbursements, and commercial insurance rate cuts have made staying in business increasingly difficult. In recent years, many practices have been forced to limit or stop accepting patients with Medicaid coverage altogether, creating a crisis of access. Families who often already struggle are forced to travel long distances for care or forgo, forgo care completely. LB527 will help reverse this trend by increasing Medicaid pay-- payments to primary care providers, allowing us to care for patients without risking financial insolvency. Additional funding for care coordination will support the extra services these patients often require. This bill demonstrates our state's commitment to children's health and signals to future medical professionals that Nebraska values primary care. Nebraska is a state that values children and families. As a pediatrician and mother, I urge you to support LB527 to ensure all children have access to quality healthcare, and that quality healthcare providers can continue to stay open and serve our communities. Thank you.

**HALLSTROM:** Any questions from the committee? Seeing none, thank you again.

**SIAN JONES-JOBST:** Thank you.

**HALLSTROM:** Next proponent. How many more proponents do we have this afternoon? Thank you. Welcome.

**MEGAN KALATA:** Thank you. Vice Chair Hallstrom and members of the committee, my name is Megan Kalata, M-e-g-a-n K-a-l-a-t-a, and I'm an OB-GYN practicing in Nebraska. I'm also the Nebraska legislative chair for ACOG, the American College of Obstetricians and Gynecologists, and a member of the NMA. As an Ob-GYN practicing in Nebraska, I would like to express my strong support for LB527, seeking to improve healthcare access and quality in Nebraska. Access to maternity care is essential for preventing poor health outcomes and eliminating health disparities. Hospital closures and the provider shortage are driving changes in access to maternity care, particularly within rural areas and among our patients who identify as black, indigenous, and people of color. County level data from the U.S. Maternal Vulnerability Index shows that women living in about 83% of counties in Nebraska have a high or very high vulnerability to adverse outcomes, due to lack of available reproductive healthcare services. This bill has the potential to significantly impact the future of maternity care in our state. Because the bill targets increased reimbursement for labor and

delivery codes and has an enhancement for rural care services, there is a significant potential to impact these maternity care deserts. If we want our patients to receive appropriate medical care, we have to make it more accessible. Access challenges caused by poor reimbursement contributes to our pregnancy care deserts in our state. In Nebraska, women living in counties with some of the highest travel times can travel up to almost 80 miles and 80 minutes, on average, to reach their nearest maternity care. Currently, there's only about 7-8% of maternity care providers who are practicing in rural counties in Nebraska. Current Medicaid reimbursement rates make it increasingly challenging for our physician practices and for other care providers to care for our patients who are covered by Medicaid. To improve the health of Nebraska's moms and babies, we have to address this workforce issue. The investments from LB527 will provide needed stability for Medicaid providers and improve access and quality for our patients. It will allow for our physicians to accept more patients with Medicaid and to reduce the disparity in access to care experienced by our patients in rural and other under-- underserved areas. ACOG, the American College of Obstetricians and Gynecologists, is in support of access to meaningful coverage for low-income women and appropriate reimbursement for physicians through the Medicaid program. Investing in Medicaid reimbursement rates will ultimately benefit our state's overall healthcare landscape. All women deserve healthcare that is safe, timely, and equitable. When we improve our access to quality care, we will be able to make Nebraska a safer, better place to experience pregnancy and birth, and it is for this reason that I fully support LB527 and urge the committee to pass this into law. Thank you for your time and consideration.

**HALLSTROM:** Thank you. Any questions? Seeing none, thank you again. Mr. Nordquist.

**JEREMY NORDQUIST:** Good afternoon, Senator Hallstrom, members of the Banking, Commerce and Insurance Committee. My name is Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t. I'm the president of the Nebraska Hospital Association, here to testify in support of LB527 on behalf of our association's 92 member hospitals. The NHA is thankful again to Senator Jacobson for his leadership on working to address, to address inadequate Medicaid reimbursement rates. As he mentioned, LB1087 last year was to increase hospital reimbursement rates, trying to get them closer to cost to help stabilize the financial picture of our rural hospitals. And since enactment, we've had a great working partnership with DHHS, and we're optimistic that final approval for that program is, is on the horizon at CMS, Medicaid is a cornerstone

of healthcare in Nebraska. I think some people maybe underestimate its role. Medicaid pays for-- in our rural hospitals-- for 33% of births, 43% of behavioral health visits, and 44% of pediatric care. While hospitals must care for all patients in need of emergency care regardless of their ability to pay, not all private physical healthcare providers have to do that. That's why it's really important for us to have fair reimbursement rates that keep those private providers appropriately incentivized to care for all Nebraskans, including those on Medicaid. And it's important to note, with this bill, we're not expanding eligibility for the program, the pool isn't getting any better. We're simply addressing ultimately, at the bottom line, the state and federal mix of who's going to pay for this. And we un-- unfortunately at-- really, until Governor Pillen's leadership, have been sitting on the sidelines there while, for the last 30 years, other states have been much more aggressive with these provider assessments. So that-- that's, that's what ultimately, LB527 boils down to. For the last 20 years, looked back at provide-- provider rate increases, and the average provider rate increase for hospitals and, and physician rates has only been about 1.6% a year when we know the growth of inflation and certainly the growth of healthcare inflation has been much higher than that. So that's what we're doing with LB527. It'll help ensure more Nebraskans have access to primary care, maternal care. It's focused on labor and delivery, preventative care, and rural access. And these investments will help provide necessary stability for Medicaid providers providing that, that primary and maternal healthcare. So thank you, again, to Senator Jacobson and to the committee for your attention on this issue. Be happy to take any questions. Thank you.

**HALLSTROM:** Any questions? Yes. Senator Dungan.

**DUNGAN:** Thank you, Vice Chair Hallstrom. Thank you for being here. We've heard from a lot of folks today, and I appreciate your testimony. So just big picture, this bill is sort of predicated on getting these federal funds, right.

**JEREMY NORDQUIST:** Yeah. Yeah.

**DUNGAN:** That's kind of the whole point of this. Suffice to say, the last 7 days with regards to federal funds going to states have been tumultuous.

**JEREMY NORDQUIST:** Yeah.

**DUNGAN:** What happens if Medicaid just stops and we implement this program?

**JEREMY NORDQUIST:** Yeah, I would say we're in no worse position than would-- we would be if we didn't receive the funds. Now, I'll just say, NHA has for the first time hired a federal lobbying firm to be actively engaged in this. So I'm getting daily updates on what's going on on Capitol Hill. And there are so many states, especially in the southeast, that rely on these programs to basically fund their entire Medicaid program. They don't do a lot of general funds there. Please don't get any ideas about that. But Congress could not pull the rug out from these programs without Medicaid across the country collapsing. So what is as of the last 24 hours, we're hearing that what some Republicans on Capitol Hill related to these programs is maybe over the course of a couple of years, phasing it down from a 6% cap on the tax down to a 5%, ratcheting them down. There may be other Medicaid cuts that certainly will be considered. They're looking at work requirements, some other things. But I don't think we're going to see as big of a shake up in Medicaid as some have projected when the administration turned. I think there may be some pullback, but hopefully we're able to make the case for why programs like this are important.

**DUNGAN:** And even taking a step back from whether or not Medicaid itself is going to continue to exist in its current iteration. I understand there's been some assurances about that. Do you have any concerns about the functioning of a program like this if there were to be the re-implementation of the freeze on federal grants or anything like-- I mean, what would the effect be if that executive order were to go into effect, or would it have an effect?

**JEREMY NORDQUIST:** Yeah. So they, they quickly clarified after that initial order that Medicaid-- it wasn't clear at first, the order said Social Security and Medicare. Then they came back and said Medicaid is, is good. Over the weekend, President Trump said he's going to love and cherish Medicaid. So for what that means in implementation, I'm not sure. But we are watching it. I mean, that first day when there was chaos, they did shut down the Medicaid payment processing system in the state. We were in contact with DHHS and it was back up within 12 hours or so. But had that continued, that would have spelled disaster for healthcare providers that they couldn't have got paid in a timely manner.

**DUNGAN:** OK. I just want to make sure we're being cognizant of sort of the national landscape as we--

**JEREMY NORDQUIST:** Yeah.

**DUNGAN:** --implement programs that are reliant on it. But I appreciate that. Thank you.

**HALLSTROM:** Any other questions? Did, did you want to do an imitation of love and cherish?

**JEREMY NORDQUIST:** No. I'm going to leave it at that.

**HALLSTROM:** Thank you.

**JEREMY NORDQUIST:** Thank you.

**HALLSTROM:** Any other proponents? Are there any opponents? Anyone in a neutral capacity? Mr. Bell.

**ROBERT M. BELL:** Good afternoon. Senator Hallstrom-- Vice Chairperson Hallstrom, excuse me-- 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, and I am appearing before you today neutrally on LB527. And I don't have a ton to say, so you get my spiel on the insurance industry right away, so maybe I don't have to do this on every ballot. Testify on. But the Nebraska Insurance Federation is the primary trade association of insurance companies in Nebraska. The federation consists of 49 member companies and 9 association members. Members write all lines of insurance, including health insurance and including HMOs. Nebraska insurers provide high-value, quality healthcare products to Nebraskans that provide financial protections to Nebraskans during difficult times. Insurance companies also have a significant impact on the Nebraska economy. By any measurement, Nebraska's insurance industry is one of the largest in the nation. According to a study recently completed by the University of Nebraska-Lincoln Bureau of Business Research, the insurance industry had a $25.77 billion impact on the Nebraska economy in 2022, including providing over 32,000 jobs to Nebraskans. The average wage for a Nebraskan working for an insurance company is nearly $92,000 annually. The federa-- federation members have been aware of this proposal since late December, and we thought it would be strange for the-- or unusual for the federation not to comment on, on a premium tax increase for our health maintenance organizations. Certainly, we understand the

goals of the healthcare providers in the state of Nebraska and do not wish to stand in the way and want to be a partner. Just a few finer, fine-- minor comments. The federation understands that the amendment that we passed out includes removal of the provisions related to the life and health guarantee-- Life and Health Insurance Guaranty Association, Association Act. We do support the removal of those provisions from this bill. Also, as our review continues, and it does continue, if insurers find any other technical fixes, those will certainly be brought to the attention of both the supporters and Senator Jacobson. And so, the Nebraska Insurance Federation is neutral on LB527, and I appreciate the opportunity to testify.

