[LB324 LB604]

The Committee on Banking, Commerce and Insurance met at 1:30 p.m. on Monday, February 27, 2017, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB324 and LB604. Senators present: Brett Lindstrom, Chairperson; Matt Williams, Vice Chairperson; Roy Baker; Tom Brewer; Joni Craighead; Mark Kolterman; John McCollister; and Paul Schumacher. Senators absent: None.

SENATOR LINDSTROM: All right, we'll get started here. Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Brett Lindstrom, I am from Omaha and represent District 18. I serve as Chair of this committee. The committee will take up the bills in the order posted. Our hearing today is your part of the public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. The committee members will come and go during the hearing. We have to introduce bills in other committees and are called away. It is not an indication we are not interested in the bill being heard in this committee, just part of the process. To better facilitate today's proceeding, I ask that you abide by the following procedures. The information is posted on the chart to your left. Please silence or turn off your cell phones. Move to the front row when you're ready to testify. The order of testimony will go introducer, proponents, opponents, neutral, and closing. Testifiers please sign in. Hand your pink sign-in sheet to the committee clerk when you come up to testify. Please spell your name for the record before you testify. We ask that you please be concise. It is my request that you limit your testimony to five minutes. We do use the light system in the Banking Committee, which means four minutes for the green light, one minute the yellow will turn on, and at five minutes the red light will turn on. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white tablets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We will need ten copies. If you have written testimony but do not have ten copies, please raise your hand now so the page can make copies for you. To my immediate right is committee counsel, Bill Marienau. To my far left is committee clerk, Jan Foster. And the committee members with us today will introduce themselves, starting at my far right with Senator Schumacher.

SENATOR SCHUMACHER: Paul Schumacher, District 22, that's Platte and parts of Colfax and Stanton Counties.

SENATOR KOLTERMAN: Mark Kolterman, District 24, Seward, York, and Polk County.

SENATOR BREWER: Tom Brewer, District 43, 13 counties of western Nebraska.

SENATOR WILLIAMS: Matt Williams, District 36, Dawson, Custer, and the north part of Buffalo Counties.

SENATOR CRAIGHEAD: Joni Craighead, District 6, Omaha.

SENATOR BAKER: Roy Baker, District 30, southern Lancaster County and Gage County.

SENATOR McCOLLISTER: John McCollister, I represent District 20, which is central Omaha.

SENATOR LINDSTROM: And our page today is Phillip Levos from Columbus. Thank you for being here, Phillip. We will take up the bills in the order posted outside and we will begin and open the hearing on LB324, presented by Senator Kolterman. Whenever you're ready, Senator. [LB324]

SENATOR KOLTERMAN: (Exhibits 1, 2, 3) Thank you, Senator Lindstrom. Good afternoon. My name is Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, I represent Legislative District 24 and I'm here today to introduce LB324. I agreed to introduce LB324 at the request of the Nebraska Pharmacists Association because I believe it is necessary legislation to protect our patients who choose to work with pharmacists in community pharmacies that are vital in providing medication and patient care services, particularly in our rural communities. Last year Senator Nicole Fox brought a bill, which was much broader, to require transparency for pharmacy benefit managers or PBMs. LB324 was changed over the interim to address only issues between pharmacies and PBMs and to add additional oversight and regulation by the Nebraska Department of Insurance. LB324 is designed to provide transparency in the process of dispensing prescription drugs to Nebraskans. Pharmacists contract with insurance companies who, in turn, utilize PBMs to manage the prescription drug benefit. Insurance companies or large pharmacy organizations most often own PBMs and PBMs often own their own pharmacies or mail-order pharmacies. For example, UnitedHealthcare owns Optum; Blue Cross and Blue Shield has an interest in Prime Therapeutics; Caremark owns their own pharmacy, CVS. Patients then get their medications from pharmacies that are in the PBM's network. In pharmacies across Nebraska, some PBMs prohibit pharmacists from sharing prescription drug pricing information with patients. Even if a patient asks what the cost of their medication is outside of the insurance plan, some plans limit the pharmacist's ability to mail a prescription drug to a patient at the patient's request, but are told by the PBM that the pharmacist must only allow the PBM mail-order pharmacy to fill and mail medications to patients. These are the types of situations that LB324 attempts to address, which should not be allowed. It is important to note that LB324 gives the Department of Insurance the necessary authority to adequately monitor the activities of PBMs with the

requirement that PBMs with business in Nebraska acquire certificates through a third-party administration. The Department of Insurance also is allowed to monitor PBM activity via the Unfair Insurance Trade Practices Act and the Insurance Examinations Act. With that, I have some testifiers here this afternoon that are from the pharmacies and the pharmacy association and would try to answer any questions you might have before they come up. [LB324]

SENATOR LINDSTROM: Thank you, Senator Kolterman. Any questions from the committee? Seeing none, we will now invite proponents to testify. Good afternoon. [LB324]

CONNIE BOLTE: Good afternoon. Senator Lindstrom, members of the Banking, Commerce and Insurance Committee, my name is Dr. Connie Bolte, it's B-o-l-t-e, and I'm a pharmacist at Charlie's U-Save Pharmacy in York, Nebraska. On behalf of the members of the Nebraska Pharmacists Association, I'm here to testify in support of LB324. And I would especially like to thank Senator Kolterman for introducing this legislation and inviting me to testify this afternoon. Interactions with Pharmacy Benefit Managers or PBMs comprise a large part of the daily workflow in a community pharmacy. These PBMs contract with insurers and employers to process prescriptions for those insured patients. The PBMs determine which drugs will be covered and negotiate with manufacturers on one end and the pharmacies on the other end. The stated intent is to keep drug prices low and to get the best deal for all parties involved. Day to day practices, however, show a different story. In the first two months of this year we have watched the amount of clawbacks increase on a daily basis. And it's my understanding that this was actually an article in the Lincoln Journal Star yesterday. This practice involves a PBM setting the amount the patient pays for the prescription then clawing back a portion of that price for themselves. In one particular instance that we've seen this year, the patient's prescription price was set at $97.71 by the PBM. The patient paid the entire price or was to pay the entire price. The clawback was $90.61 out of that $97.71. If it had been a cash-paying patient, if the prescription had been filled without insurance the patient would have paid about $27 for the medication. This practice occurs over and over again in community pharmacies across Nebraska with our patients suffering the most. Exclusive contracts between manufacturers and PBMs hurt patients as well. Recently, an expensive cholesterol medication became available as a generic. There are multiple PBMs still requiring use of the brand name and often the patient pays 100 percent of that cost. While this usually applies to deductible, using the generic medication would save patients anywhere from $50 to $100 per month, so over the course of a year that's a significant savings. The practice also applies to diabetic testing supplies. We had a patient who knew that his 2017 PBM would not typically cover his current diabetic testing supplies, so he proactively contacted his physician to contact the PBM. The physician's office submitted all of the requested paperwork and after two denials the patient received a letter on January 22, 2017, stating that the prescription for the testing strips would be covered until January 22, 2018. When I attempted to fill the prescription just this last Friday, February 24, 2017, the claim was denied. The PBM stated the patient needed a prior authorization for those strips. It took nearly 20

minutes of phone time to have the PBM enter the information that the January letter stated had been entered. This patient made three trips to the pharmacy for something he thought was covered in January. The last PBM practice that I would like to address is the mandatory mail-order pharmacy requirement. It's not uncommon for a patient to be allowed to fill the maintenance prescription--for example, a blood pressure medication or a cholesterol medication--at their local pharmacy two or three times, but then they're required to fill it through the PBM's mail-order pharmacy. Patients are often unaware of this requirement and learn of it when they are completely out of medication, standing at the pharmacy counter. In Nebraska, this requirement can be particularly harmful to patients. Our extreme temperature swings can affect medications that are sensitive to heat and/or cold, for example, last Friday. The Postal Service has made changes that can lengthen the amount of time it takes for a package to arrive. We have many patients who come to pay cash for a short-term supply of medication until their order arrives. In the long run they pay more, not less, when this occurs. Patients would like the right to be able to choose where they have their prescriptions filled, not be forced into an option they don't want. LB324 would greatly benefit patients across the state of Nebraska by increasing transparency from Pharmacy Benefit Managers. Employers and patients have a better opportunity to truly get the best deal for all parties. Pharmacists could care for their patients without the concerns of losing money on every insurance prescription they fill and thus remain one of the most successful healthcare providers in our state. And I would like to invite every one of you to stop by the local community pharmacy in your area or stop by my local community pharmacy in York, Nebraska, and visit with the pharmacist and ask some questions about how PBMs affect them on a day-to-day basis. I know they would be glad to spend the time and answer those questions. And thank you for the opportunity to comment today. [LB324]

SENATOR LINDSTROM: Thank you very much. Any questions from the committee? Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. And thank you for your testimony. I took a stab at reading this bill yesterday and I glazed over. I took another stab today and I glazed over. And could you please just explain to us the system, and without reference to any prepared text, how does it work and why is it not working and how does this bill fix it? [LB324]

CONNIE BOLTE: How does this bill fix it? I would be glad to do that. When a patient comes to the pharmacy and they bring their insurance card, we set up the processing information. It goes from the pharmacy to the Pharmacy Benefit Manager who... [LB324]

SENATOR SCHUMACHER: And who is a Pharmacy Benefit Manager? I mean, is that another company that's supposed to do the paperwork for the pharmacy? [LB324]

CONNIE BOLTE: It's a company that actually is contracted with the insurer. They contract with pharmacies as well, but they contract primarily with insurers and employers, so they take care of the paperwork of processing prescriptions. [LB324]

SENATOR SCHUMACHER: And they get the paperwork from the pharmacy who gets it from the patient? Or do they get it from the other...from the prescriber? [LB324]

CONNIE BOLTE: No, from the pharmacy. [LB324]

SENATOR SCHUMACHER: Okay. So somebody comes into you with a prescription. [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR SCHUMACHER: And they give you the script and you give them some pills. And then what happens? [LB324]

CONNIE BOLTE: Okay. Well, in between them giving me the prescription and me giving them the medication it goes from my pharmacy system's computer to the PBM's computer, who sets the price for the medication. [LB324]

SENATOR SCHUMACHER: So they tell you what you've got to charge? [LB324]

CONNIE BOLTE: That's correct. [LB324]

SENATOR SCHUMACHER: Kind of like a farmer deal. The grain elevator tells them what they have to do. [LB324]

CONNIE BOLTE: In some instances, yes. [LB324]

SENATOR SCHUMACHER: Okay. All right. [LB324]

CONNIE BOLTE: So they tell us what we can charge the patient. [LB324]

SENATOR SCHUMACHER: Okay. [LB324]

CONNIE BOLTE: They also tell the patient which amount the patient is going to pay, commonly known as a copay. [LB324]

SENATOR SCHUMACHER: And this is based upon the policy of the patient? Or who tells them what to do? [LB324]

CONNIE BOLTE: The Pharmacy Benefit Manager gets to pick the numbers and they... [LB324]

SENATOR SCHUMACHER: That would be a good racket to be in on. [LB324]

CONNIE BOLTE: They contract with the manufacturers and they tell the manufacturers, yes, we'll put your drug on our formulary or no, we won't put your drug on our formulary. Then they choose the price set by the...for the medication and what the pharmacy will be paid. In some instances--I looked before I left, I worked for approximately 90 minutes this morning before I came into Lincoln--I looked before I left. I think I saw maybe six prescriptions where the total amount of the price set by a PBM was above our cost for the medication. So why this would be of great benefit is because if there's some transparency and we can determine where they are determining their prices... [LB324]

SENATOR SCHUMACHER: So your...what you explained, your cost was below what their number was? [LB324]

CONNIE BOLTE: My cost for the medication was higher than the reimbursement set by the PBM. [LB324]

SENATOR SCHUMACHER: Okay. And they can force you to sell something for less than cost? [LB324]

CONNIE BOLTE: That's what the contract says. [LB324]

SENATOR SCHUMACHER: And you signed that contract? [LB324]

CONNIE BOLTE: Not because we wanted to, because what happens is if you don't sign a contract for a particular one, they will tell you that then they'll just be glad to leave you out of the network for other contracts as well. [LB324]

SENATOR SCHUMACHER: Okay. And behind the scenes this is the insurance company or the employer that owns this PBM who's... [LB324]

CONNIE BOLTE: It's not the employers that own the PBMs. They have contracts with the insurers. Some of them are owned by insurance companies, as Senator Kolterman stated. Prime Therapeutics is part of Blue Cross Blue Shield. OptumRx is part of UnitedHealthcare. [LB324]

SENATOR SCHUMACHER: So how does this fix that? How does the bill fix it? [LB324]

CONNIE BOLTE: I don't have enough time to go into all of the details. But by increasing transparency and by them being required to state which pricing was...they're using to determine their reimbursements by preventing them from clawing back money from pharmacies and patients, ultimately the goal is to truly get to lower pricing for patients and keep pharmacy accessible, especially in the state of Nebraska. In western Nebraska, it's hard to get to a pharmacy. And chain pharmacies are not easily accessible in western Nebraska. So small, independent pharmacies like the one where I work are very important. [LB324]

SENATOR SCHUMACHER: So the clawback is...they tell you, we'll pay you...you're to charge the patient or the patient's insurance company so much? [LB324]

CONNIE BOLTE: Right. [LB324]

SENATOR SCHUMACHER: And then they make you pay some of that back? [LB324]

CONNIE BOLTE: And they pull back an amount. Correct. [LB324]

SENATOR SCHUMACHER: And this is all in this contract that you signed? [LB324]

CONNIE BOLTE: Well, it's there in some pretty fine print. [LB324]

SENATOR SCHUMACHER: Okay. [LB324]

CONNIE BOLTE: Sometimes it's not. [LB324]

SENATOR SCHUMACHER: I'll let some of the other folks pursue more questions. I may have some more. Thank you. [LB324]

SENATOR LINDSTROM: Senator Baker. [LB324]

SENATOR BAKER: Thank you, Senator Lindstrom. I read the article you cited about clawbacks and that type of thing. You were describing a situation where if they go through insurance it would have been $97.71, but they could have...the patient could have bought it without using insurance for $27. Are you allowed, as a pharmacy, to tell them that? [LB324]

CONNIE BOLTE: With contracts, no. [LB324]

SENATOR BAKER: And would this bill take care of that? [LB324]

CONNIE BOLTE: I'm going to trust my colleague, that he says, yes, that that piece...that it does. [LB324]

SENATOR BAKER: Then you would be able to tell the patient... [LB324]

CONNIE BOLTE: We would be able to tell the patient. [LB324]

SENATOR BAKER: ...hey, forget your insurance. If you don't go through insurance, you can get this for less? [LB324]

CONNIE BOLTE: Right. Right. [LB324]

SENATOR BAKER: Thank you. [LB324]

SENATOR LINDSTROM: Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah, thank you, Chairman Lindstrom. So what you're saying, I think, is that as many as five parties can touch that prescription before that drug is prescribed to the end patient, that being the patient, that's the first point of entry; the pharmacy; the PBM, the insurance company--and in some cases the PBM is the insurance company, correct? [LB324]

CONNIE BOLTE: Correct. [LB324]

SENATOR McCOLLISTER: And then the drug company. So they never actually see the prescription, though, do they? [LB324]

CONNIE BOLTE: The drug company does not actually see the prescription. But, yes, as to all the other parties, yes. [LB324]

SENATOR McCOLLISTER: Okay. That's a lot of computer...okay. Clawbacks, is that a widespread practice? [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR McCOLLISTER: Tell me how it is that a pharmacy can give a drug cheaper to a patient than going through this entire process when they negotiate the prices. [LB324]

CONNIE BOLTE: Well, because we set a cash price. And figured into that price is a fair amount for the pharmacy, but we also take into account patients' out-of-pocket costs, where in the instance of the PBM they set a price looking to make sure that they make a profit. [LB324]

SENATOR McCOLLISTER: So what I could do, I could go to the drugstore and say, what's my cash price for that drug, correct? [LB324]

CONNIE BOLTE: You could do that. [LB324]

SENATOR McCOLLISTER: And they would offer most drugs at a substantial discount? [LB324]

CONNIE BOLTE: They would offer the drugs at a fair price. [LB324]

SENATOR McCOLLISTER: How do they obtain those drugs at such a discounted price? [LB324]

CONNIE BOLTE: It's not that they're obtained necessarily at a discounted price, but pharmacists setting their own prices tend to be more fair than a PBM when we're looking at a cash-paying patient. [LB324]

SENATOR McCOLLISTER: And some of those arrangements that the pharmacies have with the distributors obligate them to use the nongeneric drugs? [LB324]

CONNIE BOLTE: With some of the PBMs, that is correct. [LB324]

