[LB813 LB1017 LB1083 LB1088]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Tuesday, February 16, 2010, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB813, LB1017, LB1083, and LB1088. Senators present: Pete Pirsch, Vice Chairperson; Mark Christensen; Mike Gloor; Chris Langemeier; Beau McCoy; Dave Pankonin; and Dennis Utter. Senators absent: Rich Pahls. []

SENATOR PIRSCH: Okay, if I could have your attention, I think we'll get started. It's after 1:30. Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Pete Pirsch. I'm from Omaha, represent the 4th Legislative District. I serve as Vice Chair of this committee. The committee will take up the bills in the order posted. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. To better facilitate today's proceeding, I ask that you abide by the following procedures: the information is posted on the chart to your left. Please turn off your cell phones at this point, and if you do plan on testifying here today on one of the four bills, I'd ask that when the bill is being considered that you move up to the front reserved chairs so that you're ready to testify. In terms of the order of testimony, we will start with the introducing senator, move on to proponents, then opponents, then neutral testifiers, and then finally, have the introducing senator close. If you would sign in if you do plan on testifying, hand your sign-in sheet which are located...those are the pink forms there on the table in the back, hand those in to the committee clerk, Jan Foster, to your right, my immediate left there when you come up to testify. If you would...when you begin your testimony, spell your name for the record. If you could remember to be concise. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand it to the Page, one of our two Pages today, for distribution to the committee and staff. We'll need ten copies. If you don't have ten copies of the handout prepared, just raise your hand, if you would now, so that one of our two Pages can make copies for you. To my immediate left is committee counsel, Bill Marienau, and to my left at the end of the table is the committee clerk, Jan Foster. The committee members with us today, if I could have you introduce yourselves, starting with my far right, your far left. []

SENATOR UTTER: I'm Dennis Utter from District 33, Hastings area. []

SENATOR PANKONIN: I'm Dave Pankonin, District 2; I live in Louisville. []

SENATOR McCOY: Beau McCoy, District 39, Elkhorn. []

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. []

SENATOR PIRSCH: Very good. Our Pages today are Abbie Greene from Omaha and

also Alex DeBrie from Scottsbluff. The committee will take up the bills today in the following order: We will start off with LB1083. Senator Dierks is the sponsor. I know that you are here, Senator Dierks. Then we'll move on to LB813, Sponsor is Senator Gloor, and LB1017 which is Senator Cornett and also LB1088, Senator Cornett. So without further adieu, we will start with LB1083. Senator Dierks, whenever you're ready to open. [LB1083]

SENATOR DIERKS: (Exhibit 1) Thank you, Senator Pirsch. Members of the Banking, Commerce and Insurance Committee, my name is Senator Cap Dierks spelled C-a-p D-i-e-r-k-s, and I represent the 40th Legislative District. It is a pleasure to be here today. As a matter of fact, I'm not sure I've ever been before the Banking Committee before. I'm having a lot of firsts this year. I'm here today to introduce LB1083. A constituent who is a friend and practicing attorney brought the idea for this bill to me. It would change an area of statute 30-38,103, dealing with certification of trusts. I have handed out a copy of that section of statute, and as you can see, there's a list of items that may be included to confirm a certification of trust. Among those items is subsection 7 which includes the social security number of an employee/employer identification number which includes the social security number or employer identification number. LB1083 removes subsection 7, so a person's social security number will not become part of a public record. I'm concerned with identity theft and want to eliminate this information from the public domain, if possible. When my constituent contacted me, I decided to introduce the bill to bring this to the Banking Committee's attention. I appreciate your attention to this matter and will try to answer any questions you might have. And I should tell you that I haven't contacted anybody from the district; I'm not sure there will be anybody here to even testify so. [LB1083]

SENATOR PIRSCH: Very good. Thank you, Senator Dierks, for your opening. Are there any questions for Senator Dierks at this time? And Senator, did you say there was going to be somebody following you testifying or is this...so this might be...I'll tell you, then I'll just ask a quick question because I don't know if there's going to be testimony on either side. Is...and you're looking into this, would there be...in terms of your ideas simply to eliminate social security number in terms of what's required for this, correct? [LB1083]

SENATOR DIERKS: It is not really required. It's stated that it may be used, and he would like to take that may out, just get rid of it because he doesn't think it has any necessity being on there. [LB1083]

SENATOR PIRSCH: Would that then in any way make the process slower or make the information less reliable in your estimation? [LB1083]

SENATOR DIERKS: I don't think so. I don't think it would really have much of an effect. [LB1083]

SENATOR PIRSCH: Okay. Senator Pankonin has a question. [LB1083]

SENATOR PANKONIN: Thank you, Senator Pirsch. Senator Dierks, I see it's just obviously that (sub)section 7 is crossed out. You had the constituent that had the concern, and I think it's a valid one. Did you check with anybody else on this idea what effect it may have on the courts or any other part of the system? [LB1083]

SENATOR DIERKS: Not really. We did check with the bankers' lobby, and they didn't seem to have any problem with it so. [LB1083]

SENATOR PANKONIN: Okay. Thank you. [LB1083]

SENATOR DIERKS: The fact is, we wanted them to know just in case they had missed it, so if they wanted to testify and they indicated to me just before the hearing, that they probably wouldn't testify on it so. [LB1083]

SENATOR PANKONIN: Okay. Thank you. [LB1083]

SENATOR DIERKS: You bet. [LB1083]

SENATOR PIRSCH: Super. Any other questions? Seeing none, thank you, Senator Dierks. [LB1083]

SENATOR DIERKS: I won't stay around to... [LB1083]

SENATOR PIRSCH: You're going to waive your closing? [LB1083]

SENATOR DIERKS: Yeah, I think so. I think that...I think I've said all I can say (laugh). [LB1083]

SENATOR PIRSCH: Okay. (Laugh) Well, thank you. I appreciate... [LB1083]

SENATOR DIERKS: Thank you for your attention. [LB1083]

SENATOR PIRSCH: You bet. Are there any proponents of LB1083 to testify here today? Seeing none, are there any opponents of LB1083 here to testify today? Seeing none, are there any individuals here to testify in a neutral capacity with respect to this bill? [LB1083]

ROBERT HALLSTROM: Chairman Pirsch, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m, representing the Nebraska Bankers Association in a neutral capacity today. With your question, I wanted to come up...I certainly didn't want to mislead, and I'm going to be awfully sensitive on the bill here per Senator Dierks

in terms of saying I wasn't going to testify. I do just want to make it clear, the statutory provisions that are being altered are permissive in nature. The certification of trust came from the Uniform Trust Committee for the Uniform Trust Code that was adopted a number of years ago. We do not have any objections to removing this particular provision from the permissive components of that legislation. However, I did want the committee to know that it is important for us to have that tax ID number. There are simply other mechanisms by which we will get that tax ID number at the time of opening the account. Many times attorneys don't want to share or have their client share much of the trust agreement with the bank, but there are certain particulars that are necessary for the bank to know who the trustee is, who the successor trustee is, and so forth as outlined in the certification of trust, so it does provide an important purpose. Be happy to address any questions. [LB1083]

SENATOR PIRSCH: Thank you. Have you received any feedback from attorneys at the bar association? Have they, to your knowledge, formed an opinion on this? [LB1083]

ROBERT HALLSTROM: I'm not sure whether...I would assume they'd be here today if they had any position on the bill. [LB1083]

SENATOR PIRSCH: Very good. Thank you. Any other questions? Seeing none, thank you. [LB1083]

ROBERT HALLSTROM: Thank you. [LB1083]

SENATOR PIRSCH: Are there any other individuals here to testify in a neutral capacity on LB1083? Seeing none, Senator Dierks has indicated that he would waive his closing. We will therefore...that will conclude the hearing on LB1083. We will move on to the second bill scheduled today, and that is LB813. Senator Gloor, you are the sponsoring senator, open at your leisure. [LB1083]

SENATOR GLOOR: Good afternoon. Thank you, Senator Pirsch, fellow senators, committee members. I'm Mike Gloor, G-l-o-o-r. I don't know if any of you have...actually, I think I know at least one of you have dental insurance. I don't. I did have dental insurance once upon a time through my organization. In fact, remember the day that I sat down with my human resources department and put together what we called dental insurance. However, that reminded me of the fact that...as well as this bill, when it was first presented to me to consider introducing, that what we call dental insurance really is not insurance. In fact, under Nebraska statute, we don't refer to dental coverage as insurance. The coverage is referred to in statute as prepaid dental services because it's what it actually is. It's not insurance as we defined it. They'll be another testifier who I know will elaborate on this a little bit further, but let me talk about that specific issue at least from my perspective. When you're talking about medical or health insurance, when you purchase that insurance all medical procedures that you receive get some kind of

reduction in costs that's set forth in the EOB or Explanation of Benefits. When you've spent enough money to meet your deductible, $500, $1,000--I'm the lucky person that has a $5,000 deductible, but at that point in time, the insurance company pays for all or a large portion of your expenses beyond that point. The policy protects you from catastrophic illness or major medical expenses that are out there. It also brings into play the theory of moral hazard which is that if you've got some skin in the game, if you're paying some of the cost, you're more likely to be a discriminating purchaser of those services. On the dental side, however, it is just the opposite. Only certain services receive a reduction in cost, and once you receive the cap for those services, there's no further coverage. In reality, you prepay for the right to receive a certain amount of dental services and certain types of service. There is no insurance as we traditionally define it involved. It's a use it or lose it scenario. There's no coverage or protection against a major dental emergency. More for dental care, surprises beyond that tightly defined group of services will be covered. The idea of prepaid dental services started back in the 1970s. Some of you will recall that, at that time, they also talked about vision services. That still exists, but there are also prepaid legal services. That does not exist, at least didn't survive as I know it. The benefit was provided to large employers to provide as part of their cafeteria benefit plans. Employees would pay a certain amount each month, and they would receive $1,000 worth of dental services a year through a reduction in the cost of certain covered services. Under these prepaid dental policies, there are covered services such as teeth cleanings, fillings, crowns. Noncovered services are generally services such as implants or veneers. Nationally, however, there is a...let me transition here and say, the basis behind this bill gets behind what's happening nationally, and that is at least one insurer has attempted to require that dentists provide reduced rates on those noncovered services. The problem is that these services are by their very nature already outside the contract; they're not covered services. The insurer is trying to piggyback discounts for uncovered services onto a contract that relates only to specific covered services. If this practice is allowed, it will result ultimately in cost-shifting, and I cannot tell you, based upon my history in healthcare, how much I dislike cost-shifting. When services that are not covered and are not paid by either the plan or the insured, the dentist will end up making up that money someplace else. Ultimately, that dental practice will have to charge individuals with no...who have no dental coverage more to make up the difference. In Nebraska, many dental practices and the number of patients with dental coverages in those practices can be as high as 50 percent. That means that 50 percent of those people who are uncovered by that dental plan will end up paying that increased rate as it is cost shifted to them. This practice has not started yet in Nebraska. There is no dental plan I know of that is attempting to treat noncovered services as a covered service, but since it's happening in other parts of the United States, this bill is preemptive. It would ensure that we never get to that point. LB813 makes it clear that prepaid dental plans may not limit the fee charged for noncovered services. A similar bill was passed in Rhode Island. It's been introduced in several midwestern states this year, and I'm told that the dental insurance company who initiated this practice, at this point in time, does not object to

this bill. We'll see. I appreciate your attention to the testimony that will follow. I hope that we can advance the bill to the floor, and I'd be happy to try and answer any questions, although there will be other testifiers. Thank you. [LB813]

SENATOR PIRSCH: Very good. Thank you, Senator Gloor. Are there any questions? Seeing none, we will...and you'd like to close, is that correct? [LB813]

SENATOR GLOOR: Briefly. [LB813]

SENATOR PIRSCH: Yeah. We will move on to proponents then of LB813 at this point. Is there anyone here to testify in favor of? Good afternoon. [LB813]

CAROLYN TAGGART-BURNS: Good afternoon, Senators. Excuse me, I have a three- and a one-year-old, and, of course, I have a cold from them. My name is Dr. Carolyn Taggart-Burns. My last name is spelled T-a-g-g-a-r-t-B-u-r-n-s. I want to thank you for allowing me to speak to you today. I'm a general dentist, practicing in southwest Omaha. I've been practicing for eight years, but I bought my practice two years ago, so I'm relatively new as a small business owner. I'm on the board of directors for the Nebraska Academy of General Dentistry as well as the board of trustees for the Nebraska Dental Association. I speak in favor of LB813. As Senator Gloor mentioned, dental insurance is more appropriately prepaid dental service plan. Insurance in the name inherently leave the person to believe that they will have help at their lowest time. It inherently leads a person to think that during a catastrophic event, that their coverage of their dental plan will support them. This is, like he explained, the model of medical insurance where after the deductible is met, that either a hundred percent or almost a hundred percent assists in that catastrophic event. A prepaid dental plan is more like a gift card or, as I was kind of thinking, the coupon card that the local high school football team sold me as a fundraiser because the football team is making a profit whether I use it or not. The companies or providers are agreeing to take a discount, and then it's like a gift card in that the prepaid dental plan gives you a set amount on that card, and when you reach that after that you have no...no more coverage is available. Typically, a prepaid dental plan costs the consumer about $40 a month and you receive about $1,000 annual coverage. Many of you already know that the annual maximum hasn't really increased much since the inception; $1,000 was a normal coverage in the seventies as well. The $1,000 that the insurance company provides is paid toward covered dental services based on their contractual rate, meaning that if a cleaning costs $100 or if a dentist is charging $100, for example, the contractual rate may be $65. That $65 is then the portion that's applied to the $1,000 that year. If a patient has a traumatic fall or requires moderate to extensive restorative dental treatment, the patient will achieve the $1,000 and then be responsible for any services above and beyond that $1,000. Especially for trauma, the $1,000 can be met and exceeded quite rapidly. Covered services like Senator Gloor explained, are usually the two general cleanings per year and some restorative procedures like fillings and crowns, also taking out teeth

is usually covered as well as root canals. What is usually not covered is what we term posterior composites which is a tooth colored filling in the back of part of a mouth, implants, veneering, bleaching, night guards for grinding, or temporomandibular disorder. And within the past few years, I've also noticed that some of the prepaid dental plans are not even covering some of the crowns or fillings, you know, depending on that corporation's program. There will come a time when the cost-shifting will occur if the insurers are allowed to limit the amount of charges for noncovered services. The cost-shifting will likely go to the uninsured or to other insureds. That means that the prices that the uninsured will pay will likely increase in order to cover the noncovered contractual rates of other companies. The only people that cost shifting and limitations to noncovered services is hurting in the long run is my patient. I'm new to dentistry, but already I have three generations of families in my practice, and I work hard to develop the relationships with my patients because I care about them, their oral health and their overall health. The costs of the dentist remains relatively the same and constant, but having additional discounts leveraged on dentists will cause the costs to be shifted somewhere within the dental practice and usually just shared by the patients. Prepaid dental plans and insurance companies are as integral to a dental practice as patients and dentists. So we want to work together as not to push any part of that equation out. The weakest link is the patient because they don't have a say in a fee, and they don't have a say in a contractual rate per se, so we have to look forward to helping them and treating them fairly and comprehensively. Thank you for your time and consideration and a positive vote for LB813. [LB813]

