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Banking, Commerce and Insurance Committee  
October 14, 2010

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[LR334 LR406]

The Committee on Banking, Commerce and Insurance met at 9:30 a.m. on Thursday, October 14, 2010, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR334 and LR406. Senators present: Rich Pahls, Chairperson; Mark Christensen; Mike Gloor; and Dennis Utter. Senators absent: Chris Langemeier; Beau McCoy; Dave Pankonin; and Pete Pirsch, Vice Chairperson. []

SENATOR PAHLS: Good morning. Looking from this side out, you all look pretty darned good this morning. You don't have to reply back on that this way. I want to thank you for coming today for our hearing on LR334 and LR406, and we are going to do those together. And, first of all, let me introduce myself. My name is Rich Pahls. I represent District 31 which is Millard of Omaha, and what I'm going to do right now, we're going to go around and just introduce the individuals. Senator. []

SENATOR UTTER: I get to do that myself? []

SENATOR PAHLS: Yes, I'll let you do it. []

SENATOR UTTER: I'm Dennis Utter. I represent District 33 which is Hastings, Adams County, and part of Hall County. []

SENATOR GLOOR: Senator Mike Gloor, District 35 which is the area just north of Senator Utter, Grand Island. []

SENATOR PAHLS: And the ones coming in is Senator... []

SENATOR CHRISTENSEN: Mark Christensen from Imperial. Well, I've never been over here. []

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SENATOR PAHLS: We're trying to get you closer. Okay, and we have, of course, Bill Marienau and Jan Foster who help us keep everything rolling today. Again, I'm going to ask you not to have your cells on, makes things go much easier for us, and we may have some new people testifying today who have not done it before. I don't know. But be sure you fill in the pink sheet because we need that because we are recording this, and we need for you to not only say your name but I said last time, spell it correctly. And I think what we will do is...I think we're ready to go. Just before I let you start, Senator, I had the opportunity...I did not...I was not here for the last time we went over similar material. I happened to be on vacation, but I did read the transcript. And I'm asking today that we do give us new information if at all possible, so that we can try to come to some kind of resolution. And like I say, we do have the information in the past, so try not to give us the same information again. We're ready, Senator. []

SENATOR CORNETT: Thank you, Senator Pahls. Good morning, Chairman Pahls 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. I'm here to introduce LR334 and LR406. The intent of LR334 is to have further discussion of a bill I introduced during the 2010 legislative session, LB1017. This bill was introduced so that every insured Nebraskan has access to reasonable prescription drug benefits by requiring that all health plans meet the following criteria: Insurers cannot create specialty tiers that require payment of a percentage of prescription costs. Insurers cannot charge prescription copays that exceed the cost of the 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 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 expense for the 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. The intent of LR406 is to have further discussion of LB1088 which I also introduced during the 2010

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session. This bill would put in place that insurers and pharmacy benefits managers send notifications of requests for medication changes to patients and their physicians or other prescribing health professionals whenever the insurer recommends changing a patient's medication to a different therapeutic agent. Among other things, this notification will acknowledge that 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 changed; describe any financial incentives that may be provided or offered by this prescribing healthcare professional by the insurer or by the PBM; describe any financial incentives that a 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 insurer has the right to discuss the proposed medication change before it occurs. There are several people who wish to testify and will be able to give you the background of how these bills came to be in front of you today. I would like to assure the committee and the parties who are affected by this resolution that I am more than willing to work with the issues or any issues that are raised here today or that were raised during the 2010 legislative session. Thank you for your time and your consideration, and I would be happy to answer any questions that you have. [LR334 LR406]

SENATOR PAHLS: Senator, I have one question. You said you'd be willing to work with any of the groups or on both sides of this issue. [LR334 LR406]

SENATOR CORNETT: Yes. [LR334 LR406]

SENATOR PAHLS: Have we done any of that before today? [LR334 LR406]

SENATOR CORNETT: We did not do any before the bills were...we did some before the bills were introduced last year, and there was not enough time to come to any resolution. But we have from now until legislative session to come together. Michelle

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Vogel, who is following me, has been working on these types of legislations throughout the country and has a lot of solutions that will help all sides and significantly reduce any fiscal note, if not zero. [LR334 LR406]

SENATOR PAHLS: Okay. So you're telling me you're looking at the fiscal note to be zero. [LR334 LR406]

SENATOR CORNETT: That's what my intent is or as close to zero as possible. We all know what financial situation the state is facing at this time. [LR334 LR406]

SENATOR PAHLS: All right, because that was an issue by my reading transcripts. [LR334 LR406]

SENATOR CORNETT: Yes, it was. [LR334 LR406]

SENATOR PAHLS: Any questions from the senators up here? Life is good. Thank you. [LR334 LR406]

SENATOR CORNETT: Life is good (laughter). I may not be able to stay for the end of the hearing, so I'll waive closing at this time, but I will remain for a while. [LR334 LR406]

SENATOR PAHLS: Okay, thank you, Senator, appreciate it. Now, it would make life easier for us if you are going to be speaking in the future if you go to the reserves. That will give me an idea of how many people. It just...it makes things easier. [LR334 LR406]

MICHELLE VOGEL: (Exhibits 1, 2) Hi, Senators. My name is Michelle Vogel, and the last name is spelled V-o-g-e-l, and I am the executive director for the Alliance for Plasma Therapies. And I want to thank you today for holding this interim study and the hearing for LR334 and LR406 and thank Senator Cornett for introducing the two bills last session. I'm just going to briefly explain what the alliance is and then get to where

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we were when we had the hearing and bring you up to date of how I think we have some solutions that, hopefully, will make everybody happy. So the Alliance for Plasma Therapies, we're a nonprofit organization, 501(c)(3). We're located in Washington, D.C., but work with patients all across the country who primarily rely on plasma derived therapies like the immune globulin therapies factor products. And we've been working with patients who have access problems and dealing with the biggest threat that's come to be for these patients has been the Tier IV plans, the increased out-of-pocket expenses under coinsurance. And how this has really happened to be the history of this, and I alluded to that in the testimony and really followed it through after we left to make sure I was correct in the history of this and find out why are patients paying as much as they are and really did happen for Medicare Part D plans. Prior to that, I was correct. All of these therapies were covered under major medical plans. And then Congress started Medicare Part D, so that seniors and the disabled had a drug benefit, and that allowed for formularies to be established that were established beforehand. And you had the Tier I plans, generic drugs; Tier II, your brand-name drugs that were your preferred products; and Tier III, your brand names that were the nonpreferred drugs. And then all of a sudden came Tier IV, which were the specialty therapies, and those prices started skyrocketing. And it wasn't until about a year later in 2008 we started to see Tier IV come up, and now it's predicted for next year that 90 percent in Part D that there will be Tier IV plans and that it will be an average of 30 to 35 percent out-of-pocket expense, you know, 30 to 35 percent of the cost of the drugs. And in those plans, it's the cancer drugs; it's the HIV/AIDS; it's the hepatitis, the hemophilia; it's all the autoimmune drugs for lupus. I mean, these are the diseases...you're really targeting the sickest of sick populations. And so, there also...it's estimated that on the private insurance side, because what happens Medicare follows private plans that we're going to see about 50 percent of plans across the country having these Tier IV plans. So what does this have to do with where we are? Well, after we had our hearing it was very interesting. There were a lot of states that had bills out there on either eliminating coinsurance, specialty tier plans, or tapping that out-of-pocket expense for these sick populations, and Nebraska came up in these hearings. So in the state of Maryland and California and

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Hawaii and New York, the Nebraska bill came up. And the governor just signed legislation in the state of New York banning specialty tiers. Now, what's interesting in New York is that there are no specialty tiers in commercial plans. They made that a proactive mood because they saw the trend happening, and they wanted to make sure it didn't enter into the state. And so, for them to take that step, it's very interesting. There's no fiscal note on that legislation. It just basically says they found it discriminatory to charge patients who are the sickest to take the burden because insurance is meant to cost-share across. I mean, we don't...we're not meant to get sick, but we all pay our premiums and one of the arguments that came up is, well, the premiums are going to go up. Well, the premiums have been going up and many of the patients who do get sick end up picking the highest plans possible and pay bigger out-of-pocket expense to cover themselves not knowing that this is about to hit them, and they're paying hundreds of thousands of dollars out of pocket per month for these therapies, and there's no way to keep up those costs. So they have to choose, either they stay on or stay off. Now, it's interesting in New York that even with this, with no fiscal note and no insurance policy even being allowed to really...the insurance commissioner wasn't allowing plans to come in, that the attorney in that state who represents...and was really the Blues...opposed it, and they also brought in, which I'm going to bring into this just so, before the opposers come up to talk about this...about the issue of exchanges coming in because it's relevant. And we're going to be having to deal with the new health insurance reform bills in these exchanges coming in that this may interfere with our capability of dealing with negotiating plans. And they talked about that this may take away, be counterproductive to limit cost-sharing. No, because these aren't high-risk pools. This is about having some sick people plans and healthy people plans. You're cost shifting around. Everybody bears the burden. So in this case, what we looked at is saying okay, what costs money in the bill right now that has a fiscal note? And the opposition of the bill said that right now the state plans and the university plans do not have specialty tiers. And they felt that if we put in language that would eliminate some of the wonderful negotiating power that they have and some of the costs that they have on the generics and some of the wellness plans would be affected. So

