SLAMA: All right, everyone, it is that time. Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Julie Slama. I'm from Dunbar and represent the 1st Legislative District. I serve as Chair of this committee. The committee will take up bills in the order posted. The hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. The committee members will come and go during the hearing. We have to introduce bills in other committees and are called away. It is not an indication that we are not interested in the bill being heard. It's just part of the process. To better facilitate today's proceedings, I ask that you abide by the following procedures. Please silence or turn off cell phones. Move to the front row when you are ready to testify or when your bill that you're planning to testify on comes up. The order of testimony will be the introducer of the bill, proponents, opponents, neutral, and the introducer's closing if they so choose. Hand your green sign-in sheet to the committee clerk when you come up to testify. Spell your name for the record before you testify. Be concise. We run a 3-minute light system in here. Green means you're good to go, yellow means you have 1 minute left, and red means please cut off your last thought. We have a lot of people willing to ask you questions and we've got a packed room today and we want to make sure everyone's able to be heard. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard here today, there are gold sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We'll need 10 copies. If you have written testimony but do not have 10 copies, please raise your hand now so the pages can help make copies for you. To my immediate right is committee counsel Joshua Christolear. To my left at the end of the table is rock star committee clerk Natalie Schunk. The committee members with us today will introduce themselves beginning at my far left.

BOSTAR: Eliot Bostar, District 29.

von GILLERN: Brad von Gillern, District 4.

AGUILAR: Ray Aguilar, District 35.

JACOBSON: Senator Mike Jacobson, District 42.

BALLARD: Beau Ballard, District 21.

SLAMA: Our pages today are Molly and Mia. The committee will take up the bills today in the following order: LB990, LB1232, LB833, LB984, LB1110, LB1290, and LB954. As a quick note, this is our last committee hearing day for the BCI Committee for this year so be sure to thank the pages and our wonderful committee staff if you have the chance to today, they've done an outstanding job. And with that, we will open today's hearing on LB990. Senator Bostar.

BOSTAR: Good afternoon, Chair Slama and fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, representing Legislative District 29, here today to present LB990. LB990 addresses several aspects of Pharmacy Benefit Manager, or PBM, business practices that have restricted patient choice and access to their preferred pharmacy providers. First, LB990 protects patient choice by permitting local retail pharmacists to distribute prescription medications from the patient's preferred local pharmacy, either in person or via delivery. Some PBM contracts limit prescription drug delivery to patients from local retail pharmacies through the mail. These mail restrictions create significant barriers for patients from rural areas or those who may have limited mobility or who lack access to regular, affordable transportation. Second, LB990 allows nationally accredited specialty pharmacies in Nebraska to participate as in-network providers under reasonable terms and conditions. In 2022, the Legislature passed LB767, which prohibited PBMs from excluding accredited Nebraska-based specialty pharmacies from participation in the PBM specialty network so long as the pharmacy was willing to accept the PBM's terms and conditions of participation. Such terms and conditions are becoming increasingly burdensome and go far beyond what is required for national accreditation. These excessive requirements add significant costs to compliance with no clear additional benefit to patient safety or experience. This bill would prohibit such unreasonable terms and conditions that exceed those required for national accreditation. Finally, LB990 seeks to realize the intent of the compromised negotiations that led to the passage of the 2022 PBM Licensure Regulations Act, ensuring it applies to employer sponsored plan, self-funded plans, and to the Medical Assistance Program. A lot of time was spent and numerous meetings were held involving representatives of PBMs and provider groups prior to reaching consensus on the provisions of LB767 in 2022 to authorize the

Department of Insurance to regulate PBMs. It was the clear intent of all parties involved in the negotiation of the final version of LB767 to apply to all PBMs providing services to healthcare plans, including employer-sponsored plans, whether insured or self-funded. I distributed a proposed amendment with language that has been suggested by Director Dunning of the Department of Insurance that we would like to incorporate into the bill. The intent of the amendment is to clarify the plans participating in the Medicaid program will be overseen by DHHS, not DOI. There are testifiers following me that will provide detail on the significance and impact of these provisions. I would urge the committee to advance LB990. I thank you for your time and attention and be happy to answer any initial questions you may have.

SLAMA: Thank you, Senator Bostar. Are there any questions from the committee? Seeing none, thank you. We'll now open it up for proponent testimony for LB990. And I'd recommend if you are a proponent on this bill, come up to the first couple of rows. Yeah, it just makes everything easier. Welcome.

SARAH KUHL: Thank you, Chairperson Slama and members of the Banking, Commerce and Insurance Committee. My name is Sarah Kuhl, S-a-r-a-h K-u-h-l. I am the director of Infusion and Specialty Pharmacy at Nebraska Medicine. I am testifying in support of LB990 on behalf of Nebraska Medicine and the Nebraska Hospital Association. Nebraska Medicine pharmacy provides patients with the option to receive their prescriptions via in-person pickup, mail, or courier delivery at no additional cost. Patients may choose mail delivery for a variety of reasons: convenience, supporting medication adherence, or to overcome barriers associated with limited mobility, compromised immune systems, lack of transportation, or living in rural locations without a pharmacy nearby. Last fall, we received notice that one PBM would no longer allow Nebraska Medicine's pharmacy to mail prescriptions effective January 1, impacting over 330 patients and 5,500 total prescriptions. It's a struggle for patients without a car to obtain rides to the pharmacy to pick up their medications. Many low-income seniors rely on Nebraska Medicine's 340B drug discount program for financial assistance. As of just last week, the PBM walked back their position on our mail delivery and will allow us to mail to patients in Nebraska. But this legislation remains necessary, as there is nothing to prevent them or others from changing course in the future. Opponents of this bill may say that mail delivery will still be available to patients through the mail order pharmacy associated with the PBM. However, not all patients prefer to use an out-of-state mail

order pharmacy. Patients also may not be able to access financial assistance through the PBM's mail order pharmacy that we can offer. Additionally, opponents may say that this will increase costs. Nebraska Medicine is already in network and available for patients to fill their prescriptions with us in person. There's no increased cost if Nebraska medicine mails the prescriptions. By prohibiting our ability to mail, the presumed intent is to make our pharmacy a less desirable option for patients who value the convenience of the delivery-- of mail delivery. Additionally, LB990 prohibits unreasonable terms and conditions for nationally accredited Nebraska-based pharmacies to serve their patients as an in-network specialty pharmacy. After the passage of the PBM Legislature Regulation Act [SIC] in 2022, LB767, accredited specialty pharmacies in Nebraska were to be allowed to participate in PBM networks. Unreasonable terms and conditions and extensive reporting requirements are now being used to limit access to networks. The administrative burden required to meet these terms and conditions take away resources from patient care. We hire additional staff just to pull data to satisfy each individual PBM's reporting requirements. As an attachment to the testimony, we have provided a timeline of actions taken to join the specialty network of just one PBM. Despite over 16 months of work and submissions of thousands of patients-- pages of information, we have no idea how many additional steps may be required and the PBM will still not provide draft content for reimbursement for our pharmacy to review. This is just one example of the terms and conditions. Thank you for your time and I'd be happy to answer any questions.

SLAMA: Thank you so much, Ms. Kuhl, especially for respecting the light system. We've got the rest of your testimony here and we'll absolutely reference it. Are there any questions from the committee? Seeing none, thank you very much.

SARAH KUHL: Thank you.

SLAMA: Good afternoon.

MARCIA MUETING: Good afternoon, Chairman Slama, members of the Banking, Commerce and Insurance Committee. My name is Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g. I'm a pharmacist and the CEO of the Nebraska Pharmacists Association. I would like to offer some background on Pharmacy Benefit Managers. I know it's been a couple years since we talked about them. I know you've been talking to them-- about them probably all session, but just to level set. When

pharmacies first began submitting claims electronically, Pharmacy Benefit Managers were the conduit between the pharmacy and the insurance company. Prescription claims data submission is standardized from pharmacy to pharmacy and insurance company to insurance company. So everybody sending everything in the same format. When a pharmacy submits a claim electronically, within seconds the pharmacy receives a message from the PBM that-- to confirm that the claim is, is received, the patient's eligible, the medications covered, what the patient's cost is, and the amount that the pharmacy will actually get paid or reimbursed by-- or the pharmacy gets a rejection message. This instant adjudication of the claim was really important to original purpose of Pharmacy Benefit Managers. Over the last 30 years, however, the role of PBMs has expanded to much more than processing claims. Now, PBMs collect rebates from drug manufacturers on top of premiums. They conduct predatory audits that have become a profit center. They reimburse pharmacies at below-cost rates and offer contracts to pharmacies that are not negotiable, and PBMs are posting record earnings. PBMs have become vertically integrated, integrated powerhouses, many owning pharmacies, creating a severe conflict of interest. PBMs create the list of covered drugs for a plan with many prioritizing drugs that have higher rebates over low-cost alternatives, potentially driving up the cost of, of health overall. The, the dollars generated from rebates, audits, and below-cost reimbursements should be passed to the health plan sponsor or the patient. However, they are not. The FTC is investigating PBMs and the CEO of, of the National Community Pharmacists said even casual, casual observers of PBM space know how much it has changed in recent years after countless mergers and acquisitions and an explosion of tactics like take-it-or-leave-it contracting and patient steering. So in the past, PBMs have claimed that regulation will increase cost to consumers and plan sponsors. Nebraska PBM regulations barely scratch the surface of the issue and the cost of premium still increases each year. PBMs blame the rising cost on every other facet of healthcare except themselves. By passing LB990, you can ensure PBMs operate in the best interest of patients, payers, and the healthcare system. The opposition to LB990 will comprise lobbyists representing companies from outside of Nebraska. The primary PBMs are not located in Nebraska. The proponents of this bill are pharmacy owners and Nebraskans. For these reasons, I hope that you will advance LB990. And we've-- we're always asked the question, what are other states doing? So I'm giving you kind of a, a, a graphic depiction of what other states are doing as far as PBM regulation.

SLAMA: Great. Thank you, Ms. Mueting. Are there any questions from the committee? Senator von Gillern.

von GILLERN: Thank you, Senator Slama. Thank you for your testimony.

MARCIA MUETING: Sure.

von GILLERN: One of the terms you used is predatory audits. What-- tell me what a predatory audit is and what that does.

MARCIA MUETING: Sure. Oftentimes, pharmacies find themselves being audited on very, very expensive claims. And when-- if a-- even a minor bookkeeping error is discovered, the PBM can take money back for the entire claim, including the drug cost. Mind you, that prescription has already left the building. So do they do audits on prescription drugs that are $20 total between what the patient and the pharmacy reimbursement is? No, we're talking about drugs that cost thousands and thousands of dollars.

von GILLERN: Thank you.

MARCIA MUETING: Um-hum.

SLAMA: All right. Additional questions from the committee? Seeing none, thank you very much.

MARCIA MUETING: You're welcome. Thank you.

SLAMA: I'll now turn this over to my esteemed Vice Chairman, Senator Jacobson.

JACOBSON: Thank you, Chair Slama. Further proponents on LB990? Welcome.

DAVID KOHLL: Thank you. My name is David Kohll, D-a-v-i-d K-o-h-l-l. My family owns Kohll's pharmacies. We have nearly 200 employees and have been serving Nebraskans for over 75 years. The big 3 mega PBMs limit patient pharmacy access in Nebraska. They do this by restricting how far a pharmacy can deliver or mail medications to people. You might be restricted to 50 miles or 150 miles. The restriction negatively impacts Nebraskans and positively impacts the profits of PBMs. One example: the patient might be on over 10 routine prescriptions that needs to be taken at multiple times during the day. The patient has been in and out of the hospital because they're not taking their medications properly. The patient has then been

stabilized, less hospital readmissions by a Kohll's pharmacy or a Nebraska independent pharmacy because they organized the medications in a monthly package to prevent them from forgetting or not taking their medications properly. When the patient takes an extended trip over 50 miles away, the Nebraska pharmacy is not allowed by the PBM to mail the organized packaged medication to the patient's destination. Second example: Kohll's has accessibility to certain medications that aren't routinely available in pharmacies. These medications are prescribed by specialists. Their patients travel to Omaha and Lincoln from communities outside of these cities. These medications require special handling and must be dispensed by a pharmacist who has expertise with these drugs to properly educate the patients. When we are prohibited to mail these drugs and they must be filled by the PBM's own pharmacy, the patients don't get the drugs timely which significantly impacts their effectiveness. Additionally, they don't get the vital information about these drugs. When Nebraska pharmacies reach out to the PBMs to correct a contract, typically the PBM's response is either no response crickets or we don't negotiate. I've been able to determine that the PBM will try to aggressively force the patient to get their medication from the PBM's own mail order pharmacy and, in turn, charge the employer who is ultimately paying for the medication a higher amount than what the employer would pay if they got it from a Nebraska pharmacy. Senator von Gillern, you mentioned the, the audits and I wanted to expand on that. I had an employer who-- we were audited for an expensive drug, maybe $5,000. We had a little tiny error on just-- and they took all the money back, which they shouldn't have, but we didn't have much say. And so then I, I knew who the employer and the owner of that company was. I said, did you ever see that $5,000? He said, we've never been refunded by any type of audits. So just an example.

JACOBSON: Thank you for your testimony.

DAVID KOHLL: Thanks.

JACOBSON: Questions for the testifier? Senator von Gillern.

von GILLERN: Thank you for adding clarity to that. Another question, you, you mentioned earlier in your testimony about the restrictions for mailing over a certain limitation and so on. Are these contract terms disclosed prior to entering into agreements with, with the PBMs?

DAVID KOHLL: You know, they're, they're buried in, like, a 20 page, and then we look it up and say, oh, 150 miles, you know, so, you know.

von GILLERN: OK. So they are disclosed, but--

DAVID KOHLL: They're, they're disclosed.

von GILLERN: --not--

DAVID KOHLL: They're not, not--

von GILLERN: --highly visible.

DAVID KOHLL: No.

von GILLERN: OK. Thank you.

JACOBSON: I guess, I'd follow up with that question. If you chose not to enter into the contracts with a PBM, given the number of advertisements and so on that's out there, how much business would you lose as a pharmacy by not honoring and doing business with a PBM?

DAVID KOHLL: I believe in Nebraska, it's pretty-- between the 3 big ones, it's, like, 25% of each one. If we didn't enter in one of them, we, we would have 25% of the patients we wouldn't be able to serve. If it was two, it would be 50%. I know for some of the small towns, they have sometimes just one of the PBMs so it could be 80% of their business.

JACOBSON: So I, I, I just look at that more from a corollary. As a banker, if I chose not to do business with Mastercard or Visa because I didn't like their rules, they would cut me off from issuing debit cards that would-- they would honor. My, my customers would lose access to all these retailers and I just as well close down. So is that pretty much what you're facing when it comes to working with PBMs from your standpoint?

DAVID KOHLL: I would probably sell more wheelchair vans.

JACOBSON: Yeah.

DAVID KOHLL: I wouldn't be filling-- I wouldn't be filling prescriptions, very-- 80% of my pharmacy staff would be gone, but I'd need some of my other divisions.

JACOBSON: One last quick question for you. So we're talking about mailing pharmaceuticals. But don't the PBMs do exactly that with the pharmacies that they control?

DAVID KOHLL: Yeah, they're-- right. Yes, they do. But--

JACOBSON: OK. Thank you.

DAVID KOHLL: Yeah, sure.

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

DAVID KOHLL: Thank you.

JACOBSON: Welcome.

STACI HUBERT: Thank you.

JACOBSON: Go ahead.

STACI HUBERT: Chair and the members of the Banking, Commerce and Insurance Committee, my name is Staci Hubert, S-t-a-c-i, H-u-b-e-r-t. I am here as a representative of 57 independently owned pharmacies throughout Nebraska, covering 49 counties. I am here today to support LB990. We need your help to stop PBMs from their unfair PBM practices. The network I represent is CPESN Nebraska or Nebraska Enhanced Services Pharmacies network and we provide enhanced patient care services that go beyond the medication dispensing. We work with Medicaid, Medicare, and commercial plans to contract for services like medication reconciliation, synchronization, adherence packaging, and delivery like you've heard fellow pharmacy owners. But our PBM-ruled dispensing contracts are threatening our ability to keep the doors open for our community pharmacies which are one of the most trusted and accessible healthcare destinations we have. Our sustainability has been compromised by PBM practices that steer our patients away from our care and into big box stores and mail order services that are often-- more often owned by those same out-of-state PBM companies. We already help our patients that are forced to use those out-of-state mail order pharmacies. We take time in our pharmacies to call the provider to be able to fill necessary medications when their mail order didn't get to them in time. We dispose of the excess medications due to auto filling of 90-day supplies or we counsel on duplicate medications that they were taking by mistake. Mail order has shown to increase waste, increase risk, and cause undue hospitalizations which increases the overall cost of care for payers and state Medicaid programs that are funded by Nebraska taxpayers. You can see details on the attachments I passed out with my testimony. PBMs determine which pharmacies will be included in a prescription drug plans network and

how much said pharmacies will be paid for their services. Expansions of prescription drug coverage over the past 10 years mean that PBMs are involved in a majority of prescription drug transactions, so it should be no surprise that 96 of our independent pharmacies have been forced to close their doors over that same time period. It is predicted that we may lose more-- many more pharmacies in 2024. I am here today to ask why are we allowing our out-of-state businesses to take necessary healthcare pharmacy services away from our tax paying, job producing, Nebraska-owned pharmacies? Businesses, PBMs already dictate what we will get paid. We don't need PBMs limiting or just restricting how our pharmacies take care of our patients at the local level. We don't need PBMs mandating our pharmacies to sign up with their unbelievably unfair and low-cost reimbursements to be able to mail or deliver medications to our patients. Nebraskans deserve and expect protection. We don't want to take care of everyone. We just want to be able to take care of our local patients at our communities. It's simple. We need you to pass LB990.

JACOBSON: Thank you. Questions? Seeing none, thank you for your testimony. Further proponents? Welcome.

LISA CAHA: Good afternoon, Chair Slama and members of the Banking, Commerce and Insurance Committee. My name is Dr. Lisa Caha, L-i-s-a C-a-h-a. I am a registered pharmacist with nearly 22 years of experience. I earned my Doctor of Pharmacy degree from UNMC College of Pharmacy in 2002. Throughout my career, I've primarily worked in independent pharmacies, starting as an intern at Bill's Elkhorn Drugs and eventually becoming the pharmacy manager at U-Save Pharmacy in Waverly. For over a decade, I worked at Four Star Drug until its closure in May 2016 after 55 years in business. The closure was a devastating blow to both employees and patients as it was more than just a workplace, it was like a family. Fortunately, U-Save Pharmacy reopened the former Four Star location in Waverly in October 2016, where I practiced ever since. One significant challenge independent pharmacies face is low reimbursements from insurance providers, particularly impacting our ability to serve elderly patients, many of whom are on fixed incomes. Often, patients are steered towards PBM-owned pharmacies or mandated to use PBM-owned mail order services. The closure of pharmacies, like the recent shutdown of Ashland Pharmacy, creates medical deserts in rural communities, forcing patients to travel long distances, distances for their medications. We've experienced this firsthand in Stratton, my hometown, where the nearest pharmacy is over 30 miles away. Nebraskans should be able to use the pharmacy of their choice. Many commercial insurance/PBM plans

require patients to fill maintenance medications by a mail order, or from a PBM-owned pharmacy after 1 to 3 fills at our pharmacy. Sometimes the patients can opt out, but most of the time that is not an option. The biggest-- excuse me, the largest PBMs steer their patients to either the PBM-owned mail order pharmacy or go to a PBM-owned pharmacy to get their maintenance meds. I do have a few things I wanted to add that I didn't put in my testimony about some, some suggestions. So I will just talk about, like, a very small generic medication called Atorvastatin, which costs pennies. Like for the 10 milligrams strength, it's 90 cents for 30 tabs. And most insurance plans, they will charge $0 copay to the patient because, well, it's good intentions, right? Because if the patient doesn't have to pay for it, then they are more likely to take it. Well, most of the time we lose money, in like, like, we were paid 27 cents, 26 cents, 29 cents, 70 cents. So we're losing money on cheap medications, and that doesn't even cover our cost of a dispensing fee, which is like usually at least-- it used to be $12 just to break even. That's including the cost of, like, your labor, your paper, all those type of things. It's probably even more now because everything is more expensive. So I just wanted to add that. I urge you to advance LB990. Thank you. I'm happy to answer any questions.

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

LISA CAHA: Thank you.

JACOBSON: Are there further proponents for LB990?

ANDREW RADUECHEL: Good afternoon, Chairperson Slama and members of the Banking, Commerce and Insurance Committee. Thank you for the opportunity to testify in favor of LB990. My name is Andrew Raduechel, A-n-d-r-e-w R-a-d-u-e-c-h-e-l. I'm the Director of Pharmacy for Boys Town National Research Hospital. We are a not-for-profit, disproportionate share healthcare provider. Our healthcare services include acute pediatric inpatient hospitalization, surgical services, inpatient psychiatric hospitalization, and residential medical treatment program for children and adolescents with behavioral disorders and we are the region's largest pediatric mental health provider. During my tenure at Boys Town, I have watched the practice of PBM patient steering continuously grow and witnessed it negatively affect pediatric care time and again. We have many chronically ill children that travel from places like Denver, St. Louis, Kansas City, eastern Iowa, and western Nebraska. These patients often get diagnosed

with diseases that require medication therapies that have frequent dose changes and entail close supervision and coordination between the provider and the pharmacist. Families and caregivers trying to deal with a new, devastating diagnosis, giving their child a host of new medications with severe side effects, coordinating dose changes or different therapies to find out what will work, are often left confused, frustrated, and lost. Due to PBM steering, these patients are made to use pharmacies that are located far away from where they live, receive their medications in the mail with little or no support. This typically is a different pharmacy than they're used to going to and they have no established relationship with. We recently experienced this firsthand when one of our patients who had a long history of uncontrolled violent seizures was made to use a mail-in pharmacy due to PBM steering. This patient also has developmental disorders and it's very difficult to get this patient to take their medications. After many trials and different formulations of various medications, the mother is crushing the medications and freezing them in ice cubes for the patient to take. This took over a year of trial and error with several severe relapses and periods of uncontrolled seizures. It was incredibly frustrating for everyone involved to deal with PBM steering these medications away from their preferred pharmacy to one of the PBM preferred specialty pharmacies. Many times, it would take days to get a return call or get a hold of someone to help. When the family provider did get through, they rarely have the same pharmacist on duty and so the pharmacist was unfamiliar with the patient's history or back story. When the therapy was finally changed or addressed, it had to be sent by mail. This delayed important therapies on many occasions and the patient suffered because of this. Lastly, we have pediatric, pediatric patients with severe diseases, diseases who receive biologic infusions in our infusion center. Many of these patients' benefits mandate that all the infusion medications come from a specialty pharmacy. One of these patients receives infusions for a severe autoinflammatory disease. These patients' infusion appointments are scheduled weeks in advance and so it's up to the Boys Town clinic staff to ensure the drug is authorized and will be shipped to our clinic address and then walk down to our inpatient pharmacy to be mixed. This is an extremely inefficient and risky workflow, and this is just for one patient, imagine if you have 30 or 40.

JACOBSON: Can I get you to wrap up the comments?

ANDREW RADUECHEL: Yep, yep, yep, I'm done. Yep. Thanks and let me know if you have any questions.

JACOBSON: Senator von Gillern.

von GILLERN: Yeah. Thank you, Dr. Raduechel, for being here today. And we walked through the, the hospital together some time ago and helped me to understand what some of the challenges were and I want to thank you for being a, a bright, bright star in District 4. But also, I wanted to note one of the other challenges is many of your patients-- shouldn't say many-- some of your patients don't have the full support of two parent-- two parents helping them to navigate these challenges and so it's even a greater challenge. And you talked about the one parent, that the mother that crushed the medication and freezing them. But there's other challenges that, that come before you at the Boys Town Hospital and the Boys Town community that are different than what we might envision in our own homes. Correct?

ANDREW RADUECHEL: Correct. Yeah, a lot of times the social structure behind all of that. I mean, it's hard for a fully functioning, two, two parents in the family getting them to these appointments, scheduling, remembering when-- getting medications to take. It's-- yeah, it's complicated much more of the social situation when support isn't there.

von GILLERN: Thanks for what you do.

ANDREW RADUECHEL: Yeah.

JACOBSON: Thank you, Senator von Gillern. Further questions? Senator Ballard.

BALLARD: Thank you, Vice Chair. And thank you, Doctor, for being here. Can you-- your second to last paragraph that you missed about the insurer refusing to reimburse. Can you-- can you describe that a little bit more?

ANDREW RADUECHEL: Sure. Yeah, I didn't get to that part but, yeah-- so basically in that scenario-- so we, we, we-- the, the medication was supposed to be sent to us to the infusion center. It didn't make it there. The patient showed-- came in for their infusion and we didn't want-- they took time off a school, mom and dad took time off of work for this infusion and so we said, hey, you know, we'll, we'll go ahead and give you-- we have the drug, it's sitting right here, but we don't have your drug that came in from the PBM specialty pharmacy. And so we infused it, it was $22,000 worth of drug. And then when we told them what happened-- and, and they refused to pay for that, that drug so

we, we ate the cost on that and then we said we'll never do that again because we just can't-- we can't sustain it, although it feels really bad.

BALLARD: Thank you.

ANDREW RADUECHEL: Yep.

JACOBSON: Further questions from the committee? All right. Seeing none, thank you very much for your testimony. And, again, just be cognizant of the time, we, we have a full house today and we have several bills to get through so we're going to be pretty strict on the time limit. So when you're getting to the yellow try to wrap up-- begin wrapping up your comments if you would. So further proponents for LB990? Proponents? All right, how about opponent testimony? And, again, if you're opponents, if you could move to the front as well so we can be a little more efficient on getting the testifier-- how many plan to testify as, as opponents? OK. Thank you.

