WILLIAMS: Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Matt Williams. I'm from Gothenburg representing Legislative District 36, and I am privileged to serve as Chairman of this committee. The committee will take up the bills in the order posted. Our hearing today is your part of the public legislative process and is your opportunity to express your opinion on the proposed legislation before us today. The committee members may come and go during the hearing. We have bills to introduce in other committees and are sometimes called away. It is not an indication that we are not interested in the bills being heard today; it's just part of our process. To better facilitate today's proceeding, I ask you-- ask that you abide by the following procedures: please silence or turn off your cell phones; please move to the front row when you are ready to testify. The order of testimony will be the introducer, followed by proponents, followed by opponents, neutral testimony, and then closing by the senator introducing the bill. Testifiers, please sign in and hand your pink sheets to the committee clerk when you come up to testify. Spell your name for the record before your testi-- before you testify, and please be concise. We will have a lot of testimony on the bills that we are hearing today. We do use a light system. I'm going to be asking before we start each bill today how many are proposing to testify on that bill. And based on that, we will be determining whether we will limit testimony to five minutes or three minutes for each testifier. The light system is, if we are on a five-minute clock, it'll be on green for four minutes, yellow for one minute, and then the light will turn red, and we would ask that you conclude your testimony at that time. Three minutes the same way except two on green, one on yellow, and then would be finished. To my right is committee counsel, Bill Marienau. To my left at the end of the table is our committee clerk, Natalie Schunk. And many of our committee members are with us today. We are-- we have a couple of committee members that are introducing bills right now in other committees, and we had one that is sick today. So Senator Kolterman, would you introduce yourself, please.

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

LINDSTROM: Brett Lindstrom, District 18, northwest Omaha.

HOWARD: Sara Howard, I represent District 9 in midtown Omaha.

GRAGERT: Tim Gragert, District 40 of northeast Nebraska: Cedar, Dixon, Knox, Holt, Boyd, and Rock County.

WILLIAMS: And our pages that are with us today are Tsehaynesh and Noah. Thank you. If you need additional copies-- we ask that if you bring anything to hand to the committee, you provide ten copies. If you do not have ten copies with you, raise your hand and our pages will make those extra copies for you at that time. We'll take up the bills in the order printed today. So we're beginning, and we will open the public hearing on LB15 introduced by Senator Blood to adopt the Children of Nebraska Hearing Aid Act. Senator Blood, welcome.

BLOOD: Thank you, Chairman Williams, and good afternoon to the entire Banking, Commerce and Insurance Committee. And thank you for the opportunity to speak on LB15. My name is Senator Carol Blood. That is spelled C-a-r-o-l B as in boy l-o-o-d as in dog, and I represent District 3 which is comprised of western Bellevue and southeastern Papillion, Nebraska. I bring forward today the Children of Nebraska Hearing Aid Act. With this, I bring a question for you to also ponder. Can you name a medical device that changes the lives of millions for the better but is generally not covered by insurance? Well, since I'm here today you've probably guessed that device I'm speaking of is a hearing aid. With a price tag of $1,500 to $3,000 apiece, it is a device that many cannot afford and are often surprised when their health insurance in Nebraska does not cover that expense as it is considered elective. While researching this bill over the summer, it became very clear that the reasons for the lack of coverage vary according to who you ask. An insurance company may feel this is elective, but for a deaf child, hearing aids are a lifeline. Without them, quality of life drops dramatically. Children with hearing loss become isolated and have trouble engaging in life, learning, speech and other skills that help them to become part of their communities here in Nebraska. How can you expect a child to be properly educated, learn language and social skills if they can't hear? Some of you may say through sign language because there is a common misconception in the hearing community that American Sign Language is a derivative of English and therefore not a language by itself. However, the truth is that, as you can see, American Sign Language originated independently of English lin-- linguistic influence as an-- and in-- and is, in fact, its own language with its own set of rules. For those of you that have texted or e-mailed a person who uses ASL, you've probably experienced some confusion, and you probably know what I'm talking about. So there's a lot of miscommunication on both sides because it

would be hard to get your concept across. Children who grow up knowing only ASL who are able to hear later in life have many challenges to face in front of them as well. So in Nebraska, it's calculated on average that 69 children per year meet the requirements for hearing aids. So when you break down those numbers of who may be covered by Medicaid, the HearU program, or are uninsured, you're really speaking about a small handful of children under age 18 that this bill applies to each year. LB15 is asking that Nebraska health insurance companies take on the cost of these devices with specific exceptions for small businesses. LB15 exempts any group health plan offered by a small employer which is described in state statute Section 44-5260 or a policy providing coverage for a specified disease, accident-only coverage, hospital indemnity, disability income coverage, Medicare supplement coverage, long-term care coverage, or other limited benefit coverage. The reason for this bill is that there is solid research, some of which you're going to hear about this afternoon, that shows the impact of hearing properly, that it creates for adults who are-- that it creates adults who are most competitive in the work force and less dependent on assistance from the state and the federal government. This Act will result in each insured child receiving coverage for each ear affected by hearing impairment and include a hearing aid purchased from a licensed audiologist and costs related to dispensing and repairing such hearing aid, evaluation for a hearing aid, fitting of a hearing aid, programming of a hearing aid, probe microphone measurements for follow-up adjustments, ear mold impressions, ear molds, auditory rehabilitation and training, all on a continual basis to the extent the benefits paid for such items and services during the immediately preceding 48-month period have not exceeded $3,000. That was a lot of words. However, the Act will allow for the replacement of a hearing aid and the associated services within three months of the dispensing date if the hearing aid gain and output fail to meet prescribed targets or the hearing aid is unable to be repaired or adjusted. If an insured child uses a hearing aid on the effective date of this Act and the hearing aid has been deemed unrepairable or obsolete by the manufacturer of the hearing aid, the insured child will be eligible to use the benefits required by this toward getting a new hearing aid, parts, and associated services. The purpose of insurance, as you guys all know in this committee, is to spread the risk out among all of the participants. However, we also have to be reasonable. You'll note that a health insurance plan will be exempt from the Act for a planned year if using a calculation method that will be approved by the Department of Insurance that the cost of coverage exceeds 1 percent of all premiums collected under

such a plan for the planned year. With that said, the Department of Insurance may adopt and promote rules and regulations necessary to implement this Act. As of today, Colorado, Delaware, Georgia, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Tennessee, and Texas require that health benefit plans in their state pay for hearing aids for children. Arkansas, Connecticut, and Illinois, New Hampshire, and Rhode Island require coverage for both children and adults. Wisconsin recovers coverage-- Wisconsin requires coverage for both hearing aids and cochlear implants for children. So I do know that the insurance companies do not like mandates, and I clearly understand the reasoning. I'm also very aware that-- that insurance companies like Blue Cross Blue Shield they do cover cochlear implants. And we have great companies like Medica that offer you the ability and support to address health issues before they become troublesome. We have great insurance choices here in Nebraska, but I also know that this is a really small expense that I feel confident will not affect the premiums for other customers. And since you are all on this committee, I'm guessing you have mad skills to do the math yourself that support this statement. When you are doing that math, keep in mind that in the long run, estimates for the cost to the state of Nebraska for children who do not have access to hearing aids is upwards of $400,000 for each child. What it comes down to is that insurance companies are a business. They were created and are in the business to make money. And I don't fault them for this. And I'm sure their stakeholders appreciate this as well. Insurance companies were not originally conceived as healthcare. But with that said, I'm appealing to them and this committee to consider that health care is the role we are asking them to remember today. Hearing aids are not elective. Hearing aids are medically necessary. I will say it should come as no surprise that there are a number of professionals in this field that believe they should also be included in this bill. When dealing with bills like this, there always seems to be some people who feel as though they're being left out, slighted. So in an effort to compromise, we have come up with an amendment which you should have in front of you now that I hope the committee will adopt, and then vote this important bill out of committee. AM410 adds new language on page 3, line 2, so that it would read "Hearing impairment means a hearing impairment diagnosed by an otolaryngologist with an auditory assessment completed by a licensed audiologist." AM410 also adds a language on page line-- on page 3, line 13, so that Section 4(a) will now read "A hearing aid purchased from a licensed audiologist with the medical clearance from a otolaryngologist and costs related to

dispensing such hearing aid." This was a compromise that was carefully worked out between our office and several stakeholders, and we believe it'll take a large-- it'll take care of a large part of potential opposition. So I know that on an issue like this not everyone is going to get exactly what they want, but I feel like most stakeholders walked away from the table happy with this arrangement. So with that, I urge you to advance LB15 with AM410 attached to the full legislature. I'm sure you know that since we're into March, time is of the essence when it comes to getting this bill in front of the body. This is the right thing to do for the children of this state, and I need your help. And it deserves debate. Please show them, especially the ones behind me, that we understand that. Thank you. I will take any questions you might have, though I will note that there are plenty of experts in this field who are behind me who are going to be speaking with you today. And with that, since I may not get to stay for my closing I want to share a personal story with you. Some of you that know me know that I was deaf as a child, and I had a surgery called a mastoidectomy. I forgot what it was for a minute. And I took years of speech therapy because I-- I needed to hear to be able to speak properly. And even though I-- I-- I may or may not, but I assume I seem pretty poised when I speak, there's always that little girl inside me. I always have to think about the words that I say. I have to be very cautious because I have a very strong impediment, especially when it comes to the letter R. But had I not been able to have that surgery, I probably wouldn't be sitting here in front of you today. And my very first memory in life is waking up hearing in the hospital because back then all the children were in one giant room together, and hearing other people's children cry for their moms because it was dark and it was late and that's a memory that I'm-- I'm never going to forget. And I'm very grateful that mine was as simple as a surgery. And I'm a stronger person because I've had to overcome those hurdles. But those are hurdles I could have done without as well. And so I really want you to think about how this truly touches people. And we're talking about pennies. Nobody likes mandates. We're not asking for tens of thousands of dollars in equipment. We're not asking for something frivolous. We're asking for something that is not elective and that is needed. And so I hope that you listen very closely to what people have to say. And I hope that you're very open to hopefully voting this out of committee. Thank you.

WILLIAMS: Thank you, Senator Blood. Questions for the senator? Senator Gragert.

GRAGERT: Thank you, Senator Williams. Thank you, Senator Blood. Did you mention that some insurance companies actually cover hearing aids currently?

BLOOD: No, not in Nebraska.

GRAGERT: OK. I thought-- thought I heard Blue Cross Blue Shield.

BLOOD: They cover cochlear implants--

GRAGERT: OK.

BLOOD: --but those are very-- hearing aids are-- are something that's much more needed. Seemed like something out loud are all of a sudden [INAUDIBLE] are needed more so than cochlear implants and the fact that it affects more children.

GRAGERT: OK. Thank you.

WILLIAMS: Senator Blood, early in your testimony, help me with this, I think you said that you estimated that there would be 69 children?

BLOOD: Right. I took it the last 10 years. And then we looked at the previous 10 years as well. Our population has been pretty stagnant as far as how much it goes up and down here in Nebraska, and so on average there's approximately 69 children a year that are born that require a hearing aid. I believe we gave you a breakdown of who's insured and how here in Nebraska. And so you'll have a strong demographic that are covered by Medicaid already. And then we've exempted small business. And then you have the demographic, unfortunately those that are uninsured, but those that are uninsured can take advantage of HearU which is a program that-- that is [INAUDIBLE].

WILLIAMS: So how many are left after all of that?

BLOOD: Actually we're-- based on our numbers, we're guessing 8 to 10 kids a year--

WILLIAMS: OK.

BLOOD: --at the most.

WILLIAMS: And you listed a number of states that have already passed some type of legis--

BLOOD: I did.

WILLIAMS: --What's-- what's the number of those? Do you happen to have that?

BLOOD: I believe altogether it's 22.

WILLIAMS: OK.

BLOOD: Good question. And I'd also like to point out, and for some reason I think I may have deleted it before I printed this out, in 2000 this body saw fit to make sure that every child received a hearing test at birth. So every single child that is born in Nebraska has their hearing checked which is a very positive and good thing because it's much easier to catch it at the beginning of their life than 1, 2, 3 years later like with me. But the issue is that they never really finish the job which would be to make sure that those children were able to receive hearing aids.

WILLIAMS: Any additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Thanks for coming, Senator. A couple of things come to my mind. Hearing aids typically for both ears is about $6,000.

BLOOD: It can be.

KOLTERMAN: That's what mine were.

BLOOD: And you're an adult.

KOLTERMAN: Anyway. So does-- this just covers half of it?

BLOOD: No. It-- so what it does is it covers up to a certain amount.

KOLTERMAN: Right.

BLOOD: And then-- and again you want to ask the experts on some of this, but it's my understanding that 2 to 3 between the time they get their first one and-- and before age 18 because we don't go past age 18. And they still have to pay the deductible just like you would for any other service. So yeah, I mean it's kind of a drop in the bucket if you look at the big picture.

KOLTERMAN: That was my next question. So if it's subject to the deductible and you've got a sector-- some people in the private sector have a $10,000 deductible.

BLOOD: Well, in the private sector the small business under state statute, 50 employees and under, they don't-- they're exempt from the bill.

KOLTERMAN: Right. OK. Thank you.

BLOOD: We wrote it in a way that is as fair as we possibly-- possibly could be to insurance companies. And oh, you should know on your fiscal note that we are getting a new fiscal note from the University of Nebraska. They way overestimated. And, yeah, were you to kick this out, we will have that fiscal note resolved as well.

KOLTERMAN: So their $120,000 is not accurate? OK. Thank you.

WILLIAMS: Any additional-- Senator Gragert.

GRAGERT: Thank you, Senator Williams. On the young and uninsured then, is that where the other 8 to 10 that wouldn't be-- have insurance any other place or funding any other place?

BLOOD: No, the 8 to 10 are insured. You're going to have a demographic that is uninsured and they can take advantage of something called HearingU which is through the university system. And they deal with people who do not have insurance or have the funds to--

GRAGERT: OK.