SENATOR McCOLLISTER: Wow. [LB324]

CONNIE BOLTE: And it's happened more than once this year. [LB324]

SENATOR McCOLLISTER: Thank you for your testimony. [LB324]

SENATOR LINDSTROM: Senator Baker. [LB324]

SENATOR BAKER: Thank you, Senator Lindstrom. I think Senator McCollister already asked my question. But if you're my pharmacist and I would go through you for this prescription and you say, it will be $97.71. I said, whoa, could I just pay cash? Could you answer me? [LB324]

CONNIE BOLTE: According to the contract, no. [LB324]

SENATOR BAKER: So if I asked you, do you have a cash price on this, you would not be able to answer me? [LB324]

CONNIE BOLTE: No. [LB324]

SENATOR BAKER: Thank you. [LB324]

SENATOR LINDSTROM: Any other questions? Senator Williams. [LB324]

SENATOR WILLIAMS: Thank you, Chairman Lindstrom. And thank you for being here. I want to switch to something else in a minute, but on the clawback you mentioned Prime Therapeutics and the company that I forgot their name that's owned by United Healthcare. [LB324]

CONNIE BOLTE: Optum. [LB324]

SENATOR WILLIAMS: Do both of them do this clawback procedure that you're just describing? [LB324]

CONNIE BOLTE: OptumRx does. Prime Therapeutics, I have not seen that, but OptumRx does. [LB324]

SENATOR WILLIAMS: Okay. And you mentioned in your testimony or in your answer to Senator Schumacher that the clawbacks affected community pharmacies. Do they...does the clawback not affect other people that might be distributing medications? [LB324]

CONNIE BOLTE: It would not affect hospital pharmacies in that way. It would only be pharmacies where patients are coming in and picking up their medications at the pharmacy. [LB324]

SENATOR WILLIAMS: Would it affect a chain pharmacy the same way it affects you? [LB324]

CONNIE BOLTE: It would affect a chain pharmacy as well. [LB324]

SENATOR WILLIAMS: So their contract would be...let me ask a different question then. Is your contract in your independent pharmacy the same as the contract that would be signed by Walmart? [LB324]

CONNIE BOLTE: No. [LB324]

SENATOR WILLIAMS: Can you describe the difference to me? [LB324]

CONNIE BOLTE: The difference would be that Walmart, as a chain pharmacy and because they're larger, has more leverage with a PBM than we do as small independents. [LB324]

SENATOR WILLIAMS: Are you as a small independent allowed to group with another small independent to try to arrive at some size that helps you in negotiation? [LB324]

CONNIE BOLTE: We are part of a group that helps us negotiate contracts as a group with our wholesaler, but otherwise as a whole, there are some antitrust issues involved there. So we walk very fine lines. [LB324]

SENATOR WILLIAMS: I'd like to pursue that just a little bit. And if others that are going to follow you can explain this to me also I would appreciate it, to understand the antitrust aspect of that, why you're not allowed to group with all the pharmacies in an area or the state... [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR WILLIAMS: ...and do that where it sounds to me that the other side has that opportunity. [LB324]

CONNIE BOLTE: Well, and I will be honest. I'm not as familiar with the antitrust, so there may be somebody else who's better able to answer it than I, but... [LB324]

SENATOR WILLIAMS: Okay. Can we go back then? You also...we've talked some about the clawback, but you also in your testimony talked about the mail-order issue. [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR WILLIAMS: And I'm not sure I understand that. Could you go into that in a little bit more depth? [LB324]

CONNIE BOLTE: The mandatory mail-order piece, of that? [LB324]

SENATOR WILLIAMS: Yes. [LB324]

CONNIE BOLTE: Okay. [LB324]

SENATOR WILLIAMS: And you're saying there's mandatory mail-order piece that is in your contract with the PBM. Is that...? [LB324]

CONNIE BOLTE: It's not in our contract, but it may be in the patient's policy. [LB324]

SENATOR WILLIAMS: So if I'm carrying a certain drug card that's managed by a certain PBM, that's where it happens? [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR WILLIAMS: So what would that require me, as the holder of that card, to do? [LB324]

CONNIE BOLTE: Okay. For instance, let's say you took a cholesterol medication each month. You came to see me in the month of January, we filled your prescription. You came to see me in the month of February, we filled your prescription. March is coming up. You come in to see me

in the month of March. I run your prescription to the PBM and they send it back with a message saying that it's a maximum of two fills allowed at the retail or community pharmacy level and that you are now required to obtain that medication from the PBM's mail-order pharmacy. In some instances you're allowed to make a phone call to the PBM, let them know that you prefer to not do that and that you would like to continue to have the medication filled locally. But in some instances that option is not available to the patient and so then the patient...you know, as I said, they're at the pharmacy counter, they're out of medication and now they have to wait, sometimes up to two weeks. [LB324]

SENATOR WILLIAMS: And the patient, the cardholder then, me, from then on I'm required to do mail order through my PBM for that medication? [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR WILLIAMS: Can you...you mentioned this in a cholesterol medication. Are there other types of medication that fall into that same category? [LB324]

CONNIE BOLTE: Blood pressure medications, medications for diabetes would often fall into that same scenario. [LB324]

SENATOR WILLIAMS: Those types of things that I will classify as chronic that you're going to need for a long period of time... [LB324]

CONNIE BOLTE: Yes, yes. [LB324]

SENATOR WILLIAMS: ...maybe for the entire rest of your life. [LB324]

CONNIEW BOLTE: Yes, yes. Exactly. [LB324]

SENATOR WILLIAMS: Do you...in your experience with that is the cost that you have of handing me that drug, is it cheaper to have the PBM hand me that drug? [LB324]

CONNIE BOLTE: Sometimes. [LB324]

SENATOR WILLIAMS: But not always? [LB324]

CONNIE BOLTE: But not always. And I have not personally seen instances where it's been higher for the patient to get it through a mail-order pharmacy. I have read several stories on-line, but again that's not personal experience and doesn't carry as much weight here. But it occurs. [LB324]

SENATOR WILLIAMS: Thank you. [LB324]

SENATOR LINDSTROM: Any other questions from the committee? Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah, thank you, Chairman Lindstrom. And thank you, Mrs. Bolte. Isn't this really an issue of margins that without better transparency some of those big distributors get better pricing than maybe some of the smaller distribution chains or maybe even some rural towns? [LB324]

CONNIE BOLTE: That's part of it. [LB324]

SENATOR McCOLLISTER: What is the other part of it? [LB324]

CONNIE BOLTE: I would say it's not margin alone, but for me it's a matter of, can I care for my patients, can I not care for my patients. [LB324]

SENATOR McCOLLISTER: So the PBMs restrict how you could care for your patient? [LB324]

CONNIE BOLTE: I pride myself on developing relationship with my patients. I know the little lady who comes to see me three times a week because she needs somebody to hold her hand, shall we say. Forcing people like that to get their medications from mail order or pricing small community pharmacies out of the picture really does those people a disservice, because a PBM isn't going to be there for that little patient to hold their hand and take care of them and talk them through their questions each and every day. [LB324]

SENATOR McCOLLISTER: Well, thank you for doing that. And thank you for your testimony. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing...excuse me. Senator Williams. [LB324]

SENATOR WILLIAMS: I'm sorry, I've got one more question. [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR WILLIAMS: Following up on what Senator McCollister just asked, PBMs have been around managing this for some period of time now. [LB324]

CONNIE BOLTE: Correct. [LB324]

SENATOR WILLIAMS: Do we have fewer independent community pharmacies today in Nebraska than we did when they started? [LB324]

CONNIE BOLTE: Yes. [LB324]

SENATOR WILLIAMS: Do you have any statistics that would tell me how many fewer? [LB324]

CONNIE BOLTE: I do not, but we can find you that answer. [LB324]

SENATOR WILLIAMS: That would be great. Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Any final questions? Seeing none, thank you for your testimony. [LB324]

CONNIE BOLTE: Thank you. [LB324]

SENATOR LINDSTROM: Next proponent. [LB324]

TREVOR BERTSCH: Hello, everyone. My name is Trevor Bertsch, last name is spelled B-e-r-t-s-c-h. I want to thank all of you on the Banking, Commerce and Insurance Committee for giving me the opportunity to testify. I am testifying in support of LB324. I am here on behalf of the Nebraska Pharmacists Association. I am currently employed at an independent pharmacy in Norfolk, Nebraska. Although I am here to represent the NPA, I am also here on behalf of many independent pharmacy owners who were unable to actually come here and testify, because if there's not a pharmacist in the store it's not open. So we have some staffing and scheduling problems there as well. But first and foremost, what really inspired me to come was for my patients. PBMs are third-party administrators, as we've discussed, that are contracted by health

plans, employers, unions, and government entities. In short, they are the middleman. PBMs, just to give you some sort of statistics on how big they are and why it's difficult to contract as an independent, PBMs manage pharmacy benefits for over 253 million Americans, according to their trade group. Three large companies: Express Scripts, CVS Health, and OptumRX, they cover more than 78 percent of those patients. In addition, they carry staggering revenues. For instance, in 2016--you can look this up in their annual report, just do a quick Yahoo finance search--Express Scripts was $100 billion; CVS was $177.5 billion; and in 2014--Optum does a better job of hiding it--$31.97 billion. So large PBMs have been involved. They're huge corporations. They have, like we said, been involved in this business for a very long time. So what this leads me to is the main part of my testimony is that they are adversely affecting patient care and increasing the cost of healthcare in this state as well as in our country and they...all while smothering out independent pharmacies and affecting patient care. So Connie already will have discussed some of the things that I'm going to bring forth, but hopefully it just hammers home the points and also maybe can clarify some things. Clawbacks and the gag clauses in our contracts: In some instances, as she discussed, a patient's copay will be higher than the actual cash price of the medication. We are not actually allowed to discuss cash pricing for those customers. And in some cases--I'll even bring it down to a smaller level--it tends to happen with lower cost generics as well. They'll have a copay of $10 for a $4 prescription, cash. You will see it immediately on our computer that the PBM is going to withhold $9 out of our reimbursement check. So essentially the patient is paying more, we are most likely making nothing or losing money and you guys can all figure out where the money went. So by increasing copayments and increasing the out-of-pocket cost for our patients, it creates another barrier to adherence for crucial medications and increase their risk of hospitalization and relative just discomfort. Another thing that has come about, as she made clear, too, is that mail-order and specialty pharmacy. So let me just put this into perspective. There are some drugs that are extremely expensive biologicals, Enbrel and Humira. Patients that require these to live fulfilling lives and in some cases to keep them alive. The PBM will force them to use a specialty pharmacy from the PBM that will mail them a multithousand dollar medication where it could sit at the post office, when it needs to be refrigerated, for several days. Now in 2015, pharmacists say in a community we're filling these medications and all of a sudden they become special in 2016 and we're not able to dispense them. This is also restricting access to crucial medications for our patients. And when I went to pharmacy school, I went to take care of patients, not deal with insurance company red tape and PBMs. Mail-order pharmacy is also another large problem. So to summarize that up, I've had patients where the mail-order pharmacy keeps sending them the same drug and they are not coherent enough to realize that they shouldn't be taking one pill out of each bottle of the same drug. I had a patient that took five times the normal dose just because they weren't coherent enough. They just take one out of every bottle, that's how they do their medication. So that is adversely affecting patients, as well. And another area is abusive audits, which have really hurt our ability to take care of our patients. We in the last three or four months have received over 200-plus prescription audits from Prime Therapeutics and OptumRx. And

earlier in the year we filed a lawsuit against Prime Therapeutics because of some money that they were trying to take back on long-acting psych injections. They were going to take back the cost of the entire drug and also the cost of all the fills after that, so it amounted to be about $20,000. And I see I'm out of time. I would be happy to answer any questions you may have if you have some that Connie has or you already asked Connie. And this bill, I can't say enough, is a step in the right direction. [LB324]

SENATOR LINDSTROM: I think we have a couple of questions for you here. [LB324]

TREVOR BERTSCH: Yes. [LB324]

SENATOR LINDSTROM: Senator Craighead. [LB324]

SENATOR CRAIGHEAD: Thank you, Chairman Lindstrom. What prompted these audits? [LB324]

TREVOR BERTSCH: They're supposed to be random audits. They're supposed to be over all of the prescription claims. However, they tend to only be the high-dollar prescriptions, like insulin, long-acting psych injections, antirejection drugs, drugs for injectables for psoriasis and rheumatoid arthritis, things of that nature, drugs that touch the $500 mark. And they are taking back money based on clerical errors, so the prescription was written for February 15 and you didn't see it and you put February 16. Not only will they take back the cost of the drug that they reimbursed you, but also the dispensing fee and any refills after that. So you fill an Enbrel, which is $1,000 drug, you fill it ten times, they audit you and they take all that back. Do the math, $10,000. And it's not ever the generics, very rarely or they'll sprinkle one in there to make it appear as if it's random. [LB324]

SENATOR CRAIGHEAD: Thank you. [LB324]

SENATOR LINDSTROM: Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. Thank you, Senator Lindstrom. Thank you for your testimony. [LB324]

TREVOR BERTSCH: Thank you. [LB324]

SENATOR McCOLLISTER: When the ACA was passed, it prescribed a certain profit margin to insurance companies that process claims. Isn't that correct? [LB324]

TREVOR BERTSCH: I'm not sure. But to my knowledge, I believe that is correct. [LB324]

SENATOR McCOLLISTER: Is there any such limitation on profit margins for these PBMs? [LB324]

TREVOR BERTSCH: No. And, in fact, there's an issue, it's called spread pricing. How a PBM will reimburse you is they have a list that they will say is proprietary of what each drug that they will pay the pharmacy at and then what they will pay the end payer. So, for instance, the PBM is in the middle. I submit a claim to the PBM, they reimbursement me. And they turn around and bill, say, the federal government who is funding Medicare or funding...or even at a state level, funding...the state is funding the insurance or, say, Nucor, in Norfolk is funding the insurance. There will be two separate prices. They reimburse me at a lower rate and they charge at a higher rate and keep the difference, so they're...almost everything in healthcare is under so much scrutiny, except the PBMs right now. And that's why you Google things, you look in the news, this stuff is all over. It's a huge problem and it has raised the cost to my patients who are paying higher deductibles, higher copays, they are paying higher premiums and they're getting less coverage. [LB324]

SENATOR McCOLLISTER: Will your bill show what those profit margins are? [LB324]

TREVOR BERTSCH: Yes. It would allow me to...I will use Nucor as an example, who's a major employer in our town who we fill a lot of claims for. It will allow me to call up Nucor and say, hey, what is the PBM charging you, because this is what they're reimbursing me and we can see the difference? [LB324]

SENATOR McCOLLISTER: Yeah, thank you for your testimony. Thank you, Mr. Chairman. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions? Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. And thank you for your testimony. Why wouldn't the insurance company, who ultimately has got to pay the PBM so the PBM can pay you, crack down on the PBM and say, listen, you're marking this up way too much? Wouldn't they have...shouldn't they be the economic force that's putting pressure on the PBMs not to overcharge? [LB324]

TREVOR BERTSCH: You would, except they own the PBM. UnitedHealthcare owns OptumRx. So when you hear that they're dropping out of the Affordable Care Exchange because they're losing money on it, look at OptumRx, that's where they're making it. So they are...the insurance companies are often associated and have a financial interest in the PBMs. So that is why you don't see that crackdown from insurance. [LB324]

SENATOR SCHUMACHER: And basically, they're not making money off themselves, is it the government programs that they're bringing the additional revenue in from? [LB324]

TREVOR BERTSCH: Potentially. It affects all the private insurance, state insurance, Medicaid, it's even on a federal level. That's why even Jeff Fortenberry is a sponsor of some bills that are currently going through the House of Representatives and the Senate to fix it on a federal level for Medicare. It's essentially using different ways to increase revenue. [LB324]

SENATOR SCHUMACHER: And the loser, as far as on the insurance provider end of it, is probably some government program. [LB324]

TREVOR BERTSCH: Government, businesses, but ultimately--you know, you throw all that aside--ultimately it is the patient that is being affected and it's being affected adversely. And pharmacies are struggling, patients are struggling, we're paying more than ever for our healthcare and prescription drug costs and the PBMs are making out like gangbusters. [LB324]

SENATOR SCHUMACHER: Now there was some suggestion, in I think response to Senator Williams' questions, that a large chain may be able to negotiate a better deal than the little guys. Does this legislation have anything in it that gives you most favored druggist status--in international the thing is most favored nation status--where you get the best deal that they're offering? [LB324]