BILL HEAD: Senator Jacobson, members of the committee, good afternoon. My name is Bill Head, B-i-l-l H-e-a-d, with PCMA, which is the national PBM trade association. Thank you for the opportunity to testify this afternoon, respectfully, in opposition to LB990. I do want to recognize Senator Bostar who has repeatedly brought together stakeholders to have conversations. I've found those very helpful to understand the issues that pharmacists and hospitals and others have and it's been helpful in that understanding. Unfortunately, we cannot support the bill has drafted. I, I do want to address a couple statements that have made about PBMs and what PBMs do. It's important to note that PBMs are B2Bs. We're, we're, we're not an independent entity that is inserting itself into the distribution system with the supply chain. We're hired by the state of Nebraska, every state, actually. We're hired by businesses to manage their drug benefit. So when a-- when a patient is directed to use a mail order drug or receive their drugs through mail order or to use certain pharmacies, that's because that PBM has been contracted to implement that benefit that that enrollee has signed up for. And typically when there is a, a, a mail order benefit, it is the, the choice of the plan to use that because it saves them money and it saves the patient money. It was referenced earlier that a number of states have passed provisions and similar to what's passed here. I would always challenge somebody to point to a single PBM bill in a single state that has expanded access to patients or lowered costs for patients. Rebates and formularies were, were mentioned. And it is true that rebates do impact where the

brand drug goes on the formulary. But at the end of the day, it will only-- it's the plan's formularies, not the PBMs, and the plan has the final say on the formulary. So it-- and it will be based primarily if that drug is in the same therapeutic class and it is going to save the plan money, the purchaser money, then it is going to get a preferred position on the formulary. I know I'm running out of time, but I do want to say that one of the provisions in here is on specialty pharmacy. We had agreed in LB767 that there would only be one required independent national accreditation. Typically, we, we would prefer two, what we had discussed at the stakeholder meeting was not imposing additional requirements on a specialty pharmacy that was-- that they wouldn't impose on an affiliated specialty pharmacy. This goes into complete opposite direction and says you can't even impose terms-- the same terms and conditions, all you can do is require that one specialty designation. So this actually takes away even the terms and conditions. We had agreed that we would not impose any additional requirements on a specialty pharmacy that weren't imposed on a-- on a affiliated specialty pharmacy so all the conditions would be the same. And I realize that they view them as onerous, but they, they would-- they're ubiquitous. They are the same across the board. So with that, I respectfully request not advance LB990.

JACOBSON: Thank you. Questions? Senator von Gillern.

von GILLERN: Thank you, Senator Jacobson. Thank you, Mr. Head, for being here today. You made the comment, I cannot support the bill as drafted, which implies that there might be a draft of the bill that you could support. You mentioned the terms and conditions, other than some of those, what other modifications could be made to the bill to cause you to support it?

BILL HEAD: Well, I, I, I, I, I actually do like Senator Bostar's amendment on the application of Medicaid, which we were always fine with. And, and, and also, I think the-- I think if we modified the specialty language to say PBMs can impose additional requirements that aren't imposed on affiliated specialty pharmacies, that was sort of what we thought was the concern was PBMs were adding on requirements that they weren't doing to their own pharmacies or their own affiliated pharmacies, rather. And then I think something on, on the mail order provision, I think there is, typically, ancillary mail is allowed and we can sort of look, look at that. But, but on one hand you can't say that, you know, PBMs can't require mail, but then say-- but you-- and you have to allow independent pharmacies to do mail. And I think the concern we have there is there's a lot of controls on the

mail facilities, a lot of checks, checks and rechecks in automation and such. And we just want to make sure that if a independent pharmacy is going to do mail, that it be done safely and effectively. I think for the most part that probably would happen. But they don't have the sophistication that a lot of mail pharmacy has.

von GILLERN: OK. So I'll ask another follow-up question since you went to the mail issue. I can mail a letter and it doesn't matter if it's going from Lincoln to Holdrege or Lincoln to Denver or Lincoln to Winston-Salem, North Carolina. It still goes through the same processes. One might take a day or so longer, but they generally get there. And so, so what, what is the risk to limiting the distance and so on?

BILL HEAD: No, that's a fair-- no that's a--

von GILLERN: Yeah.

BILL HEAD: --that's a fair question. Well, the concern is that because mail does get lost sometimes or mail gets delayed and what is going to happen. Because we typically have in place-- if for some reason the mail, you know, you know, inclement weather, and for some reason the mail is delayed and the person is scheduled to get their medication on the next day and it's going to be delayed by a few days, the PBM mail facility or affiliated facility will typically make arrangements so that person can get a 6- or 7-day supply in the interim. Is the independent pharmacy going to be able to do that and make that accommodation that that person they've mailed it to can get something in the interim to, you know, accommodate what their medical need is for the time being? If the-- if it gets lost, if it's delivered to the wrong address, what, what, what fact-- what sort of protections do they have in place and then who replaces-- who pays for the replacement? Is the pharmacy willing to pick up the tab? Because the, the affiliated mail facility for the PBM will pay any replacement costs, right, they're not going to "rebill" the patient for the same medicine. So it's those kind of, sort of parameters around to make-- it's really the patient protection aspect of it or the patient delivery aspect of it that we want to make sure happens. But your, your point's fair. It's just having the same parameters around, you know, the delivery.

von GILLERN: And, and, and I'm, I'm not trying to engage you in an argument--

BILL HEAD: No, no, no, no.

von GILLERN: --but if I mail a box or your mail a box, both of them are equally subject to being lost or delayed by weather.

BILL HEAD: Right, no, absolutely, and it's the accommodation of when it gets lost is how that's accounted for because we have-- we have-- our mail [INAUDIBLE] have steps in place to account for that. Will they-- what steps will they have? Will they have the same steps in place to take that into account?

von GILLERN: OK. Thank you.

JACOBSON: To follow up that line of questioning, I, I guess I would just say that I've heard this-- obviously, we've been doing this a while and I've heard a lot of presentations. Many of these infusion centers, as we heard from the testifier from Boys Town, have that drug on, on hand. If it doesn't show up in the mail, they are in a position to be able to, you know, infuse a different drug. And, yet, the PBM refuses to reimburse them for the drug that got lost in the mail that they sent. So my concern is that we-- I've heard this multiple times and, yet, I don't see a real clear answer as to why those aren't being reimbursed, why they're not being-- why they're being left hanging? And it really gets back to Senator von Gillern's point of mail is mail and, and generally you've got local pharmacies that would be more than willing to step in and provide that if they knew they were going to get reimbursed. But, but once you don't get reimbursed, you're probably less likely to.

BILL HEAD: You know, and that-- and that-- and that's [INAUDIBLE] made a fair point, too, and I, I can't-- I can't argue with that. I, I think there-- because we-- what I just-- based on what I just said. If, if the-- if something is lost, my understanding is and we'd be willing to work on something to make sure this is the case. If some-- in that case, if it doesn't get to Boys Town on time when it's supposed to, that, that-- they should have been reimbursed for have-- having that. Now, there's going to have to be a, a reimbursement contract in place of some sort to accommodate that. But, obviously, because you don't want-- at the end of the day, nobody wants the patient to suffer. That's the bottom line.

JACOBSON: We would hope not.

BILL HEAD: So there has to be-- there has to be an accommodation for those situations. So certainly more than willing to work on something like that because that-- the idea of having these facilities is so that, the example I just gave. If that does happen, there's an accommodation made for that patient and, and issue.

JACOBSON: And I think we are going to get that opportunity. I, I, I think that clearly this is an issue that keeps coming back every year. And I'm hopeful that as we move forward, we're going to be able to get all the parties under one tent and really ferret out all the issues and come up with, perhaps, a more global fix in the future. I realize it's late this session and we're running out of time, but, but I think it's going to be critically important that we get this worked out before we lose all the rural pharmacies and that we come up with some kind of compromise that works for everyone. At the end of the day, this was really designed to lower, lower patient costs, lower insurance costs. But, but we're not certain that that's necessarily happening and, instead, we seem to be losing a lot of pharmacies, so.

BILL HEAD: Well, but we do-- but we do see, when these bills do pass, they don't expand access or lower-- or lower--

JACOBSON: And I-- and I-- and I think that's a fair point and I think that's got to be part of any kind of fix.

BILL HEAD: And we'd-- yeah, and we'd love to-- and we would very much like to do a deep dive with the committee at some point on exactly how we function and-- because I think-- I think it is a confusing supply chain, frankly, not just our role but, you know, the, the wholesalers, the PSAOs, the manufacturers, they get very complex, unfortunately. And you're being forced to sort of pick sides. And so to the extent we can educate each other, I think that would be helpful.

JACOBSON: I-- oh, I think that's critically important and I, I spent a lot of time last summer with the-- with the health insurers on a medigap bill. I think that was very educational for both of us and I'm hopeful we can do the same thing with PBMs. Clearly, we've got to spend some time to get this right because it's not working the way it is and I think you'd probably agree with that. [INAUDIBLE]

BILL HEAD: Absolutely. Absolutely.

JACOBSON: Thank you. Any other questions from the committee? All right. If not, thank you, Mr. Head, for your testimony. Further opponents? Welcome. Go ahead.

MICHELLE CRIMMINS: Thank you, Senator Jacob-- Jacobson, the committee. My name is Michelle Crimmins, spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s. I am a registered lobbyist representing Prime Therapeutics, a Pharmacy Benefit Manager owned by 19 not-for-profit Blue Cross and Blue Shield insurers, subsidiaries or affiliates of those insurers, including Blue Cross and Blue Shield of Nebraska. My testimony today is in opposition to LB990. And, actually, both of the pieces that I am in opposition to have to do with credentialing of pharmacies. So we've heard two pieces in the bill today already discussed. Right? We've heard about local pharmacies that want to do mail order, and we've talked about specialty pharmacies that want their credentialing requirements lowered to join the network for a PBM. And, actually, our issue is very similar for both of these. Mail order networks that have mail order pharmacies have very specific credentialing requirements that we ask to have, like, specific accreditation that is designed for mail order pharmacies. You know, there may be specialty requirements that we include in the credentialing require-- the credentialing process to ensure that quality and safety measures are met. And the processes that Bill had discussed previously for if something were to not go right, you know, how do we make sure that the member is not being missed with their care or missing their drugs? You know, processes in place for that. Community pharmacies should also be following those same requirements if they're going to be doing mail order. And this bill prevents us from having specific networks that we would require them to join to do mail order pharmacies, which would then have those credentialing requirements where they need to meet the requirements for safety and procedures to make sure that should the mail go missing, what do we do about that? You know, if they're mailing more than 50 miles away, are they going to then make the member drive into their pharmacy to get a replacement shipment? Are they overnighting it? Are they contracting with another pharmacy to dispense? What's the process? We would like to know what the processes and ensure that it's followed. And then, lastly, I want to thank Senator Bostar for the stakeholder meeting that he held over the summer. We've heard several pieces of testimony today that are not in this bill discussing white bagging, discussing contracting, payments to pharmacies. And I welcome any opportunity to continue those conversations so that we can work on the issues together.

JACOBSON: Thank you and I appreciate that.

MICHELLE CRIMMINS: Um-hum.

JACOBSON: Questions for the testifier from the committee? All right. Seeing none, thank you, Ms. Crimmins, for your testimony. Further opponents? Mr. Bell.

ROBERT M. BELL: Good afternoon. Final hearing of the-- of the year.

JACOBSON: We're all celebrating.

ROBERT M. BELL: Yes. Chair or Vice Chairman Jacobson 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 executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies, including most of the health plans in Nebraska. I'm here today in opposition to LB990. As you know, the regulation of Pharmacy Benefit Managers has been a hot topic for a number of years in the Legislature and LB767, the Pharmacy Benefit Manager Licensure and Regulation Act passed in 2002 and became operative on January 1, 2023. It provided a number of reforms and required licensure of most PBMs. I'm going to center my testimony on Section 1 of LB990, which are the definitions of the PBM Act and specifically the definition of health benefit plan. My understanding is that Senator Bostar's amendment would strike the changes in Section 1 and replace the new language with language that states to the effect of that is entered into, offered, or issued by a health carrier or self-funded employee benefit plan to the extent not preempted by federal law. Additionally, the amendment makes it clear that Medicaid contract between the Department of Health and Human Services and the PBM or Managed Care Organization should include a requirement that the PBM Act applies. The Federation believes this is a reasonable clarification to the application of LB767. It would be neutral on the legislation if the scope of LB990 was limited to that clarification. Because LB990 currently consists of other provisions on delivery and specialty pharmacy, that you've already heard about, that would directly impact the ability of insurers, PBMs, and the businesses they work with to design plans to meet the best interests of the premium payers whether the employee, employee-- employer, employee, or both, the Federation must oppose. However, if the committee decides to move-- remove those plan design provisions and focus solely on the clarification of LB767, the application of the LB767 law to MCOs and health plans, the Federation would move to neutral. And I appreciate the opportunity to testify. Thank you.

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

ROBERT M. BELL: You're welcome.

JACOBSON: Further opponents? Anyone wishing to speak in opposition to LB990? Seeing none, anyone wishing to speak in the neutral capacity on LB990? All right. Seeing none, Senator Bostar, you're welcome to close. I might note that there were 9 proponent letters, zero opponent letters, and zero neutral. You're welcome to close.

BOSTAR: Thank you, Vice Chair Jacobson and members of the committee. I think-- you know, Senator von Gillern, you talk-- a lot of your questions on things related to this are, I think, related to the ability for independent actors to make decisions, right, so whether or not terms and conditions are disclosed. And I-- and I appreciate that about you. And I, I appreciate your commitment to open market systems. But this isn't that. There's nothing open about the market here. These are monopolies. These are monopolies looking to secure more monopolistic power. That's what's happening. That's how the whole thing works. The concerns over consumer safety on mail order is odd a little bit when I don't know what processes a different specialty pharmacy has to have influence over how well the mail is delivered. We've been working for a long time in the city of Lincoln with United States Postal Service to try to get a facility moved so that we can do some development downtown. It can be challenging for our highest level government officials to even get a meeting with the Postal Service. I struggle to understand how specialty pharmacies have some inside track into the mail system because they don't. What's happening? To be clear, mail is allowed now. It's allowed now. During COVID especially, it was allowed broadly, things were loosened. So what we're seeing is independent pharmacies are mailing drugs to people for their convenience who want that option. PBMs are placing a restriction on that saying they cannot mail anymore these particular drugs, what have you, and then going and contacting those patients who receive those drugs and saying if you would like to continue getting your medication by mail switch your pharmacy. It's not a free market. We have to fix that, especially for folks in rural areas, people who can't get out. This is how they're getting their drugs. And I'm going to tell you, I'm less worried about a pill shipped from Lincoln to Waverly than I am from Florida to Nebraska. On the regulations, we passed a bill that said that our specialty pharmacies could enter into the networks. That was the law we set. We made that decision. And we said, yes, they could be-- they, they could have to follow the terms and conditions

established under the PBMs. So that has now been twisted to circumvent the laws that the-- that this Legislature passed. Now no one gets in because every time documents are sent in terms are complied with. There's a new one and a new one and a new one. After this hearing-- after these hearings, talk to some of these folks. Ask them if they've been able to get into any of these networks. Some of the largest healthcare providers we have in the state can't manage to get in to comply with the laws we set that are being blatantly ignored disrespectfully of this body and that's why we're here. That's why this bill exists. Yes, we agreed that they should have to comply with it, but now that's being used to undermine the integrity of our Legislature. I believe that's unacceptable. Happy to answer any questions.

JACOBSON: Questions? Seeing none, thank you, Senator Bostar.

BOSTAR: Thank you.

JACOBSON: And this closes the hearing for LB990. I see Senator Wayne has arrived so we'll move on to open the hearing on LB1232. Senator Wayne, it's all yours.

WAYNE: Good afternoon, Vice Chair Jacobson and fellow members of the Banking, Commerce and Insurance Committee. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, which is north Omaha and northeast Douglas County. I'll first by incorporating everything that Senator Bostar said, I don't know what he said, but he mentioned PBMs and that's enough for me to say I endorse it. I'm here to introduce LB1232, which prohibits Pharmacy Benefit Managers, or PBMs, from reimbursing pharmacists for less than the cost of the drug. The industry is going to be here today, no doubt, opposing, but some of them pulled me out earlier and told me they would be here, of course. And the bill only impacts PBMs, these are the companies that do not make the drugs. They do not disperse the drugs. They do not prescribe the drugs. They provide no patient care. Most of-- most people have no clue who or what a PBM is. Yet, because of their position in the supply chain, they yield incredible power and market consolidation has resulted in only three companies controlling 80% of the marketplace. Profits for PBMs have certainly outpaced inflation in the last decades, the profits of the big three have increased 438%, raking in over $1 trillion in revenue and reaching $7 billion in profit. I ask when companies profit at such a record rate, should we allow it or occur at the expense of, of the provider, small businesses and independent pharmacies, or at the expense of patients?

Predatory price gouging behavior by PBMs is a growing problem around the country. And since 2020, more than 30 states have enacted roughly 50 different laws regulating PBMs, many of them targeting the exact what I am trying to do today. This bill is both-- has been both introduced and passed in both conservative and liberal states. This is truly a bipartisan initiative. Along with hundreds of attempts across the country at the state level, at the federal level, bipartisan efforts are also being made with Senator Chuck Grassley of Iowa teaming up with Senator Maria Cantwell from Washington introducing a, a Pharmacy Benefit Manager Transparency Act, which is far more impactful than what I'm proposing right here but it's something as a state we should address. Around the country, you have heard this involvement and the previous bill told you some of the industries' problems or some of the problems with PBMs. Again, this bill only prevents the massive PBM conglomerates from reimbursing pharmacies at less than the amount it costs to disperse the drug. Many of these regulatory attempts touch on this while the big fortune 50 pharmacies like Walgreens and CVS would, perhaps, support this as well. The bill is really intended to help independent pharmacies around the state because they are the ones who are hurting from this practice. This bill may need an amendment. I'm not going to say every bill I draft is perfect, perhaps providing a little more flexibility so that there would be no hang-ups with pharmacies receiving discounts or rebates on certain drugs. Also, to clarify, the cost to dispense the drug is a cost to acquire the drug, not their operation-- not other operational costs. The pharmacy should be able-- should be made to hold on the actual cost of the drug. PBMs and the industry leaders should take note of the regulatory efforts around this country. This isn't the first attempt, and this isn't even the first attempt during this Legislature. People are tired of the rising costs and the out-of-control medical expenses and pharmacy expenses. Thank you to the committee and I will answer any questions.

JACOBSON: Questions for Senator Wayne? All right. I guess we're limited on our staff, our crew here today, so. Seeing none, thank you, Senator Wayne.

WAYNE: Well, I appreciate none of my no votes being here so if you can Exec on this today.

JACOBSON: Exec right now.

WAYNE: If we can Exec right now and kick it out, it'd be great. But, no, I have another bill up so I won't be here for closing. But, again,

this is an important issue and, and we just-- we got to start tackling these issues.

JACOBSON: We'll be thinking about you during the close.

WAYNE: Thank you.

JACOBSON: Thank you. All right, are there proponents for LB1232? Any proponents? And I'm going to remind you, again, of the light system. I get more cranky as we move through the process.

MARCIA MUETING: Good afternoon, Vice Chair Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g. I'm a pharmacist and I'm the CEO of the Nebraska Pharmacists Association. Many thanks to Senator Wayne for introducing LB1232. A law must be put in place to prohibit reimbursement below a pharmacy's cost. I think Nebraska is beginning to see repercussions of underpaying pharmacies, which is why I provided you with this chart. This chart not only shows you the number-- total number of pharmacies, the blue bars, over the years that have been in Nebraska starting in 2018 with 423 pharmacies and now we're down to 345 pharmacies. But the only sector that gained the number-- a number of pharmacies was supermarket pharmacies and those gains were small-ish. So we've lost independent pharmacies, we've lost chain pharmacies, we lost mass merchant pharmacies, and we've had some small increases in supermarket pharmacies. My point is, if pharmacies can't operate sustainably, they will-- they will cease to exist and they're an important part of the healthcare frame-- framework. PBM-- PBMs rely on a network of pharmacies to provide access to prescription drugs for their members. If PBMs consistently underpay pharmacies, it will lead to phar-- it will lead to pharmacies leaving their networks, reducing access to medications for members and undermining the PBM's ability to fulfill its obligations. Underpaying pharmacies could compromise patient care if pharmacies cannot stock certain medications or provide essential services. PBMs have a vested interest in ensuring that pharmacies remain financially viable to maintain continuity of care for their members. I urge you to advance LB1232. I'm happy to answer any questions from the committee.

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

MARCIA MUETING: You're welcome.

JACOBSON: Further proponents for LB1232? And welcome, Senator Dungan.

DUNGAN: Hello, glad to be here.

TOM CHOQUETTE: Vice Chair Jacobson and committee, I'm Tom Choquette, T-o-m C-h-o-q-u-e-t-t-e, speaking on behalf of supporting LB1232. At 1:30 in the morning on, on March 14, 2022, my wife got a text from her sister who lives next door asking if there was anything she could do and was very sorry about our building burning down. That's how we heard our downtown pharmacy location was destroyed by fire. The building was destroyed, but our customers responded with great commitment to our business and we retained over 90% of those customers by serving them at our second location. Why am I bringing this up? Our customers are very resilient and loyal. The current reimbursement rate is not a building destroyer, but it's a-- it's a business destroyer. We cannot sustain the underwater claims we have seen just since January 1. Bert's is a high volume pharmacy. As a matter of fact, we are fortunate to be in the top 2% of volume in the whole country. Even with processing over 12,000 to 13,000 prescriptions a year, the current losses are unsustainable. One of the three Nebraska Medicaid providers, we processed 2,285 claims this year, totaling a loss of $3,084. As an example, last Saturday night I had to go in and fill a couple of prescriptions for Dexamethasone and EpiPen. The patient was having breathing problems. I ran the claims, we made 21 cents on the Dexamethasone and we had a $125 loss on the EpiPen. This was after hours when I drove in and I won't even tell you what I was thinking. One of the primary proponents-- well, one of the primary third parties, PBMs, we've processed over 3,499 claims since January 1 with a loss of $6,700. 13% of their claims are below cost. If you're looking for a COVID vaccine, and you come in, we're expected to lose between $5 and $11 whether it's Pfizer or Moderna. We had a patient requesting a 3-month supply of a hypertensive medication. After adjudicating the claim, we were losing $161. We asked if we could only take a loss of $35 and do one month at a time. He said, I don't think so. I'll think about that. He called his HR person, HR called the PBM. The PBM called the next day and said if you don't fill the 3-month supply, we're going to pull your contract. You won't be able to fill any more of our prescriptions. So they called the next day and the next day and the next day so we did fill it. I graduated from the University of Nebraska with a bachelor's degree in pharmacy in 1978 and have been an owner for 42 years. Never, have I seen the challenges like pharmacy is facing today. The current losses we are enduring make it nearly impossible to make a profit. With the closing of over 90 independent pharmacies in Nebraska in the last 10 years, we could be

looking at devastating effects in small town Nebraska. In many small communities, the pharmacy fills gaps in healthcare not provided in other places. However, these losses are unsustainable to stay in business. I would ask for your thoughtful consideration in getting the PBMs under control in our state before it completely ruins pharmacy and eliminates even more options for patients living in Nebraska. Thank you.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none, thank you, Mr. Choquette,--

TOM CHOQUETTE: Thank you.

JACOBSON: --for your testimony.

TOM CHOQUETTE: Thank you.

JACOBSON: Further proponents for LB1232? Proponents? One of you decide. Don't make me pick. [LAUGHTER]

JEFF KILBORN: Yeah. I'd say something creative--

JACOBSON: Go ahead. Sorry.

JEFF KILBORN: --but I'm not very creative, so. Good afternoon, Vice Chair and members of the Banking, Commerce and Insurance Committee. My name is Jeff Kilborn, J-e-f-f K-i-l-b-o-r-n. As a lifelong Nebraskan and pharmacist, I've owned and operated Elmwood Pharmacy in Midtown Omaha for the past 27 years and hopefully will be able to leave it to the next generation. I'm here today to speak in favor of LB1232 and what has happened and will continue to happen regardless of what the PBMs say if they are allowed to go unregulated and continue their practices. I believe that local pharmacy-- owned pharmacies provide irreplaceable healthcare services to Nebraska communities and that LB1232 will support the continued existence of these pharmacies by reining in the anticompetitive business practices of PBMs. The monopolistic business practices of the PBMs, as previous testimonies have passionately illustrated, have resulted in over 82 locally owned pharmacies to close since 2010, stripping many Nebraska communities, especially those in our small towns and rural areas of Nebraska of the personalized and neighborly healthcare they deserve. The void by the loss of independent pharmacies cannot be filled by corporate or mail order pharmacies, which operate with the business model that's based solely on satisfying the shareholders and not the residents of Nebraska. How many in the Chamber today have received a vaccine,

needed an antibiotic, pain medication, and expected to have that prescription filled the same day or have a family member or friend who benefits from compliance packing, same day delivery of lifesaving medication, or has the trust of their independent pharmacist to discuss prescriptions in depth or to be their, their advocate in navigating the challenges of healthcare systems today as explained by other testimonies? Independent pharmacies can be counted on in these situations because our livelihood depends on it by providing excellent pharmacy services to our neighbors, by giving them a reason to choose us, while the PBMs use anticompetitive techniques that leave patients no other choice but to use pharmacy-- chain pharmacy or mail order. Yes, the argument can be made that other providers can deliver these services, but when our healthcare system is already stretched to its limit there is no guarantee. In addition to the loss of services by providing-- being provided to Nebraskans, the committee should also consider the, the loss of tax revenue due to PBMs forcing independents out of business. Tens of thousands prescriptions are, are forced to use their preferred mail order. And I'm going to sum it up here real quick. The final-- another reason is the potential brain drain. But in closing, I want to reiterate there is more at stake to Nebraskans than me as an owner complaining about the unfair reimbursement. God knows there's easier ways to make a living than operating a small, independent pharmacy. What is truly at stake is the less quality of healthcare being provided, increased prescription costs to both the individual and locally owned businesses, and loss of young Nebraskans who no longer have the opportunity to practice pharmacy at the highest level in elimination of independent pharmacy. I apologize for running a little bit over.