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maybe a solution would be to exempt those plans, however--and I put a however in there--it would be important to put language in, saying that it's important that we don't go in that role that we would hurt employees, so that we would hope that as policies move forward within...for state and university employees, that we don't establish plans that would put in specialty tiering, but it wouldn't mandate anything. This would be just for private plans, and you would not have a fiscal note. New York is also going to go back and add one other provision, and that is, to make sure that there's a cap in there because another issue came up. And it may have been Senator Gloor, you may have even brought this up about if we take care of that, what happens if that third tier starts rising out of control. And you're right, and that's why now they're looking...the other states are saying it's great just to ban it, but you have to also protect it. So I think that's why they're looking at Nebraska as the ideal legislation, and that's why all those bills across the country are being rewritten to look like Nebraska and will be introduced come next year to be identical to this state legislation. And you're also seeing in...and we don't know what's going to happen with Congress, and there's a lot of gridlock, of course, but there was a movement to reverse what's happened in Medicare Part D because it wasn't meant to be this, and it's hurting patients big time. So what's happening there is there's a movement to put a moratorium on all federal plans because it's even in the federal employees' health benefit plan to stop the growth of this. And I look...I'm going to use the word tumor to stop the tumor from growing and put a moratorium on the specialty tiering, because the only way to describe it is total discriminatory actions. I mean, because you're really targeting these populations, and I have documentation that I'm going to hand to you guys of studies for you to have that were done by the Government Accounting Office from Kaiser Foundation, from even AARP that just is mind-boggling. I didn't realize the drugs that are in these plans and how high the out-of-pocket costs get, so I will share that with you. But in terms of all of this, I would say that it doesn't need to cost anything, and that's the one important thing. And I think that with the steps that are taking place both federally, every patient organization is on board to stop this movement because it is the biggest threat to patient care. And I'm not sure if it's about negotiating power for insurance companies and wanting to keep costs

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down. I would say that for this state, we don't want to stop them from being able to work with the university and state plans, so that would be an option, but putting language in that we would hope they wouldn't go towards--discriminate against sick patients in those policies. And then moving forward, I just want to touch upon for the other bill which dealt with physician notification and switching products. That's an important bill as well, and what was brought up was, it's illegal to switch a product on a patient. And I can say, with doing some more research into that, it happens every day. And even happened to me when I switched health insurance policies. You go in and it's therapeutic substitution; it's in a class. And, again, I don't want to take away from the pharmacy benefit managers and the insurance companies from trying to bring down costs. It doesn't affect generics, but all brands are not equal, and there's differences between formulations. And, you know, be that as it may, if you go in and there's a specific...some plans are better that you can choose between the Tier II and Tier III, and you pay a little bit more for that Tier III drug. Some, you don't have a choice; they're not even on the formulary. And in that case, your options aren't that great, but physicians should have to sign something so that they know their patients have been switched. The next step which was a big problem for some of the opposers was that we want to know why they were switching, and they said, that's proprietary information. It's, you know, it's financial reasoning, not medical reasoning, and I would say my biggest disappointment in the movement of healthcare and specifically looking at it from a patient perspective is that I feel that we're taking medicine out of the hands of physicians and patients--I shouldn't say physicians--healthcare providers, and who's making medical decisions these days? Is it the doctor or the nurse practitioner who knows the patient, or is it the payer? And I know costs are skyrocketing. We have to do something, but when it gets down to it, who knows the patient well? And there's too many denials going on, and it really does cost lives of patients and even...and I have to commend the state of Louisiana to pass the legislation, saying that the doctor trumps the insurance company for six months if they think that the drug is going to benefit a patient. Wonderful move, six-month trial period. We don't have that before you today on step therapy, but I'm saying that asking for written notification, that extra little safety step is not a big deal. So I'm not really sure



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why there's so much opposition there, but there's movement to work with the others if they feel that we're stepping on proprietary information and want to understand that a little bit more. But I think that extra safeguard is really important to make sure patients are getting the right therapies, because I know my pharmacist will call me if there's a change in my policy and say, Michelle, you're getting...if it's a generic, they'll call me up and say it's another company that's making it, so you'll see a different color pill, and if you have a reaction let me know. Or your company just changed the formulary, so we're going to put you on this drug, and we contacted your doctor already to make sure it's okay. I have a wonderful local pharmacist who does that. It doesn't always happen that way, and so, I mean, those are the few things that I wanted to bring to date to you. I'm opening up to questions. I mean, I've really spent a lot of time pulling up reports for you to look at, but I can tell you that the trend is here to now stop the out-of-pocket expenses for patients because that to me is the biggest threat to the health of our patients. And I want to thank you for having this special hearing today. [LR334 LR406]

SENATOR PAHLS: Michelle, I just have one question to this last resolution you talked about, because this happened to me. They changed my medication. When does it become my responsibility to ask the question, why am I changing from here to here and my calling the doctor? [LR334 LR406]

MICHELLE VOGEL: It shouldn't be. It should be...I mean, if you...the doctor needs to be notified that the prescription has been changed, but it doesn't always happen. So if you don't get...sometimes a patient is lucky, and they get that you may have been switched...either your pharmacy benefit manager may have been changed within your insurance policy, and you may get a list that comes to you. [LR334 LR406]

SENATOR PAHLS: Right. [LR334 LR406]

MICHELLE VOGEL: And it says, these are in your different formularies; these are the drugs that you're on right now; these are the changes that need to be made. Patient,

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contact your doctor and talk to them, which is really interesting. When does it become the role of the patient to discuss with the doctor the prescriptions rather than the doctor who already prescribed medication, and you're on this medication, and you're doing great. You're doing really well, and all of a sudden, you have to mix up drugs. So I can tell you, for me, okay, who has a sleeping disorder, I have to now sit and play doctor myself, and I wake up in the middle of the night, and I have to cut a pill in half if I wake up and take another half because I'm no longer approved for slow-release drug. It's a little crazy. I'm playing my own...I'm playing pharmacy now, and, you know,... [LR334 LR406]

SENATOR PAHLS: But your doctor knew this... [LR334 LR406]

MICHELLE VOGEL: I have...he's appealing. In the meantime, in order for me to get a good night's sleep, I've got to sit and play with cutting pills in half if I wake up in the middle of the night because the other medication on the formulary doesn't work at all for me. And it will just flare up other pain syndromes I have if I don't get a good night's sleep. And so it's like...and we're just appealing and appealing and appealing to try to get the drug that I had been on for the last five years before changing policies. No problem. But it gets more serious than that when I see patients who are...there may be, you know, and I'm going to use the one drug that I know so much about because I work in this is IVIG. When I spend time with patients who all of a sudden get an insulin pump put in, and they've become diabetic, they've been on steroids for years. And all of a sudden, put on IVIG, and they're diabetic because of the steroids. Okay? There's one brand in the market that has no sugar in it, but they're on another brand because that's the one brand that's on their formulary. And now, if they were on the brand that didn't have sugar in it, they wouldn't need the insulin, so now you have a patient who's diabetic for no reason. It doesn't make sense at all, and I'm sitting here, I'm not a doctor. I'm listening to this, and I'm saying, it doesn't make sense, and to the doctors who are dealing with this, it's getting really frustrating. And I'm sitting here, pulling medical journal articles to do appeals. [LR334 LR406]

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SENATOR PAHLS: Because I think you used the same case, as I recall, from the transcript... [LR334 LR406]

MICHELLE VOGEL: Yeah, yeah. [LR334 LR406]

SENATOR PAHLS: ...I mean, what you're telling me happens all the time. [LR334 LR406]

MICHELLE VOGEL: All the time. All the time it happens and even worse now that I just was at a conference and still have data coming out on the statin drugs is that the statin drugs can cause a...and I used it in there because...and it happened to me by being on a statin drug that all of a sudden I was in New York City and going up the subway and walking up the stairs, my muscles gave out. It scared the living daylights out of me, I couldn't move. And it flared up so bad that I was in bed for a week, and these things happen. And switching these drugs, they're not all the same, and have reactions, but some patients may not have those choices or it may have been switched on them without the physician knowing. And if you're under the care of the doctor, I mean, this does...that little extra step with the doctor actually having to sign a paper, then they're knowing what's going on, and if they have to appeal they need to get involved. [LR334 LR406]