SENATOR PIRSCH: Thank you very much for your testimony. Are there any questions based on this? Just a couple of quick ones. Can you tell me what percentage of your patients currently use this kind of...come in with one of these type of setups, prepaid dental service plans? [LB813]

CAROLYN TAGGART-BURNS: I can estimate mine is a...I'm a new dentist, and so I've signed up for a lot of plans, so mine is higher than the average. Mine is about 75 percent, 60 to 75 percent. [LB813]

SENATOR PIRSCH: That means 70...like three out of every four who come in are coming..are utilizing the prepaid...okay so... [LB813]

CAROLYN TAGGART-BURNS: With a prepaid dental plan of some form or fashion. [LB813]

SENATOR PIRSCH: Okay. [LB813]

CAROLYN TAGGART-BURNS: It's...a lot of corporations are actually getting unique and some of my prepaid dental plans are actually...here's $500. Do what you want. After that, you're on your own instead of even doing any write-offs or anything like that, so

there's a lot of unique plans actually out there, too. But I'd say mine is a little bit higher than the average. [LB813]

SENATOR PIRSCH: Okay. And secondly, do entities exist in the United States anywhere today, and these are not prepaid dental services, but entities who just say, we're fee negotiators? We don't actually provide dollar one, but we go and negotiate for a price from the consumer. You pay us X amount, and we negotiate down your whatever it is...medical or dental costs or... [LB813]

CAROLYN TAGGART-BURNS: Not to my knowledge, but some...maybe some of the other testifiers might have some knowledge of that. I don't have any knowledge of that. [LB813]

SENATOR PIRSCH: Okay. Thank you very much. Senator Langemeier had a question. [LB813]

SENATOR LANGEMEIER: Thank you, Vice Chairman Pirsch. Just out of curiosity, if a family of four...if I came to your dental office and we decide, okay, we're going to go to cleanings every six months, and you told me it's X bucks...can I send you a check today for 150 bucks a month, and would you accept it, and then my kids come in and do their cleanings on schedules? Can I prepay to you, I guess, is my question? [LB813]

CAROLYN TAGGART-BURNS: Like...yeah, yeah. In my office, yes. Yes, they can do that. In other offices, I think it's yes and no, depending on the financial arrangements and such, but yes, in my office we do that. We practice that. [LB813]

SENATOR LANGEMEIER: Then my second question is, is if something happens to me and I come in and get a root canal, can I make a payment schedule out with you after the fact? [LB813]

CAROLYN TAGGART-BURNS: Well, it depends, you know what I mean? Yes...yeah, depends on the circumstances. [LB813]

SENATOR LANGEMEIER: Depends on the client, I'm sure, some... [LB813]

CAROLYN TAGGART-BURNS: Really, it...you know, if it's an emergency being seen during the week or something like that, and I have support staff there, then normally they arrange that at that time. [LB813]

SENATOR LANGEMEIER: Okay. Thank you. [LB813]

CAROLYN TAGGART-BURNS: Thanks. [LB813]

SENATOR PIRSCH: Seeing no other questions, I appreciate your testimony here today, and we'll move on to the next proponent testifier. Thank you. Good afternoon, Doctor. [LB813]

KENNETH HERMSEN: Good afternoon. Good afternoon, Senators, and thank you for the opportunity to come to testify before you in support of LB813. My name is Ken Hermsen, and Hermsen is spelled H-e-r-m-s-e-n. I'm a dentist. More specifically, I am an endodontist, a root canal specialist, and currently am the vice president of the Nebraska Dental Association. I graduated from dental school 35 years ago, and I have spent half of my professional life in full-time private practice and the other half in academics, so I've seen basically both sides of dental practice. The Nebraska Dental Association has brought forward LB813 to discontinue the practice of some dental insurance companies who are seeking to mandate fees for dental procedures that they don't cover. Simply put, dental insurance companies are amending their contracts or putting new contracts before dentists that set fees that the dentist can charge not only for the covered procedures but also for the procedures that they don't cover. As you've heard from my colleague and from Senator Gloor, dental insurance can more accurately be defined as prepaid dental services. The way it works is that the insurance companies market and sell these prepaid dental services typically to large groups such as city or state employees, teachers' organizations, businesses, corporations, universities, and other organizational units. Obviously, the insurance companies do not provide the service themselves. To provide the service, they recruit individual dentists from within the community who agree to become part of a group of providers. Sometimes this group is called preferred providers. You have heard my colleague describe covered and noncovered services. The insurance company dictates to their group of preferred providers and to the employees of the organization or our patients, what services are covered, and what fees the dental providers will receive for their services. Dictating the fees allowed for noncovered services is strictly a marketing tool by the insurance companies to make their dental product appear more appealing to the purchaser of the prepaid dental service. Well, you might ask, why don't dentists just decide as a group not to participate as providers in these prepaid dental services? Or if they already participate, why don't they decide as a group to band together to negotiate with the insurance company for higher fees or expanded services? The answer to that is that if they did that, the courts have decided that they would be in violation of antitrust laws. In short, we're simply prohibited by law from banning together to negotiate terms. Gentlemen, dentistry is truly healthcare that works. Dentists, over the years, have held cost increases to a minimum unlike other areas of healthcare that have seen enormous increases in costs. As an example of this, you may have noted that Senator Gloor mentioned that when dental insurance was first brought on the scene back in the early seventies, typically there was a $50 deductible and $1,000 maximum. Well, here we are 40 years later, and we still have $1,000 maximum on services. The dentists function as the CEO, the CFO, and the COO of their small businesses, and they do everything possible to keep the costs of providing high quality dental care with state-of-the-art

technology under control. But as with any small business, overhead costs continually grow and by having additional unnecessary discounts leveraged upon dentists, would only cause these costs to be passed on to all patients resulting in cost-shifting which has been mentioned. Insurers may say that this practice will reduce costs to the patient. In actuality, controlling the amount allowed to be charged on a noncovered service is not the way to reduce overall cost to the patients. Overhead costs of a dental office are generally fixed, and they must simply be passed on. They don't disappear. They don't evaporate. I think we all acknowledge the importance of good oral health. In 2000, the U.S. Surgeon General stated that you are not healthy without good oral health. The fact that millions of productive hours are lost each year due to oral health conditions helps prove the importance of oral health care. We further recognize that financing oral health is an important part of assuring access to care, and that insurers and prepaid dental service plans are an important part of the preventive and treatment process. However, the dentists of Nebraska should not be asked to back plans that force cost shifting to patients who are without prepaid dental services and to those patients that are insured by companies that do not participate in this practice. Thank you for allowing me to address you in the support of LB813. [LB813]

SENATOR PIRSCH: Thank you very much. Are there any questions for Dr. Hermsen? Seeing none, thank you for coming down today and testifying, Doctor, and we'll move on to the next proponent testifier. Good afternoon, Doctor. [LB813]

RICHARD FITZGERALD: Good afternoon, Senators. My name is Richard Fitzgerald, F-i-t-z-g-e-r-a-l-d. I'm a dentist practicing in Omaha, and I'm here to testify as a proponent for LB813 as a board member for Delta Dental of Nebraska. I'm one of two dentists that sit on the Delta Dental Board. Delta Dental has passed a unanimous motion at our last meeting in December, saying that we do not approve of mandating the cost of noncovered services, feeling it just isn't fair. And Delta Dental has historically been one of the large...I believe by far the largest dental service prepaid dental service provider in the state of Nebraska. We have 748 dentists that are providers with Delta Dental. Two or three years ago, two large Delta plans...California Michigan began to advance a proposition that since their main competitor, Met Life, applied the maximum allowance in billing prohibition in the net worth contracts to all services even those that were not covered, that they were somehow...that the two large Deltas were at somehow a disadvantage, and they managed to get a...they managed to get a motion through at the national Delta meeting, saying that we would go ahead and dictate the noncovered services that all the Deltas would. Delta of Nebraska and Delta of Minnesota fought against this, and we have received, until 2012, we are able to not be in part of one of these people that dictates this noncovered services. And we're hoping that by getting something done through legislatures across the country, as is being done in a lot of states right now, that we'll be able to keep a level playing field, and that we will be able to simply compete on a level by providing better services, better coverage, and not use this gimmickry, and so for that reason, the board of Delta Dental is in favor of LB813

and trying to keep the marketplace open. Thank you very much for the opportunity. [LB813]

SENATOR PIRSCH: I think we have a question from Senator Pankonin. [LB813]

SENATOR PANKONIN: Thank you, Senator Pirsch. Doctor, thanks for being with us today and your testimony. Since you've been involved with this Delta Dental and seem to know somewhat about what's going on around the country, do you know how many legislatures have passed similar legislation? [LB813]

RICHARD FITZGERALD: It's on the dockets in a number. I know in Minnesota, it's on the docket. It's happening in Missouri, but I don't know how far. It's been approved last year in Rhode Island, but I really can't tell you, and I apologize because I should have that information. A number of places. For some reason, everybody has gotten excited about it this year, and we're speaking for Delta just because we just would like to keep...we would just like to keep our competition level, and we really feel that this is just unfair so for Delta, that's what we're in favor of. [LB813]

SENATOR PANKONIN: Thank you. [LB813]

RICHARD FITZGERALD: Thank you very much, Senator. Anybody else? [LB813]

SENATOR PIRSCH: You bet. Any other questions? Seeing none, thank you very much, Dr. Fitzgerald. [LB813]

RICHARD FITZGERALD: Thank you very much, Senator Pirsch. [LB813]

SENATOR PIRSCH: And we will move on to any other proponents. Any other proponents at this time? Seeing none, we'll move on to opponents. Is there anyone here to testify against LB813? Seeing none, we'll move on to those who wish to testify in a neutral capacity. Are there any? Good afternoon. [LB813]

JAN McKENZIE: Senator Pirsch, members of the committee, for the record my name is Jan McKenzie spelled J-a-n M-c-K-e-n-z-i-e testifying on behalf of the Nebraska Insurance Federation in a neutral capacity on LB813. I've had an opportunity to express our concerns to Senator Gloor, so he's aware, and, for the record and our concerns are relative to anything in an attempt to restrict the creation of the preferred provider networks or ways that we work, and while it doesn't affect us as insurers, some of my insurers are in the prepaid dental business. And so while we don't specifically oppose the bill, we're concerned about things that might erode networking which keeps costs down for consumers, and also the issue of whether or not if we lose those kinds of incentives, especially for children to receive or consumers to receive dental care. I think you've heard in the last five to ten years that we're now seeing a pretty direct connect

between dental care and healthcare, in particular, high blood pressure and some other kinds of issues. So those are the concerns we wanted to get on the record, and I would answer any questions. [LB813]

SENATOR PIRSCH: Thank you very much. Are there any questions? Seeing none, thank you for coming down here today and testifying. [LB813]

JAN McKENZIE: Thank you. [LB813]

SENATOR PIRSCH: Are there other individuals wishing to testify in a neutral capacity with respect to LB813? Seeing none, Senator Gloor, if you'd like to close. [LB813]

SENATOR GLOOR: Thank you, Chairman Pirsch, and I appreciate the opportunity. A quick answer to Senator Pankonin's question, there are 16 states now that are considering this, and that my understanding is the reason this has become a big issue is because it's become an issue...it's starting to happen in states and is being identified as a cost shift, and as a result of that, states are now beginning to take a look at introducing legislation that would restrict this practice from happening. It would be easy to say, well, the easy answer to this and one of the testifiers addressed this would be, if you don't like it then don't sign the insurance contract. But the reality is that when an employer offers insurance to their employees, usually it's a major insurer in a community, and when you have large insurers in a community regardless of what size community...it may be a number of major insurers in a community. As a dentist, you certainly want to be able to continue providing services to those patients if they've been your patients, or attract those patients if you'd like to add to your practice in some way, shape, or form so you sign up and you become part of that insurance plan. And then out of the blue, you find out if you're going to continue that contract, which now you've built a large portion of your practice around, by the way, all these other services that aren't covered, you have to accept some sort of payment schedule that wasn't part of the deal to begin with. And, again, my aversion to cost-shifting is you'll find yourself as a provider of those services trapped into agreeing to that, but that cost shift means that everybody is not covered, and that includes the state of Nebraska through the limited amount that we pay for Medicaid, $1,000, but still that makes that $1,000 not go as far as it did when the shift has then been over to everybody not covered. So I think the state of Nebraska also has some skin in the game on this, and that's one of the reasons that I also thought it was appropriate to introduce this bill. With that, I'll end and be glad to answer any final questions if there are any. [LB813]

SENATOR PIRSCH: Super. Thank you, Senator Gloor. Are there any follow-up questions? Seeing none, we will conclude then our hearing on LB813... [LB813]

SENATOR GLOOR: Thank you. [LB813]

SENATOR PIRSCH: ...and proceed to our third bill for the day, LB1017, and I note Senator Cornett has entered the chamber and so if you...at your leisure, open whenever you're ready, Senator. [LB813]

SENATOR CORNETT: (Exhibits 1 and 2) Good afternoon, Vice Chair Pirsch and members of the Banking, Commerce and Insurance Committee. My name is Abbie Cornett, C-o-r-n-e-t-t, and I represent the 45th Legislative District. The intent of LB1017 is that every insured Nebraskan has access to reasonable prescription drug benefits by requiring that all health plans delivered or renewed on or after January 1, 2011, meet the following criteria. Insurers cannot create specialty tiers that require payment of a percentage of prescription costs; insurers cannot charge prescription drug copays that exceed the cost of that prescription to the healthcare plan, nor can they charge a copay that exceeds by 500 percent the lowest prescription drug copay in the plan. If a health plan includes a limit for out-of-pocket expenses for the benefit other than the prescription drugs, the insurer must include a provision that would result in the lowest out-of-pocket prescription drug cost to the subscriber. Either out-of-pocket expenses for prescription drugs would be included under the plan's total limit for out-of-pocket expenses or prescription drugs could not exceed $1,000 per individual or $2,000 per family for the contract year. There are several people here today who can give you background information and firsthand accounts of how out-of-pocket expenses are affecting them. I would like to assure the committee and the parties who are affected by this bill that I am willing to work with any issues raised by the introduction of this bill. And I'd like to just have some letters of support introduced into the record. [LB1017]

SENATOR PIRSCH: Absolutely. [LB1017]

SENATOR CORNETT: And just to tell the committee, this was something that I had met with Senator Pahls over the interim, actually during special session, and had discussed with him. It is an issue that for me is a personal issue, and I have done a lot of work, going back to DC to work on this issue over the last few years and introduced this bill at the state level because it doesn't look like we're making any headway at the federal level. With that, I'll be happy to answer any questions. [LB1017]

SENATOR PIRSCH: Thank you very much for that opening. Senator Pankonin, you had a question. [LB1017]

SENATOR PANKONIN: Thank you, Senator Pirsch. Senator Cornett, thank you for introducing this legislation. Besides your work, did you model it on other states or anything particular that? [LB1017]

SENATOR CORNETT: There are other states that are working on similar legislation. This is similar to what is being looked at in other states. It is not modeled directly after anything that is enacted in another state, as far as I know. [LB1017]

SENATOR PANKONIN: Okay. Thank you. [LB1017]

SENATOR CORNETT: Further questions? Senator... [LB1017]

SENATOR PIRSCH: Thank you. Yes, Senator Utter. [LB1017]

SENATOR UTTER: Impact on health insurance premiums, Senator Cornett, do you have an...? [LB1017]