SLAMA: No, you're fine. Thank you very much for testifying. Are there any questions from the committee? Yes, Senator Dungan.

DUNGAN: Thank you, Chair Slama. And thank you for being here today. This might be kind of a broad question, and I apologize if it is, but you've been working as an independent pharmacist, I think you said, for the past 27 years. What kind of overarching changes have you seen in the profession in that time, kind of related to this area? And, and can you go into a little bit more detail about some of the challenges that you've seen personally in your independent pharmacy?

JEFF KILBORN: Yeah, the biggest challenge, and Senator Bostar alluded to it in, in LB990 testimony, that there's more and more consolidation of the big three pharmacy-- the big three PBM operators that they control about 80% of the market. And, in fact, there's a handout in

that-- in my packet that addresses some of those things. But the biggest thing is we don't have a choice, that it's-- and David Kohll referred to it as well, that if we decide to not service a particular PBM insurance or a PBM patient base, we'll eliminate-- depending on which plan it is-- in my case, if I eliminated Express Scripts, I would eliminate 70-- or 60% of my business, you know, so it's a choice. You either try to take-- see-- do what you can to stay alive, take the under reimbursement for the claims, find other things to supplement that income, work on extra hours. So, you know, my hours should be being reduced because, actually, in the first time in the last 4 years, I've been able to hire additional pharmacists. But I'm working more now than I did before due to all the other things that PBMs have put on our plate, trying to figure out how to negotiate or find different niches or, or different areas to specialize in or provide other services that the neighborhood has asked for or the, the, the patients have asked for. Like, for our sake-- in our case, compliance packing that we manage medications in. You know, Senator Wayne that spoke, we have a large population that lives in north Omaha that doesn't have access to transportation and we deliver 80 to 100 deliveries every day and the majority of them or a large share of them are in east-- southeast and northeast Omaha, because those individuals don't have transportation or we have-- we are on a bus stop. And so we have multiple, you know, customers that come visit us and they take the bus. But those customers on the margins are the ones that we're talking about, just like independent pharmacies that are the ones in the margin that don't have a choice. We don't really have a voice and that's why one of the reasons I'm here today, too, is-- this is a, a character flaw on my part, but I kind of get worked up and I have a hard time finding my words. But my oldest son said, you know, Dad, you have to quit complaining about it or do something about it so that's why I'm here today.

DUNGAN: Thank you. I appreciate it.

SLAMA: Thank you, Senator Dungan. Additional questions? Senator Jacobson.

JACOBSON: Just, just a quick comment. I, I truly do appreciate you being here and, and clearly your, your testimony is impactful. It's worth your time to be here and I appreciate you being here. Thank you.

SLAMA: All right. Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, I second Senator Jacobson. Thank you very much for being here. Additional proponents for LB1232?

DAVID RANDOLPH: Glad to see you because I had this almost memorized and you weren't here. I was, like, oh, crud, who am I going to say now? [LAUGHTER]

SLAMA: Happy to be of service as always.

DAVID RANDOLPH: Good afternoon, Chairperson Slama and other members of the Banking, Insurance and Commerce Committee [SIC]. My name is David Randolph, R-a-n-d-o-l-p-h. I'm the pharmacist/owner of Dave's Pharmacies in Hemingford and Alliance, Nebraska. I'm representing myself, the Nebraska Pharmacists Association, as well as independent pharmacy-- pharmacies in the state. I'm here testifying in support of LB1232, as well as LB990, by the way. As you've heard, it is a daily occurrence when we receive next to nothing as far as reimbursements from the benefit-- Pharmacy Benefit Managers/insurance companies and, oftentimes, it is actually negative reimbursement where they don't even cover the cost of the drug. This can occur on any prescription but we mainly see it on hard to find short items, expensive generic and brand name drugs. My inventory in one store has decreased by 50% in the last year. This is not because we're filling less prescriptions, it's solely because I don't keep the medications on hand that I will not be paid the full amount on. If I receive a prescription, I will run it through the insurance, see if it's covered. A lot of times the PBMs say they cover it, but they don't cover the full cost to the pharmacy the amount of the drug that we pay. If the claim goes through, then I will actually order it in. If it won't, I won't. So it's frustrating to patients, providers, and pharmacists as well. We just want to take care of our patients to the best of our abilities and be able to make a living doing it. Not being able to provide for all of our patients' medications due to the underpayment by PBMs hinders care and doesn't give the full medication picture to any of the pharmacies involved. The one thing this bill does not address, however, and I would like to see an amendment added, is the right of refusal granted to the pharmacist. Four other states have similar laws that have passed and are on the books and being enforced with this provision. What that would mean is that when a PBM doesn't pay the full cost of the drug to the pharmacy, the pharmacist can refuse to fill that medication even if they have it on their shelf. So it's not a matter of ordering-it-in-when-I-need-it-type deal. This does two things: It allows the pharmacist to still carry a good supply of all medications that you normally would use to have on hand. And, secondly, it holds PBMs accountable for paying pharmacies fairly. You also need to remember that this is not just the cost of the drug involved, there is a cost to dispense, like Senator Wayne

mentioned earlier, and it does not cover that. PBMs will say this hinders care and cuts off prescription access to patients. To that end, I have one solution. Pay me. They may say that they have an appeals process, which they do. However, in that process, in 10 years, appealing 2 to 10 claims every day to the big three. In 10 years, I have gotten less than 10 overturning to pay me better in that regard. So it's a waste of time. It's a waste of money. They don't only don't increase the payment, they don't tell me where I can get it and what NDC or what manufacturer to use to get it at the reimbursement that they're giving me. We need to safeguard against PBMs mandating drugs be dispensed at below cost reimbursements. Imagine if the Federal Reserve told you you must give out loans at a 0% interest rate. Then when the loan is finalized, depending on the size of the loan, you must pay the reserve $5 to $200 just for the privilege of issuing that loan. This is what we're dealing with with the PBMs not allowing-- we're dealing with, with the PBMs when they're allowed to continue in these practices. Nationally, we've lost 2,251 independent pharmacies alone since 200-- or 2020. In the state of Nebraska, since 2020, we've lost 58. Cutbacks in hours, cutbacks in services are happening across the nation due to the greed of the PBMs. In Nebraska, that's 58 communities that now don't have access to pharmacy services like they once did. They either have to drive distances never seen before or have to get things through the mail. That's also 58 businesses in Nebraska not hiring Nebraskans and not paying taxes to help benefit the state. We need LB1232 to pass so we can actually start reining in these practices.

SLAMA: Well, thank you, Mr.-- thank you very much, Mr. Randolph. As always, I'm really grateful that you made the drive to be here today.

DAVID RANDOLPH: Thank you.

SLAMA: Let's see if there's any questions from the committee. Seeing none, thank you very much.

DAVID RANDOLPH: All right. Well, I'll get on the road again. [LAUGHTER] Thank you.

SLAMA: Additional proponents for LB1232? Last call. Any additional proponents for LB1232? Seeing none, anyone here to testify in opposition to LB1232? Welcome.

BILL HEAD: Senator Slama, members of the committee, thank you, again, for the opportunity to testify on LB1232. It's good to see everyone.

And I was remiss in not saying it earlier, it's always great to be back in Nebraska. Unfortunately, here in opposition to LB1232. I, I, I do want to, before I talk specifically about the bill, I do want to mention a couple of things that were raised. I found it interesting--

SLAMA: But before, can we get your name?

BILL HEAD: Oh, I'm sorry, Bill, Bill Head, B-i-l-l H-e-a-d.

SLAMA: There we got it. Thank you.

BILL HEAD: Thank you. I, I was confused because we heard folks saying that they had take-it-or-leave-it contracts, that they have to be in the network, and they have to take the [INAUDIBLE]. But then we've heard people say they can't get into the network. So sometimes I, I, I, I jokingly say we're, we're-- people forget to say that PBMs are also responsible for global warming because we do seem to get blamed for all the woes in the supply chain. And I would encourage you to look because it was, you know, mentioned about PBM profits, and I would encourage you to independently look at sources on what profit margins are for people in-- for entities in the supply chain. The manufacturers are in the high 20s, 28%. PBMs, and I know this from our members, which is we're in the 4 to 6% range. We managed to benefit 275 million Americans so there is-- there is certainly a profit to be made. But in terms of the margins, again, don't take my word for it, please, look at independent sources for what everybody is: the pharmacies, the wholesalers, the PSAOs, and, and everybody. Because if we're going to make progress on this, and I sincerely want to, we have to agree on a common set of facts. Right? And I, actually, appreciate at least what LB1232 is doing is, actually, putting, I think, the, the real issue on the table which is pharmacy reimbursement. I think a lot of the bills-- the PBMs' bills we see is really just sort of almost spaghetti against the wall and hope-- and I think the hope is that will result in higher reimbursement rates for, for pharmacies. I, I think there is a legitimate real concern about their-- about, about pharmacies. But it's not just independent pharmacies. There are actually more chain pharmacies that have closed in the state over the last 10 years and so there are other market forces at play here. You know, you have Mark Cuban now the business. You have Amazon in, in the business. So you have other-- you have other market forces in play. And I think-- I think we'd do ourselves a service if we have a discussion about what all is in play here, what are the factors that come in-- that go into the reimbursement? And certainly let's have a discussion about rural reimbursement. We've done that in other states.

Iowa is looking at it now and we're, we're working with them. But it's a-- it's a-- it's a legitimate issue and one we should address, but let's agree on the common facts first before we get-- we get into it. And for us knowing what pharmacies, you know, what limitations do they have with their wholesaler? You know, can they go to secondary markets? You know, what are their-- what are their rebates and discounts? Because we want to make sure that everybody is treated fairly, but we have to understand all sides of the-- of the ledger here if we're going to get into that. So certainly something we're open to discussing. I think this bill is way too open-ended in terms of just whatever cost to dispense because then, you know, who knows what that-- what that number is. But with, with that, again, respectfully, we oppose LB1232. We urge, urge you not to advance it out of committee and happy to answer any questions.

SLAMA: Thank you very much. Are there any questions from the committee? Senator Dungan.

DUNGAN: Thank you, Chair Slama. And thank you for being here. I missed the other bill, I think, you testified on and I apologize for that. I was introducing another bill in another committee. I agree, it's important that we start with a similar set of facts. I think that when we don't do that, we often talk past each other and that's a huge problem. I think everybody at this table has had that issue on legislation. So it is important, I think, to start there and I would agree with that. I guess first of all, you know, we had a handout that was given to us, I think, by another testifier with regard to the reduction in pharmacies in Nebraska and I know you don't have that in front of you. But according to this, in 2018 there were 200 independent pharmacies. And then by 2023, we're down to 140. So that's a reduction of about 60 pharmacies, give or take, whereas the chains had 101 in 2018 and now they're down to 88 so somewhere 15 to 20. So it seems like there's been a larger reduction in independent pharmacies between 2018 and 2023. Would you agree with that?

BILL HEAD: I would not and I don't know the source and I'm happy-- I did bring this. This is also the numbers of independent chains and it's from NCPDP which is an independent source. They, they track pharmacy numbers and, and prescription numbers and data. So it's a number we rely on. But because it is independent, it's not us [INAUDIBLE], but it has-- and, and you said 2018. So in 2018, they had 184 independent pharmacies and in 2023, 186. On the chains, 2018, 232; and 2023, 197. That, that said, the fact that they're, they're struggling is enough for us to want to come to the table and sort of

figure something out. I mean, we can-- but I-- but it goes to the, the point we're both making, which is let's agree on some common facts and figures.

DUNGAN: You said there was how many independent pharmacies in 2018 according to that data?

BILL HEAD: 184.

DUNGAN: And then how many were there in 2023?

BILL HEAD: 106-- 186.

DUNGAN: So that information says there's been an increase in independent pharmacies.

BILL HEAD: A slight-- a, a, a, a slight-- a slight increase. I'd also direct you to NCP-- NCPA, which is the national trade association for the independent pharmacies. They actually-- in their annual report last year they, actually, said that independent pharmacies were, actually, doing the best they've done in a number of years. And so that's-- and that's not-- so that's them, that's not--

DUNGAN: I, I--

BILL HEAD: --that's not us. But, but, again, but--

SLAMA: All right, listen, if we could get the feedback down.

BILL HEAD: It's a-- it's a-- it's a national number and Senator Jacobson is always very quick to correct me on this. OK, that's great nationally, but what is the impact on Nebraska? And that's why I'm saying, like, that may-- that may be the case nationally and may not be the case for Nebraska. But those-- but those are numbers that-- those aren't our facts and numbers and I'm happy to-- I only brought a copy, but I'm happy to--

DUNGAN: If you could-- yeah, if you could share that information with the committee. It doesn't have to be right now. But if you could forward that to us, I think that'd be helpful--

BILL HEAD: Yeah, absolutely. Yeah.

DUNGAN: --because it really does-- I mean, I'm not trying to beat a dead horse, but it seems like the information, the starting point is just different here.

BILL HEAD: Yes, exactly, exactly. Yeah.

DUNGAN: And, and I'm listening to testimony here from people who are sharing not just personal anecdotes but also-- I mean, it is anecdotal which is helpful, but it's also data that they're seeing in their independent pharmacies. And what they're saying is we have a problem.

BILL HEAD: Right.

DUNGAN: Right? They're saying there is an issue and they're able to outline the issue and they're able to explain that at the root of some of those issues is their interaction with the PBM.

BILL HEAD: Right.

DUNGAN: And it sounds like you are also agreeing that there is something to be done that we could do with regard to reimbursement to those pharmacies to ensure that they're not ultimately being left out to dry. And so it seems like those two things can be agreed upon: there's a problem--

BILL HEAD: Yeah.

DUNGAN: --and the way that we can potentially fix that is by ensuring that individuals are reimbursed at a higher rate or a more fair rate. So I guess I'm trying to figure out where the disconnect is then with this legislation, because it sounds like you're saying I think we should work together and fix this.

BILL HEAD: Yeah.

DUNGAN: So what about this doesn't address that problem?

BILL HEAD: Well, I think-- I think it is to the point of where we started from, frankly, because you've heard it-- well, I don't know if you were here earlier, but there's this notion that PBMs reimburse affiliated pharmacies at a higher rate when, in fact, the opposite is true. Think of it just from a purely financial sense. If I'm a PBM and I'm going to pay-- you know, I'm CVS and I'm going to pay CVS pharmacies more because then I pocket the money. I don't think I'm going to win a bid. They'll never win a bid with that-- with those

kind of numbers, right, they're going to say, hey, this is my bid. It's a little higher than the other-- my competitors but that's because I'm paying myself more. They, actually, pay themselves less because then they're, they're more competitive than their competitor. Right? They can-- they can, actually, come in at a lower bid because they're reimbursing themselves low. So I think until we agree on a common set of sort, sort of starting points, it's--we're always going to-- like you said, we're going to talk past each other and be very accusatory. I have no doubt that what's been testified from the proponents is true for their pharmacy. Is it true for all pharmacies in the state? And do we treat all pharmacies in the state equally? And, and my sense is there should be a greater sensitivity to those pharmacies that are-- you know, there's one pharmacy within 50 miles of, of-- you know, the, the nearest pharmacy is 50 miles away. I think Marcia made the point, and I-- and I respect it which is it, it serves us no good for pharmacies, like, to disappear-- for brick-and-mortar pharmacies to disappear because you become less attractive to a client if you say, well, I had 20 pharmacies in the network but 3 of them closed. That doesn't help your case when you're making a bid to a client. Right? So I know we get accused of, like, wanting to push them out which-- but the total opposite is, is true, which is the PBM is a much better bidder if the-- if, if the network is as broad as possible.

DUNGAN: Well, and I-- and I, I do agree that we need to make sure we keep more of the pharmacies open. If you could get us that information that you're basing, you know, sort of said that--

BILL HEAD: Absolutely.

DUNGAN: --that'd be helpful because I do think it'd be good to know where we're coming from. The last thing I'll ask, and I don't mean to, you know, grill you too much here.

BILL HEAD: No, no, please.

DUNGAN: So we heard some other testimony regarding the appeals process,--

BILL HEAD: Yes.

DUNGAN: --right? I think you just heard this other person say, you know, in 10 years of asking for appeals 2 to 3 times a day, there's only ever been, maybe, 10 times, you can count them on both hands,

when they've actually won the appeal. Do you have any information or data that you could share with the committee with regards to the outcome of those appeals?

BILL HEAD: You know, I'm, I'm, I'm not aware of it, but I can certainly ask-- I can ask our members for data. I know in a lot of instances, a lot of times the appeals are Medicare or Medicaid related. And so we really don't have any-- it's not really a lot of elbow room. And so a lot of times that's the instance-- I know-- I know we-- in Washington, I think there was a law passed that had DOI, sort of, reviewing appeals or making sure they were compliant with state law, what have you. And it turned out, like, of all the appeals they got, the majority were Medicare and there was nothing to be done because the Medicare rate is the Medicare rate.

DUNGAN: And, and if that's the case, I understand.

BILL HEAD: Yeah.

DUNGAN: I just would be curious if we could get that information while we're making [INAUDIBLE].

BILL HEAD: Well, I'll ask-- I'll ask if we know what the percentage--

DUNGAN: Yeah.

BILL HEAD: --is or what have you.

DUNGAN: I think that having a protective mechanism in place only benefits parties if it actually works. Right? So I just want to see what the actual outcome is on that. So if we could get that information that'll be helpful.

BILL HEAD: Right. Right.

DUNGAN: Thank you. I appreciate it.

SLAMA: Thank you, Senator Dungan. Additional questions from the committee?

von GILLERN: Yes.

SLAMA: Senator von Gillern.

von GILLERN: Thank you, Chairwoman Slama. And, again, thank you, Mr. Head, for being here. Couple of questions. The-- I think you said--

the term you said is we need to figure out where we start from and, and can we-- and I'm not here to negotiate language in the bill, that isn't-- that isn't the point of why we're here today. But you indicated you had a, a challenge with the term lower than the cost of dispensing the drug. Would a-- would a place that we could start from be that a pharmacy shouldn't have to sell the drug for less than they paid for it? Would that be a starting point that could be agreed upon?

BILL HEAD: No, the challenge in that is, though-- is that we never want to discourage the pharmacist or the pharmacy from trying to get the lowest possible acquisition cost, right, that the shop around for the, the best cost. Because if, if we get to the point where we say, at a minimum, you will get reimbursed for what you paid for the drug. Well, then we're, we're "disincenting" that pharmacist to get the lowest price, right? If they know, hey, look, there's no skin off of me if I don't get the best price on this. Right? And that's not really going to help consumers, right? There's going to be instances when I, I have no doubt, and I've said this repeatedly, I have no doubt there are instances when the pharmacy is underwater on a drug, right, that they're getting reimbursed less than what they-- what their acquisition costs. There's going to be instances when they're reimbursed more than what they paid for the drug. The issue we have is legislating profits for an industry, right? I'd rather us be able to work it out and come to sort of consensus on it. But the challenge in that is we're "disincenting" cost controls or, you know, keeping costs down is the problem with that. We're guaranteeing-- we're guaranteeing a minimum income and that's, I think, challenging for any industry.

von GILLERN: Thank you. You also made a comment that you don't want the brick-and-mortar stores to go away. But, yet, what some of the proponents testified to was that they will develop a relationship with a customer and, and have a-- have a mail in or have a, a prescription mailed to them. But then the PBM will also present a competing offer to sell those same drugs to, to that patient. I don't think that does a lot to preserve the, the brick and mortar model.

BILL HEAD: Well, it doesn't work that way-- it doesn't really work though. And let's remember mail order is just-- it's less than 10% of all drugs dispensed so it's, it's not the majority of--

von GILLERN: Which is still a huge number.

BILL HEAD: It's a huge number but it's not a huge percentage of what drugs are being-- of what drugs are being dispensed. But, again,

whatever the PBM is directing the patient, you're required to get this mail-- you know, you have to get this mailed from the mail facility or you get this-- I'm sorry, this drug from the mail facility. That is not the PBM requirement. That is the plan benefit design that that person enrolled in. A lot-- it's typical for a plan to have a mail-in opt-out that you're going to have-- these medications you have to get through mail, but you may be able to opt out of it, or they may have an opt-in mail. Like, would you like to get it in? The PBM is merely communicating the benefit design to that patient. So it's not like they're interjecting themselves and saying, oh, we're, we're going to steer because it's using-- this notion of steering is, is, is a misnomer because it's really just the benefit you enrolled in or signed up for.

von GILLERN: OK. And then, lastly-- and, and forgive me for taking some time here-- the-- I think you said it in the previous hearing but maybe not in this one for the transcribers. Who is it that you represent?

BILL HEAD: I'm sorry, the Pharmaceutical Care Management Association, which is the PBM trade association.

von GILLERN: Thank you. And you are a registered lobbyist?

BILL HEAD: I am.

von GILLERN: Thank you.

SLAMA: All right. Thank you, Senator von Gillern. Senator Jacobson.

JACOBSON: Well, I've, I've got to ask this question. You, you keep coming back to the problem is, is the, the plan benefit design and so we're just working with those, those providers and so-- or those that have the plans. But the truth is, is that the PBMs are really designing the plans and delivering it to those insureds and outlining what those terms should be. Isn't, isn't that really the case?

BILL HEAD: We will-- like, typically, we will help them develop--

JACOBSON: Help them design the plan.

BILL HEAD: No, because it's-- it, it-- I would say in, in this regard, like, help them design the formulary. Here-- like, these are all the drug classes you should probably cover-- you want to cover as an employer, right? But it depends on the size of the employer too,

because a lot of them hire consultants. They're very sophisticated. They know what their drug spend is, they know what-- they, they, they know what they're going to spend. They know what they spent last year. They, they know what they anticipate to spend this year and they're very sophisticated. And they, when it comes to the final-- best and final negotiations, they pit the PBMs against each other to get-- and, and it comes down to pennies on the dollars in terms of what they can-- you know, what they can squeeze out in terms of what they're going to pay for their, their drug benefit.

JACOBSON: Well, and, and I, I raise this question again because it seems like, again, there's, there's that involvement in designing the plans. You also made the-- made the point that the pharmacies, its local pharmacies just didn't do a better job of shopping around. Well, isn't it true that there's only so many wholesalers out there and you're buying your drugs from a various wholesaler?

BILL HEAD: Yeah, that's a-- well, that's a great point. There are-- there are three-- you know, people talk about the PBM, the three-- big three having 80% of the market.

JACOBSON: Right.

BILL HEAD: It's 80% of the claims. But the three big wholesalers have 97% of the market.

JACOBSON: All right. So how are you going to shop around when you got three wholesalers?

BILL HEAD: So typi-- so typically they-- and I, I, I, I don't want to speak for the pharmacists but they, in their contract, right to buy the drug from that wholesaler. And the wholesaler may say as long as I have that drug in stock you have to buy it from me. Well, from our perspective, there's another wholesaler who can sell you that drug for less. So because of the limitations of a particular pharmacy may have with the wholesaler they may not have access to all the markets.

JACOBSON: So how do they shop around?

BILL HEAD: Well, that's the-- that's the point I was making earlier is, like, let's look at what the role of the wholesaler and the PSAO is in all these transactions because I want to understand more what limits there may be on pharmacies in terms of shopping around.

JACOBSON: Well, I just raise this because-- OK, we heard Tom Choquette come in and testify and he talked about a patient that got a hold of him, is having trouble breathing. He ended up, this is a Saturday night, he went in, filled a couple of emergency prescriptions for-- that included an EpiPen and ended up losing money on the transaction. Now, if that-- if that pharmacy wasn't there, if he wasn't there, what was going to happen to that patient? Was he going to wait for the mail order to come in? I mean-- my, my concern is-- and, and again, I-- as I said early on, there has to be some serious work done on a comprehensive fix here. This is clearly broken. We are clearly losing pharmacies, the pharmacies are losing revenue. They have very few options in terms of shopping around, so to speak, for a wholesaler, and yet they're having these rules promulgated by PBMs that in many cases are working with the very insurance providers that are out there for these organizations to lay out a benefit plan that's really designed to, to work more in favor of the PBMs. If, if I wanted to go out and, and spec a new vehicle and do bids-- well, if I want to get a Chevrolet, all I have to do is put the specs in that give Chevrolet the advantage because they already have all the things I'm speccing in it. Guess who wins the bid? Chevrolet, because everybody else has to do something different to add on. I, I just think that the process is flawed. I'm really hopeful that we can have some time as we work through this next year to, to have some serious conversations about fixing a fairly serious problem here before we lose the pharmacies.

BILL HEAD: Can I make one, one point in that, Senator, which-- and I don't recall-- if you know-- if you recall from our stakeholder meeting this past fall, but the gentleman said he, he, he negotiates to his PSAO, right, so the PSAO is negotiating on behalf of the pharmacy to the-- with the PBM. He's one of 1,000 pharmacies that, that PSAO is representing. Clearly, there aren't 1,000 pharmacies in the state of Nebraska for retail and independent. So my question is, is that pharmacy representing all Nebraska pharmacies as well as that PSAO should or are they favoring more rural pharmacies? So those are the kinds of things that I want to-- I want to know about as well. I think that's part of what we need to understand.

