JACOBSON: OK. I think we're going to go ahead and get started. Welcome to the Banking, Commerce and Insurance Committee. My name is Mike Jacobson. I'm representing the 42nd District, Nebraska Legislature. The committee will take up the bills in the order posted. This public hearing is your, your opportunity to be part of the 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 on the table at the back of the room. Be sure to print clearly and fill it out completely. When it is your turn to come forward to testify, give the testifier sheet to the page or to the committee clerk. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets on the back table of the-- for each bill. These sheets would be included as an exhibit in an 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 an ac-- that way, we can ensure we can get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents to the bill, then opponents to the bill, and finally by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We will be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining. And the red light indicates you need to wrap up your final thought and stop. Questions from the committee may follow, which would of course be there to also allow you to say more about your testimony should they ask you a question. Also, committee members may come and go through 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. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the ro-- the hearing. Finally, committee procedures for all committees state that written position comments on the bill to be included in the record must be submitted by 8 a.m. on the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in, in person before the committee will be included on the committee statement. I will now have the committee members with us today to introduce themselves, starting on my left.

RIEPE: Thank you, Chairman. I'm Merv Riepe, and I represent Omaha, Millard, and the little town of Ralston.

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

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

DUNGAN: George Dungan, LD 26: northeast Lincoln.

JACOBSON: Also assisting the committee today: to my right is our legal counsel, Joshua Christolear; and to my left is our committee clerk, Natalie Schunk. Our pages for the committee are here today, and I'm going to have them introduce themselves.

KATHRYN SINGH: I'm Kathryn. I'm a third-year environmental and sustainability studies major at UNL.

AYDEN TOPPING: I'm Ayden. I'm a second-year psychology major at UNL.

JACOBSON: With that, we will begin today's hearing with LB410. Senator Cavanaugh, you're welcome to open.

J. CAVANAUGH: Thank you, Chairman. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Senator John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h. And I represent the 9th Legislative District in midtown Omaha. And I'm here to introduce LB410, which clarifies that prosthetics and orthotics which are medically necessary shall be covered by insurance plans in Nebraska. Prosthetics and, and orthotics are important for people who have suffered limb loss, but currently many insurers in Nebraska do not consider them as an essential health benefit covered by the Patient Protection and Affordable Care Act. LB410 is similar to the bill I introduced last year: LB1274. Most of the provisions of the bill are the same, but the sections which require reimbursement at Medicare rates has been removed. You'll hear from testifiers behind me with their personal experience, and I encourage you to listen to their stories. The devices are medically necessary, and Nebraska law should reflect that. Thank you for your time and I-- and consideration. Happy to take any questions.

JACOBSON: Questions? All right. Seeing none. Thank you. Will you re-- stay for the close?

J. CAVANAUGH: Of course.

JACOBSON: I figured you might. All right. I'll ask for the first proponent to please step forward and--

NATHAN WIGDAHL: Hello. My name is Nathan-- oh, sorry. My name is Nathan Wigdahl, N-a-t-h-a-n; last name, Wigdahl, W-i-g-d-a-h-l. I'm a community pharmacist. I practiced in Omaha for a little more than 20 years. And I'm also a below-the-knee amputee. And I'm also one of the founders of the Amputee Wellness Alliance of the Midlands. My amputee journey began in 2006. I was a highly competitive triathlete. Just completed my second Ironman distance triathlon. Unfortunately, I sustained an extremely severe ankle injury during a pickup soccer game. I broke my leg in seven different places, tore every ligament, and did a tremendous amount of cartilage damage. I went from basically being able to run marathons to not being able to take a step without significant pain. I lived with that pain with every step for the next 12 years until we made the eventual decision to amputate my left lower leg. I made this decision to amputate my leg in order to eliminate the pain I felt in every step. I made that decision to get my activity level back. And I made that decision to get my life back. Shortly after my amputation surgery, I found out that my insurance company had denied my first prosthetic. They deemed it not medically necessary. So here I am, a guy who a few years ago finished a 2.4-mile swim, a 112-mile bike, and a 26.2-mile run in one day, and now I'm fighting my insurance company tooth and nail to prove that I'm worthy of even the most basic prosthetic. This is precisely why my wife and I started the nonprofit. We saw the tremendous gap between what amputees need to live a full, active life and what insurance companies will approve. We've given out more than $100,000 of prosthetics to amputees that couldn't get these life-fulfilling devices from their insurance companies. We shouldn't have to do this. Insurance companies need to be held accountable and provide their members the devices that allow them to live fulfilling lives. This legislation is a start to holding these companies accountable. I'm sure we're going to hear, you know, people talk about the need to negotiate with suppliers and practitioners. Well, they've been doing that for years. And it may be working for their bottom line, but it's sure not working for Nebraska amputees. We certainly deserve better.

JACOBSON: Thank you. Questions? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here today, sir. I appreciate you sharing your story. I think that's really helpful for us to understand kind of the context of what we're talking about. Can you just, I guess, big picture give us an idea as to what kind of out-of-pocket costs you were looking at through this entire process?

Because I imagine, you know, between the, the surgery originally, the 12 years you had to deal with that, and then ultimately the amputation, that probably was quite a bit. Can you just give us a idea of how much this has costed you over time?

NATHAN WIGDAHL: Easily-- yeah. Easily in the six figures. Because, I mean, we have a, a high deductible plan, as many people do, and we hit our deductible every single year. And this has been going on since 2005, so. I mean, it-- easily in the six figures. I hesitate to even put a, a total, you know, beyond that. But it, it's, it's been a lot.

DUNGAN: And then just to make sure I understand it better, what kind of process did you have to go through in terms of the negotiation with the insurance company? You said they denied even the most basic prosthetic. What was that back-and-forth like in terms of your interactions with the company?

NATHAN WIGDAHL: So with me, I didn't have to do a whole lot. A lot of it was my prosthetic company that I was going to dealing with that and going through that appeals process, which took some time, you know. And that's-- it was something that I was, you know, after I, I was healed up, I wanted to get immediately on a prosthetic, but we had to go through that appeals process, which delayed everything.

DUNGAN: OK. Well, I appreciate you kind of outlining the, the process for us. I think that's helpful to understand. Thank you.

NATHAN WIGDAHL: All right.

JACOBSON: Are there que-- committee questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. My question I-- would be is on a personal choice. Did you choose-- intentionally choose a high deductible?

NATHAN WIGDAHL: We chose the plan that would be-- that we thought would be the most beneficial for our family, you know. But weighing the costs of-- you know-- and it's a difficult balance to weigh the costs of, you know, how much we're paying in premiums each, you know, each paycheck and then what we're going to have to spend out-of-pocket. So, yeah. I mean, that, that was the plan that we felt that was best for our family.

RIEPE: So as a pharmacist, you don't have-- you're not in an employer's plan. You're on your own--

NATHAN WIGDAHL: No, we're-- I, I-- yeah. I was on my employer's plan, so I didn't get to choose which company I went with. It was all the same company--

RIEPE: But you had to choose--

NATHAN WIGDAHL: I got to choose which, which level, yes.

RIEPE: --the balance between premium payments and what benefits you got.

NATHAN WIGDAHL: Correct.

RIEPE: OK. Thank you. Thank you.

JACOBSON: Other questions? I'm just curious. You mentioned that you hit your deductible every year. What-- why are you hitting the, the-- is that rela-- and related-- directly related to your pros-- prosthetic?

NATHAN WIGDAHL: Absolutely. Yeah. The-- prosthetics require, you know, constant updating, repair. They wear out quickly. Liners, sleeves, all that stuff wears out really, really fast. And typically, insurance is only going to cover two per year. And, you know, I can get a sleeve tomorrow and bump my leg on a, on a table and it's got a hole in it. So, you know, they, they just-- the potential for wearing out is, is really really high.

JACOBSON: And, and just to be clear, when-- so when you elected to have the surgery done, which, which-- obviously, I'd have done the same thing if I was dealing with that kind of pain. So-- but when you elected to have the surgery done, I, I'm gathering the insurance company paid for the surgery but were, were-- you were getting some pushback on what prosthetic you chose. Is that what it was?

NATHAN WIGDAHL: Correct. Yeah. It-- yeah. And it wasn't even, you know, a high level, necessarily, you know, that-- it wa-- it was one of the more basic level prosthetics for my first prosthetic. So we were incredibly confused on why that would be denied.

JACOBSON: Gotcha. OK. Thank you. Other questions? If not, thank you for your testimony. Thank you for being here.

NATHAN WIGDAHL: All right. Thank you.

JACOBSON: Next proponent. How are you?

MATTHEW NOLDE: I'm good. How are you?

JACOBSON: Good.

MATTHEW NOLDE: Good. My name is Matthew Nolde; last name, N-o-l-d-e. A little bit about me. I'm a father of two. My daughter's 20. My son is 18. I've been a public school teacher for 20 years. And I am a congenital amputee. So that means when I was born many years ago, I did not have my feet. I did not have my hands, obviously. I wear prosthetic legs to help me walk, live a fairly normal life, I suppose. Normal's kind of a hard word to define, but a life that I feel proud to live. A life where I can walk instead of relying on a chair. It has helped me become the person I am, the teacher I am, being active in my children's lives as they grew up. I would not have been able to do that without my prosthetic limbs. As a child, I got my prosthetic limbs from the Shriners Hospital. As soon as I became an adult, that option was no longer available. And the battle with insurance companies began. Amputees, whether they're congenital amputees like myself or someone who has been in an accident-- maybe a veteran, maybe cancer, maybe diabetes-- they're just really wanting to return a life of normalcy. And it's a battle for them to get to that point. I kind of compare it to the subzero temps we had recently. You're not going to go out, shovel your snow and flip-flops, right? I mean, maybe if you're a teenage boy. My son would probably do that. But in honesty, you're going to bundle up. You're going to wear a snow suit, overalls, and boots. That's all that amputees are asking for, is just the necessities to return back to a normal life. Some information I found yesterday about the total population of disabled people in Nebraska. It was from 9-- 2019. About 220,000 people-- very comparable to the population of Lincoln-- 37,000 of those people-- kind of like Kearney-- are amputees. Without appropriate and necessary coverage, we'll face additional health constraints, external struggles such as poverty, social exclusion. A lot of disabled amputees see cost as a barrier to obtaining care. The rise in obesity, high blood pressure, and other chronic diseases like diabetes will continue to occur should these folks not get the appropriate coverage. They're not asking for much. Not a Lamborghini, just maybe a Geo Metro. Right? Just the basics. All right. Thank you.

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

RIEPE: OK. Thank you, Chairman. My question would be, this-- as-- my experience is-- my late wife was a teacher, but that both teachers' health benefit plans are very generous, and so are state employees',

quite frankly. So which-- the health-- did you-- were you on the school plan or are you-- you're still a teacher?

MATTHEW NOLDE: Yes, sir.

RIEPE: Are you still on the health school plan?

MATTHEW NOLDE: Yes, sir.

RIEPE: Is it-- did it not cover this?

MATTHEW NOLDE: It depends on what, what leg or, or additional limb that I'm trying to get covered. Like Nate was saying, the basics can be covered at times, cannot be covered. I do also pay my full deductible every year because of [INAUDIBLE] like this.

RIEPE: And you too have a high deductible?

MATTHEW NOLDE: You know, I have my-- both of my kids on my plan. I'm a single father. Have been for-- since 2008. So like Nate said, I chose the best plan for my family. I've taught in many districts, and so between districts that plan may change. Sometimes they pay for the premium. Sometimes you have to take it out of your paycheck. But I try, personally, to make sure that deductible and premium are somewhat comparable.

RIEPE: What, what they would allow for your prostheses was not adequate, is that what you're saying?

MATTHEW NOLDE: I get the bare minimum, pretty much.

RIEPE: In terms of prostheses?

MATTHEW NOLDE: Yes.

RIEPE: OK. OK. Thank you, Chairman.

JACOBSON: Senator Hardin.

HARDIN: Thanks for being here. Of those 37,000 amputees, do, do you ha-- know any statistics or any information about how many of those might be covered by major medical like you have versus others that just don't have that at all?

MATTHEW NOLDE: Unfortunately, I don't.

HARDIN: OK.

MATTHEW NOLDE: I apologize.

HARDIN: OK. Thank you.

RIEPE: Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. And again, thank you for being here. Just for the, I guess, edification of the committee, can you explain a little bit as to what the difference is between sort of the, for lack of a better way to put it, the low-end prosthetics versus the high-end prosthetics? Like, why, why is it necessary or why would you feel it necessary to make sure you're getting a higher end product or quality product?

MATTHEW NOLDE: Right. Well, I can speak honestly about my experiences. Being a below-knee amputee, I don't have to worry about the structure that's going to be put in place for a knee, which can sometimes-- I've spoke to other amputees-- be denied because of the high technology that involves. Mine are very comparable to what I used to wear even 20 years ago. I mean, they're very low in cost. They're not going to-- I can't tell you how many times I've broken the foot part of my prosthetics because I'm just-- I mean, they're wear and tear, you know? You buy new shoes probably twice a year, right? So you think about the wear and tear of a prosthetic. It needs to be replaced. And like Nate had mentioned, sometimes insurance companies only allow you to replace them so many times a year. So there have been times where I've had to deal with a broken prosthetic foot for a year, you know, before I could get it replaced. But as far as, like, the technologies and all of the medical terms that go into it, unfortunately I can't speak to that, you know. I'm a teacher. My, my level of expertise kind of gets cut off at a certain spot.