**HALLSTROM:** Any questions from the committee? Seeing none, thank you, Mr. Bell.

**ROBERT M. BELL:** You're welcome.

**JACOBSON:** Before Senator Jacobson comes back up, we have, on LB527, 58 proponent letters, 1 opponent letter, none in the neutral capacity, and no ADA testimony.

**JACOBSON:** I hate that Senator Bostar left, because I was going to tell him that his question was so simple that I deferred it to DHHS to answer. So-- but as you know, on most fiscal notes, it is a path towards the end and there's a lot of turns along the way. Senators-- met with Senator Clements earlier today. And just to give you an example on how some of this works, he was showing me the, the increases that we've got in terms of tax receipts and where we're sitting today. And one of the big increases was pass-through entity tax. Well, we know that the pass-through entity tax is a tax that comes in and goes back out. OK. We're just holding the money for a while, but yet it is in the dollars that are shown to close the deficit at this point. So understanding all of the, the accounting for how the state operates is a little bit like understanding federal government math. I kind of go back to math that balances, and so all the numbers have to kind of balance at the end. And I was having a little trouble making a balance as Senator Bostar was. But, but trust me, it does get to that point. And the number of $117 million is the number that the governor has put into the 2026 budget. So no pressure on me to deliver the bill, but the governor's counting on $117 million, just so you know. So with that, I'd answer any questions you might have. Am I dismissed?

**HALLSTROM:** Any questions? Thank you.

**JACOBSON:** Thank you.

**HALLSTROM:** That concludes the hearing on LB527. I will turn the chair back over to Chairman Jacobson.

**JACOBSON:** All right. Well, I think we're trying to open the public hearing for LB168. So Senator Hardin, you're welcome to open.

**HARDIN:** Thank you, Chair Jacobson. And good afternoon, fellow senators of the Banking, Commerce and Insurance Committee. I'm Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB168, which seeks to protect access to the 340B Community Benefits Program for eligible safety net healthcare providers in our state. The 340B Community Benefits Program was created in Congress in 1992, permitting certain safety net providers including critical access hospitals and federally qualified health centers to purchase certain outpatient medications from drug manufacturers at a discounted price. The program's purpose is to invest those savings into expanding services for underserved communities. Savings from the 340B program help our Nebraska hospitals provide more comprehensive care for underserved patients. They invest these savings back into the communities by not only providing direct financial assistance to patients, but also by increasing access to services such as nursing homes, behavioral health programs, transportation services, urgent care, oncology, community health education and outreach, and home health services, for just a few examples. Most importantly, the savings can literally keep the doors open for some struggling rural hospitals. For example, the role that 340B plays in my local hospital, Regional West Medical Center in Scottsbluff, a hospital that has had challenges over the recent years, is 6% of their bottom line. If we were to remove that 6% right now when they are hanging on by their fingernails, it would be devastating to the 1,100-plus hospital jobs, which is the largest employer in our area. It's very important. Two things are important to note about the 340B program. The discount is paid by drug manufacturers, with no state tax or federal tax dollars, and as required by Congress. Drug manufacturers are required to provide the 340B discount to eligible entities in exchange for their participation in Medicaid and Medicare. Let me read that again-- 340B discount to eligible entities in exchange for their participation in Medicaid and Medicare. So you may be asking yourself if 340B is a federal program, why do we need to pass a state law? For decades, drug manufacturers had provided 340B drug discount pricing to eligible entities for drug dispensed both

through in-house pharmacies and community pharmacies contracted with these entities. But in 2020, many PhRMA members broke with decades of precedent and began to restrict contract pharmacy access, ignoring federal law and selfishly pocketing additional billions of dollars each year, while hurting the nation's safety net. This bill would prohibit a drug manufacturer from directly or indirectly denying, restricting, or otherwise interfering with the acquisition of a 340B drug or delivery of such a drug to any pharmacy that is under contract with a 340B entity to distribute those drugs to eligible patients. In August of last year, Johnson and Johnson announced that they would make some discounts on 340B drugs through a rebate. Hospitals would be able to buy these drugs at wholesale or acquisition cost and submit rebate claims data after dispensing or administration of those drugs to eligible patients. Due to the denouncing of the new rebate model by the Health Resources and Services Administration, HRSA, and pressures from congressional members, Johnson and Johnson ceased implementation of that rebate model process for now. LB168 includes language that would not allow the usage of the rebate model on 340B drugs. The rebate model would be an additional administrative burden that most likely would cause several rural hospitals to discontinue their 340B program. While the 340B drug discount program is a federal program, states are leading the way in safeguarding access by exercising state level authority to regulate the delivery of healthcare. LB168 does not seek to change the federal 340B program. It can't. It simply seeks to regulate the delivery of drugs from a manufacturer or wholesaler to a contract pharmacy. Arkansas passed the first law prohibiting manufacturers from imposing certain restrictions on contract pharmacy arrangements in 2021. Since then, 8 states have passed laws. And just this year, 10 more states introduced legislation similar to LB168. Since the law's passage, several manufacturers have lifted or eased their restrictions for covered entities in those states. Opponents may allege that this legislation will be caught up in the courts. However, this bill is similar to Arkansas' legislation, which has been upheld. The U.S. District Court for the Eastern District of Arkansas upheld the law against legal challenge from the PhRMA on December 12, 2022. The U.S. Eighth Circuit Court of Appeals, which is in the same judicial district as Nebraska, upheld the ruling in a legal challenge from PhRMA on March 12, 2024, PhRMA appealed to the U.S. Supreme Court. And on December 10, 2024, the U.S. Supreme Court declined to hear PhRMA's appeal, upholding the Eighth Circuit's ruling. Opponents may allege that this is a federal issue that should be addressed by Congress, but we know that every single day a law like LB168 is not in place, safety net healthcare providers are losing benefits that help

their communities and their patients, or being forced to close their doors. Although opponents may try to complicate this issue, it's simple. Support for this bill helps our local community hospitals, our local pharmacies, and safety net healthcare providers. Support for LB168 helps Nebraskans. Opposition helps out-of-state drug manufacturers hold on to more profits and raises the cost of drugs for Nebraska providers and patients. According to the Nebraska Hospital Association, 54% of all critical access hospitals are currently operating at a loss, with many of them at risk of closing. At the same time, some of the largest drug manufacturers increased their revenue in the same period by over 20%. Nationally, the average profit margin for the largest drug makers for the first 9 months of 2023 was 17.4%. On the other hand, our safety net healthcare providers depend on this program to stretch their scarce resources and meet the needs of their patients. One more thing to keep in mind, while the Legislature is tackling a significant budget shortfall, the Nebraska Department of Corrections testified last year during the special session that they started utilizing the 340B program and anticipated savings of $300,000 to $500,000 per year. During a year where we're trying to find every penny for the state General Fund couch cushions, LB168 has a large impact. I want to thank a bipartisan group of senators representing both urban and rural areas who have signed on as co-sponsors of this legislation. There's at least 1 hospital participating in the 340B drug program in 24 different legislative districts, many districts having 3 or more hospitals participating. It's of the utmost importance that we protect patients' access to healthcare services, and LB168 offers those protections. If you have complicated questions, please save them for the people behind me. If you have any easy softballs, please give those to me now.

**JACOBSON:** All right. Questions for Senator Hardin? Yes, Senator von Gillern.

**von GILLERN:** I got an easy softball I'm going to toss you.

**HARDIN:** Nice.

**von GILLERN:** This is basically a buy low, sell high, we apply the difference to the bottom line to help keep hospitals afloat.

**HARDIN:** Right.

**von GILLERN:** Correct?

**HARDIN:** Yes.

**von GILLERN:** And it's important-- you and I have had a conversation about this. It's important in your area just be-- simply because rural hospitals struggle harder than metro hospitals for a lot of reasons. But--

**HARDIN:** Yes.

**von GILLERN:** And I know this is critically important to you in your area. Is, is, is it as important to hospitals in urban areas, in your opinion?

**HARDIN:** It is.

**von GILLERN:** In--

**HARDIN:** Boys Town, UNMC, so on and so forth.

**von GILLERN:** I'm aware it contributes substantially to their bottom line.

**HARDIN:** It does.

**von GILLERN:** Yeah.

**HARDIN:** You know, what's frustrating and--

**von GILLERN:** I've had conversations with them, too.

**HARDIN:** And I, and I, I commend both those coming in support and those coming in opp-- in opposition. Because the frustrating thing is-- it's like being a firefighter and hanging on to that big heavy hose and you're in the middle of the hose. You're not directing where that water is going, and yet, you're getting thrashed around by the hose. Congress has to change this. And those ruts in the road belong in Washington, D.C. And of course, we haven't been able to get a farm bill done in several years, so I think this is somewhere way down the list for them. And so we kind of end up continuing to inherit year after year, since 1992, a lot of these ruts in the road. And so it makes it hard for everybody.

**von GILLERN:** So that, that would be my followup question. If Congress were to you know, quote unquote, fix this--

**HARDIN:** Yeah.

**von GILLERN:** --what is the fix, and what impact would that have on urban and rural hospitals?

**HARDIN:** That would remain to be seen, based on the specifics of what their fix would be. But, for example, since 1992, a lot of things in the industry have shifted. We kind of talked about it a little bit earlier, but part of it has to do with the fact that no one could have imagined. One of my own clients-- I work in the healthcare space-- one of my own clients ended up with a $2 million prescription bill for one person in one year. And that was something that in 1992 was absolutely unfathomable. And so prescription drugs, when you, you see any commercial on TV and it's a slick ad on TV and it's not an over-the-counter medicine, that's probably what's called a Tier 4 medicine. Those are about $260,000 a year with the Red Book retail value of those drugs. None of us in this room can afford that. And so, how do you get those costs lower? Well, there's all of these complicated machinations that take place, from drug rebates and so on and so forth. We've kind of zigged and zagged over the decades, but we have a very complex and very thorny, difficult-to-follow system that really has very few checks and balances along the way. And so, I would hope that whatever they would come up with, with a repair for this from Congress would take some of those considerations in mind or frankly, just make it simpler.