SENATOR PAHLS: Yeah, right. See, I can agree with what you're telling me there, but I still say as the person, part of that is my responsibility... [LR334 LR406]

MICHELLE VOGEL: As a patient. [LR334 LR406]

SENATOR PAHLS: ...as a patient to talk to...I mean, that's what I believe. I mean, and I know, I'm there. [LR334 LR406]

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MICHELLE VOGEL: But what if you're not notified, okay? [LR334 LR406]

SENATOR PAHLS: Okay, okay. [LR334 LR406]

MICHELLE VOGEL: What if you're not notified or you just get...? So say you go to your local Walgreen's, CVS, whatever, and you pick up your medicine, and you're getting it, and you're taking it, and you think, well, you're not a very...you know, you're educated and, you know, well, this is my cholesterol medicine; this is my, you know, blood pressure medicine. And these are the things I'm taking. Not everybody is sitting there on the computer and looking at all these different things. But all of a sudden, you may have the reaction or you just don't know why you're not feeling well, and all of a sudden you end up in the ER, and you had...a heart (inaudible) wasn't working well. So those are the things that I don't know how much responsibilities the patient versus the physician. But now if the physician gets the notice that it needs to be switched, then they need to make the educated decision, is that the right switch or not, and how is it going to affect the patient and be in touch with the patient? It has to go back to, physicians need to be the ones practicing the medicine. [LR334 LR406]

SENATOR PAHLS: Okay, okay. Thank you. Senator Gloor. [LR334 LR406]

SENATOR GLOOR: Thank you, Chairman Pahls. Thank you, Michelle. It's good to see you again, and I appreciate the information you give. It's been very helpful in the past and now. How does the American...I've just blanked...ACA Act...the Affordable Care Act, thank you,...the Healthcare Reform Act speak to this particular issue? [LR334 LR406]

MICHELLE VOGEL: Thank you. So Healthcare Reform, you did have a senator who wanted to be on the specialty tiers in it. It did not get into the bill. And so, this is kind of like second...round two that we need to deal with. And this is where, as I was reading what happened in New York, I didn't think that this would become an argument in the

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states, and that's why I brought it up, and I have the letter. Because as I'm reading this and reading why anybody would oppose this, I saw this come up with exchanges and why, you know, it may be counterproductive to limit cost-sharing and product selection prior to states (inaudible) petition new laws. And I wanted to bring it up to you just in case any of our opposition comes up here and uses that argument, because, again, this shouldn't be in any policy. It never was, never should be. And New York took that and said, no way, because first of all, for New York to say, we don't allow these policies, but takes up one step further and say, we're passing a bill to make sure that these policies never come into our state because we're looking at the pattern in all these other states, and they named Nebraska in that with Alabama and California, all these states that it's happening in, and say, look at how high these percentages are getting and what patient populations are being targeted. And they're just...and to pass something like to prevent that from happening to them was incredible, for them to be that proactive. And so I say that...bring it in and say, those exchanges in the, you know, introduction into that one issue and concerns me greatly is as they develop this, and we have the burden on the states to develop these exchanges and provide healthcare for children and everybody else is that it's a really strong possibility that the costs are going to be extreme, that that can be..the burden can be placed on the patient, and if we don't have policies put in place to say, you can't put in place these specialty tiers, that all of a sudden, if you do have a sick child in these plans as you're switching into it that that can happen. But, you know, and as you get rid of high-risk pools and all those things...I mean, high-risk pools were the ones who were taking care of all of this. [LR334 LR406]

SENATOR GLOOR: So the enforcement or the accountability component of this is that we're talking about not allowing policies to be sold in the state that have tiering. [LR334 LR406]

MICHELLE VOGEL: Exactly, and I think that that... [LR334 LR406]

SENATOR GLOOR: Okay. I want to make sure I understand what... [LR334 LR406]

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MICHELLE VOGEL: Yeah. And basically, as that goes forward, you're going to see...I mean, it's almost a domino effect that's happened because the number of states that introduced bills last year were quite a number. New York was the first to pass it; a lot were pretty close. Next year we're seeing a lot that are ready to go forward with introducing legislation. I would say three-quarters of the states will have legislation introduced next year, I mean, right from the git-go. And it's really the MS population, with cancer, with hemophilia, all of these groups have really come together to do it as well as on the federal level, you have working on a moratorium to stop the expansion with studies to look at the impact as well as legislation moving forward to reverse the trends. So I would say next year, I kind of want to coin it "the year of the patients" because the patients are saying, enough already. We can't afford to do it, and I think you'll hear in some new testimony what the impact has been and especially in one case it's going to come forward of how it's affected not just a mom but a mom who is pregnant, who had to make a very hard decision. [LR334 LR406]

SENATOR GLOOR: Thank you. [LR334 LR406]

SENATOR PAHLS: Senator Utter. [LR334 LR406]

SENATOR UTTER: I'm not sure I understand, and I'm not an expert on healthcare at all, so forgive me if I ask a stupid question. But I'm having trouble with the zero fiscal note, and I understand that we can probably design things so that we have a zero fiscal notice that applies to the state Legislature. But it looks to me like this is a mandate that what we're requesting here is a mandate that every health insurance policy in the state...that is sold in this state is going to contain the provisions that you're talking about here. And it looks to me like that's going to raise the premium costs of healthcare. I'm having trouble hearing this whole thing, how it can be free. [LR334 LR406]

MICHELLE VOGEL: Okay. Let me explain it to you. We never...in the past, okay...well,

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let's first start with, just from the basics of health insurance. Health insurance is about...we all pay our premiums. None of us plan on being sick, right? But some people are sick; some people never use it. Some people are using just generic medication, no problem. Some people are using the more expensive and may have higher copays. In the past, all of these medication...I mean all these medications have always been covered. They're not...some are new; most of these are 20-year-old or even older drugs. And most of the drugs that we're talking about are infusible and injectable drugs. Most of them are covered or been given in the hospital outpatient infusion centers. Some physicians are infusing them in their centers. They've always been covered under your major medical plans. When Congress developed the Part D plan, all of a sudden it gave an opportunity to put a whole new system in place to take it out of that major medical where it was covered under what you were paying in your premiums and your out-of-pocket expenses and your deductibles and everything else that you were paying. And it was cost-shared through...I mean, everybody...insurance is about cost-sharing. Everybody pays the burden. It's not a high-risk pool, and so it all evens out. When they developed Part D, all of a sudden you had these copays, and there was always copays, but all of a sudden you saw a migration that nobody really expected to happen to these...what we call specialty therapies for patients who need chemotherapy and these other very expensive...more expensive therapies and who typically need infusion nurses, you know, trained nurses giving you these therapies, and it's a life or death situation of getting it. And all of a sudden, we saw the migration of these therapies into a new tier system, what we call specialty tiers or coinsurance. And instead of paying a flat fee that's reasonable, that a person could afford, you started having to pay \$500 per infusion, \$1,000, \$2,000, \$3,000 infusion, \$4,000 infusion. How can you keep up with that? Couldn't. And no definition of what that is, just as therapies are inherent, their higher, expensive therapies started shifting those into that policy. And so as we started seeing this happen, you started getting patients who no longer could comply with taking their therapies and it had a huge impact on their care--patients becoming totally disabled, dying. And so, could you go back and take a step back and say, not the right thing to do? Let's cover you back under major medical like it should have always

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been...haven't really seen that happen yet. So what's happened is some places have said, no way, we're not allowing you to do that. And we want you to cover it like you always did. That has been New York all along; plans were still being sold there, no problem. New York got a little nervous seeing how increase...the increase in this. So they said, we just want to put up a precaution and say, we don't want you to go in this direction. You're not allowed to do this because it's just discriminatory. You can't target specific populations and say, you're going to charge some outrageous money for these therapies, and so that's what they passed. Premiums are going up, and they have been going up, and that argument has been used nonstop. We're all paying more money for our health insurance, and I think that it's not about people who are uninsured, needing insurance, paying into it. These are the people who are insured and all of a sudden get sick. And so, is it a mandate? And I know we hate the word mandates, but I mean, is it discriminating against? I mean, I don't know how you look at this, but should insurance companies be putting together policies like this? And, you know, in my opinion and a lot of people's opinions, no. It was never meant to be this way. And I could understand if all your plans were high-risk plans and you have all of this, my God, if I was an insurance company, I would say I couldn't afford to do business in this state. If you said to me, I can't have policies like this. I'm going to increase your premiums skyrocket because every single patient in your plan has cancer and needs chemotherapy, and you're telling me I can't charge them a reasonable out-of-pocket expense for the therapy. And I would say, you're right, you know, whatever insurance company Plan X, you're absolutely right. But that's not the situation here. You're taking a small population of patients and asking them to pay a tremendous amount of money. Had a hemophilia patient who had one bleed and they had to pay 10 percent. That could be \$300,000. There's no way out of pocket. They might as well say, bleed to death because that's what would happen. So yeah, I mean, you're saying to your...you're doing what New York did and what many states are going to do at this point is say, we're not going to allow you to discriminate against patients who have cancer, who have, you know, AIDS, hepatitis, who have MS, rheumatoid arthritis, all these things, and need these infusible, injectable therapies. We're saying that, go ahead with your tier plans, you know, cover...if you want to cover



