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

statement. I will now have the committee members with us today introduce themselves, starting on my left.

RIEPE: Thank you, Chairman. Merv Riepe, representing District 12, which is southwest Omaha and the final little town of Oma-- or, of Ralston.

BOSTAR: Eliot Bostar, District 29.

HALLSTROM: Bob Hallstrom, Legislative District number 1, Otoe, Johnson, Nemaha, Pawnee, and Richardson Counties in southeast Nebraska.

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

JACOBSON: Also assisting the committee today, to my right is our legal counsel, Joshua Christolear, and to my far left is our committee clerk, Natalie Schunk. Our pages for the-- are, are also here today, and I'm going to let them do self-introductions and tell us a little bit about themselves.

AYDEN TOPPING: My name is Ayden Topping. I am a second-year psychology student at UNL.

KATHRYN SINGH: My name is Kathryn Singh, and I'm a third-year environmental studies student at UNL.

JACOBSON: All right. With that said, we'll begin today's hearing with LB77. Welcome, Senator Bostar.

BOSTAR: Good afternoon, Chairman Jacobson, 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. I appear today to introduce LB77, the Ensuring Transparency in Prior Authorization Act. Prior authorization requirements create substantial challenges for patients and providers. Hospital discharges are frequently delayed, sometimes for days, while patients await approval for necessary care. In other cases, individuals resort to emergency services due to delays, and denials for medications, diagnostics or treatment can be arbitrary. The result is increased administrative burdens, wasted health care resources, and worsened patient outcomes. Rapid changes to insurance requirements compound these difficulties. Facilities often learn about new or modified authorization rules only after encountering a denial.

Physicians and their staff devote an average of 14 hours per week to managing prior authorizations, reducing the time available for direct patient care. Furthermore, 95% of physicians indicate that the current prior authorization process exacerbates burnout. LB77 addresses these concerns by ensuring clear communication of requirements, standardized forms, and enhanced transparency in prior authorization procedures. According to recent data, 87% of physicians report that prior authorization leads to higher overall utilization of health care resources, generating waste rather than savings. Among the specific impacts, 69% of physicians indicate that prior authorization contributes to the pursuit of ineffective initial treatments; 68% report, report additional office visits; 42% rep-- no increased use of urgent or emergency care; and 29% cite hospitalizations. Additionally, 83% of prior authorization denials in Medicare Advantage are overturned on appeal. Under LB77, adverse, adverse determinations must be made by qualified physicians, include clear explanations, and allow for appeal. Timely access to care is crucial, especially when treating serious conditions like cancer. 94% of physicians report that prior authorization delays, delays access to necessary care and has a negative impact on patient clinical outcomes. LB77 requires utilization review entities to respond to requests promptly. When treating a patient who has just been diagnosed with cancer, prompt treatment can mean the difference between life and death. LB77 also requires health plans honor prior authorization approvals by paying providers for their services. Prior auth-- prior authorizations must also have appropriate validity periods, be honored across plan transitions, and be excluded for emergencies, essential cancer care, and many preventative services. Finally, LB77 prohibits the use of artificial intelligence as the sole basis for denying care. It also requires that any denial be accompanied by a clear reason. These reforms are designed to promote transparency, maintain accountability, and safeguard patient health. I thank you for your consideration of LB77. Experts and stakeholders will now provide further details and share experiences. And I thank you for your time and attention. And as always, I would be happy to answer any initial questions.

JACOBSON: Are there any questions from the committee? And I might add, Senator Dungan, if you'd like to introduce yourself, and--

DUNGAN: Senator George Dungan, LD 26, northeast Lincoln. Do you want to go through the whole opening again, or?

BOSTAR: I mean, I'd be happy to.

DUNGAN: Thank you. I'm good.

JACOBSON: You, you got there in time for questions, though, so. Questions from the committee for Senator Bostar? All right. If not, we'll save them for your close. I'm sure we'll hear a lot of testifiers.

BOSTAR: Perfect.

JACOBSON: All right. Thank you. All right, I'd call on the first proponent. Please come on up, and-- I was going to say, surely there's somebody that's going to-- welcome.

AMBER McLEOD: Thank you. Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Amber McLeod. That's A-m-b-e-r M-c-L-e-o-d. I'm the supervisor of access and utilization review at the Boys Town Psychiatric Residential Treatment Facility-- PRTF-- an 80-bed facility treating children ages 5 to 17 years of age with severe behavioral and mental health issues. I am here to ser-- to testify in support of LB77 on behalf of the Nebraska Association of Behavioral Health Organizations, NABHO. We represent 62 member organizations, including community mental health and substance use disorder providers, regional behavioral health authorities, hospitals, and consumers operating across the state of Nebraska. First, I would like to thank Senator Bostar for introducing LB77, Adopt the Ensuring Transparency in Prior Authorization Act. This act aims to improve transparency and accountability in health plan prior authorizations. The legislation requires accessible criteria, a standardized review form, only allows physicians of the same specialty to make adverse determinations, and prohibits artificial intelligence only denials. The Act sets timelines for requests, ensures payment for approved authorizations, establishes validity periods, exempts certain services from requiring authorization, and mandates annual reporting to the Department of Insurance. Of the Boys Town PRTF admissions in 2024, a significant percentage of youth were funded through commercial insurance across 25 unique third-party payers. Each insurance company has a different prior authorization process, requirements, and timeline. Many insurance companies require the child to be seen by their outpatient provider within days of admission. Turnaround times for prior authorizations can vary, with some payers providing a determination within a day, up to ten days. I have seen firsthand the concern, frustration, and confusion created by these processes for families who are desperate to get their children treatment to address their mental health needs. The current practices create delays in

patient care and unnecessary stress for youth and families. When a child is unable to admit to our facility in a timely manner, it can mean another crisis event, affecting the safety of the child or others. In addition, there are often inconsistencies regarding prior authorization requirements communicated by the insurance company itself. Timely, standardized and accessible prior authorization processes are much-needed. Adopting a uniform prior authorization request form, as stated in this bill, would help streamline processes and reduce the complexities of the current system. The annual reporting component of this bill will ensure that prior authorization data is posted publicly, and the Department of Insurance can monitor any trends in denials and appeals. We applaud the meaningful, impactful changes that breaks down obstacles and allow medical decisions to be made between patients and physicians. This bill ensures qualified physicians are making decisions in a timely manner, and reviewing in any case of adverse determination. At least 30 states have introduced legislation, with several enacting reform laws related to prior authorization based on the American Medical Association's model legislation. LB77 serves as Nebraska's model in moving this important issue forward, and building on reform occurring across the country. NABHO is very appreciative of the committee's time today, and we stand ready to help improve Nebraska's health care. I'm happy to answer any further questions, and can be reached later. Thank you.

JACOBSON: Thank you. Questions from the Committee? Senator Hallstrom.

HALLSTROM: Yeah, just a quick question. You've mentioned the AMA model legislation, and then you say LB77 serves as Nebraska's model. Is our legislation the AMA model, or has Senator Bostar put something different together?

AMBER McLEOD: My understanding is they go hand-in-hand.

HALLSTROM: Thank you.

JACOBSON: Other questions from the committee? I, I have just a couple of questions, and, and maybe just teeing this up a little bit for the other testifiers. You know, I've-- I do sit on a hospital board, so I, I certainly get that perspective. I've spent a lot of time with insurance companies negotiating Medigap bill and other things, and I guess, being a businessman, I, I understand that insurance companies are, are-- they're the middlemen. OK? They're, they're trying to hold rates down; they're working, in many cases for-- to figure out how they can get the best care, but yet, still not break the bank, and--

because all of those costs are going to be passed on to rate [INAUDIBLE] payers. I-- so I see that, but this seemingly has been a bigger and bigger problem on pre-auths, and it's been a concern of mine. And I've had conversations with insurers, and I think one of the things I'm hearing and that should be in the bill here is a standard form, which I think also-- no faxes, doing this all electronic so that it can be efficient. Would you agree with that, that that's an important change?

AMBER McLEOD: Yes.

JACOBSON: OK.

AMBER McLEOD: There-- again, there's a different process across the board. We spend a lot of time reaching out to third-party payers and insurance companies to find out what that process is, ensure that it hasn't changed since the last time we had a child without insurance coverage, and so on. And the second component was the fax process, which is very time-consuming and bureaucratic. Yet many, many to most insurance companies still utilize that process.

JACOBSON: And, and then, I, I also like the part-- again, trying to avoid AI and looking at, hopefully, same specialty, recognizing that could be challenging for some insurance companies where-- when you're getting to a high-level specialist [INAUDIBLE] so they have that person there, and how do they go about that? So, what do you think is a reasonable timeframe for a pre-auth to take place in, let's say, the worst case scenario?

AMBER McLEOD: I think that depends on the level of care and type of treatment, but, 1 to 3 days.

JACOBSON: OK. Thank you. I think that's all I have for you. Thank you.

AMBER McLEOD: OK. Thank you.

JACOBSON: Next proponent.

RIEPE: Can, can I have one?

JACOBSON: Oh, excuse me. Senator Riepe, I didn't see you. Sorry.

RIEPE: Thank you, Chairman. My question would be this: is-- do you have the same problem with the 3 managed care organizations? And because they're dealing mostly with Medicaid, what percentage of

Medicaid do you see involved in this? Which is where we really come into play, because that's the tab that we're picking up and paying.

AMBER McLEOD: I don't have the exact figures, but we serve approximately 65% of Medicaid patients.

RIEPE: OK.

AMBER McLEOD: And as far as turnaround time, those can vary across the 3 MCOs.

RIEPE: So they don't have-- between the three of them, they don't have one standard uniform process?

AMBER McLEOD: Correct. And they all--

RIEPE: Which is what, I think, in some of our dealings today, we're trying to get to.

AMBER McLEOD: Mmhmm. They don't have a standardized form or a specific process. One uses an email, one uses fax, so you have the same--

RIEPE: OK.

AMBER McLEOD: --concerns there.

RIEPE: Thank you very much. Thank you, Chairman.

JACOBSON: Other questions from the committee? OK, this time, you are excused.

AMBER McLEOD: Thank you.

JACOBSON: Thank you. Next proponent. Welcome, Mr. Mitchell.

IVAN MITCHELL: All right. Good afternoon, Chairman Jacobson, member of the Banking, Commerce and Insurance Committee. My name is Ivan Mitchell, I-v-a-n M-i-t-c-h-e-l-l, and I'm here to testify in support of LB77. I'm the CEO of Great Plains Health in North Platte. I am also here to represent the Nebraska Hospital Association. First, we would like to thank Senator Bostar for introducing this important legislation addressing prior authorization reform. Prior authorization can lead to higher health care costs. Hospitals are the social safety net of society. We provide care regardless of someone's ability to pay, and not only that, we're under obligation to care for the patients until they have a safe discharge. Our hospital admitted a

patient whose sickness required multiple days on a ventilator. This patient, they were in good health prior to the hospitalization and, and through their recovery, they met medically necess-- the medical necessity requirements to be admitted to a rehabilitation hospital. Their health insurance required prior authorization for admission to Madonna; we had acceptance there, to Madonna. The insurance company utilized a third-party AI tool that denied medically-necessary care. This company that, that used-- utilized the tool is currently in the middle of a large class, class-action lawsuit, with the plainti-- plaintiffs claiming that the AI model had a 90% error rate, and the plaintiffs also claim the insurance company is aware of this issue and the error rate. This patient stayed in our hospital for more than 10 weeks, as we didn't have a safe discharge without the rehabilitation hospital admission. We appealed this multiple times, with the physician being placed on hold for 30 minutes in the middle of their workday. Our organization was never provided with an explanation about how the insurance company did not find this care medically necessary. Those days of unnecessary care denied urgent hospital care to about 15 families, based on our average length of stay for our hospitalization. The clos-- closest hospital to Great Plains Health is about 100 miles away. My colleague Curt Coleman will be here testifying as well today. Our country and states, we have a significant health care workforce shortage; we don't have enough nurses, doctors, health care providers to meet the needs for the services that we, that we demand right now. Eliminating the unnecessary bottlenecks and the administrative burden associated will improve access to care and decrease overall costs. This bill is not asking for the elimination of prior authorization, although some people might say if 98% of them are overturned, is it really necessary? But it is asking you to implement common-sense solutions that will decrease the burden placed on those trying to provide the appropriate care to our community members. Standardizing forms and processes, citing criteria as a basis for denial, prohibiting AI-only denial, setting appropriate timelines, ensuring that if some-- if something is authorized, it should be paid for seems like a pretty low bar and threshold that should be expected from an insurer. Thank you for your time. I encourage you to advance LB77. This is incredibly important legislation not only to my hospital, but to the patient seeking care all over our states. I'm happy to answer any questions.

JACOBSON: Senator Dungan.

DUNGAN: Thank you, Chair. Thank you for being here, sir.

IVAN MITCHELL: Thank you.

DUNGAN: Section 4 of the bill requires that the determinations-- adverse determinations have to be made by a physician. Can you speak to some of the importance of having that language in there, and what's happening now versus why that change would have to be made?

IVAN MITCHELL: Sure. So, a lot of times, an initial denial of care is not escalated to a physician; an AI tool can be used in some situations. And then, along with that-- we, we talked about this earlier-- my neurosurgeon has-- you know, when we escalate these things, they will get to what's called a peer-to-peer, will-- it will be another physician. He's been working with an optometrist to approve neurosurgery, he's been working with a dentist to improve neurosurgery, so kind of, kind of offensive to, to the specialist who has the training and background that they do to, to, to have their care questioned by someone who doesn't have the training to do so.

DUNGAN: Thank you.

IVAN MITCHELL: Thank you.

JACOBSON: Yes, Senator Hallstrom?

HALLSTROM: Senator Riepe asked a question about managed care organizations, and I thought I'd seen something in here. On pages 3 and 4, it says, "Health carrier does not include a managed care organization." Can you explain why that exclusion, and what the impact of it is?

IVAN MITCHELL: You know, I'm not fully aware of that specific exclusion. I'm sure we, we have some people that could answer to that. The-- we do want a streamlined process that includes the Medicaid providers as well. Again, we have our three MCOs, and as you talk to my case management team, the process is extremely different between the 3; it changes, and so standardizing that will make it more efficient for those that are actually trying to get the prior authorization, and, and decrease the administrative burden, which eventually will decrease the cost of care. Doing some back-- some, some napkin math. We have about 50 employees. When we go through prior authorizations, denials, appeals, that's a lot of people and that's a lot of money we pay to, to, to go through this process and deal with this process.

HALLSTROM: Thank you.

IVAN MITCHELL: Yeah.

JACOBSON: Senator Riepe.

RIEPE: Thank you, Chairman Jacobson. I have two questions. First is-- you talked in here about being on hold for 30 minutes. What's your estimated required employees, if you will, to deal with getting prior authorizations?

IVAN MITCHELL: Well, by the--

RIEPE: Just about-- rough number.

IVAN MITCHELL: Rough number? By the time it gets to a physician, we've probably already spent a few hours on it. You know the challenge, of course, when, when you're waiting for a doctor and you're frustrated that they're behind, you know, they'll only do the peer-to-peer between business hours, Monday through Friday. And, you know, doctors usually have a, a pretty packed day, and sitting on for another half an hour is difficult. I would say on average for, for a denial, I would probably say 1 to 2 hours of staff time is being spent on that. And then, sometimes these get escalated and take 4, 5, 6 hours, but I would say 1 to 2 hours for a, a denied prior authorization would be standard.

RIEPE: Is it true that you're no longer taking Medicare Advantage patients?

IVAN MITCHELL: We are not. Yes, we, we are the first hospital in this state to no longer accept Medicare Advantage. Of course, we see anyone. Charity care, we say-- see Medicaid, we see everyone through the E.R., including Medicare Advantage. But to have access to our specialists, we do not see Medicare Advantage right now.

RIEPE: I think you shared with me earlier, too, that one of your major employers in the area put all of its employees on an Advantage program.

IVAN MITCHELL: Yeah, they did. We had a discussion. They told us it was a super awesome, amazing national Medicare Advantage plan that didn't need prior auths and, and whatnot. This patient that spent 10 weeks in our hospital was on that plan that did not require prior authorization, so--

RIEPE: Oh, OK. The other question that I have, the divide between hospital care and, and pharmaceuticals for-- both of them require pre-authorizations. Is that 60/40, 50/50, or is there a-- is there-- what, what's, what's taking most of your time between those two separate functions?

IVAN MITCHELL: I would say, for us at least, probably the hospital care is probably more 60 to 70% medication, 30 to 40% back-end math. We do have a-- we do have a large cancer center that serves western Nebraska, and so we, we do have staff specifically set up for chemotherapy and oncology medication prior authorization. Because it's so complex, they do only that.

RIEPE: But that doesn't mean that there's not a burden on the pharmacists to have to get prior approvals from the individual practicing physician outside of the hospital.

IVAN MITCHELL: Yeah. You bet. You bet. The, the pharmacists do spend a lot of time making sure that every doctor dots every i and crosses every t.

RIEPE: You bet. Thank you. Thank you, Chairman.

JACOBSON: Other committee questions? I just have a couple of questions. I guess first, to confirm, you, you talked about prior authorization for someone you've treated, now need to move to long-term care, for example.

IVAN MITCHELL: Correct.

JACOBSON: So, that gap in time. Who picks up the tab for that?

IVAN MITCHELL: So, it depends on the payer. With Medicare Advantage, with Medicare in general, you're paid what's called a DRG, a diagnosis-related group. And so, for example, if it-- the average admission costs $10,000 for pneumonia patients. If you admit someone, Medicare will pay you $8,000. You know, it doesn't cover the full cost of care. Whether that patient stays 3 days or 30 days, you're paying the same amount. And nurses are not inexpensive, doctors are not inexpensive, hospital beds are well over $1 million to construct. And so, that additional stay is picked up by the hospital.

JACOBSON: And the other question: Medicare. Any pre-auth requirements for Medicare?

IVAN MITCHELL: Very limited.

JACOBSON: And so, how do they monitor whether they-- this was needed?

IVAN MITCHELL: Appropriate or not? Yeah, with Medicare, it's a little bit different. It's retrospective. So, you can't just do anything you want to a Medicare patient. There are, are pretty clear guidelines of what's medically necessary. We know those pretty well. And, you know, you were audit-- audited on the back side; they do not plug up your health system. They allow you to provide the care, and then of course, you're audited on the back side. And of course, if you-- I, I've never seen a situation where they say the, the-- Medicare says this patient shouldn't have gotten this care. It was, you know, you didn't dot this i or cross this t, and every once in a while, they'll ask for a payment back because of that. But that's the process for traditional.

JACOBSON: All right. Thank you.

IVAN MITCHELL: Thank you.

JACOBSON: Any last-minute questions from anybody else? Last chance. All right. Thank you.

IVAN MITCHELL: Thank you.

JACOBSON: Next proponent. Go ahead.

MARY WELLS: Good afternoon, Chair Jacobson and members of the committee. I'm Dr. Mary Wells, M-a-r-y W-e-l-l-s. I'm a medical oncologist, testifying in support of LB77 on behalf of the Nebraska Medical Association. As a medical oncologist, I practice in Omaha and Fremont, where I treat patients with all types of cancer. My special interests are in breast, GI, and lung cancers. One of the things that drew me to this field was the ability to help people more easily navigate the wide variety of challenges that come with living with cancer. In my role, I care for hundreds of patients every year with a cancer diagnosis. Every single day, I see my patients negatively affected by prior authorization. I'd like to tell you just a couple of brief stories. My first case was a young man with a toddler who developed a rare and incurable cancer we were able to treat successfully for a couple of years, at which point it began to grow like wildfire. After reviewing the science, the national guidelines, and discussing his care with my colleagues, I recommended a medication. The available science suggested there was about a 45% chance it would work. Seven days later, with his cancer getting worse

day-over-day, we were informed his insurance had denied the drug, but we could appeal. I did, and five days later, we received a note from his insurance company to let us know they were pleased to inform us the medication was covered by his plan. Two days later, he died in the hospital ICU of complications of his cancer progressing unchecked. The medication in question has a Category 1 endorsement by NCCN guidelines, and were LB77 in effect at the time this had happened, we could have begun treatment immediately instead of spending 12 days waiting for authorization. Do I know that this medication could have changed the course of his life? I don't. But it was his choice to continue to pursue treatment despite his serious circumstance. It was the choice he made, under my guidance, with the support of his wife and parents. Prior authorization took that chance away from him. I see two patients every day who are newly diagnosed with cancer. Almost always, they want to start treatment as soon as possible. I have to tell them they need to wait 7 to 14 days to start treatment because insurance-- or insurers have told us they need two weeks to review. Patients are waiting up to two weeks to start cancer treatment for no reason at all. My treatment requests in this setting always end up getting approved, because high-quality science and guidelines mean there's essentially consensus around the best treatment for most cancers. LB77, if passed, would bar insurers from requiring prior authorization specifically in this setting by making cancer care supported by NCCN guidelines exempt from prior authorization. In addition to treatment, LB77 will help with prevention, early detection of cancer by removing prior auth requirements for screenings that have an A or B recommendation from the USPSTF. These are health care services that are guideline-based, which should unquestionably be covered. Additionally, when prior auth is required, response times outlined will ensure patients are not waiting months to begin treatment. We know delays in time to treatment are linked to worse mortality. Studies show that a treatment delay of four weeks is associated with a 6% to 13% increase in the risk of death. Based on my experience, I do not think it's hyperbole to say that LB77 would be the difference between life and death for some patients. Thank you for your time. Please consider the difference this bill could make for patients impacted by cancer, and vote to advance from committee.

JACOBSON: Thank you. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. My question is, you're a board certified oncologist. Do you-- when you go for pre-authorization, do you get that from another board-certified oncologist, or is that a--

MARY WELLS: No, no, no--

RIEPE: --maybe a psychiatrist, or something, or--

MARY WELLS: No, it's, it's, it's--

RIEPE: --what, what, what kind of person do you get it from?

MARY WELLS: You don't know.

RIEPE: Or a high school graduate?

MARY WELLS: You never know. Well, so, it starts with someone who is not-- it starts with the administrative personnel. You know what I mean?

RIEPE: Oh, an administrator. They're bad to begin with.

MARY WELLS: Checking, checking-- not a-- you know, I mean, it starts with somebody trying to do their job, right? And it-- but they have a checklist in front of them, and that checklist, most of the time, says "deny, deny, deny." So, we get a denial. And I shouldn't say-- I mean, many times the initial prior auth gets approved within 7 or 14 days, because we're doing things that are so evidence-based and so guideline-concordant, there is no justification for requesting a-- or for denying, or requesting what's called a peer-to-peer. There's not enough oncologists in the state, there's not enough oncologists in the world, so often, peer-to-peers, I'm employing advanced practice, practice providers, people like nurse practitioners that work in my practice, that help do those peer-to-peers. They are typically on the phone with someone who has no idea what they're talking about. It's a family practice doctor, it's an ophthalmologist, it's an orthopedic doctor, someone the insurance company has hired to do these peer-to-peers. So, my staff are often explaining to these people what we would like to do, and then, those people often say, "Yeah, sure, go ahead, do it; that sounds reasonable," after my staff have blocked off their clinic for the afternoon, spent however long they have to spend beyond the scheduled appointment time waiting for this person to call them back, and then having a totally unnecessary discussion.

RIEPE: Do you ever have the situation where you get angry enough that you personally make the call?

MARY WELLS: Sure. It doesn't happen very often, but sure. This-- the story I--

RIEPE: Does that help? Or does it--

MARY WELLS: The story I told--

RIEPE: --does that just frustrate you more?