TREVOR BERTSCH: This bill--and I will have Joni correct me if I misspeak--but this bill does have an "any willing pharmacy" clause. It will allow any willing pharmacy that wants to contract with a PBM, essentially that the contracts should be relatively uniform across it all. We run into federal antitrust laws as independent pharmacies in order to negotiate these contracts. And you say, well, just don't accept the contract. It's not that simple. As you see, you refuse a contract through one of these PBMs, you may lose 25 percent to 30 percent of your patients. And it's not just one contract through a business, it's OptumRX across the board or Prime Therapeutics across the board. So you drop out of a contract, you're done. Most people have insurance now. [LB324]

SENATOR SCHUMACHER: Now can a pharmacy have a contract with more than one PBM or are you stuck with one? [LB324]

TREVOR BERTSCH: No, you can contract with all of them. [LB324]

SENATOR SCHUMACHER: So why don't you play the market and find out who the nicest guy is? [LB324]

TREVOR BERTSCH: Because we don't select what insurance our patients buy. [LB324]

SENATOR SCHUMACHER: Okay, so you're stuck with the PBM that represents your...the patient's insurance company? [LB324]

TREVOR BERTSCH: Correct. Correct. [LB324]

SENATOR SCHUMACHER: So you may be a member of several PBM operations? [LB324]

TREVOR BERTSCH: Correct. And it's actually illegal for us to try to steer patients toward certain insurance plans. With Medicare or even Medicaid, now that we went managed care, there's three plans to choose from. I can't say, oh, you should go with WellCare or Nebraska Total Care or OptumRX or UnitedHealth (sic: UnitedHealthcare) because they play nicer than the other one. I can't refer patients to certain insurance companies. [LB324]

SENATOR SCHUMACHER: Okay, thank you for your testimony. [LB324]

TREVOR BERTSCH: Yes. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions form the committee? Senator McCollister. [LB324]

SENATOR McCOLLISTER: One more. Yeah. Thank you, Chairman Lindstrom. Would patients see lower drug costs if this bill were to pass? [LB324]

TREVOR BERTSCH: I would hope so. It would allow the PBMs to be under the purview of the Department of Insurance. So patients, pharmacists, providers would have a place to share grievances with the Department of Insurance so that they may provide oversight to look into why

pricing is off or why people are paying too much for medications. It's a step in the right direction. And, quite frankly, I don't see what's wrong with a little transparency. [LB324]

SENATOR McCOLLISTER: Would it enhance competition? [LB324]

TREVOR BERTSCH: Definitely. It definitely would. It would allow people to essentially then fight on an even playing field and provide services and spend less time dealing with red tape. And like Connie said, nobody's going to hold people's hands to help them with their medication therapy and provide compliance packaging and take the 20 phone calls from the same patient every day because they have so many questions. It's...it does adversely affect our ability to take care of our patients. [LB324]

SENATOR McCOLLISTER: Thank you very much. [LB324]

TREVOR BERTSCH: Yep. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions? Seeing none, thank you for your testimony. [LB324]

TREVOR BERTSCH: Yes, thank you. [LB324]

SENATOR LINDSTROM: Next proponent. [LB324]

JONI COVER: Good afternoon, Senator Lindstrom and members of the committee. My name is Joni Cover, J-o-n-i C-o-v-e-r, and I am the CEO of the Nebraska Pharmacists Association and I'm here in support of LB324. I want to thank Senator Kolterman for introducing this bill for us. We've been down this road several times with trying to do some regulation of pharmacy benefit managers. And the purpose for me sitting in this chair right now is to tell you that for 15 years I've worked for the Pharmacists Association and while things change, some things stay the same. And one of the things that stays the same is the issues that we seem to continue to have with healthcare and with pharmacy benefit managers and insurance and you know. We can be grateful that we have insurance, but we also have issues that come along with that. I'm really here to answer questions. Senator Williams, you asked a question about whether we have fewer or more independents. I will get that information to you. This bill isn't really intended to be a small town pharmacy versus a large chain pharmacy issue, because we're lucky that we have some large chains in some of our small communities. But I will tell you, if some of the independents are not in business in some of our small communities there won't be pharmacy services there at all. And I have a pharmacist and one of my members who likes to talk about his best...one of his best

referral sources is the Walgreens across the street, because there are certain things that some of the community pharmacies in the small towns will provide services that the larger chains won't. So you know the hope is that everyone benefits from this. Not only the pharmacy community, but also the patients we serve. So with that, I will stop. And if you have questions. [LB324]

SENATOR LINDSTROM: Senator Baker. [LB324]

SENATOR BAKER: Thank you, Senator Lindstrom. Mrs. Cover, the situation and the conditions dealing with the PBMs have been perceived as untenable by pharmacists for some time. Why 2017? Why wasn't...why hasn't something come up before? [LB324]

JONI COVER: Well, actually, if my memory services me correctly--and I have to think about this because I don't remember what year it was--but we did bring a bill maybe seven, eight years ago to address some of these things. Last year we had a bill before this committee and it didn't move out of committee, partly because it was a short session. Last year's bill dealt with not only the pharmacy side and the PBM side, but we also included the employer's side as well. So this is an ongoing thing. So we've tried and failed. [LB324]

SENATOR BAKER: So what happened seven or eight years ago? [LB324]

JONI COVER: Well, and each time we bring a bill there seems to be some sort of nuance. That bill didn't make it out of committee either. We had an interim study and nothing happened. When we first started this journey, we were really more focused on patient steering away from community pharmacy to mail order and audits. And while those are still two big issues, we just see more and more things that are happening. And there used to be a lot more PBMs. You know, the PBM business, like healthcare, has consolidated so there are fewer of them, so. [LB324]

SENATOR BAKER: Thank you. [LB324]

JONI COVER: You're welcome. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions? Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. And thank you for your testimony. Is this bill a creative work or is it a ditto of things that are in other states? [LB324]

JONI COVER: There's a few things in there that are like other states, but I will tell you that there aren't any other states that have a bill quite like this one. And we've...we know how well it works to take somebody else's language and just try to stick it into Nebraska. It doesn't always work that way. So we've tried to be creative and address the issues in the best way. Did we do it correctly? I don't know. Some states have passed variations of different things in this bill. Some have been successful. Some have tried. Many of them don't have the extent that we do here in this bill, so. So we didn't just cut and paste something from somebody else. [LB324]

SENATOR SCHUMACHER: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions? Senator Williams. [LB324]

SENATOR WILLIAMS: Thank you, Chairman Lindstrom. Thank you, Ms. Cover, for being here. On the clawback provisions that we have talked about a couple of times, do you know of any circumstance where a PBM held a pharmacist's feet to the fire on that and when the pharmacist notified the customer, violated the gag order, so to speak? [LB324]

JONI COVER: I do. I do. I do. [LB324]

SENATOR WILLIAMS: What happened in a circumstance. [LB324]

JONI COVER: And I...honestly, I can't tell you the plan for sure, but I can certainly find that out. I had a pharmacist call me, a small community pharmacist here in Nebraska. They had a patient come in and I think the copay for their...maybe it was a coinsurance issue, but it was quite pricey. And the patient said, you know, I can't afford the meds and I wish there was something else I could do and how much does it cost me if I just pay cash? And the pharmacist said, well, I'm not really supposed to tell you. The patient said, well, tell me. So he did and it was less. So the patient was very upset and called the insurance company and yelled at them. I don't know if they...I don't know who the poor person was on the other end of that call, but anyway after that call was completed the pharmacist got a phone call from somebody in the pharmacy benefit manager program and said, we understand that you've had conversations with your patient. Your contract prohibits you from doing that. If you do that again, we'll kick you out of our network. So I know that that has happened and I will certainly find out more information. I purposely sometimes don't ask the questions about who, because I work with all these companies, too. So I will find out for you and I will get that back to you on that specific example. [LB324]

SENATOR WILLIAMS: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. Thank you, Chairman Lindstrom. When they come in and do an audit, do they actually take inventory of the drugs that you have? [LB324]

JONI COVER: I don't...well, okay, so first I'm not a pharmacist and I don't own a pharmacy so I've never had an audit done and I've never done inventory. So just so you know, I may be not quite accurate. But I think what they do is they look at the records of the pharmacy, not the prescriptions themselves. [LB324]

SENATOR McCOLLISTER: Okay. [LB324]

JONI COVER: Pharmacies are required to do an annual inventory of their drugs every year because they have controlled substances, so they have that inventory. But what they do is they look at the prescriptions that were dispensed and then other...if you get a prior authorization from a physician, they'll have that information as well. So it's the records more than really the inventory of the drugs. [LB324]

SENATOR McCOLLISTER: Does LB324 enhance the ability of someone to come in and buy drugs for cash for less than the insurance company and the PBM and all that? [LB324]

JONI COVER: I won't say that it allows you to buy cheaper. It does allow the patients to ask and the pharmacist be able to tell them without have happening what I just described to Senator Williams, so. I mean, if you're told that you need to have a brand name drug dispensed and if a generic is cheaper, the patient can ask for the generic and the plan will let you tell them then, yes, it could be cheaper. But not in all instances. [LB324]

SENATOR McCOLLISTER: But if a doctor prescribes a specific drug you're not allowed to go to a generic drug, isn't that correct? [LB324]

JONI COVER: Well, that's not completely accurate. If a physician prescribes a brand name drug and they write on the prescription "dispense as written" or "drug medically necessary" then a pharmacist may not substitute that for a generic unless they get permission from the physician. But if there is no connotation on the prescription that says that you have the DAW or whatever, a pharmacist may dispense a generic. [LB324]

SENATOR McCOLLISTER: I see. How often is the cash price for that drug lower than the deductible? [LB324]

JONI COVER: I have no idea. I would have to find out more information about that as well. I don't know. [LB324]

SENATOR McCOLLISTER: Thank you for your testimony. [LB324]

JONI COVER: You're welcome. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing none, thank you very much. [LB324]

JONI COVER: Thank you. [LB324]

SENATOR LINDSTROM: (Exhibit 4, 5) Next proponent. Seeing none, I do have a letter of support from the Nebraska Grocery Industry Association, a letter of support. I also have a support letter from National Community Pharmacists Association. We will now move to opponents of LB324. Opponents. [LB324]

ABIGAIL STODDARD: Good afternoon, Mr. Chair, members of the committee. My name is Abby Stoddard and I am a pharmacist with Prime Therapeutics, the pharmacy benefit manager that we're hearing a lot about today. And... [LB324]

SENATOR LINDSTROM: Could you spell your name for the record? [LB324]

ABIGAIL STODDARD: Oh, I'm sorry. First name, A-b-i-g-a-i-l, last name S-t-o-d-d-a-r-d. We're here to respectfully oppose this bill. This bill, in our view it really does nothing to serve any of your constituents. It only adds waste and cost to a system that can't take any more waste and cost. I want to back up to maybe a 10,000 foot level to just explain, hopefully, very clearly what a pharmacy benefit manager is, what we are not, and what we do. A pharmacy benefit manager, as you've heard from the proponents we have been called middlemen. I would say we are middlemen only in the sense that your health insurer is also a middleman. Without your health insurer, if you went to your physician you would pay whatever cash price for whatever fee, laboratory service your physician wanted. Same thing with pharmacy benefit managers. Without pharmacy benefit managers patients would pay the cash price, whatever cash price that pharmacy set every time they walked into that pharmacy. And what PBMs do, we contract with health insurers, with employer groups, with labor unions, we create high-quality pharmacy networks for them and we drive their drug costs down. I want to be very clear that we are an arm of the labor unions, the employers, the health insurers. We pay claims with their money. We don't keep any money for ourselves. Prime, for example, is owned by not-for-profit Blue Cross of

Nebraska. I pay pharmacy claims with Blue Cross of Nebraska's money. When I save money, it goes back to Blue Cross of Nebraska to drive down premiums. If there's waste in the system, if I'm overpaying, all of that money comes from consumers who use Blue Cross of Nebraska and shows up in higher premiums. It's premiums in, claims out. That's it. I want to talk to Senator Schumacher, your question of what happens when a patient goes to the pharmacy counter with or without insurance. For Prime Therapeutics, if you are a Blue Cross customer and you go to your pharmacy with a Prime Therapeutics card, that pharmacy will bill your drug, they'll subject a claim to Prime as if you were a cash paying customer. So they'll throw whatever charge against the wall that a cash paying customer would pay. We'll accept that claim and say, all right, pharmacy, I know you're submitting us this charge for this drug. Your contracted rate that you signed with Prime Therapeutics, says your reimbursement rate is X. And our reimbursement rate is always lower, 100 percent of the time. You've heard a lot about this term, clawback. I can tell you without a doubt, that is something that Prime has never done. Express Scripts and CVS will also tell you they don't do this. When you asked the proponents to point to a section of the bill that solves that issue they weren't able to point to a section because it's not there. The explanation of show me an example of where this is happening, we have been in conversations with this group for the past month and we have asked for examples so that we can get to the root of the problem. And the only answer that we've ever gotten is the answer you just got today. It was an anecdote with very few details. With Prime and with all the PBMs in this room you are always better off using your insurance than paying cash, always, because when you pay cash what you end up paying, as the proponents say, is the cost of the drug plus a markup of whatever a fair amount for the pharmacy is. That statement right there from the proponent is exactly why we have PBMs, because I can tell you from looking at my claims we have pharmacies in the system that think $42 is a fair price to pay for a box of alcohol swabs. And that's...one, I don't want to go into if that's fair or not, but it is waste and cost in the system that needs to be rooted out. And that's why people hire PBMs; that's exactly what we do. In terms of, again, who we are in the state of Nebraska in terms of transparency--I can't be more transparent than this--I am already a TPA registered with the Department of Insurance. I think the proponents truly just don't understand our industry and who we are. We have been registered for several years. We're already registered. There's nothing more to gain or lose in that whole first four pages of the bill that says we need to be registered as TPAs. I would also...we'll have other proponents (sic: opponents) here to talk about the different waste components of this bill. Every paragraph of this bill is waste to consumers that increases premiums, increases copays. So I see I am red. With that, I'll be concise and be available for questions. [LB324]

SENATOR LINDSTROM: Thank you very much. Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. Thank you for your testimony. So how do you make your money? Who pays for you guys to do what you do if you don't...it would also look like a pass through the way you described it, so how do you get paid? [LB324]

ABIGAIL STODDARD: Mr. Chair, Senator Schumacher, I guess I would ask the question of, I don't think that we always make money. Prime is owned by 13 different not-for-profit Blue Cross Blue Shield plans and more often than not...we're a private company, so I can't exactly share details. But more often than not, if we lose money our health plans are propping us up. And I think that's what you're seeing with drug costs. So I would say we don't necessarily make money, but we save money for our health plans. And when we don't save enough that board of 13 not-for-profit Blue Cross plans props us up at the end of the year. [LB324]

SENATOR SCHUMACHER: So they basically...the insurance companies basically subsidize the fact that you don't have a source of income. [LB324]

ABIGAIL STODDARD: Mr. Chair, I would say that's correct. And I think to the larger point of it is still cheaper for the insurance companies to use us than to allow their members to go out and pay cash. [LB324]

SENATOR SCHUMACHER: So you are basically a paid agent of the insurance companies? [LB324]

ABIGAIL STODDARD: I don't...Mr. Chair, I don't know if I understand your term of paid agent, but we are owned by them. [LB324]

SENATOR SCHUMACHER: You don't have any other source of income. They give you money and make up your operating costs and you do a service for them. [LB324]

ABIGAIL STODDARD: Absolutely. So we collect...they collect a premium dollar. They allocate a certain amount of that premium dollar to pharmacy services to us. [LB324]

SENATOR SCHUMACHER: And then you act as a vehicle by which they pay the pharmacies who ultimately provide the drug to the...okay, thank you. [LB324]

ABIGAIL STODDARD: Yes, Mr. Chair. I guess that is the Prime Therapeutics example. The other PBMs at the table, they do the same thing. They collect premium dollars, a certain portion of that is allocated to pharmacy services. But they will, for instance, charge a health plan an administrative fee to do that benefit...to do those benefits and that's where some of their margins come from. But I don't necessarily charge a fee to my own plans because they own me, so it's just taking money out of your left pocket and putting it in your right. [LB324]

SENATOR SCHUMACHER: Okay, thank you. [LB324]

SENATOR LINDSTROM: Senator Baker. [LB324]

SENATOR BAKER: Thank you, Chairman Lindstrom. Ms. Stoddard, help me understand exactly how LB324 would hurt PBMs. [LB324]