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under your drug policies, go ahead. If you want to cover under major medical, go ahead, but don't expect a patient to pay this high percentage cost of the drug. That doesn't cost money. That's asking them...that's a policy that the state is taking. In terms of where this fiscal note came in was on the university plans and the state plans, and saying that this is going to take away their negotiating power. We're saying, go ahead and continue to work with those, but we don't want to see you developing those plans, and they're just like, we don't want to see you doing that in the others, and how that works out. You don't do it already, so we want you to continue with that wonderful behavior that you're already showing. Continue that because you haven't developed it there, so continue providing the great services that you're providing to our state and university employees. Just don't go in that direction. If they haven't done it so far, they shouldn't need to.  
[LR334 LR406]

SENATOR UTTER: So am I to understand that in the wonderful 2,000-plus page Affordable Healthcare, that this didn't get corrected? Is that what you're telling us?  
[LR334 LR406]

MICHELLE VOGEL: That's what I'm telling you. [LR334 LR406]

SENATOR UTTER: And...and... [LR334 LR406]

MICHELLE VOGEL: And I could tell you... [LR334 LR406]

SENATOR UTTER: And so you're saying to me that we were able to cover the fact that farmers and businesspeople have to file 1099s to any person in the...that they paid \$600 to, and they didn't cover this problem, and so now we're coming to the states and asking them to cover this problem? Is that where we're at here? [LR334 LR406]

MICHELLE VOGEL: What I'm telling you is that for the problem that we saw, and that we asked CMS to look at, Centers for Medicare and Medicaid Services, was we saw

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this happening in Part D, and it's going to come back with a report to see what was going in Part D, and they said it was a small percentage of patients that were affected. Well, in theory, yes, you're right because the diseases that you're talking about are rare diseases. So, in theory, yes, you're...of the total number of Medicare patients, it is a small percentage of patients that are affected by this. However, the question wasn't asked the right way. How many plans are doing it and for those patients, even if it's a small percentage, what's the impact to those patients? So now, those reports have come out and that is what's saying is, that's the damaging thing is every patient...you know, does every patient have a right to have access to their therapies? I would say yes especially if they're paying their premiums, yeah, I would say yes. And especially when you're getting into these sicker diseases, yeah. So that was...that's a situation. Are we coming to the state (inaudible)? The states have been in control of the private insurance market, and so we are coming to the states and saying to the states, we want you to take a stand and take care of the private market and say that this is discriminatory, and we don't want to see this continue. On the federal side, you will see us out there very loud and clear to reverse what has happened, you know, so. [LR334 LR406]

SENATOR PAHLS: Okay. Thank you, thank you, Michelle. Thank you. And you said you did have some research for us? Okay. [LR334 LR406]

MICHELLE VOGEL: Thank you. I'm going to leave all of this for you. [LR334 LR406]

SENATOR PAHLS: Okay, just by a show of hands, how many people do we...plan to testify today? Just...okay, I see one, two, three, four? Four more? Okay. Again, I'm being relatively selfish here is, like I say, a lot of information was given last spring so I'm looking for new ideas. Yes. Good morning. [LR334 LR406]

SHANNON SCOTT: (Exhibit 3) Good morning. Thanks for having us. My name is Shannon Scott, S-c-o-t-t. I was also here in February testifying, and so I'm going to just quick, brief overview. I am a nurse and I also am a patient diagnosed with a primary

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immune deficiency disorder. I also have a clotting disorder that wasn't found until I threw two clots to my lung. I want to address LR406 real quick, and your question that you had to Michelle regarding the patient being responsible. As Senator Utter said, he's not necessarily healthcare versed. That is the main population I deal with. Patients don't understand the letters that they get. We deal with this on a day-to-day basis where meds are changed, and I work in pediatrics, okay--very fragile group of patients. Some are even the smallest of small, premature infants, you know, chronic, congenital defects. Medications are being changed based on the formularies, and the physicians aren't being notified till after the fact and after maybe a side effect, a reaction has already happened. And I, myself, as a nurse, spend countless hours a week appealing with insurances, finding out why the denial was made, going through paperwork, jumping through hoops for them to be able to have the medication that was working for them. We show proof oftentimes of every step we've taken prior to even getting that medication, you know, because we've become a lot more with all these appeals and denials coming in and medications being changed, we've become a lot more versed at what insurance companies are going to change and want to see. It's a lot of man-hours, and there's just not...I am fortunate enough to come from an educated family. You know, my dad, the same situation, had some medication changed, and he is well versed enough, you know, at least to talk with me and then to be able to call the insurance companies and the doctors and figure things out. But the doctor, ultimately, the responsibility falls back on the doctor and the nurses to do the appeals and work with the insurance companies which is not always easy, so I just wanted to throw that out there. As far as in regards to LR334, did any of you choose your gene pool? I sure didn't (laugh). I wouldn't change my parents for nothing. They've been the most supportive parents I could ever ask for. The guilt they feel over the suffering and the illness that I've endured my entire life, and now finally, 27 years later, 29 now, got a diagnosis to understand why I was so sick is a huge relief yet burden. Guilt...it doesn't affect just the patient--it affects the families. Now how this relates and why I mention that is because I'll be honest. My medicine is covered currently, but I also am well versed enough and knowledgeable enough to know the trends and what is going on with insurances

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currently. And we pay a really high deductible. Well, we pay a really high premium. Then my husband takes out a good amount of his paycheck to be able to cover our high deductible which we then spend 12 months trying to pay off as best we can. Sometimes we've succeeded, sometimes not, just for it to start over in January because I meet my almost \$4,000 deductible in January instantly. I'm going to try not to cry. Shoot, we've been married for almost three years. We've missed out on a lot with friends. We can't do the things that we like to do anymore. The thought of starting a family is very difficult for the fear that any day we could get a denial. Then knowing how much we have to save just to pay our deductible every month and how much we lose from my husband's paycheck and how many supplies aren't covered for...I just had...I'm struggling with a staph cellulitis which had I not been on my IVIG, the doctor flat out said, I would have been in the hospital probably dead. There's a constant fear that at any moment we could get a denial. At any moment, our insurance could say that medicine is being changed to a higher tier, and you're going to have to pay a certain amount. My husband feels...and these are his words..."somewhat trapped" because so far our insurance has been okay with us, but what if he ever wanted to change? First thing we would look at is insurance because of that fear of, would my medicine be covered? It's really hard to live with; it's hard to go to sleep at night. And the guilt I feel for being dealt these cards which I'm fine with, but it's not fair to my husband who loses sleep, works his butt off trying to make up for the hours that I can't work, the hours that I lost due to many years of undiagnosed immune deficiency multiple call-ins, having to go on disability, having to cut down to part time. He bears that burden, and my husband has never been sick. He's hardly been to a doctor in his life, and it's starting to take a toll on him emotionally, physically. That is why I'm here today as a proponent for LR334 to take some of that burden off. If this were to be passed, I think, you know, we could kind of have a sigh of relief that we wouldn't have to potentially pay, you know, 30-35 percent of my weekly medicine. I do my treatment weekly. I wasn't fortunate enough where the monthly medicine worked for me, so I have to do mine weekly. When I get a monthly explanation of benefits from my insurance company, we literally cringe and pray, literally, because it's over \$10,000 for a monthly supply...for supplies and medicine. When...you know, it's

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like we're just waiting for the shoe to drop, and it's a really hard thing to live with. It doesn't do any good for me because stress and lack of sleep just compounds my illnesses. The other thing I wanted to note is when I finally got diagnosed with my clotting disorder, after throwing two clots to my lung, they put me on a blood thinner, Coumadin. Some of you may be familiar with it or on it. Our insurance plan...that was the drug that they chose, and that was considered 100 percent covered as a preventative measure from keeping me from throwing another clot. It was 100 percent--it was zero dollars--zero dollars along with compression stockings that I wear daily to work, travel, anything like that. However, the Coumadin did not regulate my clotting. They could not get a therapeutic dose for me. I was having blood draws once to twice a week maybe to make sure I was in a therapeutic level. So my hematologist switched to an injection and that injection is in a specialty tier in my insurance and costs thousands of dollars. So, again, I'm fortunate. Once I hit the deductible, it's covered, but at the same time how can you discriminate and choose one medicine and another that does the exact same thing? It's just different and they classify it different, and it's mostly your injectables, your infusions. For instance, my cousin, we have Crohn's disease also in our family. My cousin...my uncle, my aunt died when she was 13 of Crohn's. My uncle died at 40 from Crohn's, and my cousin has bad Crohn's disease. She also has the same clotting disorder--it's genetic. But she is on biweekly infusions of Remicade. Remicade is one of those medications that is...she pays a copay. Her and her husband are teachers. Okay, so you can imagine the sacrifices that they've had to make, and she actually is fortunate to be able to get her medicine long enough because she had enough life insurance money from when her dad died from Crohn's. Otherwise, when that runs out, they wouldn't be able to afford it. So I just want to conclude and say thank you for holding this review hearing and considering it. And any questions? [LR334 LR406]