**von GILLERN:** Thank you.

**JACOBSON:** Senator Riepe.

**RIEPE:** Thank you, Chairman. My observation is, having been around for a while, is that I look at the brand line that runs down Nebraska, east-west kinds of things, and it seems to me that everything is west is now considered a desert, regardless of the service-- pharmacy, maternal, primary care, nursing, everything up and down the line. The other problem that I have is and where I'm going to be really resistant is in Section 3(2). And I'll give you a chance to respond to this.

**HARDIN:** Yeah.

**RIEPE:** It's a, a total avoidance of transparency. And you know, if there's great windfall profit to everyone involved, so be it. But you have to have transparency as far as I'm concerned, if you're going to do it. I won't, I won't participate in hiding-- as it says in here,

"shall not." And the "shall not" in terms of reporting is unacceptable to me. So you can respond, tell me I'm crazy as a dog.

**HARDIN:** No, you and I talked about this a little bit. And I think it has to do--

**RIEPE:** And I think there's an amendment.

**HARDIN:** This, this is a little bit like a, a marriage counseling experience that we're going to have, on both sides here, together.

**RIEPE:** Not you and me.

**HARDIN:** Not you and me. But it's, it's a-- do, do we trust one another? And I think the data is one of the issues that they have a concern with, in part.

**RIEPE:** Trust and verify.

**HARDIN:** Well, yeah. Trust your neighbors, lock your doors. And so I think we're going to have some challenges from those coming behind me, talking about, gee, what might happen with that transparency? Is the transparency a portal into misuse of data on the part of someone that we don't trust? And so, the same thing can be accused from the other side. We have lots of things to work out with this, because this is one of those things that knocks over lots of dominoes, undoubtedly.

**RIEPE:** All we hear in government from the public is we want transparency. We want transparency, over and over and over. If we don't give it to them, then we are part of the problem.

**HARDIN:** Indeed.

**RIEPE:** OK. Thank you. Thank you for being here. Thank you, sir.

**JACOBSON:** Senator Hallstrom.

**HALLSTROM:** Aren't those provisions only related to the nondisclosure as a condition to participating in the program?

**HARDIN:** What Senator Riepe was--

**HALLSTROM:** Yes.

**HARDIN:** --just referring to? I believe you're correct.

**HALLSTROM:** OK. Thank you.

**JACOBSON:** Further questions? I just have one. I-- as I look at this program, you've got the pharmaceutical manufacturers who are offering this substantial discount so that these critical access hospitals-- and UNMC is a big recipient, as well, which brings us into the metro side, because they serve so many people across the state. So that-- they're, they're doing this program so that these funds can go to these hospitals to help keep those hospital doors open and make this work. So then let's talk about PBMs and where they might get in the middle of this, in terms of contract pharmacies. And I, I-- it seems to me if I'm a pharmaceutical manufacturer, I want to make sure if I'm going to give this product at-- away at cost, basically.

**HARDIN:** Well, it's a discount. It's not given away.

**JACOBSON:** But it's, but it's, it's, it's an acquisition cost, if I'm not mistaken.

**HARDIN:** It is. But also, let me frame that with part of what I mentioned earlier in my, in my speech, which is that what this also gains for the pharmaceutical manufacturers is access to Medicare and Medicaid.

**JACOBSON:** Correct. Yeah.

**HARDIN:** It's not like it's happening without any benefit to them.

**JACOBSON:** And my-- but my point is, is not that. My-- I'm not willing to give-- I'm not ready to go out and put, you know, awards for pharmaceutical manufacturers. They, they do OK.

**HARDIN:** Sure.

**JACOBSON:** But it seems to be--

**HARDIN:** And I'm a capitalist.

**JACOBSON:** But it seems to me they're trying to get the dollars to the place they're supposed to be with as few people in the middle taking from it. And so, I guess I raise the question more with do you see an avenue here where PBMs could be exempt from being able to play in this program?

**HARDIN:** You know, it's very hard to live with PBMs, and it's very hard to live without PBMs, pharmacy benefits managers. Somehow-- and I think this is a part of, back to Senator van-- von Gillern's question. This is part of what has to be covered with Congress, because all of this has evolved to a point where most of them did not anticipate it might in 1992. Probably, in 1992, they didn't think it would go this long unchecked. They would have thought they would have remodeled the house by now. And so I think that, once again, I hate to defer it, but I think you're pointing on-- to a-- an issue that also needs a lot of attention within the reform.

**JACOBSON:** Well, I'm anxious to hear the rest of the testifiers. I'm glad you brought the bill back. I think it's an important bill, clearly makes a difference for critical access hospitals and that's why I've been largely supportive of, of the 340B program. I'm anxious to see if there are some things we can do to make it even better while we're trying to move it forward this year, so that's the reason for the question.

**HARDIN:** Right. You bet. I know that there are amendments coming and, and looks like there's some good ones in the stack.

**JACOBSON:** Yeah. Thank you. Yes, Senator Hallstrom.

**HALLSTROM:** Senator Hardin, I was just going to suggest that I'm very supportive of making sure that we have suitable access to rural healthcare, which means both our rural hospitals and our community pharmacies. So I-- I'm interested in determining along the lines of what Senator Jacobson has commented on, that we have a way to perhaps exclude pharmacies that are affiliated with PBMs from being involved in this, to the extent that they're causing problems for the manufacturers and the 340B discount program.

**HARDIN:** Sometimes PBM is a 4-letter word. So.

**JACOBSON:** Any other questions? If not, you got off easy. Thank you. You'll be sticking around for the close?

**HARDIN:** I shall.

**JACOBSON:** Proponents for LB168 point. Welcome.

**OLIVIA LITTLE:** Thank you, Chairperson Jacobson and committee. I appreciate the opportunity to testify before you today. My name is Olivia Little, O-l-i-v-i-a L-i-t-t-l-e. I'm here today on behalf of

Johnson County Hospital and the Nebraska Rural Health Association. And I am here in support of LB160H [SIC], which would prohibit certain actions relating to the distribution of drugs by 340B entities and collection of data by manufacturers. Johnson County Hospital is an 18-bed critical access hospital. We also have a rural health clinic in Tecumseh, Nebraska, and we extend into Gage County with a rural health clinic. Johnson County Hospital participates in the 340B program. This program requires manufacturers to provide outpatient drugs to safety net providers at a discounted price so that safety net providers can stretch resources, reaching more eligible patients and providing more comprehensive services. This program does not cost taxpayers money, as the discount on drugs come from the manufacturers. In Nebraska, 67 hospitals participate in the 340B program, including 94% of Nebraska's critical access hospitals. This is a program that is not utilized by a few, but by many. Critical access hospitals in Nebraska are operating on razor thin margins, with 54% operating a loss. In fiscal year '23-24, Johnson County Hospital had a $1 million loss, and that was after our $831,000 from our 340B benefit. So without it, we'd have been at a negative $1.8 million. Critical access hospitals operate on very thin margins while supporting needed services in our communities that even operated at a loss. The 340B program enables us to fund these services like our home health program. We lost $286,000. We started an EMS service. We lost $427,000. The home health program allows people to stay in their homes longer. There are no nursing homes, no assisted living facilities in Johnson County Hospital-- in-- excuse me-- in Johnson County. So by keeping these patients in their own homes, that's a saver to taxpayers as well. You know, once you hit the nursing home, you sell the family farm, and now you're on Medicaid and the taxpayers are paying for you. It also allowed us to have an EMS service. When we have wait times of 4 hours when you're having a heart attack in the hospital, so we have to call a helicopter, which isn't necessary. It's an overburden to the helicopters, it's unnecessary use of resources, but you have to get them out of their door. We started an EMS service and we're servicing several counties around us. Our 340B benefit was also used to fund many community benefits, including subsidized in emergency and trauma care, charity care, free monthly blood pressure checks, and community education, to name a few. And part of this benefit comes with the 340B contract relationships with our local retail pharmacies. This program allows these retail pharmacies to keep their doors open. In 2019 before these manufacturers' restrictions began, the 340B program brought in over 15% of our hospital's revenue. In 2024, with 37 manufacturers having restrictions in place, it brought in just over 8% of our total

revenue. This decreased revenue will continue if something is not done to stop these manufacturer restrictions. In addition to the manufacturer restrictions, they are now wanting to impose a rebate model which would lead to even more loss of revenue and increased expenses and administrative burden. We encourage you to the, the committee to advance LB168 in order to stop these manufacturer restrictions, and we thank Senator Hardin for introducing this bill. I'm happy to answer any questions you have.

**JACOBSON:** Questions from the committee? Senator Riepe.

**RIEPE:** Thank you, Chairman. My question is one of curiosity. How did Johnson County recover from the $1 million, followed by 286 and 427?

**OLIVIA LITTLE:** On there-- the 400--

**RIEPE:** Do you have-- well how, well how do you recover from that?

**OLIVIA LITTLE:** We have cash in the bank. We are not on our county tax rolls. We have been very fiscally responsible.

**RIEPE:** So we've had reserves.

**OLIVIA LITTLE:** Some cash reserves in there. Yep.

**RIEPE:** OK. I was just--

**OLIVIA LITTLE:** We've been trying.

**RIEPE:** I was just curious whether you had a [INAUDIBLE].

**OLIVIA LITTLE:** We had a lot of expenses this year. We had to upgrade our robotic system. As you know, you have to have a lot of outpatient services because that's where your percentage of revenue comes from and you just have to invest money. And like I said, we're using some of these funds. There is no home health service around us. We have no nursing homes. Our families are getting transported to urban areas and we don't see them in their last years.