SENATOR CORNETT: That is something that we are willing to work with the insurance industry on. The primary goal of this bill is looking at what's called Tier 3 and Tier 4 drugs. Tier 4 drugs are known as your orphan drugs or drugs that are rarely prescribed, therefore, very serious rare diseases, and the copays on them can be extremely high, depending on how the insurance company structures that repayment level for Tier 4 drugs. One of the examples is hemophilia, and we have patients from all the different...not all the different categories, but a number of different groups that are affected by this that will be speaking after me. [LB1017]

SENATOR UTTER: The impact on senior citizens as far as their drug plans that they are now paying for. If they're on Medicare, you have any feeling about what may happen to the price of those plans if something like this is adopted? [LB1017]

SENATOR CORNETT: That I do not. [LB1017]

SENATOR PIRSCH: Thank you very much. Oh, Senator Langemeier. [LB1017]

SENATOR LANGEMEIER: Thank you, Vice Chairman, and welcome to Banking. [LB1017]

SENATOR CORNETT: I was going to say, I think this may be the first time I've been here. [LB1017]

SENATOR LANGEMEIER: Yeah, my six years on this committee, it's the first time I've seen you, so welcome. In reading your fiscal note, it indicates an expenditure of $1.2 million to the state of Nebraska for our employees. [LB1017]

SENATOR CORNETT: That is something we're working on also. [LB1017]

SENATOR LANGEMEIER: My concern is, is that...well, $1.2 million to our current budget system is something to be concerned about, but a bigger impact is, as I look at the percent of citizens in the state of Nebraska, of our 1.7 million that work for the state. Roughly, you got about 6,000 state employees, that would create $1.2 million

times...take that per person times 1.7 million, the cost to the whole state to do this would be in the billions. [LB1017]

SENATOR CORNETT: The cost of not doing it is there also now. If people do not receive their medication, they end up in the hospital for extended periods of time which costs more in the long run than the cost of getting their medication. If you have a person that...and I'll use this as an example, that has primary immune deficiency, and they're unable to make their copay, and are unable to get their medication, you have lost months a lot of times from work. You have spent thousands and thousands in hospital and drug costs over and above what your insurance would be. [LB1017]

SENATOR LANGEMEIER: Okay, very good. Thank you. [LB1017]

SENATOR PIRSCH: Senator Gloor. [LB1017]

SENATOR GLOOR: Thank you, Chairman Pirsch. Welcome also, Senator Cornett. There are times I think I'm on the Health and Human Services Committee (laughter) with some of the bills we look at here. But my concern about this bill fits into the same category as my previous bill or the bill we just listened to previously, and that is cost-shifting. That there are a lot of us that don't have a drug benefit, and therefore, would not get the benefits of the pricing advantages might offer. That's going to result, I would imagine, in the insurance companies spreading this insurance premium increase that they'll likely see over everybody. And so some of us would end up subsidizing this increase for those who actually have a drug benefit. Any discussion that you've had with anybody about the concerns on cost-shifting? [LB1017]

SENATOR CORNETT: Well, if you're talking about cost-shifting for people that have a drug benefit versus don't, I can't directly answer that. But I can answer the idea of cost-shifting in that that is what insurance pools are for. You pay into an insurance policy every month, and you may never use that insurance policy where someone else may pay into that insurance policy the same amount, and their family uses hundreds of thousands of it for an illness. That's the purpose of insurance. [LB1017]

SENATOR GLOOR: Okay, thank you. [LB1017]

SENATOR PIRSCH: Are there any other questions? Seeing none, thank you very much for your opening, and I take it you're going to stay here for closing, correct? [LB1017]

SENATOR CORNETT: Yes. [LB1017]

SENATOR PIRSCH: Very good. We will move on...can I get a show of hands then from those who plan to testify in favor of this just so I have a...? One, two, three, four, five, six, seven. I just ask if you could keep your remarks to a few minutes and avoid

duplication of restating being we have nine or ten testifiers, and thank you very much. Start with the first proponent. [LB1017]

MICHELLE VOGEL: (Exhibit 3) Thank you. I also have testimony to submit for the record. [LB1017]

SENATOR PIRSCH: Oh good, thank you. [LB1017]

MICHELLE VOGEL: My name is Michelle Vogel, and I am the executive director for the Alliance for Plasma Therapies, and on behalf of patients and providers, I'd like to thank you for holding today's hearing on LB1017, an act to reform insurance prescription fee practices. And I want to thank Senator Cornett for introducing such an important bill. The Alliance for Plasma Therapies is a nonprofit organization established to provide unified powerful voices of patient organizations, healthcare providers, and industry leaders to educate about the diseases that rely on these plasma therapies and the patients who need them. And we have about 20 organizations right now that are members of this. We're headquartered in Washington, DC, but we handle casework from all over the United States and get about 250 insurance cases a year. And most of it was started, and we deal with intravenous immune globulin therapy (IVIG) for patients who have autoimmune diseases, primary immune deficiencies, cancer, neuropathies, and we also work a lot with factor products for hemophilia patients, immune suppressants for autoimmune, chemotherapy, interferon, other kinds of things that these therapies were always covered under major medical. This bill is really important because we always counsel patients that your coverage was always under major medical. We never thought about worrying about this. We always said with IVIG, make sure hemophilia...make sure that your insurance policy covered blood products. We didn't look at the drug benefits; it wasn't there. These were infusible products, injectable products. But Medicare, with developing a drug plan, started the shift into these copays and then into coinsurance. So far, you know, so far healthcare reform is kind of stalled in Washington, DC, and I spend most of my time there, so why am I here in the state of Nebraska today? Because the first patient that contacted the alliance dealing with a coinsurance was from Nebraska. This patient has a neuropathy, a peripheral neuropathy and is wheelchair-bound, and getting a prescription for IVIG will make a difference. Went in for the IVIG and was told that the nursing services wouldn't be covered, but the therapy would and you have to pay $35. He said okay, I can afford that. The bill came later, and the bill was over $4,000. That was his coinsurance, was 10 percent of the product. That was too much for him to bear, and so what is happening to this gentleman? No longer on IVIG, no chance to be out of the wheelchair. He's on steroids and deteriorating very quickly. That's what coinsurance does. These are patients, and I hear your talk about cost-shifting, about increasing the prices, premiums for patients and other people who have these health insurance policies. But I have to agree with what Senator Cornett said. We're paying our premiums; we all get into health insurance for that reason to make sure we're covered. And we all, hopefully, go in being

healthy, and we do not expect to have a horrible disease. But that day does come for some of us, and we get a horrible disease, and we pray that our health insurance will cover it. But we never expected to have a specialty tier, a Tier 4 developed and have coinsurance put in where it could be 10 to 50 percent of the cost of drugs. So you say, well, why are the pharmaceutical companies charging so much for these drugs? Because these are orphan drugs; these are drugs made from plasma; these are biologics. They're expensive; they're for small populations. So we're targeting rare diseases, chronic diseases, orphan diseases with patients who really have to make choices between life or death with being able to afford these therapies, or being abled (phonetic) or disabled. And that should not happen, and these are patients who have health insurance. And where it's gone to, the degree that this has happened is even a patient organization, like the National Hemophilia Foundations meeting, at that conference, a representative from the health insurance company made the announcement that all factor products and recombinants will be now in Tier 4. If a hemophilia patient has a horrible bleed, that product cost could be $350,000 for one day. Tell me, can you even afford 10 percent of that? So this is what we're dealing with. This is not to shift costs or anything, but again, who pays for it? I think that we're all paying for it one way or another. And I hope that we have an opportunity to really make a difference here and put piece of legislation together, work together. I invite the insurance companies to sit down and work out something that makes more sense because if these products were covered to begin with, and patients were able to get it, go back to a day where we're back there again and have insurance, what's meant to be, to cover for therapies and make sure patients are healthy, so they can continue working and contributing to society. So I thank you very much. [LB1017]

SENATOR PIRSCH: Thank you very much for your testimony. Are there any questions? Senator Gloor. [LB1017]

SENATOR GLOOR: Thank you, (Vice) Chairman Pirsch. And thank you, Ms. Vogel, for taking the time to come to Nebraska and help us with this. You had,...and I'd like to take advantage of some of your expertise on this in a national level. You had made the statement that people wonder why do pharmaceutical companies charge so much for these drugs, but this bill isn't about pharmaceutical companies... [LB1017]

MICHELLE VOGEL: No, it is not. [LB1017]

SENATOR GLOOR: ...and big pharmas. This really is an insurance bill. And I would guess that one of the risks here, if this bill were to go through, and I'm asking for your opinion, and what's happened in other states, if this is gone through. One of the risks is that insurance companies will say, then we're not covering these at all which they would have the ability to do if we're faced with accepting this or just not providing the coverage. One of our options is just to not provide the coverage to this small subset of specialty drugs. What kind of risk is that? What's happened in other states? I mean,

have we seen that? That would be the worst-case scenario, I think, for people who would want these medicines is if they drop off the formulary altogether. [LB1017]

MICHELLE VOGEL: Yeah, and I would say that, number one, they were never...it's interesting, the days of major medical because it wasn't on that so-called formulary that we have now, and that's really where it belongs, back under major medical. But I could say that in the state of Maryland right now, CareFirst BlueCross is sitting down and looking at a similar piece of legislation, and they're looking at, how do we get specialty drugs closer to what Tier 3 looks like? So they are sitting there and saying, let's not eliminate these drugs because these patients that are customers of ours need these products. How do we work to ensure that they get it? So that's what we need to do. New York, in the state of New York, there's legislation to make sure that specialty tiers don't exist because they don't, and they want to try to establish that, and New York is making sure...their members of the assembly and senate there that are trying to make sure this doesn't happen and prevent that. But I think that you bring up a really important issue, and that would be a horrible situation to see, and every day patients are denied these therapies and get letters saying it's not likely necessary, and we fight and appeal those cases, and to see it totally denied would be a horrible situation. So I think that that's something we have to look at and ensure that doesn't happen, and, hopefully, we could either look at putting it back where it belongs, major medical, or making sure that the price is reasonable. [LB1017]

SENATOR GLOOR: Except moving it back to major medical, we're dealing with price isn't part of this bill. It is a potential outcome for at least some insurers. I don't know that all would do it, but at least it's an outcome that some potential...some insurers might potentially look at, is it not? [LB1017]

MICHELLE VOGEL: I would say, at that point, that, I mean, they're discriminating against populations that they're covering and discriminating against drugs. And, at that point, I would say that we need to make sure that that doesn't happen and make sure that we legislate that they are not allowed to discriminate against these patient populations and these therapies. You know, and so I would come back to you and ask you to...you know, to make sure that that language is in here to prevent something like that from happening. [LB1017]

SENATOR GLOOR: And that may be if this goes forward, that may be something that has to be considered. [LB1017]

MICHELLE VOGEL: What we have to do, and I would hope that that would not be anybody's intent. And I would hope that the insurance companies would not want to do that to their customers. [LB1017]

SENATOR GLOOR: Let me ask you this. How is this going to be addressed? You've

talked quite a bit, and Senator Cornett made reference to this also, about national healthcare reform, and the fact that it was hoped that this might be addressed through national healthcare reform. How was it going to be addressed in the discussions at either the House or Senate level on healthcare reform? [LB1017]

MICHELLE VOGEL: Sure. Senator Rockefeller was working on this to try to figure out a way to eliminate coinsurance or put copays in that were reasonable amounts because Medicare Part D has developed Tier 4 drugs, and to try to eliminate that. And so right now everything is so up in the air of where we're going to move, and there are other senators looking at introducing separate pieces of legislation, specifically on this issue and go forward on an individual piece of legislation. And I think in Washington we'll probably see different pieces of legislation, and we may see Medicare reform, and we may see something on Part D. That wouldn't surprise me, and have this included as a topic. [LB1017]

SENATOR GLOOR: Okay, thank you. [LB1017]

SENATOR PIRSCH: Thank you very much. Are there any other questions? Seeing none, I appreciate your coming down today and your testimony, and we'll move on to the next proponent. [LB1017]

MICHELLE VOGEL: Thank you. [LB1017]

SENATOR PIRSCH: I would just ask the next...all other proponents to try to confine your remarks to three minutes, so that we can make sure that everyone has an opportunity to be heard here today, and we'll move on to our second proponent. [LB1017]

POLLY NEGRETE: (Exhibit 4) Hello. Thank you for hearing me today. My name is Polly Negrete, N-e-g-r-e-t-e. I have common variable immune deficiency, and I am also a nurse and so I am here looking at both sides. I was also fortunate enough to become a clinic manager, and so I saw the business side of healthcare also. I receive a Tier 4 drug. I receive gamma globulin which is considered a Tier 4 drug, and it has enabled me to be productive. It has enabled me to raise a child, to become a grandmother, to be a daughter, a wife, a nurse, succeed in my career. Sometimes we're talking about a bill to not penalize people that are in a Tier 4 situation, and a lot of times we use the term, orphan drug, which makes it easier for people to pull themselves away and say, well, it's such a small percent; it's such a small percent. Granted, a lot of us that are here today are a small percent. There's not that many people out there that have some of the diseases that we do. However, cancer is not a small percent. And as I look at each one of you, hopefully, God willing and the creek don't rise, it's not going to happen, but the odds are every one of you is going to be affected either yourself or by your family with cancer sometime in your life. You could be in this category also because a lot of cancer

patients' drugs are being thrown into this category, and they're penalized. For over eight years, I paid my copays; I've paid my health premiums; I did everything my coworker next to me did. I worked just as hard; I made money for my company, and I every time I went to the doctor, paid my copay. Every time I got my medicine I paid my copay, and on top of it, I paid $10,000 a year out of my own pocket because I was in that tier. So my overall costs were $10,000 to $13,000 a year. While I'm paying that out of my pocket, insurance companies were continuing to get stronger and stronger and more influential in the situations. And now, at the end of this, I mean, I'm still receiving my gamma globulin, but the end results of anybody that has a major medical illness or a situation like I do or many of us do today, the end result is, is I had to declare bankruptcy at one point. That follows you forever, as though my disease and dealing with my disease isn't enough to follow me. I don't own a home. I lost a marriage because we couldn't survive the stressors of the illness and the financial stressors that go along with it. I know that the insurance companies are very concerned and that actually, Pat Bourne, the VP for BlueCross BlueShield recently commented that the way this bill is written right now, it would dramatically and unfairly shift the cost which I think you had already asked questions about to the other policyholders. Senators, isn't that why we buy insurance? We buy insurance so that we can be in a large risk pool that has the ability to absorb cost for some, and others are never going to use it at all. You know, and also the report out of Washington last week was a little disturbing that the five major national insurance companies made a 56 percent profit in one year. And I think that, you know, we need to be reasonable, but we need to quit penalizing people and saying it's such a small portion because it really isn't, and it can and possibly will affect all of us. I thank you all for listening to me today. Any questions? [LB1017]

SENATOR PIRSCH: Thank you for your story. Are there any questions? Seeing none, thank you very much for your testimony. We'll move on to the next proponent. Good afternoon. [LB1017]