BLOOD: --cover hearing aids. And that is a grant-based program that actually you'll see in your budget.

GRAGERT: So where did the other 8 to 10-- I'm just trying-- where's the other 8 to 10 not covered? Where-- where-- where's that scenario?

BLOOD: If they have insurance, those 8 to 10 children in Nebraska are not covered for hearing aids. What we're trying to do is get it mandated that insurance companies have to consider that it's no longer elective, that it's some-- something that that child needs.

GRAGERT: OK.

BLOOD: Does that make sense?

GRAGERT: Thank you.

BLOOD: Um-hum.

WILLIAMS: Seeing no other questions, thank you.

BLOOD: Thank you, Senator.

WILLIAMS: A-- a little more in instructions for everyone that's here today. We're going-- I'm going to be asking who all would like to testify on this bill in just a minute. So get ready to raise your hands if you want to. But if you don't want to testify but you want your name listed in the record as being here in support, opposition, or neutral, we have white sign-in sheets at both doors, and you can sign into those and be part of the record today. How many here today plan to testify on LB15? OK. We're going to stay with the-- the five-minute clock. I would ask though that you be as-- as concise as possible with your testimony with this many testifiers and try not to repeat the-- the things that were said before you. So with that, we would invite the first testifier in support of LB15 to come up and testify. Here we go. Welcome, and would you, please, state and spell your name.

CINDY JOHNSON: Thank you, everybody. My name is Cindy Johnson, I-- C-i-n-d-y J-- J-o-h-n-s-o-n. I am a pediatric audiologist, and I'm here to testify on behalf of Children's Hospital and Medical Center where I work. And I've been there for 11 years. I have been an audiologist for almost 30 years, and I've been seeing children for all of those years. I'm here to testify in-- in behalf of--or on-- in favor of LB15. Some of what I was going to talk about Senator Blood has already talked about. So I'm not going to repeat all of that, but when I was doing my training back in the mid-1980s, I was at UNL. We were ecstatic if we could identify a child with hearing loss by the age of 2. That was like, whoa. And most of the time it was be-- we found kids with hearing loss because they weren't talking, or their speech was not clear to understand. And we could fit them with hearing aids and remedy a lot of-- of their hearing loss because we didn't have the technology to test at a younger age. But since then, we have developed technology, and we can do a couple of different tests. And we do it at birth. So we are finding children literally the day they're born with hearing loss. So they're screened at their birth facility. I work at Children's where we have a NICU. And so any child that's not screened at their birth facility will be brought to our-- our institution, and we will screen them there before they go home. So

I'm on the front lines. I'm the person who tells the parents that your child didn't pass the hearing test. And I'm the one-- person who tells the parents, here are your options. And I'm the person who gets to tell the parents, oh, and by the way, your insurance doesn't cover the hearing aids. So I'm the person that sits with those families, and it's hard because they didn't plan on any of this. They didn't plan for their child to be born with a hearing loss. In fact, 90 percent of children born are born to hearing families, hearing parents. So it's-- it's stressful, and they are-- that's not something that they were planning to have to deal with when they took their newborn home. We-- Senator Blood did say that in Nebraska the Legislature passed a law in the year 2000 that mandated a hearing screen at birth. And we identify somewhere between 60 and 70 babies every year with some degree of hearing loss. And now we have new guidelines that we use in order to get those children into the services that they need. And it's called the 1-6-- 1-3-6 rule. It's-- it was established by the National Center for Hearing Assessment and Manage-- and Management. And so our goal now is to screen babies by 1 month of age, have the diagnostic testing done by 6 months of age-- or 3 months of age, I'm sorry, and then have them enrolled in early intervention, and have whatever device intervention that is most appropriate for them by 6 months of age. Let me tell you, the state of Nebraska does an awesome job of screening babies. We screen 9-- over 99 percent of the babies in our state. We're doing a so-so job of getting them diagnosed by age 3 months. Some of that is due to logistics because there are only a few places in the state that do the diagnostic testing, we at Children's, Boys Town, the University of Nebraska here in-- at the Barkley Center, and then there is a clinic in Grand Island that does see some babies, but for the majority the state they have to travel. And so that takes time getting them in to see us. And then the next step after we identify their hearing loss is they see a pediatric otolaryngologist. And so they will do medical workup to-- to-- just to see if there are any other medical issues that the children have to be diagnosed with. And you'll be hearing from one of my colleagues who does that a little bit-- in a little bit. So we're-- we're-- we're doing better at getting the children into that three-month diagnosis age and then the six-month intervention age. And some-- there's lots of factors that-- that make our numbers not as good there, family compliance, distance, but-- but one of the biggest ones is-- is the hurdle of getting hearing aids paid for. If-- they're covered by Medicaid-- if a fam-- if the family has Medicaid coverage, they are covered for the hearing aids. So-- so the state of Nebraska is already paying for hearing aids through the Medicaid program. But if they don't, there-- there is no--

I don't know of any in-state insurance companies that cover hearing aids. We've had some children who have health insurance, and their parents are employed by a bigger company. And their insurance is out of another state. So every once in a while we'll get a big surprise, and lo and behold, their insurance will cover hearing aids. But if they have a-- a Nebraska-based policy, it's-- it's usually specifically excluded. And it-- the cost, you know, Senator Kolterman, you talked about cost. The cost is anywhere from $1,500 up to $3,000. So there's different levels of digital technology. And some of the higher-end digital that we fit on adults have a lot of features that aren't appropriate for children. And so we don't necessarily need to fit them with the higher levels of digital. We start out with something a little bit simpler because we want children to hear everything around them. That's how we all learned our language is by overhearing things behind you and hearing conversations in-- in another room. That's part of your brain processing all those sounds.

WILLIAMS: Thank you, Miss Johnson.

CINDY JOHNSON: Thank you.

WILLIAMS: We have a red light.

CINDY JOHNSON: All right.

WILLIAMS: Any questions of Miss Johnson? Seeing none, thank--

CINDY JOHNSON: All right. Thank you.

WILLIAMS: --you for your testimony. Invite the next supporter. Welcome, Doctor.

PETER SEILER: Thank you very much. My name is Dr. Peter Seiler, P-e-t-e-r S-e-i-l-e-r. Every time I come to the Legislature, I'm always faced with a roomful of smiling senators, so it's very nice to see-- I appreciate that, and it's nice to see you here this afternoon. I'm here representing the Nebraska Association of the Deaf. It's really-- this association is the only association that represents children that are deaf or hard of hearing. And we have had the same experiences that they have had as children. So because all of us as adults today were children previously and experienced our hearing loss. So we have looked carefully at the laws, and we look for laws that hurt our population of deaf or hard of hearing individuals. And in review of LB15, we want to show our support of this bill because

what we really need is to help and provide equal access to language development for children. Not a cure all, but it is one tool that assists their development of language. American Sign Language is one way, but a hearing aid provides them access to auditory language. And whether that child uses sign language or auditory language depends on the child's need-- needs. So Senator Blood was one of those individuals that was deafened but then was able to hear. And I have been deaf for 73 years of my life, and I used to wear hearing aids. That was back when they had the large boxes that you wore on your chest to pick up the sound in the room, and those were, you know, they're quite archaic. But parents have to give up other things if they choose to provide their child with hearing aids. In my family, there were five of us, and we lived in a one-bedroom apartment. My dad was a blue-collar worker, and he saved money to buy me the-- one of the children in the family, a hearing aid. And my brothers and sisters obviously suffered or had to go without some things because my parents were able to and chose to provide me with hearing aids for hearing access. So I, you know, I applaud my parents for the tough decisions that they made. They were determined to allow me access to education and access to be able to learn English. And, you know, today I'm able to have a PhD because of what my parents sacrificed to help me so that I could get access to education. So it was-- it was a miraculous thing for my parents to do that. But, you know, there are many families today that are struggling today to find the funding to provide their children with hearing aids. Nothing has really changed. And I think that that is a tragedy to make parents have to pursue lawyers and doctors to try to find funding to provide their children with hearing aids, and it just doesn't seem fair. So if this bill passes, it will provide support to parents so that they can help their children grow up and have access to spoken English language, have spoke-- access to a career as an adult that they choose to pursue. Parents who don't have the financial access to do this, they-- they may choose to have their child surgically implanted with a cochlear implant because insurance will pay for that. But, you know, a lot of parents don't want their children to undergo surgery at a very young age. And if they have some hearing, you know, it's not necessarily the best option for them to have a cochlear implant. Some of them, parents, choose to make that decision later so that the child is older, but that's-- that's a window of opportunity that's lost. So, you know, the critical period for young children is 0 to age 5 when they are accessing and trying to learn language within their environments. So I am in support of parents, and I would like for you to support parents in their desire to have their children develop language abilities. Children of

Nebraska need and-- this is what we need to have for them to be able to succeed. Thank you very much for your time.

WILLIAMS: Thank you, Dr. Seiler. Are there questions for Dr. Seiler? Seeing none, thank you for your testimony. Invite the next supporter. Welcome.

JOHN WYVILL: Thank you, Mr. Chairman, members of this committee. My name is John, J-o-h-n, Wyvill, W-y-v as in Victor i-l-l. I am the executive director of the Nebraska Commission for the Deaf and Hard of Hearing. I'm here today on behalf of my board, a nine-member board appointed by the Governor as an independent agency strongly in support of LB15. I just have four points to make. First of all, is that the state insurance for state employees currently does cover insurance coverage for state employees and their families. This was also raised and upgraded by Governor Ricketts recently. So we point out that the trend for being progressive in state government, Governor Ricketts and the administration had recognized this is a critical need and have adopted that for state employees on their own. Second, I come to you with this piece of legislation which is adopted in other-- a number of different states, personifies the common- sense value of the Nebraska Legislature for common-sense solutions to problems facing the citizens of this state. And so this is a practical, pragmatic solution to the challenges that will break down barriers in employment and education in the long term, and in fact, save money in the long term. Third, from a personal standpoint, I share with you, I also have a hearing aid. Medically speaking, I have a 95 percent hearing loss in both ears. I have been told by doctors and medical professionals that I would be lucky to graduate high school and don't even think about college. I became the first person in my family to graduate college and go to law school. And I do know the struggles my parents, early on, had for investing in hearing aids for them. And as an agency director I have personally seen-- as a professional seen firsthand the challenges for adults and children alike in that they-- that are struggling to manage their budget and try to find communication access which that would be for hearing aids. The last point that I want to share, but many of you may have heard about in your leadership class-- in your chamber class, is-- is a parable that's also on the Internet, so if you've seen it on the Internet, you know, it must be true, too. So the story goes: For want of a nail, the shoe was lost. For want of a shoe, the horse was lost. For want of the horse, the rider was lost. For want of the rider, the battle was lost. For want of the battle, the kingdom was lost. All for the want of a horseshoe nail. Members of

this committee, the investment of a nail by passing LB15 will ensure that our kids have the opportunity in education and employment. And all I ask for you not only for your vote but for your support. And hopefully for those that have not signed on as cosponsors to sign on to this important legislation that will make a difference and an investment in the future of our children. Thank you.

WILLIAMS: Thank you, Mr. Wyvill. Questions? Seeing none, thank you for your testimony.

JOHN WYVILL: Thank you.

WILLIAMS: Invite the next supporter. Welcome.

JOSH SEVIER: How are you doing? Chairman Williams, and members of the Banking, Commerce and Insurance Committee, my name is Dr. Josh Sevier, J-o-s-h S-e-v-i-e-r. And I'm an audiologist and a member of the Nebraska Speech Language and Hearing Association. We represent speech language pathologists and audiologists in the state of Nebraska practicing in hospitals, private practice, and school districts. I appear before you today on behalf of the Nebraska Speech Language & Hearing Association in support of LB15. If someone with a diagnosed hearing loss chooses to communicate orally, any reduction in hearing may interfere with the understanding as well as their production of speech. This is because they may not be able to hear the audible level and sound frequency level required to comprehend that sound which may in turn confuse them as what sounds they should make in order to produce it themselves. For children learning speech for the first time, the first two to three years are especially crucial. If they are unable to hear the production of a sound from friends or family, they will develop a method of speech filled with various types of speech errors. These errors, if left untreated, can lead to detriments in education which may ultimately lead to difficulty in finding employment and supporting a family of their own in the future. The best way to truly understand this is by listening to someone's personal experience. Last summer, I met a man here in Lincoln originally from New York State. He told me about a group of his cousins one in which was born deaf. This is more than 30 years ago not having a lot of the technology that we enjoy today. The other cousins went on to have very successful careers while the one cousin who was born deaf struggled with his education and had a very hard time finding employment. He now repairs furniture part-time to make ends meet. The man that told me this story is someone that truly understands the benefit that hearing aids can play in education and

success for someone born with hearing loss, and chooses to communicate orally. The man that told me the story was Lieutenant Governor Mike Foley. While the practice of hearing-- or while the price of hearing aids varies on level of technology and features within the hearing aid itself, hearing aids when properly fit to a child's hearing loss can be instrumental in the success of developing language and obtaining a proper education. Unfortunately for many families, the price of hearing aids serves as a barrier for them to obtain this life-changing technology for their children. The passage of this legislation would aid in the education and development of children across the state of Nebraska. It could be the difference between a child's ability to hear the sound of a friend's voice or a parent saying, I love you. The Nebraska Speech-Language-Hearing Association membership respectfully requests advancement of this bill that will impact Nebraska's children's lives for the better. Thank you.

WILLIAMS: Thank you, Dr. Sevier. Questions for the doctor? Seeing none, thank you for your testimony.

JOSH SEVIER: You made that easy.

WILLIAMS: Invite the next supporter. Welcome.