**RIEPE:** OK.

**OLIVIA LITTLE:** And so we're-- as a critical access hospital, you're serving whatever you can do in your community.

**RIEPE:** I thought maybe the local banker had made up the difference. Oh, excuse me.

**JACOBSON:** Senator Dungan.

**DUNGAN:** Thank you, Chair Jacobson. Thank you for being--

**JACOBSON:** Tried to clear my throat over that last [INAUDIBLE].

**DUNGAN:** Got you choked up there. Thank you for being here. I appreciate that. Similar to Senator Riepe's question, I guess, of Senator Hardin, can you speak to that Section 3, subparagraph (2)? I, I think that is the rebate portion, I think that's different than what we've had in the past--

**OLIVIA LITTLE:** Yes.

**DUNGAN:** --in this legislation. Can you extrapolate a little bit more into why that's necessary or why it's there?

**OLIVIA LITTLE:** So what they're wanting us to do is not just trans-- it's not a transparency. They're wanting us to submit medical data so they can determine if they think that transaction that got filled, that prescription that got filled at the contract pharmacy or for a patient we gave in house, is 340B-eligible. They want us to submit your medical data to the manufacturer. They want us to submit your HCPCS codes. What was your diagnosis? What was your CPT code? How do you feel about your medical data going to the manufacturer? And they are determining whether that drug qualifies for 340B. Then they're going to turn around and tell us if they think it does. And if they say no, really, what's our recourse? And it's a huge administrative burden. We have to put up the money ahead of time to buy the drug ahead of time for a contract pharmacy, because I really can predict, you know, how many people are going to come in and fill a drug 20 miles away from me. And so we have to front the cost on that, and so that's money out of the bank that we're just waiting if we get a rebate or not, that they are requiring a lot of data to be submitted, including a lot of medical data, not just financial transparency.

**DUNGAN:** So that's currently allowed under the system and this would prohibit them from requiring that?

**OLIVIA LITTLE:** So, no, it is not currently allowed. Actually, in the statute, they're supposed to go to HRSA if they would want to request a rebate model. And HRSA has denied every manufacturer that has tried that, and so now they're all suing them.

**DUNGAN:** Got it. Thank you.

**JACOBSON:** Other questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. Can you clarify a little bit, because it sounded like you're-- correct me if I'm wrong here-- that you're playing that it's a HIPAA violation, bec-- that you would not have to provide them with specific names, per say. You have to submit them with diagnoses and, and that kind of debt, but not, not the patient's name, I assume.

**OLIVIA LITTLE:** Not the patient's name.

**RIEPE:** Thank you.

**OLIVIA LITTLE:** But if you look at contract pharmacy prescriptions, it goes debatable if you have to provide them a prescription number, if that is considered HIPAA, just like a patient's medical record number is, because it's--

**RIEPE:** Really?

**OLIVIA LITTLE:** --patient identifiable.

**RIEPE:** OK. Thank you. Thank you, Chairman.

**JACOBSON:** Senator Hallstrom.

**HALLSTROM:** Thank you for being here today. Your hospital does not have an in-hospital pharmacy. Is that correct?

**OLIVIA LITTLE:** That is correct. We do not have an in-house retail pharmacy.

**HALLSTROM:** How many contract pharmacies do you have arrangements with?

**OLIVIA LITTLE:** We have 3.

**HALLSTROM:** And, and where are they located?

**OLIVIA LITTLE:** There are 2 in Tecumseh. I think there's one door in between them on the downtown square. And one is in Adams, Nebraska, since we had a rural health clinic there. They share a same building.

**HALLSTROM:** OK. Thank you.

**JACOBSON:** And I would-- I am assuming that because of that, you're not-- Walgreens, Wal-Mart, or CVS are not one of your contract pharmacies?

**OLIVIA LITTLE:** That is correct. We are not in a geographic location that has those. And when you contract with a pharmacy, you want to make sure you have a good capture rate here where your patients are getting their prescriptions filled.

**JACOBSON:** Exactly.

**OLIVIA LITTLE:** And a lot of ours do stay local.

**JACOBSON:** Great. Thank you. Any other questions? Senator Riepe.

**RIEPE:** Thank you, Chair. Do you have any mail order?

**OLIVIA LITTLE:** So the pharmacies themselves-- we are not contract with the specialty pharmacy.

**RIEPE:** In the community, though?

**OLIVIA LITTLE:** With the community, they will-- if you call the local pharmacy and you can't get to town, they--

**RIEPE:** OK.

**OLIVIA LITTLE:** --deliver to your door and they will mail it to you.

**RIEPE:** Do you have a substantial level of Medicaid or Medicare Advantage, as well? That's-- can be a problem?

**OLIVIA LITTLE:** I can't speak to the contract pharmacies on their level of Medicare Advantage.

**RIEPE:** I'm just thinking in, in, in the hospital , though, in Johnson.

**OLIVIA LITTLE:** In the hospital, I think we're at 10--

**RIEPE:** I'm not-- you know, just kind of yes-- yes, we do or no, we don't.

**OLIVIA LITTLE:** 5%.

**RIEPE:** 5? OK. OK. So your payer mix is not--

**OLIVIA LITTLE:** 5% by the amount of patients that come in and 12% based on revenue.

**RIEPE:** And, and growing? You said--

**OLIVIA LITTLE:** And growing. And growing.

**RIEPE:** And growing. OK. Thank you, Chairman.

**JACOBSON:** To be clear on that last question, with your, with your MA patients, those negotiated rates are significantly lower than Medicare and Medicaid. Is that correct?

**OLIVIA LITTLE:** I would have to defer to my CFO on that.

**JACOBSON:** I'm pretty certain they are. So.

**OLIVIA LITTLE:** I would imagine.

**JACOBSON:** That's gotta be a bigger problem as you move forward, in terms of how you make the bottom line work. So, thank you. Any other questions? We worked you over pretty good.

**OLIVIA LITTLE:** I can talk all day about this subject.

**JACOBSON:** Thank you for your testimony today.

**OLIVIA LITTLE:** Thank you.

**JACOBSON:** I would ask for any other proponents. Welcome.

**DAN DeFREECE:** Thank you. Chairperson Jacobson and members of the Banking and Commerce and Insurance Committee, my name is Dr. Dan DeFreece. That is spelled D-a-n D-e-F-r-e-e-c-e, and I currently serve as the president of CHI Health St. Mary's in Nebraska City, an 18-bed critical access hospital that participates in the 340B program. I would like to thank Senator Hardin for introducing LB168, which protects our patients' ability to get the medication they need in their community by prohibiting pharmaceutical manufacturers' efforts to impose conditions of participation so onerous that they effectively severely restrict our participation in the program. The 340B drug discount program is an essential source of support for rural hospitals and local pharmacies. In 2010, Congress extended the 340B eligibility to many rural hospitals to help them provide care in their communities and remain open. Yet, the 340B program relies on fair and compliant

action by both providers and the manufacturers who sell the 340B discounted drugs. Unfortunately, pharmaceutical manufacturers have broken the agreement and violated the letter and spirit of the 340B statute. Over the years, pharmaceutical manufacturers have imposed various restrictions to limit participation in the 340B program. These tactics include limiting the number of contract pharmacies we can access 340B drugs from, prohibiting drug shipments to contract pharmacies, which can mean patients have to travel outside our community to access their medication or even delay initiation of treatment, and 3, requiring extensive data from being-- participating hospitals in order to acquire 340B drugs, which adds unnecessary administrative burden and delay. Ultimately, patients bear the biggest brunt of this. And meanwhile, the pharmaceutical man-- manufacturers are posting the exorbitant profits. More than half of the 340B hospitals are rural providers. And since 2010, more than 130 rural hospitals nationally have closed, and more than 1 in 4 are struggling to stay open. More than half of rural hospitals report cuts to the 340B that could force them to close. 39 of 71 rural Nebraska hospitals have a 2% or less operating margin, and 29 rural hospitals experience negative margins. In closing, I urge the Committee to support LB168 and protect the 340B program for patients in our critical access hospitals who depend on it. I'll be happy to answer any questions the committee may have.

**JACOBSON:** Questions from the committee? Senator Riepe.

**RIEPE:** Thank you, Chairman. I'm looking for clarification here. Would you tell me, what's your doctorate in?

**DAN DeFREECE:** I'm a family physician.

**RIEPE:** You are a family physician?

**DAN DeFREECE:** I am.

**RIEPE:** Are you any relationship to Mike DeFreece?

**DAN DeFREECE:** Yes. Cousin. Kind of distant cousin.

**RIEPE:** OK. He was a college roommate. I, I thought maybe you were his son. That's why I was--

**DAN DeFREECE:** That's a good, easy question. Thanks.

**RIEPE:** That's all I give, is easy questions. Thank you.

**JACOBSON:** Other questions from the committee? All right. Seeing none-- oh, yes. Senator Hallstrom.

**HALLSTROM:** I just wanted to thank you being the second consecutive testifier from Legislative District 1. So thank you.