JACOBSON: And I think that's all on the table.

BILL HEAD: Yeah, fair point. Yeah.

JACOBSON: I, I, I, I agree with you. I, I am very much committed to trying to figure out where's the path forward and, and I-- and, and I think, as you pointed out, everybody's talking past each other--

BILL HEAD: Yes.

JACOBSON: --and nobody's really coming up with serious plans for let's identify the problems, let's identify how we can fix them. We're going to disagree along the way, probably, but we're, hopefully, going to come up with something that's going to be a little more palatable to everyone because I think we can all agree that it's broken today.

BILL HEAD: Certainly.

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Senator Ballard.

BALLARD: Thank you, Chair Slama. Thank you for being here, Mr. Head. Let's start at the stakeholder meeting, I was told that this is a federal issue and--

BILL HEAD: Was that on DIR?

BALLARD: I'm sorry?

BILL HEAD: Was that on DIR?

BALLARD: No, no, just-- it's, it's-- as Senator Jacobson-- it's, it's, it's not an Nebraska centric issue. There's a, a lot of-- from PBMs, not reimbursement, just PBMs in general. Do you-- so you don't agree with that, that, that statement that this is-- this should be a federal congressional fix?

BILL HEAD: Congress is looking at it. In Congress, there's a couple of congressional bills looking at PBMs and have-- or PBM-- there is, you know, federal PBM legislation being looked at. But, no, I, I think states have every right to look. And, and, again, Senator Jacobson is always good about pointing this out to me. He's, like, who cares about the rest of the country? Let's look about what happens here Nebraska, so.

BALLARD: Yeah, that was my curiosity of if--

BILL HEAD: No.

BALLARD: --are we--

BILL HEAD: Because, you know, having-- Nebraska is unique in a number of ways so, you know. And, and, and when I said earlier about NCPA saying independent pharmacies are doing well overall, that may not apply to Nebraska. I don't know that. So I don't want to say-- I'm not going to dismiss and say, see, you guys are doing well. Clearly, they're not, you hear from them.

BALLARD: OK. That was my curiosity, we're just where Congress is in this issue and, and it doesn't matter. I mean, you know,--

BILL HEAD: Yeah, well, you know, it takes-- it takes time.

BALLARD: --I'm not trying to-- I'm not trying to punt.

BILL HEAD: Yeah, it takes them 20 years to do anything anyway, so.

BALLARD: Yeah. I appreciate you being here. Thank you.

SLAMA: Thank you, Senator Ballard. Additional questions from the committee? Seeing none,--

BILL HEAD: Thank you.

SLAMA: --thank you very much. Additional opponent testimony for LB1232? Welcome.

MICHELLE CRIMMINS: Thank you, Chair Slama, members of the committee. My name is Michelle Crimmins. That is spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s. I am a registered lobbyist representing Prime Therapeutics, a Pharmacy Benefit Manager owned by 19 not-for-profit Blue Cross and Blue Shield insurers, subsidiaries or affiliates of these insurers, including Blue Cross and Blue Shield of Nebraska. My testimony today is in opposition to LB1232. And I do have prepared testimony, but I'd actually like to veer away from it a little bit given some of the comments that we've had today, and I can't help but reflect on the fact that there are many different kinds of health plans offered and different pharmacy benefits that go along with them. And we've heard about a large share of senior members that are visiting the local pharmacies. Those senior members are likely Medicare patients and at the state level and representing a plan that offers commercial markets. You know, the reimbursement rates for Medicare plans are set at the federal level and I think that leads to some of the conversation of where you were going with your last question. That's not entirely this conversation, right, but if Medicare reimbursement rates are not meeting the cost of the insurance

and we're discussing, you know, reimbursement rates that commercial insurers would be subject to, I think that is something that may need clarification on the percentage of the members that have Medicare or even Medicaid insurance because they're separate conversations. And with that, I'd like to jump into my actual prepared testimony, which is that LB1232 revises the Pharmacy Benefit Manager Licensure and Regulation Act by adding the following requirement: A Pharmacy Benefit Manager shall not reimburse any pharmacist or pharmacy for any drug at a rate that is lower than the cost required to dispense the drug. That is incredibly broad, you know. What does that mean? Does that mean how much money the pharmacy is putting into their light bill and their costs with, you know, having pharmacists hired and their rent and all of that or is that just the acquisition cost of the drug? I'm not really sure based off of this language. So I think that needs to be clarified for sure. But in addition to that, like what other industry does the state say you are guaranteed a profit on 100% of everything and we're making another business pay you 100% of that profit. I think it goes against a lot of the good stances that we have of business practices. And it does, as Bill mentioned, it takes away any incentive for pharmacies to negotiate lower acquisition costs for their drugs. That's really concerning to us. And, finally, I will remind you who pays for this increased cost of drugs. We've seen the fiscal note that has come out on this bill. It's a large number and that number would similarly be an increase for commercial plans. And that cost of increase for drugs is borne by the member, by the employer paying for the plan. Those are Nebraskans that live here that already are suffering under extremely high cost of drugs and this will just do nothing but increase them further. Thank you.

SLAMA: Thank you very much. Are there any questions from the committee? Seeing none, thanks for being here.

MICHELLE CRIMMINS: Thank you.

SLAMA: Additional opponents for LB1232?

JEREMIAH BLAKE: Good afternoon, Chairwoman Slama and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska testifying in opposition to LB1232. So our role in this discussion is that we collect the premiums from Nebraska businesses and families that are used to pay pharmacy claims. PBMs provide a valuable service to Blue Cross members by administering the plan

prescription drug benefits with the goal of providing coverage for needed medications at an affordable cost. Working with our partners in the PBM industry, health plans have been absorbing a larger share of the cost of prescription drugs over time. A report released last week found that the median annual list price for new drugs in 2023 was $300,000, 35% higher than in 2022. As a result, prescription drugs account for nearly 20% of health insurance premiums and they are the fastest growing category in spending. Unfortunately, this bill will only make prescription drugs more expensive for Nebraska families, and we also appreciate our partnership with Nebraska pharmacists because they provide access to lifesaving medications to our members across Nebraska. But it's hard to see how the additional expense to our members that would occur as a result of LB1232 would translate into any tangible benefit for our members. This bill would not increase the, the access to more pharmacies, nor would it provide additional services that enhance the wealth-- the health and well-being of our members. I also have concerns that this bill would eliminate the incentive for pharmacists to seek out lower wholesale prices for drugs which has been mentioned previously. For these reasons, we are opposed to the bill. Thank you for your attention and be happy to answer any questions you have.

SLAMA: Thank you, Mr. Blake. Are there any questions from the committee? Seeing none, thank you very much.

JEREMIAH BLAKE: Thank you.

SLAMA: Additional opponents for LB1232?

ROBERT M. BELL: Good afternoon, Chairwoman Slama, 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, the state trade association of insurance companies, including most of the health plans in Nebraska. I am here today to testify in opposition to LB1232. You've already heard all the arguments, I would agree. I, I was trying to think back to the stakeholder meeting, Senator Ballard, and I wonder if we were talking about a Medicare issue, particular with seniors if-- there's very little-- because those rates and those plans are set in, in Washington, there's, there's very little the Legislature can do on that. And we do know that there are, you know, some practices by Medicare insurers or supplement insurers that, in particular, that the pharmacists don't like or at least that's some-- that's some of the feedback that, that we have received. I wonder if,

if that would address your question. I know Michelle already hit up on that and I know Jeremiah pointed out that, you know, these costs will be borne by Nebraska premium payers whether or not they're employers or employees or individuals buying insurance on, on the marketplace and wanted to say that. One thing I haven't talked to the committee about is the actual high cost of healthcare. I've, I've talked in the past about how much of GDP of United States is going to healthcare, it's actually dropping, believe it or not, from 20% in 2020 to 17.4%, I believe, 17.2%. Part of that is because of growth in the GDP and inflation, of course, and so healthcare has not caught up. But one area that continues to increase above all other costs are prescription-- retail prescription and that's up 8.42 or 8.4% from the previous year. Most healthcare costs have gone up about 4%. And so before any decision is made that that would increase the cost on your average Nebraskan, certainly, again, appreciate the, the business that the pharmacists do and would reiterate what Mr. Head said and Mr. Blake in that we need Nebraska pharmacists. At the same time, Nebraskans want to pay less for their medicines and so we respectfully oppose LB1232. Thank you.

SLAMA: Thank you, Mr. Bell. Are there any questions from the committee? Senator Dungan.

DUNGAN: Thank you, Chair Slama. Thank you for being here, Mr. Bell.

ROBERT M. BELL: Sure.

DUNGAN: How much would the premiums go up?

ROBERT M. BELL: You know, I don't know. That's a great question. I am--

DUNGAN: Because when we hear--

ROBERT M. BELL: --not an actuary, so.

DUNGAN: --we hear that a lot, right?

ROBERT M. BELL: Yeah, sure.

DUNGAN: I mean, like, whenever there's any conversation around this--

ROBERT M. BELL: Absolutely.

DUNGAN: --there's always a concern about an increase in premiums borne by employers or actual payees. My question is always how much? Because if we're talking about $1--

ROBERT M. BELL: Yeah.

DUNGAN: --here or there to fix a larger problem, that is one thing versus hundreds of dollars. So I'm just curious if you have any estimate as to what that actual increase would be?

ROBERT M. BELL: I don't. I will tell you, insurance is quite simple at the end of the day, is that premiums equal claims. And there's some investing, there's some risk pooling that goes on that, that help alleviate-- there's, there's reasons that we, we join together to share risk. Right? But if you do something to increase the claim costs on insurance, premiums must go up. And by the way, that, that came up on a topic not related to health insurance, it came up on, on an issue related to trucking insurance that, you know, if, if you do something to increase the claim, insurance is very simple. You have to raise more premium. And unlike a lot of other businesses, not including banks, I know banks have similar regulatory provisions but, I mean, we are required to collect a premium to pay our claims rate. The Department of Insurance is not going to let us submarine rates to get market share or something along those lines so that-- I mean, we have to have the ability to, to meet the, the obligations that we have agreed to.

DUNGAN: Thank you.

ROBERT M. BELL: You're welcome.

SLAMA: Thank you, Senator Dungan. Additional questions from the committee? Seeing none, thank you very much.

ROBERT M. BELL: You're welcome.

SLAMA: Additional opponent testimony for LB1232? Seeing none, is anyone here to testify in the neutral capacity on LB1232? Seeing none, Senator waived-- Wayne waived his closing. We did receive 7 proponent letters for the record on LB1232. That will bring us to our next bill, LB833, with Senator Blood.

SLAMA: All right. Welcome, Senator Blood, to the BCI Committee.

BLOOD: Thank you, Chair Slama and good afternoon to you and the members of the Banking and Insurance Committee. My name is Senator Carol Blood, and that is spelled C-a-r-o-l B-l-o-o-d, and I represent Nebraska Legislative District 3, which comprises western Bellevue and eastern Papillion, Nebraska. Today, I'm introducing LB833, a bill that will establish the Nebraska Prescription Drug Affordability Act. Prescription drug prices for decades have been considered to be far too costly for Americans. Here, prescription drug costs are mounting for insurers and they are passing costs to everyday Nebraskans. Special interest groups representing the pharmaceutical industry have spent millions of dollars lobbying against legislation such as LB833. In fact, many of you may have already received in your phones or on your emails these very ads because they are clearly geofencing around the Capitol against this bill. I know that because I also received several. The Pharmaceutical Research and Manufacturers of America have sent opposition ads already for LB833 in Nebraska and spent $30,406,000 in 2021 in lobbying efforts protecting pharmaceutical profits across the United States. The Nebraska Prescription Drug Affordability Act is a template for how we can try to tackle out-of-control costs as the federal government has been too slow to address the issue. The goals of the Nebraska Prescription Drug Affordability Review Board are to establish Upper Payment Limits for 12 prescription drugs per year, with a maximum of 18 prescription drugs if the board deems fit, collect and evaluate data and information about the impacts of drug pricing on Nebraskans, perform affordability reviews on prescription drugs, and to make policy recommendations to the Legislature to lower the cost of prescription drugs within Nebraska. Affordability reviews will examine the average cost of prescription, prescription drugs in Nebraska, give policy recommendations to the Legislature on improving affordability and establish upper limits for select prescription drugs. The board may request information from the pharmaceutical corporations if they are unable to find the data needed to perform the review. Now, I want to discuss Upper Pay Limits further. Upper Pay Limits do not restrict how much a manufacturer can charge for a certain drug, but limits how much commercial and public payers in a state can pay, which limits how much out-of-pocket costs consumers have. The high-cost drugs targeted in other states's boards are designed to be subject to coinsurance and not co-pays where a patient must pay a percentage of the cost over the counter. The idea of Upper Pay Limits is that they are designed to save costs within the system that will then trickle down to consumers who will see reduced subscription drug costs. Once the board reviews and votes on a particular drug and whether to cap its price, an appeal

process is allowed on that decision by any interested party. They may not make this decision on more than 12 prescription drugs a year with the maximum, again, of 18 if they have sufficient staff and you'll find that in Section 8 of the bill. The Advisory Council is set up in order to provide appointed stakeholders with input to the board in order to make the best and informed decisions possible, these members will have to qualify under certain subject jurisdiction in order to be part of the Advisory Council and will be appointed by the board. The Governor appoints each board member subject to the Legislature's approval. LB833 wants to prevent conflicts of interest on the board so board members are required to recuse themselves from votes when a conflict of interest arises. Also, board members cannot be working with drug manufacturers, carriers, or Pharmacy Benefit Managers. To ensure transparency and the viability of the board, the board shall submit a yearly report to the Office of the Governor and the Legislature's HHS Committee. The report will include data about price trends for prescription drugs, the number of drugs that were subjected to an affordability review by the board, drugs that were given an Upper Payment Limit, and the impacts Upper Payment Limits had on healthcare providers, on pharmacies and, most importantly, consumers. Recommendations for policy changes to the Legislature will be included in the report as well. The yearly report will be publicly available on the board's web page, which will be located on the board's official website. I do understand the pushback on portions of this legislation, such as the Upper Pay Limit, and I do not want to force out manufacturers selling vital prescription drugs such as aids for specialized cancer medications. The truth is, many of the prescription affordability drug boards are in their first stages of inception and we do not have a large body of work to judge their success. In Maryland, the board's work has been delayed since it has-- it passed the legislature in 2019, but Colorado cast its first vote for the first drug, its affordability it considered at the end of 2023. I think the reason that I'm mostly here is really because the conversation is really at least worth having when it comes to prescription drugs. Especially since the pandemic, these prices are skyrocketing and we cannot wait for the federal government to solve the issue. And we really should seek a Nebraska-based solution. If we can have at least a board to review costs and make recommendation-- recommendations, I personally believe that, that will go a long way towards addressing prescription drug costs. I am willing to listen to recommendations, recommendations and forge a path forward for others to tackle this issue. Before I close and thank the committee for their time today, there has never been a bill that I have had that I have

seen so much money from out-of-state sources come to oppose a bill. And if you look at the magnitude of money that is spent on lobbyists to oppose anything that helps consumers when it comes to pharmaceutical costs, it's appalling. And someday we're going to have to decide what's more important. I don't fault any company if they make profits, but in the United States we are making these profits on the backs of consumers and it's usually people with limited income, people of color or seniors, and we're asking them to make decisions between things like rent and food and clothing. I know our own family has had to make decisions between a $500 prescription and groceries and we're a middle-class family. So we can keep listening to the lobbyists with their false narratives creating a boogeyman, telling you that this-- that the sky is going to fall or maybe it's time that we buckle down and put something together and start protecting Nebraskans because it's not getting better, it's getting worse. And it used to be we really not-- never saw pharma, pharma at the state level. We only usually saw it in the pockets of the people at the federal level but now we're seeing it trickle down here and that's not a Nebraska that I want to live in. And so with that, I thank you for your time and I do look forward to hearing both proponents and opponents on this bill.

SLAMA: Thank you, Senator Blood. Are there any questions for Senator Blood? Seeing none, thank you very much.

BLOOD: Thank you.

SLAMA: We'll now open up proponent testimony on LB833. And if you're intending to testify on this bill, I'd recommend coming up to the first couple of rows just so we can expedite the process and get everyone out of here in a timely fashion. Welcome.

ROBERT LASSEN: Thank you, Chair Slama and members of the Banking, Commerce and Insurance Committee. My name is Robert Lassen, that's R-o-b-e-r-t, Lassen, L-a-s-s-e-n, and I am an AARP Nebraska advocate here to speak on behalf of our nearly 200,000 members statewide. AARP appreciates the opportunity to test-- LB833 establishing a State Drug Affordability Review Board and prohibiting price gouging by drug manufacturers. We want to thank Senator Blood for bringing this important bill forward. Lowering the cost of prescription drugs is a high priority for AARP. AARP members are 50 years of age and older. Many of them, like everybody else, struggle daily to afford needed and life saving medications. A recent report by the US Department of Health and Human Services noted that the list prices on 1,200

prescription drugs rose faster than inflation between July 21st[SIC] and July 22nd [SIC}, rising an average of 31.6%. AARP's 2021 RX Price Watch report found that 2020 prices for 180 widely used specialty drugs increased more than three and a half times faster than general inflation. So it is hardly surprising that we have stories from our members facing serious health and financial consequences due to high prescription drug costs. The reality is that we often have and talk to our customers about cost to the patients, and the patients will face these costs, and most cases on medications that they'll be taking the rest of their lives. Last year, AARP successfully advocated for significant prescription drug price reforms at the federal level, including giving Medicare the authority to negotiate drug prices. However, most of the impact of those reforms only affects people on Medicare. Much more needs to be done, and can be done, on the state level. LB833 will allow the Affordability Board to review drug prices that pose an affordability challenge and set Upper Limits, Payment Limits that apply throughout the health care system to protect consumers, state and local governments, providers, and all stakeholders. The board will help ensure that consumers can have access and affordability to the prescription drugs that they need. High drug costs hurt everyone, not only those who rely on prescription drugs for-- the yellow light, here-- for their health, but also for us who are paying higher premiums on these costs, as well as out of cost-- pocket cost. And then it also affects us taxpayers who will help fund our public programs. Efforts like LB833 and others could save billions of dollars for patients, taxpayers, and our health care system. On behalf of our members and countless others, we urge lawmakers to pass this bill to rein in the high cost of drug prices. Thank you for the opportunity to comment on this important legislature. And and thank you, Senator Blood, for bringing it forward. AARP encourages you to support and advance LB833.

SLAMA: Thank you very much, Mr. Lassen. Are there any questions from the committee? Seeing none, thank you very much for being here today. Additional proponent testimony for LB833? Last call. Anyone here to testify as an opponent for LB833? Welcome.

KATELIN LUCARIELLO: Thank you. Thanks for having me. Chairwoman Slama, members of the committee, my name is Katelin Lucariello, K-a-t-e-l-i-n L-u-c-a-r-i-e-l-l-o. I am here for the Pharmaceutical Research and Manufacturers of America, where I'm deputy vice president of state health policy based out of Denver, and I am a registered lobbyist here in Nebraska. I also sit on the advisory committee for Colorado's Prescription Drug Portability Board. And I am here today in opposition

to this bill, which would establish a similar board here in Nebraska. And I want to talk about a few of the things that this bill does and does not do, or is and is not. The Upper Payment Limit in this bill is a price control. It impacts the purchase and reimbursement price of a medicine in the state. It is really not an effective way of lowering prescription drug costs for patients. No state has implemented an Upper Payment Limit to date. In Colorado, implementation has been complicated and it's faced several delays. The law passed three years ago, and the board just voted to set their first Upper Payment Limit at the end of last week, and they have said it would take six months to implement just the one. This is expensive. I was surprised to see the fiscal note on this bill as low as it is. In Colorado, the past three years have cost $1.6 billion to establish and implement the board. It is really not clear how an Upper Payment Limit would operate, and it's still an open question as no state has done it yet. In Colorado, many entities, not just manufacturers, but wholesalers, hospitals, doctors, pharmacies, insurers have all expressed concerns about how we work around a price cap that is applied only to the part of the supply chain that exists in the state. You have a document from me with quotes from letters to the board from each of these entities. And I want to be very clear, we disagree on this as a policy solution. We never think that it is OK for people to forgo or to ration their medicines due to cost. And we're happy to discuss other policy solutions that we believe would lower drug costs for patients in Nebraska, and be more of a impactful policy than this one. So thank you for your no vote on this bill today.

SLAMA: Great. Thank you, Ms. Lucariello. Are there any questions from the committee? Senator Kauth?

KAUTH: Thank you, Chair Slama. Ms. Lucariello, $1.6 billion to establish and implement.

KATELIN LUCARIELLO: I'm sorry. It was million with an "m", Senator.

KAUTH: I heard the "b" and thought, oh, my. OK. Thank you. That, that makes me feel much better.

SLAMA: Thanks--

KATELIN LUCARIELLO: And,Senator, I can provide some clarity. The original fiscal note in Colorado was a little over $800,000 for--

KAUTH: So it more than doubled.

KATELIN LUCARIELLO: --implementation, $500,000 of ongoing costs each year. And this past year, the board had to request an additional $260,000 for consultant fees to collect the data that's necessary for affordability reviews.

KAUTH: Thank you.

KATELIN LUCARIELLO: Thank you.

SLAMA: Thank you, Senator Kauth. Additional committee questions? Seeing none, thank you very much.

KATELIN LUCARIELLO: Thank you, Senator.

SLAMA: Additional opponent testimony for LB833. Seeing none, is-- oh. As an opponent? OK. Welcome back.

MARCIA MUETING: Thank you. Chairman Slama, members of the Banking, Commerce and Insurance Committee. My name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. I'm a pharmacist and the CEO of the. Nebraska Pharmacists Association. Thank you to Senator Blood for introducing LB833. This bill brings attention to the issue of medication prices and affordability. I am here to testify in opposition to LB833. I am concerned that a drug affordability board will not be effective because it does not address the root of the problem. As I have sat here before you today, just today, I have told you prices are being set by the Pharmacy Benefit Managers. And I'm providing you with a handout that shows some interesting statistics about the cost of the prescription drug benefit increasing, patient actual out of pocket costs increasing, revenue generated by PBMs and the increases there. While I understand the intention behind such boards, I believe they pose significant risks and may not effectively address the underlying issues of driving drug affordability. How will the board be able to set a price for a medication without knowing the pharmacy's cost? When-- I know that when somebody saves money, somebody loses money. And if the patient is going to be saving money on a drug, does that mean the pharmacy bears the brunt of that cost and they'll be underpaid for the medication again? How will drug shortages be addressed? Nebraska Medicaid right now is part of a multi-state purchasing pool that negotiates rebates. How will this process interfere or assist Medicaid in, in negotiating rebates? We've all heard the term follow the money. As we've heard today, the pricing of prescription drugs is set by the Pharmacy Benefit Managers. To regulate drug pricing, the PBMs need to be regulated. The pricing of

medications is based on rebates to the PBMs and not on the manufacturer's price. Unfortunately, the rebate cost savings are not passed on to the patients or their insurance plan. For these reasons, I hope the committee will not advance LB833. And I do want to make a comment about Colorado. I know that it was mentioned before, but this came across the news today where Colorado has now finally set payment for a very expensive drug, costing insurers around $46,000. It's the first one that the board has been-- has decided to be unaffordable for Coloradans. And what does that mean if you have a family member that needs that medication and they still can't afford it? I'd be happy to take any questions.

SLAMA: Thank you very much, Ms. Mueting. Are there any questions from the committee? Seeing none, thank you very much. Additional opponent testimony for LB833? Seeing none, is anyone here to testify in a neutral capacity on L833? Seeing none, Senator Blood, you're recognized to close, and as you come up, we did receive 5 proponent, 7 opponent, and 2 neutral letters for the record on LB833.

BLOOD: Thank you, Chair Slama.

SLAMA: Thank you.

BLOOD: You know, believe it or not, my favorite kind of bill is when there's opposition, especially when it's something that's going to help Nebraskans. And so I'm going to address some of the things that were said, which is kind of a fun thing of having the last word. So we did say, by the way, in our introduction, about Colorado finally addressing that one medication. So I thought it was interesting when we had both people talk about Colorado as if it had not been mentioned. But having somebody sit on a Colorado board and then come to Nebraska and say that our bill is not going to work, tells me that the bill that we crafted, the language that was crafted, I-- sorry, guys, you know, I just got back from being sick, I apologize. The language was crafted based on the Colorado bill. So to have somebody who is a pharmacist or related to the pharmacy world come and say, this is just not going to work, tells me that they're not trying to make it work in the other state. Why would you sit on a committee only to watch it fail and not help it succeed, and then come here and say, you know what, this isn't going to work and this is why? So I find that to be very telling of this industry. Again, they don't want it to succeed. What I love is they always say in their letters, and they always say in their testimonies that they don't disagree on a policy solution. They think a policy solution needs to be-- needs to happen.