MARY WELLS: Well, if you can find-- if, if you can find somebody, it helps. The problem is these doctors get assigned the cases, the doctors who are contracted with the insurance companies, and it's theirs. And there's not a person that you can call other than that person who has a schedule set for the day, and they work from 9 to 5. And it's a-- it's-- the thing that is so frustrating about it is it's not, it's not a high-level, reasonable conversation about providing great pair-- care for the patients. It's a, it's a tactic for seeing what we can get away with and what we can get away with not paying for. And it wastes my time, it wastes my staff's time, it-- most importantly wastes the time of people living with cancer, and I-- you know, the stories about horribly delayed hospital discharges while patients-- and when you're sitting in a hospital for weeks, which I have a patient right now doing who has been through heck and back with his cancer, his surgery, and he's recovering from a life threatening infection. He's been sitting in the hospital waiting on a discharge to a place very much like Madonna for a week-and-a-half, that's been denied by its-- his insurance. It's the only place he can go, and he's sitting in the hospital getting weaker and weaker and weaker, and his rehab is getting longer and longer and longer while we mess around about these prior authorizations. It's--

RIEPE: Are you sure it's to heck and back, or is it to some other place?

MARY WELLS: My mom probably wouldn't be impressed with me saying "heck" in front of a--

RIEPE: Well, and she might, she might be watching.

MARY WELLS: --legislative committee, so I can't imagine if I had said [INAUDIBLE].

RIEPE: I guess my other question would be, is-- did it ever, ever-- was your suspicion that maybe, if you're talking to another physician, it was the physician that finished last in his medical school class or hers?

MARY WELLS: I-- yeah. You know, I think there's a reason people choose to do that type of job. And what I would tell you is there's not enough money in the world to get me to sit--

RIEPE: Sorry.

MARY WELLS: Ope, your-- silence your-- I, I think it's a certain type of person that agrees to take that job, I guess is what I would say. And it, it sounds like a very boring and unsatisfying job. So I-- how you would end up in a position to use your medical training to do the work of denying often very well-justified care is a, a little bit of a mystery to me, but I won't judge other people's choices in public.

RIEPE: So you have pity for them?

MARY WELLS: I, I wonder what went wrong along the way. Because taking care of patients is so much fun. I mean, I have the best job in the world. And I-- I'd tell anybody that. I get to walk a, a difficult road with people, but I can make that hard time a little bit better using the expertise that I have. And I, I think it's a-- I really think it's a sacred profession, and-- you know, so, so what happens that you end up working denying prior authorizations on behalf of an insurance company? I don't know, but I hope it never happens to me.

RIEPE: Thank you very much. Thank you, Chairman.

JACOBSON: Senator Hallstrom.

HALLSTROM: Thank you for your passion and what you do. Just a couple of questions. One, NCCN is used twice in your testimony. What does that stand for?

MARY WELLS: Yes, it's used in the bill as well. I'm glad you brought it up. So NCCN stands for the National Comprehensive Cancer Network, and it is a nationwide, basically consensus guideline that's used in oncology. So, the-- for any cancer you can think of, lung cancer, breast cancer, leukemia, they-- the thought leaders in the field, the best oncologists in the country, often academics from all over the country, meet many times a year to review the most current state of the science. And they've put together guidance that suggests what types of scans do people need, what interval do they need those scans at, what type of treatment would be best, what evaluation should you have before starting treatment? They are really the gold standard for care in the United States, but also respected internationally. And it gives us and the insurers, actually, a very easy way to say what's

considered acceptable treatment for, for whatever type of cancer it is. There's broad consensus around these medications, there's high-quality science, and often things that don't work are noted in the guidelines as being poor choices, you know, so.

HALLSTROM: And intuitively, shouldn't that be accepted without having to put it in a statute?

MARY WELLS: It hasn't been, and therefore it-- it's in the statute.

HALLSTROM: And second, you, you talked about the, the concerns and the problems that are associated with having to wait 7 to 14 days for patient care. Would, would any type of retrospective review and clawback be any better?

MARY WELLS: I mean, you could do it, but they're never going to claw them back. I mean, the thing is that these are, these are so-- I can't think-- I've been in private practice for 5 years; I can't think of a time that one of these types of drugs or one of these types of regimens has been denied at the end of it, because there's just no grounds for denying them. There's-- the science is so robust and the guidelines are so strong that all these prior authorizations do in this setting is waste time. And it's hard to even imagine that we could do this much administrative work for something that is always approved, but there are always approved.

HALLSTROM: What type of outcome could they possibly be seeking if they wouldn't claw it back at the back end if they ultimately approve it? What is the savings to the health care system, if any?

MARY WELLS: I suspect you'll be hearing from some of them later about that.

HALLSTROM: OK.

MARY WELLS: But I, I don't see any. I mean, I think it certainly wastes hundreds of thousands of dollars of my practice's money every year that we could be spending doing literally anything else to make patients' care better. And it, it costs them money too, to hire clearinghouses to deny these claims, and-- so, I-- it seems to me all cost with very little benefit, given the rate at which these authorizations are ultimately approved.

HALLSTROM: And it affects patient care, in your opinion?

MARY WELLS: Absolutely. They hate it. I, I had a woman start chemotherapy today who very much would have liked to start last Monday for her relatively advanced but curable breast cancer, where the window is-- you know, these people that have serious but curable malignancies, we want to start as soon as we can. And I think there's a real sense of urgency on my part, and a real sense of urgency on patients' parts. But she, this morning, was starting a week later than she wanted to, and, and quite distressed, and, and I do think it negatively impacts their outcomes.

HALLSTROM: Thank you.

JACOBSON: Other questions? So, you think there will be some opponents speaking today that will be able to question on the other side?

MARY WELLS: I think, I think you'll probably get their feedback on how this process saves them money, but--

JACOBSON: All right. Thank you.

MARY WELLS: Yeah.

JACOBSON: Thank you. All right. Further proponents? I think he could have made it, if you'd have kept going. But you're next. Go ahead.

JOE MILLER: Good afternoon, Senator Jacobson, and members of the committee. My name is Dr. Joe Miller, J-o-e M-i-l-l-e-r. I'm speaking on behalf of the Nebraska Academy of Family Physicians in support of LB77. This family physician association has 1,200 members across Nebraska. Thank you to Senator Bostar for this bill. I'm a family physician who's practiced over 40 years in Nebraska. I worked for 32-plus years in Lexington as a shared owner of an independent family practice group. I did full-scope family medicine, including obstetrics and C-sections; then, I moved to Omaha to be the medical director at Think Whole Person Healthcare, and now I'm the medical director at Hillcrest Hospice. I have seen firsthand the havoc prior authorizations have created for the-- our health care system. Nebraska need reform and transparency for patients and families. The delays in care, potential treatment denials, and administrative costs associated with prior authorization are excessive. Prior authorizations for preventive care are completely unnecessary, and are, and are obstructive to keeping our communities healthy. The NAFP advocates that insurance-- insurers need to publish prior authorization requirements on their websites, and publish notices of changes of such

processes in advance. Not providing adequate communication on the requirements for prior authorizations to the changes leads to unnecessary delay-- delayed access to care for patients. The number of services that require prior authorizations is excessive. Unnecessary prior authorizations are one of the greatest sources of burnout for physicians and health care professionals, not to mention patient frustration. There are numerous types of services that should not require prior authorizations. Physicians and staff spend considerable time, as has been noted, navigating the complex prior authorization forms the insurance companies have and following on those requests, taking away from direct patient care. To give you some clear pictures-- translate this, I have provided in my information the statistics from the 2023 AMA study about prior authorization. We urge you to support LB77 to create transparency in prior authorization process, and clear communications of expectations and determination of authorizations. Nebraskans deserve quality and timely care as prescribed by their well-trained physicians. Thank you for your time, and I would be happy to answer any questions.

JACOBSON: Thank you. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Dr. Miller, good to see you again. Is the growth mostly in preauthorizations since the advent of Medicare Advantage? And does it also apply to commercial?

JOE MILLER: It does-- it applies to all coverages--

RIEPE: OK. So everybody's on the boat?

JOE MILLER: Yes. There are certain ones that are worse than others, and if you look at--

RIEPE: Would you like to name them?

JOE MILLER: No, I-- but if you look at-- if you look at the AMA report, it's in there as to which are the worst and which are-- but everybody--

RIEPE: So, if I really want to know, I can do some work.

JOE MILLER: You, you can do so.

RIEPE: OK.

JOE MILLER: And, and, and there are-- there-- when you look at net high burden, everybody was over 50%. So I-- it-- everyone is involved, some are worse than others.

RIEPE: You should be a politician. Thank you very much. Thank you, Mr. Chairman.

JACOBSON: Yes, Senator Hardin.

HARDIN: I may have missed it earlier. What percentage get declined upfront and have to-- in-- and when it comes to the billing side of things. On the other side, what--

JOE MILLER: I don't know what percentage get--

HARDIN: Initially.

JOE MILLER: Front-- I can tell you the statistics show us that the average physician has 43 pre-authorizations. We know that a, a majority of them are approved. A, a large majority are approved, but it's going through the whole process, and it just takes time. And it can be very-- in my mind, very simple, and I will use the word "stupid." You may have some, some class of-- like an ACE inhibitor, Lisinopril; you prescribe that, they deny it-- which is a generic medicine-- but they don't tell you which other generic medicine is-- and you have to guess until you can figure out which one they want. And it just denies-- it, it just takes a lot of administrative time. It also sets the patient back. There are some patients that get so frustrated with this that they will stop care, because they, they are, are-- say, I'm, I'm fed up with this whole system.

HARDIN: And is that the motivation for all of it?

JOE MILLER: I think so. I think so. It's, it's-- if, if, if enough people do that, then they may save some money. Because most of the time, they're approving it anyway, and they have to pay for the administrative people on the other side also. So-- but we're-- the average physician is 12 to 14 hours per week, people spending time doing pre-authorization for them. That's a lot of-- a lot of cost to practices, and a lot of time from physicians that could be spent one-on-one with patients. I'm-- I-- we want to take care of patients. I agree with Dr., Dr. Wells. The joy of this is taking care of patients.

HARDIN: Thank you.

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

JOE MILLER: Thank you.

JACOBSON: Next proponent. Go ahead.

MIKE DEWERFF: Good afternoon, Chair Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Mike Dewerff, M-i-k-e D-e-w-e-r-f-f. I am the chief financial officer for Bryan Health, a Nebraska-owned and governed health system with 6 hospitals across the state. I have worked in health care finance for over 35 years. I come to you today in support of LB77 on behalf of Bryan Health and the patients for whom it is our mission to serve. As you've heard and will hear from many of my colleagues today, denied and delayed pre-authorizations translates to care a patient needed that they either didn't receive in a timely manner, or didn't receive at all. In the past 6 months, the patient access team serving Bryan Medical Center and Bryan Physician Network in Lincoln have submitted 59,000 prior authorizations. This number does not include prior auths required for medication. Our team has had to add two FTEs-- full-time equivalents-- in the last 5 months to try and keep up with the increased demand from insurance companies, and yet our patients experienced nearly 2,000 days of delay for the year. From 2023 to 2024, we saw companies-- we saw the number of denials increase by 44% at Bryan. An analysis released on January 30 by the Kaiser Foundation found that Medicare Advantage insurers issued nearly 50 million prior auth determinations in 2023, up from 40-- 42 million in 2022. In the same analysis, it was found that 11.7% of prior auths were denied, yet 81% of the denials were ultimately overturned. This means we do all this work for a little over an effective rate of just over 2%. Each prior authorization represents a person needing care and a provider desperate to provide it. They're anxiously waiting a diag-- on a diagnosis or a life-saving medication. Should plan of care be determined by a patient's health care provider who knows them well, who's laid hands on them? Or by an insurance company? In the case of one patient, they were in our hospital with a bilateral below-the-knee amputation. The authorization was submitted and denied on January 26, 2024; it was appealed on January 29, denied again on February 2, and again on the 6th. A peer-to-peer took place on February 9, at which time the authorization was denied again. An appeal was submitted, but denied again on the 19th, and on March 13, the authorization was submitted for a sixth time and finally approved on March 14, at which time the patient was finally able to transfer to acute rehab. The

conclusion is this: no one can deny there's a problem here that's only getting worse. We are not here today to get rid of prior authorizations; rather, to reform a system that is not serving the patients and providers of Nebraska well. Thank you, Senator Bostar, for his-- your continued attention to this issue. We are aligned in our goal to reduce health care costs and improve patient outcomes. The current method of prior authorization achieves neither of these aims. As you hear from myself and others today, I ask that you be moved to take action in support of LB77. The patients, providers, and health care systems of Nebraska are looking for relief. I'd welcome any questions at this time.

JACOBSON: Questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. I don't think I'm divulging any secrets here, but I think Bryan Health is working with Sioux Falls, South Dakota, to try to have a better relationship on prior approvals. Is that go-- still going forward?

MIKE DEWERFF: Yes, sir.

RIEPE: OK. Very good. That's all I have at this time, sir. Thank you.

JACOBSON: Just a follow-up on that. It-- so you've got kind of a pilot program working primarily for MA, is that correct?

MIKE DEWERFF: Yes, it will be effective 1-1-26 for Medicare Advantage. Yes. We're currently working through the application process with Medicare, so.

JACOBSON: And how will that-- what's-- you know, just a snippet. How, how does that change the--

MIKE DEWERFF: Yeah. I mean, ultimately, our goal is to provide that product, that type of product to patients in Nebraska, and be a more provider-friendly Medicare Advantage program. I mean, the pre-auth is something we talk about, and that-- it's our goal to provide a more timely and consistent pre-authorization process for providers.

JACOBSON: Are we also looking at reimbursement issues as well with the MA, in terms of lowering disbursement rates?

MIKE DEWERFF: I think the effective reimbursement on Medicare Advantage programs, because of-- oftentimes because of the denial--

work-- effectively ends up being less than traditional Medicare reimbursement.

JACOBSON: Right.

MIKE DEWERFF: Mmhmm.

JACOBSON: Which is not stellar in itself.

MIKE DEWERFF: Correct.

JACOBSON: All right. Yeah. Thank you.

RIEPE: May-- may I have a quick--

JACOBSON: Go ahead. Yes, Senator Riepe.

RIEPE: Thank you, Chairman. Are you dealing with this-- new terminology's the gold card. With-- are you, at Bryan--

MIKE DEWERFF: We are. We're working with some insurance companies that provide that type of gold card, which means if you meet certain qualifications, certain requirements, you can bypass the pre-authorization process. I'd say at best, right now, it's been confusing.

RIEPE: Oh.

MIKE DEWERFF: You know, sometimes, it's applicable to one provider, sometimes it's applicable to the whole group. We're trying to work through that with the insurance companies; we'd like to partner with them on doing a gold card status, but let's make it as efficient and consistent and simple as possible.

RIEPE: OK. Thank you, Chairman.

JACOBSON: Are, are there any parts of this bill that you see are significantly important, or would have a higher priority than others? Or are there any ideas that you have that would--

MIKE DEWERFF: Yeah.

JACOBSON: --that would help fix this problem?

MIKE DEWERFF: Yeah. Good question. I, I would say we're really looking for a consistent process. As some of the physicians have testified, a

consistent definition of what a reason to deny, or a reason that would make it pre-auth-- make it authorized. And then, the timeliness, I think is an issue. In the example I gave you, we have, you know, several examples like that, where the authorization is received days, if not weeks later.

JACOBSON: And I-- it's also kind of my understanding in what I've heard from, from specialists is, when it comes to peer-to-peer, this is not like going to see the doctor, where you come in at a certain time and wait an hour to see him. You want to be-- you want to get them talking as quickly as they can.

MIKE DEWERFF: Correct. Correct.

JACOBSON: All right. Thank you.

MIKE DEWERFF: Thank you.

JACOBSON: All right. Next proponent. How are you?

JANEL FRICKE: I'm good. Good afternoon, Chair Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Janel Fricke, J-a-n-e-l F-r-i-c-k-e. I'm here to support LB77. I was in a car accident in 2013, and suffered an injury of my spine. This injury caused daily pain and discomfort to the point where I was no longer able to live the active life that I had previously enjoyed. For years, I attempted to treat my ongoing pain. I had X-rays, CT scans, MRIs, physical therapy, injections, radiofrequency ablation, chiropractic, acupuncture, massage, et cetera. I refused opioids. Finally, in 2020, after exhausting all other treatment options, I was recommended for an anterior cervical discectomy and fusion. So, that's the fusion of C3 through C5 on my neck. Despite all other treatments, I had the clear need for surgery, and the fact that I met all criteria according to the insurance company's medical policy, the prior authorization for my surgery was denied. My neurosurgeon's office appealed; it was denied. They submit a second appeal, and that was denied. The neurosurgeon then set up a peer-to-peer review, which ended up being with a pediatrician; it was denied. I then took matters into my own hands and submit a patient appeal; that was denied. Finally, I contacted the Department of Insurance. With their help, another peer-to-peer review with an actual neurosurgeon was scheduled. My surgery was finally approved. This process took five months. In April 2021, my surgery was approved and scheduled. During rounds the morning after surgery, the neurosurgeon told me more about the condition in which he found my

neck. He said that it was very unstable. Without surgery, if I had fallen or had another accident where my neck was quickly jolted, he said I was highly likely to have been paralyzed. It was-- if I was a typical patient, I would never have been approved for surgery. Patients rely on their physician's office to get medical services approved. However, because I have knowledge and experience working in medical billing and dealing with insurance, I was able to continue the fight. And, as a bonus, I have knowledge of the Department of Insurance, because my brother works as an investigator. I am one of the lucky ones. This whole process was very stressful and delayed my surgery. During the time it took to jump through all the hoops to get my procedure authorized, my pain and suffering continued for much longer than it ever should have. Now that I have recovered from my surgery, my life has significantly improved because I am now able to be physically active and lead a normal life. In reviewing LB77, I see a number of things that would have helped my case. My insurance company would have had to respond to my surgeon's request within 3 days. With the denials, a physician from the insurance company would have been required to make the denial and cite actual clinical criteria supporting the denial. My neurosurgeon would have then had the opportunity to talk directly with the physician who denied the request, and the appeal would have been with a physician who was similar-- or, familiar with treating injuries like mine. All of these guardrails would have helped me get the care I needed much sooner, allowing me to get back to a normal, productive life. Without these protections in law, more patients will risk permanent life-altering consequences for the-- from the delays of the denials. Please pass LB77 into law.

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

JANEL FRICKE: OK. Thank you.

JACOBSON: Next proponent.

CURT COLEMAN: Good afternoon, dear Chair-- Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Curt Coleman. That is spelled C-u-r-t C-o-l-e-m-a-n, and I am the president of CHI Health Good Samaritan in Kearney. First, I'd like to thank Senator Bostar for introducing LB77, which we hope you support. This ensures health care providers can deliver timely medical care to patients. It also adds important patient protection so that decisions regarding medical necessity of a provider's ordered treatment are

rendered by physicians with relevant expertise, and not solely on the basis of artificial intelligence. At least once a week at CHI, surgeries are canceled because we've not received approval of a prior authorization request by the date of the scheduled surgery, even though we are often sending those requests 10 or more days in advance. This is exacerbated on holidays, as our surgery departments are staffed 24/7, but insurance carriers are not. So, these requests take even longer to process. The costs of canceled surgeries are incredibly high for patients. This is measured in their pain and mental anguish during an already very stressful time; measured in time away from work, the cost of hotel stays, travel, and other related expenses. Delayed treatment can result in further disease progression and symptom escalation, and can lead to higher treatment costs. In the case of pending denials, the patient may be asked to assume responsibility for all charges in order to ensure that the surgery may proceed on the scheduled date. In the vast majority of those cases, these surgeries are delayed. Standardization in prior authorization process is desperately needed. We have added staff just to manage our prior authorizations, including physicians spending up a quarter of their time in peer-to -peer reviews, navigating the different requirements of each insurance carrier while remaining current on each carrier's changing requirements. Often, we learn an insurance carrier has changed their prior authorization requirements only after we have been denied prior authorization request. The various forms, technology platforms, windows for response, and office hours for taking live representative-- talking to a live representative add unnecessary costs, time, and stress for patients. LB77 would require utilization review entities to include a physician with relevant specialized experience to review adverse determinations and appeals of adverse determinations. One physician told me he receives an approval on the vast majority of peer-to-peer reviews, but this can take 3 to 5 days. Those are days the patient was waiting for the procedure or ready for the next level of care, but didn't receive it. For urgent care, we do not have the luxury of time waiting for long holiday weekends to pass, and adverse determinations are all too common. Once an appeal is submitted, on average, insurance companies are taking about 37 to 40 days to review the appeal and give a decision. To this committee, I ask that-- in closing, that you-- I urge you to support LB77, and would be happy to answer any questions the committee may have. Thank you again to the committee, and thank you again to Senator Bostar for introducing this bill.

JACOBSON: Thank you. Questions? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. And thank you for being here today, sir. In the event of a surgery being rescheduled, what does that time frame look like, then, in terms of getting it back on the calendar? Is it pretty burdensome?

CURT COLEMAN: It can be. I did-- every case is going to be different, depending on the type of surgery that it is. It could be days if the prior authorization does come through, or it could be weeks, or it may be never, depending on whether or not they finally give an adverse determination.

DUNGAN: And you kind of touched on this a little bit in your testimony, but based on where you are located, do you see a lot of people traveling a long distance to come to you for surgeries, which then, ultimately, could be canceled, resulting in any number of setbacks financially for them?

CURT COLEMAN: We do. And I can speak on behalf of my colleagues at CUMC Bergan as well. I talked to one of the physician colleagues I work with, because they have patients who travel a long way as well because they are a tertiary center. So yes, patients may travel well over an hour, two hours. Our service area extends well beyond Buffalo County and the neighboring counties out to 100 miles or more.

DUNGAN: Thank you.

CURT COLEMAN: Thank you.

JACOBSON: Senator Hardin.

HARDIN: You mentioned AI.

CURT COLEMAN: Yes.

HARDIN: How much is that being used in this context?

CURT COLEMAN: I'm not sure, actually. I don't know the answer to that question.

HARDIN: OK.

CURT COLEMAN: I wish I did.

HARDIN: I just think it's curious, because I think AI, ChatGPT, got an average of 27% on the MCATs about one year ago. And that's the tough part.

CURT COLEMAN: Yeah.

HARDIN: Clinicals are the tough part of life, right?

CURT COLEMAN: Yeah. Mmhmm.

HARDIN: You know, it's just figuring things out in general, and--

CURT COLEMAN: Correct.

HARDIN: It'll probably get there one day. But right now it's--

CURT COLEMAN: Yeah.

HARDIN: --[INAUDIBLE] fixer-upper.

CURT COLEMAN: Agreed.

HARDIN: So, I was just curious how much that might be used. And so, I'll ask the question again to some other folks.

CURT COLEMAN: Yeah, that would be great. It's meant to be a tool, but not a substitute for the things that are essential in dealing with patients' care.

HARDIN: Thank you.

CURT COLEMAN: Thank you.

JACOBSON: Senator Riepe, question?

RIEPE: Thank you, Chairman. Correct me where I'm wrong, but I believe that CHI is currently in negotiation with one managed care provider. And my question is-- that have to do with prior authorization? Or is that simply a financial issue? Or both?

CURT COLEMAN: It's part-- it's primarily financial. I'm not aware that there are any issues around prior authorization.

RIEPE: OK. I just was curious how important that might rub up to.

CURT COLEMAN: Yeah, that is not the hang-up, as, as far as my understanding as of this point.

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

JACOBSON: Other questions? I'm seeing none. Thank you.

CURT COLEMAN: Thank you very much.

JACOBSON: Further proponents. Welcome.