**DAN DeFREECE:** Thank you, Senator.

**JACOBSON:** All right. Thank you for your testimony.

**DAN DeFREECE:** Thank you.

**JACOBSON:** Further proponents? Mr. Nordquist, welcome.

**JEREMY NORDQUIST:** Thank you, Mr. Chairman and members of the Banking Committee. I am Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t, president of the Nebraska Hospital Association, representing our 92 member hospitals. We have a lot more people to come yet to talk about the impacts in their hospitals, but I did want to take-- and typically, I wouldn't do this. But we have seen in the state and I've been-- had a few members of the committee bring to my attention some messaging that's out there, related to 340B. And I want to be crystal clear about this. The ads are from a East Coast organization. I've heard from other states that the money is tied to pharmaceutical industry. I haven't verified that. But whether it's pharma itself, the industry, a billionaire backer of the industry, whatever, the ads are asserting that Nebraska hospitals are using their 340B dollars to fund healthcare for undocumented immigrants and transgender healthcare. There is not a single program at a hospital-- in any hospital in our state that's dedicated to providing care to illegal immigrants or transgender healthcare with 340B dollars. I wanted to get that on the record. So if you all have questions about it, please approach us at the association. If your colleagues have questions about them, send them our way. But I just want to be crystal clear about that point. What that ad is doing is coming in, again, from an industry that's headquartered in New Jersey and California largely, and telling Nebraskans, hundreds of Nebraskans who sit on the boards of their local hospitals, that they're doing-- implying they're doing something nefarious with these dollars. And that's, that-- that's ridiculous. And I know Senator Jacobson spends a lot of his time on his hospital board and, and hundreds of other Nebraskans do, too. And it's shameful that those ads are being run in this state.

**JACOBSON:** In fairness, I've missed a few board meetings.

**JEREMY NORDQUIST:** That's all right.

**JACOBSON:** Questions? Senator Hallstrom.

**HALLSTROM:** Have we seen these tactics in other states?

**JEREMY NORDQUIST:** Yeah, actually. Yes, thank you for bringing that up. But pretty much every state this bill is passed in and every state it has been introduced in, including our neighboring states of Kansas and Missouri, that-- they ignored it and passed the bills. And, and those bills are now laws in those neighboring states. And the other thing about our state, like Kansas, Missouri, Iowa, we are pocket of the country here-- has some of the highest percentage-- we are some of the highest percentages in the country of independent critical access hospitals. We have a lot of hospitals that aren't part of a big system, that aren't part of for-profit hospital chains, that are out there running with their local boards. That's why 340B is so critical, like for Johnson County and other hospitals I hear from. And, and, and nonhospitals, as well.

**HALLSTROM:** If I may, one more.

**JACOBSON:** Go ahead.

**HALLSTROM:** In some of the letters that were submitted, there was one opposition from oncology and some other providers.

**JEREMY NORDQUIST:** Yeah.

**HALLSTROM:** Did you get a chance to look at that?

**JEREMY NORDQUIST:** I did. And I, I don't know what the process is for the Oncology Society. Any hospital you talk to that-- especially rural hospital that provides cancer care, 340B sometimes is their funding mechanism. So the fact they submitted that really caught us off guard. So I did happen to look on their website to see if there was anything about their policy process for how they oppose a bill. And it just so happens their, their top 10 platinum sponsors are all pharmaceutical companies. I don't know if that has any impact on it or not, but it's right on their website. So.

**HALLSTROM:** OK. Thank you. Since I asked you earlier about imitations, the crystal clear could have been Jack Nicholson.

**JEREMY NORDQUIST:** Thank you.

**HALLSTROM:** Thank you.

**JACOBSON:** Any other questions for Mr. Norquist? If not, thank you--

**JEREMY NORDQUIST:** Thank you.

**JACOBSON:** --for your testimony. Further proponents? Welcome.

**ELIZABETH BOALS-SHIVELY:** Thank you. Thank you for the opportunity to testify in favor of LB168. My name is Elizabeth Boals-Shively, E-l-i-z-a-b-e-t-h B-o-a-l-s-S-h-i-v-e-l-y. Promise every year to make it shorter. It never happens. I'm a pharmacist at a 13-bed critical access hospital in Henderson, Nebraska. In relation to the 340B program and LB168, we have a contract pharmacy with the local Henderson pharmacy, as well as a single Walgreens pharmacy in York, Nebraska. The savings generated from our 340B program are being used in accordance with the original 340B reg-- legislation, which does include more than just charity care. I provided you a copy of our 340B impact statement. It shows you how we are utilizing our savings for transparency. However, not on that statement that you are missing is that that total savings number is a 37% reduction from 2023. So in one year, our savings has reduced by almost 40%, almost exclusively due to the manufacturer restrictions that are in place. These reduced savings dollars definitely played a factor when we had to make the hard decision to discontinue our labor and delivery services at my facility. We're having to really monitor our long-term care Medicaid to private pay ratios. As you'll see, a large chunk of our savings is utilized for uncompensated care from Medicaid. We also have a very significant concern that if the savings continue to be reduced, our local pharmacy will be forced to close. Our program really does understand the importance of program compliance and transparency to ensure that this program continues to be viable for everyone. To be fair, HRSA does hundreds of audits every year on several facilities. And if those aren't enough, they make us do self-audits on top of that. We can get fines for not self-auditing. They highly encourage us to have an external audit that's independent. We have one that's done 4 times a year. And if that isn't enough, the manufacturers do have a process through HRSA that they can request an audit if they think we're having duplicate discounts or significant diversion. As far as the transparency piece, I'm sharing with you our savings dollars and where they're going, but we're worried that the transparency that they're asking for is really just to create hoops to prevent us from accessing the program, not really transparency to prove where our savings dollars are going, just trying to make the program really

tedious. The current reality is that without LB168, manufacturers are going to continue to limit access to 340B pricing for contract pharmacies. And this data submission requirements are tedious at best and impossible at worst. And the rising administrative burden is making the program really not viable for a lot of critical access hospitals like mine. Thank you for your time today. I encourage you to advance LB168 to the General File. I'm happy to answer any questions.

**JACOBSON:** Thank you. Questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. Last session, along with the help of now Senator Hallstrom, we did pass a bill that increased the funding for Medicaid for pharmacists, from $3 and some prescription up to $10.38.

**ELIZABETH BOALS-SHIVELY:** Yeah.

**RIEPE:** And yet, it's talked here about trying to keep the doors open on the pharmacies. Is this a delayed response or-- I mean--

**ELIZABETH BOALS-SHIVELY:** Part of it is.

**RIEPE:** --we thought we, we thought we had them covered on the--

**ELIZABETH BOALS-SHIVELY:** For, for Medicaid, I can't speak for that. I mean, maybe we covered that.

**RIEPE:** But isn't that a big percentage of your business?

**ELIZABETH BOALS-SHIVELY:** Probably-- for the-- I can't speak for the contract-- for their pharmacy side. I don't-- we don't own it. It's not in-house. That's-- their finances are separate. For my hospital, Medicare/Medicaid makes up about 50%, 55%.

**RIEPE:** 50? Medicare or Medicaid?

**ELIZABETH BOALS-SHIVELY:** Together.

**RIEPE:** Yeah, that's normal.

**ELIZABETH BOALS-SHIVELY:** So that's 55%. So they're still struggling with regular PBMs and commercial payers, reimbursing them appropriately, as well. That's in a separate bill and a separate issue.

**RIEPE:** Does Medicare pay equally as well as Medicaid, at $10.38 per, per prescription, yeah.

**ELIZABETH BOALS-SHIVELY:** For contract or for hospital? I couldn't speak--

**RIEPE:** Maybe-- OK.

**ELIZABETH BOALS-SHIVELY:** I'm not-- I've-- there's probably someone better.

**RIEPE:** That's fair. OK.

**ELIZABETH BOALS-SHIVELY:** I'm not-- I haven't worked for a retail pharmacy--

**RIEPE:** OK.

**ELIZABETH BOALS-SHIVELY:** --in several years.

**RIEPE:** OK. Thank you, Chairman. Thank you.

**JACOBSON:** Thank you. Other questions? If not, thank you for your testimony.

**ELIZABETH BOALS-SHIVELY:** OK.

**JACOBSON:** Further proponents? Welcome.

**BRYCE BETKE:** Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Bryce Betke, B-r-y-c-e B-e-t-k-e. I am the CFO of ruralMED Management Resources, andI have been involved with the 340B program in critical access hospitals since 2012. I'm here today in support of LB168. The 340B drug pricing program has been vital to the financial sustainability of rural hospitals and their ability to provide patient care in rural areas for the last 15 years. The 340B program consists of 2 components: reduced drug costs for hospital outpatient services, excluding Medicaid; and additional revenue from retail pharmacies. The key element of the 340B program is not-- is that it is not government or taxpayer funded. It does have government oversight through the Health Resources and Services Administration, HRSA, which is an agency of the U.S. Department of Health and Human Services. 340B revenue began to decline on average by 50% in 2020, when drug manufacturers decided to limit access to certain drugs and restrict the number of retail pharmacies hospitals could contract with. HRSA has not enforced the 340B program rules and regulations and has allowed drug manufacturers to operate as they please. We are asking you on behalf

of patients in Nebraska to act with LB168 to protect rural healthcare and enforce 340B as it was designed and was working prior to 2020. The 340B program has been a lifeline to rural hospitals to provide healthcare services that may not otherwise exist. A lack of enforcement is threatening the survival of critical access hospitals and community pharmacies. Hospital margins in Nebraska average 1% to 3%, and the 340B program is a significant portion of the margins, has reduced drug costs 30-50% on average, reduce operating expenses. Furthermore, revenue from the profit-sharing with retail pharmacies increased margins, but also positively impacts the financial viability of the local community pharmacies. Many local community pharmacies are closing due to financial strain and are asking critical access hospitals to purchase them, allowing patients to still have access close to home. I would like to give the community-- or committee an example of the program's impact on a small critical access hospital with $10 million net patient revenue. They have 17 beds and an attached rural health clinic with 5 providers. Over the past 5 years, their operating margin averaged 1.3%, including 340B program revenue, one of those years with a negative margin. Without their 340B revenue, the operating margin averaged a negative 2.3%, where 4 of the 5 years were negative. The average 340B revenue in this facility is $342,000 a year. 4 years ago, the hospital purchased the local independent pharmacy so it would not close. The hospital has lost money on this venture every year, averaging $119,000 per year, to provide access for patients close to home. The next closest retail pharmacy is 20 miles away. Without the 340B program, healthcare access in this community would not be possible. That's why I am asking you to support LB168 and get it to the governor's desk as quickly as possible. The legislation protects a vital lifeline for patients in rural Nebraska. Thank you.