DUNGAN: Sure. Where do you teach at?

MATTHEW NOLDE: I currently teach at Conestoga Public Schools.

DUNGAN: Got it. Thank you for being here. Appreciate it.

MATTHEW NOLDE: Thank you.

JACOBSON: Senator von Gillern.

von GILLERN: Yeah. Thank you-- don't go anywhere yet. You say relatively low cost. I don't know if that means $100, $1,000, $10,000. Can you give us some kind of range--

MATTHEW NOLDE: Oh, it's in the thousands.

von GILLERN: --and perspective?

MATTHEW NOLDE: It's in the thousands, for sure.

von GILLERN: Thousands of dollars for a single below-the-knee--

MATTHEW NOLDE: If you're looking at--

von GILLERN: --prosthetic?

MATTHEW NOLDE: --[INAUDIBLE], it'd be twice that. For example, my prosthetic socks, I-- Nate talked about a sleeve. I still wear the old-school socks. It's kind of like a nylon. And then a couple cotton socks. Just last year, I had to get six pair, and it was $600. You know, I could go to Kohl's and buy a pair of socks for, you know, $10 or $12 or something, and-- but prosthetics--

von GILLERN: You might have nicer socks than I have.

MATTHEW NOLDE: --you know. Prosthetic socks are for some reason very expensive, so.

von GILLERN: OK. All right. Thank you. That helps put some perspective on that. Thank you.

MATTHEW NOLDE: Yeah.

JACOBSON: Other questions? All right. Seeing none. Thank you for being here. Thanks for your testimony.

MATTHEW NOLDE: Thank you.

JACOBSON: Additional proponents? Go ahead.

TRACY MILIUS: Good afternoon. My name is Tracy Milius, M-i-l-i-u-s. I have been an occupational therapist in the state of Nebraska for 33 years. And two years ago, my daughter-in-law-- who was 25 years old at the time-- was in an accident that resulted in a surgical amputation of her left arm below the elbow. This obviously was a life-changing event for this young woman. As she was in her initial stages of recovery, her doctors ordered a prosthetic device to improve her ability to perform functional activities and to live as independently as possible. Her doctors provided extensive evidence and research to support the medical necessity and the efficacy of a prosthetic for this young person, yet the prosthetic device was denied by her insurance provider. I worked

closely with my daughter-in-law and her entire medical team to repeal the claim time after time until all of the appeals were exhausted and the final decision of a denial was given. In these appeals, I noted countless everyday tasks that she could not perform efficiently without excessive wear and tear on her only remaining extremity. These tasks included but are certainly not limited to washing and drying dishes, lifting heavy pots and pans, removing a casserole dish from the oven, or a Thanksgiving turkey for her family, using a rolling pin with two hands, using a broom and a dust mop with two hands to clean her floors. In fact, she was not even able to lock or unlock the apartment door where she and my son lived. It required two hands, one to tightly grasp the knob and pull the door tight and a second hand to turn the lock in the deadbolt. So therefore she was not able to do that independently. And despite this long list of functional daily activities affected by her one hand use, the claim was, was eventually denied. And now, a little over two years after her accident, she has developed pain and limited movement with her remaining right hand due to overuse syndrome. You see, that's what happens when you only have one hand to type-- she's an accountant and uses her one hand all day to type-- to wash your long hair, to tie your shoes, to zip your coat. Overuse syndrome develops. That was specifically addressed in the appeals that confirm the medical necessity, but the insurance companies chose to ignore it. I just ask today that you consider this bill to ensure that all patients with commercial insurance have equity with the same level of coverage that patients that were on disability or receiving Medicare would receive. Thank you.

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

RIEPE: Thank you, Chairman. I guess my question-- and I'm not trying to be unduly invasive, but I assume if there was an automobile accident, there might have been a lifetime settlement for, for, for-- there was no settlement?

TRACY MILIUS: It was not an automobile accident.

RIEPE: I thought you said it was an automobile--

TRACY MILIUS: It wa-- it was just an accident.

RIEPE: Oh.

TRACY MILIUS: Sorry.

RIEPE: An accident.

TRACY MILIUS: Yeah, it was an accident. It was not automobile. And she reze-- received zero settlement from anything from the accident.

RIEPE: You're kidding. OK. Thank you, Chairman.

JACOBSON: Other questions? All right. Seeing none. Thank you for testimony. Additional proponents. Any other proponents? OK. If you're going to speak, you, you might get near the front so we can keep, keep the testimony moving. Is there anyone else going to speak as a proponent? OK. Two more. All right. Person in back, if you could move towards the front, that'd be great. Go ahead.

NICK WEBER: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Nick Weber, spelled N-i-c-k W-e-b-e-r. I'm a physical therapist and serve as President of the Nebraska Chapter of the American Physical Therapy Association. I'm here to represent our membership of over 1,400 physical therapists, physical therapists assistants, and students of accredited PT and PTA programs in Nebraska. I want to start by thanking you for your attention to this important topic today. On behalf of APTA-Nebraska, I sit in front of you today to show our support for LB410. LB410 is a step in the right direction to ensure Nebraskans with limb loss or limb difference can obtain the most appropriate prosthetic and orthotic deemed medically necessary by their physician. Having the correct device appropriately fitted is a critical factor in ensuring these individuals have access to all facets of society, including physical activity. Too many state-regulated commercial insurance plans lack coverage for or deem the recommended devices not medically necessary. Without the necessary health plan coverage, adults, childrens, and families are forced to risk harm and injury using an improper device, incur exorbitant amounts of out-of-pocket costs to get the recommended device, or live socially isolated and sedentary lifestyles without them. This can lead to significant health complications. The U.S. Department of Health and Human Services' Physical Activity Guidelines for Americans recommends children with disabilities get 60 or more minutes of moderate intensity physical activity each day. For adults with disabilities, the recommendation is 150 minutes weekly. However, according to the CDC, 50% of adults with disabilities get absolutely no aerobic physical activity. The prevalence of obesity in children with disabilities is almost twice that of children without disabilities, and the annual health care costs of obesity related to disability is estimated at approximately $44 billion in the U.S. As an association, we are focused on transforming society by optimizing movement to improve the human experience. Evidence shows that regular physical activity provides important health

benefits for people with disabilities. Those benefits include improved cardiovascular muscle fitness, mental health, balance, and a better ability to do tasks of daily life. Movement is a medicine. And physical activity is a right, not a privilege. Still today, millions of children and adults in the U.S. with limb loss, limb difference, and mobility impairment are unable to afford and access prosthetic and orthotic care that helps them be physically active due to inadequate insurance coverage. Access to proper devices is key to optimal living and quality of life for all people that extond-- extends beyond health and to every person's ability to participate and contribute to society. By passing LB410, you can reduce preventable health care costs and give Nebraskans living with limb loss and limb difference access to the affordable prosthetic and orthotic care they deserve. With that, I welcome any questions. Thank you.

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

AMBER HERRINGTON: Hello. My name is Amber Herrington, H-e-r-r-i-n-g-t-o-n. I'm also a--

JACOBSON: Can you spell your first name too?

AMBER HERRINGTON: Amber, A-m-b-e-r. I'm also a physical therapist that has been practicing for 18 years, and the majority of the patients that I see are actually patients with amputation. And over the years, I've frequently witnessed delays in patients receiving a needed device due to insurance denial. Companies are-- they frequently deny the devices, citing lack of medical necessity, or they only cover the minimal components regardless of the patient's previous function or their current function. These denials lead to monthslong delays in patients and their pro-- as they work to appeal those denials. Research shows that those that receive their prosthesis in the first three months experience 25% lower health care costs. Those who get it between four and ten months have the same costs as those that don't get a device, but it also includes the cost of their device. So we can see that someone who doesn't get that device is incurring higher health care costs as well. Receiving a prosthesis is also important for allowing people with amputation to return to work. If unable to return to work, the indirect costs are even higher for our economy. Over the years, I have trained people with a prosthesis to be able to climb ladders and lift and carry items to return to various trades, including electricians, truck drivers, farmers, and others who are imperative to our workforce. But they need the right device to do these things. If given a device but not the correct components that they need-- only the

basic components-- they often lack some of the things like shock absorption in-- that the higher level devices have. And so with this, they often end up with secondary complications. They have higher issues with low back pain, joint issues that also then lead to higher health care costs for covering those types of things. Lack of a prosthesis or one that allow-- only allows for activity leads to a sedentary lifestyle that increases our co-morbidities such as obesity, diabetes, and heart disease. And we know those are big issues in our health care system right now. And it also has significant issues on their mental health because they are not able to participate in work or society as they did before. And we know that that is also a big issue in our society right now. So providing these devices meets the health care system's quadruple aim to improve the patient experience, improve population health, and decrea-- decrease costs. We have seen that we can't just be reactive in health care, because it increases costs to our system. We need to focus on prevention and wellness, and prosthetic devices are a preventative device.

JACOBSON: Thank you. Questions? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here today. You answered my question, I guess, about the difference between sort of the different levels of devices. In your experience, how long is the normal wait between a request for one of these devices and it being approved? I know you had kind of the tiers of, you know, this many months you see a savings. What's the normal wait period that you tend to see for folks?

AMBER HERRINGTON: I would say it varies highly deba-- based on the insurance company. I would say we probably a lot of times wait at least a month. And then if they get denied, then we're spending months on top of that trying to get the device. So the longer we wait, the longer they sit in a wheelchair, they get weaker, they develop contractures. It makes them harder to use the-- to use the device once they get it. And so it just extends out how long we have to see them for rehab. And it-- they-- the longer they do that, I think they're less likely to get back to work and do some of those things that they did.

DUNGAN: And then in your experience as well, how often do people who do those appeals end up successful? Do, do you see a lot of the appeals overturned or do you see the ultimate denial stand? I know it's kind of a broad question, but.

AMBER HERRINGTON: Yeah. I would say sometimes eventually they do get overturned. But it can take all-- or they don't get completely

overturned, but they only get approved for a very basic device. And so again, those basic devices then, if they're doing high-level activities like wanting to go back to work and those types of things, they, they break. They don't provide the normal movement patterns that we would normally want that some of the higher devices do allow us to have, leading to those secondary issues.

DUNGAN: Thank you.

AMBER HERRINGTON: Yeah.

JACOBSON: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. It seems to me-- and I appreciate all the professionals that have tried to [INAUDIBLE]. But we're not talking about probably the need or the appropriateness [INAUDIBLE]. I think really we're talking about who pays. I think that-- to me, that's what we're here today to-- who's going to pay?

AMBER HERRINGTON: Yeah.

RIEPE: And I'm not-- whether this is good or that's bad, because it's all very individual for every patient, but.

AMBER HERRINGTON: And I think even-- like, part of it is, though, depending on what we pay-- or, who and what pays for this, like, the costs can just continue to grow and grow for what-- and, and choose-- and making sure we choose what's the most appropriate for that patient to use, yeah.

RIEPE: Do you have problems with "preauthoritizations" of getting those? I mean, that's been a real thing, I guess, or a concern this entire legislative session.

AMBER HERRINGTON: Yeah. I don't think they really do prior authorizations for a lot of them. You have to kind of-- well, I guess it is a prior authorization. But, yeah. You submit what you're requesting for that patient, yeah.

RIEPE: And why.

AMBER HERRINGTON: Yeah. And why. And then, and then you have to get approved before you give that device. Because like they said, it's thousands of dollars. You're not going to give somebody a device knowing-- not knowing if you're going to be able to pay for it.

RIEPE: OK. Thank you, Chairman.

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

AMBER HERRINGTON: Thank you.

JACOBSON: Next proponent.

VINCENT LAU: Thank you, Chair Ja-- Jacobson and members of the committee. My name is Vincent Lau, V-i-n-c-e-n-t; last name is L-a-u. And I'm a certified prosthetist/orthotist who practices in Omaha, Nebraska. I've been a clinician for over nine years, with six of those years here in my home state of Nebraska. And I also serve as the Nebraska lead advocate for the American Orthotic and Prosthetic Association, or AOPA. I'm here today on behalf of my profession and those we treat in support of LB410, a bill that will ensure state-regulated commercial health plans cover prosthetic and orthotic care and at an equivalent or better level than Medicare's current policy. This policy is commonly referred to as the Insurance Fairness Act and has already been enacted in 21 states in the U.S., including some of our neighboring states such as Iowa, Missouri, Arkansas, Illinois, Indiana, Colorado, and Utah. LB410 would create parity for coverage for prosthetic and orthotic devices, raising the floor on the quality of life for this population in Nebraska. The current Nebraska essential health benefit plan states that durable medical equipment, which includes orthotic or prosthetic devices, is covered when prescribed by a physician who determines the device to be medically necessary. LB410 will align Nebraska commercial insurance plans with Medicare guidelines for coverage of O&P devices. As a health care provider, I have seen countless medically necessary devices denied by insurance policies. For example, a common prosthetic device for someone with an above-knee amputation is the microprocessor knee. This device provides computer-assisted gait monitoring to provide a safe and natural gait, allowing for more efficient walking and prevent falls from stumbling or tripping. This device is coded under the Health Care Common Procedure Coding System Level II as L5856 and has been a covered benefit by Medicare since January 1 of 2005. Nearly 20 years later, we are still seeing denials for this type of device as experimental or investigative. Another example is the vertical loading pylon of Nate's prosthesis-- our first testifier-- which was effective since January 1 of 1997. It is time for patients with commercial insurance plans to be afforded equal access to devices that Medicare qualifies as an essential health care. Furthermore, LB410 will ensure the long-term viability of the orthotic and prosthetic profession in Nebraska. As a

field, O&P care is reimbursed in a lump sum upon fitting and delivery of a client's device. This payment covers all appointments, administrative and technical time, and materials used in the device. If an insurance company denies coverage of a patient's medically necessary device as prescribed by their physician, the clinic's time involved in the evaluation, casting, and administrative tasks go unrecouped. If a device is delivered without insurance coverage, the cost of care is either passed to the patient or the clinic takes a financial loss-- an undesirable situation in either case. The combination of unbilled time or waived fees threatens the financial stability of O&P providers, many of which are privately owned small businesses. And the effect is more drastic in rural Nebraska communities where a lack of O&P clinic-- nearby O&P clinic requires longer travel times for routine care. By aligning state-regulated commercial health plans with Medicare, we can keep providers and clients healthy in the long term. For the sake of those here using devices and their family members, I strongly urge you to vote in support of LB410. Thank you.