KEVIN JOHNSON: Thank you. Chair Jacobson, members of the Banking, Commerce and Insurance Committee, my name is Kevin Johnson. K-e-v-i-n J-o-h-n-s-o-n. I'm a volunteer representing AARP Nebraska, and I'm a retired retail pharmacist. AARP Nebraska supports LB77, and we thank Senator Bostar for introducing it. Let me say that I understand that prior authorizations have a place. They're there to avoid unnecessary services, and possibly some expensive procedures and drugs that may not be necessary. The handout that's going around has some, some data about patient delays, patients forgoing procedures, paying out of pocket. I'm going to relate some of my own experience. As a retail pharmacist, I witnessed undue delays and unreasonable denials. I suspected formulary decisions based on financial expediency rather than medical necessity. I also saw physicians and patients alike just refusing to run the gauntlet, giving up; patient ends up paying full price, or opting for no treatment at all. As a consumer-- and the gray hair will indicate that I'm more of a consumer-- my wife and I have had a number of issues. My wife had an approval for bilateral sinus surgery. After the surgery, oh, wait a minute, it was only approved for one side. Recently, she had a total knee replacement. Two weeks into physical therapy, physical therapy stopped for two weeks to deal with prior authorization. Why you need prior authorization for physical therapy for a total knee replacement is amazing to begin with, but that's what we experienced. I'm gratified to see verbiage in LB77 that kind of codif-- codifies language like "transparency," "readily accessible," and "easily understandable." For providers, reasonable deadlines and uniform prior authorization forms are all essential. In short, LB77 helps refocus the decision-making to patient care. Again, thank you to Senator Bostar for introducing LB77, and AARP Nebraska encourages the members of this committee to support the bill and send it on to General File. I'd take any questions you may have.

JACOBSON: Thank you for your testimony. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I see that you're a, a volunteer with the AARP, and I also know that the AARP is a big endorser of one of the major health care insurers based in Minneapolis who possibly are the the biggest deniers or "delayers" in health care approvals. Do-- does the AARP-- are they concerned about this, and are they dealing with this organization that they have openly endorsed? I don't want to name the name I could, but I [INAUDIBLE]--

KEVIN JOHNSON: And I know who you're talking about.

RIEPE: I think about everyone does.

KEVIN JOHNSON: And as a volunteer-- as a volunteer, I can't tell you exactly the answer to that question with how they, how they--

RIEPE: Would you take home that, that there is concern with their endorsement?

KEVIN JOHNSON: I, I can't speak to that. I can speak to the fact that they wholeheartedly endorse this bill and what's in it.

RIEPE: OK, that's fair enough. I'll take that. Thank you, Chairman.

JACOBSON: OK. Seeing no further questions, thank you for your testimony. Next proponent. Can I see a show of hands who else wants to speak as a proponent? You might move towards the front here, so we can kind of keep it moving. There's, there's 3 seats here in the front row. Very warmed up.

AMY GARWOOD: Good afternoon, Chairperson Jacobson, and the entire committee. My name is Dr. Amy Garwood, that's A-m-y G-a-r-w-o-o-d. I'm testifying here in support of LB77 on behalf of the Nebraska Rheumatology Society. And I am a second-generation rheumatologist, and have the privilege of blaming my father for most of these problems. I joined him after my rheumatology training in Omaha in 2006, and at that point, I was the sixth employee in our small company, and my mother was the practice administrator. He was able to retire after 50 years in 2015, and my partner, Dr. Jennifer Elliott and I now have 8 additional advanced practice providers and 40 employees. And we've-- I've seen a lot of change and worsening of the prior authorizations in the last 5 years especially. I have the privilege of taking care of people with very common, very expensive diseases like rheumatoid arthritis and systemic lupus and osteoporosis with fragility fractures. And I have seen every day how prior authorization obstacles impact patient care and my job negatively. And it's not just my job

satisfaction, it's recruiting providers to take care of people in pain; it's maintaining providers and staff to stay in Nebraska when they have opportunities every place else. And unfortunately, the current system creates unnecessary obstacles. It really feels like folks' commercial insurers will deny many common things that are community standard of care, and if we push back at all, they'll, they'll stop. And it feels like a delay tactic. Patients who are forced to wait often weeks before approval of medications that my team and I have deemed medically important for them. In some cases, denial comes from nurses and reviewers who do not have expertise in rheumatology care. And it feels like there's a rigid, algorithm-based system that determines important decisions rather than clinical judgment. LB77 proposes meaningful reforms that will protect patients while maintaining reasonable oversight. And I understand the medicines I prescribe are tremendously expensive and the disease burden is tremendously expensive. Specifically, LB77 ensures timely decision-making, requires transparency, and mandates denials from physicians who have adequate training. These are commonsense changes, and I appreciate the opportunity to be here to testify.

JACOBSON: Thank you. Questions? All right. Seeing none, thank you for your testimony. Oops, there is one. Senator Hallstrom.

HALLSTROM: Anything in the bill that is going to adversely impact patient care or patients' treatment?

AMY GARWOOD: I don't see a thing that would adversely impact them, or the people who try to care for them.

HALLSTROM: Thank you.

JACOBSON: Anyone else? All right. Thank you. Next proponent.

TAMI BURKE: Good afternoon, Senator Jacobson--

JACOBSON: Thank you.

TAMI BURKE: --and the rest of the committee for Banking, Commerce and Insurance. My name is Tami Burke. It's spelled T-a-m-i B-u-r-k-e. I prefer "Princess," but that'll work. I am here today because my-- the lady right before me just basically gave you my diagnosis. She gave you-- she's not my provider, but she might as well be. And I hate being here. I was here a year ago. You have last year's form. For the most part, nothing has changed. And in fact, reading LB77-- and yes, I am a proponent-- it talks about needing a prior auth that's valid for

12 months. And in the last 12 months, I changed pharmacies on a medicine that had been approved. I was told by the nurse that had did the prior auth that I was 1 out of 30-- for that day that she called, I was the only one that got the prior authorization. And yet, when my pharmacy had to re-run it for a refill 6 months later, I was told I didn't qualify. So, we had to go through, you know, the insurance company, save some money for a couple of months until we could get that covered. I no longer qualify for the biologic drug-- which are insanely expensive, and I understand that-- but now I go through steroids, which gave me osteoporosis. I had an infusion for that after I took a medicine that made me vomit for a month, because you have to fail first. And then, after the infusion, I was told, "oh, our bad; we really didn't mean that that was covered at that facility, so you can pay the bill for the facility for the implementation of that medicine." I wouldn't have osteoporosis if it were not for the steroid use, but there we go. I'm denied a prescription for fatigue. Fatigue is the worst thing out of all of this. You can take the pain, the deformed joints, the, the brain fog, but fatigue is insane. I don't qualify for the fatigue medicine; I did about 7 or 8 years ago, but now that's no longer possible unless I have a sleep study. I had a sleep study, and my doctor did all the paperwork for that. And then, two months later, when I was scheduled, they said, "No, you don't qualify for the sleep study." So the same company said you need to do the sleep study, but we're going to deny the sleep study. And I just take a sleeping pill now, at night, to hopefully sleep better. But that also was denied at the end of the year because they changed the formula for prior auths, so now the medicine that worked effectively I've been told this year I have to fail on two other medicines, and I have, but not within the last 12 months. And so, I have to go back and take medicine that made me sick and did not work 5 years ago, 2 years ago, just because the, the procedure changed on their behalf. None of that information is available. As a person that's purchasing this insurance, if I want to know if something is covered, I will be told by my pharmacy, "Well, we have to have your actual plan." If I want to research my actual plan, if I don't have it in force, I can't get into that document. And it's, it's very frustrating, obviously. And I obviously haven't slept, so I'm, I'm-- irritable is the nicest word I can come up with right now. So, I, I urge you-- my, my doctor called and said, please go, because you're crabby and you talk a lot. And my husband was like, just please take her for the day.

JACOBSON: If you could, I'm going to need you to wrap up.

TAMI BURKE: Yep. Yep. But all I'm saying is she sent me here because she said her patients, they-- we don't die, we just feel awful for a very long time, and the cost of that is our, our family and our quality of life. So, I'd like to think that if I don't matter, some of the other people here do. So, I appreciate your time. Thank you.

JACOBSON: Thank you for your testimony.

TAMI BURKE: Yep.

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

HALLSTROM: One point in your testimony, you said they, they denied and delayed your treatment--

TAMI BURKE: Mmhmm.

HALLSTROM: --and that saved them some money. What was it about your treatment in that intervening time that saved the insurance company money?

TAMI BURKE: I didn't get treatment.

HALLSTROM: OK.

TAMI BURKE: Yeah.

HALLSTROM: Thank you.

TAMI BURKE: Yeah, you're welcome.

JACOBSON: Other questions? All right. Seeing none, thank you--

TAMI BURKE: Thank you.

JACOBSON: --for your testimony. Other proponents. Proponents for LB 77. All right. I'll bet we got a couple of opponents, so why don't we start with the opponents. Mr. Blake, how are you?

JEREMIAH BLAKE: Good afternoon, Chairman Jacobson, 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 director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, and I'm testifying in opposition to LB77 as introduced. Before addressing this bill, I want to share with you the meaningful work that Blue Cross and Blue Shield of Nebraska is already doing in

partnership with Nebraska providers. We agree that more can be done to either-- ease the prior authorization burden for providers, patients, and payers. Our team has been meeting with providers to learn about their pain points regarding prior auth, and we are working to incorporate their feedback. As a result of those conversations, we are making several policy and process changes. For example, we announced last year that we would auto-approve seven days of care in a skilled nursing facility for patients who are ready for discharge from an acute care hospital bed. This decision was made following our conversations with Great Plains Health in North Platte. Our meetings with providers have also helped us identify internal processes that are creating unnecessary delays in the delivery of care. Once those processes are modified, many providers will receive decisions on prior authorization requests within minutes or hours instead of days. And finally, we're reviewing the data to identify procedures and services where there is little value in prior authorization. We have already identified a number of services where we see a large volume of prior authorization requests, and the approval rate is high. As a result, we will be eliminating the prior authorization requirements for these services. While these changes will have an immediate effect on patients and providers, we are also aiming for broader reform of the health care system. By shifting to a value-based care model, we can reduce the focus from the volume of services delivered and instead prioritize patient outcomes in both service delivery and reimbursement. Additionally, we have discussed the possibility of pilot projects with Nebraska hos-- Nebraska providers that eliminate prior auth requirements in exchange for shared risk. Which brings me to our position on LB77. I'm testifying in opposition to the bill as introduced because some of the provisions would hinder our efforts to modernize the prior authorization process. As introduced, this bill would also create confusion for patients and providers where we seek clarity. We are Blue Cross and Blue Shield of Nebraska; we're the only health insurance company that's headquartered in Nebraska; we operate solely within the state's borders. Because we are local, we understand that the health care challenges in Omaha and Lincoln are different from those in Alliance, Syracuse or Broken Bow. We also understand that we have a unique responsibility to, to partner with all the stakeholders in the health care ecosystem. This includes patients, plan sponsors, providers, communities, and the Legislature to support the health and well-being of our members and the communities we serve. To this end, we stand ready to-- and willing to work with the proponents of LB77 and this committee on amendments that recognize the needs of all stakeholders. If there's a willingness to continue those

discussions, I believe we can draft a-- draft a bill that makes prior authorization more predictable, transparent, and efficient for all parties. I want to thank Senator Bostar for introducing this bill. This is an important discussion for us to have, and I'd be happy to answer any questions you have.

JACOBSON: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. One of the questions I had, you stated-- correct me where I'm wrong-- that LB77, if approved, would interrupt your implementation of changes. And I'm wondering what is the timeline on your changes? Is that, you know, next Tuesday?

JACOBSON: Well, so there's a couple of different things happening, right? So, I mentioned that we're meeting with providers, and, as a result of the feedback we're getting from providers, we're implementing those changes. I would say first quarter of this year is probably a reasonable timeline for some of those changes.

RIEPE: OK.

JEREMIAH BLAKE: And again, as we look at rolling back prior authorization requirements by looking at the data, we've already started rolling back some of those requirements. And I think there's some announcements coming here in the next few weeks on those.

RIEPE: OK. The other thing I think that drives us as a state is that we're trying to look for consistency among managed care providers.

JEREMIAH BLAKE: Yep.

RIEPE: And so, I don't know whether-- there are a number that are players here in the state, and so, you would be one, but do we need to have state kinds of laws, regulations that ask everyone to come along at the same scope, time?

JEREMIAH BLAKE: Yeah. That's a great question, Senator. That's something that's going to be really important to us. And actually, I think we're going to discuss that on your bill next, is-- that's something I'm going to talk about, is that consistency across all lines of business, including Medicare, the Medicaid MCOs, commercial payers like us, and others.

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

JACOBSON: Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here, sir. A lot to digest in this bill, I know. And I do appreciate you coming and talking about some of the changes that you're trying to implement yourself as a, as a, as a company. A couple of things that I'm curious about with regards to you all in particular.

JEREMIAH BLAKE: Yep.

DUNGAN: We've heard a lot today about AI.

JEREMIAH BLAKE: Yep.

DUNGAN: Can you speak to the usage of AI as it pertains to the prior auth within your particular company for this part of the equation?

JEREMIAH BLAKE: Yes. So, what I can say about prior auth and the use of AI in prior auth is that any adverse decision that's issued by Blue Cross Blue Shield of Nebraska is made by a human.

DUNGAN: OK.

JEREMIAH BLAKE: OK.

DUNGAN: Can you say-- ah, I won't ask you that. I was going to ask if you could say the same for other companies, but that's not who you hear talking on behalf of.

JEREMIAH BLAKE: You'll let somebody else into that question.

DUNGAN: I'm sure I'll ask somebody else.

JEREMIAH BLAKE: OK.

DUNGAN: In addition to that, what can you-- if, if those decisions are being made by an individual, can you speak to the qualifications of those individuals? As we've heard here today with regards to the requirement that they be a physician--

JEREMIAH BLAKE: Yes.

DUNGAN: Do you know if those requirements are in place for your company, or, or what are we talking about with regards to those?

JEREMIAH BLAKE: Yeah. So, you got to unpack a little bit of detail here, and, and again, I, I-- I have to be a little bit careful about what I say, not because I'm trying to be obtuse or hide information from you, it's just-- again, it's how deep we want to go into our-- like, how we review prior authorizations, right? So, there's a request for prior authorization that's received. It's reviewed. It's either, you know, we either ask for more information; we may deny it, or we may approve it. So, that's done by a licensed medical professional. I, I can't say that they're done all the time by a M.D.,--

DUNGAN: Mmhmm.

JEREMIAH BLAKE: --but it's, you know, a nurse or somebody like that, right? And then you have-- if that, if that prior authorization request is denied, then you go to an appeal, right? And then, you get into whether or not it's reviewed by a physician specifically. I'd have to go back and ask on that appeal question. And then you get into external appeals and reviews, and all kinds of things, so.

DUNGAN: And the, the medical professional that's making that initial decision, are they making it based on a case- by-case analysis with regards to the specific facts and nuance of that individual request, or are they making that decision based on a rubric that they're provided by the company?

JEREMIAH BLAKE: So, they're making it based on a couple of things, right? So, they're obviously-- they're looking at the, the patient's condition, any kind of medical documentation that we receive from the provider. They're going to check that against what the medical evidence, medical literature says on this issue. And then, you also have to look at the plan documents. If it's not a covered service within a plan, if it's an excluded benefit, it doesn't-- the fact that-- it-- it's, it's not covered, right? At the end of the day, it's not something that we can pay for, because the plan document doesn't provide coverage for that. So there's, there's different things that you have to look at as well as--

DUNGAN: Right. No, that makes sense. And do you know, for you all, what the overall denial rate is?

JEREMIAH BLAKE: I don't. I will tell you that we process millions of claims every year, and the number of claims that require prior authorization is a very, very small percentage of those. And then within that, it's a small percentage that are denied, right? So.

DUNGAN: OK. Thank you for being here.

JACOBSON: Further questions? Senator Hallstrom?

HALLSTROM: I hadn't raised my hand yet.

JACOBSON: Oh, well, I, I, I--

HALLSTROM: Two witnesses now, including yourself, have mentioned having consistent treatment--

JEREMIAH BLAKE: Yeah.

HALLSTROM: --across the, the spectrum. And you both mentioned managed care organizations. I, I previously indicated there's an exclusion for managed care organizations from the definition of health care here. How does that impact anything that you're interested in?

JEREMIAH BLAKE: So, it doesn't impact Blue Cross Blue Shield because we're not an, an, an, an M-- excuse me. We're not a medicaid MCO. Right? I will tell you-- and again, this goes to the next hearing that we're going to have, is-- there are some federal rules concerning prior authorization that have been issued by the Biden administration that we're in the process of reviewing and implementing. Those rules apply to the Medicaid MCO line of business, as well.

HALLSTROM: So that may be why they're excluded?

JEREMIAH BLAKE: That would be my assumption, but I don't know. Again, I didn't write the bill, so I don't--

HALLSTROM: Perhaps Senator Bostar can enlighten us.

JEREMIAH BLAKE: Yep.

HALLSTROM: Thank you.

JEREMIAH BLAKE: Yep.

JACOBSON: Other questions from the committee? I just have one quick one.

JEREMIAH BLAKE: Yeah.

JACOBSON: The-- we talk about peer to peer.

JEREMIAH BLAKE: Mmhmm.

JACOBSON: And you're working with physicians. Some may be retired, and-- or some just agree to do this. But as you move up the scale-- let's take neurosurgery.

JEREMIAH BLAKE: Mmhmm.

JACOBSON: Probably not a lot of them running around, are there?

JEREMIAH BLAKE: No, there's not.

JACOBSON: So how do you deal with those pre-auths?

JEREMIAH BLAKE: Yeah. So, we contract with a third party that's going to review that. Again, we look for a neurosurgeon who can speak that language, understand what the medical literature requires, and make that decision.

JACOBSON: OK. All right. Thank you.

JEREMIAH BLAKE: Mmhmm.

JACOBSON: All right. Well, thank you for your testimony. Further opponents? Welcome.

MICHELLE CRIMMINS: Thank you. Good afternoon, Chair Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Michelle Crimmins, spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s, and I am the government affairs principal and registered lobbyist for Prime Therapeutics, a pharmacy benefit manager owned by 19 not-for-profit Blue Cross and Blue Shield insurers, subsidiary-- subsidiaries or affiliates of those insurers, including Blue Cross and Blue Shield of Nebraska. Prime helps people get medicines they need to feel better and live well by managing pharmacy benefits for health plans, employers, and government programs, including Medicare and Medicaid. Our company manages pharmacy claims for more than 300,000 Nebraskans, and our business model focuses on purpose beyond profits. We are not publicly traded or owned by private equity firm, and as such, it is our primary motivation-- not our primary "motivization" to maximize profits; our primary "motivization" is to do the right thing. I'm testifying in opposition to LB77 as introduced because the use of prior authorization for prescription drug insurance coverage is fundamentally different than the use of prior authorization for insurance coverage of medical services, and there should be--

therefore, should be a part of a separate conversation. For example, the duration of treatment is very different. A hip replacement surgery is completed once, whereas medication to treat any chronic condition is taken daily, oftentimes for life. This is an important distinction, because a prior authorization for a service ensures safety and appropriateness at a set point in time. Prescription drug prior authorization for prescription drugs are renewed at set intervals, and monitored for changes that may affect the safety of the drug. For example, if a cancer patient has lost a significant amount of weight, but this prescribed dose has not changed, a prior authorization provides an opportunity to reach out to the provider to ensure that the dose is correct. Prior authorization programs are reserved for a small subset of drugs, and most patients are in plans that have fewer than 10% of drugs subject to prior authorization. It's reserved for drugs that have dangerous side effects, are harmful when combined with other drugs, may be misused or abused, or if there are equally effective drugs available at a more affordable cost. Additionally, claims for health services and prescription drugs are submitted by different entities. A claim for a service is submitted by a health service provider, while a claim for prescription drugs is submitted by a pharmacy. To meet the differences, health insurers and pharmacy benefit managers have different claim platforms, meaning different technology is used to process the different claims. For these reasons, we oppose LB77 as introduced, and stand ready to work with the committee to resolve our concern over the impact of the prior authorization applicability to drugs in this bill. Thank you, Senator Bostar, for introducing this important bill, and I would be happy to answer any questions you have.

JACOBSON: Questions? All right. Seeing none. Thank you for your testimony.

MICHELLE CRIMMINS: Thank you.

JACOBSON: Further opponents. Mr. Bell. Welcome to the committee.

ROBERT M. BELL: Thank you, Chairman Jacobson. Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell. Last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies, including most of the health insurance plans operating in the state of Nebraska. I'm appear today in respectful opposition to LB77 as currently drafted. I certainly respect Senator Bostar's willingness to reach out to our

industry before session, and the proponents' willingness to listen to the insurance industry's concerns. I think Mr. Blake did a good job with describing his company's position, and the other insurers in the federation are also interested in working with our colleagues in the medical community to bring some level of reform and transparency to the prior authorization process. So, I'll just add a few additional points. First, while I understand medical providers' concerns in working through denials immediately, I do want to alert the committee that there is existing Nebraska law on both internal reviews at an insurance company and external reviews by independent third parties. It's important that any change recognize and harmonize with these existing provisions of law. Second, the federal government has become-- as you've already heard-- active on prior authorizations. As you will see in the next bill, LB467 by Senator Riepe, the Center for Medicaid and Medicare Services [SIC] has issued rules related to prior authorization that impact Medicare, Medicaid and plans on the Affordable Care Act exchanges. Again, while-- any Nebraska prior authorization language should be harmonized to those existing rules, which mostly become effective in 2027. And finally, I think the committee should be aware that prior authorization stems from the insurers' efforts to guard against fraud, waste and abuse. Insurers' role is to finance health care, and that is not covered otherwise by the government. According to the Kaiser Family Foundation, the-- in 2023, the average cost was $23,887 per family for an employer-sponsored health insurance. Looking at some data-- it-- it's a little bit strange. I was on the department's-- Department of Insurance's website earlier, and I don't know this includes ERISA plans, but $2.5 billion was collected in premium from Nebraskans for health, and if you think insurance companies are making a lot of money off of that is not the case. Loss ratios for the-- that year was 96.8% before you include expenses of the insurance company in the group market, 86.5% in the individual market. So, a little bit better in the individual market. That market has seemingly stabilized. So, look forward to finding compromise on this legislation, but as drafted, we must oppose. I do appreciate the opportunity to testify, and I do want to point out that whatever is passed as-- if it's draf-- as drafted right now, would not apply to Medicare Advantage plans. I think we heard quite a bit about Medicare Advantage; that will be covered in the federal rule. Wouldn't apply to ERISA plans, so those large employer self-funded plans. And then, the, the new agricultural plans that were exempted from insurance the-- this will not pass. Unless the Legislature, in that one specific case, wants to apply that to those plans as well. So anyway, thank you.

JACOBSON: Just to put a point on your statistics that you gave us on-- I think you said premiums collected, and then, and then claims that went out without-- before expenses, is that--

ROBERT M. BELL: Right. Right, right, right, right.

JACOBSON: So, this didn't include any profits from PBMs or other subsidiaries that are owned by the insurance companies.

ROBERT M. BELL: So [INAUDIBLE] that would include the pharmacy benefit that's paid by the insurance plan. There's some interesting-- and I-- I'm not as well-versed on the PBM, how that would relate back to the medical loss ratio.

JACOBSON: Well, I understand they have their other revenue sources that would be out there [INAUDIBLE].

ROBERT M. BELL: Oh, yeah, sure, like-- I mean, I think UnitedHealth Group has a perfect example of an organization that has its hands in a lot of things. It's dues season at the Nebraska Insurance Federation, and I got a check in the mail-- or the Federation got a check in the mail from a very large property casualty insurer that came from Change Healthcare. So, I mean, there are-- some of these companies are involved in a lot of things.

JACOBSON: OK. I just wanted to clarify that.

ROBERT M. BELL: Yep. No problem.

JACOBSON: Senator Dungan. Oh, actually, let's start with Wordekemper. Senator Wordekemper.

DUNGAN: I'll defer to Senator Wordekemper.

JACOBSON: You haven't, haven't all-- answered-- asked a question yet, because you haven't been here.

ROBERT M. BELL: You'll have plenty of opportunity to ask me questions throughout the session, Senator Wordekemper, but--

WORDEKEMPER: Great. Great.

ROBERT M. BELL: --I'll look forward to this one.

WORDEKEMPER: You, you talk about fraud and waste. So, in denying a claim, or a pre-authorization for two weeks, is there any statistics of how much fraud/waste was found in delaying the claim?