**JACOBSON:** Thank you. Questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. I-- you say here you're the chief CFO of the ruralMED Management Research. Is that a consulting company that you have?

**BRYCE BETKE:** Yes, it is. And we--

**RIEPE:** And so you consult with a number of hospitals, do you? OK.

**BRYCE BETKE:** Yes. So we have a, a group of hospitals that we service that are probably a cooperative of 24 independent critical access hospitals--

**RIEPE:** OK. Thank you.

**BRYCE BETKE:** --across the state.

**RIEPE:** That's a good idea.

**JACOBSON:** Other questions? If not, thank you for your testimony.

**BRYCE BETKE:** Thank you.

**JACOBSON:** Further proponents? Gotta race to the chair.

**ANDREW CROSS:** I'll go first. Sorry.

**JACOBSON:** Congratulations.

**ANDREW CROSS:** Sorry. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Andrew Cross, A-n-d-r-e-w C-r-o-s-s. I am the 340B Manager for Prairie Health Ventures, an alliance of over 50 hospitals and 600 affiliates. For over 50 years, Prairie Health has sought to help smaller, more rural hospitals and healthcare organizations remain strong and sustainable in their communities. I'm here today in support of LB168. The 340B Drug Discount Program is a federal drug savings program that allows for our rural, not-for-profit safety net hospitals to provide more comprehensive services and keep their doors open without costing taxpayers a dime. The 340B program has functioned as intended for over a decade. However, since 2020, 37 of the top pharmaceutical manufacturers implemented restrictions on a vital piece of this program, which our data shows costs the average critical access hosp-- hospital about $800,000 annually. Currently, 54% of rural Nebraska hospitals operate on a negative margin. Restrictions on contract pharmacies put in place by pharmaceutical manufacturers and additional reporting requirements leave many hospitals facing serious financial hardships. If, if these restrictions are allowed to continue, many rural providers reported that they will be forced to cut services or close their doors. Passing HB 168 protects our rural hospitals from these restrictions and allows them greater freedom to direct their savings back into the communities they serve. In fact, 340B's greatest strength is in the flexibility of how these safety net providers can direct their savings into the areas where their communities need it the most. Rural hospitals serve a large geographical area with a wide range of challenges, so it's important these hospitals have the freedom to choose how they use their savings for the program. Rural hospitals use their savings in various ways. A few examples include

funding OB, maternal, ambulatory, urgent care, discounting prescriptions, providing transportation services, opening clinics and pharmacies in underserved areas, and keeping their doors open. Full access to the 340B program is essential for most Nebraska hospitals and community pharmacies. Without the protections provided in LB168, access to healthcare services and local pharmacies will most certainly be reduced for many rural Nebraskans. To demonstrate the importance of the 340B program, along with my testimony, I have submitted signatures from 35 rural Nebraska hospitals and over 21 rural retail pharmacies in support of LB168. Each of these signatures represents an essential access point to healthcare in Nebraska. I and all of the signatories ask for your support on this legislation, as well. I'm happy to answer any questions about the 340B program you may have.

**JACOBSON:** Thank you. Questions? All right. Seeing none, thank you for your testimony. Could, could we let her go next, since she was on, on the, on the race earlier for the-- welcome.

**ANDREA SKOLKIN:** Thank you. Good afternoon, Chairman Jacobson and members of the committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n. And with a little different angle, I am the CEO of OneWorld Community Health Centers, located in Omaha. We have 18 different service locations, including clinics, school-based services, mobile dental and mobile medical services. I'm here today on behalf of Nebraska's 7 community health centers that are known as federally qualified. We are here to support LB168, and I want to thank Senator Hardin for introducing this important legislation. Last year, OneWorld served 53,000 Nebraskans from 22 different counties. Statewide, the 7 community health centers provide care for over 121,000 Nebraskans providing medical, dental, behavioral health, affordable medications, along with support services like transportation. 90% of our patients have incomes below 200% of the federal poverty level, and one quarter of our patients are uninsured. They rely on health centers for access to affordable care. OneWorld is fortunate to have an in-house pharmacy at our main clinic location, but our patients live in numerous counties and zip codes and also need the access to medications. And not every health center in Nebraska can afford to operate a, a pharmacy. Every health center, though, does accept or use the 340B program. Even at OneWorld, we rely on contract pharmacies, and the 340B program is critical to protecting access. Federal law mandates that health centers like OneWorld reinvest every dollar, which we do, into programming. At OneWorld, we use this for medical care, dental care, and behavioral health services. An assertion that has been heard, that you heard about that providers are pocketing this profits

is really false. In addition to investing in services for low-income patients, the 340B program ensures broad access to pharmacy services. There is a map attached to the testimony that shows the 7 community health centers and the areas that they serve across the state. You can see that even in Omaha, people travel quite a distance to get their medications. Restricting health centers to one contract pharmacy or not at all means that these patients may drive 4 hours to get their medicine. Again, as you've heard, local pharmacy access is critical to ensuring patients get the prescriptions and follow treatment plans. Access to pharmacies that are close to home and work, have extended hours, and the ability to fill specialty medication is a foundation to overcoming barriers faced by low-income Nebraskans. The contract pharmacies are critical and a cornerstone to ensuring access to affordable medication.

**JACOBSON:** I'm going to, I'm going to have to ask you to wrap up the comments, so.

**ANDREA SKOLKIN:** Yes, I will wrap it up. So we don't have the luxury, as you've heard, of waiting for Congress to take action. Access to affordable medication is fundamental, and we urge your support of LB168.

**JACOBSON:** Thank you. Questions from the committee? Yes, Senator von Gillern.

**von GILLERN:** Just very quickly, I really didn't have a question, but just wanted to thank you. I've got some personal-- had personal interactions over the years with what you do, particularly in the Omaha metro area. I'm very grateful for what you do for the community. And, and this is the program-- you were what 340B was intended to do, so thank you for, for doing what you do. Appreciate it, really.

**ANDREA SKOLKIN:** Thank you very much.

**JACOBSON:** Thank you. I'm just curious, how many contract pharmacies do you work with?

**ANDREA SKOLKIN:** We work with 17 Walgreens pharmacies, so that throughout Omaha, if they are not able to come to our main pharmacy, they can access it there. But it does require a tremendous amount of monitoring in order to use those pharmacies.

**JACOBSON:** But it's only, it's only Walgreens that you use?

**ANDREA SKOLKIN:** Yes.

**JACOBSON:** OK. And what about the outstate, if you go out to Lincoln County and that area, what's--

**ANDREA SKOLKIN:** They use more local pharmacies in their areas. I don't know the names of the pharmacies. I know in Lincoln, they use a, a pharmacy that used to be directly diagonal to the health center.

**JACOBSON:** Gotcha. Thank you. Thank you. Yes, Senator Wordekemper.

**WORDEKEMPER:** Thank you, Chair. On your map, you have diagonal, different colored lines. Can you explain what those are there for?

**ANDREA SKOLKIN:** Well, community health centers serve more or less a specific area. They-- patients may come from different areas, so those diagonal lines show that they are patients from different counties are coming to the, like, the main red area if you're looking at ours.

**WORDEKEMPER:** OK. Thank you.

**JACOBSON:** Any others? Otherwise, thank you for your testimony.

**ANDREA SKOLKIN:** OK. Thank you.

**JACOBSON:** And sir, you're next. Welcome.

**TYLER TOLINE:** Thank you. I always feel it's nice to be a long ways away from Dan DeFreece because I'm not a medical doctor-- is a hospital administrator, so. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Tyler Toline, T-y-l-e-r T-o-l-i-n-e. I'm the CEO of Franciscan Healthcare, located in West Point. Franciscan is a nonprofit Catholic healthcare system which has clinics in West Point, Howells, Oakland, Scribner, and Wisner, a critical access hospital located in West Point, and rehabilitation facilities in West Point and Wisner. I'm here in support of LB168, and I thank Senator Hardin for bringing this critical legislation. The stated intent of Section 340B of the Public Health Service Act is to stretch scarce federal resources as far as possible, reach more eligible patients, providing more comprehensive services. Designated safety net providers who are eligible for this program, like Franciscan, serve a disproportionate share of uninsured, underinsured, and vulnerable patient populations. In our case, we're the only home health and hosp-- or one of the only health-- home health and hospice providers in our area in services most critical

access hospitals can't afford anymore or have closed. So how does 340B program support vital access to care in northeast Nebraska? By allowing us to use the discount drug prices to underwrite critical services. Our home health and hospice programs have run annual losses of between $54,00 and $450,000 per year annually over the past decade. The net revenue generated by 340B discounted drugs over the time has covered those losses-- enable us to continue to provide these vital services. Additionally, our sister nursing home continues to see annual operating deficits in excess of $0.5 million. And while the 340B program revenues do not offset that entire loss, it does provide enough revenue that the losses are within a range we can keep our doors open. In past, partnerships with contract pharmacies in our local communities allowed us to support additional access points to care with our local pharmacies, as well as underwrite important services provided by Franciscan. Since 2022, we've actually had to operate our own retail pharmacy in West Point, in-- due to restrictions being placed by the drug manufacturers. In addition, during 2024, we ended up taking over another local retail pharmacy due to the lack of reimbursement. For many providers, especially in rural areas, contract pharmacy is the only way that patients can fill their needed prescriptions with 340B drugs. LB168 is an important step in enforcing the intent of the 340B statutes and protecting access to care for rural communities across Nebraska. Without cost to taxpayers, the 340B program is a proven model to maintain access to care for vulnerable populations. Without it, most likely certain-- have to reduce additional services. I encourage you to advance LB168 to General File and help protect this critical safety program. I welcome any questions the committee may have.