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

VINCENT LAU: Thank you.

JACOBSON: Further proponents? All right. Seeing none. Are there any opponents? The other guy gave us a head fake there. Acting like he was a proponent.

ROBERT M. BELL: That's all right. I thought he was coming up too. 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 am appearing today in respectful opposition to LB410. 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/Aetna, Nebraska Total Care, Cigna, and UnitedHealth Group. LB41-- LB410 requires health plans to provide coverage for prosthetic and orthetics-- orthotics and the repair and replacement of the equipment at a level that is at least equal to the coverage provided by Medicare. This provision would also-- also requires the insurance contract to allow for the insurer to use certain out-of-network providers. If the plow-- plan allows for out-of-network services for other covered benefits. Also, the bill places certain requirements on the amount of out-of-pocket sharing a plan can place on a consumer, particularly related to lifetime maximum

limits, which have already been prohibited by federal law. The insurers have a number of issues with this proposal, not the least of which is the general apprehension of state mandates. Please note, though, prosthetics and orthotics are considered durable medical equipment. In the health finance world and my understanding is that all plans already cover durable medical equipment, though not necessarily at the same levels of coverage required by Medicare. So LB410 could be an expansion of the essential health benefit benchmark of the ACA and require [INAUDIBLE] for additional cost by the state of Nebraska. Additionally, insurers object to any restriction on their ability to negotiate with health care providers on reimbursement or placement within a network. Being in a network allows the insurer to negotiate rates. The ability to negotiate rates of insurers are one of the major drivers of cost savings for Nebraskans who purchase insurance and one of the major areas of competition between health insurers. The infringement on our ability to negotiate could sev-- could severely impact the savings health insurance companies bring to consumers. For these reasons, Nebraska Insurance Federation respectfully opposes the passage of LB410. I appreciate the opportunity to testify. I will say just a couple of things. Of course, if we're talking about ERISA plans or the new Farm Bureau agricultural plans, this law would not apply if passed. I can also give you an in-depth discussion of appeals, both internal and external appeals, that already exist in Nebraska law. I think you've heard some talk about it. And then-- yeah. I think that's it before it goes red. I appreciate the opportunity to testify.

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

RIEPE: Thank you, Chairman. I used-- I think-- Mr. Bell, thank you for being here. I-- you-- I think you said most plans provide for some level of durable medical equipment.

ROBERT M. BELL: Yeah. So the AC-- so there's ten essential health benefits under the Affordable Care Act, so-- that-- which passed-- gosh, I don't even remember-- a long time ago now. And one of them is, is durable medical equipment. You heard a testifier before say that prosthetics and orthotics were included as durable medical equipment, and certainly that's the grand category that prosthetics and orthotics fit into. I think there's some-- there's some apprehension that I would say as an attorney whether or not that, that actually prosthetics or orthotics are included in EHP as it is today, some indecision related to it. But if you look at the fiscal note from the plans-- the qualified health plans that are able to sell on the, on the Affordable Care Act exchange, they're saying they are covering these already. And

that would be my, my understanding and my hope, is that all the medical insurers are covering this. Now, there could be an employer plan someplace that has decided they're not going to cover this for whatever reason, so.

RIEPE: Well, when they say they cover, maybe durable medical equipment, it doesn't mean unlimited coverage.

ROBERT M. BELL: Oh, gosh no. Yeah. There, there's all kinds of limits. You have to cover durable medical equipment. How much you cover would depend on the plan.

RIEPE: So it's sufficiently vague.

ROBERT M. BELL: Yeah. I mean-- and it's intentionally vague, right? I mean, there's ten categories under the ACA of essential health benefits, and then it's left to the states to determine-- to fill that gap out. You know, you talk about-- there was some talk about high deductible plans earlier. Even under the ACA, there are four or five, depending on the state level of cost sharing that goes into it. Bronze is at the lowest level at 60%-- where the insurer pays 60%, the insured pays 40%, et cetera, et cetera. So, yeah. There's a lot of variability in there.

RIEPE: How does the insurance industry avoid adverse selection? [INAUDIBLE]. If it's in a group, it's different than the individual, I guess.

ROBERT M. BELL: In adverse selection, that, that's a very deep subject I could get o-- on for a long time, but I don't think you want to. It's not as applicable-- it's not as applicable in the health space because underwriting is not allowed. Right? So if an individual in this room wanted to change their plan to an exchange plan, they would be more than welcome to. Say they were unhappy with Medica, they could go over to Ambetter or Blue Cross Blue Shield if they are an exchange population, which is about 120,000 Nebraskans. If it's an employer situation, it's a little bit more difficult, but you could still switch if, if you wanted to. You would have to weigh the pros and cons. How much is that employer providing for that premium? Right? How much would my subsidy be from the federal government if I went on to the exchange? There, there may be good reasons to shop, though. I mean, we always tell people to shop for their insurance. That's, that's included in, in health care. So-- but that doesn't really answer your question, but I think it's illustrative of the situation that's going on in the health care market.

RIEPE: OK. Thank you.

JACOBSON: Senator, Senator von Gillern.

von GILLERN: Yep. Thank you, Mr. Bell. The, the bill very specifically-- and I, and I have to believe that Senator Cavanaugh did this intentionally-- says equal to the coverage provided under the federal Medicare program. So I presume that sets a standard. So that standard must-- you said it's pretty vague, but the-- clearly that standard-- or-- you said earlier a durable medical device is--

ROBERT M. BELL: Oh, under the ACA.

von GILLERN: --being provided. Yeah. Under the ACA. I'm not-- sorry. I wasn't impugning what you're saying, but.

ROBERT M. BELL: Yeah, yeah. No, no problem.

von GILLERN: So, so whatever vagueness might exist there must not exist under what--

ROBERT M. BELL: Right.

von GILLERN: --Medicare says. So for those of us in the room that don't understand that, what are those differences?

ROBERT M. BELL: OK. So, so the Affordable Care Act only applies to individuals under 65, and those are commercial plans that you buy on the, quote, health care exchange. These are the Obamacare plans. Some people call them healthcare.gov plans. Those are for individuals that have not met retirement age and don't have access, for whatever reason, to employer-sponsored coverage or small group coverage or don't want to use that coverage. Medicare is typically used by individuals that are 65 years of age or older or individuals with certain disabilities, which this, this committee addressed last year related to Medicare supplement plans. So Medicare has put in some guidelines. And this is what this bill does: it mandates the coverage up to Medicare guidelines, saying you must meet those if you're a commercial health plan. And we believe those guidelines are higher than many of the commercial health plans that are out there right now. And so there's a lot more rules related in, in the Medicare space than there is coming down from the federal government on the ACA or the commercial space. And so, yeah, and it's-- it would definitely be our richer benefit. Now, I was looking at policies last night. I will tell you I found at least one policy that said they would cover at the level of Medicare

rate. That was a plan sold on the exchange. And so-- but other plans don't say that. This kind of depends on the situations.

von GILLERN: So to use the metaphor of the gentleman earlier, does-- if, if a plan says that, that you have to provide-- or, under-- an ACA plan, which-- is that a-- is that a Chevy? Is that a Kia? Is that a--

ROBERT M. BELL: You know what-- you know what's really interesting about that?

von GILLERN: --a Lexus? What are-- what are we--

ROBERT M. BELL: Depends.

von GILLERN: Give us a--

ROBERT M. BELL: So that's a pretty good plan, right? It, it's, it's, it's been dictated by the federal government, and it gave power to the state of Nebraska who made a decision to pick up Blue Cross Blue Shield's small group plan that existed in 2012 as our benchmark and said, you know, that's, that's the benchmark. And then-- so if you're another carrier, you have to at least meet that standard of that policy. And then you can go above that if you want to-- and many plans to do. And then you go on to the exchange. We were talking about the exchange. That's why I was talking about the medal. So there's bronze, silver, gold, and platinum. And that is all related to how much cost sharing goes-- involved. So on bronze, it's 60% of the insurer's cost and 40% of, of the individual's cost on out-of-pocket, all the way up to platinum, which is 90% of the insurer and 10%-- to get to Senator Riepe's question. So if you knew you were going to have a lot of out-of-pocket expenses, it would probably behoove you to get into a platinum plan if you could, so.

von GILLERN: So, so that's if you're buying on the exchange--

ROBERT M. BELL: If you're buying on the exchange.

von GILLERN: If, if I'm working-- if I'm an employee, I'm, I'm kind of stuck with what my employer's provided. I don't have a lot of option to say I want to upgrade my plan.

ROBERT M. BELL: Well, you could, you could go to the exchange, but it probably is not going to be cost beneficial. Because, like, state of Nebraska, perfect example: the state of Nebraska pays 79% of your premium cost, right, as an individual, if you're a state employee. Not a senator, of course. That's a different, different matter.

von GILLERN: You had to rub that in, didn't you?

ROBERT M. BELL: And-- so-- yeah, it's probably going to be cost-prohibitive on that. And then on a large group that's governed by ERISA, which is a significant number. I think last time I did the math, 35% of people in the private market are likely on ERISA in Nebraska. This law doesn't apply. And I just want, I want the committee to be well-aware of that, because a lot of times these mandates pass. I know there was an-- there was an individual that said a few hearings back that insurers haven't kept their promises on breast cancer screening. Well, very likely that's an employer-sponsored plan that decided we're not going to provide that coverage because we don't want to, because it's-- for whatever reason. And we know that-- we knew that occurred in our ERISA market where our plans said, hey, the state has mandated this, and the employer's like, yeah, but I don't have to cover it because I'm an ERISA plan. And I don't want to because there's additional costs related to that, so.

von GILLERN: Thank you.

ROBERT M. BELL: Yep.

JACOBSON: Senator Riepe.

RIEPE: Thank you, Chairman. With the exception of Blue Cross and Blue Shield in Nebraska, most of these insurers are national companies. How many-- how, how-- I'm just trying to get a perspective as-- where is the state of Nebraska in relationship, say, to the state of Iowa or Ohio or-- I mean, do these, like, UnitedHealthcare, have, like, a planning policy? It's not, it's not state specific, I assume, but--

ROBERT M. BELL: Every, every plan is state specific.

RIEPE: So I'm trying to figure out what their response is with legislation that tries to mandate--

ROBERT M. BELL: So--

RIEPE: --and dictate that they have to do something in Nebraska.

ROBERT M. BELL: So health insurance regulation 101 on the market side. To sell insurance-- health insurance in the state of Nebraska in the state-regulated market, you have to submit your rates and your policy to the Nebraska Department of Insurance for review.

RIEPE: So it's state specific.

ROBERT M. BELL: It's state specific. So UnitedHealth Group, if they want to sell one of their myriad of policies here, they have to file that with the Department of Insurance on an annual basis and have that approved. They have to file their rates with the Nebraska Department of Insurance and have that reviewed and approved before they can sell. Oftentimes, that happens in the fall before the end of the year. So-- but to answer-- so national plans, they kind of have a base. And then they'll go in and, and they'll, they'll modify it for that particular state and their level of, of benefits. So I think I heard there were 21 other states with a similar type of prosthetic. They would probably grab that language or look at this and stick it in their policy. And this is something that health insurers have to do on a, on a yearly basis. Blue Cross Blue Shield only sells in Nebraska. Medica, another health plan that's pretty active in Nebraska, is a regional carrier. So they only sell in the Midwest. Ambetter, I think, or Centene, Nebraska Total Care-- whatever you want to call them-- I think they're more nationwide, but certainly Aetna and Cigna and the UnitedHealth Group I believe sell in all 50 states.

RIEPE: Is it fair to say that with the filing that they make with the state Ins-- Department of Insurance that dollar amounts are fixed, but the interpretation can vary in terms of how they interpret [INAUDIBLE].

ROBERT M. BELL: Oh, my gosh. No. The dollar amount's not fixed. It's going to depend on, on the state. Like, Nebraska, Nebraska, because of our rural nature and some other things going on in our state, tends to have a little bit higher costs related to health care. So you would have to adjust your rates to fit in the-- to, to be approved in the state of Nebraska. And Nebraska Department of Insurance is not going to let you submit rates that are too low. Right? So--

RIEPE: Where I was going with that--

ROBERT M. BELL: I'm sorry.

RIEPE: --was there's no perfect interpretation of who gets what, when, and how and--

ROBERT M. BELL: Right.

RIEPE: Every case is different.

ROBERT M. BELL: Right. Right, right.

RIEPE: Some people will be happier than other people.