ABIGAIL STODDARD: Mr. Chair, Senator Baker, thank you. I think it's not necessarily a question of hurting PBMs, because like I've said, we're entirely pass through. It's a question of hurting your consumers and your constituents. Section 6, in particular, I would point to. I think my other proponents (sic: opponents) may speak to it as well, so I'll be brief. Section 6 is the portion of the bill that allows any willing pharmacy provider into our network. It also says that...so the opening of that section is, anybody that wants to sign a contract with us gets to sign a contract. It then goes further down into section (6) of section 6 and says, we can't demand any further accreditation of those providers. This basically says that anybody with a pharmacy license and a pulse gets to be in our network. And for us, for our members, that's a very costly and scary prospect. I think you'll hear from my health plan later about the fraud...the dangerous fraud issues that we have seen, even in this state. So it's a huge cost driver, because if everyone has to be in our network, pharmacies don't have to compete on price or quality. So it drives up costs and it also lowers the overall quality of our network. [LB324]

SENATOR BAKER: May I? [LB324]

SENATOR LINDSTROM: Sure. [LB324]

SENATOR BAKER: Help me understand, too, why it's a bad practice for someone to ask a pharmacist what the cash price would be and not be able to answer. [LB324]

ABIGAIL STODDARD: Mr. Chair, Senator Baker, I don't have an answer for that, because that's not something that we do. And we have, again, told the proponents to give us an example of someone who is doing this to show us to see again how we can solve it or how this bill solves it and it doesn't. Our contracts are very clear that a pharmacist can speak to the patient about their most cost-effective options with insurance. Without insurance you're on this brand, the generic might be better. You're on this generic, it's not working, maybe we'll try this other option over the counter, another brand. Our contracts don't do that at all. It's not a good practice. We don't do it. So I don't think I have an answer. [LB324]

SENATOR BAKER: So if we hear testimony that this occurs at some other PBM and not yours, is that what you're saying? [LB324]

ABIGAIL STODDARD: That is...Mr. Chair, that is what the proponents have told us, but the only examples that we have ever been shown of where this is happening is national news stories, links on the Internet of where this is occurring, so I don't know that I have a good answer for you. [LB324]

SENATOR BAKER: Okay, thank you. [LB324]

SENATOR LINDSTROM: Thank you. Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. Thank you, Chairman Lindstrom. And thank you for your testimony. What body actually negotiates with the drug company, PBMs or the insurance companies? [LB324]

ABIGAIL STODDARD: Mr. Chair, Senator McCollister, for our clients it can be a combination. But, typically, we do it on their behalf. And perhaps I can illustrate with a quick example. So...and this is...we don't set the price of drugs. We make drug companies compete for the best price. If we're looking at a category of drugs like high blood pressure drugs, it's really akin to you going out and trying to buy a car. If you want to buy a car you've got dozens of dealers, hundreds of cars on the lot. If we're looking at drugs for high blood pressure I have hundreds of drugs available, solutions, tabs, patches, injections, anything. And in that situation, I have a panel of physicians that I go to and say, okay, what drugs do my members need for high blood pressure? They give me characteristics of ten drugs that I need. I go out to those hundreds of manufacturers and say, okay, I only need ten of you. It's going to be the ten that give my employers and my health plans the best combination of price and quality. Similar to if you're buying a car you only need one car and you have hundreds of cars to choose from. And in that situation you get the price down and you can get a good deal. [LB324]

SENATOR McCOLLISTER: So price is a major consideration as you go through that process, correct? [LB324]

ABIGAIL STODDARD: Mr. Chair, to back up, when I say the...I have to go to my panel of physicians first, all of those decisions are first made by a panel of physicians and pharmacists that evaluate the drugs clinically. Only after they've evaluated them clinically can I go for a better price. My clinical panel is not allowed to consider price in any way. [LB324]

SENATOR McCOLLISTER: One of the previous testifiers indicated that oftentimes patients are forced to use brand name drugs rather than generic drugs, much to their disadvantage. Is that correct? [LB324]

ABIGAIL STODDARD: Mr. Chair, Senator McCollister, again, I...to my knowledge, Prime does not do that. And, again, I don't know if we have an example of that. In general, it is possible that that occurs because when a generic drug is first released onto the market its price is often about 80 percent of the brand. So in that situation, PBMs can leverage a really good negotiation and say, okay, brand name drug, your cost is $100. There's a generic available, but only one person makes it and even though it's generic it's list price right now is $80. So in certain instances that brand name drug will negotiate a price that is cheaper than the generic and in those cases it's possible to continue cover of the brand. The number one payer I think that I've seen done that is actually state Medicaid programs, because they get very aggressive brand discounts. So I would actually suggest members of the committee look into their state Medicaid programs, because in the states I work in the most common payer is Medicaid. [LB324]

SENATOR McCOLLISTER: So a patient then pays something closer to the generic price or are they a brand name price? [LB324]

ABIGAIL STODDARD: Mr. Chair, that is up to the health plan. For our plans, whenever they have done that, I have only seen...I've seen them take the brand and move that copay to the generic price so that the member isn't out. In your Medicaid program, I'm not sure, but. [LB324]

SENATOR McCOLLISTER: Thank you. [LB324]

SENATOR LINDSTROM: Senator Williams. [LB324]

SENATOR WILLIAMS: Thank you, Chairman Lindstrom. And thank you, Ms. Stoddard, for being here. I'm going to try to make some sense out of some things that we've heard today. And I would appreciate your help in clarifying some things for me. Let's first of all start on the clawback issue. And you said that's something that your company, Prime Therapeutics, does not engage in. [LB324]

ABIGAIL STODDARD: Correct. [LB324]

SENATOR WILLIAMS: Can you tell me about your contract then that you have with the pharmacies? Is there anything in your contract that could be described as a gag order or something like that that stops the pharmacist from fully talking about anything and everything that they would want to talk to providing patient care to one of their clients? [LB324]

ABIGAIL STODDARD: Mr. Chairman, the simple answer to that question is, no. We have no gag clauses in our contract. [LB324]

SENATOR WILLIAMS: Okay. [LB324]

ABIGAIL STODDARD: I think the only thing you may find is pharmacies, like any in street, they are not allowed to discuss prices pharmacy to pharmacy; that is more commonly known as collusion. They're not allowed to discuss with each other what prices they're paying, but our pharmacies can tell a patient whatever their most cost effective options are. [LB324]

SENATOR WILLIAMS: Okay. And they're not allowed or then your company does not engage in, even if they can talk about it, a situation of what has been described as the clawback? [LB324]

ABIGAIL STODDARD: Mr. Chair, no. Absolutely not. [LB324]

SENATOR WILLIAMS: Let's go then to the mail-order issue that was discussed about different companies and how that works. Does Prime Therapeutics engage in a situation where a pharmacy might be as it was described, prescribe for several months in a row a certain medication and then all of a sudden your card carrier is denied being able to do it that way and is pushed towards mail order from you, and can you describe that circumstance? [LB324]

ABIGAIL STODDARD: Sure. Mr. Chair, Senator Williams, Prime Therapeutics, we do offer employer groups benefits as you have described, but I think with a couple major details missing from our proponents. We do have benefits where, for example, a member when they need their drug can fill it two to three times at any given pharmacy they choose. Each time they fill that medication they receive a letter from our health plans that say, dear member, we've noticed you filled this drug. Here are your next options for filling this drug. The members are absolutely notified of this benefit. Moreover, the employer groups who choose this benefit absolutely...I wouldn't even say they're notified of this benefit, they have selected it, because for chronic medications that type of benefit saves our employers and our health plans money because we have certain pharmacies that are able to buy chronic medications with huge volume discounts. I would only add to your scenario that for Prime the chronic medications can be filled at my mail-order pharmacy, but they can also be filled at dozens of brick and mortar pharmacies across the state, Walgreens being the most present chain. So it's not that it's two fills and then you have to only go to me it's, it's two fills and then you have to go to a pharmacy that gives the employer group the best discount on that drug. And sometimes that's another brick and mortar pharmacy, sometimes it's a mail-order pharmacy, but you are not locked in only to my pharmacy, for example. [LB324]

SENATOR WILLIAMS: I don't have a Walgreens in my legislative district. You also talked about the bill opens up to where you would have to contract with everyone and you made the

comment that that would restrict people from competing on cost. Can you explain that statement to me? [LB324]

ABIGAIL STODDARD: Certainly, Mr. Chair. Pharmacy services are really like any other service that one might procure. If you're a restaurant owner and you're trying to find a pickle supplier, you're going to get the best price on pickles if you go exclusive with a wholesaler or if you tell the wholesaler that you're buying from that you're one of two wholesalers that you're working with. When we can guarantee pharmacies volume of patients that's when they give us the best discount. So right now our networks are set up with deep discounts. But the pharmacies we give those discounts to have the expectation from Prime that we are at least semiexclusive with them. When we have to open up our networks there is no incentive for the chain drugstores to give us any future discount, because when we sign pharmacy contracts as low...every time the rate goes lower they are expecting more volume of patients from us. So if we had to tell a pharmacy, hey, we expect this really deep discount, but I have to give it to everybody else in this network and anyone who wants to be in this network I have to let them in, if you're that provider, what incentive do you have to lower your price to me? [LB324]

SENATOR WILLIAMS: I'm missing something. The testimony earlier from the independent pharmacist was that they would be...because it's the cardholder that comes to them, they would in essence be contracted with multiple PBMs. [LB324]

ABIGAIL STODDARD: Yes. [LB324]

SENATOR WILLIAMS: Did I just read into what you say, that Prime might have a pharmacy outlet that would be exclusively for Prime, for Prime cardholders? [LB324]

ABIGAIL STODDARD: Mr. Chair, I think we may have confused something. The only pharmacy outlet that's exclusive for Prime holders is Prime Mail. People are not forced to use the Prime mail-order pharmacy, but that's the only members that my mail-order pharmacy serves. [LB324]

SENATOR WILLIAMS: Okay. [LB324]

ABIGAIL STODDARD: Any other pharmacy can serve patients from... [LB324]

SENATOR WILLIAMS: Okay. We'll move on. But by that I'm confused about how your deal is better. You made the comment in your testimony that you do not know of any cases where the--if

I understood you right--where the cash cost from the pharmacy would be less than that negotiated with Prime. Is that...did I understand that correctly? [LB324]

ABIGAIL STODDARD: Mr. Chair, yes. [LB324]

SENATOR WILLIAMS: Would you restate what you... [LB324]

ABIGAIL STODDARD: I think--and maybe I'm reading into your question--it's not the ingredient cost of the drug. The ingredient cost of the drug is often lower than our reimbursement and that's how pharmacies make money. The cash paying cost of the drug is the ingredient cost plus whatever markup the pharmacy thinks is fair. And our members are always better using their insurance because that markup...I don't know of any situation where that markup is less than what they'll pay for us. So...and maybe to give an example, if you're a cash paying customer and you walk in with no insurance card, the usual and customary markup on that drug might be $10. If you have benefits with Prime and the usual and customary markup is $10, our contracted rate will be $8. It will always be less. [LB324]

SENATOR WILLIAMS: But you're not including in that the cost of the drug? [LB324]

ABIGAIL STODDARD: Mr. Chair, I don't want to get too into the weeds here. The cost of the drug...if the usual and customary is $10, the cost of that drug may be $1. The usual and customary charge to a cash paying patient is the cost of the drug plus a margin markup. So if a cash paying customer pays $10, the cost of the drug might be $1, Prime's reimbursement might be $8. So the pharmacy is still making money, it's just a matter of how much. [LB324]

SENATOR WILLIAMS: We'll leave it there. Thank you. [LB324]

ABIGAIL STODDARD: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Senator Craighead. [LB324]

SENATOR CRAIGHEAD: Thank you, Mr. Chairman. And thank you, Ms. Stoddard, for being here today. I'm a little bit confused. I've heard testimony that, yes, there are gag orders and, no, there are not gag orders, so can you help me out? [LB324]

ABIGAIL STODDARD: Mr. Chair, I think the confusion comes from the proponents are telling you there are gag orders in the marketplace. I can only speak to what I know about our contracts

and what I know from working with these folks from CVS and Express Scripts that our contracts do not have that. So are there people in this room who have contracts with gag orders? No. Are there people in the nationwide marketplace? I can't answer that, we don't have those contracts. [LB324]

SENATOR CRAIGHEAD: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Senator Lindstrom. Is Prime Nebraska based or is that a larger base? Where do you office out of? [LB324]

ABIGAIL STODDARD: Mr. Chair, I office out of Minneapolis. That's where Prime Therapeutics is headquartered, but we serve and are owned by Blue Cross of Nebraska, which is Nebraska exclusive; they aren't owned by anybody else. [LB324]

SENATOR SCHUMACHER: Right, but the Prime, the PBM actually is located in Minneapolis and serves many of Nebraska Blue Cross type things. [LB324]

ABIGAIL STODDARD: Well, Mr. Chair, I guess to expand on your question, I'm officed out of Minneapolis, but we do have several hundred employees in Omaha that work for Prime as well. So we are not only in Minneapolis, we are also...we do have physical facilities based in Nebraska and we are owned by Blue Cross of Nebraska, which is only owned in Nebraska. [LB324]

SENATOR SCHUMACHER: And your relationships with not only the pharmacies, but with your clients like Blue Cross, are all established in contract? I mean, you've got the contracts? [LB324]

ABIGAIL STODDARD: Mr. Chair, correct. [LB324]

SENATOR SCHUMACHER: Okay. Are those contracts...can...I take it they're basically almost a form-like contract, at least for the basic provisions even though the compensation or rates may vary. [LB324]

ABIGAIL STODDARD: Mr. Chair, Senator Schumacher, the way I like to say it actually is if you have seen one PBM contract you've seen one PBM contract. We are owned by 13 different Blue Cross companies. None of those contracts look the same. Our health insurers and our

employers are very sophisticated purchasers of healthcare and what might be important to one health plan is not important to another health plan, so there is huge amounts of flexibility and variability. [LB324]

SENATOR SCHUMACHER: What about what the individual pharmacies, are those a form contract with fill-in-the-blanks for price and percentages of things, but is in substance a form contract, boilerplate? [LB324]

ABIGAIL STODDARD: I...Mr. Chair, I would say likely not. There are many pharmacies that through their purchasing group signed the same contract with us, but I would still say there's a lot of variability pharmacy to pharmacy, especially when you think of types of pharmacies. Mail order, long-term care, community, specialty, those are all different. But there are many pharmacies that sign the same contract with us because they're in the same group. [LB324]

SENATOR SCHUMACHER: But the folks that talked to us from the pharmacy industry before, I'm sure that they didn't sit down with an attorney and your attorney and negotiate some contract. There was a basic form with some minor modifications, just like when you buy a house or real estate contract and the blanks may change but the basic form and the substance of the contract is the same. Is that fair? I mean, you certainly don't go to each little pharmacy and negotiate a deal. [LB324]

ABIGAIL STODDARD: Mr. Chair, I would say maybe as a 10,000 foot level there are a lot of similar pieces. But what I would also like to remind the committee of is that, as the proponents said, they actually delegate their authority to sign these contracts to a buying group. So I don't know...you may hear from your local pharmacies, this contract isn't right, this isn't what I signed. I think the important thing to remember is that a lot of times they delegate that authority to a buying group and we have no idea the communications that go back and forth between pharmacies and their buying groups. [LB324]

SENATOR SCHUMACHER: So you're saying there's still another party that's involved here. You have the pharmacy, they somehow get involved with a buying group and that buying group that they're a member of somehow then gets involved with you... [LB324]

ABIGAIL STODDARD: Correct. [LB324]

SENATOR SCHUMACHER: ...so that the...they may never see the contract their buying group enters into with you? [LB324]

ABIGAIL STODDARD: Mr. Chair, I agree with you on the level of complexity. I can't understand the pharmacy that would sign...that would delegate their authority to a buying group and not demand to see that contract and not demand to know that what they're doing is in their best interest. But nine times out of ten when we hear...when we investigate complaints from pharmacies it's because they have delegated the authority to sign these contracts to a buying group and they may or may not have followed up with the buying group to see the contract that they signed on their behalf. [LB324]

SENATOR SCHUMACHER: Are the folks that testified today free to give the committee a copy of their contract should they choose to? [LB324]

ABIGAIL STODDARD: Mr. Chair, I would not think so, no. [LB324]

SENATOR SCHUMACHER: You would not think so. [LB324]

ABIGAIL STODDARD: I don't believe we can share our contracts with members of the public, no. [LB324]

SENATOR SCHUMACHER: Can they share their contract with this committee? [LB324]

ABIGAIL STODDARD: No. Mr. Chair, no. [LB324]

SENATOR SCHUMACHER: And that's not a gag order? [LB324]

ABIGAIL STODDARD: Mr. Chair, I don't think so, because you're not a party to that contract in any way. [LB324]