**JACOBSON:** Thank you. Any questions? All right. Seeing none, thank you for your testimony.

**TYLER TOLINE:** Thank you.

**JACOBSON:** Additional proponents? Looks like we got one right here. Welcome.

**JED LEWIS:** Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Jed Lewis, J-e-d L-e-w-i-s. I'm a licensed pharmacist and VP of Medicine Man Pharmacies. We are a group of small independent pharmacies. We have stores in Omaha, North Bend, Schuyler, and Wahoo. Medicine Man is a 340B contracted pharmacy in 2 out of 4 of its locations, Schuyler and Wahoo. The 340B program helps us to remain in business and have an impact in rural Nebraska. 340B

allows us to keep our doors open, ensuring that patients in rural Nebraska continue to receive the medications and care they need. Independent pharmacies are being squeezed from all sides. Pharmacy benefit managers dictate reimbursement rates, drug costs continue to rise, and DI-- DIR fees are bleeding pharmacies dry. DIR, DIR are the fees that pharmacies may see PBMs charge outside of admin fees, and are generally collected after the point of sale. In 2023 alone, our 4 stores lost over $550,000 to DIR fees. Schuyler alone lost over $100,000, and Wahoo was hit even harder, with losses exceeding $220,000. Pharmacies are closing at a pace of around 8 pharmacies per day, totaling around 2,300 pharmacies in '24 alone, or about 3% of pharmacies. While a 3% drop in the number of pharmacies across the country may not seem significant on the surface, consider that many of these pharmacies are in rural communities and their closure creates what is known as a pharmacy desert, leaving many patients without pharmacy care. In many of these rural communities, the local pharmacy is often the easiest place for patients to see healthcare. LB168 would allow independent pharmacies like Medicine Man to remain open and create access points for healthcare for many Nebraskans across the state. While mail-order services and large urban chain pharmacies may seem convenient on the surface, they cannot replace the vital role of a trusted local pharmacist, someone who knows their patients by name, who provides personal medication, therapy management, and whose a readily available healthcare resource. Without urgent action, independent pharmacies will continue to close, leaving thousands of Nebraskans stranded without access to pharmacy care. The 340B program is essential not just for independent pharmacies, but for the patients and communities who rely on us for safe, effective, and affordable healthcare. I respectfully urge the committee to advance LB168 for consideration by the full Legislature. Thank you for your time. And I'm happy to address any questions.

**JACOBSON:** Thank you. Questions from the committee? I'm, I'm gathering that PBMs are having a significant impact on your pharmacies?

**JED LEWIS:** The DIR fees are significant. I mean, I, I had eye candy in here, I would have gave you 2024's numbers. The changed healthcare breach, they're still trying to unwind all of that. And that's the problem. It was supposed to go to a point of sale. Unfortunately, you still can't go to a point of sale, because they're doing true-ups and true-ups. And these are-- we're still seeing trued up numbers on DIR fees 3 to 6 months. And with regards to some of these rebate programs that they want to propose on the 340B side, it's, it's, it's going to

be a similar model to the, the DIR side. The information overload is insane.

**JACOBSON:** What baffles me is why the DIR fees even exist.

**JED LEWIS:** You and I both. I'd, I'd love to--

**JACOBSON:** That question is going to be asked, I think, more in this committee, as to [INAUDIBLE].

**JED LEWIS:** What-- it-- and it should. Because I get a phar-- I get a question every day-- or every week about a pharmacy potentially closing that needs help from their roll access hospital that looks to want to buy them or hey, can you help us out? How can we stay in business or create a need for our community? But, I mean, with the lack of reimbursement rates and DIR fees, it's, it's troublesome. It's scary. So-- and it's not going to stop.

**JACOBSON:** Thank you.

**JED LEWIS:** Thanks [INAUDIBLE].

**JACOBSON:** Other proponents? We're working on good evening. So.

**ANDREW RADUECHEL:** Good evening, Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee. Thank you for the opportunity to testify in favor of LB186. I will be quick. My name is Andrew Raduechel, A-n-d-r-e-w R-a-d-- I'm sorry, R-a-d-u-e-c-h-e-l. I am the director of pharmacy at Boys Town National Research Hospital, former chair of the Nebraska ImmunizationTask Force, and I serve on the executive board and legislative committee for the Nebraska Pharmacists Association. The Boys Town National Research Hospital is located at 14000 Hospital Road on the campus of Boys Town, Nebraska. We are a not-for-profit, disproportionate share healthcare provider. Disproportionate share hospitals serve a significantly disproportionate number of low-income patients, and the 340B program helps to cover the costs of providing care to these uninsured patients. The 340B program is vital to Boys Town National Research Hospital and our mission, helping us offset out-of-control drug costs while providing low-cost access to care. The program is more important than ever, as drug prices are the most rapidly growing expense for hospitals. One of the qualifications for Boys Town to enroll in the 340B program is we have a contract with the state or local government to provide healthcare services to low-income individuals who are not eligible for Medicare or Medicaid. Opponents of the 340B program will

tell you that hospitals are getting rich off the 340B program and imply it is funded by taxpayers. I am here today to tell you that neither of those are accurate. It is important to remember that you cannot participate in the 340B program if you are for profit. It is also important to remember that these drug discounts are completely administered by the drug companies who continue to make record profits. No taxpayer money is ever involved. This program is used to expand vital services we would not be able to offer otherwise. In particular, rural pharmacies in many communities would cease to exist if not for the support of the 340B program. Many of the services would not be able to be sustained without support from programs like 340B. Before we added pediatric neurologic services to our mission 4 years ago, Nebraska had the lowest ratio of pediatric neurologists in the nation, at 1 pediatric neurologist for every 90,000 pediatric patients. These patients and families would have to travel to places like Minneapolis or Denver and wait 4-6 months just to see a pediatric neurologist for the first time. Boys Town National Research Hospital had 1 part-time pediatric neurology provider at that time. We now have 14. In addition, we are the largest pediatric mental health provider in the region. Nearly 1 in 5 children will have a mental, emotional, behavioral health disorder, but only 20% of those children receive care. Our services provide families with much needed support and most, most importantly, hope. We strongly support LB168 on behalf of our children and families. It is a much needed bill to protect the many children in need of care from further cuts to 340B that disrupt important life-saving therapies. I stand ready to answer any questions you have. Thank you.

**JACOBSON:** Thank you. Questions from the committee? All right. Seeing none, thank you for your testimony.

**ANDREW RADUECHEL:** Thank you.

**JACOBSON:** Other proponents? Anyone, anyone else wishing to speak in support of the bill? If not, I will open up to opponents. Clear in the back. Welcome. How are you?

**LEAH LINDAHL:** Doing fine. Thank you, Chairman Jacobson, members of the committee. My name is Leah Lindahl, L-e-a-h L-i-n-d-a-h-l, and I'm the vice president of state government affairs for the Healthcare Distribution Alliance. HDA is a national trade association representing healthcare wholesale distributors. Our members are essentially the vital link connecting roughly 1,200 manufacturers and over 350,000 points of care [INAUDIBLE] hospitals, pharmacies, nursing

homes, et cetera, that treat and serve patients, and about 1,800 of which are located across Nebraska. We are here in respectful opposition to the legislation. The stated intent within LB168 is to prohibit drug manufacturers from interfering with or denying the sale of 340B drugs to contract pharmacies. However, the language also includes wholesale distributors when-- within those provisions. And we respectfully request an amendment to remove those, those provisions from the language. Wholesale distributors work under contract with the manufacturer and any stipulation regarding how their drugs are delivered would be determined by that manufacturer. So this language would put the wholesaler responsible for the, the actions of that manufacturer. Furthermore, it's imperative to note that our companies are under strict obligations within DEA requirements, so federal requirements with how they manage controlled substances. These are also further into injunctive relief requirements with the state of Nebraska is a party to, with how they control and, and manage controlled substances going into the state of Nebraska, and that was dictated by the attorney general here. This language would actually put them in conflict with some of those requirements. And that's really why we have to kind of look for an exemption for our companies within the legislation, to remove them from that language so that they don't have to be conflicted in that way. I also want to note that the, the laws that had been cited today, Arkansas, Kansas, Missouri, those also similarly do not include wholesale distributors within their language. There was one state that passed legislation last year, similar to this-- Mississippi. That language, the sponsor of that bill is going back this session to remove wholesalers from that law. So we ask that Nebraska take that into consideration before putting this legislation in-- into effect with wholesalers included in the language. So with that, happy to answer any questions.

**JACOBSON:** Questions from the committee? Yes, Senator Hallstrom.

**HALLSTROM:** So there's just one reference to "or distributor" in the statute is what you would ask to have removed, if that's appropriate?

**LEAH LINDAHL:** Correct. Yes. Thank you.

**HALLSTROM:** Thank you.

**JACOBSON:** Any other questions from the committee? I know Senator Hardin is not here. Oh, yes he is. He's-- excuse me. He's, he's over sitting in the, in the penalty box. The-- did you reach out to Senator Hardin at all--

**LEAH LINDAHL:** Yes.

**JACOBSON:** --in the process here?

**LEAH LINDAHL:** We did, yes. And the hospital association, as well.

**JACOBSON:** OK.

**LEAH LINDAHL:** And made them aware of those concerns.

**JACOBSON:** OK. And so really, we're looking at a simple amendment--

**LEAH LINDAHL:** Correct.

**JACOBSON:** --that would, that would satisfy your concerns?

**LEAH LINDAHL:** Exactly. Yes.

**JACOBSON:** Perfect. Thank you. Other questions from the committee? If not, thank you for your testimony.

**LEAH LINDAHL:** Thank you. Appreciate it.

**JACOBSON:** Other opponents. Good evening to you.

**KATELIN LUCARIELLO:** Good evening. I'm starting my day and ending my day--

**JACOBSON:** That's right. That's right.

**KATELIN LUCARIELLO:** --with you, Senator. Good afternoon, Senator Jacobson, members of the committee-- evening. My name is Katelin Lucariello. I'm a deputy vice president of state policy for PhRMA, and I am here today in respectful opposition to LB186. I want to be very clear that PhRMA is committed to safeguarding the 340B program in, in its original intent. We support the efforts the 340B program serves in terms of providing resources for the Nebraska communities that depend on it, but we do not believe that this legislation is going to further that goal. There has been considerably weak oversight in the program since its inception, which has led to a diversion of 340B funds away from patients and caused the program to expand well beyond its original intent. And instead, the program has become a profit generator for large chain pharmacies, PBMs, and other middlemen, who own about 79% of the contract pharmacies that contract with 340B providers in this state alone. This trend is raising costs for patients, it's raising costs for states, employers, and the healthcare

system as a whole. The 340B program is a comprehensive federal program that is governed exclusively by federal law, and states do not have the authority to create new requirements that are not in line with federal law, in this case, or conflict with federal law. We agree with many that we've heard from today that there is significant reform needed in this program at the federal level to systematically address issues that have led the program to stray from its original intent. We are 100% on record and work with a coalition at the federal level that is seeking reforms there, including reforms that recognize the unique roles of rural health providers. This bill is not about reforming the 340B program, and it's not about getting rid of the 340B program. It is about shipping drugs and extending 340B pricing to an unlimited number of contract pharmacies. The bill's provisions directly conflict with the 340B program's rules and enforcement regime and restrict manufacturers' ability to impose reasonable conditions which are allowed by the federal 340B statute. I'll just close up because I think there will probably be questions and I see the little yellow light on. So, I appreciate your time and I will stand for questions. Thank you.