ROBERT M. BELL: And I, I, I should just add, when we talk about ERISA, that's why ERISA exists, right? It's because-- so my dad works at a factory here in Lincoln. And he has Blue Cross Blue Shield of Alabama. And that's because the company that owns that factory has all of their employees under one plan. That ha-- plan happens to be sold or-- it's-- they manage it. They don't really insure it. It's Blue Cross Blue Shield of Alabama. And so for all of their employees at Teledyne Incorporated, all across the United States, they all have the same plan. And that's why you have ERISA. And that's why the federal government has said, no, you can't change that, because then they would have to change it depending on the plants where, you know, you had a location. And then you would get into-- to a certain degree, even, into a certain level of arbitrage about where you might, might place some of your employees based off of the costs related to health care, so.

RIEPE: OK. Thank you, Chairman.

JACOBSON: Senator Dungan.

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

ROBERT M. BELL: Of course.

DUNGAN: I guess I'm going back to your original objection. I'm trying to wrap my head around-- and I think Senator von Gillern asked some of my questions here, but the difference between what is currently available in the private plans that you're talking about and what is covered under the Medicare standards. Because my understanding, as you said, this bill establishes a floor. If this bill were to pass, it says that all commercial insurers have to provide coverage of prosthetics pursuant to the Medicare rules as they existed January 1, 2024.

ROBERT M. BELL: That's my understanding of the first part of the legislation, yes.

DUNGAN: OK. So what current plans exist that provide less than that coverage? Like, what is-- what, what is the coverage that is less than that Medicare standard? Does that make sense? I'm looking up all the CFRs and I'm looking up all the rules here--

ROBERT M. BELL: Yeah, I don't know. I, I--

DUNGAN: --of what the current Medicare standards are.

ROBERT M. BELL: We would have to pull all of the policies for Nebraska and see what they say. Now, I did a sampling of some of those policies,

and a lot of them say they cover, you know, prosthetics or orthotics, but it doesn't really go into the great level of detail without even getting further into their plan documents, which-- there's only so much time in a day, right--

DUNGAN: Yeah. sure.

ROBERT M. BELL: --to, to pull all that documentation.

DUNGAN: So I'm-- for example, I'm looking at medicare.gov right now. And just their little primer about prosthetics says, you know, your costs on Medicare. After you meet the deductible, you pay 20% of the Medicare-approved amount for external prosthetic devices. Does that sound different than what would be available on the plans?

ROBERT M. BELL: Yeah. I mean-- yeah. I mean, that-- I mean, you're getting into the cost sharing then, which is a little bit different. Like, so Medicare may only pay up to 80%. And then you get a "medsup" policy to cover the rest of that 20%. But it-- we're talking about, I think, the type of-- in-- like, the level of prosthetic or the quality or, or, or-- I don't, I don't know. It, it seems like to me, like, we're, we're-- I think it's pretty clear we're covering prosthetics. It's just, like, how nice is that prosthetic?

DUNGAN: Sure. Well-- and it sounds like the standard that's trying to be established by this-- and I might be wrong. Maybe Senator Cavanaugh can correct me--

ROBERT M. BELL: Sure.

DUNGAN: --is whatever is deemed medically necessary. And they're saying that there can be limits. They can say that whatever you're requesting from insurance to pay for needs to be medically necessary. And I guess what I'm hearing from people who are here today testifying is that there are prosthetics or other DME that are being ordered-- or, requested, rather, that are being deemed medically necessary by the doctors that are being denied by insurance.

ROBERT M. BELL: That are finding it medically unnecessary for whatever reason.

DUNGAN: And I, and I guess that's, tha-- that's the rub, right? That's what we're trying to figure out, at the end of the day, is, like, why is insurance denying requests of prosthetics that are being deemed by professionals as medically necessary?

ROBERT M. BELL: It, it may not meet the-- their definition at, at, at the health care of medical necessity. Now, luckily, there are appeals available. And I think you heard individuals talk about those appeals. And I, I feel bad that it takes so long for some of these appeals to occur. There's two types of appeals, right? There's an internal appeal inside the insurance company.

DUNGAN: And that happens first, right?

ROBERT M. BELL: That happens first. And if you complete that, then you go to external review. External review happens via-- the portal is the Department of Insurance. But they, they send it off to an independent third-party to review that. My understanding that the-- the going rate on that's about 50/50-- 50% the insurer wins, 50% the insured wins.

DUNGAN: Specifically for prosthetics or for all--

ROBERT M. BELL: Just in general. I don't, I don't know what it is for prosthetics. So.

DUNGAN: That would be my follow-up question. I know-- you, you don't have that information.

ROBERT M. BELL: I don't have that in-- I would recommend that you contact the Department of Insurance, so.

DUNGAN: And I-- I could, but I just-- I'm curious-- yeah-- where that, that, that difference is. I guess the last thing I'll ask you is, normally, when the insurance companies come and oppose legislation, there's a concern about increasing premiums. Right? That's something we hear about. Here, when you look at the fiscal note, we're talking about sort of an offset, at least for some of if, that happens from general funds. Is there not a concern that you guys have about the premiums when it comes to this particular--

ROBERT M. BELL: Well, I, I would say two things related to that. Yeah, sure, there would be an increase. So what the QHPs would tell you-- so the qualified health plans selling on the exchange would be-- they're looking-- they think that the language here would require an additional $75,000, which eventually they would come ask the state of Nebraska for, as allowed for by federal law. And we'll see. I mean, you got to go through the process and, and see what claims come in and what we-- you would have paid before that. But then two, there is a provision of LB410 that talks about what is in network and out of network. So I think you can only go to-- I think they allow us to go to a supplier if they're in network and deny an out-of-network supplier. However, the

services after that, we have a parity statute, which parity then doesn't allow us to negotiate rates, right? Or we have a harder time negotiating rates because you're like, eh, I don't want to be your network. You're not paying me enough. Well, too bad. You're, you're-- we have to pay you the same anyway, right? And that gets into our ability to negotiate. Also to a certain degree, a, a, a degree of competition. You know, how is a Blue Cross plan different from a Cigna plan that's different from a UnitedHealthCare plan? You know, if we're all required to do the same thing, then there's, there's no variability in the market for, for whatever reason. So you may decide as an insurance company to offer that Medicare standard, which, again, I, I think I was telling Senator von Gillern, I found that in a policy. And that, that may be a selling point for you.

DUNGAN: Thank you. Appreciate you being here.

ROBERT M. BELL: You're welcome.

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

ROBERT M. BELL: You're welcome.

JACOBSON: Other oppo-- opponents? Any other opponents on LB410? All right. Seeing none. Anyone wishing to speak in a neutral capacity? All right. Seeing none. Senator Cavanaugh, you're welcome to close. And also, I might add there were 11 proponent letters, 2 opponent letters, 0 neutral testifiers. And the committee did not receive any written ADA testimony regarding this bill. Go ahead.

J. CAVANAUGH: Thank you, Chairman. Thank you, members of the committee. It was a great conversation, and I thought there was really a lot of interesting information brought forward. Bottom line is, you know, this is a question of quality of life and living a, a healthy-- have an opportunity-- a healthy life for folks. You know, one of the things I wrote down was, I think, secondary issues. So the-- some folks maybe get approved for a prosthetic that maybe allows them to walk, but it doesn't allow them to live their, their fullest life, which then leads to secondary issues, including-- had-- associated health aspects including diabetes, high blood pressure. And so there are-- folks who don't get the appropriate prosthetic end up being-- having higher health care costs overall. And so when we're talking about where costs are and somebody has to pay at some point in time, as Senator Riepe pointed out, that there are still-- they're going to be even higher costs if folks aren't getting the appropriate medical care, in--

including the-- these durable medical devices, as Mr. Bell pointed out. So that's really the question here. And as Mr. Lau stated, there are 21 other states, including our neighbors of Missouri, Iowa, and Colorado, who have some version of this requirement. I think Mr. Bell raised some very legitimate concerns, and I have had several conversations with Mr. Bell from the bill that I brought last year through the interim to when I introduced this bill about trying to address those concerns. I, of course, will continue to see if there's a way that we can address the concerns that he's raised but still, of course, get closer to the point where more folks are going to have an opportunity at that full life-- and full lifestyle. This bill, of course, is not going to address everybody's problem and it's not going to-- if we pass this, it's not going to make sure that everybody gets this type of coverage, but it would get more people in a position where they get what they need to address their issues. And so-- again, I'll continue trying to work to solve some of those concerns, but I'd be happy to take any questions.

JACOBSON: Senator Riepe.

RIEPE: Thank you, Chairman. I guess my question-- maybe it's here-- correct me when I'm wrong-- does this have an impact on Medicaid, expansion of Medicaid? Does this benefit-- would then go to Medicaid as well?

J. CAVANAUGH: I don't think it would go to Medicaid. I think it would just be to the, the pub-- or, the private insurer-- insurers, I think.

RIEPE: Well, we talked a lot about the accountability, the Obamacare plan.

J. CAVANAUGH: Right.

RIEPE: [INAUDIBLE] kind of [INAUDIBLE] Medicaid.

J. CAVANAUGH: So the Obamacare plan--

RIEPE: You know, as a state, we have taxpayer engagement in that cost.

J. CAVANAUGH: Right. And Medicaid is, you know, is separate from the marketplace private insurers you can purchase.

RIEPE: OK. I just-- because that, that could be a big number too.

J. CAVANAUGH: Right. I would imagine if there was an impact to Medicaid we would have seen it in the fiscal note, because they have no shyness about including that cost on fiscal notes.

RIEPE: Or we'll see it next year. OK. Thank you. Thank you, Chairman.

JACOBSON: Other questions? If not, thank you for your closing. Thank you for bringing the bill. I'm-- that, that concludes our hearing on LB410. And we'll move to open the hearing on LB639. All right. And we've got some who've already figured out if you're going to testify, move to the front of the room. So thank you for that. All right. With that, Senator Clouse, you're welcome to open on LB639.

CLOUSE: Thank you. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Stan Clouse, S-t-a-n C-l-o-u-s-e. Representing District 37. LB639 is actually a repeat of LB1110 brought forward by Senator Jacob [SIC] from last year. And this is a bill brought to us by the Nebraska Dental Association, which had established a dental loss ratio of 85%. Which means that for every $100 paid in premiums, $85 will be spent on patient care. If companies fail to comply, then they would have to pay the difference back to their customers. Currently, as much as 40% of patient premium dollars go to other things other than patient care according to the American Dental Association. This bill is an attempt to lower the out-of-pocket costs and improve affordability to dental care for customers. Now, behind me, we've got a lot of individuals for-- both for and against. I'm quite sure of that. And so I thank the committee for your time. And I urge you to pass this or at least give some consideration and ask if have any questions for me at this point.

JACOBSON: OK. Thank you. Questions from-- Senator Clouse. Go ahead.

von GILLERN: Thank you. How'd you arrive at the 85%?

CLOUSE: That's the, the insurance, I think the medical insurance, I think that's the number that they use too. Medical insurance premiums are 85%--

von GILLERN: OK. All right.

CLOUSE: --is my understanding.

von GILLERN: Thank you.

CLOUSE: So it mirrors that.

von GILLERN: OK. So that-- balance at 15%-- if you pay out 85%, it's presumable they can operate on--

CLOUSE: Operate on 15%.

von GILLERN: Operate-- and earn some, earn some earnings on the, on the balance, 15%. OK. Thank you.

CLOUSE: And I think you'll hear some more testimony on those numbers.

von GILLERN: All right. Thanks.

CLOUSE: OK. Thank you.

JACOBSON: And I kind of want to address that issue, but I'll wait for the first proponent testifier-- testimony to ask that question. Thank you.

CLOUSE: Thank you.

JACOBSON: First proponent testimony. You can go ahead.

LIZ PAPINEAU: OK. Good afternoon, Senator Jacobson and committee members. I am Dr. Liz Papineau, L-i-z P-a-p-i-n-e-a-u. I'm a general dentist in York, a past president of the Nebraska Dental Association. And I currently serve on the American Dental Association's council on dental benefit programs, focusing on commercial insurance. I'm here speaking in support of LB639, legislation that requires 85% of the patient's insurance premium dollars be spent directly on their care as opposed to administrative costs, marketing, and profits. It would also create standardized requirements to disclose how insurance companies spend patient premium revenue. Opponents of this bill will say this can only lead to premiums being raised, shifting the cost to the consumer, leading them to drop their insurance and deterring them from seeking necessary care. But in reality, the cost has already shifted to the consumer with high out-of-pocket costs when their premium dollars aren't being spent on their care. I have many patients who have already refused much needed treatment due to these additional costs. One in particular spends almost $900 a year in premiums, but his insurance now only covers his two routine exams a year at about $100. That's only 11% of his premium. Where are the rest of those premiums going, then? The answer is we just don't know. This bill is asking insurance companies to find ways to be more efficient with their spending without raising premiums and provide good value for the premiums they collect. Ensuring transparency and value in dental insurance rates will help reduce out-of-pocket costs for our patients, making access to dental care better and more affordable, thereby encouraging patients to get the care that they need. No doubt, employers and patients choose their plan based on the premiums, but the cheapest plan does nothing for the consumer if those premiums aren't spent on their care. Some insurance

companies may feel that they cannot meet this 85% requirement without raising premiums, and they will leave the market. Those that leave simply won't be able to provide the value needed for the consumer. And is it really a bad thing that insurers who mishandle patient premiums choose to leave the market? The transparency and accountability we're asking for in dental insurance will assure that patients are protected and that insurers who operate efficiently and prioritize patient care will benefit. I got into the dental profession so that I could help people-- most obviously, this is by fixing something in their mouth-- but today I come to you to help my patients in a different way. Ultimately, this bill really doesn't do much for me as a dentist, but it instead helps protect my patients' interests and their hard-earned money. I want them to get the treatment they need with the premiums they've already paid. In closing, I'd like you to consider that not having DLR legislation in the state of Nebraska shows that we are putting corporate profits over consumer protection. Thank you.