MELISSA DOUGHERTY: (Exhibit 5) Hi. My name is Melissa Dougherty. It's D-o-u-g-h-e-r-t-y. Thank you for allowing me to testify before you today on LB1017. My four-year-old son, Carter, and I are both from Lincoln. Carter was diagnosed with primary immune deficiency in November of 2008. After almost three years of constant sickness and numerous surgeries, it was a relief to finally have a reason behind all of his infections. Our insurance company denied Carter's doctors' request for immunoglobulin treatment. The day I received the letter in the mail, I was crushed. We finally had hope that treatments could help Carter with a healthy and normal life. I was very angry and frustrated. It came to a point during our appeals that my husband and I considered having to take out a second mortgage on our house in order to pay for the treatments. I knew that no matter how we covered the cost, Carter would have to have them. With each denial letter, I just kept getting more agitated with the insurance. How can the company tell me and my son and his doctors that they won't pay for treatment that's medically necessary? Our insurance company finally approved Carter's

treatments on a one-year trial basis in January of 2009 after three appeals. It took our doctor personally talking to the insurance company's medical director to get it approved. His treatments are done Subq at home, so it is easier for him to deal with at such a young age and has less side effects. Carter gets his immunoglobulin once a week, and it takes about an hour-and-a-half to infuse. He has two tiny needles that we poke into his thighs. Since his little legs are so tiny, it's hard to find new areas to poke each week so he doesn't build up too much scar tissue. Some weeks go better than others. He sometimes gets scared and cries and fights us. We try to talk him through it and let him know that it will help him and make him feel better. We usually try and plan a movie night or let him play his DS since he can't move around with the needles in his legs. I work in the medical field and poke people every day with needles, but having to poke my own son is one of the hardest things I've ever had to do. I have to keep telling myself that I'm helping him and not hurting him. He's such a brave little boy for having to go through this. Even though we are the ones administering his medication, our insurance charges us more money than if we would take him into the doctor's office and have it done. We have a deductible that has to be met, and then each weekly treatment gets filed under coinsurance. It doesn't go under drug coverage. The infusion company that we go through charges $844 a week for his medication and supplies. Luckily, our insurance does have a good contract with the company, but we still pay $50 a week. This is still a lot of money for the average family to pay, but what choice do we have? My husband's employer doesn't offer health insurance, so I am responsible for providing it. Last spring my employer laid off and cut employee hours, and it worried me constantly that I would not be able to have insurance for Carter or that we would have to change companies and go through the approval process again. Since starting treatments in February of 2009, Carter has become a different child. He's gained weight, grown taller, and finally gotten to have the quality of life he deserves. The immunoglobulin treatments have been a blessing for him. As a parent, you want to try to do the best for your children, and fighting the insurance company shouldn't have to be one of them. [LB1017]

SENATOR PIRSCH: Thank you for your testimony and your story. Are there any questions? Seeing none, well, Carter, you're a very brave boy, and we're glad (laughter) that you came and visited us today. Thank you very much for coming here, Carter. Yeah. [LB1017]

CARTER DOUGHERTY: Thank you. (Laughter) [LB1017]

MELISSA DOUGHERTY: Thank you. [LB1017]

SENATOR PIRSCH: Well, thank you. Okay, we'll move on to the next proponent. [LB1017]

LYNETTE ANTHONY: (Exhibit 6) Good afternoon. My name is Lynette Anthony,

L-y-n-e-t-t-e A-n-t-h-o-n-y. I am here to speak in support of LB1017 as a patient who is on IVIG therapy. I'm 60 years old, and until I started exhibiting symptoms of this autoimmune disease I have at age 53, I was one of those people that the insurance companies really liked because I hardly ever got sick, and I didn't cost them very much money. Then when I turned 53 in the summertime, I started exhibiting some unusual symptoms. I had extreme fatigue; was tired all the time; I missed a lot of work. I had very dry nose and then eventually I started having bleeding and flaking gums. I saw six different doctors and had about ten different tests--allergy tests, diabetes tests, every other kind of test. Nobody could really figure out what this was. Finally, I started breaking out in a few blistering sores, went to a dermatologist who biopsied that, and they finally determined that I have a very uncommon autoimmune disease called bullous pemphigus. What this disease will do is, it does start in the mucous membranes...my nose and my gums, and at its worst, it can put blistering sores over your entire body which are very painful, very itchy, and cause a whole lot of problems. So then once they diagnosed it, the doctors put me on prednisone which is a miracle drug. I immediately felt a whole lot better. However, it has some very serious and nasty long-term side effects. It can affect your liver; it can affect your kidneys. For me, it caused me to gain weight; it caused water retention; it put lesions in both of my knees. It was not a pleasant experience. So I was doing everything I could to find some alternative to that prednisone therapy because it was basically treating the symptoms, but it wasn't treating my disease. Finally, after three years, I found an immunologist who got me started on the IVIG. For the first year, it was every two weeks, and it was a very high dose. After that, it was every four weeks and a lower dose. For the first two years, the insurance company paid a hundred percent under major medical. After that, starting in 2008, it went from major medical to a prescription drug, and I have a coinsurance of 10 percent. My treatments right now which happen every four weeks are $4,200 so you can do the math there and see how that could be a bit difficult to handle. I'm very fortunate. I have a pretty good income. I can manage this if I budget carefully, but I'm very concerned that if it's 10 percent now, it could go up to 20 or 30 percent, and then I would no longer be able to handle this, in which case I have two alternatives. I either go back on the prednisone, and I probably won't live too long because I'll get the liver and kidney disease, or I deal with it and I start breaking out in all these blistering sores. There has been testimony on people who broke out in all these sores and didn't have any therapy that they could deal with, and it got so bad that they committed suicide rather than deal with it any longer. That's not an option for me so (laugh) I really want to see some restrictions on the insurance companies to keep them from being able to drive up the coinsurance on this, or make it an even higher Level 4, or anything that would keep me from getting the therapy I need. I also, when I'm sitting in that infusion room, there's generally another person in there with me that's getting the same therapy. Some of these people are teachers, homemakers, laborers--they don't have the kind of income I do. I don't know how they pay that coinsurance right now, and I'm sure if it gets any higher, they won't be able to pay it. So I'm just here as an advocate for myself and these other patients to ask that you please give serious consideration to the passage of

this bill. Thank you. [LB1017]

SENATOR PIRSCH: Thank you very much for your testimony. Are there any questions based on that? Seeing none, thank you very much... [LB1017]

LYNETTE ANTHONY: You're welcome. [LB1017]

SENATOR PIRSCH: ...and we'll move on to the next proponent. Good afternoon. [LB1017]

HEATHER OVERTON: (Exhibit 7) Good afternoon. Excuse me. My name is Heather Overton, and that's H-e-a-t-h-e-r O-v-e-r-t-o-n. I have epilepsy, and that actually affects more people than a lot of people understand. Here in Nebraska, it affects 30,000 people. Nationally, three million. And I can go into more stats, but we won't do that because we don't have a lot of time, but it doesn't discriminate. Anybody in this room could develop seizures from a car accident. It's not, you know, again, I won't go into that stuff. But I was diagnosed with epilepsy at 18 months, so I've been battling this for 26 years. At 14, my seizures progressively got worse, and I was diagnosed with juvenile myoclonic epilepsy which is a combination of tonic-clonic seizures which is formerly known as grand mal seizures and myoclonic seizures which are the jerking of limbs. I was having hundreds of those and three to four tonic-clonic seizures a week towards the end before I became seizure free six years ago. It took 20 years to achieve that goal--ten different neurologists. I was on every single medication possible, different combinations of those medications, different injuries. I spilled a pot of coffee all over my chest, had blisters; fell down the stairs at school. The ambulance was called. I was hospitalized more times. I mean it was...I could go on and on about all my injuries and from every single seizure falling in the bathtub, you know, having seizures, just unpleasant side effects; gaining 60 pounds on one medication when I was 17 before prom which wasn't very good. But the cocktail that I'm on now, the cocktail because it's five medications, has worked for me. And unfortunately, that is now in jeopardy because my employer has decided that they want to do mandatory substitution generic, so the Lamictal they want to put as a generic, and it will cost me...if I want to stay on the brandname, it's Tier 4, and it's going to cost me $1,584.55. So we have...for the last 15 months, I have been battling this. It has...my doctor has written a medical necessity appeals; it's just been a back and forth, back and forth process, a grueling process. I can't even explain to anybody what it feels like. I never thought anybody would ever want me to have a seizure again in my entire life. That's how I feel. Why would anybody ever (crying)...I'm sorry. [LB1017]

SENATOR PIRSCH: Take your time, please. [LB1017]

HEATHER OVERTON: (Crying) I'm sorry. [LB1017]

SENATOR PIRSCH: Whenever you're ready, just. [LB1017]

HEATHER OVERTON: Okay. It's like...it's like wishing cancer on somebody, and when you're controlled, you shouldn't wish that on somebody. And I feel like it's being wished on me to have a seizure again, and that is not fair. I've explained that having a breakthrough seizure which is inevitable is going to affect my quality of life, my ability to drive, my mood, my memory. I already have damage on my left temporal lobes from having so many seizures over a 20-year period of time. The side effects, become disabled and what most people aren't aware, death; you can die from seizures. And so when you've gone through all this, and the costs associated with it, you know, it's $6,000 roughly for my medications, but it's also...I did a hypothetical situation. If I would go to the emergency room for one visit, have a breakthrough seizure, and if I had to go to the emergency room...now, mind you, I went a lot when I was having them. And they did the ER, the squad, the blood tests, all of this stuff, an EEG which are standard procedures. My doctor just said, this is what I would run. For one ER visit, it's $6,000. That is not economical to say, we won't pay for your medication for one year which is going to be $6,000 because the $1,500 was for a three-month supply and versus the one ER visit. And I could go all the time, not to mention it's...get levels taken and all this other stuff. However, a point that I do want to get across really quick is that other healthcare plans have recognized this issue. Blue Cross...Wellmark Blue Cross Blue Shield of Iowa has changed its policy on the cost difference. When you choose...I'm quoting, when you choose a brand-name drug, when a generic equivalent is available for the following AEDs: Topamax, Keppra, Lamictal--I'm on two of those...you will no longer be required to pay the difference between the brand-name medication and the generic, so they're essentially saying that it won't be a Tier 4 drug anymore. And I think that's something that we need to look at here as well. I support the passage of (LB)1017, and I appreciate your listening. Thank you. [LB1017]

SENATOR PIRSCH: Thank you very much for your testimony. [LB1017]

HEATHER OVERTON: Any questions? [LB1017]

SENATOR PIRSCH: Are there any questions today? Seeing none, thank you for coming down here today and telling your story, so we will move on to the next proponent then. [LB1017]

CARL CLARK: (Exhibit 8) My name is Carl Clark, C-l-a-r-k. I'm here to speak for my son on the LB1017. Our son is a hemophiliac. He's a mild hemophiliac, so he doesn't have to have the replacement factor as often as many of the hemophiliacs across the country or even in our state. When he was very young, he had to have an emergency surgery. This was a little over 29 years ago. At that time, we thought that the pediatrician was pretty much in control of his medication usage, and the products that he had been selecting as his factor product was relatively safe by the standards that were then being

identified with the factor VIII concentrate. He had to have an emergency surgery. The surgeon did not talk to the pediatrician. We did not know that. A little over 20 years later, our son goes in for his routine examination through the Hemophilia Treatment Center that's located in Omaha at the University of Nebraska Med Center. And they said, you've been exposed to hepatitis C, and we're wondering, how in the world could that happen? We went back to the medical records and found out that the surgeon had administered concentrated factor VIII that was contaminated. In some ways we felt lucky because his contamination was only hepatitis C. Many of the people that received factor VIII concentrate received not only hepatitis C, hepatitis B, and/or HIV. He only got the hepatitis C. Now here's where the situation came in to bear, though, as it relates to this particular bill that's being produced. He had to undergo an 85-week treatment program equivalent to chemotherapy. He's paying for this out of his own pocket because...well, not totally out of...I mean, he's paying the copays as he goes, and when he started the program a lot of the drugs that he had were considered to be generic drugs, and they fit under what was called a $40 copay program. One-third of the way through this program, the very drugs that he had been originally been prescribed were switched to a Tier 4. He then had to pay $100 per drug for the same drugs that he had been receiving for $40. Later in his therapy, they changed his drugs, and he was under a combination of drugs. Two of them were generic, and one of them was the regular drug, but he still had to pay the $100 copay for some of them, but he ended up before it was all over, having to pay $520 a month out of his own pocket to use generic drugs. When he was on regular drugs, he felt better. He felt like he was getting improvement, but because of the difference in cost, he couldn't afford the other ones. It totally drained his whole savings account if you figured out at $6,240 a year extra that he had to pay for those last two plus years. As a computer specialist in a public school setting, his salary was not one that would allow him to do anything else. So we're at a situation right now where he's fortunate in that his insurance company will help him take care of his factor without it being in a Tier 4, but he is not convinced that Tier 4 will not happen to his factor. If it would happen to his factor, because he is on a demand program, he probably would be able to handle it in most situations. But he had to go through a procedure that took five days of treatment, paying for only the treatment of the factor that he had to have replaced, not the doctors, not the procedure...just for his product. Five days of factor for him cost $60,000. We have people in our community that have to have this on a regular basis three to five times a week. If it moved into a tiering program, we would lose a lot more hemophiliacs because they couldn't pay for it. They just couldn't do it. So I really urge that we move in a positive direction on LB1017. Thank you. [LB1017]

SENATOR PIRSCH: Thank you very much for your testimony here today. Are there any questions based on that? Seeing none, thank you, and we will move on to the next proponent. Thank you. [LB1017]

KIM BERNSTEIN: Hello there. I'm used to standing (laugh). My name is Kim Bernstein,

and today I'm here to represent the Hemophilia Federation of America. The Hemophilia Federation of America is a national nonprofit organization that assists and advocates for bleeding disorders in the whole country. As part of our mission, HFA strives to ensure availability of medically necessary treatment services to support a full range of clotting factor therapies and to educate the public about bleeding disorders. I do realize how short on time you are, so I'm going to be brief and to the point. I don't know if you're familiar with hemophilia, but you're probably familiar with insulin. A bottle of insulin is about this big. A bottle of clotting factor is more like this big, but that bottle could cost $10,000; it could cost $100,000 because it's about a dollar a unit. So a person who has hemophilia, even somebody around my size, usually men, would end up using $5,000 for a dose of clotting factor. This dose of clotting factor will replace the enzymes in the blood that cause your blood to clot. If you didn't have the product, you or I would bump our knee; it would swell, it would get hot, it would hurt. But eventually, it would stop, and we'd be able to go about our day. If you had hemophilia, that burning and swelling will not stop. Your joint will grow and grow and grow because the hemophilia...people with hemophilia don't have a clotting enzyme that stops the blood from pooling and allows it to reabsorb. The biggest problem that we have with these specialty tiers...it's sort of blood and sweating the tiers because for us, there is no way to ever pay 25 percent. To your point, Senator Gloor, if it were off the formulary, it would almost be the same thing because I can speak for the executive director of the Hemophilia Federation of America. She's not from Nebraska, she's from Wisconsin. She has a small child who has hemophilia. She was telling me she just paid her $5,000 annual deductible for her son, and that comes after one month of product. One month of product for her son is $20,000. If it were to go to the specialty Tier 4, she would be responsible for $5,000 every month for 25 percent of his product. What we really do hope to see is people who are employed and insured staying employed and insured because the place that we will really see the shift to your point is to Medicaid, Medicare, and unemployment because if I cannot work because I cannot get my products because my products are Tier 4, and the Tier 4 is going to cost $5,000 a month out-of-pocket, there's no way that I'm going to be able to stay employed because if I have joints that aren't working, and I'm in great pain, I won't be able to work. I'll end up on unemployment; I'll end up on Medicaid because by that point, I will meet the criteria for Social Security Disability and SSI, and that's basically where we'll end up shifting it, if not into medical bankruptcy along with it because there's no way that the most responsible, wealthiest person could ever pay 20 percent of hemophilia clotting products and even more a percentage as it goes along which gives us the greatest concern. Because when you have a disability that you've overcome, you spend your life looking at what you can do and not what you can't do. If you take away the lifesaving therapies that allow people to stay functional and working, they won't have the ability to work. They won't have the ability to do anything other than stay home, and we will be shifting the cost to everybody in Nebraska. [LB1017]