ROBERT M. BELL: Yeah. So, you know, and presuming that was approved-- if, if a claim was approved, there was, there was none found. And, and all the good people in here that, that testified-- I'm, I'm sure that they haven't experienced or participated-- I'm, I'm sure they haven't participated in any fraud, waste or abuse. That was the reason we started prior authorization way back when. And it, it, it has progressed. I think if you look at the statistics-- which you don't have in front of me-- certainly, in the last 5 years since COVID we have utilized prior authorization a lot more. We do say in the insurance world that about 10% of all insurance premium eventually ends up going to fraud and abuse, so-- in all lines. It's, it's pretty consistent, whether or not it's, like, a pill fact-- you know, there-- there's waste that goes on in, in the medical insurance as well as in the property and casualty world, as well as the worker compensation world, and life insurance, too. That's just a fact. So-- and you do try to catch that. How successful we are on prior authorization, that I don't know. So, I'm sorry. I don't have that information with me.

WORDEKEMPER: Thank you.

JACOBSON: Senator Dungan.

DUNGAN: Thank you. Just to follow up on my question to Mr. Blake, do you have any idea the current usage rate or, or implementations for AI in the insurance industry for the folks that you represent?

ROBERT M. BELL: I wish, I wish I had that information in front of me. I do know this. So, in Nebraska, the Nebraska Department of Insurance has issued a guidance document related to artificial intelligence. And so, if we're talking about state-regulated entities, they would have to-- well, not necessarily follow the guidance document; a guidance document is just telling you how to interpret current law. What tells companies what to expect-- and there's an expectation that you have to follow-- I mean, you can't use AI as an, as an out to not follow the law as it already exists, right? So-- and when you are examined by the Department of Insurance-- and so in this case, we're mainly talking about market conduct kind of examination. So, the-- how the insurance company has behaved in the market, has it followed the rules and laws of the state of Nebraska? You know, certainly their use or deployment of AI is going to be something that is examined. So, if they are

violating current laws or rules related to AI, then they will-- they will have to answer to the Nebraska Department of Insurance. And, and if somebody believes that the Nebraska Department of Insurance doesn't actually act on those market conduct investigations, I believe they fined Bright Health last year-- Bright Health insurance-- $1 million. So, I mean, there, there are fines that go out when they have found, you know, an insurance company in violation of the law.

DUNGAN: But prior-- if this doesn't go into effect, there's no current legislation in Nebraska preventing insurance from utilizing AI for those denials.

ROBERT M. BELL: If, if the current law-- that's its own-- my question-- and I need to go back and look to see if there's a, a requirement under current law for a human to make that determination. So. I guess I don't know the answer to that. Sorry.

DUNGAN: No, that's, that's totally--

ROBERT M. BELL: But if that does exist, then yes.

DUNGAN: OK.

ROBERT M. BELL: Or if it even contemplates, like, a person making that decision, right?

DUNGAN: Mmhmm.

ROBERT M. BELL: Yeah. If you get into the appeals of prior authorization, so, you know, there's, there's various-- so this is kind of like-- what Senator Bostar is trying to do, and, and the medical community too, which I think is, is good, is trying to come up with a process before you get to the very formal appeals that occur that are already in statute, whether or not it's an internal within-the-insurance-company appeal, or an external review, which is done through third parties via the Department of Insurance. Those decisions are made by humans. I believe there, there is a requirement, so.

DUNGAN: OK.

ROBERT M. BELL: I don't know if it says human beings, because I don't know when the law was written it necessarily considered artificial intelligence. So.

DUNGAN: And that's fair. And I think it's just an important clarification--

ROBERT M. BELL: Yep.

DUNGAN: --to make as we venture into the future together with AI. As we're sitting here, I asked ChatGPT why AI shouldn't be involved in making these decisions. And it came up with 9 reasons. So--

ROBERT M. BELL: Oh.

DUNGAN: I could put those on the record, but I'll, I'll let it sit for there. But thank you. Thank you, Chair.

ROBERT M. BELL: I, I thought you were going to ask them, like, what questions should I ask Bell, so.

JACOBSON: Senator Hardin.

HARDIN: Just looking at the broad stroke of the brush,--

ROBERT M. BELL: Mmhmm.

HARDIN: --since about 2014, America's largest health insurers have raked in about $371 billion in actual profit. And so, people see that broad stroke of the brush; they also know that about 40% of that amount of money was UnitedHealth Group itself.

ROBERT M. BELL: Right.

HARDIN: And so then, you have all others in that remaining group. Additionally, about 1 in 3 of the UnitedHealthcare claims get denied on the back side. That's another broad stroke of the brush. Throwing the pre-authorizations in it, and the foot-dragging that tends to happen in the industry, how does the industry wrestle with all of those broad strokes, I guess?

ROBERT M. BELL: Well, one thing-- I mean, with an insurance company as opposed to many other business entities that exist-- you know, that their financial records, their financial examinations is all public and is all available. And in the case of UHG, that would be, I believe, via the Minnesota Department of Insurance-- Department of Commerce, I believe it's called up there. I think they're a domestic up there. Don't quote me on that. Plus, they have other, other filings

that have to do with the SEC, things like that, so-- and again, as, as--

HARDIN: And in every state, because it's-- kind of works almost like a franchise.

ROBERT M. BELL: Well, it depends. Depends where they have their insurance companies, right? So-- correct. On the 1 in 3-- yeah. So, CMS has been requiring some, some data from insurance companies recently on their denials. I don't have all the information off the top of my head, but my understanding, too, is that, you know, what is a-- there's a-- there's a question on what is a denial, right? So if, if a physician would seek prior authorization for, for-- have a foot issue or something like that going on, and they forget some vital piece of information on that, like-- say, my name, or my date of birth, or whether or not I'm actually a United member or not, then that would-- would that be considered a denial? I think we're working through that right now, as an industry, with CMS to, to make sure that the data that is being reported is good.

HARDIN: And I'm a capitalist. Don't get me wrong.

ROBERT M. BELL: Sure.

HARDIN: Hey, that's a great-- those are great stocks to invest in. Right?

ROBERT M. BELL: Yeah. Yeah, they are. Well, I think they've gone down a little bit lately, so.

HARDIN: But, I'm just saying that--

ROBERT M. BELL: Yeah.

HARDIN: --when we're looking at the broad, the broad picture,--

ROBERT M. BELL: Right.

HARDIN: --and, and we see the foot-dragging going in with pre auths, and we see foot-dragging coming out with denied claims, and when we see massive profits in between with many-- not all--

ROBERT M. BELL: Right.

HARDIN: --of those health carriers, it makes the public a bit skeptical.

ROBERT M. BELL: Yeah, sure. And, and I guess I, I would clarify-- and I know you know this, Senator Hardin, that a company like Blue Cross Blue Shield of Nebraska, a company like Medica that does quite a bit of business here, they are mutual insurance companies, and they exist for their policyholders. So, they don't make profit. Do they pay their employees well? Do they do those sorts of things? Yes. But there's not stockholders behind them. Now, other companies-- Cigna, United, Aetna-- all companies that are members of the Federation, absolutely. They're stock companies, and are there to make profit. So.

JACOBSON: Other questions? All right. Seeing none. Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: Are there any further opponents? All right, no opponents. How about neutral testifiers? Anyone wish to speak in the neutral capacity. All right. Seeing none. Senator Bostar, you're welcome to close. I might add that there were 37 proponent letters received, no opponent letters, 2 neutral letters, and we did not receive any written ADA testimony regarding this bill.

BOSTAR: Thank you, Mr. Chairman, and members of the committee. I'm going to talk about just a few of the things that came up in, in parts of the conversation. I really-- I, I, I can't help myself, but I very much enjoyed that the committee was asked--so, we've identified a problem. I think everyone can agree with that, that there's-- we have, let's say, diagnosed a problem in this system. We heard about it a lot. And in this process here of trying to treat it, we were asked to wait. Which just feels too on-the-nose, frankly, for what we're talking about. I will say this. You know, if it, if it helps the insurers accomplish some other reforms they're trying to pursue, I am fine with having the bill just held on final reading until, you know, we get through Q1. That's OK with me. I think we get it out, get it through General, get it through Select, and then we can just give them that time, sitting there on final. I think that would work fine for everybody, then. AI came up a couple of times, particularly with Senator Dungan, and it's interesting. Some of the-- it doesn't-- from my conversations on this, it doesn't seem like the fear is that you've got an automated system that is pushing out denials on their own. I should say it's not the fear that that's happening yet. But it-- it's a question of what are the denials based on. So sure, there may be a

human that clicks the button on the computer that sends the email, or more absurdly, sends the fax to someone, you know, informing them of, of their denial of, of request. But the, the threat is that their decision is based solely on an AI system. So, sure, there's a human involved; sure, they're technically checking the boxes of the law; they're doing the thing. But they are being wholly informed by an AI process and not medical expertise. So that-- that's-- I-- I've heard defenses of why-- oh, don't worry about AI; look, there's someone there doing it; look at all the staffing we have that are doing all these-- this work. Yeah, but it-- it's what are they-- what's going into that determination? It was brought up that the forms-- so, for standardization of prior authorization forms, which I think is, is important, it was talked about that, for example, drugs and medications, prescriptions are-- or a, or a replacement hip are different than services. And so, if you, if you look at Section 6 of the bill, you'll see that there are actually two separate standardized forms that, that are being contemplated by the legislation. And so, one would in-- one would specifically be for drugs, devices, and DME; the other one-- I'm sorry, durable medical equipment. The other one would be for health care-- or all other health care services, procedures included. And so, you know, I, I, I would say that I, I agree that those things are different and would-- probably should use different forms, and that's why the bill has that. So, we're all on the same page there. You know, we, we could have had a lot more people. There were, there were more people that wanted to come and tell stories. We could have done that all day today. We could have done that all day tomorrow. We could have done that for the rest of the week. I, I genuinely do appreciate that on this bill-- and it's not unique to this bill, but, but particularly on this bill-- that the insurers, I think, are genuinely trying to work toward finding a solution. I, I think that we, we can all see that there's clearly a problem here. And it's-- you know, we can always get down this path. But you heard that it's about lives, and you heard stories that I think demonstrate that. And so with, that, I appreciate your attention to this issue. I'd be happy to answer any other questions.

JACOBSON: Thank you. So you're, you're challenge to, what, pull the bill on Final Reading if they've got everything done. Is that kind of the deal?

BOSTAR: No, no. Negative, negative, negative. No, no, no. What we're saying is, I think that we, we advance the bill, and we just have-- we request that the Speaker just hold it there on Final until we get out of Q1 and then we pass it.

JACOBSON: Oh, OK.

BOSTAR: That way, that way it's-- because they asked for a delay, and I think that that's--

JACOBSON: Yeah.

BOSTAR: The-- you know, for Q1, and I, I think we can accommodate that. We just get it there and sit on Final.

JACOBSON: I, I, I guess my question would be, as it relates to these forms--

BOSTAR: Yes.

JACOBSON: And, you know, has there been any discussion with the insurers as to what needs to be on those forms, mode in which they're-- I understand that electronic seems to be the preferred method, because otherwise you're faxing, and, and it gets on the stack, and somebody else has to load it, and-- I'm, I'm just trying to figure out logistics of where we might be, in terms of getting an agreement to do the forms. And then, what do those forms look like depending on whether it's medication or it's some other procedures, and what all needs to be there, and does there need to be medical-- other medical information sent in addition. How do you see that playing out?

BOSTAR: I think that-- again, you know, from my conversations with folks who are doing this, it's-- it seems like it's doable. Because it, it isn't necessarily that there's a, a lot of information that's being requested, but every single person does it differently; every single person asks for something a little different, or they ask it to be presented in a little bit of a different way. And it's kind of just all over the place. And so, if we can agree-- and you know what? Right? In this bill, we have the forms into two standards, right? Where we have that categorized, drugs, DME, services, you know. If it has to be 3, then it has to be 3. Right? But I don't think standardizing some of this is out of reach at all, especially when it isn't just that everyone does it differently, but it's that everyone does it differently and they're always changing it. So, not only are you-- you're trying to, trying to remember which kind of information, which kind of request, which kind of form a particular, you know, payer is requesting, but also maybe it's different than it was yesterday. And so, this is, this-- this is-- it ends up being sort of

bureaucratic nonsense. And the more of that we can get out of this system, the better. You know, you hear the stories of how much time is spent on this. You know, and of course, when we talk about time being spent, we're also talking about money being spent, and for how much these ultimately get approved, it feels like we're wasting money. And in those surveys I cited in my open, it seems like physicians are on the same page that this is driving up health care costs. This isn't, this isn't identifying waste; this isn't, you know, finding the problem. This is, this is simply self-perpetuating and expensive.

JACOBSON: Other committee questions? Senator Hallstrom.

HALLSTROM: Is the exclusion of MCOs from health care here federal regulation-driven?

BOSTAR: Yeah, I, I-- somewhat. Yeah. I mean, that was part of that conversation. Ultimately, it was decided to just not have it in this bill. I think, one, we're, we're, we're already taking-- we're, we're trying to present a comprehensive solution to the problems that we're facing. And so, a little bit, it's for simplicity. Some of it's related to federal regs, but that's kind of a mix of the, the, the reasons.

HALLSTROM: Thank you.

JACOBSON: Other questions? All right. Seeing none. Thank you. And that concludes--

BOSTAR: Thank you.

JACOBSON: --our hearing on LB77, and we'll get ready to move to LB467. And I'm going to turn the chair over to Senator-- Vice Chair Hallstrom and--

BOSTAR: One down, two to go.

JACOBSON: --take a break.

Since the beginning of this.

HALLSTROM: Senator Riepe, welcome. You may begin your opening statement on LB467.

RIEPE: Thank you, Vice Chair, and members of the Banking and Insurance [SIC] Committee. My name is Merv Riepe, it's M-e-r-v R-i-e-p-e, and I

represent Legislative District 12. I think just in this past presentation, Senator Bostar correctly stated that we have diagnosed the problem, and the-- which is the process with prior auth-- authorization, which we're all seeking a solution to. Today, I am presenting LB467, which I introduced at the request of the Nebraska Insurance Federation. This bill continues our effort to improve the prior authorization process for health care providers, patients, and insurers. Specifically, it requires health insurance companies in Nebraska to implement a prior authorization application programming interface by January 1 of 2028. By adopting this technology, Nebraska would align its requirements for commercial insurers with federal regulations already in place for government-sponsored health plans. In January 2024, the Center for Medicare and Medicaid Services issued a new rule requiring Medicare Advantage plans and Medicaid managed care organizations to use an authorization process interface called an API for processing prior authorization requests. However, certain aspects of this rule do not apply to commercial insurance plans regulated at the state level. LB467 ensures Nebraska's fully-insured health plans follow the same technological standards, creating a more uniform and efficient process for submitting and reviewing prior authorization requests. This will help reduce administrative burdens on providers, improve transparency, and expedite care decisions for patients. There will be testifiers following me who can provide additional details on the bill and the federal rule it references. I appreciate your time and consideration, and ask for your support in advancing LB467. And I'm happy to answer questions. And I will be present for the closing, sir.

HALLSTROM: I guess-- any questions of the committee?

von GILLERN: It's all you. It's all you.

HALLSTROM: It's all me. I was looking at the bill. Any questions? Senator Riepe, I just have a quick one. Anybody in particular bring this bill to you?

RIEPE: Yes. The bill was brought to me by the Nebraska Insurance Federation.

HALLSTROM: OK. And drugs are excluded, so it seems to address a concern that they raised in the last bill. And if we're looking at something that's in accordance with something on federal law, why would we wait until January of 2028 to implement this?

RIEPE: That, good sir, I will need to defer to the people who are going to be accountable for--

HALLSTROM: Thank you.

RIEPE: --A) whether it does include drugs, and the-- why it couldn't be done by next Tuesday, as we discussed.

HALLSTROM: Thank you, Senator.

RIEPE: OK.

HALLSTROM: Any other questions? If not, proponents for LB467.

RIEPE: Thank you. Thank you, gentlemen.

ROBERT M. BELL: Good afternoon, Vice Chairman Hallstrom, and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I am the executive director of, and the "regislob"-- registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies. I am testifying today in support of LB467, a piece of legislation the Federation asked Senator Riepe to carry. Thank you to Senator Riepe for fulfilling this request. The main purpose of this legislation, legislation is to highlight the need for the Legislature to contemplate the existence of new federal rules related to prior authorization application-- rules related to a prior app-- authorization application programming interface, or API. LB467 was drafted based upon similar legislation that passed in Kansas last year. Has the 2028 date, but we'll come back to that. The API required under the federal rule will allow both insurance-- the-- allow both the insurance industry and the medal-- medical community to communicate more efficiently with one another on prior authorization. Some current prior-- some current prior authorization requests are not handled electronically, leading to miscommunication and unneeded denials because of incomplete information, and other types of administrative or clerical issues. Implementation of the API should greatly lessen these-- lessen the number of these types of errors leading to less prior authorization denials. The rule applies to Medicare Advantage, Medicare managed care organization, and some qualified health plans sold on the individual federally-facilitated marketplace in Nebraska. Adoption of LB467 would also place a requirements in the federal rule than on state regulated commercial plans. Of note, LB467 does not, as drafted, include the 72-hour

deadline for urgent prior authorization appeals or the 7-day non-"urgement" timeline, nor does it apply-- does the federal rule applied to drug coverage. Merely, the legislative bill adopts the API requirements for all state- regulated plans, as currently drafted. As the Legislature proceeds down the path of common-sense prior authorization reform, please keep in mind these federal government guidelines. It would be a struggle for either the insurance companies or the medical providers or consumers to comply with all the state laws and federal regulations if they're not harmonized. I appreciate your consideration of LB467, the opportunity to testify to things the federal rule does not apply to drugs. That's why-- and the Legislature wanted to make that explicitly clear, that it didn't apply to drugs. It doesn't mean that if in the negotiations that occur on prior authorization, that drugs could or could not be included. I am "efforting" to find out why it doesn't include drugs, and what the federal discussion was related to that. And then 2028, the, the guidelines go into effect in 2027. I think Kansas wanted to give it a year before it applied to other commercial plans, so.

HALLSTROM: Thank you.

ROBERT M. BELL: You're welcome.

HALLSTROM: Any other questions of the committee? Seeing none. Thank you.

ROBERT M. BELL: You're welcome.

JEREMIAH BLAKE: Good afternoon, Vice Chairman Hallstrom 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 director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in support of LB6-- LB467. I also want to thank Senator Riepe for introducing this bill, as it open up-- opens an important conversation on the prior authorization issue. As the committee deliberates on ways to reform the prior authorization process, I would like to provide the perspective of a health insurance company focusing on implementation and compliance. Currently, Blue Cross is in the early stages of implementing the federal rule for the Medicare Advantage and exchange plans, effective January 1, 2027. As Senator Riepe and Mr. Bell have already summarized the federal requirements, I won't repeat these points. What LB467 aims to do is extend certain requirements of the federal prior authorization rule to the state- regulated health insurance market to streamline the process

for everybody. However, self-funded ERISA plans, which are not subject to the federal rule or the state prior-- or any state prior authorization bill. As you may know, federal ERISA law allows plan sponsors to offer uniform coverage to employees across multiple states, eliminating the administrative burden of complying with the insurance laws in all 50 states. To give you some context, more than 700,000 Nebraskans were covered by an ERISA plan in Nebraska in 2023. The number of people covered by a state-regulated insurance plan was about half that number. So, as we consider LB467 and LB67-- or, LB77, our strong preference is that the Legislature align any new state requirements on prior authorization with the federal rule. This alignment would provide uniformity for providers and payers. But if the Legislature diverges significantly from the federal rule, it could create more confusion and frustration for provider and-- providers and patients. Under this scenario, we could possibly have one set of rules-- one set of prior authorization rules for federal programs like Medicare Advantage, another set of rules for state-regulated health insurance plans, and potentially yet another set of rules for ERISA plans. So, aligning state law with the federal requirements would likely encourage health insurers and ERISA plan sponsors to adopt the same requirements, creating a uniform process for providers to submit prior authorization requests. Therefore, I urge us to work together to craft a bill that creates a transparent and uniform prior authorization framework that benefits all parties. Again, I want to thank Senator Riepe for introducing this important bill, and I'd be happy to answer any questions you have.

JACOBSON: Questions from the committee? All right. Seeing none. Thank you.

JEREMIAH BLAKE: Thank you.

JACOBSON: Further proponents? Other proponents? A fitting crowd, looks like. All right. We'll move to opponents, anyone who'd like to speak in, in opposition to the bill. OK. Neutral testifiers? All right. Seeing none, Senator Riepe, you're welcome to close. Oh, and I might add that there were 3 proponent letters, 0 opponent letters, no neutral testifiers, and we did not receive any written ADA testimony regarding the bill.

RIEPE: Thank you, Chairman Jacobson, and committee members. The prior authorization process has caused a great number of concerns in our culture that values health care services and a process that's responsive to our immediate needs. My answers to have-- is to have

some uniformity, so that providers don't have to deal with different processes among different carriers, and I think that the managed care organizations needed to be included in that process as well. That's what I have, sir, and I would answer questions that I might be capable of.

JACOBSON: All right. Thank you. I think you're capable of quite a few questions. Questions from the committee? All right. Seeing none. Thank you for your close.

RIEPE: Thank you, sir.

JACOBSON: That closes our hearing on LB467. We'll move on to open the hearing on LB457. Senator Bostar. Welcome back.

BOSTAR: It's good to be back. Good afternoon again, although not for the last time. Chairman Jacobson, 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. Today, I'm here to present LB457, a bill to improve the preparedness of Nebraska schools and licensed child care programs for responding to anaphylaxis. Anaphylaxis is a severe and potentially life-threatening allergic reaction that requires immediate medical intervention, typically through the use of an epinephrine injector. Every year, children across the country experience anaphylactic episodes in schools or childcare settings, where a delayed or improper response can have dire consequences. As of 2022, an estimated 197,282 Nebraskans have food allergies, and more than 36,000 are children. Currently, Nebraska lacks a comprehensive statewide approach to managing anaphylaxis for both schools and child care programs. LB457 seeks to fill this gap by requiring the Department of Health and Human Services in consultation with the State Department of Education to develop statewide model policies that guide school districts and licensed child care programs on best practices for preventing, responding to, and communicating about anaphylaxis. This legislation provides recommendations and resources to help ensure that Nebraska schools and child care facilities are well prepared to respond effectively to severe allergic reactions. By July 1, 2026, school districts that do not already have an anaphylaxis policy will be required to adopt one. Likewise, child care programs caring for children with known severe allergies will need to adopt and publish an anaphylaxis policy in their program manuals or handbooks, helping to promote consistency and clarity in emergency response procedures. LB457 also proposals to make epinephrine auto-injectors-- or EpiPens,

vital for saving lives during allergic reactions-- more accessible and affordable for the nearly 200,000 families in Nebraska grappling with food allergies by capping the out-of-pocket expense to no more than $60 per two-pack for covered individuals. The absence of a cure for life-threatening food allergies underscores the critical importance of epinephrine auto-injectors for preventing fatal anaphylaxis, which is a life-threatening allergic reaction that, without prompt administration of epinephrine, the consequences can be dire. In 2022, a Papillion-La Vista eighth-grader tragically died after eating a granola bar that contained peanuts because he did not receive epinephrine in time. Unfortunately, one of the greatest burdens severe allergy patients and families face is the rising cost of epinephrine auto-injectors. Currently, the cost of brand-name EpiPens ranges from $650 to $730 depending on the pharmacy, and the generic version costs between $320 and $750, making it too expensive for many Nebraskans who cannot simply afford the only medicine that can save their lives. This trend is nothing new, as six years ago, CNN reported that these life-saving devices had increased by more than 400% since 2007. While the price of epinephrine auto-injectors continues to rise, so too has the use of high-deductible health insurance plans, as they have increased nationally by 83.7% over the last ten years. This combination is problematic for food allergy families, as a recent NBC News story summarized the problem: even as the cost of EpiPens and other epinephrine auto-injectors have stabilized, many are paying thousands of dollars out-of-pocket each year due to high-deductible insurance. For a typical family living in Nebraska with a child who has a severe allergy, they must purchase, each and every year, at least two packs of epinephrine auto-injectors: one for at home, the other for at school, which means that their total cost of $1,400 is 88.2% of the median monthly mortgage payment in Nebraska of $1,586. For families with children who have severe allergies, this bill provides peace of mind, knowing that schools and child care providers have clear standardized procedures to prevent and respond to anaphylaxis. It also makes epinephrine injectors more affordable, reducing financial barriers to obtaining this essential, life-saving medication. With that, I thank you for your time and attention. I'd be happy to answer any initial questions.