JACOBSON: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I've, I've looked into some of the-- you know, my question is-- and will be is, who's the primary beneficiary of this? Is it the consumers or is it the proprieters?

LIZ PAPINEAU: It's the consumers. There's actually-- again, like I said--

RIEPE: --expect your response to be.

LIZ PAPINEAU: Yeah. There, there's no change to our fees. When we are contracted with an insurance company, there is a contracted fee. So I'm not raising that fee. I'm not getting any more. It's just who pays for it.

RIEPE: But you would be getting more-- potentially more business.

LIZ PAPINEAU: If--

RIEPE: And, and full payment maybe instead of lowering [INAUDIBLE].

LIZ PAPINEAU: Potentially.

RIEPE: I'm not-- yeah.

LIZ PAPINEAU: Sure.

RIEPE: OK. That's all I have. That's my biggest concern. Thank you, Chairman.

JACOBSON: Other questions? Is there going to be someone from your association going to testify as well?

LIZ PAPINEAU: Dr. Morrison will be also.

JACOBSON: I'll wait for her. Other questions? Thank you. Appreciate him. OK. I misunderstood the first name--

LIZ PAPINEAU: Sorry.

JACOBSON: --so thank you. All right. With that, thank you for your testimony. Next proponent. How are you?

TERYN SEDILLO: How are you today? Good afternoon. My name is Dr. Teryn Sedillo, spelled T-e-r-y-n S-e-d-i-l-l-o. I'm a general dentist in Omaha, and my practice is dedicated to serving patients with special needs and those with medical complexities, including the geriatric population. I'm here today to speak in support of this bill. Patients with special needs are often left behind when it comes to dental care. They face overwhelming barriers, transportation challenges, physical limitations that prevent them from caring for their own teeth, and also a lack of affordability. This system is failing them. A good example is one of my patients who has cerebral palsy. They struggle with muscle control, making it nearly impossible to brush and floss effectively. Over time, this has led to multiple areas of severe tooth decay and gum disease, but it doesn't stop there. Their chronic dental infections make it harder for them to eat, worsening their already fragile nutritional status. The inflammation from their untreated gum disease exacerbates their muscle spasticity, making daily life even more difficult. This is not just about teeth. This is about their overall health. Many of my special needs patients have a private dental insurance plan. However, the plan is not a quality plan. Often, it has limited coverage, low annual maximum limits, and leaves them with high out-of-pocket costs. There seems to be a theme here. If the patient has a primary dental plan, they'll usually have a secondary plan if they have disabilities, which is, is Medicaid. Medicaid is on the hook-- not the primary plan-- for the significant amount of the bill. Therefore, the state is paying what the primary insurance is not covering, which is often the bigger price tag. In early 2000s, the Affordable Care Act assured that all medical plans had an 85% medical loss ratio. In addition, Medicaid is held to the same standard. Medicaid, a plan that includes a disproportionate amount of the sickest patients, can meet

that 85%. Why shouldn't we hold our state's commercial plans to the same standard? Why should Nebraskans and Nebraska employers who purchased the dental plans be subjected to bad dental plans? I am committed to caring for this underserved population, but I need your help to hold dental insurance companies accountable. My patients need their dental plans to work for them. This is especially critical for patients who require treatment in the operating room, whether it's a special needs adult or an elderly patient who must have dental clearance before receiving lifesaving cancer treatment or an organ transplant. If they can't get their infected teeth treated, they can't move forward with the medical care that they need to survive. This is a matter of health, fairness, and accountability. And I urge you to support this bill and help make Nebraska's dental insurance system work for its people. Thank you.

JACOBSON: Thank you. Well, I'm going to need to run to another committee for a bill hearing, but I-- so I'm going to ask you my question and turn it over to Senator-- Vice Chair Hallstrom to complete the hearing. I, I was asked to carry this bill last year. I did introduce it last year. I was-- I had-- I was handed a bill the last day of bill introduction, introduced the bill, then did some investigation and decided that I wouldn't carry the bill this year because I, I re-- learned some valuable information, I think, from last year's hearing, which really had to do with the fact that the, the volume of dollars that go into a dental insurance plan are very, very small compared to health insurance plans.

TERYN SEDILLO: Sure.

JACOBSON: And as a result of that, the percentage of overhead is significantly higher. So to have the same payout ratio for dental insurance as medical insurance is just not in the realm of reality. And as a result if-- in, in my opinion, if this bill passed, it would drive a lot of insurers out of the state. I don't think there's any question about that. We'll hear that from opponents later, but just to-- wanted to make sure I got that on the record, is that the, the approach that you're taking with this bill is to mandate how much has to be paid out as, as to what has to be covered. And so it's, it's a different approach. But, you know, I think there is competition in the industry. And I'm a big believer in capitalism. And if there's all kinds of money being made by the insurers in this, there would be more clamoring to get into it. And yet there seems to be no question on the part of the people I talked to last year that, you move to this, goodbye, health-- dental insurance plans in Nebraska.

TERYN SEDILLO: And you know what? That may benefit our, our patients. Because listen to this: you don't want a terrible plan. And respectfully, thank you for bringing this forward last year. I wasn't here to speak on this at that time. I do see where you're coming from. Absolutely. But the thing is if Medicaid, our taxpayer dollars, can meet that 85%, why can't our commercial plans with the higher premiums?

JACOBSON: The problem I find in my part of the state is there aren't any Medicare-- Medicaid providers. The, the dental insurers decide they don't want to take Medicaid because they're not getting paid enough. So I would be careful going down that road because we have a, a, a medical desert because the dentists in our area refuse to treat Medicaid patients because they're not getting paid enough. And so that is an issue that we probably need to be addressing as well when it comes to that.

TERYN SEDILLO: Oh, 100% agree with that.

JACOBSON: So, so with that, I just, I just wanted to confirm to-- get on the record as to why I did not carry the bill this year and some of the concerns that I have. And with that, I'm gonna turn it over to Senator von Gillern-- or, Senator Hallstrom. One of those other senators.

TERYN SEDILLO: Sure. Leave us when I got--

JACOBSON: Yes. That's right.

TERYN SEDILLO: --when I am ready to drill you.

JACOBSON: Does anybody else-- does anybody else have a question from the committee?

TERYN SEDILLO: That's convenient.

JACOBSON: If not, thank you. Thank you for your testimony.

TERYN SEDILLO: Thank you.

JACOBSON: And Senator Hallstrom, cheers.

HALLSTROM: Thank you, Chair.

TERYN SEDILLO: Any other questions?

HALLSTROM: Thank you.

TERYN SEDILLO: Thank you.

HALLSTROM: Next witness.

SCOTT MORRISON: Oh, Senator Jacobson. Please stay. Because I got some other answers for you.

JACOBSON: You can give them to the committee.

HALLSTROM: Yes, sir.

SCOTT MORRISON: Thank you. Good afternoon, Senator Jacobson and senators of the Banking, Commerce and Insurance Committee. I'm Dr. Scott Morrison, S-c-o-t-t M-o-r-r-i-s-o-n. And I am a periodontist from Omaha, past president of the Nebraska Dental Association, and current legislative chairperson for the Nebraska Dental Association. I speak to you today in support of LB639, a bill that is, in its simplest form, a consumer protection bill regarding dental insurance. It would require dental insurers to spend at least 85% of their premium revenue on dental care. The bill promotes greater investment of patient premiums in dental care and calls for transparency and accountability in reporting how premiums are spent so that patients and their employers can evaluate the return on investment in dental insurance premium. I would like to talk about concerns previously expressed by the insurance industry. One concern is that insurance premiums will have to be increased to comply with an 85% dental loss ratio. Based on required transparency reporting in other states showing insurers are spending at or near 85% of premiums on care, I believe there are insurers in our state that already conform or are close to conforming with an 85% direct-- or-- I'm sorry-- dental loss ratio. I refer you to the fiscal note of LB639 that I gave you a copy of that's highlighted-- section that the state employee plan and the ur-- university plan already meets the minimum loss ratio. It is disappointing and somewhat telling that insurers immediately threaten premium increases, which would put even more burden on patients rather than considering looking for ways to improve operational efficiencies to protect their revenue generation models. It has been said that 85% is an arbitrary threshold, yet there is ample precedence for this percentage. It has worked for over a decade is a consumer protection for major medical coverage since passage of the Affordable Care Act. And it currently exists for the adult dental side of the Medicaid program in our state, as you've heard. I do acknowledge that differences exist between medical insurance and dental insurance. However, of the two, I would say that dental insurance is less complicated, much more predictable, and therefore should be simpler to administer. Incentivizing dental

insurance plans to become more efficient to ensure patients get more paid for will be better for all Nebraskans. Another concern is that insurers that cannot comply with LB639 will leave the state. As stated previously, our intent is not to reduce the number of dental insurers in the state to-- but to maximize the benefits to patients for the premiums paid into insurance programs by patients and their employers. If an insurer cannot comply with an established DLR, then perhaps consumers-- your constituents-- are better served by not engaging with that insurer and instead engaging with an insurer who better prioritizes patient care by striving to reach an established DLR, resulting in better return on the consumer's investment. In summary, insurers are concerned about this reform because it does not allow them to continue with the status quo in offering their products. Dental loss ratio is a needed consumer protection that will incentivize dental insurance plans to do what they were designed to do in the first place: pay for patient care. I ask you to support LB639 and move it out of committee. Thank you.

HALLSTROM: Senator von Gillern.

von GILLERN: Thank you for your testimony. I know enough about this industry to be kind of dangerous, but I believe that this is true, that your loss ratios change year over year depending on the types and the number and quantities of claims that are made. Correct?

SCOTT MORRISON: Correct.

von GILLERN: So, so the statement on the fiscal note, the DAS and university report that the respective plan carriers currently meet the minimum loss ratio could be a snapshot, not a trend.

SCOTT MORRISON: I agree. And when I read that, I had some concerns about that because it's in-- it didn't even give me a percentage in there.

von GILLERN: OK. So we should not necessarily take this as a statement that that's always the case.

SCOTT MORRISON: But I'm going to assume that the accounting group was looking at 85% because that's what's in the bill. But you're right. It can vary.

von GILLERN: Right. But again, it's a, it's a snapshot in time, not necessarily that they always mean--

SCOTT MORRISON: Correct.

von GILLERN: --when-- of course, the bill would require that, that always mean-- OK. Thank you.

HALLSTROM: Senator Dungan.

DUNGAN: Thank you, Vice Chair Hallstrom. Thank you for being here today, sir. You mentioned as you were walking up that you had some responses to Senator Jacobson. I'm just curious. I-- you were obviously here for his-- the last testifier and some of the questions that were raised there. Do you have, I guess, any relatively brief responses to some of the concerns that were raised in that last back-and-forth that happened? I just am curious what your response is.

SCOTT MORRISON: Yeah, sure. So I, I, I think his concern was about 85%. I would agree that-- 85%, let's say, for a small group might be out of the question. 85% for a large group I think is feasible. There is four states that I have in front of me that I can give you information on that have transparency. They don't have all the bill that, that we're looking at. But they in 2023 were averaged at 85% with their large groups. So-- or, with a large group. So I think it's feasible. I think there may need to be some discussion on the small groups. And out of 12 states that are currently engaged in legislation or this legislation, of those 12, the majority of those have an 85% DLR ratio.

DUNGAN: And do you know in those other states that have implemented that 85% if there's been negative consequences that have been seen since it happened?

SCOTT MORRISON: So I can give you the-- the best information is out of Massachusetts at an 83%. There are some of the smaller groups, as I get information on that have, that have packed up and left. The numbers I get are anywhere from three to eight of those. I tend to believe the number three-- obviously, because that's a better number for me, but. That's my, my most trusted information, I guess, that, that says they've left. And so that's a concern. However, I know that there isn't a lack of insurers in the state of Massachusetts.

DUNGAN: Thank--

SCOTT MORRISON: [INAUDIBLE] small group.

DUNGAN: Thank you. I appreciate it.

SCOTT MORRISON: Yeah.

HALLSTROM: Any-- Senator Riepe.

RIEPE: Thank you. Thank you, Chairman. Thank you, Dr. Morrison. I think one of our bigger problems in the state of Nebraska is access, particularly in our rural markets. Do you think that this 85% or whatever that variable might be will provide some incentive for more dentists to relocate into the rural parts of Nebraska and/or maybe even incentivize some of them to take more of our Medicaid? I understand we have an extremely high waiting list for Medicaid patients.

SCOTT MORRISON: Yes. The two may be mutually exclusive [INAUDIBLE], so. But I think--

RIEPE: Well, I'm trying to marry them.

SCOTT MORRISON: Yeah. I think to try and induce those into the rural areas, I think-- certainly if there's an employer in a rural area that has a good program, I think that's going to draw a dentist or has as the potential when you look at a, a town or a municipality that, that might be more of an interest to a dentist to come to [INAUDIBLE]. The Medicaid issue's maybe a whole separate issue, but it does re-- revolve around costs-- or, or, fees, I should say. And so, you know, I, I don't know if you can marry the two, but I'm not sure I can say that increasing this is going to get better input from Medicaid [INAUDIBLE].