They always say that. But I want you to tell me the one time, in the the amount of time any of you have been here, that anybody brought forward a legislative solution to you. It's really easy to say we think medications are not affordable for people, and as a, a, a pharmaceutical company, we think that something should be done. But they will never, ever bring legislative text toward-- to you so we can actually do something. This is an opportunity for us to indeed take them up on that offer. You don't have to pass a bill as written. You have the ability to amend it in the committee and make it better, or make it so it is framed better to the opposition's concerns. But I do know that if we keep ignoring it, what's going on now is going to keep happening. People die. That's not a pretend thing. People die. People don't take their medications because they have to decide whether they can afford their medication, or they can afford food. We're not talking about lower income families. We're talking about middle class families. We're talking about whether they get to have another year with their mom who's dying from cancer. We get to talk about whether a person that has a severe disability is going to live a quality type of life, or suffer for the rest of their life. I just can't express how important this is. And to do nothing just plays into everything that they have been doing for decades. And you notice I handed out your profit sheet of all the top ten pharmaceutical companies in the United States. They can afford to help us. They will still be making a lot of profit. And there are, I think I still gave you a list of what? There's ten states now that put together affordability boards? It's happening everywhere. The sky is not falling. We have to figure out what we're going to do. So all I ask is that you know that we did work on this bill for seven months, that we put together what we thought was the absolute best choice for Nebraska. But I again cannot stress enough. If not this. What? And after I'm gone, if you don't vote this out, or you don't amend it and give it a go, somebody needs to pick up the pace because this is more important than property taxes. This is more important than appointing people to different boards that pertain to sports and whatever else. This is about people living a quality of life, being around for their families, and being able to provide for their families. You guys can make a difference in a lot of Nebraskans' lives, and I just beg you to not just blow it off. Whether you vote it out or not, someone please pick up the ball and run with it next year.

SLAMA: Thank you very much, Senator Blood. Are there any questions from the committee? Seeing none. Thank you very much.

BLOOD: Thank you.

SLAMA: This brings to a close out hearing on LB33 [SIC LB833]. Next up is LB984, Senator Hardin. Welcome.

HARDIN: Thank you, Chairwoman Slama. 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 present to you LB984, which seeks to protect access to the 340B drug discount program for eligible safety net health care providers in our state. The 340B drug discount program was created by Congress in 1992, permitting certain safety net providers, including critical access and safety net hospitals and federally qualified health centers, to purchase certain outpatient medications from drug manufacturers at a discounted price. Two things are important to note about this program. The discount is paid by drug manufacturers with no state tax or federal tax dollars, and drug manufacturers are required to provide the 340B discount to eligible entities in exchange for participation in Medicaid and Medicare. 340B eligible entities in Nebraska include 68 hospitals. The great majority, 59 of those, are rural critical access hospitals. All seven Federally Qualified Health Centers in Nebraska are also 340B eligible entities. Discounts from the 340B program help these safety net health care providers meet the needs of underserved patients. They invest these savings back into the communities by providing direct financial assistance to patients, but also by increasing access to services such as behavioral health programs, ambulance services, community health education and outreach, home health services, as a few examples. For decades, drug manufacturers had provided 340B drug discount pricing to eligible entities for drugs 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. As of January of 2024, 29 drug manufacturers have significantly cut access to 340B discounts by restricting partnerships between eligible health care providers and community and specialty pharmacies. Drug manufacturers are restricting these partnerships to avoid offering 340B discounts on medications, including on some of the most costly specialty drugs they sell. LB984 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 340B drugs to 340B eligible patients. Under a 340B contract pharmacy arrangement, the eligible health care provider buys the drugs

from the manufacturer, but has them shipped directly to the contract pharmacy. In this way, the eligible health care provider can increase access to 340B discounts by expanding the pharmacy network available to serve the health care provider's patients. These contract pharmacy arrangements are beneficial for a few reasons. Contract pharmacies provide an additional access point for patients to receive the drugs they need, without patients having to travel far distances. Because the majority of rural hospitals do not operate their own retail pharmacies, and very few operate specialty pharmacies, relationships with community and specialty pharmacies are critical to accessing discounts on the drugs their patients use. Over half of 340B hospitals in Nebraska contract with community and specialty pharmacies to dispense drugs to their patients. These partnerships provide additional business for local community pharmacies, allowing them to serve patients more close to home. 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 health care, the practice of pharmacy and drug distribution. LB984 does not seek to change the federal 340B program. It simply seeks to regulate the delivery of drugs from a manufacturer or wholesaler to a contract pharmacy. 12 states have introduced similar legislation so far this year. Arkansas passed the first law prohibiting manufacturers from imposing certain restrictions on contract pharmacy arrangements in 2021. Last year, Louisiana passed its own contract pharmacy law. Since the law's passage, several manufacturers have lifted or eased their restrictions for covered entities in those two states, Arkansas and Louisiana. Opponents may allege that this legislation will be caught up in the courts. However, in Arkansas and Louisiana, these laws are benefiting safety net health care providers now. Every single day, the law is not in place, meaning Nebraska patients may be forced to drive hundreds of miles or lots of hours to access their prescriptions, and safety net health care providers are losing benefits that help their communities and their patients. Additionally, it's important to note that the law in Arkansas has been upheld by the district court, which is in the same judicial circuit as Nebraska, that's the Eighth Circuit. Although opponents may try to complicate this issue, it's really very simple. Support for this bill helps our local community hospitals and safety net health care providers. 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, the average net operating margin for the state's hospitals declined from 6.6% in 2021 to 1.8% in 2022, a decline of 72%. 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 nine months of 2023 was 17.4%. Our safety net health care providers depend on this program to stretch their scarce resources and meet the needs of their patients. Yet you can refer to the articles that were handed out, or I will be handing out in a little bit to reference these numbers. I want to thank the bipartisan group of 17 senators, it's actually up to 18 now, representing both urban and rural areas who've signed on as co-sponsors of this legislation. In both Arkansas and Louisiana, where this legislation has passed, it did so with overwhelming support, and I'm hopeful we can reach a similar outcome here in Nebraska. If you have complicated questions, please ask those of the professionals behind me. I'm here for the easy questions, so I'll take those now.

SLAMA: Thank you, Senator Hardin. Are there any easy questions for Senator Hardin? Seeing none, thank you very much. Will you be sticking around to close?

HARDIN: I will.

SLAMA: Wonderful. Well, now we'll open it up for proponent testimony on LB984. Welcome.

OLIVIA LITTLE: Hi, there. Thank you, Chair-- Chairperson Slama and members of the Banking, insurance and Commerce Committee. I appreciate the tes-- opportunity to testify before you today. My name is Olivia Little, O-l-i-v-i-a L-i-t-t-l-e. I am here today on behalf of Johnson County Hospital and the Nebraska Hospital Association, and I'm here in support of LB984. Johnson County Hospital is an 18 bed critical access hospital, along with a rural health clinic located in Tecumseh, Nebraska. Our service area extends into Gage County as we have a rural health clinic in Adams, Nebraska. Johnson County Hospital participates in the 340B program. The program requires manufacturers to provide outpatient drugs to safety net providers at a discounted price, so that the safety net providers can stretch resources, reaching more eligible patients and providing more comprehensive services. This program does not cost taxpayers money, as the discounts come from the manufacturers. In Nebraska-- I have some stats in there that Senator Hardin talked about. So in fiscal year '23, Johnson County Hospital had a 340B benefit of $676,000. The 340B benefit is a combination of 340B savings and 340B contract pharmacy utilization. Critical access hospitals are already operating on a very thin margin, while supporting needed services in our community that operate at a loss, as

well as community benefits. The 340B program enables us to fund these services operating at a loss, like our home health program. This program allows people to stay in their homes longer and lessens the burdens on taxpayers by keeping people out of assisted living and nursing homes, which Medicaid, a program supported by the taxpayers, may have to cover if the person does not have enough finances to pay. While our hospital takes a financial loss on this program, our 340B benefit continues to allow our hospital to provide the service while staying, staying off of the county tax rolls. Our 340B benefit was also used to fund our community benefits, which included subsidized emergency and trauma care, charity care, free monthly blood pressure checks, toenail care and community education, just to name a few. Part of our 340B benefit comes from our contract pharmacy relationships with our local retail pharmacies. The 340B program is vital to these retail pharmacies as well, to keep their doors open and serve our communities. Before the manufacturers' restrictions began, our 340B program brought in over 15% of our hospital's revenue. In 2023, with 29 manufacturers having restrictions in place, our 340B program brought in less than 7% of our hospital's revenue. We foresee this downward trend to continue if something is not done to stop these manufacturer restrictions. We encourage the committee to advance LB984 in order to stop these manufacturer restrictions, and we thank Senator Hardin for introducing this bill. And I'm happy to answer any questions you may have.

SLAMA: Thank you very much, Ms. Little. Coming from District 1, it is wonderful to see a constituent here. Any questions? Senator Kauth.

KAUTH: Thank you. Chair Slama. Ms. Little, so what changed? So the federal government had set this up, it'd been running just fine, what was it that made people start backing off of doing this?

OLIVIA LITTLE: The manufacturers put restrictions into place. Some came in and said you have to choose a single contract pharmacy. We have three contract pharmacies, and so we had to designate one for that particular manufacturer. Another manufacturer, it, it doesn't apply to us and said the contract pharmacy has to be within 40 miles. They just keep coming out with more and more regulations--

KAUTH: To narrow--

OLIVIA LITTLE: --to narrow it down. They can basically put it out and say what they want in it. And we use this program so much to fund our community benefits, and like programs like home health. The nursing

home in our town shut down. We have nowhere to put people. And so as these keep getting restricted, they keep coming out, we're up to 29 manufacturers and we're talking large manufacturers. This is really detrimental. It's detrimental to our independent pharmacies who have testified previously. They said without the 340B program, we would close our doors.

KAUTH: OK. Thank you.

SLAMA: Thank you, Senator Kauth. Are there more questions from the committee? Seeing none, thank you very much for being here.

OLIVIA LITTLE: Thank you.

SLAMA: Additional proponents for LB984. Welcome.

ELIZABETH BOALS-SHIVELY: Hi. Members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in favor of LB984. My name is Elizabeth Boals-Shively, E-l-i-z-a-b-e-t-h B-o-a-ls-S-h-i-v-e-l-y. I'm going to work on shortening my name so it takes up less time. I've been a critical access pharmacist for 12 years now. I will tell you that my practice has changed dramatically in the last three years in comparison to the first nine. I am taking care of more patients, sicker patients, than I've ever taken care of in the past. Our 340B program is really critical. We don't necessarily use the savings for giving away free drugs to people that are low income, but we still use our savings with frugality. We-- in, in 2023, our savings was $668,700 between the hospital and our one contract pharmacy. We spent $31,000 on charity care, two low income patients, $177,000, a little more than that, to cover bad debt. And the largest chunk was to cover underpayments from Medicaid, mostly to keep our long term care facility open. It was likely going to close its doors without our 340B program in place. All of our spending is-- was $748,300, which was $80,000 more than the savings we brought in. So we're not rolling in the bank, you know, with, with our 340B savings, we're using them to serve the patients that need us the most. But if you've been to a hospital, any hospital, in the last 2 to 3 years and haven't seen a construction project, I would have a shock on-- look on my face. Because if you came to my facility, you'd see we just opened a new O.R. Suite, and to the outside it makes us look like we are just rolling in the dough. But what you're not going to see is my O.R. that was before that. It was built in the 1960s. We're finding out it had asbestos in it. We couldn't fit a single another body in the room and still maintain a sterile field and do the procedures. We also came

very close last summer to having to cancel procedures because we couldn't maintain temperature and humidity. So we're using those savings, you know, to make sure we're keeping our services open. We're only contracted with one independent pharmacy because of the pharmacy restrictions. There's one other pharmacy that we serve in another community that we can't contract with because it's not financially viable for either one of us, and it is also in danger of closing its doors. So thank you for your consideration, and I hope you advance LB940--LB984.

SLAMA: Thank you very much, Ms. Boals-Shively. Are there any questions from the committee? Senator Jacobson?

JACOBSON: I just have one quick question, I'm just curious. I appreciate the information and breakdown of the numbers, I think that's something a lot of people really don't realize that-- what rural hospitals are faced with in terms of free care, uncompensated care, under-- under-reimbursed care. Do you have a rough idea of what your Medicaid patient population is?

ELIZABETH BOALS-SHIVELY: I just have the number that you see in front of you. That's a combined-- the 62% Medicare, Medicaid, uninsured combined in front of me. I could definitely get that for you, though, from my CFO. She has the--

JACOBSON: But, but I think this is-- this is--

ELIZABETH BOALS-SHIVELY: -the exact number on it.

JACOBSON: Thank you. Well, this is a big issue. And I think as you go across rural Nebraska, we, we see this same story over and over and over again. So hopefully with 304B [SIC] and LB1087, we're going to be able to provide some relief, and-- but this is an important program we need to [INAUDIBLE]. I'm pretty certain that the manufacturers can afford this.

ELIZABETH BOALS-SHIVELY: Yeah.

JACOBSON: Just a thought.

ELIZABETH BOALS-SHIVELY: I do know for a data point for our nursing home alone, it's usually somewhere between a 60/40 split, 60%, private pay right now of 40%, and we still need those savings just to keep the [INAUDIBLE].

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Seeing none. Thank you very much for being here today. Additional proponent testimony for LB984? Welcome.

KATHY NORDBY: Good afternoon. Thank you for hosting me, Chairwoman Slama and the members of the committee. My name is Kathy Nordby, K-a-t-h-y, Nordby is N-o-r, d as in dog, b as in boy, y, and I'm the CEO of Midtown Health Center, a Federally Qualified Health Center located in Norfolk. But we have satellite clinics in Madison and in West Point. I'm here today to support LB984, and would like to thank Senator Hardin for introducing this important legislation. Last year, Midtown Health Center served over 8,200 patients. And we served in 14 different counties up in northeast Nebraska. In addition to our clinic locations, we also provide behavioral health services at ten elementary schools in Madison and in Norfolk. We offer tele behavioral health, medication management, psychiatric consultations in a-- in a large area in northern Nebraska. 80% of our patients are at or below 200% of poverty, and nearly a quarter of them are uninsured. They rely on Midtown for access to affordable care. We don't at this time have an in-house pharmacy. For years, we've existed with the understanding that contract pharmacies are acceptable and, and common practice as we implement our 340B program. It's critical to protecting the medication access for low income Nebraskans, especially when you consider my service area. What's really great about 340B is it really mandates that we reinvest our, our savings and in the 340 program into our programing. We can actually demonstrate these, these savings going towards chronic disease management and, and health education programs. We do some patient assistance programs like our transportation service and our language line, and we use the remaining funds to develop new opportunities that increase access for our patients. The most recent one is opening medical hours within a substance abuse treatment center. Any assert-- assertion that the providers are simply pocketing for profits is simply false. While each health center gets to make its own decisions about how they use these funds, we can demonstrate that universally, and we would rise to that challenge. In addition to investing in, in, in services for low income patients, we assure access. And if you-- I think our third page shows you a map. If you look at my service area, it's the light blue in the northeast corner. And if you think of me having one single pharmacy to serve that entire area, you can say, gosh, how do you get your refills? And I'll kind of summarize here because I don't want to go over, but really, I-- in the last four years, they, they implemented these restrictions where they

were limiting the number of pharmacies. I quit trying to create those partnerships that would both benefit local pharmacies, but also would benefit my patients, that I could open a relationship with the pharmacist in, in Laurel, per se, which is so much closer than me trying to get access there. I'm working with my local pharmacists that I do have contracts with to deliver care, but it creates a challenge. And so I really think that this is an overreach. I know it's a national problem, but we're asking for the simple solution that Arkansas and Louisiana put upon it, to just say, not right now, let's let the courts figure it out, so.

SLAMA: Thank you very much, Ms. Nordby. Are there any questions from the committee? Seeing none, thank you very much for being here today.

KATHY NORDBY: Thank you.

SLAMA: Additional proponent testimony for LB984? Welcome.

JESSIE McGRATH: Good afternoon, Chairman Slama, members of the committee. My name is Jessie McGrath, J-e-s-s-i-e M-c-G-r-a-t-h, and I'm here in support of this bill. I moved back to Omaha in the middle of last year, and, and I've been getting involved in some of the things that are going on in the state. But back in California, I am the secretary of the board for APLA Health, which is a federally qualified health center. And we have eight medical facilities. We treat 18,000 patients a year, providing them with medical, dental, behavioral science services, HIV specialty care. And we're able to do this because of the 340B program. That gives us additional resources that we can use to provide health care to individuals. My mom, who was a strong, strong proponent of rural health care, she was on the board of the Dundee County Hospital for years, the Dundee County Hospital Foundation. And it was from her that I got my wanting to help people in my community get affordable, good health care. The 340B program is something that funds a lot of rural hospitals, a lot of FQHC health care groups. And it's what helps funds [INAUDIBLE]. The manufacturers and distributors have been trying to put roadblocks up in place of, of our facilities being able to get these funds. When I talked with my executive director last night, mentioning that I was going to testify on this case, he goes, well, it's the only program that I can think of that John Thune and Maxine Waters are in bed with together. So, it's that important because of the rural nature that we get out into the outback of the state. Those funds are critical. They are sometimes the only thing that is going to keep that facility open. And to have this type of protection is absolutely amazing. When I mentioned this to my

executive director, he goes, we have been trying for the last few years to get this passed in California and we can't get it. But if you want to protect your rural hospitals, if you want to protect your, your rural providers, this is a, a key bill that needs to be passed to make sure that they can continue to receive those funds, because sometimes it is the difference between being able to operate and not being able to operate. So thank you, Senator, for bringing this bill. I applaud you for that and I hope you all will support it.

SLAMA: Thank you very much. Are there any questions from the committee? Seeing none, thank you for--

JESSIE McGRATH: Thank you.

SLAMA: --being here today. Additional proponent testimony for LB984? Welcome.

JED HANSEN: Welcome. Thank you. Thanks, Chairwoman Slama, and thank you, Senator Hardin, for introducing this bill. And good after-- good afternoon, senators of the committee. My name is Jed Hansen. I'm the executive director of Nebraska's Rural Health Association. Jed, J-e-d, last name Hansen, H-a-n-s-e-n. Before I get into some of my written comments, I just would like to point out that each and every one of you, the testimonies that you've heard have been rural and about rural. And this bill is particularly of interest to the Rural Health Association and to our rural health infrastructure. Nebraska's rural health infrastructure includes 62 critical access hospitals, nine rural regional hospitals, one rural emergency hospital, six Federally Qualified Health Centers, and around 200 ambulatory health clinics and rural health clinics, whose work directly affects over 140 communities across our state. And nearly all of these communities and health systems are affected by 340B. I led-- fast forward a little bit that just-- critical access hospitals are, are-- which are often the backbone of health care in our rural areas, 340B is particularly vital. Critical access hospitals operate on thin margins, as you've already heard, and face unique challenges, including transportation, high patient-- high per patient costs, and serve populations that are, in general, in greater need of medical services and financial assistance. The 340B program offers a financial reprieve for our hospitals, and allows them to stretch limited budgets and improve and expand access to care, including essential services such as oncology, infusion, transportation programs, reduced insulin costs for patients and employees, diabetes, diabetes education, long term care services, EMS ambulance services, OB services, and charity care that would

otherwise be unsustainable in these communities. These funds are so important to critical access in rural communities that 98% of our hospital leaders surveyed on 340B stated that they would have to reduce services with additional cuts to the 340B program. Unfortunately, our hospitals have seen an erosion with 340B, with 87% of our hospitals reporting reduced 340B dollars over the last two years due to noncompliance of the program with pharmaceutical companies. Of these signaling losses, nearly a third reduced 340B revenue between 15 and 75%, which in real dollars is approximately-- or is between $250,000 and $1.3 million because of these restrictive practices. I'll-- just knowing that I'm short on time, you know, it's just-- it's a testament to our collective commitment to ensure that 35% of our family members, neighbors and friends that call our rural communities home have access to high quality local health care. And the sustainability of this program is paramount to, to the health of our communities. So I ask you, please support LB984. Thank you.

SLAMA: Thank you very much, Mr. Hansen. Are there any questions from the committee? Seeing none, thank you for being here today.

JED HANSEN: Thank you.

SLAMA: Additional proponent testimony for LB984. Welcome.

ANDREW RADUECHEL: Hello. Chairperson Slama and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in favor of LB984. My name is Andrew Raduechel, A-n-d-r-e-w, last name, R-a-d-u-e-c-h-e-l. I am the director of pharmacy at Boys Town National Research Hospital. We are a disproportionate share hospital. So 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. In one study, 340B participation of disproportionate share hospitals was associated with a 29% increase in charity care spending, a 4% increase in discounted care, and a 19% increase in the income eligibility limit for discounted care. 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 the health care 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. It is important to remember that you cannot participate in the 340B program if you are for profit. This program is used to expand services we would not be able to offer otherwise. Many of the services we provide would not be able to be sustained without

support from programs like 340B. We added pediatric neurologic services to our mission four years ago. Nebraska had the lowest ratio of pediatric neurologists in the nation, at one pediatric neurologist for every 90,000 pediatric patients. We had many newborn babies in our community presenting with serious neurological symptoms like seizures. Others were genetic conditions like spinal muscular atrophy that would be fatal if not treated in the first few months of life. These patients and families would have to travel to places like Minneapolis or Denver and wait 4 to 6 months just to see a pediatric neurologist for the first time. Boys Town National Research Hospital had one 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 have or will have a mental or emotional or behavioral health disorder, but only 20% of those children receive care. Our services provide families with much needed support, and more, more importantly, hope, hope that things will be OK. In 1917, when Boys Town started, we were able to help five boys. Last year we helped over 500,000 boys and girls with our mental health and behavioral health services. We strongly support LB984 on behalf of our children and families, and open to any questions you may have.

SLAMA: Thank you very much, Mr. Raduechel. Are there any questions from the committee? Seeing none, thank you very much for being here today.

ANDREW RADUECHEL: Thanks.

SLAMA: Additional proponent testimony for LB984? Any additional proponents for LB984? Seeing none, is anyone here to testify in opposition to LB984?

JORDAN WILDERMUTH: Good afternoon, Chairperson Slama and members of the committee. My name is Jordan Wildermuth. J-o-r-d-a-n W-i-l-d-e-r-m-u-t-h. I'm a registered lobbyist and represent the Health Care Distribution Alliance, representing wholesale drug distributors that work to distribute ov-- nearly 10 million health care products daily, including to over 1,800 entities situated across Nebraska. We are opposed to the inclusion of wholesale drug distributors in LB984. It does not accurately reflect the role of each entity within the supply chain and has some unintended consequences. Wholesalers work under contract with the manufacturer to warehouse, pack, and ship their drugs to downstream purchasing partners such as pharmacies, hospitals, and physicians. If a 340B covered entity, or a covered entity's designated contract pharmacy orders a manufacturer's

drug through a 340B account, and the manufacturer participates in the program and has instructed the wholesaler to load the 340B pricing into those accounts, wholesalers will fulfill those orders at the 340B price provided by the manufacturer to the wholesaler once the wholesaler has validated the entity as a covered entity or designated contract pharmacy. As such, wholesalers have-- do not know what price-- we are not making these determinations, and nor would we be able to do so or have any purview over that process. We do not play a role in setting 340B pricing, nor are privy to it until we're provided the pricing to the wholesaler. LB1984 is also conflicting with a wholesaler distributor's obligations under Federal Drug Enforcement Administration regulations, and national injunctive relief requirements, requirements in which Nebraska is party to. Specifically, we are required to identify suspicious orders and report those orders to DEA and stop shipment. If this legislation went into effect, wholesale distributors would be put in a position to either comply with federal law and regulations, or follow state law and violate federal law and settlement agreement requirements. Historically, these 340B bills have not included wholesale distributors, including in Arkansas. We are currently working on amendments to legislation in Iowa, West Virginia and Oklahoma to remove wholesa-- wholesalers from their language. So happy to answer any questions from the role of the wholesaler on this bill, as well as any other information that was brought up previously in committee on wholesaler PSAOs.

JACOBSON: Thank you. Questions from the committee? Yes, Senator Kauth.

KAUTH: Thank you, Vice Chair Jacobson. Mr. Wil-- Wildermuth?

JORDAN WILDERMUTH: Yes.

KAUTH: So for you guys, did something change? Did you stop participating in the 340B or have you never participated? And this is changing that?

JORDAN WILDERMUTH: Yeah. So we are simply-- we buy-- we purchase the drugs from the manufacturer at the wholesale acquisition cost. And then we have our customers, which are hospitals, pharmacies, they are ordering their drugs through a distributor, whether that be 340B covered drugs, or just regular drugs. So we do not know whether a 340-- whether a drug is a 340B drug until that information is provided to us by the manufacturer, so that we can enter in that pricing for the pharmacy or the customer when they get their shipment from us.

KAUTH: So, but when 340B first started, you guys participated in that program at a national level, correct?

JORDAN WILDERMUTH: We are-- so we are not-- we're just the middle, like we just deliver the drugs, we don't pi-- like, we don't have a like a role in that part of the-- like, we're just the entity that buys the drugs from the manufacturer, fulfills the orders from the customer, whether that's a 340B drug or a non drug, we fulfill our orders for our customers.

KAUTH: OK. Thank you.

JACOBSON: So thank you for opening us up to whatever questions we might want to bring. So how many wholesalers do represent?

JORDAN WILDERMUTH: So we have 37 distributors that are a membership of the, the trade association.

JACOBSON: How many operate in Nebraska?

JORDAN WILDERMUTH: There are three for certain that I know of.

JACOBSON: OK. So you're telling me that there's a wholesale acquisition cost that you purchase these drugs from, from the manufacturers, right?

JORDAN WILDERMUTH: Correct, yes.

JACOBSON: And then you distribute it to pharmacies?

JORDAN WILDERMUTH: Correct.

JACOBSON: And I presume you make a profit in spreading between, don't you?

JORDAN WILDERMUTH: We do not.

JACOBSON: You don't make a spread--

JORDAN WILDERMUTH: So we sell. So we-- the--

JACOBSON: Then why are you in business, how are you in business if you don't make a spread?

JORDAN WILDERMUTH: We are in business by the fees that we charge manufacturers for the shipping and handling of those drugs. And then

we sell the drugs at cost to the pharmacies, hospitals. Our fees only come from the manufacturers' side of it.