SENATOR SCHUMACHER: If I've got a contract to buy a car or a contract to buy a house, I can run a picture of it in the newspaper. There's no...unless there's a confidentiality clause or some law that says it's confidential, why can't I put it on the Internet? [LB324]

ABIGAIL STODDARD: Mr. Chair, I would say, there are confidentiality clauses with our pricing for the same reason that if you're Target you can't publish your vendor contracts that you pay from your suppliers. By making that... [LB324]

SENATOR SCHUMACHER: Not unless there's a...if there's a gag order in it I can't, but if there's no gag order I can publish it to anybody I want to publish it to. [LB324]

ABIGAIL STODDARD: Mr. Chair, I think we're confusing an issue of the gag order when it's speaking to patients about their drug costs and a gag order when it comes down to pharmacies sharing their reimbursement rates with the public. Our contracts state that a pharmacist can speak to a patient freely about the cost of their therapy options. They do not say that they can publish the rate that they get paid from Prime Therapeutics, because when you publish those rates that leads to tacit collusion among members of the industry and so that is federally prohibited. [LB324]

SENATOR SCHUMACHER: There's been several references now to antitrust law as if somehow there's some protections coming out of there. But I'm hearing a lot of violations or potential violations of antitrust law all over the place here, particularly when you tell a committee with jurisdiction that they cannot get the facts that they need in order to make a determination on a bill such as this because it's all confidential. And the confidentiality insisting is coming from you, as I gather it, not the other party to the contract. And yet you tell us there's no confidentiality phrases in these contracts. [LB324]

ABIGAIL STODDARD: Mr. Chair, as I have stated, there is no gag order in our contracts that prohibit a pharmacist from discussing with their patient how much their drugs cost. [LB324]

SENATOR SCHUMACHER: But there is a gag order that prevents them from talking to this committee about what's in those contracts. [LB324]

ABIGAIL STODDARD: Mr. Chair, those contracts are not public. [LB324]

SENATOR SCHUMACHER: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing none, thank you very much. Next opponent. Afternoon. [LB324]

MICHAEL HARROLD: (Exhibit 6) Good afternoon, Mr. Chairman, members of the committee. My name is Michael Harrold, that's M-i-c-h-a-e-l H-a-r-r-o-l-d, I am with Express Scripts, pharmacy benefits manager out of St. Louis, Missouri. We represent employers, health plans, unions, the Department of Defense is one of our clients, so we have a broad array of clients. We are an independent pharmacy benefit manager in the sense that we are not owned by a healthcare company. We are not...we don't have a retail pharmacy that we are in conjunction with, and the marketplace actually has varying, differing types of models. So you have some where you have a PBM that is owned by a health plan. You have a PBM that is aligned with a retail pharmacy. You have a independent PBM like we have. You have Prime Therapeutics, which is with just Blues'

plans. So there's differentiation out there in the marketplace. We all sort of have our different niches I think that we try to use to compete. I am here in opposition to this bill. A number of...this bill both gets into very specific issues, a number of which you've heard about like clawbacks and other things, and then it gets into some larger philosophical types of issues, which go around everything from the transparency to disclosures to the relationships and the contracts between a pharmacy benefit manager and a client and the pharmacy benefit manager and the pharmacist, etcetera. A lot of these issues were looked at and studied intently when Medicare Part D was created, because a lot of the same types of concerns were raised about what's really going to be good for the consumer, what are the cost impacts going to be, what are the roles of PBMs? So if you went back circa whatever year that was when Part D started doing these things, there were requests of the Congressional Budget Office of a number of other what you could I think consider to be probably the most impartial, the Department of Justice, others, that looked into these issues. And what they essentially said is that PBMs did a very valuable job and that we were able to lower costs for plan sponsors and for consumers. We did that by having a certain amount of mass and size that did allow us to negotiate with pharmacies, as well as drug manufacturers, and to use that leverage to try to squeeze margins. And that's what we did. So any time you squeeze someone's margins then they're not always going to be the most happy with you. So we tend to have issues with both drug manufacturers who don't like what we do and we have issues with pharmacists who don't like what we do. But it's in a very competitive field in the PBM realm and it's also a very competitive field in the pharmacy realm, as it is in the drug manufacturer realm. Some of the specific issues that have been mentioned, something like a clawback, Senator Baker, I believe you said you had read the article this morning. I think that's probably an article that starts off with a Pennsylvania pharmacist. It's been in a number of...it's been syndicated. My company is mentioned in that article. We don't do clawbacks and it points out that we even go to the extent that we have on our Website, why we don't do it. So I did want to point that out in that it's not something that everybody does. What we do is that we want to be sure that...we believe that a member ought to pay the lowest cost available to them when they go to the pharmacy counter. That could be, hopefully, it's the negotiated rate that we have, but it could be the copay. If it's a $2,000 drug, the copay is probably a lot less. It could be the pharmacist's usual and customary that they submit. Whatever the case may be, we want to structure it so that the individual pays the least that they would pay when they leave the pharmacy counter and we want to be sure that they pay for it underneath their benefit, because we have records where we do drug utilization review and other types of analysis for safety purposes every time they come up to a pharmacy. So those are very important to us, that they pay the lower cost, but that they also stay within the system and that they use the benefit. If I could just give one...and I just want to make the clear point that what we do, we do because our clients have us do it. We have contracts that we negotiate with them, that they negotiate with us, that we compete for. And there's a number of things that have been talked about that we couldn't do if it wasn't part of the contract. I couldn't do mandatory mail unless a client chose that. There's different things that clients might choose to do and those are the way that these contracts

generally are structured. I see that's I'm at yellow. I'm sure there's some questions, I'd love to field some. I will leave it at that before I get red. [LB324]

SENATOR LINDSTROM: You have until red, unless you want to stop now. That's fine. Any questions from the committee? Senator Baker. [LB324]

SENATOR BAKER: Thank you, Chairman Lindstrom. Mr. Harrold, have you read through our LB324? [LB324]

MICHAEL HARROLD: I have and it's rather marked up. [LB324]

SENATOR BAKER: All right. So point to me specifically things in here that would hurt you and tell me why. [LB324]

MICHAEL HARROLD: Well, I'll start with the...I mean, there's been discussion about mail order. So you can go to section...it will be on page 6 where it talks about "any willing pharmacy" and there not being any willing specialty pharmacies; excuse me, it's page 5. What page 6 includes is that there can't be any accreditation standards. The way that I would say that is that we have...let's talk about specialty pharmacy. It is the most expensive element of the prescription benefit these days, because they are these new brand, name, wow drugs that have come to market. They're truly miraculous drugs, but they're incredibly expensive and they're also very complicated in many ways. I mean, they can be living organisms and it's very different, in some cases, than just if you're taking an oral solid. But we have invested and competed to be best positioned to manage that expensive drug, meaning that we've been able to go to our clients and say, here's data that shows that I can get a better cost for that expensive drug. Not only can I get a better cost for that expensive drug, I have data that can show you that the adherence rates when my specialty pharmacy is being used is 5 percent to 7 percent to 10 percent higher. Adherence rate is huge as far as the outcome, being healthy, for a particular patient. I've gone further, my company has. We have what's called therapeutic resource centers. These are groups that are clustered around individual classes of disease. It could be neurology, it could be oncology, it could be rheumatoid arthritis or inflammatory diseases. These are pharmacists that do nothing all day but talk to people on the phone about that particular condition, so they get hundreds and hundreds and hundreds of people that they talk to. They have the muscle memory of what types of experiences do these people have when they... [LB324]

SENATOR BAKER: If I may interrupt, what in here takes that away from you? [LB324]

MICHAEL HARROLD: It basically says that a client cannot choose to make me exclusive and that we cannot exclude a Nebraska pharmacy from a specialty pharmacy network... [LB324]

SENATOR BAKER: Where...what are you on? [LB324]

MICHAEL HARROLD: ...at the bottom of page 5. As long as the pharmacy is willing to accept the terms of the agreement. [LB324]

SENATOR BAKER: Go through that one more time for me here. [LB324]

MICHAEL HARROLD: Okay. The pharmacy benefit manager shall not exclude a Nebraska pharmacy from participation in specialty pharmacy network as long as the pharmacy is willing to accept the terms of the pharmacy benefit manager's agreement with its specialty pharmacies. [LB324]

SENATOR BAKER: And that hurts you because? [LB324]

MICHAEL HARROLD: It actually hurts the client I think, because what we...what I was trying to explain is that we have come up with a higher model of care that has more expertise in a particular disease state for a particular member that's going to be having that drug. And that as well as a retail pharmacist may be, that they may have two patients a month that come in on a particular drug to treat a particular condition, whereas the pharmacists that we have in our designated resource centers are doing it all day every day. And you can couple that, Senator, with--when you go to the next page, page 6--that says the pharmacy benefit manager shall not mandate accreditation for a contracted pharmacy as a prerequisite to either, one, mailing a prescription drug or being reimbursed for it or participating in a network or plan. So when you sort of put those two together you're saying that, okay, well, maybe they can meet the terms and conditions, but maybe my terms and conditions is that you actually--and not mine as much as it's what the plan is going to want, that standard--to have that higher level of care that you're able to provide. Maybe I want a specialty pharmacist available 24/7, because I'm paying for the healthcare and I know that it's going to again increase it here and it's lower cost, have a better health outcome. [LB324]

SENATOR BAKER: Thank you. [LB324]

SENATOR LINDSTROM: Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. Thank you, Chairman Lindstrom. I don't want to go too far afield, but if this PBM model is so great how come drug prices are the fastest growing component of healthcare in this country? [LB324]

MICHAEL HARROLD: I'm not sure that they are, first of all. What we are seeing is that there are certain drugs where the cost is incredibly high. And it's because there's new amazing drugs that are coming to market or there are some examples where the system has been manipulated by the Martin Shkrelis that you're probably familiar with, but let me give you an example of what we can do and how a scenario can play out. Hepatitis C, a drug came out...miracle drug, I believe it was in 2014. And it was a drug called SOVALDI and it had an upper of 95 percent cure rate; a miracle drug. Only drug on the market. There was no competition. So they brought the drug to market, Gilead, at $84,000. They'd actually bought it from another drug company that had developed it and then finished developing it. They were going to market for about $35,000. They brought it out for $84,000. The way that most formularies work is that if a drug comes that is that much advanced from what's out there, our P and T committees, pharmacy and therapeutic, usually say you have to cover that drug. It's a breakthrough. You had a lot of states that actually had a supplemental budget where they had to add $20 million, $30 million, $40 million because all of a sudden this drug was out there. Well, a competitor came along and they were about to get their drug approved by the FDA. But it wasn't as simple as SOVALDI, SOVALDI was a pill you took once a day for 12 weeks. The competitor, which was AbbVie and they had something called VIEKIRA PAK, for that you had to take three or four pills of one type and then a fifth pill of a different type, so it made it a lot more difficult. If you have to take just one pill, then there's probably a greater likelihood that you're going to take that one pill than if you have to do additional pills. So that gave a lot of people in the marketplace some hesitancy. What we did is that we negotiated with them to get a vastly reduced price for that drug for our members. There's 85 million people that we cover, but that actually use our formulary it's about 25 million. But what we had to do was that we had to convince our clients, how do we best attack and approach this problem to save money? And so what we had to do is that we had to give guarantees that there would be certain adherence rates for those people that were going to take the more complicated regimen. And it did work. So the day that we announced that agreement, then the market just collapsed. The price of that drug, of getting a hepatitis C cure essentially was cut in half, and then everybody else jumped in and cut their different deals. You know, they went to one or the other. So that's just one example of high drug prices. I can't...we can't control the marketplace when there's no competition. But when we can use competition, then it's exceedingly helpful to do so. [LB324]

SENATOR McCOLLISTER: Competition does work, doesn't it? [LB324]

MICHAEL HARROLD: Yes, it certainly does. [LB324]

SENATOR McCollister: Thank you very much. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Senator Williams. [LB324]

SENATOR WILLIAMS: Thank you, Chairman Lindstrom. And thank you, Mr. Harrold for being here. At the beginning of your testimony you talked about the awkward position that a PBM is in where you may not have very many friends, where the pharmacists don't like what you do, the drug companies don't like what you do. What I'm missing in that is...I want to read a sentence from one of the opponents or, excuse me, proponent letters that we received that says: Passage of this bill would allow independent pharmacists to compete with national chain drugstores. Why don't...do you have an idea of why we don't have any of the national chain drugstores testifying in opposition or in support of this bill? [LB324]

MICHAEL HARROLD: I believe you'll have one testify in opposition, CVS, following me. [LB324]

SENATOR WILLIAMS: Okay. [LB324]

MICHAEL HARROLD: And there is... [LB324]

SENATOR WILLIAMS: But they own a PBM, right? [LB324]

MICHAEL HARROLD: They do. They do. [LB324]

SENATOR WILLIAMS: Yeah. Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing none, thank you very much for testifying. Next opponent? Good afternoon. [LB324]

EMILY McGANN: Good afternoon, committee members. My name is Emily McGann, E-m-i-l-y M-c-G-a-n-n, I work for CVS Health on the state government affairs team. As has been mentioned several times, we have a little bit of a unique business model in that we have a PBM division, which is known as Caremark. We also have retail pharmacies and have had great expansion in Nebraska in the past several years. We are just shy of 30 stores around the state. And we also do mail order, specialty, long-term care, and have miniclinics inside our stores that are staffed by nurse practitioners. Specific to LB324, as my PBM colleagues have mentioned

there are a variety of concerns that we have. One thing that I think on the pharmacy piece that's worth mentioning is when we're talking about networks and the any willing pharmacy provision, I think it's very important to remember that PBMs have requirements of having pharmacies in our networks that meet certain location requirements for the federal government. So in rural states like Nebraska, it's incredibly important that we network with the independent pharmacies in rural communities because they're integral to us meeting our requirements. And as a result of that, the reimbursement rate can actually be far higher because independents have better leveraging power, being the only show in town. And maybe to the point a little bit of why CVS pharmacies aren't more involved on this bill and this is more of a Caremark issue is that we see independent pharmacies as a piece of the puzzle. I mean, we need them and they need us and we're all working together to provide care for patients. I don't have too many additional comments that my colleagues didn't cover. I do think that the cost component is something that should be considered. As we know, fighting the rising cost of healthcare is something that's on top of mind for all parties these days. I would echo, just so you hear it from me, CVS Caremark does not participate in clawbacks and we do not have gag clauses in our contracts, but other than that I would stand for questions. [LB324]

SENATOR LINDSTROM: Thank you. Questions from the committee? Senator Williams. [LB324]

SENATOR WILLIAMS: Thank you, Chairman Lindstrom. And thank you, Ms. McGann, for being here. Since you brought up the issue of the rural areas and the mileage requirement, can you go into a little more detail of that of what the distances are and how that all works? [LB324]

EMILY McGANN: You know, I don't have the details on that and I can get that to you, but it's CMS requirements that we're mandated to. [LB324]

SENATOR WILLIAMS: Okay. I think those are important parts of this decision for those of us that are from rural areas that deal with those independent pharmacies that have distance related to them, but also deal with rural independent pharmacies that compete head to head with Walmart and others. [LB324]

EMILY McGANN: Sure. Sure. [LB324]

SENATOR WILLIAMS: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Other questions from the committee? Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. Does CVS have any operations in Europe or any single-payer universal coverage countries? [LB324]

EMILY McGANN: No, we do not. We operate pharmacies in the United States and in Brazil. We have a small chain in Brazil, but, no. [LB324]

SENATOR SCHUMACHER: Okay. Thank you. [LB324]

SENATOR LINDSTROM: Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. Thank you, Chairman Lindstrom. Thank you for your testimony. How about any retail stores in Canada? [LB324]

EMILY McGANN: We do not. [LB324]

SENATOR McCOLLISTER: Do not? [LB324]

EMILY McGANN: We do not. We do have some in Puerto Rico. [LB324]

SENATOR McCOLLISTER: Can you obtain drugs cheaper from that country than you can this country? [LB324]

EMILY McGANN: You know, I really don't have expertise on that. There have been some news articles as of late about drug importation. And I think that that's a top-of-mind topic. I'm not sure that it would directly impact anything that's in this legislation. [LB324]

SENATOR McCOLLISTER: Thank you. [LB324]

SENATOR LINDSTROM: Senator Brewer. [LB324]

SENATOR BREWER: Thank you, Mr. Chairman. This is kind of following with Senator Williams' question, as far as western Nebraska--I don't have North Platte or Scottsbluff, but if you get just the other side of Broken Bow all the way to Wyoming and all the way to South Dakota--are there any stores in that piece of Nebraska? [LB324]

EMILY McGANN: Any pharmacies in your network or CVS pharmacies? [LB324]

SENATOR BREWER: CVS. [LB324]