SENATOR PAHLS: I see none. Thank you for your testimony, thank you. [LR334 LR406]

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SHANNON SCOTT: Thank you. [LR334 LR406]

MELISSA DOUGHERTY: (Exhibit 4) Hello. My name is Melissa Dougherty. It's D-o-u-g-h-e-r-t-y. I wrote out a speech, but I also testified last year. So I don't have a lot of new information. I just kind of wanted to show that I am supportive of...I actually still called it LB1017 mainly because treatments have helped my son so much, and just by looking at him he looks really healthy. He has just been very healthy because of his treatments. When he was diagnosed, he was...we were denied three times by our insurance company. He went an extra three months before we started treatments without getting them because the insurance kept denying him and not wanting to pay. I know it's really expensive. We do his treatments weekly at home, and his treatments are \$1,284 a week which is a lot of money. Luckily, our insurance has a good contract with the company we go through and our out-of-pocket is about \$50 a week which we meet his out-of-pocket max pretty quick which is \$2,000. And that may not be very much, but to a two-child, two-working-parent family, it is a lot, and insurance is a big thing. My husband works for my parents which are self-employed. They don't have insurance because of the cost of insurance at their work, so it's my responsibility to provide that. And it's very scary with the work environment how it is and with people being laid off, always thinking about that and losing hours because your child is sick or because you're sick, to lose your job and lose your benefits. I mean, that's my main reason for working is for insurance to provide for my son so he can be healthy. He was on 18 antibiotics the year before prior to being diagnosed and had three bouts of pneumonia. And last year, our full year with being on treatments, he was only on three. So he doesn't need speech therapy anymore because his speech was impaired so much from being sick so often, and he's gained like five or six pounds in a year. He's naughtier than sin. I keep saying I'm going to take his treatments away (laughter) because he was so good when he was sick, but he feels so good, and so he's ornerier, and just socially he's just living the life that he deserves. And, you know, as a parent, you always want the best and it's horrible to have to constantly worry about the medical bills and the medical insurance turning you down. We were approved the first year on a trial basis and had to reappeal the

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second year, and I just held my breath until I finally got that approval from the insurance company that he was approved for the second year because you never know where you had to fight the first time three times to get it approved. They could actually see that, yes, it was necessary and it helped him and made him get to enjoy life. He shouldn't...I mean, no child should have to suffer. And it's horrible to have to go through. He's had a horrible start from the beginning and, I mean, he's just finally getting to enjoy his life, so thank you for letting me come again. [LR334 LR406]

SENATOR PAHLS: It appears he is enjoying it. [LR334 LR406]

MELISSA DOUGHERTY: Yeah, he doesn't like to sit still (laughter). It's hard for him to sit still so... [LR334 LR406]

CARTER DOUGHERTY: But now I did. [LR334 LR406]

MELISSA DOUGHERTY: Now you did (laughter). So he doesn't like to do his needles, but he does realize that it helps him. [LR334 LR406]

CARTER DOUGHERTY: I don't cry. [LR334 LR406]

MELISSA DOUGHERTY: Nope, he doesn't cry. He's very brave so he knows it makes him feel better. [LR334 LR406]

CARTER DOUGHERTY: Um-hum. [LR334 LR406]

SENATOR PAHLS: Okay. Well, I see no questions and thank you for testifying today. [LR334 LR406]

MELISSA DOUGHERTY: Thank you. [LR334 LR406]

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SENATOR PAHLS: The both of you. Good morning. [LR334 LR406]

SHAWNA SCHILDT: (Exhibit 5) Good morning. My name is Shawna Schildt, S-c-h-i-l-d-t. And I'm just going to read mine because I wrote it. I'm a 30-year-old wife and mother of three. I was diagnosed with common variable immunodeficiency back in '04 at the age of 24. I started receiving the IVIG infusions to help me maintain the good IgG levels to help my immune function. I'm employed at St. Elizabeth here in Lincoln. I started there in July of 2002, and I work in outpatient surgery. I also work in direct patient care, so it's important for me to stay healthy and for my coworkers and my patients and my family. My infusions continued monthly until my husband and I became pregnant with our first child in '05. Well, during the third trimester, your physician increases your dosage about 150 percent because it goes to the baby, and so they want to make sure that I had enough for me so I can stay healthy. And so that stayed, and then after you're not pregnant anymore, they drop you back down to your normal levels. Well, that happened again in '09 with my second pregnancy to make sure you have a healthy child and both of my other children have been very healthy. Well, my insurance through St. Elizabeth has been excellent until January of 2010. My medical coverage for my child and myself is about \$79 every two weeks, so I do pay for insurance. It includes \$1,000 deductible for my family, a \$500 deductible for myself which normally with not having children or anything, we wouldn't meet our deductible. It included a \$20 copay and \$35 copay for specialists. And that was...my infusions weren't considered copay visits or anything. It was always covered 100 percent which I have documentation to show. It was covered 100 percent. In January of 2010, it all changed. They offered new plans for their employees, and I chose the best plan, you know, the highest paid plan because I knew that my infusions were expensive. However, it increased to \$111 every two weeks which is, you know, only an increase of \$31 every two weeks, but with a young family...and that's about \$818 every year. The plan offers the same deductible and the same out-of-pocket costs, so that was good. But it went from the flat copay plan that we usually had to the 20 percent coinsurance for my infusions, now our 20 percent coinsurance. So in December, I called the insurance



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company to make sure that my infusions would be covered. They informed me that it would be. I had preauthorization up until December of 2010, so that everything would be covered. And so I'm like okay, I went ahead and got my January infusion, went ahead and got my February infusion. And then shortly after I got my February infusion, the bill came for \$504 and that was just for January, knowing I was going to get a bill in February for another infusion. So now I already owe \$1,108 and then we found out we were pregnant. So I had to stop getting my infusions because, you know, we didn't have enough money. I mean, that's a lot of out-of-pocket, and then having three children. So I haven't had my infusions since. I don't know if the baby got enough during my pregnancy. I don't know if I have enough left anymore. I don't know if he's going to be immune. I don't know if he is going to be healthy. We've already gotten...he's already had a cold at three weeks which is really scary for a small child. (inaudible) still lingering on. I'm sure you heard him grunting. But you never know. I don't know if I'm going to continue to be healthy. Since being pregnant, I was sick. We had the stomach flu. We had a couple of viral infections, and I had a couple...a sinus infection. So, and then working which I've always worked up until the end of my pregnancy. Well, this time I was so sick and tired and exhausted that I got put on light duty. So, I mean, I was still working but I couldn't work up until the end. I wasn't as strong, and I just feel if I would have been on my infusions or I would have had them, it probably wouldn't have happened. But it's...you know, you just...I wish I was able to get my infusions, you know, but I can't afford \$504 every month, you know, with them. And so we just...I haven't got them. I had to choose, you know, my family or my health. And I mean, at this rate, I'm choosing my family and we're not going to spend the money on \$504 a month, so I just stopped getting my infusions. So I just...what would you do in the situation, you know? I mean, would you keep paying \$504 for yourself and take it out of your family's income and your house and, you know, what you need to do? So we just chose to stop my infusions, and I don't know if maybe this will change things if we pass this, if maybe it will help. You know, maybe my insurance will start covering again. I won't have this 20 percent coinsurance, but I don't know. That's all I have. I do have some paperwork that shows my insurance that it covered up until January when my plan changed. I can leave

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that for you but. [LR334 LR406]

SENATOR PAHLS: Yes, we have a question. Senator Gloor. [LR334 LR406]

SENATOR GLOOR: Thank you for coming and sharing with us, Mrs. Schildt, and I'm sorry for the challenge in front of you. St. Elizabeth's, I believe, is a self-insured plan. Did you share this in your story with the benefits staff at St. Elizabeth's? [LR334 LR406]

SHAWNA SCHILDT: Did I? No. [LR334 LR406]

SENATOR GLOOR: I mean, are they aware of the challenge that you're faced with as a result of this change in their insurance policy? Because they, not an insurance company, made this decision. I believe they are self-insured. I'm positive that they're a self-insured plan. I think part of the challenge for us as we consider it is even if we were to pass this legislation, it wouldn't change self-insured plans. They'd be exempted from that. So if somebody wants to correct me on that in later testimony they can. But I tell you that just so you understand the challenge with your employer and what we do here is really they're exempt from, you know, legislation we may institute that would change that. [LR334 LR406]