RIEPE: So you're not promising that?

SCOTT MORRISON: No.

RIEPE: All right. Thank you, Chairman.

HALLSTROM: Yes, sir. I, I just got a question. And, and maybe I can take a little bit different approach here. The last witness as part of their testimony said, why should Nebraskans and Nebraska employers who purchase dental plans be subject to add dental plans? Is it a necessary adjunct that because you're below 85% that it was a bad dental plan or-- could you maybe clarify that [INAUDIBLE]?

SCOTT MORRISON: Yeah, sure. So it-- again, in areas or, or states that have some transparency already established, I've seen numbers in the 9%, 6% realm. And I think as a consumer that would be something that would upset me seriously if I knew that that was that low. Even at 40% I'm not sure that I would be comfortable. 50%, you're getting closer, and so on. So--

HALLSTROM: And have we provided any percentage that we believe exists in the Nebraska market?

SCOTT MORRISON: No, I have no access to that kind of information.

HALLSTROM: And are you suggesting if you had that low of a percentage that automatically-- and I guess the component parts I'd look at are, are premiums too high for dental coverage? Are co-pays too high? Or are provider rates not high enough? Just any of those issues that are a direct result of, of the low loss ratio.

SCOTT MORRISON: In regards to the low loss ratio, I-- it-- I can't necessarily comment on that because that's the insurer's decision to try and set up a business model that works for them. As far as provider reimbursement, obviously-- and, and Senator Riepe asked this earlier-- if, if you still have a max on your benefits, you might get closer to that max, but you're probably not going to reach it. Only 2.8% of plans reach that max, where they get to $1,500 or $1000, whatever the max is.

HALLSTROM: Thank you. Any other questions for this witness? Thank you, sir.

SCOTT MORRISON: Thank you.

HALLSTROM: Any other supporters of LB639? Any opponents?

KATE McCOWN: All right.

HALLSTROM: Yes, ma'am.

KATE McCOWN: Hello. Well, good afternoon, Chairman Hallstrom and members of the committee. My name is Kate McCown, K-a-t-e M-c-C-o-w-n. I am the Vice President of Compliance at Ameritas Life and our supplemental insurance products, which includes dental, vision, and hearing. Ameritas employs over 1,300 Nebraskans and 2,600 people nationally. We provide dental insurance benefits for over 330 Nebraskans and 3.3 million Americans nationwide. Today, we are testifying in opposition of LB639, which seeks to require dental plans meet a loss ratio of 85%. Dental plan premiums, as you've heard, are typically 1/20 the premium of a medical plan. There's a substantial difference between medical and dental funding for operational expenses. A monthly family medical premium in Nebraska averages $2,000, while a monthly family dental premium averages $100. While they are 1/20-- dental premiums are 1/20 of medal-- medical premiums, they both have the same administration expenses such as processing claims, answering calls, administering policies, and fraud prevention. With an 85% loss ratio, a medical plan has $300 for those expenses. A dental plan would only have $15 to perform those same activities. Dental carriers would be forced to increase premiums to continue to provide the same service

for their customers while meeting the regulatory obligations. And this is not anecdotal information. As I handed out in this exhibit, the CHBRP report-- in 2024, proposed legislation in California to establish a dental loss ratio of 83% was reviewed for financial and dental market impact by the impartial organization, the California Health Benefits Review Pro-- Program at the University of California, Berkeley. They found that dental loss ratios would lead to an-- premium increases, market withdrawals, reductions in producer compensation, dropped coverage, a move to ASO or self-funded plans, and market consolidation. For these reasons, California subsequently did not pass the bill. Of the 20 states over the past three years that have-- that the dental association has introduced this type of legislation, none have passed. In 2022, Massachusetts voters passed a ballot initiative for 83%. Seven dental carriers have stopped offering dental plans in the individual small group market or have exited the state. Ameritas stopped selling in the individual and small group markets in the state. The bottom line: loss ratios required under this bill would raise dental premiums. It would also impact carrier choice and access to coverage. As an addendum to my testimony today, I have entered in the record more detail on why Ameritas left the Massachusetts market, the value of the dental plan, and a specific dollar amount breakout of an individual plan premium here in Nebraska. Just pointing out that the total profit for Ameritas, as advised by my actuaries, was 3.1% of the premium, or $1.37 of a $44.12 premium. For these reasons, we oppose LB639 and urge you not to move the bill forward. Thank you very much for your time and consideration.

HALLSTROM: Thank you. Any questions from the committee? Seeing none. Thank you for your testimony.

KATE McCOWN: Thank you.

HALLSTROM: Any additional opponents to LB639?

KAITLYNN BOONE: Members of the Banking, Commerce and Insurance Committee. My name is Kaitlynn Boone, K-a-i-t-l-y-n-n B-o-o-n-e. I am the Compliance Director of Mutual of Omaha's Group Insurance Division. Thank you for the opportunity to express Mutual of Omaha's opposition to LB639. We are deeply concerned that this bill will create unintended consequences that severely impact access to dental care and benefits for Nebraskans. If enacted, this bill would reduce employer and consumer options for purchasing dental coverage, compromise quality customer service, and reduce use of and access to dental services. Mutual of Omaha is a Nebraska-based Fortune 500 company. We sell a diversified portfolio, including both individual and group dental

policies. Mutual insures over 26,000 individuals impacted by this bill. You've heard already about some of the, the monetary amounts that differ between the major medical insurance as well as dental insurance. I'm not going to repeat those statistics, but a Medicare-- a medical carrier, in contrast-- we, we share some of the same fixed costs, such as implementing a group, enrolling members, providing ID cards, maintaining a robust network of provided-- providers, negotiating rates for services, and maintaining a claims paying system. These costs exist as fixed costs today even though we would have a significantly less amount compared to a-- premium compared to a medical carrier. If dental plan carriers cannot cover the costs of all administrative expenses under the 85% loss ratio, then those carriers will be faced with the difficult decision of whether it is possible to continuing offer dental plans in Nebraska. Additionally, this creates further disruption in the market, negatively impacting dental providers and consumers when carriers exit the market and-- reducing choice for Nebraskans. This bill borrows the loss ratio from a mejer-- major medical insurance rather than the fundamentally different dental insurance. Medical plans have high deductibles and out-of-pocket maximums. Dental plans, in contrast, have low premium and low maximums with-- which reflect the predictable, lower cost, routine dental care. Congress intentionally omitted the dental insurance from the Affordable Care, Care Act's loss ratio provisions because MLRs do not capture or communicate the value of low premium insurance products like dental plans. The dental insurance market features considable-- considerable competition and stable premium, unlike that of medical plans, to which the minimum loss ratio is appropriate. I do want to address a statement that has been made earlier regarding accountability and transparency. This does exist today in this market. It exists today in our rate filings. As you may know, the Department of Insurance does review our rate filings. They're just down the street here. And that, that process, you know, we go through that with their actuaries and our actuaries to work through that rate filing. So that is a, a publicly avair-- available document. Because of the del-- because of the dela-- deeply negative consequences of this bill and the lack of any demonstrable benefit to Nebraskans, Mutual of Omaha asks that the committee not move LB639 forward. Thank you for your time and consideration.

HALLSTROM: Any questions from the committee? Seeing none. Thank you for your testimony. Any further opponents of LB639?

ALEX YOUNG: All right. Good afternoon, Vice Chair Hallstrom, members of the Committee on Banking, Commerce and Insurance. My name is Alex Young. That's A-l-e-x Y-o-u-n-g. And I'm the Legislative Director at the American Council of Life Insurers. And today, I'm here to testify

in opposition to LB639. The American Council of Life Insurers is comprised of 275 members, representing 93% of [INAUDIBLE] assets across the United States. Our members are dedicated to protecting consumers' financial well-being through the various products they offer, including dental insurance. Now, with that introduction out of the way, I'm going to be totally candid. We did prepare a letter for y'all, but I forgot to print enough copies. Luckily for me though, Mr. Bell and the NIF [INAUDIBLE] clean up and they printed copies, so they'll share that momentarily. But in that, you'll see our written testimony signaling not only our opposition and NIS, but NADP's and AHF's to this bill that would create a dental minimum loss ratio of 85% for dental benefit plans. I'm not going to go into that written testimony word for word, but you know, in your spare time, definitely give it a gander. I'm going to give a brief background and highlight some of the key points to our opposition of the bill. While a minimum loss ratio is currently applied to major medical insurance as a result of the Affordable Care Act, this particular bill would extend a mandate at an 85% loss ratio to dental plans. The impacts of this would leave very left to cover the administrative expenses of these dental plans, whose cost to consumers is typically 1/20 that of major medical. This type of Affordable Care Act mandate found in LB639 if instilled on dental benefit plans would simply result in reduced dental options for consumers at higher premiums, which ultimately would diminish dental health outcomes for consumers across the state. For instance, as was mentioned earlier, in Massachusetts, the only state to tap-- to pass this type of dental MLR, which they did through a ballot initiative-- we've already seen the dental insurance market contract significantly even while they struggle to implement the mandate. We've seen seven fewer carriers, which equates to roughly a 30% decline in options for consumers in the small group and individual markets in Massachusetts. Dental insurance is good for consumers, consumers' health, and the reduction of availability for consumers would come with great negative effects. Dental coverage is closely linked to the regular utilization of preventative dental care, which is critical to avoiding acute oral health issues and pain. It's also been shown that regular preventive dental care and cleanings have shown to alleviate the effects of inflammation from other medical conditions like diabetes or chronic heart conditions. Again, the minimum loss ratio requirements in LB639 would have a cascade of consequence on the dental benefits marketplace, such as leading to lower dental coverage rates among Nebraskans and thus worse dental outcomes. So for those reasons, I hope that you will oppose LB639. And again, I want to thank you all for having me today to speak on the bill.

HALLSTROM: Thank you.

ALEX YOUNG: Yup.

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

ALEX YOUNG: Excellent. Thank you.

HALLSTROM: Next opponent.

ROBERT M. BELL: Good afternoon again, 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'm the Executive Director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurers. Also been asked to testify on behalf of Blue Cross Blue Shield of Nebraska. I'm here to testify in opposition to LB693. As you've already heard from both-- from Ameritas, Mutual of Omaha, and ACLI, I will be brief. I definitely appreciate Senator Clouse listening to our concerns pretty much from the moment he introduced LB693. So thank you. I've also handed out a letter that Mr. Young referenced from the federation, the National Association of Dental Plans, America's Health Insurance Plans, and the American Council of Life Insurers. But there's just two brief things I just really want to bring to your attention. First, we talk a lot about the Nebraska domestic industry. And we have a lot-- a number of life insurers in particular. And they are all very active in dental insurance. And these include-- you've heard-- you heard from Ameritas and Mutual of Omaha, but also a physician's mutual insurance company in Omaha, Aflac, Pacific Life, Blue Cross Blue Shield of Nebraska, MetLife, and Dental-- Delta Dental of Nebraska. They believe and have witnessed that these are signif-- a bill like this has a significant effect on their operations within the state. And then second, I know we heard about transparency. Where does the money go? Where does the money go for insurance companies? All of that's public information. If you want to find out what the financial status of an insurance company is, all you need to go-- particularly on Nebraska domestic, go on to the Nebraska Department of Insurance's website and click on their annual-- it's not the annual. It's every five years, their financial examination report. They are also required to provide their executive compensation schedule to the Department of Insurance. Doesn't necessarily have your dental loss ratio in it, per se, per line. But it has all the other information from all the various products and all the premium that they bring in, the taxes that they pay, the expenses that they have, et cetera, et cetera. So we're very transparent. All of our financial

information's already out there. So with that, we oppose LB693. I appreciate the opportunity to testify.

HALLSTROM: Thank you. Any questions? You are excused. Thank you.

ROBERT M. BELL: Thank you very much.

HALLSTROM: Any other opponents to LB639? If not, anyone in the neutral capacity? Senator Clouse to close.

CLOUSE: Thank you, Vice Chair Hallstrom. OK. We heard a lot of good information on both sides, and I've been here long enough to know that eventually something's [INAUDIBLE] because people don't give up that easily. So this is the second time this bill's come around. So I'm hoping that we'll be able to reach some type of an agreement or work together to come up with something. Don't know what that is. Don't know what it looks like. But I think compelling arguments on both sides of this. So I think we just need to sit and listen to it and figure out what direction we want to go. So with that, I would open it up for any questions.

HALLSTROM: Any questions for Senator Clouse? Seeing none. Thank you for being with us today. Before we close the hearing, we had 21 letters proponent, 7 opponent letters, no neutral letters, and no written ADA testimony regarding LB635. We'll move next to LB715. Senator Bostar.

BOSTAR: This looks much more manageable.

HALLSTROM: Yes. Senator Bostar.

BOSTAR: If I could have this-- thank you. I believe the-- oh, clerk. Thank you.

DUNGAN: I'm was gonna say your red light's on.

HALLSTROM: You may go.