SENATOR PIRSCH: Thank you so much for your testimony. Are there any questions? Senator Gloor. [LB1017]

SENATOR GLOOR: Thank you, Chairman Pirsch. I need to also then direct a question that I directed to Ms. Vogel to you, and that is, is your group concerned at all that one of the unintended consequence would be that insurers or more likely self-insured employers, would make a decision to drop some of these medications off formularies completely. [LB1017]

KIM BERNSTEIN: Well, if... [LB1017]

SENATOR GLOOR: And so we're faced with no coverage as opposed to limited coverage. [LB1017]

KIM BERNSTEIN: Well, quite honestly, sir, if we have to pay more than $5,000...if we have to pay $5,000 a month in order to get the product, because people who provide the product will not continue to deliver the product, if you aren't paying your portion, it might as well not be on the plan if you shift it to a Tier 4 with a 25 percent copay. [LB1017]

SENATOR GLOOR: But that isn't necessarily going to be...it depends on the plans and what's covered under the plans, doesn't it? [LB1017]

KIM BERNSTEIN: It could, but I'm not as concerned about it coming off as the Tier 4. I don't think that would happen. It's medically necessary; there's no way that you can have...there's no way that you can live without clotting factor if you're having a bleed. [LB1017]

SENATOR GLOOR: But... [LB1017]

KIM BERNSTEIN: It would be a tragedy if it came off... [LB1017]

SENATOR GLOOR: It would be. But that's why...yes, that's why I called it an unintended consequence, but... [LB1017]

KIM BERNSTEIN: ...in Maryland...yes, sir. What we did find in Maryland, there was an issue several years ago where there is rate control and there's community rating. And I attended those hearings, and what they did eventually, they looked at taking blood products off, and they decided not to. They did explore that and, instead, they worked with some of the copays for...I believe they increased the copays on some products and allowed other people to have generics in order to keep the blood products on. [LB1017]

SENATOR GLOOR: So they came up with some sort of compromise as opposed to a mandate? [LB1017]

KIM BERNSTEIN: That's exactly...they went through it because they wanted to be sure that they could keep the blood products on because by taking them off...if you take IVIG, people end up in the hospital. So you're going to end up paying for hospitalizations and days off of work and all sorts of other things. I don't think... [LB1017]

SENATOR GLOOR: Yeah, that would be the best argument, I think. [LB1017]

KIM BERNSTEIN: I don't think I've ever seen a situation where they actually looked at taking clotting factor off entirely. I mean, we've looked at that, and I...so prior to...I did work for 15 years in a program to help people with Social Security, SSI and insurance issues, and we've looked at this for a very long time, and I have never seen a situation where that was really approached. [LB1017]

SENATOR GLOOR: Okay. Thank you. [LB1017]

KIM BERNSTEIN: Thank you. [LB1017]

SENATOR PIRSCH: Are there any other questions? Seeing none, thank you for coming down and testifying here today. And we'll move on to the next proponent. [LB1017]

SHANNON SCOTT: (Exhibit 9) Good afternoon, Senators. Thank you for hearing me today. My name is Shannon Scott, S-h-a-n-n-o-n. Scott is S-c-o-t-t. I'll keep this short and brief as I know we've kind of been repeating a little bit, but I do want to...but, you know, I'm a concerned constituent, a nurse, and a primary immune deficiency patient as well as a factor V Leiden patient, a clotting disorder patient. I have both an immune deficiency disorder and a clotting disorder, require medication to...which are specialty medications, blood thinner I take daily, and weekly I Sub-Q Ig. My concern is in regards to this bill passing, and my support I'd like to share is that without passing this bill, my husband and I daily have a fear of what if we are going to be presented with having to spend more out-of-pocket for my enabling medicine. I was on the verge of disability, was out of work for about a year-and-a-half after working in the hospital, working through multiple illnesses, sick all the time, unable to hold a job, and we have since encountered thousands and thousands and thousands of dollars of debt due to inability to work. We would not be able to afford my medicine that allows me to hold a job if, indeed, the insurance companies did move my medicine into a coinsurance or a percentage pay where I have to pay a percentage of my medicine. I, too, meet my deductible after the end of January which is $3,450 which is already a lot out-of-pocket that we have to pay. We know we have to have that every year, and since we've only been dealing with this for less than a year, we haven't had the ability to get caught up. And it would be a devastating tragedy for my family if we were unable to afford my lifesaving medicine. I'll let you read my written testimony. It pretty much sums up why I support this bill. Any questions? [LB1017]

SENATOR PIRSCH: Thank you very much. Are there any questions? Seeing none, appreciate your coming down here today and testifying. And we'll ask for the next proponent, if there is. If I could just ask, could you raise your hand if you're a proponent who has not had a chance yet to testify? Okay, so this is probably the last one. [LB1017]

MELISSA SCHWEITZER: (Exhibit 10) I think I'm the last. Okay, good afternoon, everybody. My name is Melissa Schweitzer. First name is M-e-l-i-s-s-a. Last name is spelled S-c-h-w-e-i-t-z-e-r, and I'm also here from Washington, DC on a voluntary basis today on behalf of patients and families who are affected with rare diseases that we've talked about today. I'd like to take the time to thank all of you for holding today's hearing, and especially thank Senator Cornett for introducing such an important bill. I am a certified genetic counselor, and as such, I see families on a regular basis who are at risk for rare genetic diseases. These diseases can include a number of different disorders, some of which are caused by enzyme deficiencies which can lead to a buildup of harmful chemicals in the body that cause destruction of tissues such as the brain, heart, and muscles. This can ultimately lead to a lifetime filled with health problems and, in some cases, death in childhood. And prior to about five to ten years ago, there were no treatments at all for some of these diseases, and these children died. Now, we are fortunate that research has come a long way, and there are enzyme replacement therapies that can lead to a better quality of life. So as we continue to diagnose rare diseases and develop innovative therapies to treat these, we need to ensure fair coverage of these lifesaving therapies. It is horrible to tell a parent that their child has an enzyme deficiency disease or a mitochondrial disorder or another rare condition...thanks, sorry. And not too long ago, those would have been a death sentence, but as science progresses, so does the chance for these children to have a profitable future. Besides being a genetic counselor, I'm also a patient with a rare genetic disorder, and as you've heard from some of the patients today, I, too, have a primary immune deficiency, and am lucky to have the IVIG therapy that replaces the antibodies that I'm missing, and this helps keep me as infection free as possible. But specialty tiers and coinsurance are words that I hear too often as a patient. They are frightening to me as a patient as well as a genetic counselor for the patients that I see. I just have to ask, how can we let insurance companies target the most vulnerable populations--our children, our rare disease populations, our genetic disorders communities, by putting up barriers to affordable treatments? One of the biggest celebrations this past year was when Congress passed the Genetic Information Nondiscrimination Act, but what good is that if the insurance companies make patients pay up to 50 percent of the cost of these most expensive therapies? The insurance companies may say, why are the pharmaceutical companies making these therapies so expensive, and we can't afford to bear the cost of these therapies? But my answer to that is that these drugs are for rare populations, and why do we purchase insurance policies to ensure that we have coverage for our families? So on behalf of my fellow

patients and families with rare genetic disorders, I urge you to support the passage of this bill. Thank you. [LB1017]

SENATOR PIRSCH: Thank you very much. Are there any follow-up questions? Seeing none, I appreciate your coming down here today and testifying. And I will just ask one more time, are there any other proponents? Okay, seeing none, we will move on then to opponents. Are there opponents of LB1017 here to testify today? Good afternoon. [LB1017]

CLINT WILLIAMS: (Exhibit 11) Good afternoon. Thank you very much. My name is Clint Williams. That's spelled C-l-i-n-t W-i-l-l-i-a-m-s. I am the director of pharmacy for Blue Cross Blue Shield of Nebraska. Blue Cross Blue Shield of Nebraska insures over 7,000 Nebraskans who carry our card. It's in the interest of our members that we oppose LB1017 because of its mandate on benefits that will result in premium increases for our members. I want to talk today about how (LB)1017 is written in its current form, and how we feel that's going to impact our members. And I'd like to start just by talking about some of the tiers that we currently use to help direct folks to cost effective therapy. So it's been mentioned in the language that there are three tiers and then a fourth tier, as many of the folks have talked about earlier. We use generic as one tier; formulary brand as another tier; and nonformulary brand as a third tier. And then, again, we do have a number of plans who use a fourth tier that would encompass the specialty drugs. These drugs are typically expensive, and many of them require special handling. There's a number of specialty pharmacies that have now grown up throughout the country that specialize in the handling of these, and we've also found that many retail pharmacies do not carry these products, but they will order them in from time to time and, again, that's because of their expense. Specialty tiers have been used by us and other health carriers and pharmacy benefit managers, often called PBMs, to direct membership pharmacies that have typically better discounts and, again, I mentioned the special handling. In addition, with the three tiers, we've used copay differentials for a number of years now, and they are an important and effective way for us to provide incentive for cost effective therapies. In its current form, LB1017 would restrict the highest drug copay to no more than 500 percent of the lowest copay for a health benefit plan. It seems that LB1017 is focused on specialty drugs, but it does include all drugs as is written today. Under this bill, as written, we feel there will be a lower incentive to use more cost effective therapies--formulary brands, generic drugs. For example, we have some plans that have a zero dollar generic copay. In those particular plans, we would have to change the brand copays to zero dollars as well. We also have some plans that utilize a $5 generic. Those particular plans would have to change their higher copay to $25. This would impact our customers and also our members. Another thing to note is brand drug prices for both specialty and nonspecialty drugs, have grown at a faster pace than generic drugs. Generic drugs have actually seen a decline in recent years probably due to some of the $4 generics that you see with a number of the pharmacies out there, but also more competition within the generic drugs. The one concern we have

with this bill is that it does address the out-of-pocket costs, but we are...it does not address the increases in brand-name costs that we're also seeing that are causing pressure as well. (LB)1017 does not allow insurers to create specialty tiers that require payment of a percentage cost of prescription drugs. Blue Cross Blue Shield of Nebraska does not use a flat coinsurance for its benefits, and that includes the three tier, but also the four tier as well. We do have plans that have coinsurance, but they have a maximum, so there's a maximum out-of-pocket for a 30-day supply on the specialty, and then it can vary with the other three tiers. We feel this benefit has done a good job of promoting the use of cost effective medications. We also believe it's been effective at steering folks to some of these specialty pharmacies where we can get better discounts, and they have...they specialize in the handling of these particular drugs. There's also some other clinical services they provide as well. In addition, LB1017 has an out-of-pocket expenses provision that would include it either with the medical benefit or as a separate...there's a $1,000 maximum for an individual and a $2,000 maximum for a family. We are concerned that this could also impact the incentive for generic or formulary brand drugs, and it could also lead to increased premiums. Last, I'd just like to mention that we do...we use in health plans and PBMs use a number of utilization management programs, sometimes known as preauthorization, step therapy, prior authorization, and there's other names as well. And we do that as a way to help steer folks to cost effective medications and manage costs. It's our experience that extensive use of these programs is not desired by physicians or by patients, but it would be something with language such as this, that we would have to consider expanding in order to help manage some of the costs for our customers. It's for the aforementioned reasons that Blue Cross Blue Shield Nebraska opposes LB1017, and I'd be happy to take any of your questions at this time. [LB1017]

SENATOR PIRSCH: Thank you for your testimony. Are there any questions based on this? Seeing none, thank you. We'll move on to the next opponent if there's... Can I get a show of hands from those who plan on testifying in an opponent capacity? One, two, three. Very good. Thank you. [LB1017]

JAN McKENZIE: Senator Pirsch, members of the Banking, Commerce and Insurance Committee, for the record my name is Jan McKenzie, J-a-n M-c-K-e-n-z-i-e, testifying in opposition to LB1017 on behalf of the Nebraska Insurance Federation. I want to just go back to some comments that I shared with you last year regarding bills such as this which are mandates related to health insurance. And just not so much about the topic, but more about where we are in Nebraska, and what these kinds of bills potentially mean, in particular, if you look at the fiscal note. Last year I gave you information, and you might remember my little chart with the diagram about what has happened overall in Nebraska with who's covered under this kind of bill. We have more than 60 percent of Nebraskans now included in some sort of ERISA plan. The language in (LB)1017 is such that it says if you are exempted, this does not apply to you. In 2008, we had 12 percent of Nebraskans uninsured. I haven't seen the numbers for 2009, but with the

economic situation the way it is nationally, I'm going to guess it's at least at the same number, if not more. That leaves a bill like this affecting 28 percent of Nebraskans. Who are those people? Those are the small employers, self-employed, farmers, mom and pop grocery stores, kinds of businesses who are probably already carrying $5,000 to $10,000 deductibles because they're purchasing their own insurance. And I know, because as a small business myself, I have to go out and shop through an insurance broker for my insurance and my family's insurance or my employees' insurance. It's not provided to us. So I'm concerned again this year that we're looking at something else that might instead of solving, trying to solve one problem that we create an even greater uninsured population in Nebraska. And that, in fact, a lot of people who think they would be getting this coverage would not because they're in an ERISA plan, and so the public is confused. Why if we pass this, don't I get this benefit? That happens all the time, and we're constantly trying to explain what an ERISA plan is and why that didn't affect them. The other thing I want you to remember is from a couple weeks ago when we were talking about mandate light legislation. The dollar bill I gave all of you talked about where the dollar goes for your insurance premium, shows that 7 cents of that dollar goes to profits and to the consigns of consumer services that go along with the insurer doing their business. The rest of it goes to paying for the actual costs that are assimilated or connected to what physicians, hospitals, outpatient clinics, and the pharmaceuticals cost. There are also premium taxes and other kinds of things that have to be paid. So we're looking at 14 cents going for drugs, and we're looking at what the overall cost is to the business of doing business. The dollar that is split up like this is dollars paid in by premiums. It's dollars paid in by people who are in that plan or employers who buy that plan for their employees. If you're fortunate enough to be an employee of the state of Nebraska, the state pays 75 to 79 percent of your cost of health insurance. Cost sharing and pooling for us all to cover risk is exactly what insurance is about, but it's only as much as is paid in can be paid out, not more. We can't pay out everything to everyone without adjusting premiums year after year after year. So we can add as many things as we want to what needs to be covered under health insurance, but at some point in time, the premium can't be afforded any more, and that's just the way it is. I know you as a committee know that, but just in light of, I think, some folks maybe have not heard that whole side of it before. I thought it was important to bring up again. I think we really need to consider whether or not doing something that is always a good thing for people who have great need sometimes has a countereffect in creating a whole series of problems for other Nebraskans, so we have to carefully balance what we're looking at in terms of mandates and, in particular, mandates that require that everybody treat the world the same way. We're looking for accessibility and affordability for Nebraskans. We want people to have as many choices as possible when they look for a health plan, and I think you know we've always opposed anything that tries to create a one-size-fits-all approach. With that, I'd answer any questions you might have and appreciate your attention. [LB1017]