EMILY McGANN: Oh, I'd have to let you know. [LB324]

SENATOR BREWER: Okay. [LB324]

EMILY McGANN: I would tell you that if there's a Target store in that area, CVS acquired the Target pharmacies in the past year. So if there's a Target pharmacy, that would be a CVS. [LB324]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing none. [LB324]

EMILY McGANN: Okay. Thank you. [LB324]

SENATOR LINDSTROM: Other opponents? [LB324]

JEFF HUETHER: Good afternoon. Senator Lindstrom and members of the committee, my name is Jeff Huether, that's spelled J-e-f-f H-u-e-t-h-e-r. I'm director of pharmacy for Blue Cross Blue Shield of Nebraska and here to testify in opposition to LB324. LB324 covers a wide range of subjects, many of which have been addressed by people testifying before me today, so I'll try to skip over duplicate efforts in portions of my testimony. In short, LB324 adds a significant amount of regulation to an already heavily regulated healthcare finance system, but it does not add much in the way of protection for Nebraska consumers. Nebraska currently has a prompt pay law that applies to most providers' claims. Blue Cross Blue Shield of Nebraska adheres to these standards in our claim payments. It is important to note that rather than amend those existing standards to include pharmacies, this regulation adds to compliance costs by creating an entirely separate and distinct standard. Section 12 of the bill requires PBMs to mail an explanation of benefits to the patients for each of the patient's pharmacy claims for a particular prescription drug. Currently, our PBM processes, at least for Blue Cross Blue Shield of Nebraska, in excess of four million claims per year for our members. Mailing costs alone would be substantial and in view of the fact that the current system of claim settlement for pharmacies settled most claims instantly, this particular requirement would add significant cost to the overall transaction. And as I close, I wanted to call the committee's attention to one section we think sums up the bill fairly well. Our contracts with providers typically include provisions that hold our members harmless in the event a provider makes a mistake in billing. Section 11(1)(h) overrides the protection we extend to our members and says that if there is an overpayment, the pharmacy can bill the covered individual for the drugs received. If adopted, this would transfer

the consequences of a mistake from the pharmacist who made the mistake to Nebraskans. In summary, LB324 includes a series of subjects which when combined do not necessarily add up to a good idea. I'd be happy to answer any questions that the committee has. Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. Thank you, Mr. Chairman. Thank you for your testimony. Specifically, how would greater transparency increase your cost? [LB324]

JEFF HUETHER: Yeah, so I think looking at--and not to jump on all the other particular testimonies that were here today--providing additional transparency, depending on how you look at it through the bill, obviously as we look at through at least the "any willing provider" or "any willing pharmacy" particular provision, would allow the ability to additional pharmacies to be considered in network at whatever rates that they may choose, which at the end of the day--and rates, meaning discounts--would ultimately then increase the cost that our Nebraskans pay, particularly from if a medication is more expensive because of that. Although our members, in particular, and the constituents in Nebraska may pay the same amount, depending on what their benefits are in particular, but the overall cost of the medication may be higher. So with that, and coupled with the other parts of my testimony today, would add cost to this overall. [LB324]

SENATOR McCOLLISTER: Thank you. [LB324]

SENATOR LINDSTROM: Any other questions from the committee? Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. Thank you for your testimony. We heard testimony earlier about on these audits where if a pharmacist maybe read a prescription that was supposed to end on the 15th of the month, but it was the 16th and didn't read it close enough, but advanced a thousand dollar drug and advanced some subsequent renewals of that drug that they could get clipped for having to reimburse that thousand dollar drug and the price of those subsequent renewals. Is that true? [LB324]

JEFF HUETHER: I particularly...thank you for your question. I particularly don't know of any situation where that has occurred or at least nothing that has been brought to my attention. I'd also defer that to my PBM colleagues in that particular situation as well, based on what they may or may not have seen. [LB324]

SENATOR SCHUMACHER: I thought in your testimony you made some comment about it would shift responsibility and cost from the person making the mistake to the Nebraska policyholders. [LB324]

JEFF HUETHER: Got you. My apologies on that confusion. It's in particular to one of the sections in the legislation that relates to, if the pharmacy feels like they didn't get reimbursed enough that they could then bill the member the difference, which at least with our particular contract with our members, there's no...by having a contract on file and signed you're not going to--what we call--balance bill the member, meaning you're going to make up the difference by charging the member more than what's provided in the contract. [LB324]

SENATOR SCHUMACHER: And do you have the objection as we heard earlier to sharing your templates, your boilerplate contracts with the committee? [LB324]

JEFF HUETHER: Considering my role within Blue Cross and not having that particular contract between me and the pharmacy, I wouldn't be able to answer that. [LB324]

SENATOR SCHUMACHER: Thank you. [LB324]

SENATOR LINDSTROM: Thank you. Senator McCollister. [LB324]

SENATOR McCOLLISTER: Yeah. To what extent does the Banking Department of Nebraska manage what those PBMs do, if anything? [LB324]

JEFF HUETHER: That's a great question. I'm not sure, necessarily, how much that overlap is, to be honest with you. [LB324]

SENATOR McCOLLISTER: Thank you for your testimony. [LB324]

SENATOR LINDSTROM: Thank you. Any other final questions? Seeing none, thank you very much. [LB324]

JEFF HUETHER: Thank you. [LB324]

SENATOR LINDSTROM: (Exhibits 7, 8, 9) Next opponent. I do have a couple letters in opposition to LB324. One from Medica and the other from Pharmaceutical Care Management Association. Those letters are in opposition. We will now move to neutral testimony. Any neutral

testifiers? Seeing none, I do have a letter in the neutral capacity from Mr. Nathan Leach. Senator Kolterman, you're ready to close. [LB324]

SENATOR KOLTERMAN: Thank you, Mr. Chairman. Well, where do we go from here? Senator Baker, early on you asked, why now? Why are we bringing this bill this year? To be quite honest with you, nobody was crazy enough to carry it before. My constituents brought this bill to me, really. The reality is my local pharmacies, whether we're talking about Osceola or York or Henderson or Seward, they're the ones that are concerned, because their margins are being cut dramatically. I have testimony, some letters that I've received telling me that if they have to keep doing what they're doing they're probably not going to be in business in the next couple of years because their margins are getting cut considerably. I've been in the insurance business for 40 years. And I will tell you, when we first started selling health insurance it was a very small part...prescription drugs was a very small part of the equation. The premiums...you could say that it was almost negligible at times. Today with the Affordable Care Act we're now looking at somewhere between 20 percent and 30 percent of a monthly premium going to pay for prescription drugs. Where would we be without them, though? I can tell you this firsthand, my wife gets a shot every two weeks that's $8,000. She'll get that the rest of her life. That's $200,000-and-some a year just for one shot. We need pharmacy and we need growth in the pharmacy industry, big pharma, we need that to happen. But how are we going to come to a situation where we're leveling the playing field so that the small town pharmacies in rural Nebraska can service their clients just like the CVSs and the Walgreens and Walmarts? I don't know what the answer to that is. I will tell you that the PBMs have been very forthcoming with me, very honest and open with me. We had a nice dialogue. Didn't answer my questions, though. The problem is, there's just too much...they don't have any regulation at this present time. Banking doesn't regulate them, the Department of Insurance doesn't regulate them. What we're asking here is that we get somebody to regulate it through the Department of Insurance as a TPA. That's being handled now for Prime, because they are a TPA in Nebraska. It's always bothered me when you've got a health insurance premium that you're paying to a company on one side and then they own another part of the puzzle as well, so they're getting it on both ends. They're getting it from the PBMs and they're getting it from the premium payers. But ultimately, the premium payer is paying all of it. So clawbacks? The clawback abusers aren't here today, but it's going on, dramatically. Discounts? We didn't hear about rebates or discounts at all today, but that's going on as well. So where do we go from here? I'm just a proponent that the Department of Insurance ought to have some say in this, at least be able to have somebody in the state of Nebraska that can regulate these organizations. I'm not a proponent of large regulation, but at the same time I think for the sake of the consumer there ought to be some sort of regulations that pertains to PBMs. If this bill isn't the complete answer, then we work on it some more. But this is my first attempt to try and promote this. I think it goes a long ways to help and I'm welcome to suggestions. So with that, I'd try and answer any questions that you might have. [LB324]

SENATOR LINDSTROM: Thank you, Senator Kolterman. Senator Schumacher. [LB324]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. Thank you, Senator Kolterman. Today CNN is reporting that President Trump said, nobody knew healthcare could be so complicated. Do you agree? [LB324]

SENATOR KOLTERMAN: I would agree with that. But you know, if we followed Senator Riepe's suggestion in the bill we passed last year, it would become pretty uncomplicated again with his proposal that we initiated last year with direct primary care. [LB324]

SENATOR SCHUMACHER: Thank you, Senator. [LB324]

SENATOR LINDSTROM: Thank you. Any other final questions for Senator Kolterman? Seeing none. [LB324]

SENATOR KOLTERMAN: Thank you. Now I have to go open on another bill, so I'm not going to be able to hear Senator Riepe. [LB324]

SENATOR LINDSTROM: Okay, sounds good. And that will end the hearing on LB324. Speaking of Senator Riepe, he is here to introduce LB604. [LB324 LB604]

SENATOR RIEPE: (Exhibit 1) Chairman Lindstrom, members of the Banking, Commerce and Insurance Committee, I appreciate the opportunity to be here. It's always exciting to me to be able to spend an afternoon listening to items that talk about reform and transparency in healthcare. I am Merv Riepe, my name is spelled M-e-r-v, my last name is Riepe, R-i-e-p-e, and I represent Nebraska's 12th Legislative District which is Omaha, Millard, and Ralston. I would like to say before I really start, is I'm excited to hear about the pharmacy transparency and the word transparency is something that's exciting to me. Today I'm here to introduce and hopefully to excite you about LB604 and how it promotes healthcare price transparency and an incentive to price shop. Senator McCollister and I have had more than a couple of discussions about healthcare transparency and I know it's a keen interest to both of us. Before I talk about the merits of Right to Shop, I want to address your concerns and mine regarding the fiscal note. The fiscal note is caused by a mandate on the state of Nebraska for state employees. I do not like mandates and I am working with the Department of Administrative Services to bring the fiscal note to zero as we will be eliminating the mandate by allowing DAS to start the Right to Shop program through executive action. Hopefully, I have calmed the water that allows me to proceed with sharing Right to Shop. Price transparency is the essential first step in harnessing what is now the unsustainable growth of cost in receiving healthcare. Healthcare economists predict that

by 2050, without reform, consumers in America may be required to spend upwards to 50 percent of disposable income on healthcare. That is obviously not sustainable. We are currently exploring how to address the shortcomings of the Affordable Care Act, which was in reality not an affordable care act, but rather an unaffordable insurance act. And that plays a little bit to President Trump's comments about the complexity of healthcare. Success in restraining healthcare costs requires consumers to become responsible for healthy choices and engage in the healthcare cost. When an unknown third party is paying with no personal impact, consumers elect to not care and assume more expensive care is better care. That's what we're told. Right to Shop engages consumers in the process of best service, best price, best location, with a resulting best value. Now consumers have skin in the game. How does Right to Shop work, you say? First, your medical practitioner prescribes a procedure or service. Second, you go on-line or call providers of that procedure or service to identify your best price options and service. Third, you select the best value with an acceptable location. Fourth, you have the procedure or service completed and the results sent to your practitioner. Fifth, you are financially rewarded for at least 50 percent of cost saved. I want to present takeaways from a Right to Shop experience as reported in New Hampshire. And those would be: Incentives drive shopping--members are 11 times more likely to use a transparency program when incentive rewards are included. Incentives sustain shopping--roughly 90 percent of program enrollees have shopped at least once with two-thirds repeat shopping and earning incentives each year from 2011 to 2014. By contrast, most insurer transparency tools report 2 percent engagement. Three, incentives drive savings--the program averages approximately $650 in savings each time it is utilized. And the last is, the incentives produce a return on investment. In 2015, New Hampshire's program achieved a 13 to 1 return on investment. The state of New Hampshire has saved $12 million and consumers have saved in excess of $1 million. Conclusion: Like direct primary care, last session's 48 to 0 legislative vote to reform healthcare, Right to Shop is a common-sense approach to addressing exploding healthcare cost. It is simple, flexible, and best of all it works. By extending these concepts all insured consumers, Right to Shop will bring much needed relief to patient consumers. Thank you for your time and attention. One proponent following me is Tom Newell, who is a Senior Fellow of the Foundation for Government Accountability, and he's come here today because he has experience and knowledge in regard to Right to Shop. I will attempt to answer questions you might have. [LB604]

SENATOR LINDSTROM: Thank you, Senator Riepe. Senator McCollister. [LB604]

SENATOR McCOLLISTER: Thank you, Mr. Chairman. And thank you, Senator Riepe, for this legislation. Is it necessary for a medical consumer to ask the hospital to bundle the cost of a particular procedure in order to make a valid comparison? [LB604]

SENATOR RIEPE: Good question. And, of course, a lot of hospitals do have procedures that are bundled. And, obviously, you can always ask for it. They may or may not comply. If they don't

and you think that you can receive the service at another hospital that will bundle it so that you can price compare, then you're free...and I believe in free market that you're free to go to that other hospital to get your bundled service, if you will. [LB604]

SENATOR McCOLLISTER: If you have a particular doctor you're working with and he doesn't have...what do they call it? Doctor rights or... [LB604]

SENATOR RIEPE: Privileges. [LB604]

SENATOR McCOLLISTER: ...privileges in a hospital you want to use, are you forced to change doctors? [LB604]

SENATOR RIEPE: Well, I'm always real...having worked with doctors for a lot of years and knowing their temperament, I'm really pretty sensitive about telling anybody they need to change doctors, because it will come back to you. You'll get a call from him in short order. More and more, though, people are aligning with systems as opposed to necessarily one particular physician. They will align either with CHI, the Methodist system, or they will align with the Med Center system. Now, some physicians don't like that, because at one time...the physician as you know is the captain of the ship. And that was the person you went to first and then he would tell you where you're going to the hospital. That's changed a lot because of just the cost, the size of healthcare, the complexity of healthcare. And of course the hospitals want to keep you in their system, so they want to use their MRIs and they want to use their everything, because that's where these not-for-profit hospitals become quasi-profit hospitals. [LB604]

SENATOR McCOLLISTER: Thank you, Senator. [LB604]

SENATOR LINDSTROM: Thank you. Any other questions for the senator? Seeing none, will you be sticking around for closing? [LB604]

SENATOR RIEPE: Thank you, sir. I will be around. [LB604]

SENATOR LINDSTROM: Great. Thank you. We will now move to proponents. [LB604]

TOM NEWELL: (Exhibits 2, 3) Thank you, Mr. Chairman. My name is Tom Newell, the last name is N-e-w-e-l-l. Mr. Chairman and honorable senators, thank you for the opportunity to testify in support of LB604. And first of all just let me say, as a former Oklahoma state representative, I know firsthand how difficult your job is, as was just evidenced in the first part of this hearing today. During session you have multiple bills and you hear from various points of

view on all those multiple bills. And normally, no matter what decision you make, you're going to make someone unhappy. And so I just want to say thank you for your service and I honestly believe that, and in this particular issue I'm sure you'll hear from various sides as well. So thank you for the opportunity to present one side. Healthcare costs and health insurance premiums, as you know, continue to skyrocket. Since 1998, U.S. medical costs have increased twice as much as general consumer prices. One of the main problems in healthcare I believe is the lack of cost transparency and the incentive for patients to, therefore, compare those costs and, in other words, have real competition. In most of the market, again that area general consumer prices, those are first-party purchases, meaning the person spending the money is also the person using the product. And they care about both cost and quality and this drives competition, which always, always increases quality and decreases cost over time. However, when it comes to healthcare, today only 10 percent of healthcare purchases are out-of-pocket or first-party purchases. This is down from 47 percent in the 1960s. So I believe and the Foundation for Government Accountability believes that one of the keys to increasing competition in healthcare is dramatically increasing the patient's involvement. This will require two things. First of all, transparency of costs. But then, secondly, incentives, because again over time the patient has been conditioned to not really care about costs, because they just think about their own out-of-pocket and the insurance is going to pay the rest. If you could just consider these two specific stories. Senator Riepe kind of gave you some broad things and I gave you some handouts that cover some of the information that Senator Riepe mentioned about New Hampshire. But consider two particular real-patient scenarios. Jason is an employee of a medium-size Maine employer with 70 employees and he was diagnosed with Crohn's disease two years ago and prescribed a medication he must receive through infusion therapy every four to six weeks. When treatment began the cost for the first infusion was $28,000. His out-of-pockets were $6,000 and therefore you can imagine that his small employer was realizing that their insurance premium was going to go up the next year because it was a small pool and this one claim alone was going to drive their costs up. It was $28,000 at that one hospital closest to him, but consider that the exact same infusion therapy just a few blocks away was only $14,000. And even just a little bit further away the option was only $10,000. All of these options were in network for Jason, but no one called to inform Jason or his employer about the less expensive options. Now consider Jim, also in Maine, also working for an employer, but his employer has an incentive-based program. Jim was scheduled for a knee replacement surgery. The average cost for the procedure in the state is $34,000, but the closest hospital charges $60,000. Jim's employer again offers an incentive-based program and so he shopped around and found out that his surgeons--he didn't have to change surgeons, it was a surgeon he wanted--his surgeon had operating privileges at several different facilities and discovered that there was another facility not too much further away that was only $25,000. So Jim asked for his surgery to be scheduled at the lower-cost facility, which way only 30 minutes away. He saved his employer plan and so he received an incentive check. Now the numbers were this: average cost is $34,000; his procedure was $25,000, which created a $9,000 savings overall. So because he was saving the insurance

company money they gave him 50 percent of that reward back to him in an incentive payment. That meant that his out-of-pocket cost went from $6,000 down to $1,500 because he had that $4,500 incentive payment to go back towards his out-of-pocket cost. As Senator Riepe mentioned, this is happening in other states, New Hampshire, specifically. Let me just say that when it comes to the fiscal note we passed similar legislation in Oklahoma. Our state health insurance agency also said it was going to be a fiscal note, but we got them to look at bundled savings and so they are doing that now. Oklahoma County, which is a large county in Oklahoma, is self-insured. They began to do something like this with a bundled payment system and a large provider in Oklahoma County. And that county year over year is seeing hundreds of thousands of dollars in savings as a result of that now. I'll be happy to answer any questions. [LB604]