SENATOR PAHLS: It's my understanding, if you're self-insured, the insurance company may deny it but the group themselves can change that, can they not? [LR334 LR406]

SENATOR GLOOR: They can design it however they wish. [LR334 LR406]

SENATOR PAHLS: Yeah. I mean, they had it...I mean, I think when you go appeal to them, so I would take the senator's advice to your employer. I mean, because I think they have a group there because I'm familiar with that process just as a word of advice. [LR334 LR406]

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SENATOR GLOOR: Yep, you should. You should talk to them. [LR334 LR406]

SHAWNA SCHILDT: Okay. Thank you. [LR334 LR406]

SENATOR PAHLS: Thank you, appreciate your attending. [LR334 LR406]

DAVID ROOT: Sort through the paperwork, excuse me. Thank you for having me this morning. My name is David Root. I represent Medco Health Solutions. We are a PBM. That's a Pharmacy Benefit Manager that operate in the state of Nebraska. We currently administer the drug portion of benefit plans for about 24 percent of the state of Nebraska. That's about 480,000 people in the state. To keep with the wishes of the Chair and the committee, having been before this group earlier this year, try very quickly to just briefly bring a few things into focus and for both of the pieces of legislation and then take any questions that you guys might have. Addressing LB1088, the idea of therapeutic substitution, we have heard today a number of times that substitutions or switches in the vernacular take place on a regular basis. Very quickly, I'd like to give you a very brief overview of what therapeutic substitution is. Therapeutic substitution is the switching of one...for the simplest terms, one brand drug to another brand drug. In the state of Nebraska, as in all other 49 states, you cannot perform therapeutic substitution without contacting the physician and getting a new script because it's a new drug. The pharmacist is not able to reach into the back of the counter in their bag and pull out a different drug and say, Mr. Jones, here. If they're going to substitute, if therapeutic substitution is going to take place, the doctor must write a new script. I cannot say that clearly enough. The doctor has to write a new script. The presumption there is that the medical conversation that needs to take place, and we would all agree completely, that the decision needs to rest with the patient and the doctor. The medical conversation there that needs to take place does take place. The doctor is the one who makes that decision. There are reasons for therapeutic substitution. Typically, there are three of the most common reasons. Number one, the plan may not offer on the formulary, the drug that the doctor has prescribed. Now, it is our hope not to get off-topic, but it is our hope

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in the future that e-prescribing will help address that issue because e-prescribing, the doctor will have a very clear idea of what your particular formulary is and will then be able to pick an appropriate drug that is on that formulary, so that may eliminate that, and we are working with legislatures in all 50 states as well as other companies and the AMA and others to develop an e-prescribing system to help eradicate that situation or lessen its effect. The other reason that therapeutic substitution may take place is that the doctor may prescribe a particular drug for a patient who, let's say, was less than forthcoming with the doctor with the other drugs that they may be taking, whether they be over-the-counter or prescription. That patient then presents to their pharmacist a script for this new drug. The pharmacist looks at that person's profile in their computer, realizes that they're taking another drug that may very well have an adverse reaction to the drug they've just been prescribed and will then call the doctor and initiate some sort of substitution or the doctor will say, no, this needs to...I know that. This patient needs to take this medicine; this is what I want. But those are medical interventions in order to avoid potentially lethal side effects. The other option is...the other reason for therapeutic substitution is that oftentimes there may be a cheaper drug available to the patient that the doctor may simply not know about in which case, again, the patient presents to the pharmacist, and the pharmacist may say, Mr. Jones, there is a...you know, this drug is going to cost this much, according to your plan. There is a cheaper alternative. Let's get your doctor on the phone and see if I can get a new script for that, if you want to. And Mr. Jones has the ability to say no, this is what I want, and I'll pay for it. Don't worry about it. Or that would be great. I'll go sit down for a moment, and you go have a chat with my doctor. That third category, we also heard if I heard correctly, we also heard, alluded to, that there are letters that patients receive, and they may or may not be sophisticated enough users of healthcare to understand the implications of those letters. Typically, those letters are sent to these patients from the plan advising them to take that letter to their healthcare physician. The contents of that letter will say that, did you know that there is a cheaper alternative that is available to the patient? If you think that it's appropriate, you can write a prescription for that. The patient cannot take that letter to the pharmacist and utilize it as a prescription because it is not a prescription. In the

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state of Nebraska, as in all other 49 states, you have to be licensed to write a prescription and they're doctors, so the doctor has to write that prescription. But it is a...because we realize that there are patients that are not that sophisticated in their healthcare needs and necessities, that letter is something that they can take to their doctor, present it to the doctor, and the doctor can then sit down with them, decipher it, and have that medical conversation as to whether or not therapeutic substitution for whatever drug they were originally prescribed is a good idea. And it's...just to be candid, I find it somewhat offensive to listen to the fact that...to be heard that therapeutic substitution switching without doctor's permission takes place every day. If that's the case, then they have carnal knowledge of people who are violating the law, both federal and state. And it should not be tolerated. We will not tolerate it. The pharmacist will not tolerate it. It's already an illegal act. If they have that knowledge, they need to turn those people in immediately, immediately. I cannot stress that enough. It is already illegal to do that. And as far as the notion of generic substitution, we've gone over that topic at some length in the intervening hearing that we had over these bills earlier this year, and I would just, you know, direct you to the Nebraska state law 71-5403, drug product selection, and that talks very...in great detail. Nebraska has a very good dispenses written law with respect to generic substitution. So I don't really feel the...necessary unless you all have questions about that, I don't feel necessary to review over that. Very briefly then, the other...moving over to the other bill, LB1017, and I believe there are others that will come behind me that will speak more directly to that. But there's a couple of components to the language of that bill that I'd like to just address. Number one, we did hear about New York, and that is true. The information you heard with respect to New York is true. It's important also, though, to note that New York did not have a fourth-tier specialty program in their state. The plans there did not offer fourth-tier specialty pharmacy. They had the typical three-tier program. Since that bill's passage, there is right now a great degree of discussion with respect to what will happen to New York payers' premiums with respect to the elimination of the fourth-tier specialty pharmacy component. These drugs that you've heard about are expensive. They are treating rare diseases; they are treating complex diseases. As science

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progresses, they will treat even more complex and even more rare diseases. Very, very quickly, to give you an example, there is now a drug that is on the market for fourth-tier prostate cancer which is the worst prostate cancer that...you're terminal at that point. It has already been proven in fourth-stage. It's a biologic manufactured drug which means they take a sample of your particular prostate cancer. They pull the proteins off that prostate cancer, and in the lab they make a drug specifically designed to attack your proteins on your cancer. So the drug that's manufactured for you, Mr. Chairman, would not necessarily work for you and vice versa. In fourth-tier terminal prostate cancer patients, it's added 6 to 12 weeks of life for these people. The next phase of the trial is to move back to stage 1, 2, and 3 where it is anticipated that it could possibly act almost as a vaccine against the disease or something short of that. But, in other words, the point to that is that they have very high expectations for its assistance in that cancer when applied at an early stage. And, as we know, prostate cancer is, thankfully, one of those cancers that is detectable at an early rate. That drug costs \$10,000 a treatment. Most of that cost is the manufacture of the drug in the lab for your particular proteins. It is expensive. There is no doubt about it. But in order for a plan to cover that drug, they can either charge premiums or copays. That's the only way a plan has the ability to cover the cost of the drugs. The cost of the drugs is set by the manufacturers. The plans have the ability to charge premiums and copays. And as I said, in New York, the unknown right now is that we don't know what it's going to do to premiums and, frankly, we don't know what it's going to do to copays in the third tier. So they're not allowed to have a fourth tier. If the plans are going to continue to offer those drugs, where are they going to put them and what is the employee, if you will, what is their contribution going to be towards the cost of those drugs? The other option...the other horrible option is that there may be plans or employers who simply no longer offer a drug component in their health plan. And, you know, we hope that we don't get to that situation. That doesn't serve anyone's purposes. One more final comment I'll leave you with LB1017, the language in LB1017 also stipulates no more than 500 percent of the lowest cost copay in the plan. Many plans, and I believe including the state of Nebraska plan, has a zero copay for generics at Mayo. That would be the lowest cost copay in the plan which

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means 500 percent of zero is still zero which means these drugs...there would be no copay for those fourth-tier specialty drugs. The plan is still going to have to figure out how to pay for those drugs if they're going to offer them to their enrollees, and that money, again, can only come from copays and premiums. If there are any questions from anyone in the group, and I'll be around a little bit later as well. [LR334 LR406]

SENATOR PAHLS: (Recorder malfunction)...see any. I will...okay, I will say that I, you know, it almost seems like...and I know we have the proponents and opponents. It almost seems like a split personality type of discussion here between both sides. So I think part of our obligation is trying to go through everything and see what the actual facts are. [LR334 LR406]