SENATOR PIRSCH: Senator Langemeier. [LB1017]

SENATOR LANGEMEIER: Vice Chairman Pirsch, thank you. Ms. McKenzie, thank you. [LB1017]

JAN McKENZIE: Thank you. [LB1017]

SENATOR LANGEMEIER: For the record, you didn't give us a dollar. You gave us a photocopy of a blue cut up dollar into divisions (laughter). [LB1017]

JAN McKENZIE: Oh, well, you know, I didn't want to have to report that on my accountability and disclosure (laugh). [LB1017]

SENATOR LANGEMEIER: That's why I disclosed it right now (laughter). We've heard this discussion before this committee that it won't apply to ERISA plans, and that seems to be always an easy excuse out which I'm...over time I'm not buying, less and less. In your mind, can this be expanded out to cover ERISA plans? Can the state trump a federal ERISA plan? [LB1017]

JAN McKENZIE: No. No. [LB1017]

SENATOR LANGEMEIER: Okay, that's what I wanted to hear. Thanks. [LB1017]

JAN McKENZIE: You're welcome. [LB1017]

SENATOR PIRSCH: Seeing no other questions, thank you, and we'll move on to the next opponent. [LB1017]

DAVID ROOT: Thank you. My name is David Root. That's R-o-o-t, and I represent Medco Health Solutions. We are a PBM or pharmacy benefits manager that operates in the state of Nebraska. A pharmacy benefits manager or PBM is the entity that administers the drug component of a healthcare plan. Currently, we handle about 25 percent of the state of...about 25 percent of the population of the state of Nebraska. In the interest of the committee's time, I'll try not to repeat some of the things that we've heard but echo their concerns. The bottom line here is that these drugs are expensive. There's no question about that; no one's denying that. They're expensive for a variety of reasons. What's at issue with what's been written in (LB)1017 is the simple fact that in many instances based on the plans's construction, they would be faced with a choice of either elevating the cost which would have the net effect of having some employers who buy health insurance for their employees drop away, so you'd potentially increase the population that's uncovered or is covered medically, but not covered with a drug component. The other option, as we heard previously, would be for the plan or the employer to simply purchase a plan where these drugs are just not covered period. If they're not covered, then there's no prior authorization request; there's no medically

necessary; they're just not covered which creates a whole different set of cost shifts because now you have people who have to go other places in order to get those treatments that they need. Really, that's...I mean, that's the crux of this issue. I think we've heard it from three or four different people. If there's any questions, I'll be glad to take them. [LB1017]

SENATOR PIRSCH: Thank you for your testimony. Are there any questions? Seeing none, I appreciate your coming down today, and we'll move on to the next opponent. Good afternoon. [LB1017]

DAVID DEDERICHS: Good afternoon, Mr. (Vice) Chair and members. Thank you for your time. My name is Dave Dederichs, and the last name is spelled D-e-d-e-r-i-c-h-s, and I work for another pharmacy benefits manager called Express Scripts headquartered in St. Louis, Missouri. We cover the prescription drug benefit for 575,000 Nebraskans, approximately. At least, at this time we do, and I'm not going to elaborate on any further testimony. I just want to echo the concerns of the three previous testifiers and respect your time. With that, if you have any questions, I'd be happy to answer them. [LB1017]

SENATOR PIRSCH: Thank you for your testimony today. Any questions? Seeing none, thank you. And hear from the next opponent. [LB1017]

MICK MINES: Senator Pirsch, members of the committee, for the record, my name is Mick Mines, M-i-c-k M-i-n-e-s. I'm a registered lobbyist, appearing today on behalf of the National Association of Insurance and Financial Advisors of Nebraska. Again, in the interest of time, let me just say that we're opposed to the bill for several of the reasons or all of the reasons we've heard thus far. Primarily, as those people that are on the ground, the deal with consumers and clients every day, we're concerned that cost shifting may very well increase the cost of the product that's available to our clients, and additionally, as Senator Gloor had pointed out, there's a concern that the products may not be available for our clients. In other words, those products that are available may either be unaffordable or, again, not available. With that, again, we're in opposition to this bill, and would be glad to answer any questions. [LB1017]

SENATOR PIRSCH: Thank you. Any questions? Seeing none, we'll move on to the next opponent. [LB1017]

JACK CHELOHA: Good afternoon, Senator Pirsch and members of the committee. My name is Jack Cheloha. The last name is spelled C-h-e-l-o-h-a. I'm a registered lobbyist for the city of Omaha. I want to testify in opposition to LB1017 today. The city of Omaha employs roughly 2,200 people. The city is self-insured on our health insurance and our workers' comp insurance, and also on our prescription program. From the testimony that you've heard today, this cost would be spread out; ultimately would increase costs for

the city of Omaha which is funded through taxpayer revenue, and for those reasons, we've seen double digit increases in terms of healthcare cost in pharmaceuticals, etcetera over the last, you know, numerous years. And so just because of the costs concerns within this bill, we felt we had no position other than to oppose it, so I'll try and answer any questions you might have. [LB1017]

SENATOR PIRSCH: Very good. Any questions? Senator Gloor. [LB1017]

SENATOR GLOOR: Thank you, (Vice) Chairman Pirsch. Mr. Cheloha, Omaha is self-insured, is it not? [LB1017]

JACK CHELOHA: That's correct. [LB1017]

SENATOR GLOOR: So under ERISA, as has been pointed out, whatever we do at the state level would not have an impact on your need to adhere to this particular piece of legislation, at least as I remember and understand it. [LB1017]

JACK CHELOHA: Right. I think that's been mentioned, the legalities. I'm not certain how all that would work at this point, so we just wanted to make sure. [LB1017]

SENATOR GLOOR: Okay, thank you. [LB1017]

JACK CHELOHA: Thank you. [LB1017]

SENATOR PIRSCH: Seeing none, thank you. Are there any other opponents of LB1017? Are there any here wishing to testify in a neutral capacity? Seeing none, Senator Cornett, if you'd like to close on your bill. [LB1017]

SENATOR CORNETT: Thank you very much, Vice Chairman Pirsch and members of the committee. As you can see, there's been demonstrated a need today with a number of Nebraska residents that fall under these drug categories. The federal government, under the Rare Disease(s) Act, recognized that there are diseases and medications that require special treatment under the law because they're not profitable to produce these medicines and/or to treat the patients. The insurance companies last week in the New York Times reported a 56 percent profit. Pharmaceutical companies certainly aren't going bankrupt, but we have patients in this state that are unable to get their medication because of a copay when they are paying insurance premiums. I have offered to work with the insurance companies, and over the course of the last couple of weeks, I'd had contact with Blue Cross Blue Shield, but the lobbyist from DC that has been working on these issues has not received any phone calls from them in return. I spoke with a representative from Medco last week and provided all the information to him also. There was no phone call. Nebraska is an insurance state as we all know. It's very hard to get changes done in this state with insurance law. But understand, there are people with

needs that are not being met in this state, and that is what we are here to address, and with that, I would be happy to answer any questions. [LB1017]

SENATOR PIRSCH: Thank you, Senator Cornett. Are there any questions for Senator Cornett? Very good then. That will then close the hearing on LB1017, and we will prepare for the hearing on LB1088. I would just like to add that we will take a brief break for about five minutes in between now and then if you'd like to stretch your legs out in the hall. [LB1017]

BREAK []

SENATOR PIRSCH: All right, I think we're going to resume. The final bill of the afternoon is LB1088. That is a bill in which Senator Cornett, you are again the sponsor, if you'd like to open to the committee. []

SENATOR CORNETT: Thank you, Vice Chairman Pirsch and members of the Banking and Commerce Insurance Committee. My name is Abbie Cornett, C-o-r-n-e-t-t. I represent the 45th Legislative District. The intent of LB1088 is that insurers and pharmacy benefit managers send notifications of requests for medication changes to patients and their physicians or other prescribing health professionals whenever the insurer or PBM recommends changing a patient's medication to a different therapeutic agent. Among other things, this notification will acknowledge no medication change will be allowed without the authorization of the original prescribing healthcare professional, clearly identify the original prescribed medication and the medication to which the patient would be charged, describe any financial incentives that may be provided or offered to the prescribing healthcare professional by the insurer or the PBM, describe any financial incentives the health insurer or PBM may receive to encourage a medicine exchange, explain any cost-sharing changes for which the patient would be responsible should the medication change take place, state that the insured has the right to discuss the medication change before it occurs. There are a number of people wishing to testify and will be able to give you background on how this bill came in front of you as the bill prior did. As with most bills, there are several entities impacted by this bill. I just wanted to assure the committee that those parties and I will be happy to work with any of those parties on any of the issues they may have. I'll be happy to answer any questions. I will waive closing because we're execing (phonetic) in another committee. [LB1088]

SENATOR PIRSCH: Very good. Are there any questions for Senator Cornett? Seeing none, I do appreciate that. Can I see a show of hands of those who are...oh, do you have a handout here for the pages? [LB1088]

SENATOR CORNETT: (Exhibit 1) I'm sorry, I have a...letters of support for LB1088. [LB1088]

SENATOR PIRSCH: Thank you. Can I see a show of hands of those who plan on testifying in favor of this LB1088? Okay, very good. If I could have the first proponent then? I might add, we are joined here by Senator Christensen. [LB1088]

MICHELLE VOGEL: (Exhibit 2) Hi. I'm Michelle Vogel, M-i-c-h-e-l-l-e V-o-g-e-l, the executive director of the Alliance for Plasma Therapies, and on behalf of the patients and providers, I want to thank the committee for holding today's hearing on LB1088, an act to reform insurance prescription fee practices, and to thank Senator Cornett for introducing this bill. As I stated before, I'm the executive director for the Alliance for Plasma Therapies which is a national nonprofit organization. And we really are an organization of patient organizations, providers and some industry leaders working on access to lifesaving therapies like intravenous immune globulin therapy (IVIG) headquartered in Washington, DC. But we do get insurance questions all the time in cases on an annual basis from all over the United States, and on average we're getting about 250 cases a year. And we work with patients who have cancer, autoimmune diseases, neuropathies, primary immune deficiencies. One of the major issues in dealing with casework has been switching of products, and this really has become very evident in terms of the issue of IVIG. In categories and classifications of drugs, I think of them...they're all the same. There's eight different brands of IVIG in the market, but each one has a different formulation. And what we found out was when Medicare--I know it doesn't pertain directly here, but when Medicare changed its rules back in 2005 after the MMA Act of 2003, we saw a huge shift when physicians no longer were treating their Medicare patients with IVIG, and the patients were shifted to the hospitals. What happened is that whatever brand was at the hospital, they would give that to the patient. No notification went to the physician. And what happened was all these adverse reactions occurred because they're all different formulations. One of the greatest is that if you're a diabetic, and you get a product with sugar in it, you're going to have a severe reaction. So physicians need to be notified by the pharmacist and know that this product is being switched. Is it okay? And if it is, it may be as easy as slowing down the rate of the infusion and being premedicated with Tylenol, Benadryl, and steroids and following the patient closely or not going ahead at all because it will be a disastrous result. This is, I mean, that's one example of what happens with switching of brands, of products. But on the other hand, with every day therapies, we get calls from patients who get a notice from their pharmacy benefit manager, and here's your list of drugs. These are the lists that your physician has prescribed for you, and this is a list that you're covered. Go to your doctor and have him write the prescriptions that are on the list of covered drugs. Who's prescribing medicines? Is it the insurance companies or is it your physician? So when you go in and you go to see if you could switch products, okay, well, then you say, well, Doctor, can I...you know, all blood pressure medicines are the same; all antidepressants are the same; all statin drugs are the same. Is it a big deal that we just switch brands? The answer is yes, it is because antidepressants work very differently in the chemicals of your brain. Statins, if you're on the wrong product and if the doctor is not following you properly...you know, you're not following properly with the doctor and

telling what side effects may happen, you can develop an autoimmune disease called myositis. And so these things happen all the time, and this is where we're concerned. This is nothing to do with substitution to generics, doesn't touch generics. But it has to do with making sure that the pharmacist, physician, and patient are aligned and making sure that if a product is going to be switched, that the physician is notified and the patient is notified, and that the physician signs off on it. This is not to give extra work to pharmacists and have this nightmare of telling a patient at the pharmacy window--sorry, your product's not covered; come back later. You never want to put a pharmacist in that horrible position because the pharmacist actually gets all the prescriptions and knows how they interact with each other, and know the best drug reactions for these patients and are counseling the patients. We want the pharmacist back in the role of counseling patients like they should be. And so, that's why this bill is really important. We want good health outcomes for our patients. We want to make sure that they're getting the right prescriptions, and so on behalf of patients and providers, I urge you to support and advance this bill, and I believe all Nebraskans that have healthcare policies with prescription coverage should be sure that their treating physician or provider, be it a nurse practitioner or whoever is writing that prescription, are choosing the best medication for them and is notified if they need to switch to a different brand of medications and the reasons why. And no patient should be switched to another brand or forced from their current medication regimen without notified prior to any changes in the medication to prevent any unnecessary adverse consequences to their health. That's...thank you. [LB1088]

SENATOR PIRSCH: Thank you very much for your testimony. I believe there's a question by Senator Gloor. [LB1088]

SENATOR GLOOR: Thank you, (Vice) Chairman Pirsch. Thank you again for your testimony on this. You used an example that I'd like to walk through a little further and that is, I'm on IVIG therapy. I live in another community, an hour and 15 minutes west of here. I come to Lincoln to a sporting event, and I go into crisis and am brought into a local hospital's emergency room. Does this bill require that emergency room to contact my physician before they can change me...and they don't carry my IVIG product. They carry another product that their medical staff is happy with, but it's different than what I'm currently on. Does this bill require that they get ahold of my physician and check with my physician before they start treating me with new IVIG therapy? [LB1088]

MICHELLE VOGEL: Yes. [LB1088]

SENATOR GLOOR: We don't think that's cumbersome or risky...? [LB1088]

MICHELLE VOGEL: No. I think it's risky if they don't, and I'll tell you why. The side effects to IVIG besides having anaphylaxis which is terrible without having...going into meningitis from the medication is horrible. Strokes are horrible. Renal failure is horrible.