JACOBSON: But you all-- but you guys are all profitable, correct?

JORDAN WILDERMUTH: Our profit margin is 1%.

JACOBSON: I don't care what the margin is, you're profitable, right?

JORDAN WILDERMUTH: Yes.

JACOBSON: I mean you do a lot of volume. So the margin could be really thin, but a lot of volume.

JORDAN WILDERMUTH: Yes. Correct.

JACOBSON: OK.

JORDAN WILDERMUTH: That's correct.

JACOBSON: Lots of volume times sales spread, but still a lot of money.

JORDAN WILDERMUTH: Yes.

JACOBSON: Right. OK. I'm just trying to understand this in terms of the whole PBM change as well, because--

JORDAN WILDERMUTH: Sure.

JACOBSON: We were hearing earlier that pharmacies need to do a better job of negotiating. So how do they negotiate? How do they negotiate with you? With, with your members?

JORDAN WILDERMUTH: Sure. So they will work with wholesalers and have nego-- They can go to a certain wholesaler, find out what the cost is. They can negotiate with other wholesalers for the for the same drug, and--

JACOBSON: Drug by drug, or how, how do they do that?

JORDAN WILDERMUTH: I mean, generally they usually have a contract with a primary wholesaler, and then if they can't get products through the primary wholesaler, they will usually contract with a secondary wholesaler.

JACOBSON: And how do they get price differentiation if all you are is a delivery man, your, your customers?

JORDAN WILDERMUTH: So--

JACOBSON: I mean, we were being told earlier that the pro-- that the pharmacies, local retail pharmacies, need to do a better job of negotiating price with their distributor. The distributors are your customers, or your-- the people you represent, right?

JORDAN WILDERMUTH: Right.

JACOBSON: So how would they go about negotiating a price?

JORDAN WILDERMUTH: The-- if I'm-- purchasing, purchasing power, if they're-- if a number of, like, if a number of pharmacies are able to go in and purchase--

JACOBSON: So they have to do it together. So an individual pharmacy who's, who's actually filling prescription drugs at a loss, how, how are they going to be able to get their costs down so that they can comply with PBMs and still have a positive spread?

JORDAN WILDERMUTH: We sell the drugs at the wholesale acquisition cost to the pharmacy. And a lot of our customers are small, independent pharmacies.

JACOBSON: But you're telling me that the manufacturers are actually setting the price. So correct, the wholesale acquisition cost?

JORDAN WILDERMUTH: That's correct. Yes.

JACOBSON: So I'm, I'm still back to how would-- how would a local pharmacy negotiate that price lower. I, I'm--

JORDAN WILDERMUTH: It comes down to--

JACOBSON: I can't imagine how it can happen. Would that be what you're saying? Yeah.

JORDAN WILDERMUTH: Reimbursement.

JACOBSON: Yeah. All right. Thank you.

SLAMA: Thank you, Senator Jacobson. Senator Kauth.

KAUTH: Thank you, Chair Slama. Just one more question. Do, do you guys use rebates or do you benefit from rebates at all?

JORDAN WILDERMUTH: No.

KAUTH: OK, so I'm, I'm kind of with him, how do you make your money?

JORDAN WILDERMUTH: On a bonus-- it's a service fee from our distributor members to the-- we charge the manufacturers a fee that covers, like, the shipping, the handling. Because it is, you know, it's easier for a distributor to have a-- a pharmacy to have or a hospital have a relationship with a distributor than having to have a relationship with all the different drug manufacturers. And so we provide that service, and then charge the manufacturers that handling fee. Sometimes there's the extra cold storage fee depending on medication. So that's where we make our--

KAUTH: So kind of a--

JORDAN WILDERMUTH: --profit.

KAUTH: --customer service--

JORDAN WILDERMUTH: Correct.

KAUTH: --intermediary.

JORDAN WILDERMUTH: Yes.

KAUTH: All right. Thank you.

SLAMA: Thank you, Senator Kauth. Additional questions from the committee? Seeing none, thank you very much.

JORDAN WILDERMUTH: Thank you very much.

SLAMA: Additional proponent testimony for LB984. Opposition. I'm so sorry. Additional opposition testimony for LB984.

KATELIN LUCARIELLO: Hello again everyone. I'm sorry to put you through me-- 30 seconds of me reading out my name, but good afternoon. My name is Katelin Lucariello, K-a-t-e-l-i-n L-u-c-a-r-i-e-l-l-o. I am the deputy vice president of state policy for PhRMA in the Rocky Mountain region. I am also a registered lobbyist here in Nebraska, and I'm here today in opposition to the bill. I think that our previous conversations around PBMs are fitting, because to a certain extent,

there is overlap between this bill and the PBM conversation. We agree, as the industry that funds the 340B program, that it is absolutely crucial that the 340B program really, truly benefits safety net providers and helps underserved communities in Nebraska. This is a federal program that we are crucially committed to, but we respectfully disagree with this legislation. As stated before, the 340B program was started to help safety net entities treat low income and under-- uninsured patients. But due to changes in federal guidance that do not have the force of law, the program has really expanded in a way that has allowed funds for 340B to be diverted away from patients and important safety net providers to contract pharmacies and PBMs. And as a result, the 340B program has grown dramatically since its establishment. It is a comprehensive federal program, as you've heard, which has governed federally, and states largely do not have the authority to create new requirements that are not in federal statute or that conflict with that federal 340B statute. We agree, significant reform is needed. We think it is needed at the federal level and are part of coalitions looking to pass legislation federally to systematically address problems and abuses within the 340B program. That means that it's strayed from its original intent. This bill really exacerbates many abuses within the 340B program by contract pharmacies, which many of which are owned by the big three PBMs. And because of this, this program for contract pharmacies has been less about benefiting patients and more about profit for the large chain pharmacies and PBMs. The bill benefits those hundreds of contract pharmacies in the state which are not hospital pharmacies, and nearly half of those pharmacies belong to the three largest PBMs and are located outside of the state. In addition, whether manufacturers can be required to provide these discounts to those contract pharmacies and ship drugs to those contract pharmacies at a 340B price is being litigated in the two states that have passed legislation similar to this bill, Arkansas and Louisiana. I appreciate your time, and I am open to questions. Thank you.

SLAMA: Thank you very much. Are there any questions from the committee? Senator Jacobson.

JACOBSON: OK, I got to ask. So we had an earlier testifier was talking about-- OK, I'm looking at the [INAUDIBLE] here, and you can't see this, but here's Boyd County up here, and here's Deuel County down here. Now, if there's only one pharmacy they can work with, how are they going to get their prescriptions? You're going halfway across the state.

KATELIN LUCARIELLO: So thank you, Senator, for your question. The requirements are about contract pharmacies, not the individual, like, hospital providers. So hospitals with an in-house pharmacy could still dispense.

JACOBSON: But if they don't have an in-house pharmacy.

KATELIN LUCARIELLO: Then, there are-- I can't speak to specific manufacturer restrictions, but the restrictions vary. And typically contract pharmacy, there would still be a contract pharmacy that would be able to operate if there was not an in-house pharmacy.

JACOBSON: So the other question I guess I have to follow up with is we heard earlier from testifiers for PBMs that the local rural pharmacies need to somehow figure out how to get their pricing lower. How do they do that if the distributors are just simply distributing and getting paid by the pharmaceutical manufacturers who you represent, how do they negotiate lower pricing individually, as individual pharmacies?

KATELIN LUCARIELLO: Thank you, Senator. So as an individual pharmacy there-- either you negotiate directly with a distributor, or you can negotiate with the manufacturer in limited instances.

JACOBSON: Didn't the distributor just tell us that they don't work price, they just get paid a fee from the pharmacy, pharmacy manufacturers.

KATELIN LUCARIELLO: Yeah. Thank you for your question, Senator. I don't want to contradict him because he understands that part of the supply chain is better than I do. My understanding is that when a wholesale distributor contracts with a manufacturer to distribute a drug, the manufacturer pays them fees and some discounts off of the wholesale acquisition cost of the medicine. That is then-- can be negotiated basically, typically with pharmacies will negotiate at like economies of scale, like they'll band together in order to leverage that purchasing power to get lower prices.

JACOBSON: And who are they negotiating with?

KATELIN LUCARIELLO: They are negotiating with the wholesale distributor, it's my understanding, at a function of the wholesale acquisition cost.

JACOBSON: I think that's one of the reasons we're having trouble understanding is because this is clearly conflict, conflicting

testimony in terms of how the process works. And I'm just trying to get to the-- a solution. You know, I'm just trying to figure out how we get there. And, and, and that's what makes this a little complicated. But, but I appreciate your testimony, and I appreciate where you're coming from. I think, what I'm hearing is that there may be some tweaks that could be done in this bill to be able to streamline this, I assume, to where we can get these-- staying away from, really, these-- the PBM operations and try to get it focused really in these hospitals that really, truly are needing it and using it. But I guess I'm hearing that you have the med center, who, who's, who's, who uses it to some extent. All these rural hospitals, they're-- this is critically necessary. Are there changes you see in this bill that we could make to make it palatable to your-- the people you represent?

KATELIN LUCARIELLO: Thank you, Senator. You-- I think with this legislation, it's difficult because we see a federal fix as necessary, and we see a federal fix as necessary because there is a program that requires systematic change rather than creating kind of a patchwork of state policy with broad legislation that rewards both the-- acknowledge, I'll acknowledge that very good actors in the system, but also a number of actors that are abusing the system. And this bill is kind of a broad based policy versus at the federal level, where we think there could be more granularity and recognition of the need for an approach that recognizes basically the, the needs of rural health providers and small community health centers.

JACOBSON: Do you realize that that does not give me much comfort at all, that we're relying upon the federal government to do something to fix rural hospitals' problems doesn't seem to really resonate well with me. So I'd like to try to-- try to do something at the state level if we can, so I'd be open to kind of understanding what solutions you might be able to bring to the table.

KATELIN LUCARIELLO: Thank you. Senator, if I may, I also got into state health policy because we work a little bit faster than the federal level does. I will say, I think in terms of a federal solution, we're really closer than we ever have been before. There's currently an FTC investigation that's been initiated into PBMs uses of 340B revenue. There is also a, a draft of legislation that's circulating for comments with the intent to introduce legislation, for comments by April 1st by a bipartisan group of senators I think it was acknowledged earlier, including Senator Thune from South Dakota and

Moran from Kansas, which addresses not only this issue but the unique issues that rural hospitals face.

JACOBSON: Thank you.

KATELIN LUCARIELLO: Thank you.

SLAMA: Thank you, Senator Jacobson. Additional committee questions? Senator Ballard.

BALLARD: Thank you, Chair Slama. Thank you for being here. You mentioned the Arkansas and Louisiana court cases. Were those-- were the complaints subject around the authority of the state to, to enact the legislation?

KATELIN LUCARIELLO: Yeah. Thank you for that. Because we're in active litigation, I can't talk specifically about the complaints. I can get you some information about the complaints. They, they do have to do with the ability to-- for states to impart restrictions or additional requirements on federal, on a federal program, amongst other-- amongst other issues with the legislation.

BALLARD: And you said that was in the court of appeals, where that's going?

KATELIN LUCARIELLO: Yes, the Arkansas litigation is currently in the court of appeals, and the Louisiana litigation is also active.

BALLARD: OK. Thank you.

KATELIN LUCARIELLO: Thank you.

SLAMA: Thank you, Senator Ballard. Additional committee questions? Seeing none. Thank you very much.

KATELIN LUCARIELLO: Thank you.

SLAMA: Additional opponent testimony on LB984? Last call. Any opponent testimony on LB984? Is there anybody here to testify in the neutral capacity on LB984? Seeing none, senator Hardin, you're recognized to close. And as you come up, we did receive 5 proponent, 2 opponent, and zero neutral letters for the record on LB984. Senator Hardin to close.

HARDIN: Thank you. I'm passing out some information for you all to take home. It's gripping reading. I'm sure it will put you straight to

sleep. In that stack, when you get it, I would like to direct your attention to this fun little document, it says 340B Manufacturers Interference. We just chose seven interesting ones out of the 29 that were available to us. And I would direct your attention to the revenue that was made while there were infractions going on in just the last few years since 2020. It's interesting timing, isn't it? I would agree that we have a federal fix that's necessary. And given that we have a Congress that can't seem to come up with a budget on a regular basis, we now want them to fix a 32 year old law. So I think we're going to be waiting a while. But I would say that the greatest abuse, and what needs to be fixed, is on the part of the drug makers who are cashing in on record revenue in the billions, while simultaneously punishing the patients in the facilities who can least afford those challenges. I would point out that for Pfizer at the top of this list, and this is from 2022, they made $100 billion that year. 2023, they fell way off, kind of went back to where they had previously been around $58 billion in 2023. And so I would also point out to you another fun document in the stack that I gave you called 340B hospitals by legislative district. We have 92 hospitals in the state as I understand. 68 of those are 340B recipients. Of those, 59 are in the rural areas. So you can kind of see those of us who are listed. It starts with District 1, Senator Slama, flip it clear over to the back and we get to, well, District 48 is the last one that participates, that would be my district. And the very last hospital listed there is Regional West Medical Center in Scottsbluff. Thanks to Mr. Mel McNea, who is our interim CEO we can celebrate the very first quarter in 20 years of being in the black as opposed to in the red. And I asked Mr. McNea what role 340B plays in our local hospital. And he said it is 6% of our bottom line. If we were to remove that 6% right now when they're hanging on by their fingernails, it would be devastating to the 1,100 plus jobs, which is the largest employer in our area. It's very important. So what we have going on, I would say, since 2020 is obfuscation. Let's just make it harder to cash the checks. Let's make it harder for people to get access to these drugs, and as Senator Jacobson pointed out, there are some strange diagonals that can happen across the state of Nebraska in some of our areas and, and in a snowstorm, that's a long ways to get from point A to point B to get a drug filled. I'll take your questions.

SLAMA: Thank you very much, Senator Hardin. Are there any questions from the committee? Seeing none. Thank you very much.

HARDIN: Thank you.

SLAMA: All right. That brings us to a close our hearing on LB984. We'll give everybody a moment to turn the room around as we prepare for LB1110 with Senator Jacobson. Senator Jacobson, you're welcome to open.

JACOBSON: Thank you very much. Chair Slama. Members of the Banking, Commerce and Insurance Committee. My name is Mike Jacobson, M-i-k-e J-a-c-o-b-s-o-n. I represent Legislative District 42. I'm here this afternoon to introduce LB1110, which would establish that dental carriers be required to spend a minimum amount of the premium it earns on actual dental services during the plan year. As introduced, the bill sets this amount at 85%. If the minimum is not met, the carrier would be required to return the excess premium to the insurer. I'm going to stop with that piece of my prepared testimony and just wing it from here and let you know what I'm--what I'm thinking here. We've had an interesting discussion this afternoon. OK? We've heard from PBMs and we've heard them talk to us about these local pharmacies, hey, if you can't get your costs down, hey, it's on you. It's all about patient care. Isn't that what we heard today? This is all about delivering quality patient care. And now I'm going to shift gears a little bit because now we're talking about shoes a little bit on the other foot, and we're trying to figure out how can we get dental coverage and dental care to people across rural Nebraska and throughout the state? I can tell you, when you come out in our part of the state, it's a dental desert when it comes to Medicare, Medicaid patients in particular. I would also tell you that there's ongoing concerns about the percentage that gets paid out of the premiums that are paid in in terms of actual care. Now, in fairness, I did meet, after introducing this bill, and I was asked to carry this bill late in the session, and let me also preface, I don't intend this bill to pass this year. It's not prioritized, it's late in the session, so everybody relax, we're, we're not going anywhere here today, other than we're going to hear some testimony today from both sides of this issue. And I think we need to listen to that testimony, because I think you're going to hear two sides of an issue here that I think is going to require, and we should be giving some additional consideration to. To give you a little bit of a preview, I think we're going to hear that dental insurance is a little bit different than health care insurance because the premiums are much smaller. And if you're going to have overhead costs, you can't pay off the same percentage when you have a much smaller amount of dollars coming in. And I agree with that. And I think that's a very valid point, and frankly, that's going to make that 85 very, very difficult to hit.

However, at the same time, that number today is way too low. And there needs to be some kind of indication from employers and others who are offering this as a, as a benefit package, the premiums that are being paid, that in fact, we're seeing some coverage out there. I think it's important that we make sure that that part happens as well. So that's the crux of what this bill is about. Again, it's not going to pass this year because there's no priority on it, and it's late in the session. But this is a starting point for a discussion. And that's what I hope we can have today, is a little bit of a discussion from testifiers as to where we are, because in future years, I think we're gonna need to be prepared to look at this and figure out if there's a better solution. With that, I'd stop, Chairman, Chairwoman Slama and ask for any questions.

SLAMA: Thank you, Senator Jacobson. Chairman, Chairwoman, you've called me worse things than that.

JACOBSON: That's all. I do it all.

SLAMA: Any questions from the committee? Seeing none, thank you very much.

JACOBSON: And I'll stay for my close. Not that I'll get-- not that I'll close, but I'll stay.

SLAMA: That's so kind of you.

JACOBSON: Thank you.

SLAMA: I'll now open it up for a proponent of testimony on LB1110.

DAVID O'DOHERTY: Not going to pass this year? Good afternoon, members of the committee. My name is David O'Doherty, D-a-v-i-d O apostrophe D-o-h-e-r-t-y. And I'm the executive director of the Nebraska Dental Association, representing 70% of the Nebraska dentists. We'd like to thank Senator Jacobson for introducing LB1110. Dental insurance is very different from medical insurance. Namely, you don't get rated when you buy dental insurance. It's more like a dental benefit plan. Also, dental plans have annual maximums. In other words, the total amount your dental plan will pay towards your care in a 12 month period usually ranges between $1,000 and $1,500. Once you hit that, you're done, or they're done paying for you. According to the National Association of Dental Plans, only 2.8% of people on a PPO plan reach their dental maximum each year. So where does that unused portion go? LB1110 would help to return that to the patient. The Affordable Care

Act dealt with dental care in a pretty strange way. It called dental care for children an essential health benefit under the ACA. Adult dental is not included. One of the consequences of having dental care not part of Obamacare, is that a lot of very well-designed consumer protection provisions, like a medical loss ratio, that are enabling more Americans to access medical care, do not apply in the dental world. LB1110 fixes that. Dental care consistently ranks number one in terms of health care services people delay or avoid because of cost, as affirmed in multiple studies and multiple data sources. Even for health care services with benefit structures similar to those of dental care, like vision, for example, financial barriers are far less. The way dental care insurance is structured, including the use of annual maximum benefits, significant co-insurances, 20 to 50% for services beyond preventative care contributes to the high degree of cost barriers the beneficiaries experience. For most adults with private dental insurance, total outlays on premiums, co-insurance, co-payments actually exceed the market value of the dental care consumed. I have three handouts that are going around. The first one is from the Colorado Department of Insurance that they have a reporting requirement for MLR dental plans, but they don't have a rebate portion. So you can see quite a few are already hitting the 80 to 85% requirement on an MLR. The second handout is from PPI, a Washington based company that basically summarizes the testimony you'll hear on the proponent side today. And the final handout is arguments that you're going to hear in opposition ti-- opposition side, the ones that were raised also during Obamacare passage, and answers to those opposition claims. Thank you for listening today, and I'd be happy to answer any questions.

SLAMA: Fantastic. Thank you very much. Any questions from the committee? Seeing none.

DAVID O'DOHERTY: Thank you.

SLAMA: Thank you very much. Additional proponents for LB1110?

LIZ PAPINEAU: Good afternoon, Committee members. Thank you, Senator Jacobson, for introducing this bill. My name is Doctor Liz Papineau, L-i-z P-a-p-i-n-e-a-u. I'm a general dentist in York, and the immediate past president of the Nebraska Dental Association. And I'm here speaking in support of LB1110, which, as you've heard, is legislation that would require dental insurance companies to meet a minimum dental loss ratio, or DLR. This requires 85% of patients' premium dollars be spent directly on patient care as opposed to

administrative costs, marketing, and profits. It would also create standardized requirements for dental plans to disclose how they spend their patient, patient premium revenue. And the concept of DLR isn't it new, as you heard. Medical loss ratio or, MLR requirements have been in place for medical insurance companies for years, most ranging from 80 to 85%. And Nebraska Dental Medicaid is also required to follow DLR at 85%. Currently, eight states have laws in place regarding DL or and/or reporting requirements, with 13 other states filing legislation in 2023 and 2024. And DLR can work in the states with this legislation with very little disruption to the market. In Massachusetts, for example, especially in the smaller group markets. Some insurance companies have left. But others have come in to take their place, and those that left just weren't able to provide the value needed for the consumer, in our case, the patients. So when patients are looking for a benefit plan, they need to be able to choose one that provides the proper benefits relative to the cost. And this bill would address that by asking the insurance companies to be more transparent with where their premiums are being spent, and then by actually spending the majority of dental premiums on dental treatment. Many companies are already close to meeting DLR. This bill is simply asking them to meet the same standards that medical insurance companies have had to for years. And there really is no reason that dental insurance companies shouldn't have to follow the, the same rules. Over the past several years, many dental insurance companies have been raising their premiums while covering fewer services for our patients, leaving them to foot the bill. So where are those extra premiums going if they aren't being used on patient care? Perhaps to executive or administrative salaries and bonuses? This unfortunately leads to many patients refusing much needed treatment because their dental benefits are not covering their fair portion. They simply can't afford to pay for premiums, only to have a minimal portion of them be used on their actual dental care. Why should our patients be expected to pay an unfair percentage of executive and administrative salaries with their premiums? I got into the dental profession so I could help people. Most times this is obviously by fixing something in their mouth, but with this bill, I can help protect their interests and their hard earned money. I can help make it affordable for them to get the treatment they need with premiums that they've already paid for. In closing, I'd like you to consider that not having DLR legislation in the state of Nebraska shows that we are siding with corporate profits instead of consumer protection. Thank you.

SLAMA: Thank you very much, Mr.-- Doctor. I'm sorry, I was so focused on pronouncing--

LIZ PAPINEAU: The last name?

SLAMA: --the last name, right.

LIZ PAPINEAU: It's all good.

SLAMA: Is it Papineau?

LIZ PAPINEAU: Papineau. Yeah.

SLAMA: Oh thank God. I'm so sorry.

LIZ PAPINEAU: It's all good.

SLAMA: Are there any questions from the committee? Seeing none, thank you very much. You have my apologies.

von GILLERN: It's the last one.

SLAMA: I need more caffeine.

ADAM LAMPRECHT: Greetings, Senator Slama and the members of the committee. My name is Adam Lamprecht, A-d-a-m L-a-m-p-r-e-c-h-t. I'm a general dentist in Fremont, and vice president for the Nebraska Dental Association. I'm here today to testify in support of LB1110. As you know, Fremont's a blue collar community like many other Nebraskan towns. Most of my patients are the hardworking, hardworking factory and meatpacking plant employees who are vital to our state's economy. Many of them have not had dental care, like you or I, because they come from countries where oral health isn't accessible, or it simply hasn't been a priority for them. Once employed, though, they are offered benefits packages that for many includes dental insurance for the first time. For most, it still take some time to seek dental care because of fear, language barriers, or lack of awareness. After years of paying their dental premiums, they finally get the courage to visit us. As you would expect, many have a long list of treatment concerns, much of which can be urgent. Our patients assume that because they have been paying for dental insurance or have had their benefit for years, their dental care will be taken care of with the help of their insurance. Unfortunately, it is becoming more common these days that we are left informing patients that their benefit, or as we like to call it dental coupon, will not cover the recommended treatment as

they expected. This is usually followed up with the patient asking well, why am I paying for dental insurance? Fortunately for some, we are able to complete treatment, but for many treatment is left unfinished. The situation is not unique just to Fremont. The American Dental Association states that only 50 to 60% of Americans with private dental insurance use it. Dental offices across the country continue to see increased denial of services, minimal changes in reimbursement, and annual dental insurance maximums that have not changed since their inception in the 1960s. One would assume, then, that dental insurance premiums and the cost of dentistry have stayed flat as well. We all know that this is not the case. So where are all those premium dollars going? Well, we don't know because dental insurance companies are not currently required to provide consumers with that information. The available data suggests that 25% or more of the premiums go to CEO wages, shareholder dividends, and high administrative costs. This means less coverage for our patients' dental needs and more people left with poor oral health. LB1110 would provide our patients and consumers across the state the right to ensure that their premiums are going directly towards their dental care. They would provide the same transparency that is already required by our medical insurance carriers. We know this model works in medicine, so why should it not work dentistry as well? Our patients' dental experience-- our patients' dental insurance experience in Fremont is no different than those in Norfolk, North Platte, or Scottsbluff. Nebraskans are hardworking people who deserve to know how their hard earned money is working for them. Dentists also want to ensure that our patients-- when our patients walk through the door, the majority of their premium dollars are being used for their own dental care. This will allow more patients the ability to complete treatment as-- the treatment-- the treatment they need. We all know that good oral health leads to improved overall health and well-being. Please help by supporting LB1110. It represents an important patient protection measure that will strengthen dental insurance for all. Thank you for your time and support.

SLAMA: Thank you very much, Doctor Lamprecht. Are there any questions from the committee? Seeing none, thank you very much for being here today. Additional proponent testimony for LB1110. Last call for proponent testimony on LB1110. Seeing none. Any opponent testimony for LB1110. Welcome.