JACOBSON: Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. On the EpiPens, I saw in your document here someplace you said $60 for a two-pack?

BOSTAR: Correct. That would be the cost-sharing.

RIEPE: OK. What-- can you tell me what the shelf life is on EpiPens? I should know that, but I don't.

BOSTAR: Yeah, so, it's-- generally, by the time you get it, it's about a year. But we had-- so, I brought legislation last year as well that was-- is similar, and, and in conversations as well as testimony from that hearing, you know, sometimes you get six months out of it. So, it's-- it, it varies a bit, but you should expect to be having to replace your stock every year.

RIEPE: OK. And I don't believe that it has to be refrigerated.

BOSTAR: No.

RIEPE: OK. My, my other piece along with that is, is at Children's-- which you know I was at for a number of years-- we told-- we consulted-- and we had a big share of the market in Omaha and somewhat in Lincoln. We told our parents, you need to carry an EpiPen if you have a child, just like you would your phone. You need to make sure the babysitter-- that you leave one there, and you make sure that your school, that you provide it for your most valuable thing in your whole life, if you have a child that may-- and definitely for those that do have a peanut allergy. So, I-- you know, as a, as a parent myself, you know, I would give up shoes to-- as most parents would-- to make sure that I had one, and not expect the insurance company to do that. I'd ask you to respond [INAUDIBLE] maybe-- I didn't mean to lecture. I just--

BOSTAR: Sure. Well, you know, from my interactions with parents that are facing the challenges of having to afford to pay for these, I, I think they all-- I, I haven't met a single one that wouldn't do everything they could to ensure the, the safety of their children. But for some, it may, it may mean selling the house. I mean, there are incredible costs associated with this.

RIEPE: But, but $60 for a two-pack?

BOSTAR: That's what the bill would set it at.

RIEPE: Yeah?

BOSTAR: Currently, it's, it's hundreds and hundreds of dollars for a two-pack.

RIEPE: Oh, OK.

BOSTAR: That's the problem. The problem is these things cost a few bucks to make, they've been around for a long time, it's not particularly complicated. But-- I'm just going to say bad actors in the industry have taken advantage of the situation, knowing that individuals and parents alike will spend whatever it takes to ensure their child doesn't die if they're simply exposed to something they have an allergic reaction to. And so, whenever you're in that position, and if your motivation is simply to make as much money as possible, you're going to charge a lot of money.

RIEPE: It's a single source?

BOSTAR: It's not. But let's just say--

RIEPE: Are you saying price fixing?

BOSTAR: It seems like a lot of the suppliers of these things have followed each other. Certainly not going to imply any cartel behavior, but the prices are high across the board. And, and, you know, I'll just say at the front end of this hearing, you know, we-- again, we've been working on this legislation for-- since 2023, and I actually-- I really do appreciate the insurers on this one, because it's, it's broadly understood that there is a critical problem right now with this particular drug, that, that frankly-- we, we just need to do something like this.

RIEPE: Is this comparable to the insulin problem that we had?

BOSTAR: Yes, but I would say while this impacts, I think, fewer individuals, right?

RIEPE: Yeah, probably so.

BOSTAR: I think there are fewer individuals that are, that are carrying an EpiPen around than are relying on insulin.

RIEPE: Yeah.

BOSTAR: The, the price disparities on this are actually so much worse.

RIEPE: OK. Thank you very much. Thank you, Chairman.

JACOBSON: So, what about those who are uninsured?

BOSTAR: I really hope they get insurance. For folks who are uninsured, and they have to-- if they require a constant supply of EpiPens, it would be cheaper to get insurance on some level, especially if you're talking about needing to supply them for a child who has to have them at school, at home. And the thing is, ideally, right? You're talking about a two-pack for at home and a two pack for at school, and honestly-- I talk to a lot of parents, it's also another one in their backpack.

JACOBSON: Right.

BOSTAR: Right? And because it's not just even splitting up the two-back into locations, because, you know, in the instructions you get the first time you're prescribed an EpiPen-- which I had the pleasure of, of getting for the first time a prescription for an EpiPen, just in the last two months, for the first time ever-- you're, you're told that, you know, if the first one doesn't work, you can, you can basically take another 10 to 15 minutes later. You know, if you're still having challenges, or if it's causing difficulty breathing or something else. So, you really kind of want to have two around, because it's not-- it's likely that one will solve the immediate problem at least long enough to get you to more sustainable care, but it-- not necessarily. And so, you want to be within reach of two. And so, you're, you're now talking about doubling everything.

JACOBSON: All right. Senator von Gillern.

von GILLERN: Senator Bostar, I, I don't know very much about this. I, I presume the dosage is similar to most other drugs. The dosage for a 60-pound child is different than a 200-pound adult, and so you couldn't-- it's not like a school could have, you know, five EpiPens that would work for every kid. Would that be the case? Or?

BOSTAR: I, I mean, they are auto-injectors, so they're all pre-dosed. Now, the question of whether or not-- I don't really know the answer to your question. I can absolutely find out.

von GILLERN: I can imagine what the nurse's office looks like at school, if they got, you know, if they got 20 or 30 kids, the, the supplies to keeping track of all that.

BOSTAR: Now-- and keep in mind there are, there are some schools that will have just a-- an EpiPen around for, for who-knows-what, right? Emergencies. Who's keeping track of when that expired? Right? Is that

being renewed all the time? And also, a lot of schools will very, very specifically-- and, and, and daycare providers and things like that-- ask parents to bring them in so that they can be held at school, because also-- again, right, these are really expensive. And so, let's be, let's be honest, right? The school doesn't want to pay for it either, so it's-- someone has to pay for these things. They are required for people to keep on living who have certain allergic conditions, and they have-- and it's a-- it's not a particularly durable drug.

von GILLERN: Another follow-up question. The-- what is insurance paying-- typically paying for these now? Are they excluded, or do they, do they fall under a co-pay, typically?

BOSTAR: It varies. But, you know, that's why, you know, in the open, I talked about sort of the high-deductible health insurances, because you're, you're generally going to-- you're going to eat a lot of the costs of these if you have a high deductible plan.

von GILLERN: OK. All right.

BOSTAR: And, and so, it's going to be the-- hundreds or upwards of thousand-plus dollars for-- especially for children.

von GILLERN: It's also safe to presume if you got a high-- well, no. Never mind. I wasn't going to-- I'm not going to go there.

BOSTAR: Your premiums may be lower, right? Because that's-- I mean, I get it; it's all trade-offs, but it's-- it doesn't change the reality that we're talking about something that can be made for $3--

von GILLERN: Thank you.

BOSTAR: --that's being sold for $700.

JACOBSON: Now, you mentioned that there's a, a generic out there. So, if there's a generic, I'm trying to figure out why there aren't many, many more generics, given the price where it's at and the relative low cost to produce the drug.

BOSTAR: Look, I am ready and willing to go into the EpiPen manufacturing business with any of you.

JACOBSON: Let's get together after here.

BOSTAR: Say the word. Sure. But, but ser-- I mean, honestly, some of the generics are a bit cheaper; still hundreds of dollars for an EpiPen, and some of the generics are, are somehow more expensive than the name brand ones, and I haven't figured out how that works. But I think it's because sometimes you can get into-- when we talk about pre-auth, you can get a situation where a drug can be substituted for something that is a generic, and I, I suppose that there's, there's some manufacturer out there that's priced their generic higher than even the name brands, because they're just-- they're going to get it on the margin. I don't know.

JACOBSON: They can.

BOSTAR: Yeah.

JACOBSON: All right. Well, thank you. Any other questions from the committee? If not, thank you. And I guess we'll open it up to proponents.

BOSTAR: Thank you.

JACOBSON: How many want to speak as a proponent? OK, let's get one up in the chair, and let's have everybody else move towards the front. How are you?

HANA NIEBUR: Good. Chairperson Jacobson, members of the Banking, Commerce and Insurance Committee, good afternoon. My name is Dr. Hana Niebur, spelled H-a-n-a N-i-e-b-u-r, and I am here speaking on behalf of the Nebraska Medical Association and the Nebraska Academy of Allergy, Asthma and Immunology. I am a board-certified physician specialized in pediatrics and allergy immunology, and I have been practicing in Nebraska for over ten years, treating patients with these life-threatening food allergies. I'm here today to express my strong support for LB457, because it will save lives. As a pediatric allergist, I have witnessed firsthand the terrifying speed at which anaphylaxis can take hold. It starts with itching or swelling, but within minutes, a child may struggle to breathe as their airway swells shut. Without immediate access to epinephrine, anaphylaxis can be fatal. It is heartbreaking when families hesitate to use their epinephrine device because they are not sure if they can afford to replace it, or if they have to make the hard decision to only have one device instead of the recommended two. That should never happen in our state. LB457 does two critical things: first, it ensures Nebraska schools and licensed child care programs have clear, evidence-based

policies to prevent and respond to anaphylaxis. While we do have Rule 59, we do not have a universal standard. But this bill will provide consistent, medically sound guidance so that every school and child care provider knows exactly how to protect children with severe allergies. Two, it makes epinephrine more affordable by capping the out-of-pocket costs at $60. Many families struggle to afford epinephrine injectors, which can cost hundreds of dollar per-- dollars per set, most painfully felt when one pharmaceutical company suddenly increased its pricing from $100 to $600 in the late 2000s, with no change to the actual device itself. But delaying or rationing this medication is dangerous. Imagine a child having an anaphylactic reaction at school, and the nurses reaches-- nurse reaches for an epinephrine auto-injector that the family couldn't afford to refill. We should never allow financial barriers to determine whether a child lives or dies. This bill is about ensuring preparedness and access to life-saving medication. Schools already have plans for fires and tornadoes; anaphylaxis is just as urgent, and far more common than people think. In fact, 11% of schools report at least one episode of anaphylaxis per year. I urge you to pass LB457 and take this vital step to protect Nebraska's children. Thank you for your time, and I'd be happy to answer any questions.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I think providing them or providing the funding for them is one thing, and then keeping track of their expiration dates, if they have some, or when they're older, or who has them, and I-- you know, the administrative side of this thing will be probably as costly as the epinephrine pens.

HANA NIEBUR: Most schools and daycares--

RIEPE: I can assure you, if you send this to DHHS, they're going to assign probably upwards to six people to administer this, knowing DHHS.

HANA NIEBUR: I disagree, because this is something schools and daycare facilities already have to navigate as this is becoming--

RIEPE: So they would take the responsibility?

HANA NIEBUR: -- more common. It is more providing them the infrastructure they need to be able to carry this through.

RIEPE: OK. That infrastructure is--

HANA NIEBUR: That wouldn't be that easily part of current licensing.

RIEPE: --going to cost something. I mean, that's all I can-- thank you.

JACOBSON: All right. Further questions from the committee? All right. Seeing none. Thank you for your testimony. Next proponent, please.

KATHERINE WHITE: Good afternoon, Chairperson Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Katherine White, K-a-t-h-e-r-i-n-e W-h-i-t-e, and I am here today in support of LB457. My two-year-old son Tucker is one of the more than 36,000 children with food allergies in the state of Nebraska. He was diagnosed with life-threatening peanut and egg allergies when he was only six months old. Since then, he has outgrown his egg allergy, but now has anaphylactic allergies to cashews and pistachios. Because of this, we have to carry two EpiPens with us everywhere we go. They are the only tool available to help reverse or slow the effects of anaphylaxis, a life threatening allergic reaction that requires emergency treatment. Food allergies do not run in my family, so you can imagine my surprise when I learned that, without insurance, a two-pack of EpiPens cost somewhere between $650 and $750 out-of-pocket. With insurance, that cost was still going to be around $300. On top of the outrageous cost for this necessary, life-saving medication, each pack of EpiPens has a shelf life of only a year. Even if we make it through the year without having a reaction that warrants using EpiPens, they still have to be replaced annually to guarantee efficacy. Furthermore, many medical providers recommend having at least two packs of EpiPens once a child is school-aged: one for home, and one for school or daycare. You can imagine the financial burden this can place on a family just to have peace of mind that your child has access to the life-saving medication they may need in case of exposure to their allergens. Food allergy diagnoses already take a taxing mental health toll on parents. There's currently no cure for food allergies. We have to constantly read food labels and trust that daycare providers, educators, friends and family members understand the risks and take necessary precautions in order to avoid a reaction. It breaks my heart to think that the cost barrier for auto injectors may force some families to choose between having access to this life-saving medication or greater financial stability. Passing LB457 and providing affordable access to EpiPens would help alleviate some of the stress and burdens that food allergy families face. I am also happy to see that, in LB457, Senator Bostar also included a requirement for DHHS and the State Department of Education to develop

anaphylaxis policies for school districts and licensed child care programs. Nearly 8% of children have at least one food allergy, which equates to an average of two children in every classroom. Life-threatening allergic reactions can happen any time, anywhere, with little notice. This legislation would help ensure that parents can have peace of mind, knowing that their children's caretakers are trained on how to handle EpiPens in case of an anaphylactic reaction. At this time, multiple states, including Illinois and Colorado, have successfully passed and signed into law legislation to cap the cost of EpiPens, and over 35 states have laws that permit public entities, including schools, to stock undesignated stock epinephrine in case of an emergency. By passing LB457, Nebraska will set a crucial precedent for other states, and ensure that life-saving medication can be readily available and accessible to capable individuals in the case of an unexpected allergic reaction. Depending on the severity of this reaction, this could literally be the difference between life and death. Thank you for your time today, and I encourage you to vote LB457 out of committee. At this time, I'm happy to answer any questions.

JACOBSON: Thank you. Questions? You mentioned Colorado has this. Do you know how they're paying for it?

KATHERINE WHITE: I don't exactly. I know I've done some research into it, but I would have to double-check just offhand. But I know that most of the states that have passed legislation have similar legislation where it would be a cap at $60 on a two-pack of epinephrine.

JACOBSON: But who would be paying $60?

KATHERINE WHITE: That, I would have to double-check with you.

JACOBSON: OK. Thank you. Appreciate it. Thanks.

KATHERINE WHITE: Of course.

JACOBSON: Further proponents. Welcome.

JENNIFER SCHMITZ: Thank you. Chair Jacobson, and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify today. My name is Jennifer Schmitz, J-e-n-n-i-f-e-r S-c-h-m-i-t-z, and I serve as the program director of Kids 'R' Kids Learning Academy of Southern Hills. At Kids 'R' Kids, it is our mission to ensure that every child in our care feels safe,

loved, and inspired. I am here today in support of LB457, and I would like to extend my gratitude to Senator Bostar for introducing this bill. With over 15 years of experience in the child care field, I have seen firsthand how significant impact the food allergies have-- or, food allergies and other inter vit-- inter-- I'm sorry. Environmental triggers can have on children. As a parent of a child with a severe allergy, I understand the importance of having proper policies and protocols in place to respond to-- effectively in case of an emergency. However, not all child care centers are equipped with the necessary knowledge or resources to handle such situations promptly and safely. Today, I want to highlight why LB457 is ins-- is essential in supporting child care programs and improving the safety for our young children. Early in my career, I worked with a family whose child had a severe peanut and tree nut allergy. The mother took the time to train us to tell us to recognize this-- or to teach us to recognize the signs of anaphylaxis, and how to use the EpiPen in an emergency. Despite this, there was no formal policy in place to guide us through such a situation, which left me feeling uncertain about the best course of action to protect the child in our care. Years later, I found myself in a similar situation as a parent. My daughter experienced an allergic reaction to store-bought baby food while being treated for RSV. It was the quick thinking of the respiratory therapist who identified her issue. As a new parent, I had no idea what signs to look for, or even how to respond. After my daughter was diagnosed with severe allergies to latex and bananas, I made it my mission to ensure that everyone who interacted with her, whether in a medical or child care setting, knew exactly how to respond in an emergency. LB457 is a vital step in ensuring that licensed child care providers who care for children with known food or other allergies have clear policies and procedures in place to handle anaphylaxis emergencies. The bill would help create an environment where children with severe allergies can be cared for along the side of their peers, with confidence that the providers are prepared to act swiftly and appropriately. While I understand that there may be concerns and of-- there may be concerns about the challenges of implementing these policies, I believe that with the support of the Department of Health and Human Services, who can offer sample policies and training, this process would be manageable and ultimately beneficial for all involved. Each child's need may vary, but having a baseline of required policies will ensure consistency and clarity across all child care settings. Thank you again for the opportunity to speak today, and for your continued commitment to the well-being of our state's

children. I urge you to vote in favor of advancing LB457, and I would be happy to answer any questions you may have.

JACOBSON: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I noticed in your document that you said: as a new parent, I had no idea what signs to look for on how to respond. My question would be, is-- then, is the state obligated by-- and maybe should be by law that we have to conduct an ongoing routine educational program to make sure that all parents are keenly aware of not only this issue, but every other issue that a child might be exposed to?

JENNIFER SCHMITZ: I don't think that that's what's in the bill right now, so.

RIEPE: No, I know it's not in the bill, but is it a duty that should be law?

JENNIFER SCHMITZ: Well, as a new mom I have to watch how to put a car seat in my car; I have to watch how to administer medicine; I have to watch how to bathe my child; I have to watch-- you have to watch all of these videos to leave Bryan or St. Elizabeth. And I believe-- because of my child having it, I believe, along with other parents, that yeah, it is a very-- there is-- there's an uptick of allergies going on, and it is very crucial to have that be a part of that education.

RIEPE: OK. Is it fair to assume you think that's a state responsibility for that education?

JENNIFER SCHMITZ: Who pays for it now?

RIEPE: I don't think the state does.

JENNIFER SCHMITZ: That's who it would-- made it. That's who made the videos that you watch at a hospital.

RIEPE: Oh, so you do have education? Did you just miss it? You have "I had no idea what things to look for."

JENNIFER SCHMITZ: It's not on anaphylaxis. As I just stated, it's on car seat, it's on bathing, it's on safe sleep. There is not one for anaphylaxis.

RIEPE: Well, it sounds like if it's a state responsibility, they need to adjust to-- I don't want to [INAUDIBLE] for the-- Mr. Chairman, thank you.

JACOBSON: Thank you. Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here today.

JENNIFER SCHMITZ: Yep.

DUNGAN: So, you currently are the program director at Kids 'R' Kids Learning Academy.

JENNIFER SCHMITZ: Uh-huh.

DUNGAN: Is that a, a-- sorry. Is that an early childhood education center?

JENNIFER SCHMITZ: It is a licensed-- yes.

DUNGAN: OK.

JENNIFER SCHMITZ: It is a licensed early learning center.

DUNGAN: So, I'm looking at the fiscal note for this, which I don't know if-- you've probably haven't had a chance to look at that.

JENNIFER SCHMITZ: Sorry.

DUNGAN: It's zero cost to the state, is what it looks like. And one of the things they talk about in there is, you know, this bill is, is requiring DHHS and the Department of Education to work together to create that anaphylaxis plan you're talking about.

JENNIFER SCHMITZ: Correct.

DUNGAN: Part of why they say that's going to be zero cost is currently, there are-- under Title 92, Chapter 59-- requirements that early childhood education facilities have some plan with regards to anaphylaxis.

JENNIFER SCHMITZ: Correct.

DUNGAN: Is that fair to say?

JENNIFER SCHMITZ: Yes.

DUNGAN: OK. And so part of-- it sounds like what this bill is seeking to do is to-- through DHHS, working with the Department of Education, clarify and maybe expand on what that plan is. But it's your understanding that plan currently exists, they're just trying to make it more specific to ensure individuals know what to look for, and things like that.

JENNIFER SCHMITZ: It exists in some child care settings, but not all child care settings. So, if we're talking licensed child care, we're talking family home, there's child care centers out there that probably don't have it, and there's family homes that probably don't have it. So, from what I'm understanding is it would just give us a basis, a line, a baseline as to how to create that policy if they don't have one in place.

DUNGAN: And it sounds like, to me, it's just putting procedures in place for how to respond to these kind of things, correct?

JENNIFER SCHMITZ: Correct.

DUNGAN: Do you feel, as a provider, at, at an early childhood education that this puts on you some sort of unfunded mandate? Or is this something that you think you're willing to follow all the procedures there?

JENNIFER SCHMITZ: I already have it, so I'm willing to follow any procedures.

DUNGAN: OK. Thank you.

JENNIFER SCHMITZ: Yep.

HALLSTROM: And would--

JACOBSON: Go ahead.

HALLSTROM: Would you think the amount of policy should be acceptable if someone doesn't have-- doesn't want to go to the burden of putting something different or extra together, that the design is for the model policy to satisfy what needs to be in place?

JENNIFER SCHMITZ: Yes, there are already policies that they give us, if a new child care center were to open. They already give us a stack of policies to write our policies on, so that would just be a piece of paper added into that policy.

HALLSTROM: Thank you.

JENNIFER SCHMITZ: Yeah.

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

KARLA LESTER: Thank you. Thank you, Chairman Jacobson, Senator Bostar, and members of the committee. I am Dr. Karla Lester, K-a-r-l-a L-e-s-t-e-r. I'm a pediatrician and fellow of the American Academy of Pediatrics. The mission of the AAP is to attain optimal physical, mental and social health and well-being for all infants, children, adolescents and young adults. I'm here today to represent the Nebraska chapter of the AAP. I'm also a mom of three; two of my children, who are now ages 24 and 18, have severe food allergies, and always carry an epinephrine auto-injector with them. My oldest child, Katherine [PHONETIC], would be here today advocating, but she's an M1 at UNMC, and is in an anatomy lab right now, so. Having a child with a life-threatening allergy is an everyday, sometimes every-minute worry. I've also worked with Lincoln Public Schools for a number of years since my daughter was diagnosed as a toddler with a severe peanut allergy, and I worked with the district to put in place a food allergy policy. The school nurses are required every year to work with students who have all sorts of health issues, including asthma, food allergies, risk of anaphylaxis. Many students have individualized health plans. My students have a 504 plan-- my children do-- that helps define what plan there is. So, there's the policy, and then the individualized health plans that each student has. So, that's how districts work and do that. The CDC reports an increase in prevalence of food allergies in the US of 50% since the 1990s. The biggest risk of allergies an-- is anaphylaxis, a severe life-threatening allergic reaction, which may be triggered by a wide range of allergens. Anaphylaxis can happen within seconds to minutes of exposure, and can lead to hospitalization and even death. So, when I prescribe EpiPens-- and EpiPen is the branded epinephrine auto-injector, and they have a patent by the FDA that extends well into 2025. So, they've had the monopoly. EpiPen is the brand; epinephrine auto-injector is the medication. So, we give two-packs so that-- the plan is that with any sign, hives, swelling of the face, cough, wheezing, any respiratory distress, you administer the first dose of epinephrine. I always tell the nurse, don't call me, call 9-1-1, administer the second dose of epinephrine. I don't want to know until my kid's in the ambulance, please. Thank you. While avoidance of a known allergy is key, the only way to potentially treat anaphylaxis is with epinephrine. LB457

ensures children with life-threatening allergies have a safe environment by requiring anaphylaxis policies in licensed child care programs and schools, and limits the cost of the total amount that a covered individual is required to pay, not to exceed $60. These medications can be unaffordable for families. While manufacturer programs are available to help defray costs, few families will qualify given the stringent criteria. The cost of epinephrine auto-injectors, as Senator Bostar had shared in his proposal, is ranging from $320 for generic epinephrine, if you're lucky, to up to $700 for branded EpiPens. Capping the cost will allow families and schools and child care centers to have access to life-saving treatment. Over the years, I've had many fam--

JACOBSON: I'm, I'm going to need you to wrap up your comments, please.