Migraines aren't unpleasant but tolerable. [LB1088]

SENATOR GLOOR: Yeah, yeah. [LB1088]

MICHELLE VOGEL: Exactly. That's a better scenario. All the others are realistic. It's really important for the doctor to know they should be able to pull up and see what product you're on, and, hopefully, it's the same product. But typically for IVIG, it's not an emergency going into your scheduled infusions. But if you have to go to another infusion center, and it's your time, you will hope that the situation is in place that they can call up because they've got to get that medication prepared anyway. It's not quick that they can get in touch with your physicians and say, this is the brand we have. Is it okay to use it? And if not, they slow down the rate of infusion, and they premedicate and make sure that everything...the protocols are being done correctly because if not, you will see the type of adverse reactions you can have, and it's pretty horrendous. [LB1088]

SENATOR GLOOR: And the adverse reaction...I mean the...I'm going to assume the medical staff at some of the large infusionary facilities here in Lincoln will have medical staffs that are comfortable with product that they're using here. But you're saying, just the difference in product alone...if I had been started on the product here, I wouldn't be having the adverse reaction. But the fact that I'm on a different product, my system is used to that different...I'm trying to understand because they're not going to make a bad decision, I don't think, in this community but... [LB1088]

MICHELLE VOGEL: No, but switching brands at any time can cause an adverse reaction because the formulations of these products are so different. I mean, all the chemicals in the products have differences from having different types of sugars or no sugar at all, having salt content, having pH. There's osmolarity and osmolality. I mean, there's all different types of things in these products. I had to do actually a letter for Chairman...at that point was Greenwood of Energy and Commerce Committee to go through all the differences of these products, and I sat...it was a lesson in reading product labels and looking at the differences in these product formulations. They're very different even the Centers for Medicare and Medicaid Services actually debundled the codes of IVIG and gave them each their own separate code for reimbursement because the products shouldn't be in one class. They're so different in formulation, and patients have such different reactions, so I would say in this case, I would hope that that pharmacist...that this legislation would be passed, and that pharmacist would call up the doctor and say, can we switch over, and what kind of premedication will we need to use to ensure that my patient would be okay? [LB1088]

SENATOR GLOOR: Well, if this is passed, it isn't...you would hope it's the law. That's why... [LB1088]

MICHELLE VOGEL: Well, it would be the law. Right now we hope those things happen;

they don't. Okay? [LB1088]

SENATOR GLOOR: Okay. Thank you. [LB1088]

SENATOR LANGEMEIER: Are there any other questions for Ms. Vogel? I do have one because Senator Cornett didn't bring it up in her opening testimony. She indicated when she opened on LB1017 that that was a result of trying to get this passed on a federal level, and there was no results in the future. Is...to your knowledge, is LB1088 the same situation? Is this something that's being tried to be done on a federal level that has been unsuccessful, or is this just a total different issue? [LB1088]

MICHELLE VOGEL: Totally different issue. [LB1088]

SENATOR LANGEMEIER: Okay, very good. Thank you very much for your testimony. [LB1088]

MICHELLE VOGEL: Thank you very much. [LB1088]

SENATOR LANGEMEIER: Very good. Further testimony in support or proponent to LB1088? Welcome back. [LB1088]

MELISSA SCHWEITZER: Thank you. See if my voice cooperates this time. (Laugh) Hello, everyone again. My name is Melissa Schweitzer, and again, I'd like to thank you for holding this hearing. In this testimony...yes. [LB1088]

SENATOR LANGEMEIER: I need you to spell your name again, though. [LB1088]

MELISSA SCHWEITZER: Oh, I'm sorry. M-e-l-i-s-s-a, Schweitzer is S-c-h-w-e-i-t-z-e-r. [LB1088]

SENATOR LANGEMEIER: Thank you. [LB1088]

MELISSA SCHWEITZER: (Exhibit 3) In this testimony, I'll be really focusing on my diagnosis as a patient. I know firsthand the differences in classifications of brand medications because I am a patient who relies on intravenous immune globulin therapy or IVIG. Thirty years ago I was diagnosed with common variable immune deficiency which is a type of primary immune deficiency, a genetic form of an immune deficiency. My diagnosis finally came after a childhood of chronic recurrent infections, and at that time, back in the seventies, IVIG was not yet available, so I relied on prophylactic antibiotics and the careful management of my immunologist. Then in 1987, I started my monthly infusions of IVIG, and at that point, I really felt that if I had to be born with a rare and chronic condition, at least I was lucky to be born with one for which there is an effective therapy. By replacing my antibodies and thus reducing the number of

infections I experience, it has allowed me to lead a relatively normal and rewarding life. Because of IVIG, I've enjoyed a successful career as a genetic counselor and patient advocate, working to help educate and support other individuals affected by rare genetic and chronic diseases. Because of IVIG, I've also had the immense fortune of becoming a wife to a wonderful husband and a mother to two beautiful children after once wondering if I would have ever had the opportunity of becoming a mother at all. Because of IVIG, I feel that it is my personal and professional mission to help work toward a solution that will restore access to these important therapies to all patients who rely on them. I've also learned that after years of being on one brand of IVIG, I developed an allergic reaction to the brand that I had been on for many years and needed to switch to another product. So working closely with my immunologist, we reviewed the unique qualities of the different brands of IVIG to determine which would be best for me, and Michelle outlined those very different formulations, and the differences between some of the different brands. Since there are eight different brands of IVIG, it was important that we determine which one would work best for me with the least side effects. Once that decision was made, even though I typically receive my IVIG at home, and that usually occurs every three weeks, and it takes about three-and-a-half to four hours, I went to my physician's hospital infusion center to receive two infusions to make sure that I tolerated the product, and then I returned back to home infusion. And just addressing some of the questions Senator Gloor had, regarding the different...you know, you can be on a product for many years and never...be doing fine and still have that potential of reacting because it is a blood-based product, comes from thousands of different donors, so there is that ability there. So with IVIG and many other medications, you can be...as I just mentioned, I think the important thing to keep in mind is that the relationship between the doctor, the patient, the infusion nurse is really sacred for patients like me to ensure that I receive the right brand of IVIG at the right rate with the right premedications in the right site of care. Not everyone is as lucky as I am. My immunologist actually writes on my prescriptions in very bold letters, no substitutions allowed because he knows that that could be detrimental to my health. Apparently, he has had some experience in the past of outside entities trying to dictate what is best for his patients which puts his patients in harm's way. So this legislation is a step in the right direction to protect patients and ensure that physicians are writing the best prescriptions for patients and not having insurance companies and PBMs dictate switching brands which can cause irreparable harm. Therefore, I urge you to support and advance LB1088. Thank you. [LB1088]

SENATOR LANGEMEIER: Thank you. Are there any questions for Ms. Schweitzer? Seeing none, thank you very much for your testimony. Very good job. Further testimony in support of LB1088? Welcome. [LB1088]

LINDA STONES: (Exhibit 4) Good afternoon, Senator Langemeier and the members of the Banking, Commerce and Insurance Committee. My name is Linda Stones, L-i-n-d-a S-t-o-n-e-s. I'm a registered nurse, and I reside in District 30 here in Nebraska, and I am

here today on behalf of the Nebraska Nurses Association. The Nebraska Nurses Association represents over 20,000 nurses here in...throughout the state of Nebraska, and while we support the content of LB1088, we also request a slight amendment to the title. The title of this bill should be changed from the Physician and Patient Prescription Act to the Practitioner and Patient Prescription Act because medical care is provided by a wider variety of providers than just physicians, so we just want to make note of that. But we are also here...the nurses of Nebraska are here today in support of the protection of the relationship between the practitioner and the patient. Patient safety and care is our number one concern. We understand the issues related to escalating healthcare costs, but feel that the balance...balance is the key, and patient safety needs to be at the core of our decisionmaking. Nurses are not in opposition of substitution. In fact, we encourage the use of substitution to decrease the economic burden of illness and injury on our patients. However, nurses believe that activity of medication substitution really belongs within the practitioner and patient relationship, not between pharmacies and insurance payers. Substitution that occurs outside of the practitioner and patient relationship impedes the patient's ability to manage their illness, and you've heard that a lot here already today. And practitioners really have a difficult time effectively and efficiently managing the disease process, and it puts patients at risk for errors and may, in actuality, have unintended consequences of actually increasing the cost of care. Substitution does impede the ability to manage illness. Medication is not an exact science. As we deal with individuals who are very unique in their individual responses, internal responses, just as they are unique in their external appearances, our patients...one patient's response to a certain drug may be entirely different than another patient's experience. Medicine is really about trying to figure out what works best, and so it's very difficult if you are a practitioner, and you're trying to prescribe medications to a patient, and you think that they're well controlled on a certain drug, and then all of a sudden they start having difficulties, and you can't quite figure out what the issue is. And it's really a process of elimination to try to figure out what the issue is, and if you're not aware that a brand-name drug was switched to a generic or therapeutic substitution occurred within a class, it's kind of like trying to bake a cake, but not knowing who's throwing all the ingredients into it. So substitution really needs to be where the practitioner is aware of what is going on with the medications. People who are not educated in the healthcare arena really struggle with the terms that we use in healthcare. Our patients are not fluid in the language, and the healthcare language is not very easy to understand either. For example, there are medications with multiple names--analgesics which is a broad classification of drugs, we have Tylenol, acetaminophen, ibuprofen, Motrin, naproxen sodium, Aleve. Those are all drugs that fall within that realm, and you may very well be able to match a generic name with a trade name, but for...when we get outside of those common drugs, it's very hard for our patients to understand. And so, when we start dealing with patients, and they come to us as providers now, a lot of the people that are here with these unique situations, these unique illnesses, really know their drugs, and they really become the experts. But there are some people out there that are very...that are very, not as educated, and not as well

versed in their medications, and they'll come to us, and they'll say they're on...they're taking their water pill or they're taking their blood pressure pill. But we assume that it's the one that we prescribed, but it may not be. It may be through therapeutic substitution; it may be a different drug. And so for us, it's very important as providers to understand what exactly is being prescribed to our patients. Not only do the drugs have different names, but they also look differently, and so it's very important too. A lot of times when you're working with patients, I as a nurse and we're getting ready to send them home, we are training them on what their prescription protocols are. Even my eye doctor sent home with take one drop of the pink cap a day and take two drops of the yellow capped eye drops a day, and that's how we go home as patients, knowing what our prescriptions are supposed to be...our prescription routines are supposed to be. And so if we fail to provide the practitioner and the patient and educate them on what the differences are when we substitute these drugs, there can be significant confusion. And this happened with my grandmother, and it was a case where it was just a generic substitution, placing a...she was on digoxin, and then she was moved to Lanoxin which is the generic drug. But in her mind, she needed to take the little yellow heart pill every day, and when they substituted it for the bigger, white heart pill, she didn't get that she needed to stop taking the little yellow heart pill. So poor Grandma who was 95 years old, living on her own, and doing very well, actually was overdosing herself for a period of time. And it took multiple physician visits, office visits, multiple drug levels. We were trying to figure out what in the world was causing her blood levels to go up, and only after some astute observation and actually, when the little yellow pill ran out, and she asked for more did we realize that she had actually been overdosing herself because she had a few of her pills left over, and they were crossed over, so she was taking both. But that's when we finally uncovered what she was doing, so you can see where the healthcare environment is so complex that unless we have a single person that's responsible for understanding what's going on with that patient's care, patients can be at risk. And so that's why we as nurses are not against substitution. We just really feel strongly that the physicians have to be involved in that decision. Physicians or practitioners have to be involved in that discussion, and be the ones helping making the decisions for the patients. The Institute of Medicine put out a report, talking about preventing medication errors, and they estimated that 1.5 million Americans are injured every year by medication errors. And the estimated cost of that is $3.5 billion. Now, that is all errors, and that's not just errors related to substitution, but substitution is part of that, and out of that report came the recommendation that establishing and maintaining strong provider patient partnerships is the key to reducing medication errors. And so, we ask that you support (LB)1088 to put the decisions on substitutions where the discussions and decisions belong between the patients and their practitioners. It is the responsibility of all individuals and their healthcare environment to promote patient safety and to look for areas to reduce cost. That is my role as a nurse, but the final decisions as the plan of treatment must ultimately lie with the patient with the full knowledge of the patient's primary provider. So we ask you on the name...on behalf of the mothers and fathers out there, grandmothers and grandfathers and children and

grandchildren that are all at risk that you will support LB1088. And I do...before I close, I do want to ask...state one more thing, and, Senator Langemeier, you had asked, what is going on in a federal level? And while there's not a bill like this on the federal level, one of the basic tenets of healthcare reform that has been identified at the federal level is the lack of coordination of care. And that's where the majority of the patients and the majority of the expenses occurs is because of the lack of coordination of care. And so with healthcare reform, I sit on a national committee, and what we are trying to do with healthcare reform is really promoting those things that can help us coordinate care across all the continuums, across all the different providers because as you're hearing today, there are people that are getting in the gaps, and I as a nurse, every day see people that are caught in the gaps, and that is very difficult because you have these large complex institutions that are trying to run healthcare, but there are people that are being affected by this every day. And so, I think this is a small piece for us today is to come and ask you to support (LB)1088, and we do think that the discussion about substitution belongs with the practitioner and the patient, so I'll entertain any questions that you might have. [LB1088]

SENATOR LANGEMEIER: Very good. Are there any questions for Ms. Stones? Seeing none, thank you very much for your testimony. [LB1088]

LINDA STONES: Okay. Thank you. [LB1088]

SENATOR LANGEMEIER: Further testimony in support or proponents of LB1088? [LB1088]

HEATHER OVERTON: (Exhibit 5) My name is Heather Overton, H-e-a-t-h-e-r O-v-e-r-t-o-n, and I've already told you about what I've been going through, so I won't go into that into detail. And I haven't personally been affected by the therapeutic substitution, but I have been affected by the bioequivalent substitution, so I'm going to tell you a little bit about that, and how that affects not only myself, but persons with epilepsy in specific since that's a condition I'm familiar with. There are two distinguishing features of epilepsy that suggest AED switching or antiepileptic drug switching should be approached with special caution. First, seizure control can be an all or nothing proposition. Any slight changes in medication can mean the difference between a fully controlled condition or breakthrough seizures. The consequences of a breakthrough seizure can be catastrophic. Seizures increase the likelihood of a person's bodily injury and death, which we talked about. The often result is significant social development and developmental consequences including a loss of driver's license, loss of employment, loss of self-esteem, and consider also, if a person was to have a breakthrough seizure while they were engaged in various activities of daily life such as driving, they not only put themselves at risk, but they put other persons at risk on the road. So it's not only individual...it's public safety. And finally, another consequence of a breakthrough seizure can be costly with significant expenses...medical expenses--the ambulance, ER, doctor

visits, and the drug monitoring with the generic to generic testing, or brand to generic, or the...any kind of switching. A person with epilepsy needs to have...their levels need to be stabilized, and generics have a large variance, anywhere from 80 to 125 percent, so if they get one medication one month, their pharmacist changes their medication. And this month they're getting medication A, generic A or medication A, and it's 85 percent. And the next month they're getting 125 percent, and the next month they're getting 100 percent. Well, their levels are going like this, so they're going to have a seizure. It's inevitable they're going to have a seizure, and if you're on multiple medications such as myself, you know, like I said, there's a narrow therapeutic index that a person has to follow, that doctors need to follow. Generic AEDs do not provide the same level of bioequivalence to patients because the difference of formulations and needlessly expose them to seizures and their life threatening consequences. AEDs are narrow therapeutic index medications where the slightest variance in quality can cause seizures and even death. It is a proven fact that generic AEDs do not provide overall cost savings to the plan due to the costs that I had already mentioned. A recent study showed that between 20 percent to 30 percent of epilepsy patients, who were switched from brand to generic or any switching suffered breakthrough seizures. And I have cited all of this in my testimony if you want to go back and read that. It is clear that variances in the formulation of AEDs, however slight, can mean the difference...I feel like I'm repeating myself...can mean the difference between controlled epilepsy and breakthrough seizures. According to the article on neurology, the risk of hospitalization following generic to generic substitution was close to two times higher compared to brand use. The risk of fractured or head injury was nearly three times greater following generic to generic substitution, and the relatively common practice of polytherapy was significantly associated with risk of fracture or head injury relative to monotherapy. Based on this, there is no doubt there is no generic available for epilepsy patients who are controlled on brand AEDs. And I will be happy to provide you with any of the supporting documentation that I've cited in my testimony, so if you would like that, I will get it to you. Please keep in mind that I'm not saying generics are bad, and yes, they are cost effective. However, they...it's not cost effective when they're switching among different versions which cause seizures and side effects. Decisions need to go back into the physicians' hands and not the insurance companies who need to stop playing God and risking our lives. Thank you. Does anybody have questions? [LB1088]