JEREMY FITZPATRICK: Welcome. Sen-- Chairman Williams, and members of the Committee, thank you for having me, and my name is Jeremy Fitzpatrick. I am the chair of the board of commissioners for the Nebraska Commission for the Deaf of Hard-- and Hard of Hearing, and I'm the parent of a child who wears hearing aids, my son Quinn, who is here with me today. We're one of these families that-- that aren't covered who have insurance, have always had insurance, but that insurance doesn't cover hearing aids. And this is like I think a classic issue where if you're poor enough, the government will help. If you're affluent enough, that's something you absorb. And if you're a working-class middle family, you really get squeezed, and that's-- it's the case here. Senator Williams, you had asked how many-- how many states have passed a law. I think the number is up to 24 now. Iho-- Idaho just passed it. There is a growing trend. It's, in the last five years, an increasing number of states who are passing this law. Senator Kolterman, you'd asked about the cost. It's probably more like 3 to 5 for kid's hearing aids and their-- deductible's an issue which you raised, but I will tell you, those families will take whatever help that they can get. And the fiscal note that you have received is wildly inaccurate as-- as to the university. It needs to be corrected. I'm here to support LB15 and urge you to vote for it.

This is an Act that will both help families as we've just talked about and also is a smart fiscal conservative good choice for the taxpayers of Nebraska. Other folks commented that the studies have been done. When you don't get to these kids early, the social and economic costs on the back end is something like $400,000 per child. So for this $3,000 to $5,000 investment on the front end every three years or so, there is a chance to save the taxpayers a tremendous amount of money and also not lose the human potential of those individuals. What was also mentioned is that in 2000, this Legislature passed the law requiring hearing screening for children. And that law made a dramatic--dramatically affected my son's life because we knew immediately in the hospital Quinn had some hearing issues. And we could get right after it, he's had hearing aids since he was four months old. And the senators who passed that law made a dramatic influence in his life that's going to continue for all of his life. And long after they have no longer been in this body. That's true with LB15, you have the opportunity by passing this law to make a dramatic difference in the lives of Nebraskans today and well into the future. And I urge you, as the chairman of the board of commissioners for the Nebraska Commission of Hard of Hearing and as a parent of a child who wears hearing aids to please support this bill. It is-- affects families across the state and you can help them. Would you like to say anything?

WILLIAMS: Quinn, can you spell your name for us?

JEREMY FITZPATRICK: How do you spell your name?

QUINN FITZPATRICK: Q-u-i-n-n.

JEREMY FITZPATRICK: There you go. Quinn. And what would you like to tell them?

QUINN FITZPATRICK: Please, help children who have hearing aids like me.

WILLIAMS: Thank you, Quinn. Quinn, what grade are you in?

QUINN FITZPATRICK: First.

WILLIAMS: First grade?

QUINN FITZPATRICK: Um-hum.

WILLIAMS: OK. Let's see if there's any questions from the panel. Any questions?

JEREMY FITZPATRICK: Thank you.

WILLIAMS: Seeing none, thank you for being here. Next proponent. Welcome, and if you could tell us your name and spell it for us, please.

JASPER PAYNE: My name is Jasper, J-a-s-p-e-r P-a-y-n-e.

WILLIAMS: You may go ahead.

JASPER PAYNE: So I want you to pass the bill because it really helps-- helps me to-- just because see-- I'm hard of hearing. And it's-- it's a lot-- it's-- but the grade-- I'm getting good grades in school, and that's only because of the hearing aids. And if I didn't have them, I would not be getting good grades. And I-- and it also really helps me with my relationships because without hearing, relationships would just be really hard. And that-- it-- that's why they-- and also it just so many-- the-- there's just so many details that are just-- like there's so many like costs and details that are really hard because they're not covered by insurance. Because if they were, it just-- it just take a whole lot of stress off me-- me.

WILLIAMS: Thank you, Jasper. What grade are you in?

JASPER PAYNE: Seventh.

WILLIAMS: Seventh grade. Where do you go to school?

JASPER PAYNE: Omaha Virtual School.

WILLIAMS: OK. Good for you. Are there any questions from panel members for Jasper? Seeing-- whoop, Senator Kolterman.

KOLTERMAN: Jasper, thank you for coming today. When did you start wearing hearing aids?

JASPER PAYNE: I think, ever since I was born. I don't exactly remember, but I've had different hearing aids over the years. These are behind the ears, and I got-- I got them about two or three years ago.

KOLTERMAN: So early on in your life, correct?

JASPER PAYNE: Well, early on in my life-- life I had a BAHA so. And that costs a lot more and it's really tricky then because like-- like if-- if it's-- one little water drop would like basically destroy it so.

KOLTERMAN: So you're very courageous to come here and talk to us today. Thank you for coming.

WILLIAMS: Any additional questions? Thank you, Jasper. Invite the next supporter. Good afternoon.

LARYSSA PAYNE: Good afternoon. My name is Laryssa Payne, spelled L-a-r-y-s-s-a, last name Payne, P-a-y-n-e. So yes, you've brought a bit of pain. Sorry, I can't resist. Good afternoon. Thank you so much for everyone who has shared. Thank you, everyone who is listening. Thank you, Senator Blood, for bringing forward the bill. I am so excited and hopeful and urge you, please, to vote for this. He was born thirteen and a half years ago. When he was born, he was in the NICU. And in the NICU, they were checking out other issues and said, oh, by the way, we think he has a hearing loss. And my heart sank. I am a first-time mom. I don't know what I'm doing anyways, but I want to love him. And I love him with all my heart, but what do I do? And then we go to the hearing professionals, and they test him and, yep, he's got a hearing loss at two months old. OK, what next? We need a hearing aid. Great. Is it covered by insurance? No. And that is so frustrating because that is expensive and we couldn't. And then they told us there was the window that would close, that if you didn't get it on him by about four and a half, five months, that window-mapping brain, and just the brain, not just producing the sound later but the brain to map it and the neurons, it needs it by then. And we-- the only option for us because we're one of those families, again, like another family shared, we are not rich enough to pay for it ourselves. We're not poor enough that we are covered by Medicaid or, etcetera. And we have insurance. We've always had insurance, but we-- it doesn't cover that. And this is so key because it connects them to language. One of my dearest fear-- dearest desires and then fears conversely were, could he ever hear music because we lear-- love music, but most importantly, would he know what I love you meant? Could he understand it when I said it to him? Would he be able to produce it? Because, as someone mentioned earlier, what the brain can take in, it can eventually produce. And so my greatest fear was would we get this? So we had to reach out to one of the organizations, but we had to wait on them and wait and wait. And the window was getting closer and closer.

And it was a lot of stress. Because meanwhile, we're also being told by other hearing professionals, Boys Town, etcetera, was at home, talk, talk, talk at him. Get him all that language. Give him that brain that opportunity to get it into him. But it's hard to focus, and it's hard to just keep that up for someone when you're worried and stressed about where's the money going to come from. And that window was closing. Finally, in the literal nick of time, we got the letter saying half of the aid would be covered. We asked our church for the other half and they, thankfully, kicked in, but not every church can do that. Not in your family, you know, they said yes to us. They had to say no to other people. So I am so grateful for the help that was given, but it would have been such a difference to be able to just get that-- get that covered right away without worry. And then even when we get it, what did I have to do? OK, three to five years, we'll need another one. Got to start planning now. Got to start saving now. We still didn't have it. We had to do another fund-raiser; ask for help again. I don't want to just ask for help. I want to give help. We want to be contributing members. He wants to be a contributing member. And so it was just-- it was just a lot. I mean he's a new-- he's a-- I'm a first-time mom. There's a lot to learn about how to help a kid who's-- and you heard him, you heard him be-- he's an introverted, hard of hearing kid who could come before you guys and speak boldly, clearly. That took a lot of work. I am willing to do the work. That is my backpack. I'm more than willing to take on the extra needs, but what was for me, the hearing aid not being covered, that was a boulder. Boulders need help from others. We need that boulder to be lifted. Please lift the boulders off of the lives of our families. And it will just do so much because language connects him. He wanted to be oral. It's true, people could do ASL, but a CI would never help him. That wouldn't work. His type of hearing loss, specifically conductive hearing, the BAHA-- it's an acronym and it includes the word conductive aid because it's the type of hearing loss he had. He would never be helped by a CI, so that insurance would never even be needed. It'd be a silly thing to do for us. So I-- I am so desperate for a chance to help other families who have a conductive loss, who come up and know that, to have a chance to be covered. And so the conductive loss, it totally disconnected him because language is the root of being social. Language we need to map, and he wanted to be oral. We would have gone to ASL had he needed it, but he loves being oral. He loves talking. He loves being Dr. Seuss. He would come up with his own rhymes. He loves Hachiman and Ninjago or Legos or can talk your ear off about Minecraft as it were needed and he is a part of robotics. He is a-- imagine a kid who is a part of robotics cre-- he gave good

ideas to a theater class, The Rose, recently who other kids appreciated all because of the hearing aid which was tough to cover so, please, support us. Thank you so much for hearing us out. One of the best joys of my life is when as a young, little one finally heard him say I love you to me. And then I knew he'd been hearing I love you from me all along. Thank you for listening.

WILLIAMS: Thank you, Miss Payne. Questions? Seeing none, thank you for your testimony. We'd invite the next proponent. Welcome.

LYNN JOHNSON-ROMERO: Good afternoon. My name is Lynn Johnson-Romero. It's a long one. It's L-y-n-n J-o-h-n-s-o-n hyphen R-o-m as in Mary e-r-o. Good afternoon, Chairman Williams and members of the committee. My name is Lynn Johnson-Romero. I work with students who are deaf and hard of hearing in Westside Community Schools. And I'm here to support LB15. Every day I work with deaf and hard of hearing children born into hearing families and born into hearing communities who end up coming mostly-- most of these students come to me and it's a mainstream school. They're mainstreamed. They go to school in their communities with their peers. And so after they are identified with hearing loss at birth, which Nebraska does a wonderful job with that, they come to me as students. So with the cost of hearing aids proving a substantial financial burden, many of those deaf and hard of hearing infants and toddlers don't get access to language that's critical for healthy development. Language deprivation, which you've heard a little bit about today, often then has a lasting negative impact not only on the child's education but also on their social and emotional health. If you struggle with language, you struggle with reading, and then you struggle with math, you struggle with social studies, you struggle with all of those things. So access to language at a very early age is critical. And I see it every day. Families don't have the money to pay for hearing aids. And so that infant or toddler, when that language learning window is very, very important, they have intermittent or they don't wear hearing aids because their family doesn't have the money to get them hearing aids. They may not have known from the beginning, may not have access to some of those organizations that can help with that. I'd like to read an experience that I recently had. I promised a group of my students that I would share this with you. As part of my job, I regularly meet with small groups of my students to talk about self-advocacy in the classroom. Last week, I was telling a group of my elementary age students, who have named themselves, the Deaf Warriors, which is a derivative of Westside Warriors, I was telling them about this bill. I asked them what they would want you to

know. We talked about it for a while, and there were several stories, but we collectively came to an agreement about this. So they replied, without hearing aids kids like us would miss out on school. They talked about missing out on family situations, at the Thanksgiving table, at the Christmas table, missing out on what you've also heard about is incidental language. That's the foundation of how we all learned spoken language, hearing our family's talk, hearing our parents talk to us. That's called incidental language. And when you don't have access to language, you don't have access to that incidental language, that foundation of how we learn. So one of the sixth-graders, who I'll call Jane, went on to tell us a story of how when she was little, her mother was forced to take out a loan to pay for Jane's hearing aids. Jane's mother is a single mom who works 40-plus hours a week to provide for her family. When she inquired about getting Jane, then three-years-old, hearing aids for her moderate hearing loss, health insurance denied her claim. They told her that Jane's hearing aids would be considered a luxury. I can tell you from years of experience, equal access to language is certainly not a luxury. It is a necessity in the pursuit of a successful life. I want to thank all of you for your time on behalf of myself, as an educator, my current and future deaf warriors, and their families. I urge you to support the Children of Nebraska Hearing Aid Act, so that we can ensure equal access to language and learning for all of our children who are deaf or hard of hearing in Nebraska.

WILLIAMS: Thank you, Miss Johnson-Romero. Are there any questions? Seeing none, thank you for your testimony. Invite the next supporter.

KATIE BRENNAN: Hi, I'm Katie Brennan, K-a-t-i-e B-r-e-n-n-a-n. I'm a speech language pathologist, and across my career, my area of focus has been in working with children who are deaf or hard of hearing. And I've worked with a lot of children who did not have access to technology early on, and, you know, the same things, barriers with funding for devices or access to devices. And developing their speech and language skills is really hard when we can't do it when our systems want to do it, when we can't work in developmental synchrony. We are working against the clock. We are thinking about brain plasticity and when that critical period for language development closes, we can't wait until kids are six or seven, when families can save enough to get hearing aids. We've-- we've lost our moment. That moment, that ship has sailed, and we're going to find-- have to find different ways to get these children through our educational system. Our educational system is an auditory-based system. Our kids sit in

classrooms and listen to the teachers, readings, and auditory-based tasks. So when we have kids who are delayed in their auditory skills, and their speech and spoken language skills, it really trickles down into how they can participate academically leading to what other opportunities for employment later in life. We know that early access to sound through hearing technology is critical for developing speech and spoken language skills for children who are deaf or hard of hearing. Children who don't have that access on average are going to be one to four grade levels behind their peers simply because they don't have access to that language through hearing. And if we can intervene and prevent that, we really should. So I also have a personal connection to hearing loss. My husband, who's home sick today, has a hearing loss, and he was lucky enough to be in a family who could afford to provide him hearing aids when he was younger. And now he has a PhD, and he's a faculty at UNL and is working on researching and developing better hearing aids for individuals with hearing loss so that they can achieve their potential. So I hope that the committee recognizes the importance of this legislation for providing access to our children to achieve their potential. So, you know, maybe there's somebody out there with that hearing loss and just needs hearing aids to go out there and invent some amazing thing and that they're not held back by their hearing loss.

WILLIAMS: Thank you, Miss Brennan. Questions? Seeing none, thank you for your testimony.

KATIE BRENNAN: Thank you.

WILLIAMS: Invite the next supporter.