SENATOR LINDSTROM: Thank you very much for your testimony. Any questions from the committee? Senator Williams. [LB604]

SENATOR WILLIAMS: Thank you, Chairman. Thank you for being here. Does it take a 50 percent incentive to encourage somebody to take advantage of saving money? [LB604]

TOM NEWELL: Obviously, the larger the incentive probably the more they're going to want to do that. But I think that's going to be what this committee decides they can pass and what can pass. I would say 30 percent, 40 percent, it's still an incentive, but the larger the incentive the more people you're going to have to make use of it. [LB604]

SENATOR WILLIAMS: And if I understand this correctly--and correct me where I'm wrong on this--that this would require the insurance company...again, you were sitting here for the previous testimony. If I'm carrying that blue card, that insurance company is who I would call. So they would be required to put together some either on-line or connectivity that I could look at and say, this is an MRI here, this is a knee replacement here, this is...is that correct? [LB604]

TOM NEWELL: And correct me if I'm wrong, Senator Riepe. I saw earlier versions of the bill. I don't believe that this is a mandate for private insurers. I believe it gives them the option of doing that. And, by the way, it's been my experience in many states that actually many of these insurance companies already kind of have a mechanism in place. In other words, they know those different costs in different places, but there's no incentive for them to encourage the patients, etcetera. If you were mandating your state employee health insurance to do that, then, yes, they're going to have to make that available. Sometimes some states have actually hired a third-party provider that will actually call that patient up and say, listen, we notice you've been referred to a surgery. Do you know that you have these other options available at these various costs? [LB604]

SENATOR WILLIAMS: Okay, thank you. [LB604]

SENATOR LINDSTROM: Thank you. Any other questions? Senator McCollister. [LB604]

SENATOR McCOLLISTER: Yeah. Well, thank you for your testimony. Interesting. Why was there a fiscal note at all? If it's a matter between the insurance company and the patient, how is the state involved? [LB604]

TOM NEWELL: I believe, and again I could be wrong here, but I believe the fiscal note was attached for the state employee insurance part of the plan. And again, without stepping on any toes, but I served in the legislature for six years, I can tell you in Oklahoma our particular agency was the status quo, they'd been doing it a certain way, they simply didn't want to have to do it any other way. And at least in Oklahoma, when an agency doesn't like something they can oftentimes make sure that a fiscal note gets attached that can kind of discourage legislators from enacting the bill. Now, that's speaking from my experience in Oklahoma. I don't want to necessarily project that here, but that's been my experience in other states. [LB604]

SENATOR McCOLLISTER: Even when it ultimately saves them money? [LB604]

TOM NEWELL: Even when it ultimately saves money, yes, sir. [LB604]

SENATOR McCOLLISTER: Okay. When hospitals start competing on the basis of price, doesn't that flatten the differences? [LB604]

TOM NEWELL: Over time it would drive down the costs in general, yes. [LB604]

SENATOR McCOLLISTER: Thank you. [LB604]

SENATOR LINDSTROM: Senator Baker. [LB604]

SENATOR BAKER: Thank you, Chairman Lindstrom. Mr. Newell, is it your understanding this proposal of Senator Riepe is just for state of Nebraska employees? [LB604]

TOM NEWELL: That was my...when I saw the original version of the bill I believed it made it optional for private insurers, but it was a mandate for state employee insurance, yes. [LB604]

SENATOR BAKER: So in Nebraska there is apparently self-insurance. But supposing...all right, so supposing there was an insurance company instead of self-employment (sic: self-insurance), wouldn't they have to agree? All right, so the patient goes...instead of spending the average $34,000 for a knee replacement, gets it done for $25,000. Isn't the insurance company going to have to voluntarily say, thank you, here's $4,500. When we consider they've already paid the full cost of what that procedure was at $25,000, why would they cough up $4,500 more? [LB604]

TOM NEWELL: Well, it's a two-pronged thing. First of all, I think part of the question as I hear it would be, why wouldn't they already be doing this if it saves them money as well? And I can't pretend to put myself inside the mind of the insurance companies. But it's literally...this is not just a concept or a theory. Everywhere it's been tried it works, it saves money. So I don't know why someone would be opposed to it. [LB604]

SENATOR BAKER: I like the concept. I just was curious as to whether they would follow through and do that, say, no, sorry, we covered your full cost. That's it. [LB604]

TOM NEWELL: In the example I gave you from Maine in the first case, I mentioned that all three of those things were in network in the same insurance company. And yet you would think that, as we heard earlier, maybe that insurance company is going to say, wait a minute, 30 minutes away they're charging half as much. Why are you charging so much? You're not going to be in network if you're doing that, but it happens all the time. I have a colleague who actually usually testifies on this subject more than I do, sent me a note just this morning that he looked at a chest x-ray in Omaha that was $3,500 and that exact same chest x-ray here in Lincoln was only $750. And so again you have these price discrepancies. But several years ago when I was first elected I was actually in the hospital and was...the doctor was saying, well, I want you to have these procedures done. And my very first question was, well, how much are those going to cost me? And he looked at me like I was crazy. And I think he was being honest when he said, I don't know how much they're going to cost you, but I think you should have that done. Now take that a step further now, when oftentimes in today's healthcare environment many doctors are actually affiliated with a hospital that then does these maybe chest x-rays. And so he just automatically or she automatically refers me to that hospital's x-ray unit, when in reality if I as a patient knew that I could ask to go somewhere else I could maybe go literally a block away or two blocks away to someone that's not affiliated with that doctor and that hospital and get a cheaper service. And that's why the incentive is so important. We've just been conditioned nowadays to not even ask that question, how much is it going to cost? [LB604]

SENATOR BAKER: Last question: How difficult was it for you to get people to tell you how much it would cost? [LB604]

TOM NEWELL: Extremely difficult. [LB604]

SENATOR BAKER: What kind of turnaround time did you have? [LB604]

TOM NEWELL: In all honesty, in that particular case I was never told. And again because I'd been conditioned this way, I asked the question. But at that point I literally had state insurance because I was a legislator and it was good insurance. But I did discover this, just a few years prior--I was also a pastor--and I had just moved churches and did not have insurance and had to have an MRI. And so I got a cash MRI because I was paying out of pocket and it was $500. Fast forward, two years later I got the exact same MRI on my back and my out-of-pocket cost was about $1,200 and that was on top of what the insurance company was paying and it was the exact same MRI on my back. [LB604]

SENATOR LINDSTROM: Thank you. Any other questions? Senator Schumacher. [LB604]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. And thank you for your testimony. Did I understand you just to say that in Oklahoma you got insurance as part of your compensation? [LB604]

TOM NEWELL: Yes, sir. That is correct. And I will admit, actually very good insurance. [LB604]

SENATOR SCHUMACHER: Can I ask what they pay as salary? We might want to move. [LB604]

TOM NEWELL: Salary is $36,000 and then you get the state employee benefit package, which includes insurance on top of that. [LB604]

SENATOR SCHUMACHER: Thank you. [LB604]

SENATOR LINDSTROM: Any other questions? Seeing none, thank you very much for your testimony. [LB604]

TOM NEWELL: Thank you. [LB604]

SENATOR LINDSTROM: Other proponents? Proponents? Seeing none, we'll now move to opponents. Anybody in opposition to the bill? Seeing none, we will now move to neutral testimony. [LB604]

BO BOTELHO: (Exhibit 4) Good afternoon Senator Lindstrom and members of the committee. My name is Bo Botelho, B-o B-o-t-e-l-h-o, Chief Operations Officer for the Department of Administrative Services. I am here today to provide neutral testimony regarding LB604 as originally drafted. I've met with Senator Riepe and his staff several times about the bill, regarding the fiscal impact to the state. And of course removing the mandate on the state would nullify our fiscal note, but the...and I'll speak to that because there were several things brought up in the testimony from the previous testifier that I think misses the point of our fiscal note. The basis of our fiscal note is that at the state of Nebraska, like New Hampshire, is a self-insured plan. And this bill was designed for a fully-insured plan, which is geared more toward your private insurance companies. And the impact to the state is that the bill would prohibit the use of premiums to do the cost share. Well, that's all we have is premiums. We don't have profit. This is geared more towards sort of a profit-sharing model. So what they're saying is, the private insurance companies can't use their premiums to offset the cost, because they don't want to raise the cost to the participants, pay them back with their own coin so to say. So for the state to implement this plan as it's drafted, we would have to create a new fund and we'd have to fund that initially with General Funds as opposed to our premium, which is right now how we're paying all our healthcare benefits, is through our Health Care Fund, which is all funded by premiums. So the basis of our fiscal note is that if we did it like this, we would have to create a new fund, put money in it, and pay out through there. The other thing, Senator Williams, you brought up, you do it with less. New Hampshire's plan is using a 10 percent as opposed to 50 percent, which again makes sense for a self-insured plan, because you are driving it off of premiums. If your payout is something as large as 50 percent, eventually it's going to start to cause you to increase premiums. And if you look at how health plans run, 80 percent of your cost is to probably about 20 percent of your members, but everyone is paying premiums. So if you start to raise your premiums for a 50 percent payout, some employees are getting a cash benefit, but the other employees are paying more into it. And it's not how...it would not work for a self-insured plan. So we would have to measure that payout to a point with what we think our actual expenses are to balance it with our premiums. So it's a little bit more complicated with a self-insured plan than an employee ensured plan, because it's all enclosed. Everything is paid for for your premiums and you increase your premiums, you increase your costs across the board. So you have to have that percentage such that you are incenting employees to lower cost services without driving up the cost of the plan as a whole, because we don't have profit to share. [LB604]

SENATOR LINDSTROM: Thank you. Any questions? Senator Baker. [LB604]

SENATOR BAKER: Thank you, Senator Lindstrom. Mr. Botelho, let me push you a little bit on what you just said. If I'm a state employee and I go in for a knee replacement...and you don't tell me where I need to go, is that correct under the...? Okay. So I could go to one hospital and it would cost me the $34,000 and if I did that, then you'd have to pay that out of what you've got in the pool, minus whatever copay there is. So why wouldn't you want to create a system where I shopped a little bit and I could get that for $25,000? It's not going to cost you more money, it's going to save you money. All right? [LB604]

BO BOTELHO: Yes. And we would want to create that system, Senator. I'm not saying that it costs...this type of cost-sharing model would not work in the state of Nebraska. It seems to be working in New Hampshire. What I'm saying is the bill as drafted is geared towards a fully ensured profit-sharing model. I don't have profit. So we would have to modify this to work as a self-insured model so that our percentage payout works with our premiums. [LB604]

SENATOR BAKER: Could that be done? [LB604]

BO BOTELHO: Yes. [LB604]

SENATOR BAKER: Okay. [LB604]

BO BOTELHO: And I pointed out in my fiscal note that the conflict here is that you're saying I can't use premiums and that's all I have. So if I can't use that, I need some other funds. [LB604]

SENATOR BAKER: Okay. But if it were changed so you could use premiums to do that, you're going to be better off. [LB604]

BO BOTELHO: Yes. Yes. Healthcare costs keep going up, so we're always looking for ways to drive that cost down. The state pays 79 percent of the premiums, employees pay 21 percent. There's a lot of money going in there, so if we can start to drive the cost of healthcare down then hopefully you can do so in a way that would eventually either keep your premiums at...maybe perhaps decrease their rate of increase or even bring them down. [LB604]

SENATOR BAKER: So that's why you're testifying in the neutral capacity,... [LB604]

BO BOTELHO: Yes. [LB604]

SENATOR BAKER: ...because there's certain constrictions right now that wouldn't work, but that you're not opposed to the concept. [LB604]

BO BOTELHO: No, not at all. That's what I told Senator Riepe and his staff. [LB604]

SENATOR BAKER: Okay, thank you. [LB604]

BO BOTELHO: It's just that this bill is not designed for self-insured plans, it's for a fully insured. [LB604]

SENATOR BAKER: Okay. [LB604]

SENATOR LINDSTROM: Thank you. Senator McCollister. [LB604]

SENATOR McCOLLISTER: Yeah, thank you, Mr. Chairman. But if the match or the reward went down to 10 percent, apparently the fiscal note would drop as well? [LB604]

BO BOTELHO: The fiscal note isn't so much...I can't even calculate what that 50 percent payout is. The fiscal note is based on two things. One is, if I can't use premiums, you're going to have to create a fund that I can pay the match out, which we figured 2 percent of...I think we took a 2 percent of our annual payout of last year, which comes out to about $3 million. The other cost would be that our current third-party administrator doesn't have this type of service, so we would have to go out and get a vendor to manage this to start to do the cost calculations and handle the payouts, which is what New Hampshire did as well. So that's the basis of the fiscal note. I don't know what the correct percentage would be. Like I said, New Hampshire is using something around 10 percent. We would have to basically calculate...our premiums are based on actuarial studies. We look at our funds experience, we look at potential cost, we look at industry cost and figure out what that number would be and apply it. And then over time we can adjust that payout accordingly as we start to see our costs going up or down. [LB604]

SENATOR McCOLLISTER: Once you give that state employee the information, ultimately is it his choice or her choice where to have the procedure performed? [LB604]

BO BOTELHO: Yes. You're incenting them to...they now have a benefit if they choose the lower cost provider because they could get some money out of it. I don't think there's anything even in the bill as written that would allow a...certainly not the state and we would not want to or even a private company to force them to choose the lower cost. It's an incentive, it's not a mandate on

the employee. I don't believe there's any type of mandate on the individual seeking care in this bill. [LB604]

SENATOR McCOLLISTER: Yeah, thank you for your testimony. [LB604]

SENATOR LINDSTROM: Thank you. Any other questions? Senator Schumacher. [LB604]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. And thank you for your testimony. Let's posit a situation where you have a large enough area to do this in. And three providers of the service of whatever particular procedure it is, one provides at $20,000, one at $15,000, and one at $10,000. And that the consumer really doesn't have much incentive one way or the other as to price because the insurance company is going to pick it up or the government is going to pick it up, whatever. Wouldn't the odds be that you would have some people who under the present system would go direct to the cheapest provider just because they didn't know any better and didn't have a reason to care, but when you institute this program I suddenly would have an incentive to find who the highest one was and pretend I was going to go there so I could claim the incentive? [LB604]

BO BOTELHO: Yes. I mean, if there's a benefit to seek a lower cost provider, absent anything else there's going to be some money involved perhaps, I would say, yes, they would, unless they have a reason. You know, they really prefer one physician over another. That always figures into healthcare. They have their physician and they're going to go to that regardless. The other thing that New Hampshire did at the same time they implemented this, was they implemented deductibles. Well, we already have deductibles. So even now currently we do provide information as to cost. And for employees who haven't yet met their deductible, depending on what plan it is how much their deductible, they may still choose the lower cost provider because it does still save some money because of the deductible. But generally speaking, if they benefit from paying a lower cost for the same service, they're going to seek the lower cost services. [LB604]