OWEN URECH: Thank you. Good afternoon, Chair Slama, members of the committee. My name is Owen Urech. That's spelled O-w-e-n U-r-e-c-h, and I serve as the director of government relations for the National

Association of Dental Plans. NADP is the largest nonprofit trade organization for dental coverage, and our members include insurance carriers and supporting organizations that provide dental coverage for over 200 million Americans. I'm here today to testify in opposition to LB1110, which would establish an 85% minimum loss ratio for dental insurance in Nebraska. NADP is concerned that this bill would set an arbitrary standard for carriers, and harm access to dental care and the affordability of dental coverage through higher premiums and market consolidation. Dental plans offer preventive focused benefits in a competitive market, with over 30 carriers operating in Nebraska. Premium increases for dental coverage have remained consistently below inflation over the past several years, averaging less than 1% increases annually. When purchasing dental coverage, like other supplemental benefits, research shows that individuals are highly price sensitive. The choice between selecting and not selecting coverage is often based on the premiums alone, and going without dental coverage can have serious ramifications for patients' oral health. To date, Massachusetts is the only state which has passed similar requirements to this bill, and they were passed through a ballot initiative in 2022. The other states that have passed loss ratio related bills have been reporting, or some form of statistical test done based off of those reporting, not similar to the number that is currently being proposed in this bill and was passed in Massachusetts. NADP commissioned a study with Milliman, a leading consulting firm, to calculate the impact of the loss ratio requirement in Massachusetts, and found that the requirement could raise premiums on small group dental plans by as much as 38%. Massachusetts is still working to finalize the implementation of those requirements, but we have already started to see other negative effects. Five insurance carriers have left the small group market in Massachusetts, and brokers have reported to carriers and to their customers that they are receiving significant concern about the stability of the dental insurance market from the uncertainty around these pending negotiations. Also, to date, there are no new insurance carriers that have filed to offer products in Massachusetts. At this point, because the regulations are also pending, there's no way for them to be able to file to do additional coverage, because all of this is still up in the air. If enacted in Nebraska, LB1110 would-- could cause similar market consolidation and premium increases, and leave small businesses and individuals with fewer options for dental coverage at significantly higher costs. Thank you for your consideration. I'm happy to take any questions.

SLAMA: Thank you very much, Mr. Urech. Are there any questions from the committee? Senator Kauth.

KAUTH: Thank you, Chair Slama. What is the average profit margin for your members?

OWEN URECH: Yeah, the average profit margin, I believe, is between 2 and 3%.

KAUTH: Thank you.

SLAMA: Thank you, Senator Kauth. Additional questions from the committee? Seeing none, thank you very much, Mr. Urech.

OWEN URECH: Thank you.

SLAMA: Additional opponent testimony on LB1110.

KATE McCOWN: All right. Good afternoon--

SLAMA: Good afternoon.

KATE McCOWN: --Chairwoman Slama and members of the committee. My name is Kate McCown, K-a-t-e M-c-C-o-w-n. I'm the vice president of compliance at Ameritas Life Insurance Corp. for our health insurance products, which includes dental, vision, and hearing. Ameritas employs over 1,300 Nebraskans and 2,600 people nationwide. We provide dental insurance benefits for over 330[SIC] Nebraskans and 3.3[SIC] Americans nationwide. Today we are testifying in opposition of LB1110. Our perspective is that dental loss ratios are different from medical loss ratios and for good reason. Dental plan premiums are typically 1/20 of the medical plan premium. To date, no financial analysis rooted in data or based on a proper study has been done on the impact of dental loss ratios on affordability and dental accessibility for both individuals and small businesses. Arbitrary loss ratios for dental plans are haphazardly modeled after medical plans, and could be punitive to Nebraskans, and are not good economics. What would a dental loss ratio be, all things equal, if it was aligned with medical? A monthly family medical premium averages $2,000, while dental family premium is $100. An 85% loss ratio means the medical plan has $300 to cover administrative expenses such as processing claims, answering calls, providing policy documents, fraud protection. A dental plan would have $15 with an 85% loss ratio to perform those same activities. There is a very wide gap there when both carriers perform very similar administrative activities to adhere to regulatory

requirements. Dental carriers would be forced to increase premiums in order to continue to provide the same service for their customers while meeting those regulatory obligations. In 2022, Massachusetts did pass the ballot initiative, applying a 83% loss ratio. However, residents of those states were not given the full detail of the potential ramifications of applying a loss ratio that is intended for medical plans. At least five dental carriers have stopped offering dental plans in the individual and small group markets in that state. Ameritas was one of those carriers. The bottom line is that a loss ratio as required under this bill will raise dental premiums, which is counterproductive to increasing access to quality care and improving oral health for Nebraskans. For these reasons, we oppose LB1110 and urge you not to move the bill forward. Thank you very much for your time and consideration.

SLAMA: Thank you very much for being here today. Questions from the committee? Seeing none, thank you.

KATE McCOWN: Thank you.

SLAMA: Additional opponents for LB1110. Welcome.

RIKKI PELTA: Thank you. Good afternoon, Chair Slama and members of the committee. Thank you for the opportunity to testify in opposition to LB1110 today. My name is Rikki Pelta, R-i-k-k-i P-e-l-t-a. I am senior counsel with the American Council of Life Insurers. ACLI's-- ACLI is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. ACLI's 280 member companies are dedicated to protecting consumers financial well-being through life insurance, annuities, retirement plans, long term care insurance, and supplemental benefits, including dental insurance. The unintended consequences of this bill would likely lead to higher premiums and lower access to dental care for Nebraskans. A mandated loss ratio does not work for dental insurance. When the Affordable Care Act was passed, it included a minimum loss ratio for medical insurance. For several reasons, the MLR was not applied to dental plans. For these reasons, it should not be applied now. Dental benefit plan's design fundamentally differs from major medical plan design. Dental plans focus on paying a greater share of preventative services that encourage regular visits to the dentist, and then preclude the need for more costly procedures in the future. So dental premiums are, on average, about 1/20 of mental-- medical premiums. While the plan designs differ, the functions necessary to administer the plans are very similar. Both types of plans must administer claim payment,

customer services such as call centers, network development, anti-fraud and consumer protection measures, etc. This bill would leave 15% of premium dollars for plans to spend on these administrative services. In Nebraska, dental premiums average about $25 per month, so that would leave only $3.75 to administer the plan, which is not nearly enough. In order to continue operating, carriers would likely have to raise premiums to be able to afford the plan administration or leave the market in Nebraska, as we're seeing in Massachusetts. Less choice and higher premiums would negatively impact Nebraskans. Dental insurance is very price sensitive, and a rise in premiums is likely to result in a reduction of coverage. Those without dental insurance are far less likely to go to the dentist, skipping regular preventative services, which then increases the likelihood of developing more serious dental and then potentially overall health problems. A 2021 study found that 65% of people without dental insurance have skipped dental visits due to cost. 59% say that the top reason for not visiting a dentist is cost. So it's crucial to keep dental premiums low and preserve a robust market. LB1110 would have the opposite effect, and for that reason ACLI opposes. Thank you for your time and consideration today.

SLAMA: Fantastic, fantastic. Thank you, Ms. Pelta. Are there any questions from the committee? Seeing none, thank you very much for being here today. Additional opponents for LB1110.

LIZ LYONS: Good afternoon.

SLAMA: Welcome.

LIZ LYONS: Hi, Chair Slama, members of the Banking, Commerce and Insurance Committee. My name is Liz Lyons, that's L-i-z L-y-o-n-s, and I'm the registered lobbyist here on behalf of America's health insurance plans, otherwise known as AHIP, and Blue Cross Blue Shield of Nebraska. As the testifiers before me alluded, there are unintended consequences to LB1110, and I want to thank Senator Jacobson for putting this bill together in this capacity to have the conversation. As others alluded before me, the primary concerns are shared with AHIP and Blue Cross Blue Shield. Increased premiums, we've heard that a number of times. An 85% MLR requirement could force insurers to raise premiums to comply, which ultimately shifts the costs to consumers and employers. Reduced access, higher premiums could lead individuals to drop, hindering access to necessary care and ultimately fewer choices. This legislation could discourage insurers from offering dental plans in Nebraska, limiting consumer choice. I want to thank the committee

for having this hearing today, and I would like to answer any questions for you.

SLAMA: Thank you very much. Ms. Lyons. Are there any questions from the committee? Seeing none, thank you very much. Welcome back, Mr. Bell.

ROBERT BELL: Thank you very much. Chairwoman Slama, 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, the state trade association of Nebraska insurance companies. I'm here today in opposition to LB1110. You've already heard from Ameritas and the national trades, so I will be brief. I definitely appreciate Senator Jacobson listening to our concerns pretty much since the moment that he introduced the bill. So thank you to Senator Jacobson. One thing I just want to bring to the, the committee's attention, and this is a particular issue for the federation. A number of Nebraska domestic insurers are significant dental carriers, including, as you heard from Ameritas, Mutual of Omaha, Physicians Mutual Insurance Company in Omaha, Aflac, Pacific Life, Blue Cross Blue Shield of Nebraska, MetLife, and Delta Dental of Nebraska, one of the Federation's newest members, along with Geico, who is also a Nebraska insurer, but they do not sell dental insurance. Those would be great commercials. Two thing-- well, one-- two things I couldn't let pass. Many of those companies are mutual insurance companies. They do not make profits. So we heard about money going to the profits of the shareholders and, and whatnot. Those companies exist for the benefit of their policyholders, those are mutual insurance companies. So Mutual of Omaha, Physicians Mutual Insurance Company, Blue Cross Blue Shield of Nebraska's a mutual insurance company, Ameritas is a mutual insurance company. You can't buy stock in those companies. Now, there are some of our companies do buy stock, and they do make profits. And two, if, if dentists are interested in the financial status of insurance companies, they are free to go to the Nebraska Department of Insurance's website and read their financial examination since so many of these large carriers are domesticated in Nebraska. All of our information is online, and examined by the Nebraska Department of Insurance. And so you can learn about their executive compensation, or their board compensation, of, of their reserving, and where the money goes. That's all regulated by a group of laws about that thick that you have passed. So, I don't know if that equal transparency occurs in the dental world. If it does, hopefully somebody will direct me in that direction. But with that, we oppose LB110 [SIC, LB1110]. And I

want to say it's the last time I'm testifying before the committee today not to preview what I'm doing on the next two bills, but I'm not doing anything. So thank you to the pages. I want to say I haven't handed out a single handout all year, so you're welcome. And to Joshua [PHONETIC] and Natalie [PHONETIC] for their hard work and, and to all the members for listening to the really exciting world of insurance. It is important to our state. To Chairperson Slama, it's your final Banking hearing, and I think you're the only member that's not coming back. So thank you for your service. And, we appreciate your service to the committee.

SLAMA: Thank you very much. And in addition, I'm sure Director Dunning will appreciate your shout out to the DOI as well.

ROBERT BELL: Oh, yeah, I'm sure he's still watching.

SLAMA: Any, any questions from the committee? Seeing none, thanks again, Mr. Bell .

ROBERT BELL: You're welcome.

von GILLERN: You guys area lock apparently, apparently.

KAUTH: What?

von GILLERN: You guys are a lock .

SLAMA: Yeah.

von GILLERN: Said you're coming back.

KAUTH: Oh, good.

SLAMA: You can blame him if it all goes wrong.

ROBERT BELL: Maybe.

SLAMA: Additional, additional opponent testimony for LB1110? Seeing none, is anyone here to testify in a neutral capacity on LB1110? Seeing none, Senator Jacobson, you are welcome to close. And as you come up, we did receive 3 proponent, 5 opponent, and 1 neutral letter for the record on LB1110.

JACOBSON: Thank you, Chair Slama. I'm going to be very brief in my close. I would just say that if anyone questions whether the insurance lobby is doing their job, drop an insurance bill, and I can tell you

that before you get to the rotunda, they're going to be talking to you about what you just introduced. So that's for whatever that's worth. Well, let me just say this. I am sensitive, and as I said in the open, this is an issue that probably needs some more study. But I know we heard a lot of testimony here about, well, premiums are going to go up. But if you had a DLR, then the premiums are going up and it seems benefits are going to go up as well. But to me, the question as an employer is, if I'm paying a dental insurance benefit to my employees, and I'm paying a premium, at what point does that premium not create enough yield back to my employees, to where I'd be better off just to tell our employees, you go to the dentist and we'll pay the first dollars of your dental bill, no matter what it is equal to whatever the benefit cost is for the insurance, and we call it a day. So there is a number, I think, out there where that. DLR needs to apply. It's probably not 85%, but it ought to be some number. I don't know that we just say we're going to throw this premium in, it never gets used or a lot of them don't take advantage of it. I think there's a number out there, and I think that's the thing we've got to sort out and figure out what the answer is. I get it. If you can't make money as a health-- as a dental insurance provider, you quit offering it. I can tell you as an employer, if I'm paying a premium and I don't feel like I'm getting a return, I just quit paying the premium and we cancel the insurance and we go a different route. So I think there's a middle ground here to figure out what the right answer is so that we can get a better product in the back end. But yet everybody's got to make, make it work on the other side. So I, I told you you'd have some various testifiers. You got it. I did my deed, did this primarily for Senator Slama, so thank you very much.

SLAMA: God bless you, Senator Jacobson.

JACOBSON: I know. I know. and it's the last time I'll be able to testify in front of you on a bill.

SLAMA: Me and my therapist will talk about that one.

JACOBSON: I know you will. Thank you very much.

SLAMA: Are there any questions for Senator Jacobson? God bless. This brings to a close our hearing on LB1110. Next up is Senator DeBoer with LB1290. We'll take a moment for the room to reset as well. Welcome, Senator DeBoer.

DeBOER: Thank you.

von GILLERN: Has she been here before?

SLAMA: Yeah, she has.

DeBOER: One time. This is my second time, I think. And both times were the last day of the hearings this biennium. So clearly, the Chair adores me.

SLAMA: It's nothing personal.

DeBOER: Good afternoon, Chair Slama and members of the Banking, Commerce and Insurance Committee. I' m Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, representing Legislative District 10 in northwest Omaha. I appear today to introduce to you LB1290, which seeks to resolve an issue brought to my attention during the Supreme Court Commission on Guardianship and Conservatorship meeting this past December, of which I am a member. As members of this committee are aware, disabled individuals in care facilities are often provided $75 per month from their own funds to spend on expenses not covered by their government benefits. These expenses could be anything from clothing, shoes, beds, mattresses, dental services not covered by Medicaid, and non-covered supportive devices like an electric scooter. Importantly, these needs do not include food or shelter expenses covered by other programs. Because it is widely known that the $75 per month allowance is insufficient to cover expenses, federal regulations have allowed the creation of Enable accounts and special need trusts, or SNTs. Enable accounts can be formed if the individual was disabled prior to the age of 26. SNTs are divided into multiple categories, their first party, third party and pooled SNTs. First and third party SNTs are often for individuals older than 26 and younger than 65 when they become disabled, and pooled SNTs are often used by individuals 65 years or older by folks with limited resources. Currently, when determining eligibility for government benefits, the Department of Health and Human Services or any government agency in line with federal regulations does not count assets in Enable accounts, nor first or third party SNTs against an individual. However, Nebraska's statute is unclear on how to treat pooled SNTs. LB1290 seeks to correct this by saying that standards for eligibility for government benefits shall not be more restrictive than federal regulations. So currently there are some individuals who have been deemed ineligible for government benefits by DHHS solely because of the money they put into a pooled SNT. Other individuals have not had their pooled SNT count against their eligibility. It should be consistent, and LB1290 will guarantee that consistency. So if you want to understand how this works out,

imagine that I have a disabled child who is 65 in an assisted living facility and I'm 87. I don't have a lot of money left, but I'm going to leave my child $7,000 because my kid needs special compression shoes that are never available at used goods stores. So new shoes are often more than $75 and likely aren't covered by any government benefits. So I establish a pooled special needs trust for my child, administered by the QLF Trust managed by First Nebraska Trust Company, which is based here in Lincoln. And then I think I have them covered for as long as the money will go. What I don't realize, though, is that when I do this, DHHS has the discretion to decide if that money should count against my child's eligibility for Medicaid, potentially cutting them off from Medicaid services that they desperately need. Obviously, I never wanted this, I wanted what was best for my child. But unfortunately, this is the reality that many Nebraska families have faced. But we can change that. 22 states currently are like Nebraska's current law, where we penalize disabled seniors. Nine states have some various restrictions on counting pooled trusts in income, and there are 13 states plus the District of Columbia that do not penalize disabled seniors for their pooled trust assets. To finish, I would like to address the fiscal note. I believe there's a disconnect between what I think LB1290 does and what DHHS thinks. LB1290 provides clear guidance on how DHHS and other government agencies should treat pooled SNTs. There are two widely used in Nebraska, the Arc trust, which is a federally approved-- which is federally approved, and the QLF trust managed by First Nebraska Trust Company, of which DHHS has already reviewed and approved. As such, I do not believe there would be a massive increase in reviews the DHHS has to undergo. Also, these trusts are managed by a corporate fiduciary. I imagine DHHS is concerned that these pooled trusts will lead to maybe an increase in burdens for them when reviewing. However, I believe the clear guidance in LB1290 will help DHHS and those in the field during the review process. I do not believe we will see a large increase in 65 year olds with disability-- 65 years old and older with disabilities moving into our state because of LB1290. But maybe that's part of what DHHS is concerned about, and thus the need for more staff beyond their current needs. So I passed out AM2728 to you, which collects-- corrects a slight drafting error which your committee's legal counsel caught and brought to my attention. So thank you to legal counsel. I also handed out Lisa Myer's testimony from the Office of Public Guardian, who was unfortunately unable to stay for the hearing, but that's, that's there for you to read. I think that would be really helpful. And then LB1290 will harmonize Nebraska trust statutes for our disabled population and ensures that elderly,

disabled Nebraskans can cover small needs that remain unmet by their $75 allowance each month. So we've talked a lot about wanting to make sure that Nebraskans stay in Nebraska their entire life, and I think LB1290 is part of that puzzle, a piece of that puzzle.

SLAMA: Thank you, Senator DeBoer. Are there any questions from the committee? Senator Du-- Senator Dungan.

DUNGAN: Thank you Chair Slama, and thank you for being here, Senator DeBoer, I think we've talked before about how this is a very important issue to me, the DD community's, I think, very near and dear to my heart and a number of other people's here. This seems like it gets at an overall issue that we have in the DD community of this sort of cliff effect, right? Where there's this desire overall to ensure that people in the DD community can sort of just live and exist as more neurotypical or non special needs people do. But if they get too much money, they lose benefits or things like that. So this seems like it really tries to address that problem. So for that I really appreciate it. Do you know, generally speaking, how many people we're talking about this would probably affect with regards to these trusts? I can't imagine it's very large.

DeBOER: I, don't know how many. So I suppose I can get that information to you. I think it's just those who are 65 and older who have this particular kind of pooled trust.

DUNGAN: So yeah, it's probably-- I'm, I'm guessing it's a relatively small--

DeBOER: There's two pooled trusts that really exist. So we could just call them and ask them.

DUNGAN: OK. I appreciate that. And a little bit more. You kind of talk a little bit about the inception of where this came from. Can you speak to a little bit more detail as to sort of how this came about with regards to the idea of why this was-- how this was identified as an issue?

DeBOER: Actually, I was at the-- so I, am on the Supreme Court's Commission on Conservatorship and Guardianship, and I was at the December meeting and they were explaining that this was a problem, and if only the Legislature would do something about it. And I sat there for a while and I was like, hi. And it was my first meeting. So that was how it came about, is I said, I guess maybe we should do something

about it. Yeah. Because apparently this is-- the problem is that we're not even being consistent. So some folks, the money that they have in their pooled trust will count towards their income for purposes of determining benefits, and other folks, it won't count for purposes of determining benefits. So right now we're not even being consistent.

DUNGAN: So this is mostly just meant to be clarifying language of how we should act moving forward?

DeBOER: Yeah. And what it says is we shouldn't do something more restrictive than the federal government does. So.

DUNGAN: That makes sense. Thank you. I appreciate it.

DeBOER: Yeah.

SLAMA: Great. Thank you, Senator, Senator Dungan. Additional committee questions?

JACOBSON: I, I-- Quick question. Thank you, Senator DeBoer, for, for bringing this. I think some of us are looking at this and thinking, oh, this is a bill that really needs to move forward. But, given that there's a fiscal note tied to this bill, do you have a path forward?

DeBOER: I would love for you to tell me one. How's that? Can I write on your bill somewhere?

JACOBSON: Well, I, I, I appreciate your bringing the bill. I think it's an important bill. And it's probably unfortunate we're as late as we are with where we are on-- and the fact that you got that relatively small, but yet a fiscal note which probably knocks you out for consent calendar, so.

DeBOER: Yeah. You know, if the committee has room in a priority bill, I'm always, always willing to do-- to have a ride, but if not, you know, I'll bring it back again.

JACOBSON: Thank you.

DeBOER: Thank you.

SLAMA: Additional committee questions? Seeing none, thank you very much, Senator, Senator DeBoer. We'll now open it up for proponent testimony on LB1290. And just from a raise of hands, who is planning to testify, proponent, opponent or otherwise, on this bill? Great.

Thank you. That gives us a heads up for the next bill introducer. So that they can be here. I guess she's already here. Welcome.

BRAD MEURRENS: Good afternoon, Senator Slama and members of the committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I am the public policy director at Disability Rights Nebraska. We are the designated protection and advocacy organization for persons with disabilities here in Nebraska, and I am here in strong support of LB1290. LB1290 would solidify the right of persons with disabilities to develop and retain their special needs trusts, so that they may save money or build money for expenses to enhance their quality of life. Medicaid is often instrumental for persons with disabilities to live in the community, and is the primary source of health care and community-based supports for many people with disabilities. The Medicaid program is the major, and sometimes the only source of funding for the long term supports and services that many people with disabilities rely on to live and remain in the community. Special needs trusts can play an important role in the life of persons with disabilities, as they preserve the beneficiaries eligibility for public benefits, while enabling them to save for additional expenses central to their quality of life, or that governmental benefits will not provide, such as medical and dental needs, equipment, training programs, education, treatment, rehabilitation, eye care, and transportation. If you have further questions or need more information, I would direct you to our legal staff in our office as we are always happy to provide whatever expertise we can provide-- we can to the committee. We would suggest that you advance the bill. I'm open for any questions?

SLAMA: Thank you very much, Mr. Meurrens. Are there any questions from the committee? Seeing none, thank you very much for being here today.

BRAD MEURRENS: Thank you.

SLAMA: Additional proponents for LB1290.

EDISON McDONALD: Hello.

SLAMA: Welcome.

EDISON McDONALD: My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska, advocating for people with intellectual and developmental disabilities across the state. We're here in support of this bill. Normally, we

talk about issues along this line more with the Revenue Committee members. But today, I want to talk to you all about the benefits and some of the tools that we are able to leverage to help make sure that people with disabilities can work, continue to work, and can make sure that they can have a solid, consistent living. In the handout that I am attaching from the National ABLE Resource Center, we lay out-- it lays out basically kind of the main categories of tools that are available. One being ABLE accounts, two being special needs trusts, and three being pooled special needs trusts, and you can have first and third agents on both of those. These tools help to make sure that individuals can better manage some of the difficulties of addressing the benefits cliff. For our community, the benefits cliff, normally, you're talking about just a little bit of a gap. For people with disabilities, it is a humongous gap that is just absolutely unimaginable. I know I came to this work because I hired a young lady with a disability, tried to give her a raise of a couple dollars an hour, and she said, no, I can't take that because I'll lose $60,000 a year in access to Medicaid. What are you supposed to do as an employer when you want to go and promote a good, hardworking employee? So now, in this role here at the Arc, I talk families through how do they make sure that they're thinking through quality financial planning. And these are the tools that are really available. Typically with ABLE accounts, it tends to be more kind of the short term quick needs. And then also, you know, part of this is just looking at the cost. As you look through this sheet, it lays out the costs of these different types of entities. And special needs trusts can cost thousands of dollars to set up. But pooled special needs trusts are significantly cheaper and offer a lot of the same benefits that may not necessarily be available in an ABLE accounts. So I think that this is a fantastic additional tool and clarification of our current statutes that will help to ensure that more people with disabilities are able to retain their assets, and are able to continue to work. That-- any questions?

SLAMA: Thank you very much, Mr. McDonald. Are there any questions from the committee? Seeing none, thank you very much for being here today. Additional proponent testimony for only LB1290? Seeing none, is anyone here to testify in opposition to LB1290. Seeing none. Is anyone here to testify in a neutral capacity on LB1290? Seeing none, Senator DeBoer, you are recognized to close. And as you come up, we did receive 2 proponent, 2 opponent, and zero neutral letters for the record on your bill.

DeBOER: OK. Thank you. Apparently, I may have said 13 states when I meant 18 states that have already done this. So just in case I didn't

say 13, I just mispronounced it, I meant 18. And so this is something that I think, you know, if, if we can figure something out here, I think this is something that's really good that we should do. And I will say, for the record, I was joking with the Chair when I said she must not like me because she gave me the last committee day. I was just joking. That's all, unless there are any questions.

SLAMA: Sounds great. Are there any committee questions? Seeing none, thank you very much, Senator, Senator de Boer. This brings to a close hearing on LB1290. Next up, last but not least, Senator Kauth with LB954.