EDISON McDONALD: [INAUDIBLE] Hi, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We're a membership organization with 1,500 members and 9 chapters that advocates for people with intellectual and developmental disabilities to ensure their full inclusion into our community. We strongly support LB15, and would like to thank, Senator Blood, for introducing the bill and the committee for hearing us out today. According to the CDC, 1.4 per 1,000 babies are diagnosed with hearing loss at 40 decibels or more. According to a 2013 study, 40 percent of these children will have a co-concurring disability. Frequently, this is an intellectual or developmental disability. It is difficult enough to ensure that a child has access to their basic rights. If they have hearing loss, this is increased. If they have hearing loss, and they also have a co-concurring disability like a developmental or

intellectual disability for the children that we represent, this adds extra barriers. And unless we can ensure that we're able to protect these and help ensure that people are able to fully communicate, it can cause some significant delays. As you've heard earlier, this is of increased importance because of the development of a child happens significantly at younger ages. For-- this is particularly concerning for children with hearing loss who have these co-concurring disabilities. On average, according to a 2005 study, a child with a-- with hearing loss will have a developmental disability diagnosed at least a year later than a child that does not have that co-concurring disability which can cause significant delays for that child and cause significant barriers to their further education and development as a member of our community. By passing this bill, you will help to eliminate these barriers faced by these children. I know that I've said this before in front of other committees that some of you serve on, but I want to bring it back up. For our members, there is a constant battle to navigate services. Even trying to find basics like a doctor, dentist, a barber can be an increased difficulty finding someone who's willing to work with a child with a developmental disability. The normal process for parents with children with disabilities can really be tremendously difficult to navigate. We're excited about this common-sense process to ensure accessibility, and we urge you to support this bill. Thank you for your time.

WILLIAMS: Thank you, Mr. McDonald. Questions? Seeing none, thank you for your testimony. Invite our next supporter. Good afternoon.

LESLEY TUREK: Hello, my name is Lesley Turek, L-e-s-l-e-y T-u-r-e-k. I am a former tax accountant turned stay-at-home mom to five children ages eight to one and a half years old. Of our five children, two require hearing aids as part of their daily living which includes education. My husband and I had no reason to believe our children would be born with hearing loss. When our second son, Kale [PHONETIC], was born, he failed a newborn hearing screen. After several follow-up appointments, the hearing loss issue was tabled. I began staying home when Kale was almost two-years-old. After spending more time with him and seeing him develop language, I could tell something was wrong. We followed up with testing at Boys Town and was told Kale would need hearing aids and that insurance did not cover this cost. One thing I can say through experience is that this news is very hard to take. We were in unchartered territory. On top of creating a new normal for Kale and learning about hearing loss and what our family needed to do to catch Kale up to his peers, we had to find a way to obtain hearing

aids. We were very fortunate to apply for and receive a grant, but without that option, we would have not been able to afford the large, unexpected cost of hearing aids like many families in our situation. The benefits of hearing aids for Kale are hard to enumerate. Kale was able to communicate much easier and better almost immediately after being fitted with hearing aids at two and a half years old. We were able to get services through our school's special education program. And with the help of the hearing aids, Kale is currently in first grade and able to spend the day in a mainstream classroom where he excels academically and socially. I am very confident in saying that Kale would not be in his current situation without hearing aids. We had a daughter after Kale who does not have hearing loss and then another son. Our fourth child, Jackson [PHONETIC], who is here today, was fitted with hearing aids at two and a half months old. We were not planning on the financial burden of another set of hearing aids. Watching an infant hear for the first time is an unexplainable experience. His eyes lit up and he instantly stopped fussing. At his current four-years-old, Jackson is able to speak and play like his peers. Once again, without hearing aids, Jackson would have a very hard time socially and academically. While he is currently not in preschool, I know that his learning would be greatly affected. Both our sons have been great wearers of their hearing aids and want to wear them. Even as children, they recognize the benefits of hearing aids. I believe hearing should be treated as a necessity, not as an optional benefit. And I know it was asked earlier who those 8 to 10 kids a year are who can't afford them, and I have two of them. We live a modest, modest life, modest vehicles, modest home, and the expense of that, every three to five years to have new hearing aids for our kids, just would be very difficult for our family. And so we just ask for your support in this bill. Thank you.

WILLIAMS: Thank-- thank you, Miss Turek. Questions? Seeing none, thank you for your testimony. Next proponent.

RYAN SEWELL: Good afternoon, Chairman Williams, members of the committee. My name is Ryan Sewell, R-y-a-n S-e-w-e-l-l. I'm a pediatric otolaryngologist, that darn word, otherwise known as an ear, nose and throat doctor. I did my residency training at Nebraska Medical Center, went to Boston Children's to specialize in pediatric otolaryngology and have been practicing in Nebraska for nearly ten years. I am here on behalf of the Nebraska Medical Association and in support of LB15 and the amendment. We'd like to thank, Senator Blood, for bringing forth this bill as well as working on the amendment. As

you've heard from firsthand knowledge the impact hearing loss can have on these children and these families. You've heard of the speech and language delay. You've heard of the educational impacts, and what you haven't heard is maybe the overall society--costs to society. Some studies have estimated that untreated severe to profound hearing loss can cost upwards of $1 million mostly in lost potential-- earning potential. Really our goal whenever we see a child is to help them achieve their full potential. And that's really what these hearing aids do, allow these children to have and to meet their full potential. As this mother noted previously, it's an interesting or kind of invi-- invigorating experience to see a child wear a hearing aid for the first time and to actually see what's going on around them. It's also equally exciting to hear a family say there's no way my child would keep that in their ears, and you see them back three months later and they say they won't take it out. They can see the difference immediately when they put it in there, and it's that reason why the Nebraska Medical Association supports this bill. We support the increased access to this-- to hearing aids as well as the services that these children require. Thank you, Senator Blood, for working on this bill. And I'm happy to answer any questions you may have. Thank you.

WILLIAMS: Thank you, Dr. Sewell. Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. And as a hearing-impaired person myself, I'm grateful for it and my wife is grateful for my hearing aids. [LAUGHTER] The question I have is, is there such a thing as a secondary market for hearing aids? Can you buy a used hearing aid on eBay, for example?

RYAN SEWELL: So it's a good question. I don't know the answer to that, but the problem is even if you could buy the hearing aid, it's not-- it's not just like trying on a pair of-- pair of shoes, you know, you've got to have that hearing aid programmed to your specific hearing loss. There are programs where used hearing aids are donated, and that-- they will be fit to the children through those means. So there are some other avenues to gain currently where children do not have access to hearing aids where we can get them through used hearing aids or other services like that.

McCOLLISTER: But the programming itself is-- is a very modest cost. It's the acquisition cost that-- that's so substantial. I just-- I--

there must be a prohibition against selling hearing aids on the open market.

RYAN SEWELL: Is there one?

_____: There is.

RYAN SEWELL: OK. There is. I didn't know that. [LAUGHTER] I'm glad she didn't leave the room.

McCOLLISTER: Should-- should-- should we make that a part of the bill to make hearing aids available, used hearing aids available?

RYAN SEWELL: Well, it's a little bit, I guess, beyond the scope of what, I guess, I had looked at this. I'm-- I guess I would be afraid in those cases, you know, most people aren't getting rid of their hearing aids until they're basically obsolete. You know, the technology's changed to the point where the next generation is there. So you would be giving, you know, older equipment, potentially, you know, broken equipment, those types of things. It may be even more expensive to continue to service those older models than before, but I don't-- I don't have access to that data to answer that question.

McCOLLISTER: But even a used, somewhat obsolete hearing aid is better than none at all, correct?

RYAN SEWELL: I would say that's probably true.

McCOLLISTER: OK, thanks very much, Doctor.

WILLIAMS: Additional questions?

RYAN SEWELL: Thank you.

WILLIAMS: Thank you, Doctor, for your testimony. We'd invite the next proponent.

AMBER McLAUGHLIN: My name is Amber McLaughlin, A-m-b-e-r, last name M-c-L-a-u-g-h-l-i-n. Dear members of the Banking, Commerce and Insurance Committee-- first of all, I would like to thank, Senator Blood, for introducing LB15, the Children of Nebraska Hearing Act. And also thank you to Jeremy Fitzpatrick for keeping us informed of how the bill was going. I live in Omaha with my husband, Brian [PHONETIC], and our two daughters, Leah [PHONETIC] and Emmy [PHONETIC]. I brought my daughter, Leah, here with me today because she is deaf in her left

ear and hard of hearing in her right ear. She was diagnosed with hearing loss at 15-months-old. She actually passed her newborn hearing screen so we had a false negative in the-- in the NICU and so it was-- she was about 15 months when we got diagnosed. So we lost valuable learning and language time in the plasticity of her brain. We found out that our medical insurance did not cover the cost of hearing aids. We were very shocked. My husband and I both work full-time with good in job-- with good jobs with insurance provided. We wanted Leah to have her necessary hearing aids right away. The cost of her initial hearing aids for both ears was over $4,000 for us, and we did not have that kind of money just sitting around. So we took a withdrawal out of our 401(k) that we were not expecting to have to do at the time. We understood how important her hearing is to her language and education and social development. There isn't anything I wouldn't do for this child right here. It would directly positively impact our family if LB15 will get passed. I worked hard to always show Leah that there isn't anything that she can't do just because she is hard of hearing. Her hearing aids help us with this goal. Thank you all for this opportunity to come here and show our support for the bill. I also serve as the president of the Nebraska Hands and Voices nonprofit organization. Our organization provides support, education, and advocacy to families with deaf and hard of hearing children in Nebraska without bias towards one communication-- communication method over another. I know that many of the Nebraska families in our organization utilize hearing aids with their children. Thank you for the support of your hardworking and often understood-- underserved population in Nebraska.

WILLIAMS: Thank you, Miss McLaughlin--

AMBER McLAUGHLIN: Thank you.

WILLIAMS: --and welcome, Leah. Any questions? Seeing none, thank you for your testimony. We'd invite the next supporter.

DANIELLE SAVINGTON: Good afternoon, Senators, Chair-- Chairman Williams. My name is Danielle Savington, that's D-a-n-i-e-l-l-e S-a-v-i-n-g-t-o-n. It's funny because sometimes I forget how small the world is. I came here today, and as I was researching what I wanted to say, I was thinking to myself how I didn't really have any skin in this game. My children have full hearing. They might pretend they don't when I ask them to clean their rooms, but they can hear me. And as I was researching, I was thinking about how I intended to come here and say some things because I think it's the right thing to do. But it

really didn't have a direct impact on my life. And I was listening to the testifiers, and Jasper Payne came up to testify. And I recognized Jasper because my son is a fourth grader at Omaha Virtual Academy, and he and Jasper are on the same robotics team. And Jasper has at times helped my younger son build his robot. And it occurred to me how very, very small this world is, even with such a small community of children in Nebraska who need this type of help. So I was reminded, again, that sometimes doing the right thing exposes us to opportunities to see how small our world really is. So what I had intended to come here and talk about is just how small this ask is. The numbers of children that are impacted in Nebraska by this are very, very small, but I think that the funding for it is absolutely available. And the reason why I think that is because I was looking over Dataomaha and the NADC which provides disclosures of funds that have been received by the insurance companies to help campaigns be run for Unicameral senators, and I found some interesting information that I think is relevant to this ask. I found that Senate-- Senator Gragert received $3,000 from 2014 to 2018, not all the money in any given year, but this is the window of time that I looked at. Senator Kolterman received $7,850. Senator Williams received $7,800, and Senator Lindstrom received $17,150. That's $35,800, a little over that, that has been received from the healthcare industry. That's pennies, right? Pennies in the campaign funds that are received that provide the access to this opportunity for senators. And it's pennies that $35,000 could provide 8 to 10 kids hearing aids in a year or 3 years. So I think that when I put that into perspective, it really struck me that it's not asking a whole lot of money. Those donation amounts aren't ones that should raise anyone's eyebrows. Those are all appropriate amounts of money that are necessary to obtain political office. And I think if we can justify it as appropriate donation amounts, we can justify it as appropriate money to spend on Nebraska's children. When the new Nebraska slogan came out, Nebraska, it's not for everyone, I think a lot of us were shook because Nebraska is known as being a place everyone wants to raise their children. And so LB15 really brings that into perspective with the fact that when you're raising children in Nebraska, we want our laws and our schools and our communities to do everything we can to support our children. And I think that it's especially important for these last few children who really need this very small ask to be codified and made part of our legislation and part of our bills, so that they have the best opportunity to go to school with all of our children and provide opportunities for them and be friends and just engage in the same social atmosphere that all the rest of our children

have an opportunity to engage in. So with that, I thank you for your time.

WILLIAMS: Thank you, Miss Savington. Questions? Seeing none, thank you for your testimony. Invite the next supporter.

NATHAN SCHMITZ: Hello. Nathan Schmitz, N-a-t-h-a-n S-c-h-m-i-t-z, and I'll tell you, I want to keep this one short, but I just kind of want to come up here as a parent to-- of a child that uses hearing aids. Ours is a little bit different. My son did pass his newborn hearing screening. We didn't actually find out until about halfway through his first-grade year of school that he needed hearing aids. So at that time huge shock. And then to turn around and then hear that, hey, by the way, we need money for those hearing aids insurance doesn't cover. Having three other kids at home on top of the child that needs hearing aids, you start going, OK, wow, how are we going to come up with this money? And it-- we were lucky we were able to get a grant and help out. But, you know, we're like a lot of these other people that just-- that have talked to you guys today. You know, we're kind of in that area where, you know, we make enough money that we can't-- you know, Medicaid wouldn't cover it. You know, we don't make enough to where we can pay for it out of pocket. But again, we were lucky to get a grant to do it. But what we've seen is-- is just a complete 180 since my son's gotten his hearing aids. He hated school. He was in trouble all the time. I mean he spent his kindergarten year in what they called the safe seat, a time-out, OK? He-- he didn't like doing anything. Little did we know, part of it was he couldn't hear. He got those hearing aids towards the end of his first-grade year. He-- now he loves reading. We can't get a book out of his hands. He sits, and he's top of his class in reading, and he'll sit there and do anything and everything he needs to do, and enjoys going to school. So when I look at it, I look at-- at an education side of it. I mean, we require kids to go to school. Why are we not giving them opportunities and the best chance of learning while they're in school? If they can't hear, they don't have that opportunity like everybody else does. Thank you.