DAVID ROOT: If I may, I'm just slightly...I'm not sure I understand that. Help me with when you say a split personality. I'm not sure...(laugh). [LR334 LR406]

SENATOR PAHLS: Well, one side is saying this and the other side is saying that. I mean... [LR334 LR406]

DAVID ROOT: Oh, okay, okay. Well, that's fair enough and I think we have to be...I think we have to be careful to make sure we understand all of the issues at play. And I think we have cost issues. We certainly have care issues, meaning people who need care and need these medications. It's undeniable. We also have to decide what side of the aisle, if you will, we want to come down on with respect to should healthcare be free? Should there be some, you know, should employers and enrollees have some skin in the game? And that's a decision, I mean, that's why you guys run every November and, unfortunately, that's a decision that you guys are going to have to wrestle with. But I think you're right. I would agree with you, understanding what you said, I would agree. But I think it's very important that we make sure we understand that there are a lot of buckets that ultimately have to be reconciled in order to come up with a final product. [LR334 LR406]

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SENATOR PAHLS: Okay. Senator Gloor. [LR334 LR406]

SENATOR GLOOR: Thank you, Chairman Pahls. That's kind of stimulated me to think of a question to ask your opinion. And, by the way, given what Senator Pahls's system has put up with this past year, I'd take some of his protein if I needed it. I think it would be good for me. Isn't it interesting that we have gravitated to a tier system with pharmaceuticals, but we don't have a tier system when it comes to, let's say, somebody who's in for a routine stress test which is a Tier I or we go in then for a graded exercise test which is a Tier II and so on and so forth, or images that are routine: X-rays Tier I; a CT is Tier II, an MRI is Tier III. Is it, as has been posed here today, because Medicare paved the way for this to be a tiered system? How did we get to where we pull pharmaceuticals off in a way we don't for other therapeutic or diagnostic exams? [LR334 LR406]

DAVID ROOT: The way we got there was a synthesis or a growth model, and what happened was we invented managed care for medicine--medical managed care, and it worked. It helped keep costs down. And as that developed, the states and others, you know, they put in mandated benefits, things that had to be covered under the medical component and that type of thing. But ultimately, the insurers, the payers would go to the insurance companies and others and say, I need to manage my costs. So they developed the managed care system. If you go back in your life to going to the pharmacy as a young parent or a young person with your parents, you'll remember there was this thing called "rack rate." There was no pharmacy card. Your fathers and mothers didn't have pharmacy benefit cards. They went to the pharmacy, the pharmacist. They gave the pharmacist the prescription, and the pharmacist said, those pills cost X, and you paid. And depending on your insurance plan, it may or may not have come out of your deductible, whatever the case may be. In the early days it didn't even do that. It was just considered pharmacy. Well, as we developed and explored managed care on the medical side, we would start to see...we were continuing to see



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increasing costs in healthcare, and they looked at it and said, what are these increases? Why are we having these escalating, increasing costs? Well, pharmacy is unmanaged. All right, a group of people that were a whole lot smarter than I was...am, started to look at, well, can we apply managed medicine principles to managed pharmacy principles? Developing tiers for drugs, incentivizing the use of generics, those types of things. It was...and that's why I say, it was sort of an organic and natural growth to where we now have a managed pharmaceutical care section of the benefit. And that's what we're talking about here. We're talking about the managing the spend from the payor, be it the employer or the employee, but the payor's perspective in order to provide those drugs and those treatments at something that resembles an affordable rate. The problem we have that goes along with answering this question is as we develop those systems, we have this third hand that interjects itself intermittently with no warning, and that third hand is science. That third hand is the discovery of whatever the next technology is that keeps people who formerly became ill and died, keeps them not only alive but in many cases, allows them to continue to have a long and fruitful life and be fulfilling members of society. And we don't know when science is going to come inject itself because we read about it in the paper. Well, they've discovered this or they invented that. And it's...that doesn't happen in a vacuum. That has an impact on the medical...on our medicine and our healthcare system and how we apply it. And it forces us to privately ask questions that we don't like asking, and we really don't want to know the answer to. But we have a system right now where healthcare is not free for everyone. It has to be paid for by someone. And the one thing that I wrote down as I heard comments was that, you know, these costs that we're discussing don't simply evaporate. They don't go away because it's the right thing to do. I think in the last meeting we...at the last time we came together, I think, Senator Gloor, you used the phrase, cost shifting, and gave the example of the balloon. If you squeeze on one end, it moves over on the other and, I mean, that is...as painful as that is and as unfortunate as that is, that is a reality in a system where you pay for a service. I mean, I think that answers your question. I mean, it's... [LR334 LR406]

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SENATOR GLOOR: Yeah. I appreciate the history. Thank you. [LR334 LR406]

SENATOR PAHLS: Seeing no more, thank you for your testimony, Mr. Root. [LR334 LR406]

DAVID ROOT: Thank you. [LR334 LR406]

JAN MCKENZIE: Senator Pahls, members of the Banking, Commerce and Insurance Committee, for the record my name is Jan McKenzie, spelled J-a-n M-c-K-e-n-z-i-e, testifying today on behalf of the Nebraska Insurance Federation. And I do have new things to talk about for the committee today because we have a whole new world in terms of our health reform efforts. Senator Gloor, I kind of want to address the issue that you asked regarding how does PPACA impact this? A few weeks ago, you had a long, long hearing about what's happening regarding healthcare reform, and I believe all the committee members got this lovely little handbook distributed about what's happening this year, next year, the year after, the year after, the year after, the year after. Well, the thing that's most pertinent to what we're talking about today has to do with what's in process right now but will be in effect in 2014. Under the Healthcare Reform Act, there is a provision now that the Health and Human Services Director will create what's called an Essential Benefits Package. Every Exchange health plan that every state or groups of states, however they set their Exchange up, every plan must have certain things in it. And in the bill, there are a list of some preliminary things that every plan has to have. Basically, what that's going to create is sort of what is mandated in every plan, and if a state wants to add something more than that, the bill says the state must pay for anything above the Essential Benefits Package. So if something is of critical importance to a number of groups, it should be presented at present to HHS at the federal level, because they will determine what we have to have in every health plan. And what it means as to every state will pay for anything beyond that is still as many pieces of PPACA undefined, not certain if it's a tax credit, not certain if it means the state has to pay for the premium. Certainly, if a person buys from the Exchange in Nebraska in

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2014, whatever we have beyond what is in the Essential Benefits Plan will either need to be repealed, as we're understanding it now, if we have things that are beyond what is essential package or paid for. So that's really going to change the way we look at a number of things here, I think, both at the federal level where we've always known that's the only way you could get to self-insured plans and ERISA plans, but also for us in terms of anything that we may think is important to our Nebraska population. If it's important, then we've got to figure out a way to pay for it. That's certainly going to change all kinds of things. My suggestion to the committee would be, as our Department of Education or Department of Insurance looks at their planning grant that they received to look at what our Exchange will look like, that we probably ought not take any measures regarding benefits, mandates of any type until we know exactly what this Essential Benefits Package is going to include, and then we can have some discussion. We're already in a situation where we'll need to come in and repeal LB551 that we passed with the age of dependency last year, Senator White's bill, because the federal PPACA has different language and different requirements than what we have and now we've created the confusion for not only the insurers but the public and folks trying to access what we all agreed was a good idea. So I can't answer lots of detailed specific questions about it, but I just wanted you to be aware as we look at these things, that this is a very important part of what's in PPACA that I believe Michaela Valentin mentioned a couple of weeks ago in her presentation. But a whole new world plus every...there will be different types of plans offered--Gold, Silver, Bronze, Platinum. I don't know. They don't have a Diamond level. But lots of things will be different in terms of what insurers are required to do and what the state will be required to pay for if we want to go beyond. [LR334 LR406]

SENATOR PAHLS: Jan, you did say that we probably will need to repeal Senator White's bill. [LR334 LR406]

JAN MCKENZIE: Yes. [LR334 LR406]

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SENATOR PAHLS: You did endorse that, though, did you not at the time? [LR334 LR406]

JAN McKENZIE: Yes, yeah. [LR334 LR406]

SENATOR PAHLS: Okay, I'm just...want to give you a little bad time. Also, I...the director says let's...we need to go slow on insurance changes, any major changes because of the unknown... [LR334 LR406]

JAN McKENZIE: Right. [LR334 LR406]

SENATOR PAHLS: ...and I do know the study they're doing. So your suggestion is that we hold off, is that what you're telling me on these decisions? [LR334 LR406]

JAN McKENZIE: Yes. [LR334 LR406]

SENATOR PAHLS: Okay. Well, what I'd like to have you...I have that book because it was all the committee. Would you make sure that Senator Cornett's office gets that also? [LR334 LR406]

JAN McKENZIE: Sure, absolutely. [LR334 LR406]