KAUTH: Saving the best for last, right? All right. So I do want to point out that I am Julie's final bill that she will ever hear as committee Chair. So as such, I claim the right of[INAUDIBLE] a committee bill. Does everybody say yes? So LB954 is about biometric autonomy. Technology is growing faster than many of us can comprehend. The ability of our devices to track us, our movements, our biometrics and even our feelings, is both exciting and concerning. Exciting because we have the ability to analyze so much more information to use it to improve ourselves. Concerning because we currently don't have a handle on who else is using that information and what they might be using that information for. You've heard it said that if a product or service is free, you are the product. LB954, the Biometric Autonomy Liberty Law is designed to establish your ownership rights over your biometric and biological data. As quickly as things in technology are progressing, it is important to create these guidelines now so that they can be adjusted as new technology and new uses for technology develop. And I will say that you have a new amendment as of this afternoon, AM2717. We have been working for months to get all of the people on board with this bill and we've made lots and lots of changes. We're willing to still make some if we need to, but we feel like it's very, very close. Biological data means data that provides a characterization of the biological, physiological, or neural properties and compositions of an individual's body or bodily functions. Biometric data means retina or iris scans, fingerprints, voiceprint, hand or face geometry-- I'm not even going to try to pronounce that word biometrics-- brainwave, heart, pulmonary, reproductive, or other biometrics. LB954 asserts that the biometric and biological data are the property of the individual. That individual may sell or otherwise consent to its use. Consent can only be given by those 19 years old or over and there must be an opt-in to the collection or sale of that data, rather than an opt-out. An organization that is given permission to collect this data must make

that data secure and portable upon written request by the owner, must be protected from disclosure and corruption, and must be destroyed within one year of the last interaction between parties or the expiration of the written consent. Exceptions are provided by those organizations who are already following strict protocols for collection of data. Banks follow the Gramm-Leach-Bliley Act, medical communities use HIPAA, university level research uses FERPA, and law enforcement acting within the scope of their authority. The current iteration of the bill may need revision to explicitly state how law enforcement can collect or utilize biometrics. This bill should be seen as a complement to LB1294, introduced by Senator Bostar, which provides a much broader umbrella of data. LB954 is focused specifically on the individual and their rights to control their biometric and biological data. A key part of this bill is that no one can be coerced to use devices that collect biometric data or be forced to have a device implanted. There are exceptions to this bill for the use of this data for specific security purposes by an employer, by the judicial system, or by state agencies who have a legal right to require the data for participation in their system, such as the DMV. The intent of this bill is to provide consumer protection from the oversharing of your biometric data from the tech companies collecting it. I welcome any questions, but Dr. Andrea Neuzil is following me and she is way, way smarter than I am at this.

SLAMA: Well, thank you very much, Senator Kauth. Are there any questions from the committee? Seeing none, thank you very much.

KAUTH: I will stay to close.

SLAMA: Oh, thank you for making that sacrifice. We'll now open it up for proponent testimony on LB954.

ANDREA NEUZIL: I know it's late.

SLAMA: Oh, it's not too bad at all.

ANDREA NEUZIL: I know you had a wonderful long day. So I will try to keep it brief, but I will also be open to any questions that you may have. My name-- first of all, thank you, Senator Slama. Good luck with your new baby at home.

SLAMA: Thank you very much.

ANDREA NEUZIL: My name is Dr. Andrea Neuzil. It's in N-e-u-z-i-l. And in 2014, the Office of Personnel Management sent me a letter, along

with 21 million other people, letting me know that my Social Security number was involved in a data breach and they paid for the remediation of a credit management company. And if my bank has ever had a credit card or username or password that has ever been breached, I've been able to change my username or password or have that credit management service protect me. However, with the use of the biometric data, whether it's my iris scan, my fingerprint, or any neuro data collected from an EEG or EMG or fMRI wavelength monitor, that is information that's "bioidentifiable" and cannot be changed. What LB954 does, is it establishes clear guidelines for that collection, possession, and disclosure of that biometric data. It emphasizes the importance of informed consent in the language of a seventh-grade reading lexile. And that's important for the fact that we've got users of other devices that are much younger than 19. By mandating the entities to develop the retention schedules and destruction guidelines, LB954 promotes accountability, transparency, and the management of such information. Furthermore, it prohibits the coercion of wearing biometric devices and ensures that individuals are not compelled to provide their biometric data against their will. In addition, LB954 empowers the Attorney General to enforce the compliance of the Biometric Autonomy Liberty Law and, therefore, provides recourse for individuals harmed by violations of those biometric privacy rights. We must establish the right of cognitive liberty and to protect our freedom of thought, rumination, mental privacy, and self-determination over our own brains and mental experiences. Neurotechnology has an unprecedented power to either empower or oppress us and the choice is yours. Any questions?

SLAMA: Thank you very much, Dr. Neuzil. Are there any questions from the committee? Senator von Gillern.

von GILLERN: Thank you for your testimony. Conversation I've had with Senator Kauth in, in-- about this bill is when you-- when you-- when you pull one of those out of the box--

ANDREA NEUZIL: Yeah.

von GILLERN: --and it gives you the option of reading the 82 pages of waivers and claims and everything else, and it doesn't work unless you click yes. Now, to explain to me-- and forgive me if I missed it-- but explain to me the difference. Why am I not just going to do that because that's what's required?

ANDREA NEUZIL: Excellent question. It's actually a 422-page agreement--

von GILLERN: OK. [LAUGHTER]

ANDREA NEUZIL: --which is longer than Macbeth. What's different about what that user agreement that we're-- what's different about LB954 versus LB1294, which does allow for the biometric data to be sold by those controllers. But what LB954 does is it allows for the consumers to be allowed that language in a seventh-grade reading lexile. And it's a pop-up where it's an option-in, they call it data nutrition labels. And data nutrition labels are used not just for that-- almost like a cookie service. Where am I going to enable my tracking and is this going to optimize? Can I sell this? So what this bill is asking, is it's asking you, do I have the right to collect? Do I have the right to store? Do I have the right to sell that data? And so when you pick--

von GILLERN: So it's a separate waiver that your attention is drawn to.

ANDREA NEUZIL: It's at the point of use. Yes.

von GILLERN: OK.

ANDREA NEUZIL: And what it's different about when you pick up that phone is it also allows for you to say yes or no, whereas right now that agreement is you can't not not say yes. Otherwise, you've just paid $1,000 for a paperweight.

von GILLERN: Yeah. Thank you.

SLAMA: Thank you, Senator von Gillern. Senator Ballard.

BALLARD: Thank you, Chair Slama. Are any other states trying to tackle this issue? Is there any other legislation across the country?

ANDREA NEUZIL: Yes and no. I would say that this is the gold standard of this kind of privacy act and Senator Kauth has worked really hard with several other agencies that will be able to testify that we've carved out some additional protections for, for use. We talked about in LB1294 that Colorado with the-- with their civil-- the right of action and how that is not what we're doing here with LB954. Instead, the Attorney General is-- you can file a civil action and relief, have injunctive relief. So what's different about this is it also states

explicitly that you will never be required or coerced to wear or be subject to that biometric technology.

BALLARD: OK. Thank you.

SLAMA: Thank you, Senator Ballard. Are there any additional committee questions? Seeing none, thank you very much, Dr. Neuzil.

ANDREA NEUZIL: Thank you. Good luck.

SLAMA: Thanks. Additional proponent testimony for LB954? And if you are planning to testify on this bill, we're not church, we encourage you to come up to the top couple of rows just to expedite things. Welcome.

CHRIS ZYLA: Hi. Good afternoon, Chairperson Slama and esteemed members of the Banking, Insurance and Commerce Committee [SIC]. My name is Chris Zyla. Last name is spelled Z-y-l-a. I'm proud to sit before you today as a lifelong Nebraskan. I hold a master's degree in political science and have served for the Omaha metro area for the last 12 years as a public school educator. I would like to thank you for allowing me to testify in front of your committee today as an impassioned advocate for LB954. If adopted in its current form, LB954 stands to be one of, if not the most consequential data privacy loss of the 21st century. LB954 is comprehensive in nature and is poised to be the gold standard of data privacy protections to quote the great Dr. Neuzil. If adopted in its current form, LB954 not only protects Nebraskans, it will become a model for other states across our union. LB954 clearly defines the broad forms of biometric data accessible by public and private entities. Forms of biometric data covered by the bill include, but are not limited to, fingerprint and iris scans, scans of facial geometry, brainwave data, as well as heart, pulmonary, and reproductive biometrics. LB954 ensures that these unique signatures remain the property of the individual. Let, let me repeat, under the Autonomy Liberty Law, these individual modalities remain the undisputed property of the individual. LB954 does not delineate into shades of gray when it comes to the ownership of biometric data. It affirms that we, as Nebraskans, are entitled to ownership over our own unique biological signatures. Period. Furthermore, LB954 empowers individuals to determine the circumstances upon which the use or transfer of their biometric data is appropriate. The bill requires entities to obtain explicit consent from the individual before use or ownership of said data can be transferred to entities. For Nebraskans, this is commonsense thinking and commonsense legislation. No entity,

public or private, is entitled to our biometric signatures without our express consent. I understand the unique challenges of legislating in this area, as the use of biometric data by entities is broad ranging and in continuing states of development. Undoubtedly, the collection usage of biometric data may provide key advancements in the areas of technology, medicine, or even education. Still, LB954 does not prohibit the usage of biometric data for scientific research or even for the advancement of private enterprise. Rather, it simply reaffirms what Nebraskans already know to be true, that we are the sole proprietors of our biometrics. Any use of our biometric data and unique biological signatures should occur in a manner that is transparent and one that receives the express consent of the individual. Thank you very much for your time this afternoon and thank you for having the moral courage to protect the liberties of Nebraskans.

SLAMA: Thank you very much, Mr. Zyla. Are there any questions from the committee? Seeing none, thank you so much for being here today.

CHRIS ZYLA: Thank you.

SLAMA: Additional proponents for LB954. Welcome.

EMMA YEAGER-CHAEL: Hi there. Good afternoon. My name is Emma Yeager-Chael, spelled Y-e-a-g-e-r-C-h-a-e-l, and I'm here to express my support of LB954 and my concerns regarding, regarding my biometric data. There are forms of technology that I have refused to indulge in due to my own fear. I'd love to track my fitness with an Apple Watch or a Fitbit. I'd love to delve more into meditation and intentional living with apps such as Muse, Meta, or NeuroSky. As a woman, I'd love to be able to check my phone and find out if I can wear white pants that day with a period tracker. Without this bill, I'm not capable of utilizing these sorts of apps. As it currently stands, there are sorts of apps-- these sorts of apps can collect, store, and sell my biometric data. The Apple Watch can track my heart rate, blood pressure, blood oxygen levels, and other health-related measures. This infor-- this information can then be sold at random, allowing private insurers to potentially have access and deny care or increase premiums based on my alleged private information. As someone with a family history of Alzheimer's and dementia, I have firsthand experience with the difficulties mental deterioration can cause. I'd like to take preventative action by utilizing wearable technology that measures biometric data such as EEG and EMG, which measures the levels of stress, fear and pleasure, and identify potential neurological

conditions such as ADHD, schizophrenia, and things of that nature. This information is incredibly useful to me. However, it should not be stored, gathered, or sold without my consent. As it currently stands, this information can be sold to public and private entities and can affect employment, future job opportunities, and has the potential to result in denied services such as healthcare coverage, life insurance coverage, car insurance, credit worthiness, and a home loan based on an algorithm or an ideal candidate. Currently, covered under HIPAA, conversations that I have with my doctor or any interactions that happen in a hospital regarding my menstrual cycle are private. However, technological devices and applications available currently for consumer use track this data without regard for that privacy. They collect, store, and sell that data with no thought or the risk of selling my health data. These risks include, but are not limited to, insurance companies having access to health data without going through the proper legal channels and employers having my data and using this to affect my working hours, wages, and insurance offered to me. Even more frightening, it can be purchased by potential stalkers, exes, and Internet creeps having access to data regarding my body and sex life which is a direct threat to my well-being. As a citizen of Nebraska and a voter, I implore you to advance LB954. Thank you.

SLAMA: Thank you very much, Ms. Yeager-Chael. Are there any questions from the committee? Thank you so much for being here today.

EMMA YEAGER-CHAEL: Thank you.

SLAMA: Additional proponents for LB954? Welcome.

HAYDEN HRABIK: Hi. My name is Hayden Hrabik. Last name is spelled H-r-a-b-i-k. I have a prepared statement but I made the mistake of writing it before reading anybody else's so it's very, very short and it does not cover what I have now discovered I probably should have. So I am going to somewhat sidestep what I have written down here but it's going to touch on the same general idea of which is general security, not just security in the small scale personal level, but even all the way up to a national security level. I'm a veteran. I just separated from the Military at the beginning this month. While I was in service, we were hammered repeatedly on our PII protection, personally identifiable information. This was anything that we post on Facebook, our, our, our addresses, our family members, our passwords, these things are extremely, extremely important to our security as service members. As it stands right now, I do not have the ability to take the same precautions that I do with Facebook, Twitter, Instagram

when it comes to facial recognition software, when it comes to voice recognition, and cloning software when it comes to fingerprints. These protections just do not exist. Right now, Apple has my face. They just do because I use my face to unlock my phone and they can do whatever they want with that. And, again, as somebody who was just a service member not too long ago, having a foreign adversary of that level having access to my face if they just buy it from Apple is extremely concerning. The ability for our foreign adversaries to protect themselves with their cyber security warfare programs is massively concerning for national security. On a much smaller scale, as has been touched on by the other proponents of this bill, even individual threats to our individual lives are extremely viable without protections for our personally identifiable information, including the biometrics of us. If somebody has access to my fingerprints and throws them on a crime scene because they just bought them somewhere on the Internet, I'm now in massive legal litigation simply because my biometric data was not properly protected. This bill protects that biometric data and ensures the security of that biometric data. If it's gathered, collected, it ensures that I get the choice of whether or not it's sold and it ensures that companies are held responsible if they fail to secure these things.

SLAMA: Well, thank you very much, Mr. Hrabik?

HAYDEN HRABIK: Hrabik.

SLAMA: Hrabik. OK. And thank you very much for your service to our country.

HAYDEN HRABIK: It was a party.

SLAMA: Are there any questions from the committee? Thanks again for being here. Additional proponent testimony on LB954?

SPIKE EICKHOLT: Good evening, Chair Slama, and members of the committee.

SLAMA: Welcome.

SPIKE EICKHOLT: I know, I can hardly believe it. My name is Spike Eickholt, S-p-i-k-e, last name E-i-c-k-h-o-l-t. I, I appear on behalf of the ACLU of Nebraska as their registered lobbyist in support of LB954. I've never been in front of this committee this year and it's an honor to be here. And it's a pleasure to be here for your last time, or at least a privilege, I should say.

SLAMA: Thank you.

SPIKE EICKHOLT: The ACLU does support the concepts behind this bill, and that is some sort of control or limitation on commercial surveillance, commercial collection of data, as well as government surveillance of government collection of data. You heard Dr. Neuzil testify earlier. A couple of things I wanted to elevate, and I don't know if I have the most recent version of the amendment that was provided to me last week, but I think that some of the components are still in the current amendment as well. And that is this bill does provide for a recognition that biometric data is the property of the people from where that data was collected. That's in Section 4 of the amendment that I have. Senator von Gillern asked about the written consent and this is another key part of this bill that has got meaningful written consent that is individualized and not just buried in a series of texts and advisements. Another thing this bill does in Section 11 of the version that I have is it tries to limit the monetization of this data by these private companies, the sale of profit that can be done. But one thing I wanted to talk about, and I'm passing out or having passed out some articles, is how sort of the state and the government, particularly the law enforcement that works with tech companies to collect and utilize this data. And I wanted to have some local, actual Nebraska examples that you can kind of look at and consider because this bill does touch on these things. One of the articles I'm handing around and it's called: City Council approves an agreement for LPD to use updated DMV facial recognition software. That was an announcement that was made in May of 2022, in which the Lincoln Police Department entered into an agreement with a facial recognition software company to sort of utilize images and pictures that they got from different Crime Stoppers' type photos and so on. And then they would surveil and search the DMV database to see if they had matches there. Another article I wanted to mention is this notion of license plate readers and it's called: Lancaster County Sheriff to put six automated license plate readers along I-80. The Lincoln Sheriff-- the Lancaster County Sheriff's Office has got a series of these license plate reader cameras. What they do is they collect and record every vehicle that drives by that camera. So when Senator Kauth drives on I-80 and, presumably, Senator von Gillern drives down I-80 back and forth, your information is being collected. The agreement that is had-- that has-- the Lancaster County Sheriff has with the provider is that if the sheriff wants a specific plate number or they want, like, a date and time location for cars that are driving by, the company will provide it. I've looked at these contracts. The contracts

explicitly provide that all of that data, all of the data that is harvested and collected belongs to the company providing the service. What are they doing with it? Another article I showed you is called: Nebraska reaches $11.9 million settlement with Google. Last-- in November 2022, the previous Attorney General announced a settlement with Google in which Google was tracking user data in Nebraska. If you ordered-- do an app and it would give you the option of track while using or track always or track never, it didn't matter, Google was collecting it always. There's certain utility and value in this, and it's good that this bill has the remedy that the Attorney General goes after offenders of this law because your Attorney General already is doing that, at least he has done before. I see I'm out of time but if, if anyone has any questions, I'll answer them. But I, I-- we do support the bill and Senator Kauth is onto something. We appreciate her for bringing it.

SLAMA: Thank you very much, Mr. Eickholt. Any questions from the committee? Gosh, if you never were able to come in support of one of my bills, I am grateful that you were able to come in support of Senator Kauth's. So thank you very much for being here.

SPIKE EICKHOLT: Well, they're special, Senator. [LAUGHTER] Thank you.

SLAMA: Additional proponent testimony on LB954?

SCOTT THOMAS: Good afternoon, Senators.

SLAMA: Welcome.

SCOTT THOMAS: My name is Scott Thomas with Village in Progress. I don't usually testify about predations in the private sector largely because--

SLAMA: Could you please spell your name, please?

SCOTT THOMAS: Oh, I'm sorry.

SLAMA: It's for the transcribers.

SCOTT THOMAS: S-c-o-t-t T-h-o-m-a-s. And I was saying I don't usually testify about predations in the private sector largely because the private sector does everything more efficiently than government. But I think this particular issue is relevant and I think that the government has an obligation to act to protect the interests of the citizens. So I'll just give you a brief story. So my daughter and I,

we have Six Flags memberships, and the way that works is that they deduct annually a certain amount from your card, whichever one you have on file, and then they issue you a card with your name and your picture so that they can identify you at the gates. And in 2018 they switched over to a fingerprint scanner and I neglected to enroll in that program. We opted out of it and we were visiting-- the Six Flags memberships work at every park-- and so we're visiting a different park not our home park. And the people in the line prompted my daughter, put your finger on the-- on the scanner pad. And she started putting her finger and they said, go ahead, put your finger back again. I said, hold on, what's going on here? And they said, your daughter's finger didn't show up in the system. I said that's because we're not in the system. We opted out of it. He's like, well, we're putting everybody in it now so you just go ahead and just-- and we'll scan it in. It's going to have to-- you know, you have to do it three times and I called for a supervisor. The supervisor came over and sided with me and let us in the park anyways. In 2020, 2 years later, I get this postcard that says a class action lawsuit was brought on behalf of everybody who had their biometric data harvested by this process and I get $60 from some class action settlement and I just got to come collect it. I'm not selling my daughter's fingerprints for $60. So that's just one example of how that could be used contraveniously. I don't-- I don't think it's a good practice to gather the data of individual citizens and I appreciate the bill and the Senator for bringing it. Any questions from the senators?

SLAMA: Thank you very much for being here today. Any questions from the senators?

SCOTT THOMAS: Thank you so much.

SLAMA: Again, thank you so much for sharing your experience.

SCOTT THOMAS: I didn't recognize you, Senator Slama.

SLAMA: I know, I cut off all my hair.

SCOTT THOMAS: And I thought-- and I thought Arch was coming up to testify before me. [LAUGHTER] I was like, I need to go home for the day. I appreciate you all.

SLAMA: Additional proponent testimony on LB954? All right. Seeing none, anyone here to testify in opposition to LB954?

BEN BURAS: Yeah, so-- Ben, B-e-n, B-u-r-a-s. I checked-- I checked neutral on the box or the form, whatever. And so-- but, I guess, I'll go with neutral because I, I haven't read-- I, honestly, haven't read the language of the bill. But, but, honestly, I mean, like, you just-- you-- all you need is a high school level physics education to know that nobody really owns anything, so, like-- and, you know, you take computer science, you know, most of this is binary. It's just ones and zeros in a database. So you, you don't-- you really-- no-- nobody really here owns anything. It's just the guys in handcuffs here. Yeah, they can throw you in jail. That's true, they can. But if you're dumb enough to put your data out there on the Internet then you deserve to, to have whatever happens to you. Like, that's your choice. People need to realize that. And as far-- I mean, you know, I studied computer science enumeration. It's, it's attaching a string to a digit. The Social Security Act was illegal, but I still think FDR was a great president. I do. They had to do something. But that's, that's enumeration. It's illegal per the constitution-- the United States Constitution, the supreme law of the land. The Social Security Act was illegal. So, yeah, I mean-- well, I spilled the beans, didn't I? So there you go. All the Republicans can, they can go kick grandma out of her house because the Social Security Act was illegal. So, oh, damn. Let's go throw grandma out on the street. So, yeah, that's, that's where I'm at right now, so.

SLAMA: All right. Thank you very much. Are there any questions from the committee? Seeing none, thanks for being here today. Additional opponent testimony for LB954? All right. Seeing none, is anyone here to testify in a neutral capacity on LB954? Welcome.

ROBERT J. HALLSTROM: Chairperson Slama, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear on behalf of the Nebraska Bankers Association in the neutral capacity on LB954. I primarily want to just extend my thanks to Senator Kauth and Mr. Duey for sharing the draft of the legislation before the session started to allow us to have some input on behalf of the banking industry. Excuse me. The banking industry has been subject to diligence, privacy, and data breach provisions for over 25 years pursuant to the Gramm-Leach-Bliley Act. We had originally suggested to Senator Kauth that we would like an exclusion, which has been the case in many of these data privacy bills and biometric bills across the country that have been adopted in other states. And she was gracious enough to accommodate that request once we started working with Senator Bostar on LB1294. We expanded our request a bit and she, again, conceded to, to make that change so that we basically have excluded financial

institutions, affiliates of financial institutions, and data that is subject to Title V of the Gramm-Leach-Bliley Act under both this bill and LB1254. And with that, I'd be happy to address any questions. I think Mr. Schrodt is going to follow me, probably be like Mr. Irrelevant in the NFL draft by being the last witness before the committee this year. I, too, would extend my thanks to the committee and to the pages and to the clerk and to the general counsel and, and be gratuitous like Mr. Bell was earlier and you'll probably be glad that both of us are done testifying for the session, so. With that, any questions, would be happy to address.

SLAMA: Thank you, Mr. Hallstrom. Any questions from the committee? Seeing none, thanks again.

ROBERT J. HALLSTROM: Thank you.

SLAMA: Welcome, Mr. Schrodt. For the record, you are not Mr. Irrelevant.

DEXTER SCHRODT: Thank you, Chairwoman Slama. I appreciate it. Dexter Schrodt, D-e-x-t-e-r S-c-h-r-o-d-t, presidency of the Nebraska Independent Community Bankers Association. In case you're curious, in the afternoon, it's now snowing outside and it feels like the temperature is 9 degrees, so FYI. So I'll be quick. We'd also like to extend our thanks to Senator Kauth for recognizing that financial institutions are subject to a pretty stringent federal rule regarding privacy, as you heard from the proponent testimony as well. So we appreciate her recognizing that and not increasing the regulatory burden on our community banks. And the, the only other thing I'll say is, for the record, thank you to the pages. I think we've had like 5 during this hearing, so well done. Big thanks to committee clerk and legal counsel and, of course, a big thank you to Chairwoman Slama. Your steadfast leadership of the committee the last several years has been appreciated and is in line with the long-standing tradition of this committee. So we, we generally appreciate it and we wish you the best of luck.

SLAMA: Thank you very much, Mr. Schrodt. I appreciate it. Any questions? Senator Dungan.

DUNGAN: Thank you, Chair Slama. Thank you for being here. I would just like to point out that Mr., Mr. Irrelevant just played in the Super Bowl--

DEXTER SCHRODT: Thank you.

DUNGAN: --so don't take it as an insult.

SLAMA: But he lost the Super Bowl.

DUNGAN: Fair.

DEXTER SCHRODT: At least he was there.

DUNGAN: But just want to point that out here on our last day of hearings.

DEXTER SCHRODT: I appreciate that.

SLAMA: Fantastic. Anything else for the good of the cause? Seeing none, thank you, Mr. Schrodt. Anyone else here to testify in a neutral capacity on LB954? Seeing none, Senator Kauth, you're recognized to close. And as you come up, we did have 6 proponent, 5 opponent, and 4 neutral letters for the record on your bill.

KAUTH: Thank you. And I will say that a lot of those that came in online were reading the original bill and we have had many, many, many iterations. So I would hope that they would go back and look at it with the new iterations. So it's clear biological and biometric data can be-- are being used to develop products, marketing, and are being directly sold to others. This is an area with unknown potential to businesses and unknown dangers to the rightful owners of that data. It is absolutely imperative that we put something in place. And, Senator von Gillern, you had asked about-- and we had talked about that before. If you say no, then you have a brick right there. We put that in the bill. It's in-- under the AM2717, Section 10, line 4, which is on page 6, and it says: A private entity shall not provide a difference in any service or good provided to any individual who does not consent to the collective-- collection or possession of biometric data or biological data. We want to make sure that that doesn't happen because you're in a catch-22 if you--again, you buy something, you think it's going to be great, and you say, yeah, but I don't want to share. That makes sure that you don't have that paperweight. So I appreciate everyone sticking around. I would like to have this voted out 8-0 so we could maybe amend it to the committee bill. That is my wish. We'll see if that actually happens, but thank you all very much.

SLAMA: Thank you very much, Senator Kauth. This brings to a close or hearing on LB954 and our hearings for today.