KARLA LESTER: OK. I've had many parents ask me if they can use expired epinephrine because they can't afford the cost of a refill for a new prescription. Of course, the answer is no. So epinephrine auto-injectors represent the most basic and essential treatment for anaphylaxis, and can prevent serious health consequences, including hospitalization and death. Access to epinephrine auto-injectors lowers overall cost of care. Our state has an opportunity to provide protection for Nebraskans and maintain access to life-saving medications. Please support LB457 for Nebraska children and families. I'm happy to answer any questions.

JACOBSON: Questions from the committee members? Senator Riepe.

RIEPE: Thank you, Chairman. I have two questions.

KARLA LESTER: OK.

RIEPE: Did you say when the patent expires?

KARLA LESTER: From what I've read, it's 2025. But, as you know, with the FDA, then they're renewed, so.

RIEPE: So, we may get some generics coming up?

KARLA LESTER: I have no idea.

RIEPE: OK.

KARLA LESTER: You know, and the generics, still, are hundreds of dollars.

RIEPE: My issue-- or, as-- comment. I'd ask you if you agree with this. The issue is not the need, but the issue is who pays.

KARLA LESTER: As--

RIEPE: I think we all agree that we want these kids to have EpiPens if they have-- if they have a peanut allergy.

KARLA LESTER: Right. Mmhmm.

RIEPE: The question here is who pays? Is it the state, or is it the parents? Or-- well, who pays?

KARLA LESTER: Well, right now it's the parents, and they do everything they can to afford it. But it's-- the issue is, the problem is that children-- many go without having access to life-saving medications because of the cost.

RIEPE: But I go back to my issue. Then, if it's not the parents, then it's the state. That's it. There's nobody else. Or the insurance company.

KARLA LESTER: Yeah, the insurance. I mean, my husband and I are both physicians. I mean, we're a high-resource family of two children with-- who require EpiPens, but-- you know, we can afford it, but I don't think our insurance has covered the cost. I think it's an exclusion.

RIEPE: OK. Thank you, Mr. Chairman.

JACOBSON: Just a quick follow-up to that--

RIEPE: Sure.

JACOBSON: --questioning, because I, I-- you're exactly right. I, I mean, it's the parents, it's the state, or it's the insurance company. And it's easy to say just let insurance paid for it. But then, that also backs up on premiums for everybody going up. And so, that becomes kind of a vicious cycle if you get it. I mean, people can't afford insurance because there's also a lot of mandates out there to do certain things, and I agree with Senator Riepe that the need is certainly there. The challenge is always who pays for it. And, and that's one of the things we've got to continue to work through, in terms of are there foundations, are there other private sources out there to be able to, to fund this seemingly very high need? But I'm

sure there are others that will be out there that'll say there's also this problem, and who's going to pay for that? So, I, I appreciate the testimony today. And, and clearly, it's, it's a, it's a real challenge.

KARLA LESTER: Yeah, it's a life threatening issue for children.

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

KARLA LESTER: Thank you.

JACOBSON: Other proponents. Hello.

FABIANA UBBEN: Hi. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Fabiana Ubben, spelled F-a-b-i-a-n-a U-b-b-e-- U-b-b-e-n. You'd think I would get my name right, huh? Thanks for, for listen to my testimony today, when-- I'll speak a little bit more of the, the measures of the LB457 to just ensure that the staff is prepared. So, when we first sent our toddler to daycare, I ran through every possible center-- scenario in my head. The usual vulnerability I felt as a parent was magnified of my youngest son, Lucas [PHONETIC], who has severe food allergies. I was terrified, so I talked to his teacher; I walked them through how to use the EpiPen, stressing that if they ever need to, they must call 9-1-1 immediately. But I could see the panic in their eyes. Maybe there was just my eyes, but I could see that the teacher was nervous, so I steadied myself and I said, you never need it. Maybe I was trying to reassem-- reassure myself, too. So, the EpiPens are there for worst case scenario in my head. My goal was to reduce exposure altogether. So, a few days later, we realized that while Lucas' school-- the classroom was nut-free, but the rest of the school was not. And that was just-- wasn't enough that, that he was one-and-a-half, and my husband was like, oh, I don't want to leave him anywhere where there is peanuts, he will die. He could die. So, we met with the school director, who explained that they typically defer to parents on how to handle food allergies, as to every child's situation is different. So, I understood that, but I felt scared. To our relief, she graciously offered to make the entire campus nut-free. I was so grateful. Yet, I wondered: aren't there laws to ensure that children like my son have a standard level of protection in both schools and daycares? That's when I learned about Elijah's Law, tragically named after a three-year-old boy who lost his life due to an athletic [SIC] reaction while in daycare. This is in New York. My heart shattered for his parents. The

thought of leaving your child at daycare and never bring them home is just unbearable. So, I was determined to do something. That's when I reached out to Senator Bostar and his team, asking if they would consider introducing similar protections in Nebraska, which, it turns out, they were-- they've been working on this for a while also. Thank you so much, Senator Bostar. They not only listened, but took it even further with the price cap of EpiPens, which-- I understand the challenges. But I ask you to support LB47 [SIC] provides essential safeguards for children with life-threatening allergies and establishing statewide guidelines for schools and licensed child care facilities. It's a safety net when the parents are not there. So, it's scary to leave your kid in a place, and we want to make sure that everybody is, is ready to act in, in case of a life-threatening emergency. So, I ask the committee to support LB47 [SIC] so that every child, regardless of health conditions or limitations, can grow, learn and thrive in a safe school environment. Thank you for your time, and I welcome any questions.

JACOBSON: Thank you. Questions? All right, seeing none. Thank you for your testimony. Next proponent. Welcome.

ELIZABETH EVERETT: Thank you. Chair Jacobson and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify today. My name is Elizabeth Everett, spelled E-l-i-z-a-b-e-t-h E-v-e-r-e-t-t, and I'm the deputy director of First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on supporting policies that provide quality early care and learning opportunities for our state's youngest children. I'm here today to testify in support of the child care provisions of LB457. I would like to thank Senator Bostar for introducing this important bill. Ensuring the health and safety of children and child care programs is essential for fostering a nurturing, secure environment where young minds can develop, explore, and grow. As child care providers know when parents enroll their children, they are entrusting their most precious asset to the care of others. By prioritizing health and safety, child care programs enhance parents' confidence in the services they provide. However, the approach to managing food and other related allergies varies across states. In Nebraska, the Child Care Licensing Act requires all licensed child care programs to maintain a record for each child before enrollment. This record must be kept current, and include, among other details, a list of the child's allergies. If a child care program serves a child with food or other allergies, it must make necessary accommodations such as providing an alternative meal or snack. However, there is no

current requirement for child care programs to have a policy in place for managing a severe allergic reaction should one occur. LB457 addresses this gap. It mandates the Department of Health and Human Services, in consultation with the Department of Education, establish a model anaphylaxis policy to guide child care programs in caring for children with known allergies. This policy would include guidelines for prevention and divide-- indiv-- individualized health plans, emergency response, and communication. The bill further stipulates that only those licensed child care programs that serve children with known allergies must adopt an anaphylaxis policy, ensuring that the requirements are targeted and appropriate. This bill is a practical and reasonable approach. By only requiring programs that care for children with allergies, LB457 ensures that providers who may not be equipped to manage such care are not unduly burdened, while still protecting the children who require such special accommodations. Once again, thank you for the opportunity to testify today in support of LB457. I strongly urge the committee to advance the bill to General File, and I'd be happy to answer any questions.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Are you a 50-- is First Five a 501(c)(3)?

ELIZABETH EVERETT: First Five Nebraska is an initiative of the Nebraska Children and Families Foundation, which is a 501(c)(3).

RIEPE: OK. Has your organization explored with other philanthropic organizations to establish a fund specifically for this particular issue?

ELIZABETH EVERETT: Not this specific issue, but we have partnered with other organizations that give general funds out to parents and to providers to support whatever needs they have.

RIEPE: But you don't have anything within First Five that says this is a bucket of money for distribution of EpiPens and yadda, yadda, yadda?

ELIZABETH EVERETT: No, First Five Nebraska does not give out grants.

RIEPE: OK. They're a very-- Nebraska's a very generous community. I know that there-- any time you mention kids, there are a lot of people that are willing to step up, but-- thank you very much, Mr. Chairman.

JACOBSON: Further questions? All right, seeing none. Thank you--

ELIZABETH EVERETT: Thank you.

JACOBSON: --for your testimony. Any further proponents? All right. Seeing none. Are there any opponents to LB457? Seeing none. Are there any neutral testifiers? Mr. Bell.

ROBERT M. BELL: I came back just for this. Popping around, talking about salvage titles, prior authorization, and now EpiPens. Good afternoon, Chairperson 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 the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today in a neutral capacity on LB457. As you know, the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies, including many of the health plans operating in the state of Nebraska, such as Blue Cross Blue Shield Nebraska, Medica, CVS Health, Nebraska Total Care, Cigna, and the UnitedHealth Group. Section 4 [SIC] of LB457 would place an out-of-pocket cap on EpiPens at $60 for a two-pack, which typically lasts a year, if you don't have to use them. EpiPens are a life-saving treatment for individuals with certain allergies that can lead to various types of shock. Of note, EpiPens are not treatment and not preventive services under federal law, meaning that the-- to provide a cost sharing cap requires Subsection (1)(b) of Section 4 [SIC] related to high-deductible health plans and health savings accounts. According to the Internal Revenue Service laws and regulations, to be eligible for a health savings account or HSA, an individual must be enrolled in a high-deductible plan. High-deductible plans are intended to spur consumer choice when making health care decisions. The IRS provides that to be a high-qualified-- or, a qualified high-deductible plan for an HSA, the plan cannot cap out-of-pocket costs for non-preventive services such as EpiPens. As a result, the Federation has worked with Senator Bostar to include necessary language to preserve HSAs in Nebraska. HSAs are very popular in Nebraska, and provide tax benefits to those who utilize such accounts. Many, if not all, health plans already cap the cost of-- cap out-of-pocket costs for EpiPens, except in certain HSA-eligible high-deductible plans, and some do not have any cost sharing at all. Though LB457 does not get to the root cause of the cost of EpiPens-- i.e. the pharmaceutical industry-- it is-- does important work for Nebraska families who happen to need EpiPens. One final note: be aware that LB457 would not apply to health plans governed by ERISA or the newly-created agricultural plans passed last year. Because the Federation understands the life-saving nature of EpiPens in emergencies, but generally opposes health care insurance mandates, the

Federation is neutral on LB457. I appreciate the opportunity to testify.

JACOBSON: Thank you. Questions for the testifier? Yes, Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here again, Mr. Bell, for--

ROBERT M. BELL: Yep.

DUNGAN: --running around. I appreciate it.

ROBERT M. BELL: Yep.

DUNGAN: Is it fair to say, then-- am I understanding your testimony correct that-- or, correctly, that if passed, LB457 would not be overly burdensome on the insurance companies that you represent?

ROBERT M. BELL: Correct, and-- so, if there, if there are any plans out there that are charging, you know, $500 for co-pays for EpiPens, you know, they-- they're not squawking about LB467 [SIC], right? And I think part of that is because many of them don't, right? Because they understand that these are necessary items that folks need. And if you have a peanut allergy, as an example, if you can provide immediate care to an attack, then you don't spend time in a hospital, which of course, eventually, is paid by an insurance company. And, you know, spending time in hospitals is tremendously expensive for health insurers, it's disruptive to lives, everything along those lines. So, yeah.

DUNGAN: So, it's sort of an upstream investment in order to save that cost down the, down the line for you all?

ROBERT M. BELL: Right. It's almost preventive, right? It almost is.

DUNGAN: Almost there.

ROBERT M. BELL: But it is not. It, it-- you don't, you don't take an EpiPen unless you have an attack. And there's some nuances in the IRS regulations related to that in health savings accounts, which is why we need that additional language in there in case the IRS comes back on a plan and says, hey, you can't do this,--

DUNGAN: Mmhmm.

ROBERT M. BELL: --or you're disqualified from using an HSA, which is not a result anybody wants. Then, you can make that-- then, the plan would say, no, you do have to pay full costs until you meet your deductible and other co-insurance requirements. In those cases, many times, Nebraskans who have the option of going into the high-deductible plan also have an option not to go into a high-deductible plan, so something, certainly, they would want to consider when purchasing their health insurance.

DUNGAN: No, and that makes sense. I just-- I-- we've had some concerns, or heard some concerns here today, I guess, about who's paying for this. Right? It's either the person, the government, or the insurance company, and the fiscal note represents that there's $0 to the state. And so, if the insurance is the other person we're talking about here, you're saying that you don't believe if this bill passed, it would financially be overly burdensome on insurance companies?

ROBERT M. BELL: No, I mean, I, I don't. So, like, the state health plan, as an example; I, I don't believe you have to pay for any cost-sharing related to an EpiPen. Yeah. And, and, you know, the difference between $60 and, you know-- I, I, I, I missed part of the hearing, so I apologize. I forget what the, the going rate is on an EpiPen. That's-- that will pair [SIC] in comparison to the drugs that we'll hear about on the next bill, so.

DUNGAN: Got it. OK. Thank you, sir.

JACOBSON: Other questions? Yes, Senator Hallstrom.

HALLSTROM: Yeah. Mr. Bell, I appreciate the industry coming in and addressing the HSA part of that. And just for the record, for purposes of this bill, these are preventative care items so that they can qualify without meeting the minimum deductible. Is that correct?

ROBERT M. BELL: I don't have the language in front of me right now, Senator Hallstrom. I'll need to go back and check.

HALLSTROM: It says--

ROBERT M. BELL: I thought, I thought we created a, an exclu-- a, a, a-- necessary language. But let me double check on that and get back to you.

HALLSTROM: It says "except that for items or services that are preventative care," then the deductible doesn't [INAUDIBLE].

ROBERT M. BELL: Right. So, if the IRS would later on find EpiPens to be preventive, then they could be included.

HALLSTROM: Thank you.

JACOBSON: Other questions? All right. Seeing none. Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: Any other neutral testifiers? All right. If not, I'm going to ask Senator Bostar if he'd like to do a very brief close, and also note that there were 8 proponent letters, 1 opponent letter, 0 neutral letters, and we did not receive any ADA testimony regarding this bill.

BOSTAR: Thank you--

JACOBSON: Welcome for your brief close.

BOSTAR: Thank you, Chairman Jacobson, and fellow members of the committee. Just-- you know, there was some-- I feel like maybe I need to clarify a couple of things. One, this isn't the state buying EpiPens; this isn't the state putting EpiPens in schools or daycares. It is putting a, an out-of-pocket maximum on eligible insurance policies for policyholders when they are prescribed an EpiPen. I was, I was-- Senator Riepe, I was a little surprised, you asked a lot of sort of-- to be honest, like regular everyday people to justify themselves to-- in front of the state, but no questions for the insurance industry, which is fascinating. This is a good bill. This is a good bill that's been worked on for years. Every part of it. We've referenced the plans that HHS, that education, what they-- how what the work they do already interacts with schools and daycares. This closes some gaps. It also says-- it also acknowledges that a lot of these places already have full comprehensive plans. And if you do, great, you're done. There's nothing you need to do. But if you're a school that doesn't, well, you, you probably should, and here, here's some model language that can help. We worked with schools, we worked with school districts, we worked with school boards, we worked with child care centers to make sure that this was right. And we worked with insurance to make sure that, on the EpiPen side, that this made sense and that folks could live with it. I understand the risk of-- if we do this, tomorrow someone will say that something else would be covered. And you know what? It's going to be me showing up saying something else should be covered. I get it. But I think we should, we should trust insurance to fight their own battles for them. And that

when they say this mandate doesn't pencil out, this will ultimately lead to increases, great, let's have that-- let's have that conversation. But when they say, you know what? One, there's a problem here; two, this isn't-- you know, ultimately, we're also-- we're looking at some of those downstream impacts, and that-- this is acceptable, so we're going to be neutral. And granted, that, that didn't-- that wasn't overnight. That took from 2023 to now to get to that place. But that's where we are now. And so, I, I hope people will see this for where we are today. And with that, I'd be happy to answer any other questions.

JACOBSON: Well, I don't know when the last time was that the insurance company-- industry came in and testified in a neutral capacity on any of your bills. I'm not sure that's going to hold for the rest of the day, but [INAUDIBLE]

BOSTAR: I suspect it won't. But what-- but when, but when they do, we should celebrate.

JACOBSON: We should. We should. But it still seems like we've got a gap that we need to probably address somehow, in terms of those that are uninsured, because they still seem to be out there. And I would still encourage all of your proponents to kind of help think about is there a private way to fund that gap that's out there.

BOSTAR: A hundred percent. And those folks are in a really, really very difficult position. And I guess my request to the committee would be to-- let's-- what's represented in this bill is what, after years of work, is what we can do now that everyone has agreed to, and we should certainly always be looking for solutions to the problems that we don't get to fix in the moment.

JACOBSON: Yeah. Other questions? All right. Seeing none. There were-- I think-- yes, I think that was, that was included, and you're, you're-- thank you for your testimony. And that'll conclude the hearing on LB457. And we're now ready to move right into our final bill of the day, or of the evening, LB109. And welcome, Senator Bostar.

BOSTAR: Thank you, Chairman Jacobson, 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 the Legislative District 29. I'm here today to introduce LB109, a bill to prohibit pharmacy benefit managers from requiring white bagging, restricting

pharmacy delivery options, and ensuring Nebraska pharmacies can participate in specialty pharmacy networks if they meet accreditation standards. Many Nebraskans may be unfamiliar with pharmacy benefit managers, although I actually suspect that that is going down every day-- or PBMs. Yet, these powerful entities influence how millions of Americans obtain and afford their prescription drugs. PBMs negotiate coverage and pricing for prescription medications, granting them enormous power over patients' access to treatments. Consider a scenario. You visit your doctor for a medical issue, receive a diagnosis, and need medication that requires professional administration. In a hospital or health system model, the pharmacy dispenses this medication for your infusion, adjusting as necessary to accommodate any changes in your health status. Under a payer-mandated white bagging model, however, PBMs, vertically integrated with mail order pharmacies and insurance companies, can circumvent the hospital and insist that your medication be shipped from their specialty pharmacy. Patients have no choice in the matter, and PBMs can impose white bagging even if it raises costs or forces you to travel farther for your care. Hospitals often report being sent the wrong dose or even the wrong medications from PBM specialty pharmacies. In other instances, hospitals don't receive the shipments on time, if ever, and are forced to cancel and reschedule patient procedures until the next dose arrives. Hospitals also lose control over quality standards, not knowing where the medications came from or where they've been, but are still forced to accept all risks and liability. For patients, these errors and delays can lead to missed workdays and long drives to have medication administered, all while possibly having to turn around and go back home with nothing to show for it. LB109 also strengthens PBM regulations to protect consumer choice, and ensure fair access to pharmacy services in Nebraska. The bill prohibits PBMs from restricting how retail community pharmacies dispense or deliver prescription drugs, ensuring that covered individuals can receive their medications in a way that suits their needs. It also prevents PBMs from banning pharmacies from offering shipping or delivery services. LB109 ensures that Nebraska pharmacies are not unfairly excluded from specialty pharmacy networks if they hold appropriate accreditation and agree to reasonable contract terms. These terms must align with national accreditation standards and not impose excessive or punitive fees on participating pharmacies. Three PBMs control roughly 85% of the insured market, allowing them to impose less favorable reimbursement rates and take-it-or-leave-it contracts on independent pharmacies and rural hospitals. In Nebraska, we've seen independent pharmacies shutter in both urban and rural communities,

leaving large areas with only one or two pharmacy options. Meanwhile, rural hospitals are also struggling to stay open, even as PBM profits continue to climb. LB109 would prevent PBMs from imposing unreasonable contract terms on Nebraska pharmacies, and ensure that nationally-accredited specialty pharmacies can join PBM networks, disallowing any requirements that exceed national accreditation standards. White bagging can cause serious, potentially harmful disruptions to patient care; the-- this disruption to care results in insurance companies making decisions that belong to doctors and their patients. We all want to find ways to lower the costs of health care, but not-- but none of us should do so at the risk of harm to a patient. Thank you for your time, and I'd ask for your support of LB109. I'd be happy to answer any initial questions.

JACOBSON: Questions for Senator Bostar? Yes, Senator Hallstrom.

HALLSTROM: Senator Bostar, I-- and I have to leave in a few minutes to go somewhere else this evening, so I just wanted to get something on the record, and maybe you can respond to it before I have to leave. The fiscal note-- and I understand we've got, we've got the clinician-administered drugs, and the white bagging, and the brown bagging, and the sandbagging that's gone on on these types of issues for years. But the state doesn't appear to look at what they might be paying excessively on their Medicaid program, because of PBM practices. And-- but yet, we have $4.58 (million) and $5.498 million in fiscal impact. I'm looking at some of the issues in it, and it gets public knowledge with regard to PBMs overcharging states on the Medicaid managed care organizations, both the MCO and the PPM practices. And what they've identified are excessive and deceptive administrative charges, spread pricing, undisclosed self-dealing, et cetera, et cetera, on and on and on. If you'd just like to comment on the fiscal note and your concerns about that, if, if any. Maybe they're just mine.

BOSTAR: Well I-- well, thank you. I mean, I think this is, this is fairly representative of something that we run into a lot where, you know, our-- we don't, we don't do a lot of dynamic scoring for fiscal notes, so it's, it's just kind of dollar-in, dollar-out impacts are secondary. And, and I-- you know, there are times where we really see the kind of consequences of that. I think this is one of those times. Again, you know, the fiscal note-- there's, there's a lot to, to look through on this, and get through. So, we will be working to better understand where some of the assumptions are coming for that leads to the, the output results of the numbers. But I think that there's,

there's-- there are opportunities within this fiscal note. I will say that.

HALLSTROM: I just hope we can maybe get the interest and attention of the attorney general and others that might look at other aspects of this program from a dynamic scoring perspective.

BOSTAR: Of course. Of course. Thank you.

HALLSTROM: Thank you.

JACOBSON: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. For clarification, I think that you implied that I sit here for the benefit of the third-party payers. I tell you why I do sit here, is I sit here to make sure, or to try to promote that we have affordable health policies for those of us-- or those individuals who are not on government health care.

BOSTAR: Me too.

RIEPE: Well-- OK, so we share a, a mutual goal; it's just a different road to get there?

BOSTAR: I think we can get there together.

RIEPE: I'm, I'm OK with that.

BOSTAR: Appreciate it.

RIEPE: OK. I appreciate you. Thank you. Thank you, Chairman.

JACOBSON: Other questions? If not, you will stay for close?

BOSTAR: Of course.

JACOBSON: Then I'll invite the first proponent for LB109. How are you?

WILLIAM SAALFELD: Good. How are you doing?

JACOBSON: Good.

WILLIAM SAALFELD: Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is William Saalfeld, and I'm a rheumatology nurse practitioner with the Arthritis Center of Nebraska here in Lincoln. I'm here today to support--

JACOBSON: Can I get you to spell your name?

WILLIAM SAALFELD: Oh, sorry. Last name, S-a-a-l-f-e-l-d.

JACOBSON: If we could do first and last, we appreciate both.