SENATOR LANGEMEIER: Very good. Are there any questions for Ms. Overton? Seeing none, thank you very much, did a great job. Further testimony in support or proponent for LB1088. [LB1088]

CARL CLARK: (Exhibit 6) My name is Carl Clark, C-l-a-r-k. I come back before you because the situation that I have with our hemophiliac son is very much related to the two together. What I want to focus on in this particular situation, however, is the fact that during the 85 weeks of treatment program, part of that program time he was on a...one type of drug, and when he went back to refill it he was given a different type of drug. His

reaction to those two medications were different. He felt like he had been receiving in the first case where he had been under one type of drug, he felt like he was actually starting to make some progress toward the effects of the hepatitis C. When he was put on the other kind, it was not working in the same manner that the first had. He went back and asked if he could be put back on the other one and they said, yes, but it will cost you, and he couldn't pay the difference. So he had to stay on the program. At the end of 85 weeks, the doctors determined that this treatment was not working, and they took him off of everything, and he still has hepatitis C. We can't help but wonder in our minds if he had been able to keep up on the drug that was making him feel better, if it would have taken care of it; we have no way of knowing. But that is a question that we have in our mind, and in his mind as well. We know that...we hope that LB1088 will return the dialogue about prescription drug benefits and risks back to the doctor and patient. Physicians or practitioners rather than the insurers know about the treatment programs that will or won't work for their patients. Thank you. [LB1088]

SENATOR LANGEMEIER: Very good. Are there any questions for Mr. Clark? Seeing none, thank you very much for your testimony. [LB1088]

CARL CLARK: Appreciate your time, thank you. [LB1088]

SENATOR LANGEMEIER: Thank you. You did a great job. Further testimony in support or proponent of LB1088? [LB1088]

KIM BERNSTEIN: Hello again. I'll be very brief (laugh). [LB1088]

SENATOR LANGEMEIER: Welcome back. [LB1088]

KIM BERNSTEIN: Okay, thank you. I'd like to speak in support with conditions... [LB1088]

SENATOR LANGEMEIER: Oh, I need you to... [LB1088]

KIM BERNSTEIN: I'm sorry. Kim Bernstein... [LB1088]

SENATOR LANGEMEIER: You got to redo your name. [LB1088]

KIM BERNSTEIN: Kim Bernstein, B-e-r-n-s-t-e-i-n. I'm here representing the Hemophilia Federation of America. Again, we are a nonprofit organization that represents the interests of people with hemophilia across the country, and we strive to have accessible access to healthcare that's appropriate for people with hemophilia. The thing that's very important...there are only three points I want to make, with people with hemophilia often have comorbidity such as hepatitis C, HIV--two conditions which were...which came nitrogenically in response to contaminated blood products. The products are now clean,

however, the people who still have the residual effects of the products have very complex medical conditions in which substitutions can be a big problem. If the substitution is appropriate after consultation with the doctor, that's one thing, but if it's made without consultation it could cause a large problem rather than a small one. Again, people with hemophilia can take some drugs and not others. Something as simple as switching out something with acetaminophen for something with aspirin could cause life-threatening conditions as well as very expensive conditions because, at that point, you would have major bleeds requiring thousands of dollars in clotting factors. So switching without checking with the medical treater can be a huge problem for a very small savings. We support the bill. We think that it's very important, and we think that it's got the safeguards to protect the health of people with hemophilia. Thank you. Are there any questions that I may answer? [LB1088]

SENATOR LANGEMEIER: Very good. Are there any questions? Seeing none, thank you very much for your testimony, very good. [LB1088]

KIM BERNSTEIN: Thank you. [LB1088]

SENATOR LANGEMEIER: Further testimony in support or a proponent to LB1088. Seeing no more in support; those in opposition to LB1088. Welcome back. [LB1088]

DAVID DEDERICHS: Thank you, Mr. Chair (sic: Senator Langemeier) and members. Again, for the record, my name is Dave Dederichs. Last name is D-e-d-e-r-i-c-h-s, and I work for Express Scripts. I didn't elaborate earlier on what my company does, but I'd like to take 20 or 30 seconds just to give a quick 30,000-foot overview of what a pharmacy benefit manager is. We administer the prescription drug benefit for health insurance companies or for government entities or labor unions or Fortune 500 companies, anybody that contracts to have part of their health insurance prescription drug benefit, we will essentially adjudicate or administer that benefit for them. In fact, our largest contract is with the United States Department of Defense. We service our armed forces. Our goal as a pharmacy benefits manager is to reduce the waste in drug spend for both our clients and ultimately the members, the patients of our clients. And we do this through multiple channels. Number one, we utilize generics whenever possible, and in 2008, a PricewaterhouseCoopers study came out that said the average cost of a brand new medication was $120 where the average price of a generic was $34. When you negotiate discounts from brand-name drug manufacturers. We are one of the largest pharmacy benefit managers in the country. We provide prescription drug benefits for 75 million Americans, and we dispense around 750 million prescriptions a year, and so there is a serious incentive for drug manufacturers to negotiate good costs with us because we are providing them access to so many people through some of our master formularies. We also encourage the use of mail order pharmacy for maintenance medications, so if you have a chronic condition, and you need to be on a medication for a series of years, for the rest of your life, we can help you save money through getting

90-day supplies in the mail. We also do drug utilization reviews. A lot of people, myself included, I have multiple pharmacies...retail pharmacies...around my house, and whichever one is most convenient for me to use I often use because they're all part of my retail pharmacy network. However, my PBM which is my company, has access to all the different scripts I've had filled at all the different pharmacies, and they're able to do drug utilization reviews to find out if there are any adverse reactions that could potentially happen from all the different scripts that I'm taking. So we do a lot of that. One of the things I want to make clear before I continue further is that this bill does not deal with generic substitution. It says it in several places, and I believe Senator Cornett said it in her introduction, but we've heard a lot of testimony about generic substitution. This bill deals with therapeutic interchanges, and the best way that I can describe that is maybe through giving example. Now, I think we've all heard of Lipitor. It's a cholesterol reducing agent. Another type of drug that also reduces cholesterol but made by a different brand-name manufacturer is Zocor. They both do the same thing, maybe differently, and their chemical makeup is different. Now a generic substitution occurs when Lipitor...it doesn't have a generic equivalent yet, but when they lose their patent protection, and a generic is introduced into the market, it has the same chemical equivalence. It is chemically identical to the brand-name drug. Now a therapeutic alternative, again they treat the same thing, but they have different chemical compositions. Now, I'll let the plans talk about this if they come up here today. But when they decide...our clients decide what they want on their formularies, they can look at the different types of drugs that treat conditions. We can make recommendations to them about what types of drugs to use, but ultimately it is their decision. There's a few things I wanted to mention to you today. Number one, it is existing law that if a person when they're getting their script filled, finds out that the prescription is for a drug that is not on formulary, but something else is--a pharmacist is required by law to contact their physician to get either the script changed or to initiate a prior authorization or step therapy procedure with the insurance company to make sure that that drug can be dispensed. It is absolutely illegal for pharmacists to make a therapeutic interchange without physician consent. Second, we heard some testimony from different people that their medications need to be brand. Well, that's also...that can be referenced to part of existing law. If a doctor writes on a prescription, dispense as written or DAW, a pharmacist is legally obligated to dispense the medication as it is written. They cannot make a substitution even if there is a generic available for that brand-name drug that is chemically identical. The law is, if a doctor writes dispense as written, it needs to be dispensed as written. Finally, this bill, if implemented, it does much more than require us to notify a physician's office which we already do in the case of a therapeutic interchange, but it also requires us to disclose certain proprietary financial information which if you are a patient, and you want your prescription filled, and we are required to not only notify the physician's office to get their approval for a therapeutic interchange, but then we're also supposed to notify our headquarters to find out if there's been any rebate information associated with the therapeutic interchange, where it could be potentially talking about a delay in the dispensation of medication for a patient, so it

becomes a public safety issue as well. I could get a little more into the disclosure requirements. This legislation would take away the ability for individual plans that contract with companies like Express Scripts to have certain contract terms. If they want to have rebates from drug manufacturers sent back to them as a client of ours, then they can negotiate in the contract process. This bill essentially would place a mandate on us and all of our contracts in the state of Nebraska to disclose certain proprietary financial information. And lastly, the one thing I wanted to share with you is while I mention that this bill does not deal with generic substitution, I wanted to give you a real life example of how this affects commerce like in my company. I've referenced Lipitor earlier, and my company used to have Lipitor as one of the primary cholesterol reducing drugs on its recommended formulary to our clients, and it was pretty pricey. In fact, I went to drugstore.com just yesterday and found out that a 30-day supply of Lipitor is $96 for 10mg tablets for one month. The generic version of Simvastatin which is a generic version of Zocor, so a competitor's generic version is only $20 for the same 10mg of a 30-day count of tablets. So what our company did when our pharmacy and therapeutics committee came together, they're a national panel of experts from various medical disciplines, and they review the efficacy literature for certain drugs, and then they make recommendations about which drug should be included on our formularies. It's only after they make their recommendations based on the medical efficacy of the drugs that it goes to our finance committee so that they can look at the different finances for these drugs on our various formularies. We found out that Zocor could be effectively used for Lipitor in most cases, and Zocor has a generic version available. From 2006 to 2008, our company was able to save $1 billion for our clients, 750 million directly for our members, 250 million eventually for the members of our clients, ultimately the patients. So therapeutic interchanges do work. It is already the law, and I don't want to take up any more of your time because I'm sure there other opponents, but this issue is very important to us, so thank you, Mr. Chair (sic: Senator Langemeier). [LB1088]

SENATOR LANGEMEIER: Very good. Are there any questions for Mr. Dederichs? Seeing none, thank you very much for your testimony. [LB1088]

DAVID DEDERICHS: Thank you. [LB1088]

SENATOR LANGEMEIER: Further testimony in opposition to LB1088. Welcome back. [LB1088]

DAVID ROOT: Thank you. Again, my name is David Root, R-o-o-t, and I represent Medco Health Solutions, a PBM that does operate in the state of Nebraska. We've heard a significant amount of testimony with respect to IVIG. I think it's important to make sure that we look at this bill as it's written. It would address all therapeutic substitutions that take place in the state not just those with IVIG. I also think it's important to go over briefly with the committee the existing, what we heard from Mr.

Dederichs, the existing laws in the state. In order to perform a therapeutic substitution, a pharmacist or, in our case, a PBM, is required to contact the physician to get another script, so that medical communication is already required by law to take place. Pharmacist does not reach into his or her bag and pull out a drug that they think is appropriate. They just can't do that, and they don't do that. The other issue I'd like to bring up with respect to how this works in more emergency situations, I think Senator Gloor addressed an issue with IVIG, but rightly as we heard, those tend to be less of emergency type situations and more planned situations. But if this bill were in process and someone were to present with an emergency and present themselves to a hospital, this bill would require treatment to be postponed until such time as they can reach out to the doctor and confirm their current course of action for treating that patient. That could result in needless amounts of delay in patient care. Hospitals operate under their own formularies and make...you know, the assumption is that the doctors at the hospitals will make sound medical judgment and sound medical decisions for those patients. Waiting is, in many instances, in an emergency not necessarily considered a sound medical decision. As we heard, one other thing I want to bring up, therapeutic substitution is a tested method of lowering plan and consumer drug spend which allows in discussions some overlap with the bill that we previously discussed, increasing...it allows plans to increase drug coverage at affordable prices for more and more people. Putting things like (LB)1088 was put...putting bills like (LB)1088 in place that put impediments to plans, structuring an affordable drug program only serves to limit access and increase costs for the majority of people. And again, I also want to reiterate that it is important to understand that this bill does not address generic substitution. It is only addressing therapeutic substitution which is already addressed in existing law by requiring you to have that conversation with the doctor in order to get a new script. It is simply...that is the only way it can be conducted. If there's any questions, I'll be glad to take them. [LB1088]

SENATOR PIRSCH: Thank you for your testimony. Are there any questions? Seeing none, we'll move on. Are there any other opponents to LB1088? Good afternoon again. [LB1088]

CLINT WILLIAMS: (Exhibit 7) Good afternoon again. My name is Clint Williams spelled C-l-i-n-t W-i-l-l-i-a-m-s. I am the director of pharmacy with Blue Cross Blue Shield of Nebraska. Blue Cross Blue Shield of Nebraska has over 7,000 members who carry the Blue Cross Nebraska card. It's in our interest of our members today that we oppose LB1088. We feel it's inconsistent with current Nebraska law and could potentially require disclosure of confidential information as been testified earlier. I won't spend a whole lot of time on that since that's already been covered. I will talk a little bit about some of the letters that Blue Cross Blue Shield of Nebraska uses and the purposes that they are for. We do send out letters to our members informing them if they are taking certain class of medications that there are generic alternatives and formulary brand alternatives and also ask them to speak with their physician if those are options that work for them.

Again, that is what is required by Nebraska law that that switch can only occur with their physician. We feel that there's not a lot of information on the cost for our members, and we want to try to help them out as much as we can and make informed decisions. We think that one of the things that could help with some of the issues that we've heard today are things like electronic prescribing and health information exchange. There was a lot of discussion about not knowing which medication is which, which one they're using. And we think health information exchange, there's an initiative going on here in Nebraska called NeHII, that we think will help with that in the future and would alleviate some of this. But because of some of the ambiguous language, especially around the financial disclosures and then the potential for disclosure of confidential information, we are opposing the bill. And I'd be happy to take any questions. [LB1088]

SENATOR PIRSCH: Thank you. Are there any questions for this testifier? Seeing none, appreciate your coming down here today. Is there any other opponents? [LB1088]

JAN McKENZIE: Senator Pirsch, members of the Banking, Commerce and Insurance Committee. For the record, my name is Jan McKenzie, J-a-n M-c-K-e-n-z-i-e, representing the Nebraska Insurance Federation here in opposition to (LB)1088. The Legislative Health Committee of the Federation, who includes Blue Cross Blue Shield, voted in opposition to this bill for a couple of reasons. Several of those have been stated already for the record. It's been a long afternoon. I would just note that we're not real happy about the Department of Insurance being involved in a practice of developing notifications for something that we believe belongs in Health and Human Services, and we also agree that there are some proprietary requirements there that would be violated by passage of (LB)1088. [LB1088]

SENATOR PIRSCH: Thank you for your testimony. Are there any questions? Seeing none, thank you. [LB1088]

JAN McKENZIE: Thank you. [LB1088]

SENATOR PIRSCH: (Exhibit 8) Are there any other opponents of LB1088? Seeing none, are there any here to testify in a neutral capacity? Seeing none, Senator Cornett...she indicated that she would waive her closing, and so we will. That will end the hearing on LB1088 as well as the hearings for today. Thank you all for coming down to testify. [LB1088]