WILLIAMS: Thank you, Mr. Schmitz. Any questions? Seeing none, thank you for your testimony. Any additional supporters? Seeing none, we'll move to opposition testimony. Invite the first opponent. Welcome, Mr. Bell.

ROBERT BELL: Good afternoon, Chairman Williams, and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell. My last name is spelled B-e-l-l. I am the executive director and

registered lobbyist for the Nebraska Insurance Federation. I am here today to testify in opposition to LB15. It's obviously a very difficult issue. I think you've heard a lot of great testimony on the benefits of-- of hearing aids. It's certainly a noble cause. And I'd like to thank, Senator Blood, for drafting this legislation in a-- in a narrow manner. But I think the question becomes is how do you-- how do you pay for this? I think everybody can agree that hearing aids are-- are useful especially for children with hearing loss. And so I thought I might take a little bit of time today and talk about mandates in general especially related to health insurance. The world has changed with the passage of the Affordable Care Act. If there was a-- prior to 2014 the states could pass mandates and there wasn't necessarily a-- a fiscal impact on the state of Nebraska for-- for doing that, outside of their own insurance plan. So, you know, the state employee health plan or the university health plan would, you know, be required to-- to cover those costs, but, you know, any state-regulated type of health insurance plan-- there wasn't really a bill that was going to be paid by the State Legislature or the state of Nebraska. Here with the passage of the ACA, it has become the responsibility for the state of Nebraska, if a mandate is passed after 2014, to provide those insurance companies some sort of payment after they have gone through the process. There is a provision under ACA that-- it doesn't prohibit states from passing mandates but it does pro-- does require them to pay the costs back to the insurers. And the reason for that is that the federal government is paying premium assistance to individuals who buy money on the individual, excuse me, it-- it requires, for individuals who are buying insurance on the individual market, a lot of them are receiving premium assistance from the federal government. The-- the federal government's trying to protect itself or the states would go out and they would pass lots of mandates. And-- and I also would just like to briefly, you know, bring up, this-- this bill is-- the scope of it is extremely limited. But keep in mind it's probably even more limited than maybe you know because this cannot include ERISA plans. And so any health plan that would be governed by ERISA which-- I don't have exact numbers in front of me but maybe 50 to 60 percent of the people insured by the state of Nebraska-- or insured in the state of Nebraska say through their employer health benefits, this is-- this is not going to impact because that's regulated by the federal government and the State Legislature cannot touch that. So you might have some employers like the state of Nebraska that does provide this benefit. You might have other employers that do not. And any time, in fact, when you think about mandates on-- on health insurance world, there could be-- let's

say, the state would pass this hearing aid mandate for the individual market. If you had it-- if you were an employer with XYZ Corporation and your insurance did not provide that, you're actually going to probably see some movement from those ERISA plans to individual plans. And that's a good financial decision for those people involved. It's just something to consider. Our-- our insurers have historically, you know, wanted the market to kind of take care of itself. And-- and you're starting to see that with-- with some of the plans-- and I see my time is going short. I think-- I think I'll just leave it at there. We're opposed to all health insurers' mandates no matter how noble they may be. There is a cost to this and it's a matter-- it's a decision for this Legislature. It's a policy decision, and it's how do you pay for those mandates? And one just gentle pushback from-- I heard from a previous testifier is that all insurance companies are for profit. And that's not true. Many insurance companies are for the benefit of their members. So thank you.

WILLIAMS: Thank you, Mr. Bell. Questions for Mr. Bell? Senator Gragert.

GRAGERT: Thank you, Senator Williams. You mentioned that insurance companies are kind of taking care of it themselves. Why haven't any insurance companies covered hearing aids, or?

ROBERT BELL: Well, I said-- I said the market, maybe. They have the option. They can cover hearing aids if they would want to. So if you're an employer, let's say, designing a plan, like the state of Nebraska, they-- they added in hearing aids. I was reading about it on-- on my phone there, just kind of looking it up after reading the fiscal note, and it would appear that the University of Nebraska does not provide that. And for whatever reason, that employer and that insurer when they got together and came up with that plan, made those decisions that they did. You know, there may be-- so and then-- I'm not aware of any other insurers or any other plans that are-- that are out there and I haven't researched it, to be honest with you, you know, what insur-- insurance plans in Nebraska are covering this, and what are not or who isn't, so.

GRAGERT: What about a private individual like we-- you know, her testimony? They had one child, and maybe they'd want to get hearing aid insurance. And if they're going to have another child, can they get it?

ROBERT BELL: Can they get insurance?

GRAGERT: Yes.

ROBERT BELL: Yes, absolutely.

GRAGERT: Hearing aid insurance?

ROBERT BELL: Well, hearing aid insurance. I don't know if there is hearing--

GRAGERT: [INAUDIBLE] insurance [INAUDIBLE].

ROBERT BELL: --aid insurance. Or health insurance?

GRAGERT: We're talking about hearing aids today.

ROBERT BELL: Yeah, right.

GRAGERT: Can we get hearing aid insurance at-- can a private individual get a hearing aid insurance, if--

ROBERT BELL: I'm not aware of that, Senator. I-- I think-- I think the concern of the insurance company that would write that insurance would be the concern they call adverse selection and that the only people that would buy that insurance are those that would need the benefit, so.

GRAGERT: Thank you.

ROBERT BELL: Um-hum.

WILLIAMS: Any additional? Senator Kolterman.

KOLTERMAN: Thank you. Thank you for being here, Mr. Bell.

ROBERT BELL: Thank you, Senator.

KOLTERMAN: Just as-- as a side, there is hearing aid insurance available just like there's dental insurance available. It's typically sold as part of a group contract as a-- as an ancillary benefit. So that's something that's newer on the market, and some companies provide hearing insurance. I believe the state of Nebraska's coverages has some hearing aid insurance in it, but so your larger employers in many cases will provide that. Is that accurate?

ROBERT BELL: I know the state of Nebraska does--

KOLTERMAN: Yeah.

ROBERT BELL: --provide that coverage. Yes.

KOLTERMAN: So it-- it's kind of what-- what an employer chooses to do and what an employer chooses not to do. And it all deals with the costs associated with the plan. Is that-- is that accurate?

ROBERT BELL: That-- that's very accurate. I mean really the question is, how do you pay for this, right? Is it insurance companies through the premiums--

KOLTERMAN: Yeah.

ROBERT BELL: --which on the individual plan would then mean the state of Nebraska? At some point there would be a bill to be paid by the state of Nebraska which-- I mean, this is why you all make $12,000 a year, right, to-- to make these difficult decisions. Is it Medicaid? Is it some other payer that would be out there? You know, there's-- it-- like I said, everybody can agree this is a very noble cause, and there is great benefits to obviously having hearing aids if you have a hearing loss as a child. The question is, how do you pay for that?

KOLTERMAN: Thank you.

WILLIAMS: Seeing no other questions, thank you, Mr. Bell--

ROBERT BELL: Thank you.

WILLIAMS: --for your testimony. Invite the next opponent. Welcome.

MISTI CHMIEL: Good morning-- good afternoon. My name is Misti Chmiel, spelled M-i-s-t-i C-h-m-i-e-l. I am a board-certified hearing instrument specialist licensed by the state of Nebraska since 1998, and the current chairperson for the Nebraska licensure board for hearing instrument specialists. It is that-- the opinion of that board, and does not necessarily represent the view of the Department of Health and Human Services or the Division of Public Health, that LB15 be amended to include hearing instrument specialists as providers of hearing aid and hearing-related services for individuals 16 and under who have been properly diagnosed by an actively licensed audiologist, ENT otolaryngologist, or medical doctor. While the licensure board commends and supports the efforts to include 16 and

under as third-party recipients for hearing instruments and hearing services, we feel it was an unfortunate oversight not to list hearing instrument specialists as approved providers and, therefore, oppose LB15 as currently written. We strongly feel that any legislative bill in the state regarding hearing aids or hearing instruments should include hearing instrument specialists as licensed by the state in that language. Lastly, while the eastern part of the state may be well-staffed with many audiology professionals, that is simply not true of the many outlying rural areas of Nebraska, and LB15 if passed as is with only audiologists, and I now understand there's an amendment to include otolaryngologists, being eligible providers for third-party reimbursements for 16 and under may limit many younger individuals with a hearing disability access to timely care, lead to undue expense or travel hardship for the family of the hearing-impaired child. In summation, the Nebraska licensure board for hearing instrument specialists is requesting LB15 be amended to include hearing instrument specialists as approved providers. And I thank you all for your time and consideration today.

WILLIAMS: Thank you for being here. So-- so your question is not about the underlying bill itself, it's about the providers that would be listed.

MISTI CHMIEL: That's right.

WILLIAMS: And specifically for--

MISTI CHMIEL: Yes.

WILLIAMS: --hearing instrument specialists.

MISTI CHMIEL: Um-hum.

WILLIAMS: OK. Thank you.

MISTI CHMIEL: Um-hum.

WILLIAMS: Any additional questions? Thank you for your testimony.

MISTI CHMIEL: Yep.

WILLIAMS: Next opponent. Welcome.

EMILY MARQUIS: How are you? Good afternoon. My name is Emily Marquis, Emily, E-m-i-l-y, Marquis, M-a-r-q-u-i-s, and I am here representing

the Nebraska Hearing Society. I'm actually pretty much following the same verbiage that Misti just said, that we are looking more so from the point that we support the bill. However, we would like it to include the speech-- hearing instrument specialist, as well. My main concern is I live in Omaha. I'm not going to have a problem finding an audiologist or an otolaryngologist ENT to provide care. People in western Nebraska are going to be having a lot of trouble with that. And they have a lot easier we-- sorry, we want it to be able to have patients have access to care, and it's a hardship on these families already to be able to get the diagnoses, take time off from work, and everything else. That if they had access to care closer to home, it'd be a lot easier on their families. So we are for the bill. We just want it to be rewritten to include hearing instrument specialist also.

WILLIAMS: Thank you, Miss Marquis. Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. So this is truly, at least in your view, a scope of service--

EMILY MARQUIS: Yes.

McCOLLISTER: --issue. What equipment do you have-- let me rephrase that question-- a professional audiologist has equipment to test hearing. Do you have that same equipment?

EMILY MARQUIS: Yes. It's an audiometer, and they're calibrated annually. And it's going to show the same results as any hearing test.

McCOLLISTER: Have you been through the 407 process at all with the HHS Committee to review scope of service or--

EMILY MARQUIS: No, thank goodness, not yet.

McCOLLISTER: --[INAUDIBLE]? OK. That's all that I have. Thanks for coming.

EMILY MARQUIS: Thank you.

WILLIAMS: Any additional questions? Seeing none, thank you--

EMILY MARQUIS: Thank you.

WILLIAMS: --for your testimony. Invite the next opponent. Seeing none, is there anyone here to testify in a neutral capacity? Seeing no one, as Senator Blood is coming up to close, we do have some letters. We

have 24 letters that the committee has received as support for LB15. We have no letters in opposition and no neutral letters. Welcome back, Senator Blood.

BLOOD: And thank you, Chairman Williams. And thank you for listening to today's testimony. I know that was a lot to sit through, and I appreciate your patience. But I think it was good for you to hear all of these stories because they were all very different in how the hearing aids had affected their lives. I actually want to thank the Nebraska insurance industry. They were right. I wrote it in a very narrow fashion for a reason because I met with them knowing they would be coming in opposition prior to this hearing in the fall. And after meeting with them, I rewrote the bill, and I did narrow the scope because I look at this as-- as eating an elephant, you know, you've got to do it one bite at a time. And I want to make sure that we at least go somewhere. And when they talk and that they put in that-- they give you that fear of, well, it's going to raise premiums. I think that that young lady that talked a little bit about how, and no offense because we all receive donations, but I thought that was a really good perspective. If that, you know, you're talking about I think she said $36,000 over an election cycle, you know, we're not talking about a lot of money here. We're talking about a very small of money-- amount of money that can change a child's life forever. And then we have to also remember that if we don't get those hearing aids to that child, we have documentation, we have research that shows it could be up to $400,000 that it costs taxpayers in the long run. My speech therapy that was provided to me through my grade school wasn't free. A taxpayer or taxpayers paid for that speech therapist in my grade school to help me. I can't stress enough how important this is. It is not a big ask. We're not asking for hundreds of thousands of dollars. We're not even asking for $100,000. It's a very small ask. I know that bills like this have been before you in the past, but the bill was written differently and this bill is a very narrow scope. So I really-- I just pray that you sincerely look at the numbers and we'll be bringing you a different fiscal note for the university. And put them in perspective because you're going to change a child's life. And unfortunately, I also have to address the hearing instrument specialists who came forward. We did a lot of research, and a hearing instrument specialist only has to graduate from high school and take an on-line course to get a license in general. Having a hearing aid specialist treating a child is a disservice to the child. The audiology, speech language pathology, and medical communities prefer not to have them included in the bill, and that would be my preference

as well. And it's not because I don't think that they do-- they don't do good work out in the rural areas especially-- especially, but you have a really small window of time to do this, right, and impact that child's life. And we want to make sure that our bill addresses that. And so with that, I am open to any additional questions. I do appreciate your time today, and I do appreciate the patience that you showed as people testified.

WILLIAMS: Thank you, Senator Blood. Are there questions for the senator before we close the hearing? Seeing none, that will close the public hearing on LB15. The committee will take a short break. We will start back at 3:15.