JACOBSON: William, W-i-l-l-i-a-m; Saalfeld, S-a-a-l-f-e-l-d. I'm here today to support LB109, and address the critical impact of PBM practices on our ability to provide timely, affordable care, particularly for patients needing infusion therapies. Our in-house infusion center is vital for treating patients with complex rheumatological conditions. It allows us to provide timely, personalized care, reduce patient burden and potentially control costs. However, PBM practices are jeopardizing this crucial service. Three key issues demand your attention, which is, number one, reimbursement restrictions and white bagging. PBM increasing-- PBMs increasingly limit reimbursement for in-office infusions, often mandating white bagging, requiring us to obtain medications from their specialty pharmacies. This disrupts our established supply chains, introduces logistical nightmares, and often results in reimbursement rates that don't cover our costs. This directly threatens our ability to provide these essential treatments to our patients. Number two, prior authorization challenges. The prior authorization process is unnecessarily complex and time-consuming. For example, on January 6 of this year, I ordered a biologic, Infliximab, for a patient with ankylosing spondylitis who had UHC insurance. Despite thorough documentation and a peer-to-peer review that was requested on January 29-- I wrote the order on January 6-- UHC denying coverage for the two versions of the biologic drug we had in stock, preferring their formulary product. An expedited appeal was recommended by the physician, and that appeal is still pending to this day. This type of delay has significantly impacted my patient's health and quality of life; it also highlights the lack of transparency in PBM formulary decisions. During the peer-to-peer, the UHC medical director offered no clinical or scientific reason when asked by myself why our stocked medications were denied. PBM vertical integration is number three, with PBMs owning specialty pharmacies, creating a clear conflict of interest. They steer patients to their pharmacies, even if it disrupts established patient-provider relationships, and potentially increases costs. This vertical integration, coupled with PBMs' promotion of their own private label biosimilar products, further limits patient choice and creates an unfair playing field, having even greater control over the rebate structure. These practices have a significant impact. They reduce patient access to care, increase costs for

patients, and compromise guideline-based care. If reimbursement rates remain inadequate, we may be forced to scale back our infusion center, leaving patients with fewer options and potentially longer wait times. LB109 offers solutions that can ensure fair reimbursement for in-office infusions, streamline prior authorization, protect patient choice regarding where they receive their medications, and increase transparency in PBM practices and formulary decisions. I urge you to support LB109. It's vital for protecting patient access to timely, affordable, and personalized care they deserve. Thank you.

JACOBSON: Thank you. Questions? Yes, Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here today, sir.

WILLIAM SAALFELD: You bet.

DUNGAN: My sort of guiding principle in a lot of these conversations is just patient care. Right? We're talking about trying to make sure patients get the best care possible, it's affordable, make sure people are taken care of. One of the concerns that you raised with regards to the white bagging is the, I guess, "logistical nightmares," as you put it, in there. Could you just briefly give a little bit more detail as to what kind of logistical nightmares can happen with regards to this white bagging process?

WILLIAM SAALFELD: Well, for instance, with this patient, the, the appeal is still just in limbo, somewhere. It's gotten to the point the biosimilars, where these high-dollar reference products that are supposed to be more affordable, cheaper drugs than the reference products. So, like, brand-name Remicade, there's three FDA-approved biosimilars. And so, based on these, just at a whim, like, non-transparent negotiations with a drug manufacturer, a specialty pharmacy-- as an infusion clinic and a private practice, are we supposed to keep in-house every version of that drug just on whatever the patient's insurance formulary dictates that day? It's not sustainable. It's disrupting of even keeping an in-house supply chain of drugs available to provide at a timely manner to a patient. These are autoimmune conditions that they can have end organ damage if you don't treat it expeditiously. And like I said, I wrote that order on January 6; this is February 10. So, I mean, there's-- outside of just any number of in-stock infusion supply chain issues, it's also at the whim of-- it's like a restaurant: if I'm supposed to call them and say, you know, Friday night I want to show up and I want you to get

this steak from a farmer that I chose to be sent to you, there's a lot of room for problems there. And how is it transported, you know? How was it grown, you know? What'd they put in it? I don't know. What if I get sick? What happens?

DUNGAN: No, and that makes sense. And I think one of the-- one of the things that I've often heard with regards to white bagging that can be a concern that's been raised with me is, you know, any number of things can change between the time that that drug is being sent to you,--

WILLIAM SAALFELD: Right.

DUNGAN: --and when you get it, and whether it's, like, the weight of a patient, for example, that might change the amount that you want to distribute once they get-- there's a lot of different factors that are in flux, and that this time between it being sent to you, and the fact that you can only utilize it in the capacity that you receive it creates a problem.

WILLIAM SAALFELD: Right.

DUNGAN: Is that fair to say, too?

WILLIAM SAALFELD: Yeah. Even in real time, when we're seeing patients, the guideline-based care is you put their disease in low-disease activity quickly, and if possible, remission. The biologics have changed the paradigm, especially in rheumatology, of how we treat patients that used to just have the expectations you will become permanently disabled by your disease. The--

DUNGAN: No, I, I appreciate your testimony. You said a lot of words I don't understand, but I get your general gist, so I appreciate it.

WILLIAM SAALFELD: That's all right. That's OK. No, I'm-- all of our diseases, basically the immune system's too active, it can't tell that parts of your body are you, and it tries to attack and kill it.

DUNGAN: Yeah.

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

WILLIAM SAALFELD: Thank you.

JACOBSON: Other proponents? Good evening.

ANDREW RADUECHEL: Good evening. Thank you for having me back. Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in favor of LB109. 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 Boys Town National Research Hospital. During my tenure at Boys Town, I have watched the practice of PBM steering continuously grow, and witnessed it negatively affect pediatric patient 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 the 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, or receive their medications with little or no support. This typically is a different pharmacy than what they're used to going to, and have no established relationship with. I would like to direct you to the document including in my testimony entitled White Bagging Verse Hospital (and) Health System Model. As you can see by the comparison, there are at least three extra steps, sometimes many more, in the white bagging model. At extra step two and three, the provider must start over and write an additional order or prescription. This additional order is not put into the health system's electronic health record, and many comprehensive safety checks are bypassed. At steps four and five, the health system must coordinate medication delivery through the mail to the clinic address. It will then have to be transported to the site of infusion. Common issues often encountered include misdirected mail, loss of drug integrity because they're perishable, delayed delivery, and patients rescheduling. Finally, since several days or weeks have gone by, if the patient status changes and the dose needs to be changed, instead of adjusting the dose from the health system, another white bag drug will need to be ordered and sent, many times delaying therapy. This is an extremely inefficient and risky workflow, and this is just for one patient; imagine if you have 30 or 40 of these. On numerous occasions, we have had patients show up for their appointment, but the biologic was never shipped. The first time this happened-- and I've told the story here

before-- we took the biologic out of our pharmacy stock, so the patient wouldn't miss this important therapy. The insurer refused to reimburse us for the medication cost, and therefore we had absorbed $22,000 in unnecessary medication costs. After this event, we had no change-- we had to change our policy, and would no longer use our stock when the specialty medication does not show up. This continues to and has caused delays in this therapy, not only for this patient, but other patients on biologic therapies. Pharmacists are dedicated to getting the right medication to the right patient at the right time. We strongly support LB109 on behalf of our children and families, and I stand ready to answer any questions you have. Thank you.

JACOBSON: You mentioned taking this drug out of your own stock and treating the patient with that.

ANDREW RADUECHEL: Right.

JACOBSON: And said you weren't reimbursed for it. Can you tell me the time frame of when that happened? How recent was that?

ANDREW RADUECHEL: Well, the one I referred to was from a couple of years ago, but we continue to have issues like that all of the time. For instance, we infuse a, a, a drug that's a gene therapy, life-saving drug on a, on a newborn baby. It was $1.7 million for the infusion. We didn't receive that-- now, that one was approved, but like we talk about, with delays, this is all a part of the same problem. We infused that in July, outlaid $1.7 million; we didn't receive payment until January of this year, after lots of back and forth. So-- but, but we don't do this practice anymore so we don't get caught in that bind. And we just, we just-- when somebody comes in and their biologic didn't show up, we just don't infuse it, unfortunately.

JACOBSON: Well, so let me understand this. So, you're saying that--

ANDREW RADUECHEL: Sure.

JACOBSON: --this one infusion, one treatment, was $1.7 million?

ANDREW RADUECHEL: Correct. Yep.

JACOBSON: And-- but that didn't get shipped through the white bagging process, why didn't [INAUDIBLE]

ANDREW RADUECHEL: Right. That was a normal prior auth; it got authorized or whatever, but payment was held for six, seven months.

JACOBSON: But why didn't that come through white bagging, and be provided by the special pharmacy?

ANDREW RADUECHEL: Because we refused to, to do it any other way. And, and it's, it's a pretty-- it's an-- really, obviously, very expensive drug that needs to be handled. It comes in, like, a cooler that's $70,000, and it's GPS-tracked, and there's a bunch of--

JACOBSON: But you have insurance pre-auth to take it out of your own stock, or order it separately.

ANDREW RADUECHEL: Right. Right.

JACOBSON: And $1.7 million--

ANDREW RADUECHEL: $1.7 million for one infusion. Yeah. And then, you know, we need-- again, delaying, you know, payment for it for whatever reason, until 6 or 7 months. I mean, we can do that. But I could imagine a smaller places like, you know-- how are you gonna-- how are you going to make ends meet, in those situations?

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

HARDIN: This is a different question.

ANDREW RADUECHEL: OK.

HARDIN: Both drugs that are developed or developed in the United States, right? In terms of those that are designed [INAUDIBLE] that way. Germany has a, a system where they essentially don't allow duplicative drugs. Right? They-- if you-- if we've got one version of a drug, they kind of put a rubber stamp of "no" on anything that they deem to be too similar.

ANDREW RADUECHEL: OK.

HARDIN: Innovation is a wonderful thing. Have we taken it to an excess of our innovation, if you will, to a point where maybe we're strangling ourselves with our innovation? Because you can't use our drug; you've got to use this drug that's less than one tenth of a degree different by separation, and so now we're going to insist that you have to use this one.

ANDREW RADUECHEL: Well, it's certainly-- I mean, the, the issue that the gentleman spoke about right before me certainly is something-- we,

we, we dealt with the exact same situation of the biosimilars, where you carry two or three of them, but then, no. You know, now they pick this one, it's-- there's-- we don't know that they're picking it, we don't know that that's the new one; we just find out when that patient gets approved, now. It's like, OK, we got to add that to formulary, we've got to take that through committee, we got to start stocking that. And by the way, do we need the old one anymore? Because sometimes, we stop carrying that, and then they switch back to that. And so, you're kind of just-- it's like Whac-A-Mole. You're, you're really trying to-- but I think the innovation in, in, you know, lowering the cost of drugs is a good idea, obviously, with the biosimilars. I don't, I don't know if that doesn't-- has unintended consequences that maybe aren't so-- maybe aren't what was intended initially.

HARDIN: I appreciate you being here.

ANDREW RADUECHEL: Sure.

JACOBSON: Other questions? All right. Seeing none. Thank you.

ANDREW RADUECHEL: Thank you.

JACOBSON: Other proponents. And if you're a proponent, I'd really ask if you'd please come to the front of the room so we can expedite the hearing.

AMY GARWOOD: Good afternoon, Chairperson Jacobson, and members of the committee. My name is Dr. Amy Garwood, that's A-m-y G-a-r-w-o-o-d, and I am a little cog in this wheel. Although we care for-- we had 1,200 new patient encounters last year among our ten providers; 15,000 established patient office visits, and 5,000 visits who only saw our "I-team," which is infusion and injection team, referencing back to the A-team in the good old days, right? So, our I-team is a set of five nurses with a lot of experience administering fancy infusion medicines and subcutaneous shots. And these are all for autoimmune conditions like RA, psoriatic arthritis, systemic lupus, and then injection meds for osteoporosis. And a lot of those patients are on Medicare; straight Medicare, there's no authorization needed. Medicare's great, but we have resisted and declined white bagging and brown bagging for years, because it will put me out of business. It will take the 40 people we employ out of business. I am an unabashed, unashamed capitalist. I'm not ashamed of making a profit. I'm also taking care of people. And my motivation is in the best interests of

my patients. So, I respect that insurance companies and PBMs need to make a, a profit as well, but for 5,000 patient encounters that don't go through an MD, or a PA, or an APRN, I am relying on my inventorying and my protocol and systems in place from my wholesaler. And when an insurance company demands that my patient get infused at their home, I have to argue. And all within the last year, I have to argue with commercially insura-- commercial insurance to please don't make this woman with brutally deformed rheumatoid arthritis who lives in a trailer in rural Thayer County get infused Infliximab at home. That's a medicine that you can have anaphylaxis to, and that is just not safe, and I'm not putting my name to that. So, I've respectfully asked that she get infused at the hospital because it's safer. Or, my 22-year-old lupus patient who has been in the hospital three times in the last two months, who's desperately trying to save her kidneys, gets discharged from the hospital and is on a monthly medicine; her insurance demands that cyclophosphamide get shipped from the PBM specialty pharmacy, and I can't find a single infusion place in the whole county that will infuse her under those circumstances. So, now this woman is back in the hospital on dialysis as a direct result of white bagging. Or, my patient from outstate Nebraska, who I met in the hospital when he was coughing up blood due to vasculitis, a disease that will kill him. I needed four weeks of rituximab; I got the first two in the hospital, and I can't get the second two because his insurance puts up tremendous obstacles for me, as an outpatient physician. I'm begging you, please consider my small business in this regard, and every other private practice doc who provides infusions and injection services. Thanks very much.

JACOBSON: Questions? All right. Seeing none. Thank you. Further proponents? Hello.

AMANDA PEKNY: Hi. Good evening, Chairperson Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Amanda Pekny, A-m-a-n-d-a P-e-k-n-y. I am the pharmacist in charge at CHI Health St. Mary's, an 18-bed hospital that serves the community of Nebraska City. We are fortunate to offer a variety of outpatient specialty care services, including infusion and injection treatments to our patients. I appreciate the opportunity to support LB109. Pharmacy benefit managers and insurance company practices are creating significant barriers, as evidenced by the rise of free drug programs run by PBMs, and mandates to use third-party specialty pharmacies. These practices harm both patients and pharmacies like mine, limiting patient choice and access to care. Here are a few examples. Case 1 is a delay of care. Patient A was prescribed a weekly at-home infusion,

but was required to utilize the white bagging process with their insurance. The specialty pharmacy refused to ship their medication until a prior authorization was approved. Our facility called the pharmacy to arrange for shipment, but due to a holiday, it was closed. The patient had to wait an additional week before they received their medication. Delays in establishing the drug program jeopardized the patient's health by delaying necessary treatment. This could have been avoided if our hospital had been able to directly purchase, purchase the medication. Case 2 is unnecessary waste. Patient B had-- was prescribed a medication that was to be infused every four to eight weeks. The specialty pharmacy auto-shipped the medication every four weeks. The patient's medication was discontinued, and several vials that were shipped had to be wasted as they could not be returned to the specialty pharmacy or to be used for another patient. This shows that white bagging practices can cause waste of expensive medications, and it is not a responsible use of health care resources. Case number three is increased risk. Patient C was prescribed medication costing approximately $50,000 per vial. In this case, the specialty pharmacy did not ship the product until it-- the date it was due to be infused. Because of this, the hospital had to purchase this medication to prevent a delay of care. Our hospital also took a financial risk without guarantee of reimbursement. Utilizing our medication supply disrupts federal requirements for tracking medications, and creates potential risks for the hospital and the patient's plans of future treatments. In summary, LB109 is important for hospitals like mine to deliver high quality care to our patients. Thank you to Senator Bostar for introducing LB109, and to the Banking, Commerce and Insurance company-- or Committee for your consideration for this important patient care and safety issue. And I welcome any questions the, the committee may have.

JACOBSON: Questions? All right. Seeing none. Thank you for your testimony.

AMANDA PEKNY: All right. Thank you.

JACOBSON: Further proponents? Hello.

LISA JURJENS: Hi. Good evening, Chairman Jacobson, and the other members of the committee. My name is Lisa Jurjens, L-i-s-a J-u-r-j-e-n-s, and I've been a registered nurse for over ten years. I work at Cozad Community Hospital, which is a critical-access facility in central Nebraska. I'm the sole full-time infusion nurse at my facility, and have been in this role for three years. Today, I would

like to share some of my personal experiences with you regarding white bagging medications, and how these affect the patients I care for daily. The primary effects I've-- I have observed include delays in patient care, the increase in health care costs, and a significant increase in workload for myself, our hospital pharmacist, and most importantly, the impact it has on my patients. Delays in patient care stem from the complexity of the white bagging process itself. When a patient's insurance company requires a white-bagged medication, the verse-- first step I must make is setting up a time to discuss what this requires of the patient and myself to provide the necessary treatment. This visit alone is an appointment a patient must make, potentially causing them to miss work or school. During our initial discussion, the patient must provide specific information about the specialty pharmacy that is going to provide the medication to our hospital for administration. Most of the time ,the patient does not have knowledge of this information, so I must call a provider or insurance company to obtain it, leading to yet another delay in care. Upon agreement with our white bagging policy, the patient then is required to reach out to the specialty pharmacy to arrange shipment. If there are difficulties in the patient reaching the specialty pharmacy, there's another delay. The medications must be shipped according to strict guidelines to ensure the integrity of the drug. Pending any delays caused directly by the shipping company, the medication arrives at our facility. Our pharmacist inspects the package, and may refuse the medication if storage conditions are inadequate or the medication appears to have been tampered with or damaged in any way. There is another delay for the patient receiving administration, and the additional cost for the med and return shipping. After verification of the medication, I then attempt to schedule the patient to come in for administration. If a patient is unable to take my call, it's likely that there will be ongoing communication delays, as I am frequently occupied with caring for other patients. Subsequent administration is scheduled, but often must be rescheduled due to delays in medication shipments, resulting in patients having to take additional time off for their appointments. We currently have a patient whose insurance mandates a white-bagged medication, and we are facing challenges in obtaining payment for the administration fee. Along with the increased workload, this also places a financial strain on our small critical-access hospital when reimbursement for administration costs are not received. Today, I've shared several examples of how white bag medications disrupt patient care, including delays, lost work time due to phone calls and appointments, and the added financial burden on both the patient and

our facility, as, as well as an increased workload. As a strong advocate for my patients, I trust that you will consider all of these factors in support of LB109. Thank you for your time, and I welcome any questions.

JACOBSON: Questions from the committee? All right. Seeing none. Thank you.

LISA JURJENS: Thank you.

JACOBSON: Next proponent. How, how are you?

SARAH KUHL: Good, thank you. Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Sarah Kuhl, S-a-r-a-h K-u-h-l. I'm the director of infusion and specialty pharmacy at Nebraska Medicine. I'm testifying in support of LB109 on behalf of Nebraska Medicine because it will remove arbitrary barriers that limit our ability to provide extraordinary care to our patients. We've already heard a lot about white bagging, so I want to focus on and share some of the other practices that this bill does to help protect patients. So, LB109 states that a PBM shall not restrict a person's ability to choose how a pharmacy may dispense or deliver a prescription to them. Nebraska Medicine provides patients with the option to receive their prescriptions via in-person or mail delivery. 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 a rural location without a pharmacy nearby. In the fall of 2023, we received notice that one PBM would no longer allow Nebraska Medicine to mail medications to our patients. For the past year, we have fought to try to get into the mail order network, and continue to face new obstacles from the application. We received an overwhelming response from our patients about the impact of this change in access. Opponents of this bill may say that mail delivery will still be available to our patients through the PBMs' mail order pharmacy, however, not all patients prefer to use out-of-state mail order pharmacies, as they do not offer the level of in-person customer service, wraparound support, financial assistance, and integrated pharmacy services that we can provide. LB109 also prohibits PBMs from using unreasonable terms to prevent pharmacies from being in their specialty network. The 2022 PBM Licensure and Regulation Act was passed to allow accredited specialty pharmacies in Nebraska into PBM networks, but now, unreasonable conditions and extensive reporting requirements are being used to restrict access.

Our Nebraska Medicine specialty pharmacy and providers work together to treat chronic, serious, or life-threatening conditions such as cancer or multiple sclerosis. The administrative burden required to meet the terms and conditions from PBMs diverts significant resources from patient care. Some PBMs have started to levy significant fines, or can remove a specialty pharmacy from their network if unreasonable metrics are not met. As an attachment to this testimony, we have provided a timeline of the actions we have taken to meet the terms and conditions to be included in the specialty network of just one of the major PBMs. We have submitted over 1,000 pages of information, exchanged over 100 communications, consumed thousands of hours of time building reports for the application, spent thousands of dollars in consulting and legal fees. After all this, we have resorted to hiring outside legal counsel in hopes we will finalize the contract. PBMs continue implementing strategies that limit patient choice of their preferred pharmacy and disrupt continuity of care between providers and patients with the intent to drive business elsewhere. On behalf of Nebraska Medicine, we respectfully ask you to-- for your support of LB109, and ask the committee to advance this important bill to General File.

JACOBSON: Thank you. Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here. Just curious, as an expert-- I would call you an expert in this industry-- what is articulated to you as the virtue or the benefit of PBMs? When you-- when you're in this world, why do you get told that PBMs are good?

SARAH KUHL: Sure. So, my role at Nebraska Medicine, I have the privilege of also helping support and design our own employee plan. And so, obviously, we have a unique position as being an employer plus also a caregiver for patients. We've struggled and worked really hard to find ways to leverage a PBM in appropriate ways to take care of patients, and find ways to save money and negotiate pricing, but it's not easy for most other employers to do and understand when it's benefiting their patients and their employees, or when it's potentially having other reasons of driving business to another location.

DUNGAN: So between, I guess, your job and your, your expertise and where you work here with Nebraska Medicine, and being told that there's the benefit, do you think it balances? Or, do you think that maybe the PBMs are more problematic than the benefit they provide?

SARAH KUHL: I would say I would look at where PBMs are at for profits this year, and understanding-- I think that tells a lot about why health care costs have gone up so much.

DUNGAN: Thank you.

JACOBSON: Senator Hardin.

HARDIN: This is a damning document.

SARAH KUHL: It's very frustrating. That's after we passed the bill to try to get it to network, and we're still not there.

HARDIN: So, this is someone who is clinging to quality of life or life itself, or lots of [INAUDIBLE]

SARAH KUHL: This bill would certainly help with those.

HARDIN: Thanks for being here.

SARAH KUHL: Thank you.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony. Other proponents of LB109. How are you?

ELIZABETH BOALS-SHIVELY: I'm good. Thank you for the opportunity to testify in favor of LB109. My name is Elizabeth Boals-Shively, E-l-i-z-a-b-e-t-h B-o-a-l-s-S-h-i-v-e-l-y. I'm a pharmacist at Henderson Health Care Services, a critical acc-- critical-access hospital. First and foremost, LB109 is about patient safety, it's about improving care, and it's about having access to medications. My facility has made the decision that we won't do the white bagging process that's being addressed in the bill. It's an ethics decision for us, and that ethics keeps getting questioned when we have patients that-- am I doing more harm than good? But we really refer to DSCSA, the Drug Supply Chain Security Act. We're really supposed to be able to track a drug when it's shipped from the manufacturer all the way to the patient at the vial level, not just this lot or this brand or anything; it's supposed to be a very specific number. We're working towards that. And so, this white bagging process really prohibits that, and inhibits patient safety, as far as we're concerned. We do try to-- if a white bagging process is required, try to get the [INAUDIBLE] bill process approved. It's been successful one time, but otherwise we just have to ship patients sometimes an hour away. You've heard about the storage concerns. Before our current policy, have had

doses just shipped to our nursing home because we're both at 1621 Front Street, and took me about an hour-and-a-half to find it after it said it was delivered because it went to the wrong location. We talk about cost, and I really feel like it's squeezing the balloon, and that the cut's kind of cost neutral, and that PBMs are going to tell you that they're saving money. But I feel like they're getting the profits and we're just getting more costs that we're not getting reimbursed for, so. Thank you for your time today. I really encourage you to advance LB109 to General File.

JACOBSON: Questions from the committee? Seeing none. Thank you for your testimony today. Next proponent. Any other proponents? All right, seeing none. Could there be any opponents? Mr. Blake, how are you? It is evening, yes, yes.

JEREMIAH BLAKE: It is evening, thank you.

JACOBSON: So let's try to avoid night, if we can.