BOSTAR: Good afternoon, Vice Chair Hallstrom, fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar. That's E-l-i-o-t B-o-s-t-a-r. Representing Legislative District 29. Here today to introduce LB715, a bill that would require state-regulated insurers to provide coverage for pre-exposure prophylaxis medication-- commonly referred to as PrEP-- when prescribed by a health care provider. PrEP is one of the most effective tools available for preventing the transmission of HIV. LB715 ensures that cost is not a barrier for individuals who need this lifesaving

preventive medication by requiring coverage by Nebraskan insurers. The U.S. Preventive Services Task Force, USPSTF-- the nationally recognized authority on evidence-based preventive care-- has given PrEP its highest recommendation, determining that it provides a substantial net benefit for preventing HIV infections. In 2021, 107 Nebraskans were diagnosed with HIV, the highest number of new HIV diagnoses since 2010. On average, Nebraska sees 81 new diagnoses per year, with an estimated 1.2 million Americans living with HIV and thousands of new diagnoses each year. Increasing access to PrEP is essential for protecting public health. Research has shown that when taken as prescribed, PrEP reduces the risk of HIV transmission by up to 99%. LB715 is a proactive step for reducing new HIV infections in Nebraska and aligns our state with national best practices. Requiring insurance coverage for PrEP demonstrates Nebraska's commitment to expanding access to essential preventive care. This legislation not only saves lives but also reduces long-term health care costs and advances our goal of ending the HIV epidemic. Recent legal challenges to the preventative care provisions of the Affordable Care Act have placed coverage for many essential preventive care services, including PrEP, at risk. By passing LB715, Nebraska can ensure that its residents continue to have access to this potentially lifesaving medication regardless of federal uncertainty. I would thank you for your time and attention. Be happy to answer any initial questions you may have. And encourage your support of LB715.

HALLSTROM: Thank you, Senator Bostar. Any questions? Senator von Gillern.

von GILLERN: Admittedly, I know nothing on this topic, so this-- don't read anything into my questions. Who, who would take-- who would be prescribed this medication?

BOSTAR: Individual--

von GILLERN: What is the demographic or what is the--

BOSTAR: Individuals who are considered high risk of contracting HIV.

von GILLERN: Which would be?

BOSTAR: I think that there's a, a number-- I mean, that's something that would be worked out with your health care provider. But I think there's a number of factors.

von GILLERN: So it's, it's-- so it's-- and again, I, I, I'm completely ignorant on this, so don't read anything in it. It's-- would this be equivalent to-- I'm opening up a whole nother can of worms-- a, a child

taking a polio vaccine to prevent them from getting polio? I mean, is this--

BOSTAR: I mean, while it's not a vaccine-- right? It, it's a, it's a, a prescription medication that should be taken continuously while an individual's at risk. It does, it does function in a similar way from the, from the patient perspective of, of preventing a particular disease from getting a foothold within, within your body.

von GILLERN: I'll listen to the testimony. If I, if I still don't understand it, then--

BOSTAR: Sure.

von GILLERN: --I'll ask you some more questions. Thank you.

HALLSTROM: Any further questions? Senator Riepe.

RIEPE: Thank you, Chairman. I, I guess my first question would be, is this a, a new enough procedure that many insurance companies just haven't caught up with the idea of having coverage for this particular thing?

BOSTAR: So I would say that this-- insurers are covering it now.

RIEPE: They are? OK.

BOSTAR: Yes.

RIEPE: My second part of that question would be is, is Medicaid currently covering this? I'm always looking for situations where we're expanding Medicaid beyond our affor-- affordability.

BOSTAR: Yeah. Any, any, any plan in compliance with the ACA is covering this.

RIEPE: OK.

BOSTAR: So yes is the answer to your question.

RIEPE: OK. Thank you. Thank you for being here in the committee.

von GILLERN: Any other questions of the committee? Seeing none.

RIEPE: It's just you and me left.

von GILLERN: Will you stay to close?

BOSTAR: I wouldn't want to lose another member.

von GILLERN: Thank you. Yeah. Thank you. As Senator Jacobson noted in his intro, senators are presenting bills in other hearings, so. Has nothing to do with the topic of the bill. Welcome the first proponent for LB715. Welcome. Good afternoon.

ALEX DWORAK: Good afternoon. Thank you, Sub-Vice Chair von Gillern. My name is Dr. Alex Dworak. I ran to another hearing so I suppose I can't, can't throw shade. My name is Dr. Alex Dworak, A-l-e-x D-w-o-r-a-k. It is my honor to testify today in strong support of LB715. I am speaking for myself as a physician expert who treats and prevents human immunodeficiency virus, or HIV, as well as on behalf of the Nebraska Medical Association, of which I am a proud and award-winning member. Pre-exposure prophylaxis, or PrEP, is over 99% effective for the prevention of HIV transmission when taken as directed. It is highly cost-effective, costing as little as $30 a month cash price, which I checked last week at our pharmacy at my FQHC, versus the cost of thousands of dollars per month for first-line HIV treatments. While the survival improvements for people living with HIV are a marvel of modern medical science-- one of the greatest achievements of my short career-- that also means the cost of treating HIV for a lifetime have increased substantially. In this case, to say an ounce of prevention is worth a pound of cure is a dramatic understatement. For a hypothetical 22-year-old who acquires HIV and is treated with first-line treatment-- and currently, the lifespan for somebody living with HIV is the same as anyone else's-- which was not the case when I was a medical student or throughout most of this epidemic. They used to die very young-- a conservative estimate of treatment until age 72 will be $4.5 million for that one person's HIV medication alone, not counting regular medical visits, regular lab work, and enhanced cancer screening, which are all recommended by the professional societies that I ascribe to as a doctor. Compare that to 20 years of PrEP medication, which-- presuming someone's 20s, 30s, and 40s were a lot more rambunctious than mine were or ever could have been-- that would be $7,200 for 20 years of prevention. That's a ratio of 0.0016, or 625 to 1. I'm a physician, not a banker or economist, but that seems like a good return on investment to me. And I can tell you as a doctor who treats HIV and who's had to break the news on many occasions, the human suffering isn't just some rounding error in this. Even as I'm telling people, I can look them in the eye with today's medicines and say, you're going to be OK. It wrecks people. They're in tears. They don't know if they have any future. The shock keeps them from hearing me. And it is terrible as a doctor, let alone as the person who's getting that news. And so I can't put a price on preventing even one of those

conversations. I know nobody here can. And I would love to prevent as many of those conversations as possible. As mentioned, in 2021, Nebraska saw the highest number of new HIV diagnoses since 2010 with 107 new diagnoses. And that's not just a blue or city thing. The number of new cases in rural areas of the state-- where I can attest that there are fewer people who are trained and competent to prescribe this PrEP medication-- nearly doubled and was over 35% of new diagnoses, according to Department of Health and Human Services. Rural people are just one of many populations that face health disparities that I have struggled against in my clinical work as well as a past board member of Nebraska AIDS Project and as an active NMA member. In 2022, there were 90 new diagnoses. And so clearly now is not the time to go backwards on preventive services. This bill will help prevent the deterioration of coverage for this important preventive medication. I've been practicing for 15 years. I've practiced before we had PrEP and I've practiced now during PrEP. I've had patients who couldn't get access to it and I have to stare them in the face and say, this treatment exists, but you can't have it because you can't afford it. And I've also been able to get people on it. I wish I had more people coming to see me and my partners to get on PrEP, because that's how we end the HIV eci-- epidemic. This has been a worldwide scourge, and we can put our hands on it and stop it from hurting more people, and PrEP is how we can do that. So I thank you very much for your time. And your vote to advance LB715. Be glad to answer some of the questions that you posed from my experience as a practicing clinician, if you would like. And I'm very happy to take any other questions the remnants of the committee may have.

von GILLERN: Thank you. Does the committee member have any questions? Senator Riepe.

RIEPE: Thank you. Thank you. Welcome. Glad to have you here. I don't know enough about the medical technology and so I always have to refer-- rely on expertise, which is the safest [INAUDIBLE]. I do have ongoing concerns about the endless cost that we see that keep coming at us as a committee, this included. And I think you said something that it wasn't affordable for some patients--

ALEX DWORAK: When--

RIEPE: [INAUDIBLE] for some taxpayers, it's maybe not-- it's not just this, but other stuff is just, you know-- we're running, you know, on our affordability.

ALEX DWORAK: Well, I--

RIEPE: [INAUDIBLE] we're seeing it in this year's budget. So.

ALEX DWORAK: Appreciate it, Senator. And thank you for representing the best district, District 12.

RIEPE: Yes. District 12.

ALEX DWORAK: So I think that's-- a lot of the affordability issues have been before this was generic. And so some of these things have gotten a lot better. There are some new treatments. So the, the PrEP that's being mentioned here is a daily pill, which needs to be taken regularly to have the, the effect that it needs. Just this past summer, there's a newer-- so there are some every two month injections, which also have some cost, but which are very effective for prevention. And there was a once every six months injection of a new or a novel class of medicine, a capsid inhibitor called lenacapavir, which works extremely well and which can offer protection to populations that are at extreme risk, including those in abusive relationships and those who are being trafficked, as well as those who don't have access to regular medical care, high-risk groups where they don't have a bottle that says, I'm too-- I'm-- you know, somebody can just Google and say, oh, you're taking this, which might put them at risk if they're already being subject to violence. It's just a shot that they can get at a clinic and nobody can tell, and that gives them a lot of benefit. And I agree that costs should be a concern for a fiscally responsible legislature. I do have a fair number of patients who are living with HIV who are on Medicaid as well as other state insurance and Medicare. And again, preventing HIV versus treating it, there's-- it's orders of magnitude off, as I said. Just for looking up the sticker price-- and that doesn't include all the other associated costs, the potential psychological trauma that somebody undergoes which may benefit from mental health therapy. But again, just-- if we're-- if we want to be fiscally responsible, which I appreciate, as somebody whose kids are coming to voting age and inheriting our state, this is one of the biggest slam dunks I think that you're going to find. I mean, it's just so, so, so much cheaper to prevent this than it is to treat it.

RIEPE: You did say there's a, a generic out there.

ALEX DWORAK: Yes. So there are tenofovir disoproxil fumarate, which is the older one, tenofovir alafenamide. Both co-formula with emtricitabine. And if anybody's not asleep and wants to nerd out about pharmacology, see me afterward. But, yes, they-- there's two pills, which-- one of which has been generic for some time. Both of them are typically accessible. And the injectable cabotegravir, which is a

different class of medicine, is still on bra-- on patent. Lenacapavir, the novel one I mentioned, which works for six months, which is incredible-- just a revolution in treatment-- that's also still on patent. But eventually those will go generic too. And so this will be getting even better and better and more affordable as time goes by. But even just making sure that the cost of the pills is covered for the working poor across Nebraska. Because if somebody has private insurance, they might not be able to get the inexpensive price I mentioned, which is 340B at our FQHC. This could cost somebody hundreds of dollars a month, which, if you're working paycheck to paycheck and want to be responsible and want to be proactive and want to stay healthy and, and contribute to the public health, that might break your bank if you're not wealthy.

RIEPE: OK. Thank you. Thank you for being here. Thank you, Chairman.

von GILLERN: So the-- got a couple of questions. In, in your statement, you say that-- or, the NMA statement says that costs can be as little as $30 per month. Is that the generic?

ALEX DWORAK: That's the generic that I double-checked. Again, under the 340B program at our FQHC. I'm, I'm not-- I couldn't speak for certain to what could be negotiated. But in general, compared to the, the-- it's quite inexpensive compared to the cost of a first-line anti-retroviral, which is also recommended by the American Academy of HIV Medicine, the Infectious Disease Society of America, AAFP, ACOG-- I could go on and on-- which will be bictegravir, Tenoviral alafenamide, emtricitabine or Biktarvy. That is thousands of dollars a month just sticker price. And with insurance, that's still extremely expensive. Again, it it's revolutionary-- I mean--

von GILLERN: So the-- I'm sorry for interrupting you. The, the-- so the $30 a month cost is--

ALEX DWORAK: That would be for Truvada, generic, which is one pill once a day of two, two nucleoside inhibitors that are over 99% effective in preventing HIV if someone has access to it and takes it.

von GILLERN: OK. So-- OK. So here's what I'm struggling with. We're talking about this unbearable, untenable cost. $30 a day does not-- or, $30 a month does not seem-- it's, it's a lot to someone who doesn't make much money. But we're also talking about a prevention of something that is highly behavioral in nature how it's acquired. And you mentioned some scenarios I hadn't thought about, someone who might be trafficked, and other situations that would be completely beyond their,

their control. And that's a unique situation. But, but generally, what we're talking about is preventing a disease that is highly behavioral in how it's acquired.

ALEX DWORAK: Oh, it's mostly acquir-- or, transmitted through things like sex or injection drug use, which are separate things, of course. I also just recently lectured about Ryan White. The Ryan White Program was named after him. I'm not sure if y'all are familiar with that. He was a 13-year-old hemophiliac who received a [INAUDIBLE] transfusion. There was a lot of screening to prevent that, but there was also--

von GILLERN: Ryan White would not have been on this medication.

ALEX DWORAK: No, because he died long before this became available.

von GILLERN: Well, but-- nobody's going to give this to a 13-year-old kid.

ALEX DWORAK: At this is-- at this point, we have a lot of other screening for blood donors. And every time I go to the Red Cross for the 13 gallons I donate, they ask me a lot of invasive questions about who I have sex with and where I've traveled and if I've had a [INAUDIBLE] transplant and such, so.

von GILLERN: OK. All right.

ALEX DWORAK: Yes.

von GILLERN: OK. That's help-- helpful. Thank you for the-- your testimony.

ALEX DWORAK: Thank you.

von GILLERN: Seeing no other questions. Thank you for being here. Any other proponents?