[BREAK]

WILLIAMS: [RECORDER MALFUNCTION] to come back into session and welcome-- welcome everybody back. We'll be opening the public hearing on LB501, Senator Hunt's bill to require insurance coverage for in vitro fertilization procedures. We are going to go to a three-minute light for this hearing. I will warn you of that now. So that means two minutes with the green, one minute with yellow, followed by a red light, and we'll ask you to wrap up your testimony at that time. So welcome, Senator Hunt.

HUNT: Thank you very much, Chairman Williams. And thank you to my friends and colleagues here on the Banking Committee. I'm Senator Megan Hunt, M-e-g-a-n H-u-n-t, and I represent District 8 in midtown Omaha. Today I'm presenting LB501 with a suggested amendment which I passed out to all of you. The amended bill would require health insurance providers to cover fertility preservation for cancer patients and in vitro fertilization procedures. Infertility is the inability to become pregnant or sustain a pregnancy to live birth, and it is a medically recognized disease. According to the U.S. Centers for Disease Control and Prevention, this condition has become increasingly prevalent in recent years, growing 20 percent from 6.1 million individuals in '95-- 1995 to 7.3 million in 2002. And we know that that number has continued to rise. Today the physical and emotional well-being of one in eight couples of child-bearing age is impacted by the struggle to become pregnant and start a family. Infertility is a recognized, treatable medical condition. When aspiring parents have timely access to such treatments, 70 to 80 percent achieve successful outcomes. Treatments with impressive success rates such as this should be available to all Nebraskans. The average cost of in vitro fertilization for an uninsured patient is

$7,500 per treatment cycle and $6,000 in medication costs, a price tag that is prohibitive for many middle and lower-income Nebraska couples. I can say I couldn't afford that personally. A study conducted by Mercer Global found that only 19 percent of employers provide coverage for IVF. High costs and low coverage rates put these treatments out of reach for about half of all people struggling to become parents. Currently, 15 states have passed legislation requiring insurers to offer some form of coverage for infertility diagnosis and treatment. Nebraska couples wishing to grow their families may look to employers in fertility-friendly states such as Texas, Louisiana, or Illinois. Indeed, I received several letter-- letters from Nebraskans who are looking at this option because the potential of having a family was more important to them than living in Nebraska. So I did receive several letters of testimony from people who said, you know, if this doesn't work for us, we're going to have to move out of state so we can have coverage for this procedure and start our families. One woman who submitted testimony wrote, "When I found out that 15 states have passed legislation requiring insurers to offer coverage for infertility treatment, I felt cheated by the state of Nebraska." I know that the fiscal note attached is a little daunting, but I believe that the return on investment will more than make up for the costs. A study conducted by the in-- by independent health economist, Lindy Forte, found that insurance coverage for IVF results in a reduction in prenatal, neonatal, and delivery costs, long-term disability costs, and premature birth rates. So that would be a slight overall savings to the health care system, and I'm more than willing to work with the committee on that fiscal note to-- to come to a manageable place on this bill. I'd also like to explain the amendment I proposed. It would require coverage for fertility preservation treatments for patients who are being treated for cancer. Cancer treatments can disrupt hormone production, damage parts of the reproductive system, and result in infertility. Some patients delay cancer treatment in order to first fulfill a deep desire to become parents, risking the possibility of their cancer worsening. These services are becoming increasingly important for the emotional outlook and the quality of life of survivors, of cancer survivors. I decided to bring this amendment after a constituent reached out to share his experience with fertility preservation as a cancer patient with me. He explained that fertility preservation procedure assured him that he would one day be able to have a family. This gave him the strength and motivation to fight and thankfully overcome his cancer diagnosis. He is now the proud father of a beautiful fifth-generation Nebraskan. I knew from a young age that I wanted to grow up to be a mother. All Nebraskan

families should be able to experience the joy and meaning that children can bring to their lives. We will be doing a great disservice to middle and lower-income Nebraskans if we don't ensure that they have access to these resources. So in closing, I urge you to move this bill forward and I'd be happy to answer any questions.

WILLIAMS: Thank you, Senator Hunt. Questions for the senator? Senator, I'm-- I'm reviewing the-- the fiscal note, and the question that I would have with your amendment, having not had the opportunity to review the amendment, I would assume this fiscal note will get larger with your amendment because we're covering more issues?

HUNT: That's a safe assumption. I-- I really regret that I didn't have the opportunity to talk to the person from the fiscal office who put this together because I actually have some questions about some of these numbers that don't add up with what the research-- our office did. So I think that the conversation with this note needs to continue especially given the amendment that I brought.

WILLIAMS: OK. Thank you.

HUNT: I want to be sensitive to the cost, for sure.

WILLIAMS: Right. Seeing no other questions, thank you, and I'm--

HUNT: Thank you, Chairman.

WILLIAMS: --assuming you'll be staying to close.

HUNT: I will. Thank you.

WILLIAMS: OK. We would invite the first supporter of LB501 to come testify. Welcome.

JESSICA McCLURE: Hi, my name is Jessica McClure, J-e-s-s-i-c-a M-c-C-l-u-r-e, and I can safely say this is the most nervous I've ever been testifying here, and I'm going to try not to cry before I even start. It's going to be hard. So this is my beautiful daughter who is with me today. I thought I would have her between my two years of law school, but that didn't happen for me. Thank you. I was lucky. After law school I did have her; it took me three years. And then we knew right away we wanted a second child, and it took so long for the first that we tried right away. And after three years we started going to specialists, and I was really lucky because the health insurance I had actually did cover it. And it was so rare that I kept having to remind

the facility in Nebraska to run my insurance because they weren't used to someone having coverage. And I went to-- I did three different procedures and none of those worked. And the best option for me was IVF which my insurance did cover to a-- a percentage. And I was kind of hesitant about it because of-- it's just-- I mean, it's really hard on your body. And I have one kid, so I figure, you know, how hard is-- can this be? But after all the other options didn't work, and I kept getting negative pregnancy tests after negative one, I said, OK, let's do this. And one thing I really don't recommend is starting IVF while you're running for office. I had to give campaign speeches in the middle of injections because I wanted to quit my day job to run full-time, and so I had a time line in hand. We were going to do one round. My insurance capped at $10,000 for the medication alone. I had to pay a couple thousand out of pocket, so I don't know exactly where the numbers are coming from, but $10,000 is a lot of money. And I still have some leftover medication from that, but it feels like it's worth more than gold to me. And then I started IVF, and doing the injections while giving campaign speeches across the district. And it didn't really work very well. I had a little bit of complication with that, and I didn't do my time line very well. So I was not able to actually do-- I was able to do the harvest. I wasn't actually able to do the implantation procedure. And then my insurance coverage stopped. So now I have to come up with $5,000 of my own money out of pocket if I ever want to have a kid again. I'm taking the bar exam this summer, that kind of feels out of reach to me. So what I'm saying is this might not seem-- this may seem electives to some of you who haven't been through this, but to me it's not elective. Every time someone asks me when we're going to have a second kid, it's like daggers in the heart. It's hard to-- hard to explain. I'm not joking when I say I can't have another kid. It's pretty tough dealing with that on a daily basis. So I'm sorry I'm crying, but this is a really emotional part of my-- my life. And I really hope you give at least a good consideration before deciding on this bill. Thank you.

WILLIAMS: Thank you, Miss McClure. Any questions?

JESSICA McCLURE: Sorry.

WILLIAMS: Seeing no questions, thank you for your testimony. Invite the next proponent. Welcome.

SARAH MARSHALL: Thank you. Good afternoon, my name is Sarah, S-a-r-a-h, Marshall, M-a-r-s-h-a-l-l. I'm a resident of Omaha and testify today in full support of LB501 which requires insurance

coverage for in vitro fertilization procedures. I have to start by disclosing that I am an assistant professor at the University of Nebraska Medical Center, but I testify today as a private citizen. My testimony is offered separate from my role at UNMC, and I have used vacation time to be here during my regular working hours. Having spent nearly $20,000 on infertility treatments in 2018, my husband and I were elated by the news that the university would offer coverage for infertility-related care in their 2019 health insurance plan. We're grateful for the university's foresight in offering such coverage. As more prospective employees inquire about insurance coverage for infertility treatment during their job search, I believe this benefit will serve to attract qualified individuals to the University of Nebraska system. However, the $15,000 lifetime maximum benefit for infertility treatment imposes limitations for university employees interested in pursuing assisted reproductive technology. Typically, it's estimated that in vitro fertilization, or IVF, costs $12,000 to $15,000 per cycle. However, these estimates do not include thousands of dollars in medications and multiple monitoring appointments required for continued treatment. Further, most IVF patients require multiple cycles before achieving a viable pregnancy. And while costs for each couple or individual undergoing treatment varies based on their protocol, the $15,000 lifetime maximum benefit for university employees is not adequate, and those without any coverage are often forced to finance treatment by tapping into their life savings, depending on private loans, or asking family and friends for assistance. I recently spent a significant amount of time res-- comparing prices for the prescription medications I would need for an IVF cycle. The copays for the prescription medications I needed were manageable, however, the amount our insurer's preferred pharmacy would have applied toward that $15,000 lifetime maximum was over $10,000. We would have used two-thirds of our maximum benefit before we even began the first stage of treatment. Instead, my husband and I chose to pay for our medications out of pocket because the price for those medications decreases significantly for self-pay patients. We assumed this financial burden so that IVF procedures could be applied toward our lifetime maximum benefit. Further, the imposed maximum has driven my husband and I to seek care at a facility in New York State, a facility that uses a shared cost, high volume approach to offer infertility treatment at significant savings. So in addition to our out-of-pocket expenses for medications in 2019, we've already incurred thousands in travel costs and will incur more in the coming months. Rather than seeking treatment from highly qualified specialists in Omaha, we're forced to travel to maximize our insurance benefit,

adding undue stress to an already emotional and physically draining process. The financial burden of infertility treatment is tremendous, and many couples or individuals cannot afford to pursue treatment at all. Having a family should not be a privilege available only to those with financial means to pursue treatment. Fifteen U.S. states already mandate insurers to offer partial or full infertility coverage. The state of Nebraska would take a significant-- significant step in the right direction toward joining those states by lifting the lifetime maximum for university employees and requiring-- requiring coverage for all others. I reiterate my support for LB501 which requires insurance coverage for in vitro fertilization procedures.

WILLIAMS: Thank you, Miss Marshall. Questions? Seeing none, thank you for your testimony.

SARAH MARSHALL: Thank you.

WILLIAMS: Invite the next supporter.

MEAGAN MORRIS: Hi.

WILLIAMS: Welcome.

MEAGAN MORRIS: My name is Meagan Morris, M-e-a-g-a-n M-o-r-r-i-s, and I am here today to testify in favor of LB501. I am a registered nurse. I am also currently working on obtaining my doctorate degree to become a nurse practitioner with a focus in family medicine. I am a wife, and have been suffering from infertility for just over three years now. Three years ago, my husband and I tried to start our family. After a year we were unsuccessful, so we sought fertility treatment. In 2017, we started intrauterine insemination, or IUI. After four rounds of unsuccessful treatment with that, we moved on to IVF this past December. It cost $18,000 for just that one round of IVF treatment, and my husband and I were fortunate enough that we had some saved up already. So we have not been one of those couples that had to take out a loan or had to ask family for help, but after spending that money and having that one round be unsuccessful, we are taking a break just because of the huge, huge financial burden that it's taken on us. IVF, infertility in general, is not just a huge financial burden, but it's emotionally hard, financially hard, physically hard on the woman that's going through it. It was $5,000 just for medications, $8,000 for the egg retrieval, and $4,400 for the transfer. So each additional transfer we do after this will also be $4,400. All of this was out of pocket, not to mention the constant labs and ultrasounds that you have

to do going through the entire process as well. So in total we've spent, between IUI and IVF, $30,000 out of pocket in the last two years and still have not been successful in starting our family. We do plan to move forward with this, but like I said, we have to take a financial break. And in my medical chart it will say, medical diagnosis infertility. This is a medical diagnosis, and I am a huge supporter of LB501 because I believe insurance should cover this. It is a medical problem, and it affects way more people than I ever, ever knew until I started going through it myself and talking to other people. There are multiple nurses I work with who are going through it. I have found family members who stayed silent about it because it's just a taboo subject. Nobody wants to talk about it. So I'm here today to raise awareness and let you guys know that this is a huge, huge issue, and there are so many women who want a family so bad that we will do whatever it takes financially to get there. You can't really do anything to help us with our emotional burden or our physical burden, but you can help us financially. So I'm here today to please ask you to support LB501.

WILLIAMS: Thank you, Miss Morris. Questions? Seeing none, thank you for your testimony. Invite the next proponent. Welcome.