**JACOBSON:** I would ask if you could spell your first and last name for us.

**KATELIN LUCARIELLO:** I forgot. And it's a doozy. K-a-t-e-l-i-n L-u-c-a-r-i-e-l-l-o. Thank you.

**JACOBSON:** Thank you. Senator Dungan.

**DUNGAN:** Thank you, Chair. And thank you for being here today. You've obviously been here through the testimony that we've had for the proponents of this bill. And you and I have spoken, I guess, a little bit about this as well. It sounds like you've one of your major concerns is folks enriching themselves essentially, off the 340B program. How do you reconcile that with the number of folks that came in here today, who sound like their critical access hospitals and other healthcare providers who operate in a loss ratio, essentially. And they're, they're saying this 340B program is essential to being able to continue to provide these necessary services for individuals in their community. How does that reconcile with this assertion that there's going to be some sort of profit being made or that it's for self-enrichment for others?

**KATELIN LUCARIELLO:** Yeah. Thank you, Senator, for your question. I think both things can be true, is what I would say. There are

absolutely providers that are safety net providers that are using these funds exactly as they should be intended to be used. There are other providers that we know are using these funds for ways that we would not say that align with the original intent of the 340B law. Couple that with a number of-- or with the growth in contract pharmacies and PBMs entering the program and siphoning away funds from those providers and arguably, from the patients that the 340B program is intended to serve. And I would say that those are a couple of the primary ways that we see the 340B program not working as intended, coupled with the testimony that we see today. Yeah.

**DUNGAN:** And I appreciate that. I, I guess my, my number one concern always in these kind of questions is helping patients, and that-- that's my number one concern when we talk about this. And these issues are incredibly complicated and really complex, especially for folks watching at home who don't have this background. But I guess that's my concern. So when I hear folks come in and, and express this concern that if we don't enact this legislation, we're going to continue to see access to safety net programs dwindle, it just has me concerned. So I guess that's my overarching issue, I think, with this. Have you had a chance to speak with Senator Hardin about these concerns, with regards to ways to differentiate the, the critical access programming from other ones that you're concerned are misusing these 340B funds?

**KATELIN LUCARIELLO:** We did have an opportunity to talk with Senator Hardin in the Rotunda today, not about that in particular, or any suggested amendments. We didn't get into detail on that. I believe that we mentioned that we do have some options available and would like to continue to have conversations.

**DUNGAN:** OK. Thank you.

**KATELIN LUCARIELLO:** Thank you.

**JACOBSON:** Other questions? Senator Hallstrom.

**HALLSTROM:** When I first met with representatives of your company, I indicated that I was concerned with access to rural healthcare, both with regard to rural access-- rural critical access hospitals and community pharmacies, and expressed my concern over the element of this problem that's associated with PBM-affiliated pharmacies. Do you have any data that reflects how much of the expansion of, of contract pharmacies involves PBM-affiliated pharmacies?

**KATELIN LUCARIELLO:** Yeah. Well, let me quickly go back to 2010 when there was an expansion in guidance and not statutes surrounding contract pharmacies. And it allowed an unlimited number of contract pharmacies to participate in the program. That's really when we see more PBMs entering the program. I can't say how that corresponded with the growth, but I can tell you today, about 70% of the P-- of the pharmacies participating in the program are affiliated with large PBMs or chain pharmacies.

**HALLSTROM:** And is there any data available regarding the markup or the profit that is made by PBM pharmacies, vis a vis community pharmacies?

**KATELIN LUCARIELLO:** Well, well, there is definitely data that's coming out surrounding profits. In 2018, there was a study done by Berkeley Research Group that found that about $13 billion in the 340B program was being siphoned off by PBMs. In 2018, the 340B program is a $24 million program. Today, it is a-- or I'm sorry, a $1 billion program. Today, it is a $66 billion program, and so I imagine those profits have increased exponentially. Minnesota recently published a report, their department of health had a-- published a report in compliance with a 340B transparency bill that was passed a couple of sessions ago. The revenues being made off of contract pharmacies and other third parties in that program was around $121 billion or $1 in every $6 of revenue in the 340B program.

**HALLSTROM:** But is there any comparison to how much PBM-affiliated pharmacies make individually versus a community pharmacy?

**KATELIN LUCARIELLO:** Yeah, that's a great question. The best data that I can think of comes from a comparison between PBMs dispensing 340B, 340B medicine, so PBM-controlled pharmacies dispensing 340B medicines. And it found that they were making about 72% profit off of those medicines. Compare that to your average independent pharmacy dispensing a non-340B drug, the profit margins are far lower, around 22%.

**HALLSTROM:** So they're 70% of the market, and they're making 72% profit, PBM-affiliated pharmacies?

**KATELIN LUCARIELLO:** On 340B drugs. That's what the data showed. Yes.

**HALLSTROM:** Thank you.

**JACOBSON:** So just as a followup to that, if we were to amend this to prohibit pharmacies associated with PBMs from this, how, how big of an

impact would that have in terms of available, because I'm assuming some of the bigger chain pharmacies would be eliminated from participation?

**KATELIN LUCARIELLO:** I believe the way that the amendment was written, it is tied specifically to PBM and PBM-affiliated pharmacies. And so, some of the larger chain pharmacies would likely not be captured there if they are not owned or affiliated with a PBM.

**JACOBSON:** OK. Thank you. Other questions from the committee? All right. Seeing none, thank you.

**KATELIN LUCARIELLO:** Thank you.

**JACOBSON:** Other opponents. OK. How about the neutral testifiers? OK, pretty decisive group here today. With that, Senator Hardin, you're welcome to close. And I might mention there were 47 proponent letters, 5 opponent letters, 2 neutral letters, and the committee did not receive any written ADA testimony regarding this bill.

**HARDIN:** Of the 5 opponent letters, 3 of those were from outside Nebraska: Washington, D.C., Kansas City and Minnesota. I appreciate everyone coming out today. This is a big deal because, well, at the end of the day, it has to do with billions of dollars across the country. And so, it's an expensive thing. And so I really do appreciate it. All of the amendments that we've discussed will certainly be considered. And we'll talk with parties on both sides. I would say that outside of today, neither my LA or not-- nor I can remem-- know of anyone who reached out to us before today, for those who are in opposition. So just saying shame on you for not reaching out to us earlier. I know you're staring at the back of my head, and we'll all get over this.

**JACOBSON:** No, I will, I will tell you that's a question I've asked all of the oppos-- of the testifiers before--

**HARDIN:** Yeah.

**JACOBSON:** --is if you're not reaching out, why not?

**HARDIN:** Right.

**JACOBSON:** And if you tell us this is, this is a great cause but this isn't the right bill. And-- but we got fixes, then why, why are we waiting on the fixes?

**HARDIN:** Yeah.

**JACOBSON:** So we'll maybe wait a week to exec so that the fixes can be brought. But--

**HARDIN:** Great.

**JACOBSON:** --let's bring fixes if we got problems.

**HARDIN:** I agree the PBM issue needs to be looked at, dealt with, so that would be at the top of the list. I would say it's somewhat rich to criticize the hospitals that are operating on a 1.4% margin across Nebraska to say that they're enriching themselves while the average from the last registered year of the pharmaceutical world is a 17.4% increase for them. That's billions and billions of dollars for the pharmaceuticals, so I'm just saying put that into some context. There were little hospitals like Kimball, Nebraska, that take advantage of this. You heard from Boys Town National Research Hospital, as well. So this is one end of the state to the other. So this is a big deal. Again, really appreciate everyone who came out here and, you know, shared with all of us. When you say 340B and you say this is what we're going to talk about today, guess how many out of 100-- well, guess how many senators out of 49 actually know what that is? Not very many. And yet, it is a profound issue. And so, I really appreciate everyone's testimony on this and, and we'll, we'll keep polishing.

**JACOBSON:** Questions for Senator Hardin? Senator Riepe.

**RIEPE:** Thank you, good sir. My question would be is just what is the-- we've talked a lot about rural hospitals. What about nonrural hospitals? How do they benefit and to what degree? Because, you know, I've been led to believe that it's, it's a, you know, a cash infusion, serious cash infusion for nonrural hospitals. The big met-- big urbans.

**HARDIN:** If your hospital is not participating, it'd be a good thing to find out why they're not participating. And so some of that burden is not so much, I think, a palm to the face from that program. It is just simply to say it's something that I think that the hospitals need to currently review what their needs are and see if they can, in fact, qualify. But, yeah, it's, I think, 54 of our 92 hospitals are participating at this point.

**JACOBSON:** Other questions? All right. Seeing none, thank you. This concludes our public hearing on LB168. I'd ask the committee members

to hang around just a minute. We'll go through a brief-- I think brief executive session. So if we could ask everyone to leave the room so we could go into executive session.