SENATOR PAHLS: I think that would help in the discussion that's...I'm sure that's going to go on. [LR334 LR406]

JAN McKENZIE: Yeah. [LR334 LR406]

SENATOR PAHLS: So I think at least everybody ought to understand what 2014 means to us all. [LR334 LR406]

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JAN MCKENZIE: Right. Lots of changes. Thank you. [LR334 LR406]

SENATOR PAHLS: Yes. Thank you. Well, seeing no more...we have one more? Good morning. [LR334 LR406]

PAUL PLOFCHAN: Good morning, Senator Pahls. I appreciate this committee hearing. My name is Paul Plofchan, P-a-u-l P-l-o-f-c-h-a-n. I'm the government affairs representative for Pfizer, and I just wanted to just take one minute. I don't have written testimony, but I did want to just sort of clarify a couple of things, at least...or at least add to the discussion. And first off is that dealing with the therapeutic substitution bill, I don't think that the two sides are that far apart, and I salute the senator for suggesting that they sit down and talk about it. And I would offer that, on the discussion, I think the real issue is everybody agrees that therapeutic substitution is illegal. I think the bill is simply asking that when these campaigns and we heard admitted today that there is direct communication to the patients, that I think they have some nice suggestions in the bill about what those communications could look like, so that both sides would have the information you were looking for, Senator, so that the patient could make a good decision with their doctor, so they don't have to go to the pharmacy and have their agents change. But when they would have the opportunity in their physician's office with their physician to have an intelligent conversation, and we can make a change. So if the PBM, for example, is going to write to the patient, I think in the bill are some requirements that they could put in that communication whether we need to pass it via law or whether we could do that via some sort of rules or some sort of agreement, I'd leave up to the two sides to discuss, but clearly, we could have a well-informed process. And I think in the language of the bill, they ask for things such as, well, what are the alternatives? What is the reasoning for their switch? What are impossible incentives that may be in play for the switch? Those are all reasonable things, I think, that all people as consumers would want to know and maybe those could go in the bill. I mean, maybe those could go in that communication, that the PBMs have said that they're sending and maybe that's a good solution, and it doesn't need legislative action. I mean, there's

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another way to go about doing that. The other thing I wanted to talk about was on the...the comment about the PPACA. You know, 2014 is a long time away, and it is possible, though, to...as we try to address well, what is the federal government going to do? And I think it was correctly testified here that the state would be having to pay for anything that goes above and beyond the federal requirement. But I don't think that eliminates the fact that we have Nebraskans who are struggling to get this care, and you could approach it in different ways. One way you could do it is you could sunset the requirement that says that in 2014, if the federal law isn't going to cover this in the Essential Benefits Package or if the state's requirements are costing more money and they can't substantiate, you know, those programs and so if the state would have to pay then the requirement could be sunsetted. My point is that there's people who are struggling with this. These are real families that are trying to do that, and I sort of took offense to the testimony that the people that testified on half of the bill don't want to pay. The testifiers are all paying their premiums, but what happened was they...just like I do, I pay my premiums for my family for catastrophic coverage. God forbid if something goes wrong in my family; I don't want to all of a sudden be reindividualized out of the pool. You know, I'm paying my premiums now to protect against catastrophic illness. When I get one, I don't want to be moved to a special class and says, okay, all of a sudden, hey, you're one of the guys that got sick. You no longer get the benefits of the large pool. You're going to have to assume more individual risk. I think that's what they're asking for and suggesting about the improvements in the fourth tier. So I'd be happy to ask any questions, but I just want to...or answer any questions rather, but I just wanted an opportunity to clarify those two points. [LR334 LR406]

SENATOR PAHLS: Well, what I'm taking out of it, you said sunset could be an option. I'm just saying this for those people out there, it could be an option. And you know, those around here know I like the idea of sunsets for other reasons. But also clarity between patient, doctor, and the pharmacy--is that what you're saying when you somehow provide...? [LR334 LR406]

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PAUL PLOFCHAN: Precisely. I think there's a lot of frustrated people here. There's frustrated patients; there's frustrated physicians and frustrated payers. I mean, it's a difficult situation, and I think there's some things in that bill that talk about what should be communicated to the patient and the physician so that they can have a better conversation. They seem fairly reasonable. Perhaps we don't need to do it legislatively but improving the communication which we know is going on doesn't seem to me like a bad goal. [LR334 LR406]

SENATOR PAHLS: And I will agree with the last comment. Not everything has to be done up there in the Chamber. If it can be done and...it doesn't need to be legislation. [LR334 LR406]

PAUL PLOFCHAN: Right. And it seems to me that this is a war going. For example, the comment about the, you know, that somebody has to pay. Of course, people know we have to pay. That's why people buy insurance. They're trying to buy as part of a large risk pool, and they're paying their premiums, and also the comment about the copays, one being zero and since some people have zero copays that the fourth tier would mean that the specialty tier would also be zero. That's not the intent of the legislation or the people speaking to it. That problem can be addressed in some simple conversations. So forgive me for interrupting you, Senator Pahls. [LR334 LR406]

SENATOR PAHLS: Okay. No, no, the word conversation seems to me may be part of the lacking, and I'm hoping those...go ahead, Senator Christensen. [LR334 LR406]

SENATOR CHRISTENSEN: Not a question, but I'll make a comment that if there's one thing that we could get people to do, which I know is impossible, that's look at proactive healthcare. In my valley where I grew up, my dad lives, my brother lives, family has lived, everybody...I can go down every household down that river has...everybody has died of cancer. The kids that have moved away don't. That tells you there's something wrong in that valley. But most of them don't take the proactive care. After my mother

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died of cancer, we went to purified water. Everybody now has outlived my mother. Everybody in our family has extended that on. My family has actually went to...my personal family to adding high vitamins, things this direction, trying to get more proactive on being healthy. And trouble is, nobody thinks about that till they are sick and what everybody said was generational cancer in our area, we have broken out of. But I have a lot of neighbors that have moved in that don't understand the generational that aren't doing the things they need to do. And tough part is, no one looks at that, including my family, till like I lost my mother. So we started getting more proactive on...because everybody said it was generational cancer, but it isn't because we've had so many kids leave. And I'm not saying that's the situation with any of the testifiers, but proactive healthcare if we could get this nation on taking care of our bodies, the nutrients and exercise, we could end a lot of the high cost of insurance because we wouldn't have near as many sick people. But, again, preaching to the choir because nobody will listen. [LR334 LR406]

PAUL PLOFCHAN: Well, I'll listen to you. It's a really good point, and we certainly agree with you at Pfizer on prevention and wellness. And you'll also be pleased to know that that is in PPACA now and trying to have more preventative and wellness packages and zero copays for that, so that people participate in that, so that people don't find an economic reason not to do that. And whether that will work or not will wait to be seen, but I think it's...I'm glad you raised the point, because it's relevant to today's discussion about copays, because to get people involved with that, they'll do that at zero copay and zero cost-sharing for preventative medicine. And I agree with you, and I hope like you do that that helps curve the cost curve. And when we apply that to the masses of Nebraska, and I think we have good reason to believe that. Look at what the state of Nebraska is doing with the state employee plan and the wellness program. And look what that is doing to the premiums for Nebraskans that are, you know, in those plans and where their increases are...those in the wellness portion of the state employee plan are seeing, I believe, it's a zero growth this year in their premiums. And so, hopefully, we can apply that across the masses. I'm sorry about your family's struggle with cancer



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certainly and your community's struggle with that, and you know, I think that that's a relevant point also to be bringing back to those that testified for the copay bill today because I think that, you know, those are those debilitating illness...those serious debilitating illnesses that we all want protection of. Isn't that the big fear that everybody has? It's why I've been paying insurance for my kids all my life. It's not so that I can get my well baby visits or I can get my annual visit. I could pay cash for that. I wouldn't pay a \$13,000 premium a year for \$500 worth of healthcare, but why do I pay it? I pay it for catastrophic coverage, so God forbid, should I have a child with leukemia I could spread that cost around the group. I still want to pay my share, but I want to spread that cost. What's happening with the fourth tier specialty, though, is once you get a diagnosis with that, all of a sudden I'm removed from that group, put back into another group and I'm required to pay. And I think that's why you saw action in New York. And, yes, it's true, I think, that you don't know what the ramifications of New York will be, but I'm pretty much betting that they're still going to...that insurers and PBMs are still going to provide healthcare in New York and whether there was a health Exchange or not. So, anyway, thank you for your remarks. I think they are pertinent and I appreciate them so. [LR334 LR406]

SENATOR PAHLS: Any other questions? Okay, thank you. [LR334 LR406]

PAUL PLOFCHAN: Thank you. [LR334 LR406]

SENATOR PAHLS: Appreciate it. Well, it does appear more discussion needs to be made on this topic and seeing no more testifiers, that will close this session. Thank you. [LR334 LR406]