JED HANSEN: Thank you. My name is Jed Hansen, J-e-d, Hansen, H-a-n-s-e-n. Thank you, Senator Williams and committee for this opportunity. Please use this testimony as strong endorsement in favor of LB501. Both my wife and I are ER nurses in Omaha. In addition, I am also a healthcare researcher with the focus on access to medical care. In vitro fertilization coverage in Nebraska is an issue that affects me both personally and professionally. Over the past two and a half years, my wife and I have been unable to successfully get pregnant. Last November, we finally began intrauterine insemination, or IUI, as an infertility treatment option. This month will-- was our fourth attempt, and we find out this Friday if she's pregnant. We remain hopeful. Regardless of this week's outcome with our pregnancy, the journey that my wife and I have been on together has been challenging emotionally and physi-- and financially. Beginning a year and a half ago, as the reality of our situation began to sink in, I've watched my wife cry each month as we've learned that she's not pregnant. Watching our friends and relatives announce their pregnancies and seeing deliveries, delivery pictures is no longer a happy process for us. Each announced-- each announcement and each moment now brings more tears and more questions of why us. Adding to this painful emotional journey is the financial toll that infertility brings. As nurses, the

health system that we work for and received for-- infertility treatments from does not cover the bloodwork, ultrasounds, medications, or procedures that we need. We sit in the fertility clinic multiple times each month and oversee other coup-- other couples with coverage that may have moderate copay amounts or may not pay anything at all. At the same time, we've just been asked to pay up-front and out of pocket. In the past four months alone, we've spent just over $14,000 in out-of-pocket costs that are nonreimbursable and cannot be applied towards a deductible. This is a considerable amount of money and has affected our ability to save for the future, go on vacations, and make needed updates to our home. We will not be able to afford IVF treatment this year without going into debt through either a second mortgage or credit cards. We are simply not sure how we are going to pay for infertility treatments moving forward. The sad reality is that others are not as financially fortunate as we are and may not be able to attempt-- attempt at all. Passage of this bill gives us hope that we'll be able-- that we'll not have to sacrifice our financial future in order to have the complete family that we need. Research on infertility shows that it's a growing concern. Male fertility rates have dropped each decade since being tracked in the 1970s. Women are also seeing added difficulty in achieving pregnancy as greater educational and economic opportunities have led to delays in pregnancy and more fertility issues. Moreover, research has consistently shown that women struggling with infertility have high rates of anxiety and depression as you've already seen. In one study, depression and anxiety rates among women were matched those of cancer patients. Opponents to this bill are likely going to discuss the cost of adding IVF to our collective health policies. It's an important topic and should be a consideration with any policy that this committee brings. However, what opponents of this bill may fail to talk about is the cost incurred by not covering IVF. Inferti-- infertility treatments account for well over half of all multiple births. The cost of delivering twins is over $80,000 higher than that of a single birth. Delivery of triplets or more averages nearly $400,000 over a single live birth. When costs are factored in totality, the additional cost of IVF coverage to existing plans are shown to rise less than $24 annually, equaling less than one half of a percent in total premium costs. Last year, significant opposition to a similar bill heard by this committee was related to ethic issues regarding infertility treatments. The rebuttal to this argument, and I would like to go on record, is that IVF coverage has been shown to reduce the number of cryogenically stored embryos-- embryos in states where it's covered and has dramatically reduced the number of

selective removals associated with alternative infertility treatments such as IUI.

WILLIAMS: Thank you, Mr. Hansen. I'd like to give you an opportunity to just sum up quickly if you would, please.

JED HANSEN: Yeah. So in-- in sum, IVF coverage shows that it would have minimal impact on premium costs, and in addition with that, would decrease any type of ethical dilemmas espoused by some opposed to this type of bill. Thank you.

WILLIAMS: Thank you, Mr. Hansen. Are there questions? Thank you for your testimony.

JED HANSEN: Thank you.

WILLIAMS: Invite the next proponent.

MEGAN HOLLIBAUGH: I apologize in advance. I timed this last night, and it was five minutes. So I'm trying to desperately cut as I'm sitting-- sitting in my chair. OK, so my name is Megan Hollibaugh, M-e-g-a-n H-o-l-l-i-b-a-u-g-h. Married into it; not my fault. OK, so my husband Josiah and I have three beautiful children. Like many couples in Nebraska, we struggled to become pregnant and to maintain pregnancy. We tried unsuccessfully for six years to become pregnant. After four IUI attempts and about $8,000 spent, we opted to proceed with in vitro fertilization only partially understanding the financial, physical, and emotional toll it would soon take on our jobs, our marriage, and our family. Our first IVF cycle was in October, 2009. It cost over $10,000 plus the cost of medications. For most couples this is an additional cost, you know, $5,000, $7,000, $10,000 depending upon what medications are prescribed, but we were very lucky. As a federal employee, my healthcare coverage through Blue Cross and Blue Shield actually covered my fertility meds, so that saved us. I paid a measly $450 in medication copays, but we were still left to try and figure out how to come up with more than $10,000 to cover the actual retrieval and transfer as well as all applicable ultrasound monitoring and bloodwork. We were forced to open up a new credit card, maxed it out, pulled all of our available money out of our savings, utilized all remaining funds on our flexible spending account for the year. After weeks of daily injections, pills, patches, lab monitoring every two to three days, and countless ultrasounds, we had our egg retrieval. We got 25 eggs, things look good. Three days later we transfer two embryos back, hope for the best. The remaining ten viable

embryos were frozen so they could be used for a later cycle. We found out nine days later that the cycle had been unsuccessful. We were not pregnant. We were absolutely crushed. All the money, ten grand, gone, boom, in an instant. Medications with potentially horrible side effects that I'd injected into my body, again, for what? But we weren't ready to give up. We still had ten embryos on ice. If we could come up with another $3,000, we could complete a frozen embryo transfer the next month. At this point we were out of money, so I reached out to my parents. They loaned us the $3,000 to complete the frozen transfer. Embryos thawed, two survived, transferred them back. Boom I got pregnant, yay; miscarried at seven weeks. We're devastated once again. So it was a new year. It was now 2010, and we had luckily chosen to max out our flexible spending account. So we had $5,000. Our neighbor, who had seen our struggles and had no kids, gave us $1,000. We diverted money from our savings and 401k accounts, and, again, my parents helped us finance the remaining costs for the $11,000. We transferred again two blastocysts, and a week later we found out that we were pregnant. Our pregnancy was successful. We delivered healthy baby girls, twins, in October of 2010, but our IVF journey cost us $25,000. That doesn't count the IUIs before that. We were somehow able to come up with that money, but if we couldn't our next step would have been to refinance our house, pull money out, to be able to try and have another IVF cycle, another chance. There's no guarantee. IVF is not a guarantee, and the fact that we were even considering refinancing our home for a chance at having a baby makes my head spin. The ability to have a child, the IVF should not simply be for the upper classes of society. It should not bankrupt anyone. This should be a right for all. We were lucky to have the financial means and parental financial support to be able to go through the IVF process until we achieved success. Many others don't have this as an option, so I would strongly encourage the committee to consider what they would do if faced in a similar situation. Would you be able to come up with $25,000 over a few short months to have a chance at getting pregnant or having a baby? Or what if it were your child struggling to have your grandchild? Mandating insurance coverage-- mandating insurance companies provide coverage for those wishing to opt in for IVF coverage is absolutely the right answer. As a woman who has been through the infertility struggles and IVF, I can attest that it's hard enough to endure the physical and emotional aspects of infertility and IVF without having to be financially strapped and stressed out by the process as well. Thank you for your consideration.

WILLIAMS: Thank you, Miss Hollibaugh. Questions?

MEGAN HOLLIBAUGH: Nobody?

WILLIAMS: You did it in three minutes--

MEGAN HOLLIBAUGH: Yes.

WILLIAMS: --just fine.

MEGAN HOLLIBAUGH: Sweet. I was talking really fast.

WILLIAMS: Thank you for telling your story. Invite the next proponent. Welcome.

JOSIAH HOLLIBAUGH: My name is Josiah Hollibaugh, that's J-o-s-i-a-h, last name is H-o-l-l-i-b-a-u-g-h.

WILLIAMS: And it's your fault.

JOSIAH HOLLIBAUGH: And it's my fault. Yep. I totally out-kicked my coverage, didn't I? We currently reside in District 9. I'm here with my wife, Megan, and I'm in full support of LB501. And I just want to start by briefly giving you my personal history. I was born in Aurora, Nebraska, lived in Stromsburg area twice, District 24. My father worked at Robertson's Furniture in Grand Island, and we lived just west of Tornado Hill. And that's District 35. I graduated from Ainsworth High School, up by Valentine, competing in athletic events up and down Highway 20 very close to District 40. My family's been in Nebraska since the late 1800s, ultimately settling on a farmstead just south of the South Loop River seven miles north of Sumner, Nebraska, and a handful of miles south of Broken Bow. That's your district. I currently live in District 9 after living in Omaha for the past 19 years. I apologize for the brief personal history, but I feel it is important because I feel that I fulfill the title of a prototypical Nebraskan. Infertility is not an issue that is widely discussed and was als-- off-- is often hold-- held in some sort of taboo limbo. These issues which tend to be very intimate and private-- and to be honest, nobody wants to have infertility issues. However, this is not an isolated issue that only affects a small portion of couples as they try to begin the family-building process. According to the CDC figures that were updated through 2015, one in eight individuals/couples have difficult-- difficulty getting pregnant or sustaining a-- a pregnancy. Many of these diagnosis have reached ep-- epidemic levels worldwide including diseases such as endometriosis, polycystic ovarian syndrome,

pelvic adhesions, fi-- fibroids, polyps and diseases of the fallopian tubes. There are additional factors which have also increased male infertility as well. This has created an overwhelming need for assistance in the family-building process. Family-building options for these affected populations are costly. Often the affected population, studies have shown that two-thirds of these couples resort to spending well over $10,000 in infertility treatments. It has been shown that the cost is the primary barrier for those seeking family-building assistance. The average cost for a single IVF cycle tends to exceed $15,000 in medical procedures alone with an additional $10,000 in pharmaceutical medications to facilitate the procedures. Nebraska is not alone in pursuing these better avenues to help ensure that we remain the best place to raise and grow a family. At the time of this hearing, there are 23 other states including Oklahoma, Missouri, and Texas that have current laws in place or are considering legis-- legislation to ensure that family-building financial assistance can be ascertained with the assistance of the current medical insurance. IVF is also covered by Medicaid. Fertility challenges and associated reproductive diseases do not dis-- discriminate. These issues fall upon women and men of all ethnicities, religious beliefs, socio-- socioeconomic status, and political affiliations. It seems like the Nebraska way, that providing access to medical care for family-building should not discriminate as well. It also seems like the Nebraskan way to allow couples/individuals the opportunity to begin family building regardless of disposable incomes. As a fellow Nebraskan, I implore you to support and move LB501 to the floor for further consideration. This legislation is of vital importance to the family building minded individuals/couples that call Nebraska home. Without our Unicameral providing the push in a positive direction to provide the assistance, I fear that we may lose these individuals/couples to the states that offer this type of assistance. Based on my experience, we will lose small business owners, brilliant business professionals, teachers, high-ranking IT professionals which is a detriment to us all. Thank you for your time.

WILLIAMS: Thank you, Mr. Hollibaugh. And how old are the twins?

JOSIAH HOLLIBAUGH: They are eight. And they're all of it, too.

WILLIAMS: Any questions? Thank--

JOSIAH HOLLIBAUGH: Thank you.

WILLIAMS: --you for your testimony. Invite the next proponent. Welcome.

OSCAR SINCLAIR: Thank you. Senator Williams, members of the committee, my name is Oscar Sinclair, O-s-c-a-r S-i-n-c-l-a-i-r. I'm the pastor of the Unitarian Church here in Lincoln, down A Street, and I'm here to speak to LB501 as a person of faith and as a person who is recently a parent. There are other people today speaking about the medical and financial aspects of this bill. That's not my role, but I want to be clear on what the-- the moral question of this bill is. Should medical ability to conceive or ability to afford medical treatment determine whether or not folks can become parents? In reviewing testimony of the bill from last session that came before this committee similar to this one, I wanted to come and ensure that there were a multitude of religious voices speaking to this issue. To me, it is clear that folks who are committed to becoming parents should be-- should be given every opportunity to do so. That is a moral question and a question that my faith speaks directly to. I'm also a person without quite the same experience as some of the people that have spoken already, but my wife and I also struggled to have a child. And while I didn't know this when I walked in the room today, when I was 25 I was diagnosed with Hodgkin's lymphoma, and the first thing that we did before we started chemo was that we started fertility preservation treatments. Those were paid for out of my own pocket because I knew at that time that eventually I would want to have children. It is a difficult thing to ask anybody in their 20s to think about mortality or the ability to parent, but medical treatment doesn't give us options sometimes. So I'm happy to speak to that issue as well. So with that, I would urge you to advance LB501 out of this committee. And if you have any questions, I'm happy to answer them.

WILLIAMS: Thank you, Reverend Sinclair. Questions? Seeing none, thank you for your testimony. Would invite the next proponent. Welcome.

MEG MIKOLAJCZYK: Good afternoon, Chairperson Williams and members of the committee. My name is Meg Mikolajczyk, M-e-g M-i-k-o-l-a-j-c-z-y-k, and I'm the deputy director for Planned Parenthood in Nebraska. Planned Parenthood provides sexual and reproductive healthcare at its two health centers in Nebraska, and our vision is communities where every person has the opportunity to lead a healthy and meaningful life including the right to choose if, when, and how to start and grow their families. Although our health centers do not provide in vitro fertilization services, we do counsel patients

and refer to other providers when issues of infertility arise. All Nebraskans, regardless of socioeconomic status or biology, deserve access to safe and affordable health care including fertility treatment. We support LB501 because we value Nebraska families. In 2016, 1.7 percent of infants in the U.S. were conceived using assisted reproductive technology. In vitro fertilization is the most commonly used method of that type of technology. As we've heard today, there's so many reasons that people may need in vitro fertilization to help them have the families that they want. And people shouldn't be prohibited from doing that simply because of needing cancer treatments or having endometriosis. LB501 affords many more Nebraskans the opportunity to begin or expand their families when the time is right for them. As we've heard a few times, 15 states already provide this coverage, and 10 of those states mandate in vitro fertilization coverage. Again, out of cost-- pocket-- out-of-pocket costs are enormous. People here have talked about it much more effectively than I can, and I appreciate them all sharing their stories, too. When you're faced with tens of thousands of dollars and the strong desire to try to have a family, you're ultimately in a-- in a very difficult if not impossible decision. Nebraskans deserve to have access to reproductive services that allow them to lead the life they envision. And this includes the right to get pregnant and have families when and how they want to. Planned Parenthood wants everyone who wants to be a parent to have that opportunity. So we applaud Senator Hunt for introducing this bill, and we urge the committee to advance this legislation. Thank you.

WILLIAMS: Thank you. Any questions? Thank you for--

MEG MIKOLAJCZYK: All right. Thank you.

WILLIAMS: --your testimony. Invite the next supporter. Going once. We will switch then and invite the first opponent to LB501. Welcome.