SENATOR SCHUMACHER: But right now, just by the nature of the distribution, a third of them are going to each of those three providers. And I happen to be in one that's going to the...that would normally go to the cheap provider. But because I want to claim the incentive, I'm going to seek out the expensive one and say I would have gone to those guys first, because I want the bonus. [LB604]

BO BOTELHO: Yes. Okay. You could imagine that scenario where you would have an individual that is going to perhaps get a monetary benefit they would not have received otherwise, yes. [LB604]

SENATOR SCHUMACHER: Okay. And then conversely, if each of those three providers on that particular procedure were stacked up one, two, and three, but on a different procedure were stacked up three, two, and one, just the reverse, then by forcing or incenting people to go to the cheapest, I'm hurting the cash flow that's necessary to maintain their overall operations, because I'm forcing or incenting people to find the cheapest place for the particular service, but that place is relying upon its high priced other service to offset its cheapness and be able to offer the cheapness and thus...you know? You see what I'm saying? [LB604]

BO BOTELHO: Yes. I don't think there's enough state employees necessarily to impact the medical industry as a whole. But again, you could imagine if you had enough people thinking like this that it could eventually perhaps impact the charges across the state and start to drive down costs in general. I don't know if the volume would necessarily do that. As far as the state, we're obviously concerned about our health plan and our premiums, okay? This is a lot of money for the state of Nebraska and if we can decrease costs even a little it does behoove the state. I don't know if it would necessarily drive employee behavior to the level that you certainly could think about and consider, I just don't know. [LB604]

SENATOR SCHUMACHER: I mean, this may be talking mandate just for the state, but theoretically if it's good for the state it should be good for everybody else. And then we would have that population large enough to see that. And unless somebody is getting filthy rich in the medical system--and maybe they are, I don't know--right now, they've got to fund themselves some way. And so a high cost service is offset by a low cost service in the same institution may be the way they fund themselves. And so what do we do systemically if we cut off money going into the system? I don't know. Thank you. [LB604]

BO BOTELHO: I don't know, Senator. [LB604]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing none, thank you very much for your testimony. [LB604]

BO BOTELHO: Thank you. [LB604]

SENATOR LINDSTROM: Next neutral testifier. Good afternoon. [LB604]

ERIC DUNNING: (Exhibit 5) Good afternoon, Mr. Chairman and members of the Banking, Commerce and Insurance Committee. My name is Eric Dunning, for the record, that's spelled E-r-i-c D-u-n-n-i-n-g. I'm a registered lobbyist appearing today on behalf of Blue Cross and Blue Shield of Nebraska, here to testify in a neutral capacity on LB604. We understand that LB604 is

a bill that is part of a larger effort by government to get insureds engaged in the cost of their healthcare through cost transparency tools. Now you know this isn't the first time the Legislature has looked at the issue of cost transparency tools. I believe it was in 1999, insurers were mandated by the state of Nebraska to be in a position to put together a good-faith estimate on the cost of care. That's been there since 1999. And Nebraska has had an interest in there the whole time. Now, I've spoken to a number of you personally on the issue of cost transparency tools and their utilization. Our best number had been that the tools that I'm describing were used by a bit more than 2 percent of our members. I am happy to report, however, that recently we've seen the beginning of a slight increase in use. In January 2016, we had 19,100 users. In January 2017, we had 21,951 users. That's a 13 percent increase. It's not as high as we'd like it to be, but we are committed to working to increase member usage over time. We've had a long track record of providing cost transparency tools to our members voluntarily, without a government mandate. We recognize that empowering our members with cost transparency tools can help them manage the cost of healthcare to their own benefit and to help keep that cost of healthcare in check because remember, to the extent that people are below their member out-of-pocket limit their deductible and cost-sharing obligations under the policy make it to their benefit to seek lower cost healthcare options. Our current tool is designed--because of that out-of-pocket cost--to help our insureds understand costs as applied to them, rather than providing a mere cost estimate that includes information on where the insured is at relative to their annual cost sharing. This information is more relevant than a simple price list. We use the term current cost transparency tool to describe our current efforts in this area because we're committed to constant improvement with those tools. In September, we launched a new updated cost transparency tool through a vendor, HealthSparq. Our new tool offers the availability to find the in-network doctors and hospitals, search for one-time service costs, see the full spectrum of care, and read patient reviews. The new solution is much more user friendly and is regularly tested to verify vendor usability. One of our better enhancements is the ability to see the cost of larger episodes, for example a knee replacement. Members can get an idea on what it costs from the tests up front to the surgery to the physical therapy and follow up afterward. That wasn't previously available in tools that you may have seen. The other major portion of the bill that we'd like to address relates to our future interests in the area of cost transparency. LB604 does include a fairly prescriptive requirement for a rewards program for insurers who choose to participate under the act. Under section 7, insurers must provide incentives for members who shop for services; significant incentives. We are currently looking at the issue of whether and how rewards will drive behavior change. We have not found that that's been actually definitively answered to our satisfaction. Incentives and rewards are on our transparency road map to test. This is in the early stages for us, but it's something we have identified that needs more discovery. The tools I have just described are something that we've implemented voluntarily. We didn't need authorization. We don't need a mandate. Our efforts in this area are going to continue whether the bill moves forward in its current form or not. We agree that this is an area that could benefit our members and we will be voluntarily moving forward in this area. And with that, I'd be happy to answer any questions that

you might have. I would point out that I passed out a very detailed one-pager on our efforts in this area. And I apologize for the very small size of the font. It's an awful lot of information to put on a page in the back. [LB604]

SENATOR LINDSTROM: Thank you, Mr. Dunning. [LB604]

SENATOR McCOLLISTER: Yeah, thank you, Mr. Chairman. And thank you, Mr. Dunning, for your testimony. When you compare costs for when Blue Cross uses their Website, do you bundle the services from a hospital for a particular procedure? [LB604]

ERIC DUNNING: That's one of the things that we're very excited about with our new tool that's going to allow us greater ability to do that, yes, so that you don't have to know as a consumer, well, gee, a knee replacement comes with some up front tests and then a procedure and then PT/OT or whatever else is involved. We have a typical suite of services there. [LB604]

SENATOR McCOLLISTER: Is the hospital obligated then to only charge you that amount no matter what occurs? [LB604]

ERIC DUNNING: The hospital is bound by our contracts and they are not allowed under those contracts to say, whoops, it cost more than we had initially agreed with Blue Cross and therefore we are going to turn around and bill John McCollister for the difference. [LB604]

SENATOR McCOLLISTER: Thank you. [LB604]

SENATOR LINDSTROM: Thank you. Senator Baker. [LB604]

SENATOR BAKER: Thank you. I'm looking at the Blue Cross Blue Shield Website. Are you...where would I look if I want to look at... [LB604]

ERIC DUNNING: It would be easier for me to do it if I could see it, but it's in our member tools. And it's important to note that you don't get access to it unless you provide your information and sign in. [LB604]

SENATOR BAKER: Okay, you have to log in. [LB604]

ERIC DUNNING: That's right. [LB604]

SENATOR BAKER: Okay. [LB604]

ERIC DUNNING: And again, that's because it's tied to where you are in your deductible and cost-sharing year. [LB604]

SENATOR BAKER: Okay. [LB604]

SENATOR LINDSTROM: Thank you. Any questions? Any other questions? Senator Williams. [LB604]

SENATOR WILLIAMS: Thank you, Chairman Lindstrom. And thank you, Mr. Dunning, for being here. Have you been able to or will you be able to in the future, track the people that use your Website to see what choices they are making? If they go to your Website and say, here's a knee replacement here, here's a knee replacement here, will you be able to track their choice? [LB604]

ERIC DUNNING: You know, I really can't speak to the issue of how we're going to go about tracking that and what that functionality is. I think that one of the things though that we appreciated about this area is that to the extent that we identified that as a potential way of encouraging traffic, we can do it. [LB604]

SENATOR WILLIAMS: You hinted in your testimony something about incentives used to drive behavior and did you indicate that you are going to be using potentially some incentives? [LB604]

ERIC DUNNING: No. I believe I indicated and I hope that I indicated that we are investigating that now. We're in the information gathering phase from our vendor and others. [LB604]

SENATOR WILLIAMS: To see what that might be. [LB604]

ERIC DUNNING: Sure. And to see if they've got any data over time to back that up. You know, it's one thing to say, well, this year it's been a phenomenal success. But what happens next year? Is it sustainable? [LB604]

SENATOR WILLIAMS: Do you know...if you know--and I know you represent Blue Cross--but there are other large insurance carriers out there. Do they offer similar type tools on their Websites about cost comparisons? [LB604]

ERIC DUNNING: I'm feeling a little on shaky ground but I will say, sir, that I have been in other public fora and heard representatives of our major competitors in the state. I haven't heard anybody from Medicare address this point, but other major competitors I've heard have similar tools that they're also very proud of. And they'd probably tell you they were better than ours. [LB604]

SENATOR WILLIAMS: I won't comment on that. Last thing, you heard the previous neutral testifier talking about the issue of self-insured. And in addition to that plan, would I be correct that there are a number of other what could be termed self-insured type arrangements out there where Blue Cross is up front, they're issuing cards, but they are actually being paid a fee to simply manage the healthcare claims that are going on and underneath that you, in essence, have a self-insured plan? [LB604]

ERIC DUNNING: Correct. [LB604]

SENATOR WILLIAMS: Would those types of plans need the same scrutiny that we were just hearing about with the state self-insured plan? [LB604]

ERIC DUNNING: Well, I would tell you that the state's self-insured plan is a little different than most employer-sponsored self-funded groups, because it's a government plan. It's issued by a government. Most employer-sponsored self-funded groups are governed under ERISA and regulated by the federal Department of Labor and, therefore, outside of the jurisdiction of the state. So they're covered over by the federal government. [LB604]

SENATOR WILLIAMS: Okay, gotcha. Thank you. [LB604]

SENATOR LINDSTROM: Thank you. Any other questions from the committee? Seeing none, thank you very much. Any other neutral testifiers? Seeing none, Senator Riepe, if you'd like to close. [LB604]

SENATOR RIEPE: Thank you, Mr. Chairman and committee members. I'd like to say that reform and transparency are essential and transparency is essential to get to reform. I think in looking at this a number of states have gone to--Senator McCollister and I have talked about this at different times--have gone to statewide transparency programs; Arizona and Wisconsin are two. The problem got to be those were very authoritarian, very high structured, almost regulatory types of transparency processes. That is not what works. What works is you put the hands in the consumer and they will go and chop this thing out. And you have to have enough incentive in this thing, as they say in Florida, to make the juice worth the squeeze. You got to give them

something. My argument would be this: If an enrollee in the plan finds a price and saves $1,000, he or she gets $500 and the carrier gets $500. The one that loses more is the expensive provider. It's not the health plan that loses money in that. This is money that they would not have had before. So it's the provider. My experiences was, when I was at Bergan--and this was much to my chagrin--our radiologists at the hospital also had free-standing radiology centers in the community and so you could get the same interpretation, same doctor, same everything. And you know I had a lot of shall we say discussions with our administration about how ridiculous it was, because I can assure you that the compensation that we paid to those radiologists was healthy. So I didn't like the fact that they had this conflict of interest. That was another aside, if you will. I would also say this, I know UnitedHealthcare and Blue Cross have price shoppers. I think we're told that they result in about 2 percent use. We've got to get people engaged more in personal responsibility for their healthcare, but they've also got to get some skin in the game. They've got...and we have to provide that with incentives. That's what works. Money works. Money that they can save works without having it be so unduly complicated that it's one big headache. When I go back to reform I like to go back to the words of Winston Churchill who said, failure is not an option. And we must...he didn't say this, that was his, failure is not an option, period. My comment is, is we must make the complex simple. We have to get these things down to bite-sized, chewable solutions and we have to get there, and quite frankly, in healthcare the clock is ticking. We don't have a lot of time, in my opinion, before everyone throws up their hands and says, well, let's just go to a national health insurance. I think we would all regret that. With that, you've had enough sermon. So I will quit. Thank you. Any questions? Whoops, I'm sorry. [LB604]

SENATOR LINDSTROM: Any questions? Senator McCollister. [LB604]

SENATOR McCOLLISTER: Yeah. Thank you, Mr. Chairman. And you're absolutely right, Senator Riepe, we have had transparency in healthcare discussions. In your role as Chair of HHS, state of Nebraska currently insures a great many people on Medicaid. How will managed care...how could we work managed care in a way that would provide greater transparency in price competition? [LB604]

SENATOR RIEPE: Well, we're starting down the rabbit hole of managed care, and we'll see how that goes. I, for one, am personally not a big fan of managed care, unlike if you take Medicare, your choices are wide open for someone that's on Medicare. On Medicaid you have...on managed care Medicaid you have a narrow network, so you have a limited number of providers that you can get the service from. So your choice is a lot less in Medicaid than it is in Medicare. And sometimes you get adverse selection of the providers who are willing to participate in Medicaid because of lower reimbursement. So one could argue that you probably get a better access to better practitioners and better hospitals with Medicare than you certainly do with Medicaid. [LB604]

SENATOR McCOLLISTER: Thank you. [LB604]

SENATOR RIEPE: Now, I still think there are opportunities. And I come back to and I have another placeholder bill, if you'll bear with me, Mr. Chairman, is that I've got in there coming up to Revenue which talks about HSAs. And it's a placeholder. And I had a meeting on Saturday with Congressman Bacon to find out what's coming down from Tom Price, he's the new Secretary of Health. And it's a placeholder that if we would get block grants we can come in and amend the "bejeepers" out of this particular bill and then build our own plan. And my component piece is this: You allow...through the HSA you allow people...and the three feeders on that would be, is one, employers contribute. The HSA would be just like a 401(k) plan. The employee has to contribute. The state or the block grant would contribute. So you have three pipelines into the HSA. In my envision of this is, that HSA--call it what you will--would be able to pay premiums out of that. If there was anything remaining in that it would be a lifetime fund. You could put it into your estate, so you don't have an incentive to just spend it for the sake of spending it. Out of that, I would like to see...again, coming back, direct primary care. And then you have probably state risk pools for the very...that 5 percent of those that are very expensive. And then you would also allow private commercial, so we're not trying to do the commercials out of this. On the direct primary care or on the high risk pool you would have high deductibles. On the direct primary care you have...because it is direct primary care and the doctor is paid on a monthly basis, you have no copay, no deductible, and 80 percent of the care can be taken with primary care. So you get most of that taken care of. The really bad stuff, the hospitals, the medical specialists, the pharmacy, and the outpatient gets taken care of. I want to go to one of your comments, if I may, too, a little bit. You talked about the bundling and everything else. What we do in the hospital business is, if we start to lose money on it and you're in surgery, we just call down and talk to the anesthesiologist and tell him to cut out the anesthetic, kind of just...okay, okay. We don't. That will be in the record and I want to set the record straight. [LB604]

SENATOR McCOLLISTER: The life insurance pays off then. [LB604]

SENATOR LINDSTROM: We have one more question, Senator Riepe. Senator Schumacher. [LB604]

SENATOR SCHUMACHER: Thank you, Chairman Lindstrom. Thank you, Senator Riepe. I'll be before your committee in a few days on a bill, so you'll have an opportunity to get even with me for this question. [LB604]

SENATOR RIEPE: Oh, thank you. It sounds like it's going to be hard. [LB604]

SENATOR SCHUMACHER: But if while they're shopping they end up dying, could we call this shop till you drop? [LB604]

SENATOR RIEPE: Yes. [LB604]

SENATOR WILLIAMS: Only if they're in an elevator. [LB604]

SENATOR RIEPE: I'm not going to refer to gender in any way on that question. You know, my wife is a shop till you drop, but not me so much. [LB604]

SENATOR LINDSTROM: (Exhibit 6) Any other questions for Senator Riepe? I apologize, I forgot one letter in a neutral capacity. Mr. Nathan Leach is neutral on this bill as well on LB604. So with that... [LB604]

SENATOR RIEPE: Sir. [LB604]

SENATOR LINDSTROM: Oh, I'm sorry. [LB604]

SENATOR RIEPE: I think we do have one in favor, too. And that was Americans for Prosperity. Ironically, Matt Litt sent it me as Chairman of HHS. I think he thought the bill was going to be there. I shared it. We'll have to get...I didn't realize. [LB604]

SENATOR LINDSTROM: And we did get it. It did get around to the committee, so we appreciate that. [LB604]

SENATOR RIEPE: So thank you very much. [LB604]

SENATOR LINDSTROM: Thank you so much. And that will end the hearing on LB604 and that will end the hearings for today. Thank you very much. We'll see you tomorrow. [LB604]

SENATOR RIEPE: Thank you. [LB604]