JEREMIAH BLAKE: Try to make this quick. Good evening, Chairman Jacobson 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 director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, and I'm testifying in opposition to LB109. Our opposition to this bill is because it will increase costs for our members, and create new barriers for care for families in rural Nebraska. Nothing in this bill seeks to address the perceived patient safety issues that have been raised by the proponents. Instead, this bill is an attempt to create a state-mandated monopoly on the most expensive prescription drugs in the market. I'd like to give you a few examples of the unscrupulous practices we've seen from hospitals. We had a discussion earlier about some of these very expensive multimillion dollar blockbuster drugs. We had one of those claims come through last year. These are scientific miracles, but they're also very expensive. The member-- our member who was treated with one of these drugs-- the list price on that drug is $2.4 million. The hospital adminis-- that administered that drug submitted a claim in excess of $6 million for that drug. They were asking for a $4 million profit on that one drug. While some may argue that these claims are rare, the incidence of these claims is increasing among our members. But it's not just about the money. The tactics used by some of the Nebraska hospitals are causing stress for families. For example, we had a child in central Nebraska that needed a special-- specialty drug administered by a clinician. The family had been traveling multiple

hours each way for treatment, so we worked with the, the family's-- or, the child's treating physician; we found a local physician who could administer the drug at a local nearby clinic. This worked, worked for a while until we received a call from the mother because the local clinic would no longer administer the drug. When we looked into it, it turns out that the physician was also an employee of the local hospital. Upon, upon finding out about this arrangement, the hospital required the physician to administer the drug at the hospital, and it's not hard to understand why. When the child was receiving treatment at a local clinic, the cost was about $5,000 per incident. At the hospital, the same treatment, same town, for the same child by the same doctor, the same care was provided at $30,000, so they'd marked up the drugs by six times what we were originally paying for it. So, not only did this cause-- this episode cause stress for the family, but it also increased the family's cost sharing obligation as a result. And finally, this bill would exacerbate health care access issues for families in rural Nebraska. We have physicians in our network who ask if we can ship drugs to them because they cannot stock these drugs. This bill makes it nearly impossible to accommodate those requests, requests, meaning that more Nebraskans will have to travel for care. So, this bill will increase costs for the most expensive drugs and make it harder for patients in rural Nebraska to access care. For these reasons, we oppose LB109. I thank you for your attention, and I'd be happy to answer any questions that you have.

JACOBSON: Senator von Gillern. Or, not-- yes, von Gillern.

von GILLERN: Thank you. Thank you, Mr. Blake.

JEREMIAH BLAKE: Yeah.

von GILLERN: The two stories that you told, your scenarios that you shared with us about the, the markup on those drugs, were those--

JEREMIAH BLAKE: Yes.

von GILLERN: --34-- 340B scenarios?

JEREMIAH BLAKE: I don't know. We don't have visibility into whether or not it's a 340B drug.

von GILLERN: Would that be a-- maybe a-- I probably don't want to say if that's a safe assumption, but that sounds like the kind of math that we would see if those were 340B.

JEREMIAH BLAKE: No, so-- well, I don't know is the short answer.

von GILLERN: OK. All right. Thank you.

JEREMIAH BLAKE: When I referenced the $2.4 million, that's what I would consider, like, the advertised price. That's the list price, not any kind of 340B discount.

von GILLERN: Well, one of them you said was $2.4 versus $6 million, the other one $5,000 versus $30,000 at the hospital. The $5,000 versus the $30,000 sounds like it--

JEREMIAH BLAKE: I think--

von GILLERN: --would fall into that category.

JEREMIAH BLAKE: If I had to assume, right? If, if the individual was getting care at a clinic from a physician that was affiliated with the hospital, and there was 340B el-- available for that hospital, that might have carried over to the care they were receiving at a-- at the clinic, so.

von GILLERN: All right. Thank you.

JACOBSON: Other questions? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. Again, thank you for being here. For every action, there's a reaction. If LB109 is passed, what will be the reaction?

JEREMIAH BLAKE: Well, what-- so, what we do right now-- and again, there-- there's somebody behind me that can talk a little bit more about the pharmacy benefit. But Blue Cross Blue Shield doesn't technically do a lot of white bagging. OK? What we do is what we call site-of-care, right? And that's by working with a local outpatient clinic to have a drug administered, and the cost of that care is so much less expensive at an outpatient clinic than it is at the hospital. This bill has language in it that would make it very difficult to maintain those arrangements. So, this effectively would steer all of that care to a hospital where we're seeing these claims for drugs are three to six times more expensive for the same drug. So, if you extrapolate that over a large population of insured individuals, the cost of care is going to go up, claims are going to increase, and premiums will increase.

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

JACOBSON: Other questions? Yes, Senator Wordekemper.

WORDEKEMPER: Thanks for being here. Would this bill increase costs for patients that would order a medication and self-infuse at home, which would not have to go to a hospital or clinic for that infusion?

JEREMIAH BLAKE: So, I think there's language in the bill, if you look at page 3-- well, I think there's language in here, and I, I probably should know this off the top of my head. But I think there's language in here that, that discourages-- I'll use that word, "discourages"-- that type of scenario, right? What we call brown bagging, where you send it to the individual and they self-administer the drug.

WORDEKEMPER: Thank you.

JEREMIAH BLAKE: Yep.

JACOBSON: Other questions? All right, seeing none. Thank you.

JEREMIAH BLAKE: Thank you.

JACOBSON: Other opponent testimony? Hello.

MICHELLE CRIMMINS: Hello. Good afternoon, Chairman Jacobson, and members of the Banking, Commerce and Insurance 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 the government affairs principal and registered lobbyist for 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. Prime helps people get the medicine they need to feel better and live well by managing pharmacy benefits for health plans, employers and government programs, including Medicare and Medicaid. Our company manages pharmacy claims for more than 300,000 Nebraskans, and our business model focuses on purpose beyond profits. We are not publicly traded or owned by a private equity firm, and as such, it is not our primary "motivization"-- motivation to maximize profits. Our primary motivation is to do the right thing. The testimony that we heard from proponents of the bill focused on the importance of ensuring safe access to prescription drugs, and Prime agrees that patient safety is a top priority. And I'd like to thank Senator Bostar and the "commitity" members for providing the opportunity to discuss the tools in place to ensure safe delivery of prescription drugs by specialty

pharmacies and mail order pharmacies. I'm testifying in opposition to LB109 as introduced, because the bill, as written, impacts our ability to ensure safe and affordable access to prescription drugs. PBMs require all pharmacies to meet a set of requirements to join their networks, referred to as the credentialing process. To join a PBM's network, specialty pharmacies and mail order pharmacies are required to prove their ability to safely dispense specialty drugs by obtaining accreditation from independent accreditation organizations. One accreditation organization is the Utilization Review Accreditation Commission, or URAC. To gain URAC accreditation, pharmacies must submit documentation proving that they meet infrastructure requirements, have proper pharmacy operation procedures in place, medication distribution and patient service standards, as well as performance monitoring processes. Every year, URAC releases a report showing the performance metrics of accredited specialty and mail order pharmacies. I've provided each of you the most recent report for both specialty pharmacies and mail order pharmacies. Both reports show that prescription drugs are delivered successfully and accurately to the intended dest-- destinations with more than 99% accuracy. You'll also see a 97% customer satisfaction rate for specialty pharmacies. So, you may be wondering how this applies to LB109. Section 1 of the bill prohibits plans from requiring the use of white bagging. White bag drugs are delivered by specialty pharmacies to the hospital or clinic, and many hospitals and clinics use the same specialty pharmacies to deliver drug-- the drugs used in their clinic outside the white bag process. The safety of the drug delivery is the same, whether it's been ordered by the clinic or the PBM. The URAC reports provided show that the specialty drug deliveries are very safe. Section 2 allows retail community pharmacies to mail prescription drugs to patients without meeting the requirements of a mail order network. This means there will be no oversight to ensure the pharmacy has the infrastructure in place to safely mail the prescriptions, or that there are processes in place to ensure the drug is safely delivered. For example, what happens when a drug is shipped across the state and it's not delivered as expected? For this reason, we oppose LB109 as introduced, and stand ready to work with the committee to resolve our concerns. Thank you, Senator Bostar, for introducing the important bill, and I'm happy to answer any questions.

JACOBSON: Any questions from the committee? Senator Hardin.

HARDIN: This is a terrible question. I apologize in advance. Do we need to change how we do drugs, how we distribute drugs? We have a manufacturer that makes them. Eventually someone takes it, and we

really do have amazing results with what can happen today with these drugs. In between those two places is where all of the consternation takes place, right? And so, one place, they'll-- spends-- requires a lot more money for the exact same drug; we have time issues, we have delivery issues, we have safety issues. If the patient doesn't get the drug when they need the drug, that's a safety issue in and of itself. We have all these challenges. Should we change the model so that it frankly works more like banking? Or that it works more like the electrical provision, or something like that? Whoever's closest wins, and we start with the needs of the patient first. And so that-- I'm just, you know, posing the question, are we thinking about this wrong? So that the ownership doesn't start all the way through, because there's a lot of these drugs that can be provisioned from multiple places, sources. Right? This PBM has it, but so does this PBM over here-- has access to that same drug. Whoever gets to the patient first wins. And I'm just saying, I think we're maybe doing this distribution thing the old way and not the best way. I just wanted to pose that question. Would you comment on that for me?

MICHELLE CRIMMINS: Yeah, I think you'd be hard-pressed to find anyone that says that our system works perfectly. Right? I-- working for a PBM, I think Prime would agree there's room for improvement, and we actively work to improve it every single day. I think with your question, it's important to realize that different drugs have different requirements that they need. Like, we heard earlier about drugs that need refrigeration. There's a very special--

HARDIN: Can I get this in? Just so you know, I've worked in the industry a very long time, and so I understand those dynamics and we are trying to get it for the record, and so that's good. But let's say-- all things being equal, let's say that that specific drug for this specific, appropriately diagnosed situation-- because I have had clients who have sat and waited for very expensive Tier 4 medicines to be delivered in exactly this white bagging situation while their health suffered miserably.

MICHELLE CRIMMINS: Mmhmm.

HARDIN: And so, I'm saying we just knew for a fact that it was right down the street, but they couldn't get access to it.

MICHELLE CRIMMINS: Mmhmm. I will say Prime Therapeutics is a practice that does not rely on white bagging, but we do need to ensure that our customers have affordable access to drugs. So, the examples that

Jeremiah provided, where there's large markups by the hospitals for prescription drugs-- if they would negotiate to get reimbursed the same amount that a specialty pharmacy would, that would resolve the problem, but we don't see that. And I think everyone can think of an example where you hear about someone goes into the hospital and they get an Advil that you can go to CVS down the street and get for a couple dollars, and you have $100 charge.

HARDIN: Right. And there are a few bad actors among those hospitals out there. I won't deny that. But at the same time, there's also tremendous bad acting in PBMs with something called drug rebates. There's not a drug rebate; there are seven drug rebates, and they're worth a lot. They're like bearer bonds, and they can end up in the strangest of places. They're ostensibly supposed to be for employers or basically the met consumer for those really expensive drugs, right? And I'm just saying both have their own world of bad acting. The hospitals have some bad actors, and so do the PBMs. And that's why I'm saying, do we need to rethink this whole middle section about how we distribute drugs? Because they're wonderful. We have amazing scientists who are coming up with astonishing things. I have friends who've had cancer, the same cancer more than once, who've said, hey, the second time I had it five years later, didn't even know I had it because of the amazing drug I was able to take. OK? I'm just posing the question and saying I think that somehow we have to remodel this whole industry.

MICHELLE CRIMMINS: Well, thank you for that comment. I think we both agree that it's, you know, amazing what the drugs do for patients today, and we want to make sure everyone has the access at an affordable rate.

HARDIN: Yeah. Thanks for being here.

MICHELLE CRIMMINS: Thank you.

JACOBSON: Other questions? I would just mention, probably on defense of hospitals and charging-- upcharging for an aspirin or an Advil, they-- as we know, when you look at reimbursements for Medicare, Medicaid, which is a high percentage of the population they see, and if they lose money on those patients, they don't get fully reimbursed. Consequently, the insurance-- private insurance-- insurers have to step up and make up the difference. Or, you're look-- looking at upcharging for things like that in the hospital, to really make it come back into balance. The key is, is that hospitals, if you look

across the state, their margins are very, very tight, and, and it's, it's-- it makes it very difficult. But with that said, I guess I did want to point out, if I'm not mistaken, Prime Therapeutics is partially owned by Blue Cross Blue Shield?

MICHELLE CRIMMINS: That's correct.

JACOBSON: And Blue Cross Blue Shield is a mutual--

MICHELLE CRIMMINS: Correct.

JACOBSON: --insurance company based in Nebraska.

MICHELLE CRIMMINS: Correct.

JACOBSON: Yeah. So, it's not like we have a private equity company out there owning them, it's not like they've got a big shareholder base. This is their profit, so to speak, come back in to the members itself, and-- which are the insurers.

MICHELLE CRIMMINS: That's correct.

JACOBSON: So, it kind of-- it circulates back to premiums, I think, to Senator Riepe's point earlier that, you know, this is somewhat of a zero-sum game when you look at it from that standpoint, so. So, I appreciate the testimony. This is a very, very complicated subject, and I think we got two more testifiers here that are probably going to shed a little more light on this, so. I don't know who's next, but thank you for your testimony.

MICHELLE CRIMMINS: Thank you.

ROBERT M. BELL: We'll give you a break before you get another PBM up here, but-- good afternoon, 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 the executive director and registered lobbyist for the Nebraska Insurance Federation, and I appear today in respectful opposition to LB109. You know that the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies, including most of the health plans. I do want to express my appreciation to Senator Bostar for trying to bring together the medical providers and the insurance companies over the years on white bagging. You're actually going to-- and that's like bringing in two groups that don't want to agree on this one issue, which is difficult. I, I will point out on March 3, you're going to

hear a bill-- and that is LB533 by Senator Kauth-- and that provides safety provisions related to many of the concerns that you heard today related to tracking of drugs and the safety of the drugs provided in the white bagging process, or the brown bagging process. And so, we do take patient safety, obviously, seriously; we do take finances very seriously. So, you know, I think in a perfect world-- not that we live in a perfect world, but if there was a drug out there that cost $5,000, it wouldn't matter if it was coming from the hospital, or if the payer was commercial insurance or Medicaid or Medicare, that hospital would be appropriately compensated for that, and then paid for their administration as well, which they are under white bagging. And, you know, the consumer would just have to pay that, that $5,000. I think-- just a, a couple of other points I wanted to talk about. I-- you know, Senator Dungan asked a question of whether or not, you know-- what would happen if PBMs didn't exist. I don't know the answer to that, to be honest with you. Maybe we're about ready to find out. I don't know, if I'm reading the Wall Street Journal accurately. A drug that costs $1.7 million-- and we heard a, a drug about costing $2.4 million. The, the PBM's role, to some degree, is to negotiate that price down for the insurance company. And if we're running into drugs costing that much, it's, it's pretty frustrating, right? I mean, why does it-- why does a drug cost that much money? But I'm going to come back to that point in just a, a minute. But I, I will say there are PBM provisions in this as well, related to mail order, related to specialty pharmacy. We're certainly open to have further discussions on that; we're also open to have further discussions on if we can come to some sort of compromise related to safety and cost. Again, we-- you know, we kind of feel like we're getting gouged, or our premium payers are, on some of those situations that Jeremiah brought-- or, Mr. Blake brought up. Final, final point on the $1.7 million, and the two point-- I mean-- and I've been waiting to say this for a while-- it's kind of a miracle, right? That you-- one, the, the science is a miracle, but two, that you have a financial product that, that you purchase for a lot of money, but that is going to pay that amount for you to, to save your life. I mean, most Americans are going to be unable to pay that without heavy financing by a bank, maybe. And I can't afford a $1.7 million drug, right? Not without the whole group. Everybody providing a little bit of, of money for that. So, there are good things about insurance, right? So that we can share in that risk. With that, I appreciate the opportunity to testify. Thank you.

JACOBSON: Questions for Mr. Bell? All right. Seeing none. Next opponent. Is there anybody else going to testify on the-- on this bill? Mr. Head, welcome.

BILL HEAD: Mr. Chairman. Saving me-- saving the worst for last, I guess.

JACOBSON: I, I didn't say that. I didn't say that.

BILL HEAD: Chair, Chair Jacobson, and members of the committee, my name is Bill Head, B-i-l-l H-e-a-d. And I'll repeat that. I know it's complicated. It's great to be here. I want to say I represent the, the Pharmaceutical Care Management Association, which is a mouthful, I know. PCMA. We represent the PBM trade association. On a personal note, it's always great to be back in Nebraska. I went to school here, including law school on East Campus. I worked in LRD and PRO for a number of years, and I have lots of family and friends here, so despite being respectfully in opposition to Senator Bostar's bill, I'm-- it's a pleasure to be before you. I want to spend a couple of minutes talking about PBMs in, in response to some of the things that were said, and then I'll get to specific concerns about the bill. Every single state employee program, including Nebraska, hires a PBM. Virtually every state Medicaid program, including Nebraska, hires a PBM. And they do this because PBMs save money. I can appreciate, though, the pharmacist perspective, which is, OK, just make sure that savings is a-- are, are back. And I, and, and, and I get that. But it is a very common-- I think as Senator Hardin was sort of alluding to-- it is a very complex system. I don't think it was intentionally designed that way, but certainly, like, on the medical side too, it's been piecemeal and it's very complex. So it's the real "palloon"-- balloon; when you push in one side, it pushes out the other. In Nebraska, PBMs help manage the drug benefit for about 1.7 million Nebraskans. And again, it's because they save money. According to the FDA, the average cost of a new drug is over $200,000. So, somebody has to help manage that cost and try to bring that cost down. In congressional testimony, the CEO of Novo Nordisk, which manufactures Ozempic, stated that the people with health insurance pay an average of $35 a month. Those people with health insurance-- those health insurers, excuse me, have a PBM, which brings down that cost. And it was mentioned about profit margins-- I would encourage you to just Google it; don't take my word for it-- what the profit margins are for everybody in the drug supply chain, starting with the manufacturer and PBMs. Running short on time. I do want to get to the specifics on the bill, where section-- Sections 2 and Section 3 dealing with mail

order. Not complying with the terms and conditions means that they can mail drugs without having a mail license. In-- under the court of-- the board of-- Nebraska Board of Pharmacy, if you want to be a mail facility, you have to have a mail order license, particularly if you're going to-- then send them out-of-state, you have to have a license in the state your mailing to as well. And on accreditation, what we had talked about on both these issues at, I think, our last stakeholder meeting was-- and we agree with this-- is the PBMs should not impose standards or requirements on non, non-PBM-affiliated pharmacies that they-- different standards on non-- non-affiliated pharmacies, if that makes sense. Is that it'd be a fair and level playing field for all pharmacies so that they could mail, but it's under the same terms and conditions, and the accreditation, same terms and conditions as, as well. So the-- and we shared amendments to try to get to that point with the senator's office. So, with that, I'm happy to answer any questions.

JACOBSON: Questions? I know you traveled a long way to get here. And I-- we've had this conversation as recently as last night, but depending on where we go with this-- and it's still my intention to-- I doubt if we're going to solve all the issues on PBMs this session, and it would be in my intention to have hearings next summer on a, on an interim study, to really get all the parties together and try to shake out-- there's a lot of finger-pointing back and forth, and I think there's, there's a solution here that we've all got to kind of earnestly try to figure out how to get to it. And that would be getting big pharma in the, in the room as well, who really sets the drug prices.

BILL HEAD: Yeah. Absolutely. Happy to come back in any time. Again, it's always a pleasure, so.

JACOBSON: All right. Thank you.

BILL HEAD: Thank you.

JACOBSON: Any questions? Otherwise, thank you. And Senator Bostar, there were 11 proponent letters, 0 opponent letters, 1 neutral. We did not receive any written ADA testimony. Please take all the time you need for your close.

BOSTAR: Just, just to be clear there, there's no neutral?

JACOBSON: I think I asked if anybody-- is there any neutral testifiers? I didn't think so. I thought that.

von GILLERN: Safe bet.

JACOBSON: But thank you, yeah.

BOSTAR: Generally on issues like this, people feel one way or they feel the other way. So--.

JACOBSON: It's hard to be neutral.

BOSTAR: It's fair that there are no neutral testifiers. Well, thank you, Chair Jacobson, members of the committee, for a, a, an exciting day. You know, there's obviously a lot to, to kind of take in here. The white bagging issue is, is a real issue; it deserves attention. There is-- I think, Mr. Chair, as you said, there's, there's a solution out there, and one that we should very much try to find, and I hope as a committee we have that motivation. On some of these other issues in the bill, you know, we did, we did a lot of PB-- well, we've done a lot of PBM work every year for the last-- since I've been here. But we passed, really, a large PBM sort of package reform bill. It was, it was Kolterman, then-Senator Mark Kolterman bill something like four years ago. Maybe it was three. And I think we've-- Senator Riepe, you probably served with Kolterman, and you did, maybe, for a minute as well, Mr. Chair. And that, and that was the product of-- you know, I think he'd, he'd introduced it four years ago, we passed it three years ago, we spent a year in continuous meetings. Most of the people behind me were sort of there as well. And, and we found a place to, to land, and we passed it. And that was, that was important. It was important that we got that done. Some of the things-- and this is one of the challenges with term limits, because there were a lot of agreements that were made throughout that that were supposed to be represented in the bill, and were generally represented, but, you know, where there are opportunities to find gaps in statute, you know, I think if money's involved, rest assured someone will try to find them. And so, that's what some of this is here today as well. We-- our intent was very clear that non-affiliated pharmacies should be able to join the, the, the PBM network pharmacy. And we put in accreditation requirements and everything else. And sure enough, as soon as that bill was passed and other pharmacies wanted to join, the PBMs went above and beyond accreditation requirements and made up a whole bunch of new ones about everything that these pharmacies had to comply with. And, and it-- so, it was interesting when the representative from

Prime talked about URAC, the-- one of the accreditors-- about how-- why we should have faith in the process because they're accredited, and accredited means so much and it's so valuable, and they're checking everything. But at the same time, when an outside pharmacy wants to join the network, URAC's not enough. They want to require everything else, too. And they'll say they make their own pharmacy also comply with the mountains of paperwork and documents, but they're all sitting in the same office, so they're shoveling paper from one desk the other, going, "Look at that. We complied!" At the same time, all other pharmacies that aren't affiliated can't get in because every time they get close to complying, PBM networks got a new requirement they absolutely need. So, one of the things this bill says is accreditation is enough. And you heard today from the testimony that PBMs believe that accreditation is immensely valuable. It's everything. So, we should be satisfied with a pharmacy that can meet those standards of accreditation to join those networks. And that was the intent of the bill four years ago, and folks found a way around it. And if you look at the law, we wrote it in there, but that's not what's happening today. The other thing that's happening is-- you know, we can talk about some bad actors and, and folks doing some things that we would find distasteful, and one of those is if you're currently receiving your medication from your local pharmacy via mail. Let's say you live out in rural Nebraska, you get your-- you get your meds via mail, the PBM can tell your local pharmacy that you're not allowed to mail it anymore and prohibit you from doing so. So then, your pharmacy tells you we're sorry, we know you've been getting your, your meds by mail, but we're no longer-- we can't mail it to you anymore, you got to come in and pick them up. Maybe that's a two-hour drive, depending on where you live. So, that's really frustrating for that individual. But then, you get contacted by a PBM specialty pharmacy and they tell you, "Why don't you switch to us? We'll mail it to you." There's no safety issue here. It's the same drug being mailed. It's just a simple way of trying to, frankly, steal customers from local pharmacies. That's the other thing this bill does, too, is it would say that they can't prohibit a pharmacy from dispensing medication via mail or delivery, particularly when the specialty pharmacy-- the PBM's pharmacy-- is doing the exact same thing, and they just want to stop a local pharmacy from doing it so that they can go to that individual and say, if you still want the convenience of mail, you've got to switch to us. It's bullying. We've had a long day. Happy to answer any questions.

JACOBSON: Questions for Senator Bostar? It has been a long day. All right, seeing none, that will conclude our hearing on LB109, and for the committee, we're not going to exec tonight, but I think we have--

von GILLERN: Come on.

JACOBSON: --an amendment on the, on the 340B--