ANDREW RADUECHEL: Hello, members of the Banking, Commerce and Insurance Committee. Thank you for the opportunity to testify in favor of LB715. My name is Andrew Raduechel, A-n-d-r-e-w R-a-d-u-e-c-h-e-l. I'm the Director of Pharmacy for Boys Town National Research Hospital. I'm here today on behalf of the NHA to support LB715. This bill would require coverage for pre-exposure prophylaxis, medication for the prevention of hum-- human immunodeficiency virus, HIV infection. When prescribed by a physician or health care professional legally authorized by law to prescribe such a medication, this legislation would require that one of several effective therapies be covered by a plan but does not prevent

the application of deductibles or co-payments. Pre-exposure prophylaxis is a preventative approach designed to lower the risk of HIV infection. And as-- good doctor before me mentioned a lot of the same things I'm going to mention. The process involves taking a daily medication that prevents the virus from establishing itself. So over 1 million new HIV infections occur yearly worldwide, with more than 30,000 annually in the United States. There are no effective vaccines to prevent HIV transmission. The only two tools we have for HIV prevention are behavioral education and PrEP medication. Among persons who are adherent to treatment, PrEP can reduce the risk of HIV transmission by greater than 99%. However, less than 1/3 of people who meet PrEP indications have ever been prescribed PrEP. Uptake has been particularly limited in certain populations who are at greatest risk for HIV infiction-- infection, at-risk African Americans, Hispanic Latin Americans, and adolescents. PrEP therapy also saves significant health care dollars. With generic versions available, PrEP medications can cost as little as $240 per year. One NIH study estimated that the lifetime medical costs avoided by preventing one HIV infection in the United States was approximately $300,000. So if you take those times 100, you can kind of get a sense of what that would be for Nebraska. So $24,000 versus $30 million to treat someone with HIV. This bill is about access to care. I recognize this bill addresses what may be an uncomfortable subject for some, but the NHA ensuring access to potentially lifesaving medications, LB715 is consistent with our mission to improve the health, well-being, and quality of life for all Nebraskans. I stand ready to answer any questions you have.

von GILLERN: Thank you. Questions from the committee?

RIEPE: I guess I--

von GILLERN: Senator Riepe.

RIEPE: Thank you, Chairman. I'm looking at this. I'm just--

ANDREW RADUECHEL: Yeah, yeah, yeah.

RIEPE: [INAUDIBLE].

ANDREW RADUECHEL: It's complicated.

RIEPE: [INAUDIBLE]. I go to the one sentence and then I quote, is, with generic versions available, PrEP medications can cost as little as $240 per year. So that-- my question gets to be is that, that seems to be a little threshold.

ANDREW RADUECHEL: Yeah. Yeah, I agree.

RIEPE: And so, you know, I'm always concerned about setting precedent for other expenses. You know, at what point in time do we cover everything? I mean, $240. It's-- you, you can't have an addiction to Scooter's and-- or, or coffees for $240 a year.

ANDREW RADUECHEL: Yeah, I agree. And, you know, I think the biggest thing is, like, this isn't mandating that insurance company has to cover all of the costs. There was a sentence in there too about, about co-pays and having, you know, some out-of-pocket costs for the patient. So I think it's just including it on a formulary that it's, that it's available as a treatment. And, you know, being a health care professional, I've, I've been stuck with a dirty needle before. It's not just-- you know, that's obviously the rare occasion that I've used for it, but it does have, you know-- [INAUDIBLE] health care plan for an employer or a hospital. It-- you know, you'd want to cover something like that. Obviously, workmen comp would probably cover that type of situation, but. Yeah. I, I think it's, it's, it's more of the making it available as a formulary option and that, you know, that's there's two or-- there's three different ones out there, so picking the, the low-cost one would be, would be easy.

RIEPE: I just think [INAUDIBLE] would like to do--

ANDREW RADUECHEL: Sure.

RIEPE: [INAUDIBLE] particularly in Michigan more than others is, what can we really come up with the money to do?

ANDREW RADUECHEL: Understood. Yeah.

RIEPE: Regardless of [INAUDIBLE]. It's just-- it's, it's a, it's a spot that we'd probably kicked the can down the road and all of a sudden under the new policies there's no more road, road down--

ANDREW RADUECHEL: Right.

RIEPE: --in the way.

ANDREW RADUECHEL: Yeah.

RIEPE: So that-- thank you for being here.

ANDREW RADUECHEL: Sure.

RIEPE: Thank you for your expertise.

von GILLERN: Thank you, Senator Riepe. Couple questions. The-- you mentioned you, you've been-- as a provider, you've been stuck with a needle before.

ANDREW RADUECHEL: I have.

von GILLERN: Would most help-- are most health care providers taking this and would most of them?

ANDREW RADUECHEL: Oh, oh, yeah. For-- yeah. And it's, it's-- you know, it's been around-- so Truvada's been around since 2012. That's why there's a generic version available. But absolutely. I would not hesitate to take this therapy if I was stuck with a, a dirty needle suspected of--

von GILLERN: Well-- I mean, you would have to be taking it beforehand, right?

ANDREW RADUECHEL: No. You can take this after you've been exposed. Right, right. This is--

von GILLERN: Oh. All right. I didn't-- I did not understand--

ANDREW RADUECHEL: Nope. Yep.

von GILLERN: OK. All right.

ANDREW RADUECHEL: This is-- yeah.

von GILLERN: OK. All right. I-- OK. I keep hearing the term preventative, so I--

ANDREW RADUECHEL: It's, it's prevent-- it's preventing the-- yeah-- high risk for people--

von GILLERN: OK.

ANDREW RADUECHEL: --who've been exposed. But it's present-- prevent-- preventing the infection from taking [INAUDIBLE].

von GILLERN: OK. So, so let me ask you a different question. If-- so this is-- is this-- iss-- quite often issued in a pill form or provided in a pill form or--

ANDREW RADUECHEL: There's different formulations, correct. Yeah. The, the cheapest one is a pill form that you have to take everyday.

von GILLERN: So someone could come in and say, I want a prescription, I want to be on this. And you'd say, here's your bottle of 30 pills. Come back and refill it in a month or whatever.

ANDREW RADUECHEL: Right.

von GILLERN: So if, if we're-- and again, I want to be very sensitive in how I say this. If we're talking about a population that is making what some might categorize as unwise decisions about their sexual behavior--

ANDREW RADUECHEL: Sure.

von GILLERN: --how, how much can they be trusted to take a pill every day?

ANDREW RADUECHEL: Well, it-- there's all kinds of different studies out there about who's-- who takes it. Actually, there's a lot of success with people only taking it three or four days a week. That's beside the point. But, yeah, the, the best-- the 99 cent-- or, the 99% is those people who are taking it, you know, six to seven days a week. Yeah. So as a health care professional, once the-- you know, we've crossed that-- right? Once we cross the, the bridge over the river of, you know, they've been exposed or whatever, then it, it's on me to, to treat them and to-- right. But the-- there's obviously a behavioral component too that-- like I mentioned.

von GILLERN: I mean, it-- again, if we're talking about making good, you know, wise decisions, you know, the use of a, of a condom would, would achieve the same outcome for a lower cost if one was to make wiser decisions in their sexual behavior.

ANDREW RADUECHEL: For people choosing-- yes, for sexual activity.

von GILLERN: Yes. Yeah. And, and-- understood. There are other ways to, to acquire it. So I understand that. OK. All right. Thank you.

ANDREW RADUECHEL: Mm-hmm.

von GILLERN: Thank you. Appreciate that. Senator Riepe has another question.

RIEPE: Yes, I do. Thank you. I thought-- I'm not trying to be too clever. It's-- it sounded like in your description this is another version of the morning after pill.

ANDREW RADUECHEL: I-- so what's-- the question is, is it like a morning after pill?

RIEPE: I thought that's what I heard you say, that you can take it the morning after.

ANDREW RADUECHEL: Well, it's, it's, it's, it's, it's, it's for both. It's for high-risk lifestyles, but, yes, it's also for when you've been exposed to, to, you know, a situation whether you knew it or whether you found out later that, you know, you were exposed.

RIEPE: You did describe it as you can take in the morning after. Is that what you said?

ANDREW RADUECHEL: Well, you can take it after you've been exposed.

RIEPE: OK.

ANDREW RADUECHEL: Yes.

RIEPE: That's all I wanted to hear. Thank you.

von GILLERN: OK. Seeing no other questions. Thank you. Appreciate it.

ANDREW RADUECHEL: Thanks.

von GILLERN: Any other proponent testimony? Seeing none. Is there any opponent testimony. Seeing none. Is there anyone who'd like to testify in a neutral position?

ROBERT M. BELL: Even the page thought I would be opposed. Senator von Gillern and Senator Riepe and Senator Hardin. 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 to testify today neutrally on LB715. The Nebraska Insurance Federation, the state trade association of Nebraska insurance companies, including most of the health plans selling in the state. The health insurers certainly appreciate Senator Bostar reaching out prior to the session on LB715. Just a couple of notes. The federal Patient Protection and Affordable Care Act of-- ACA, requires many health plans to cover certain preventive services without cost sharing for consumers. Broadly, these preventive services fall into four categories: one,

evidence-based screening and coun-- counseling; two, routine immunizations; three, preventative services for women; four, preventative services for youth and children. Pre-exposure prophylaxis medication, or PrEP, falls into the first category of evidence-based screening that has been recommended by the United States Preventative-- Preventive Services Task Force-- which, for brevity, for the rest of my testimony, I'm just going to say task force. In 2023, after significant study research, the task force recommended that clinicians precribe-- prescribed PrEP to all adolescents and adults at an increased risk of HIV. Based off of these recommendations, covered health plans implemented, implemented pursuant to the requirements of the federal-- these recommendations were implemented by covered health plans due to the requirements of the Affordable Care Act. So as a result, we cover PrEP. We certainly appreciate the continued interest of Senator Bostar to ensure that our state law matches the federal law. We are neutral on LB715. I, I will say two things. So there is no cost sharing related to this under ACA plans because the task force has determined that it meets, I believe, Class A. So Class A or Class B findings of the task force are provided without cost sharing. Doesn't matter what type of plane you're in. Senator Bostar did something that's very smart in this legislation, is that he allows cost sharing should the United States Supreme Court determine that the task force was constituted-- unconstitutionally, which is litigation that's ongoing right now. So in that case, it's Kennedy v. Braidwood Management. Thank you.

von GILLERN: OK. Any questions from the committee? Seeing none. Thank you, Mr. Bell.

ROBERT M. BELL: You're welcome.

von GILLERN: Anyone who'd like to testify in a neutral capacity? Seeing none. Senator Bostar to close. And while you come up, we had 15 proponent letters, 5 opponent letters, 0 neutral, and 0 ADA testimony.

BOSTAR: Thank you, Senator von Gillern and members of the committee. Again, I appreciate the line of questions related to the fiscal interests of the state and whether or not we can take more things on. Again, to be very, very clear to the committee, this is covered by all health plans-- all health plans that can call themselves insurance. It is covered currently without any cost sharing. If you pass this bill, no one is going to become covered who is not covered today. The point of the bill is to guard against legal uncertainty at the federal level and ensure that regardless of what happens with current existing litigation that this will be covered as it is now for everyone eligible. The difference being, though, that if something were--

happened on the federal level that-- oh, we'll say weakened the position of the preventive task force, then this bill would require that coverage continue, but it would allow for cost sharing at that point, which currently is not permitted. So again, there's no-- you're not taking anything on you that don't already have. And I, I, I should have been, I think-- I guess, a lot clearer in my open when I said this is currently covered by everybody, but it's currently covered by everybody. I appreciate your time.

von GILLERN: Questions from the committee? Senator Riepe.

RIEPE: Thank you. OK. You mentioned there's litigations [INAUDIBLE]. I'm totally unfamiliar with this. Is there a lot of litigation going on?

BOSTAR: There's one case that Mr. Bell cited the name of, and it's, it's in the U.S. Supreme Court. And it's related to the medical designations by the U.S. Service Preventive Task Force-- Preventative Service Task Force. And it, it's-- the litigation doesn't center around any treatment or clinical intervention or medication or anything like that. There's no-- no one is questioning the guidance of this group. I think everyone understands the value of those designations when they give those-- a particular treatment or intervention a high grade. Then it becomes required coverage. No one's questioning any of that. It's simply a question as to constitutionality of delegation of authority of this group. And that's what's being fought. The, the, the lawsuit has been ongoing. It was being defended by the Biden administration, and it is now being defended by the Trump administration. So both of the last administrations are defending the challenge to this task force, basically taking the side that, no, this is, this is constitutional. And this is-- I, I suppose they see some benefit in it. But that's the case that's happening. There's not a lot of litigation. There's one case, but it's a high-profile case. And, and I just want to ensure that the folks who are relying on this are going to be able to continue to-- should, should this litigation go, frankly, the wrong way.

RIEPE: So you're looking for continuity.

BOSTAR: I am, I am looking to maintain the status quo and ensure that our health care, our health insurers, our payers aren't saddled with a spike in HIV treatment costs, because currently they've been able to keep those costs down by ensuring full coverage of the, the PrEP medication.

RIEPE: OK. Thank you.

BOSTAR: Thank you.

von GILLERN: Any other questions? Seeing none. That'll close our hearing on LB715 and will close our hearing for the day in the Banking, Commerce and Insurance Committee. Thank y'all.