NOAH TABOR: Thank you, Mr. Chairman, members of the committee. My name is Noah Tabor, N-o-a-h T-a-b-o-r. I am the regional government relations manager from Medica health plan. Medica is a nonprofit health insurance company based in Minnetonka, Minnesota, and it's appropriate on this day you have some Minnesota weather going on today, goodness, gracious. We have been serving Nebraskans in the individual market since 2016. We are currently the only carrier in the individual market, and we serve about 90,000 lives in that space. We are also proud to partner with Nebraska Farm Bureau offering an association health plan for Nebraska farmers. As a nonprofit health

plan, we are absolutely committed to making sure that we are bringing forward options to our members that are high quality options but also with a nod towards affordability. I'm sure you all hear in your districts about the costs of premiums. The cost of healthcare is high. We, as a nonprofit health plan, try to be hyper cognizant of the cost of our products. We are also very sensitive to the challenges of infertility. The burdens are economic, social. They are very real. I am quite moved by the stories we've heard today, and I thank the conferees for coming. Medica stands in opposition to this bill, though, because of the economic impact. The fiscal note before you, the section regarding the health exchange, the fiscal note is around $5 million. Medica is the sole offerer on the health exchange in Nebraska, worked with the Department of Insurance to provide that estimate. That is a very real cost. Because that mandates-- mandates in vitro fertilization services would be in excess of the essential-- essential health benefits, or EHB, the state would be required to pay that amount. The economic impact, as you've heard, is significant for people going through infertility challenges, but the economic impact of a fiscal note of that size is also significant. We would encourage the committee to not move the bill forward as we work to control premium costs for our members and we are cognizant of the state budget and taxpayers of Nebraska. I'm happy to answer any questions, Mr. Chairman.

WILLIAMS: Thank you, Mr. Tabor. Questions? I'd like to ask a question about Medicaid and the coverage currently.

NOAH TABOR: Um-hum.

WILLIAMS: Is in vitro covered currently under Medicaid in Nebraska?

NOAH TABOR: You know, Mr. Chairman, I'm not sure.

WILLIAMS: OK.

NOAH TABOR: I think that'd be a question-- I'm certainly happy to follow up with--

WILLIAMS: I'll-- I'll [INAUDIBLE]--

NOAH TABOR: --DHS or one of the MCOs. I'm not sure, Mr. Chairman.

WILLIAMS: And I know you've probably have not had a chance to look at the amendment that was offered although you've heard here. Would it be

your educated guess that that's certainly going to increase the fiscal note?

NOAH TABOR: Yes, sir. Again, I'm not an actuary, but yes, kind of the expanded services, contemplated amendment would certainly increase the cost. I would also say that the $5 million cost is-- it's a conservative estimate, and the cost as the bill is drafted could far exceed that.

WILLIAMS: OK. Thank you. Any additional questions? Seeing none, thank you,--

NOAH TABOR: Thank you.

WILLIAMS: --Mr. Tabor. Next opponent.

ERIC DUNNING: 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 and the director of government affairs for Blue Cross and Blue Shield of Nebraska, here today to testify in opposition to LB501's requirement that Nebraskans must buy coverage for in vitro fertilization. By way of background, Blue Cross and Blue Shield of Nebraska is part of a mutual insurance holding company structure. We have over 1,100 Nebraska-based employees, and 80 years ago, we were founded to serve our members and not to generate profits for shareholders. We continue not to have shareholders and we continue to operate under those principles today. But based on some of the issues related to the specifics of IVF that you have heard or will hear later, I'd like to tell the committee about a broader concern about-- that bills like this have for us as a state as well as for the broader market. It's important to remember that the state of Nebraska does not have jurisdiction over a broad part in the insurance market. There are many incentives for employers and individuals to move from state-regulated products to federally regulated products to avoid, in part, state requirements that add costs to policies such as the one before you today. Based on the most recent charts that I've seen, they're 2014 data but I've not seen anything better and-- and more up to date, the bill wouldn't apply to the 14 percent of Nebraskans who are covered by Medicare. And the bill does not apply to the 33 percent of Nebraskans who get their coverage through self-funded plans which are beyond state regulation under federal ERISA law. For these reasons, excuse me, for these reasons, Blue Cross and Blue Shield is

opposed to LB501. And I'm happy to answer any questions you might have.

WILLIAMS: Thank you, Mr. Dunning. Questions? We heard testimony earlier that it would be, I think the term used was, a minimal increase in cost to add this coverage. What's your reaction to that statement?

ERIC DUNNING: Based on the data that you have in front of you just from-- from Medica, the publicly reported data, we don't believe that that-- I just can't agree with that.

WILLIAMS: Thank you. Any additional questions? Seeing none, thank you for your testimony.

ERIC DUNNING: Thank you, sir.

WILLIAMS: Welcome back, Mr. Bell.

ROBERT BELL: Hello, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell. Last name is spelled B-e-l-l, and I am the executive director and registered lobbyist for the Nebraska Insurance Federation. I'm here to testify in opposition to LB501. Again, not unlike the last bill on hearing aids, very compelling testimony. The thing I think I took away is that it's a very expensive procedure. And again, it's a question of-- of how do you pay for that and who pays for that. You've already heard about ERISA. You've already heard about the ACA. I think-- I would point out when the ACA went into effect in 2014, one of the things, it might be a little bit of a red herring issue, but one of the things that we heard about was the cost of-- of Nebraskans that were over 60, so 60 to 65, paying for pregnancy services as an example. And people were outraged about that. And the ACA plans, you had to-- you had to buy it all, and that's part of-- part of pooling and things like that. It was understood it was very similar to what was going on with employer-sponsored coverage. But you take a-- you take an extremely expensive benefit for a small portion and there's going to be some pushback from-- from the people that have to eventually pay that bill. And that's always something to keep in the back of mind, although I'm preaching to the choir with the senators. I know that you have very difficult decisions to make in many different policy issues where you have to choose between one side or another. So I would just say that, again, we're-- we're opposed. There's a-- there's a very high cost to

this. This cost will go back on insurance premiums which we're doing our best to keep down. And I appreciate the opportunity to testify.

WILLIAMS: Thank you, Mr. Bell. Any questions for Mr. Bell? Seeing none, thank you--

ROBERT BELL: Thank you.

WILLIAMS: --for your testimony. Next opponent? Mr. Sedlacek, welcome.

RON SEDLACEK: Thank you, Chairman Williams and members of the Banking, Commerce and Insurance Committee. For the record, my name is Ron Sedlacek, R-o-n S-e-d-l-a-c-e-k. I'm here on behalf of the Nebraska Chamber of Commerce and Industry as well as the National Federation of Independent Business in Nebraska. I believe Mr. Hallstrom attempted to file a timely letter but wanted to be sure that he was on the record and on the committee statement in opposition. Many trade associations and local chambers of commerce in addition to company members of ours do offer-- offer either group insurance coverage or, as you had heard before, the federal ERISA-type plans. And in this regard, well over half the plans and upwards to, maybe close to 70 percent are now under nongroup-- nonstate-regulated plans. We're talking about the majority of state plans-- or the majority of plans not even being subject to the legislation at hand. And from that aspect we represent essentially those other consumers of insurance products that are going to be directly affected by this proposal. Consumers in the sense that many of our members do offer these plans as an employee benefit, and they're struggling with affordability and availability issues. And the fear is that as we get priced out of the market, there'll be fewer and fewer plans such as this available, and the individual coverage will become more and more expensive. And we could see the unintended consequences of this type of legislation on such individuals as well as businesses. Now they may decide to drop the coverage and provide additional compensation to employees perhaps to get on the individual market, but that's not always the case. Escalating costs and health insurance, when you look at the top three issues that are of concern to business, healthcare is among the top three. The other's work force, and then maybe taxation and regulation can interchangeably be second or third. So, you know, Nebraska has had-- had low insurance premiums over time, and that was because we were one of the states that resisted piling on additional mandated benefits. And then we tried to stick as best-- as close as possible to the federal ERISA program so that we could also be competitive in regard to offering these programs. So in representing those members, while very

well-intentioned, every mandate that we come across is well-intentioned, we understand the concern. We understand the decisions that you have to make as legislators, but we would just call to mind that there is another side of the equation and that is the affordability, availability of what we have right now. With that, I'll conclude my testimony.

WILLIAMS: Thank you, Mr. Sedlacek. Any questions? Seeing none, thank you for your testimony. Invite the next opponent. Welcome.

MARION MINER: Thank you. Good afternoon, Chairman Williams and members of the committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here testifying on behalf of the Nebraska Catholic Conference which advocates for the public policy interests of the Catholic Church in advance of the Gospel of Life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here to-- to testify in opposition to LB501 on the behalf of the Conference. Now many thousands of couples trying to conceive suffer from infertility. Almost all of us know a number of people who have had to endure it including members of my own family. The Catholic Church supports-- or suffers with those couples and accompanies them with spiritual and psychological counseling and moral support. The church also assists them in overcoming infertility by ethical and morally good means. In taking that approach, the church demonstrates its respect for the marriage of each couple, the man and woman's own individual integrity, and the dignity and invaluable worth of every human life. I do want to say it is important from the outset to acknowledge that we all likely know one or many couples who have had children through IVF. In expressing our opposition to this policy, it's certainly not our wish to alienate or condemn anyone. And in addition, it's important to emphasize that those children brought into being through IVF are as deserving of love, protection, and care and affirmation of value as any other child. They are recognized and valued as such by the church and I hope by us all. In vitro fertilization has become common in our society, and it's not difficult to recognize why. It gives couples an opportunity to beget life biologically descended from them when the natural avenue for during-- doing so is or seems to be closed. The end toward which IVF is directed, having biologically descended children is certainly a great good. This good end, however, does not justify the means by which we attempt to attain it. In vitro fertilization does not assist in achieving pregnancy through an act of sexual union, that act proper to marriage that is naturally ordered to the procreation of children.

Instead, IVF replaces the marital act making the child produced through this procedure a fruit of human manipulation of reproductive material rather than of a unit of active love between two people. Additionally, in practice IVF almost always results in more new individual lives coming into existence than is possible for the mother to carry. Multiple embryos which are human life during the first eight weeks of development come into being. The general practice is that only the healthy or the strongest embryo or embryos are then implanted into the mother or the surrogate's womb. The rest are frozen for later use or scientific experimentation or simply discarded as medical waste. These are direct attacks on human life at its earliest and most vulnerable stage. In addition, it is common for multiple embryos to be implanted in order to increase the chances that at least one will survive. Where more than one does survive, it is common for the weakest to be aborted and discarded. Finally, IVF encourages the commodification of children as things to be bought in the marketplace rather than as free gifts which come to us from God. The risk of treating children like market goods is only amplified where participation in IVF is not limited to spouses as is the case with LB501. This policy allows for new children to be created by parents who have no relationship to each other, other than that their reproductive material has been joined in a laboratory. Insurers would have to cover such nonrelational and adult-centered child production under LB501. So to conclude, given the inherently problec nature of-- problematic nature of IVF, the conference opposes policies that would promote further usage of it including mandatory insurance coverage. With that my time is up, and the conference urges you to indefinitely postpone LB501.

WILLIAMS: Thank you, Mr. Miner. Questions? Seeing none, thank you for your testimony.

MARION MINER: Thank you.

WILLIAMS: I'd invite the next opponent. Seeing no one, is there anyone here to testify in a neutral capacity? Seeing none, Senator Hunt, if you'd like to come up. While you are coming up, we have received a substantial number of letters on LB501. We have 37 letters supporting and we have 3 letters in opposition.

HUNT: Anyway.

WILLIAMS: Welcome back, Senator.

HUNT: Thank you very much, Chairman Williams, and thanks everybody. And I-- I want to acknowledge the people who came to testify today. My office, we introduced 19 bills this year, and we did not do a lot of work organizing testimony for this bill. And so I want the committee to know that these are people who were not round up by my office. And we-- I'm just very moved that people feel so passionately about this issue that they came to Lincoln today in the weather to speak about this and why it matters to them. I, surprising nobody, do not come from an insurance industry background. And so there are-- there's some testimony that we heard today that I would like to double-check on and make sure that we're on the same page in terms of numbers. I was looking at this table that was given to me by one of the testifiers who's a nurse at UNMC, I believe or-- and it talks about all the other states that-- that have insurance mandates for in vitro fertilization. In Massachusetts, there are no restrictions on insurance for in vitro, and an analysis of insurance rates in Massachusetts found that it only increased coverage costs per $1.71 a month. So that's something that's interesting to look at and something that's definitely worth digging more into, that maybe the increased cost for insurance is not as much as we think it will be. But-- but we'll see; let's look at that. So infertility impacts over 10 percent of Americans. And to lump this population's desire to have children with elective surgeries or different medical procedures is really unfair. Infertility is a disease, and in vitro fertilization is a legitimate highly successful treatment for this disease, for this diagnosis. Offering coverage for in vitro fertilization will help grow Nebraska by supporting our neighbors who want to grow their families. It's time we followed the example of 15 other states that have done this and secure the right of every Nebraskan to pursue a life of happiness and fulfillment by being able to start a family. Thank you very much.

WILLIAMS: Thank you, Senator Hunt. Any questions as we finish up. All righty. That will close the public hearing on LB501. At this time we will open the public hearing on LB316 from Senator Kolterman to adopt the Pharmacy Benefit Fairness and Transparency Act. Let's-- let's wait just a minute, as people are moving, before we start.

KOLTERMAN: Ready to go?

WILLIAMS: We are ready to go. Welcome, Senator Kolterman, to open on LB316.

KOLTERMAN: Good afternoon, Chairman-- Chairman Williams and fellow members of the Banking, Commerce and Insurance Committee. I'm Senator

Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, and I represent the 24th District in the Nebraska Legislature. LB316 is a legislative bill that I brought to you on behalf of the Nebraska Pharmacist Association. I introduced similar legislation, similar more expanded legislation in 2017, and other senators before me have also attempted to pass PBM transparency legislation with no success. I feel that this is an important issue and one that the Nebraska Legislature needs to address. Understanding the role that Pharmacy Benefit Managers, or PBMs, play in healthcare is a bit complex. I believe it's necessary legislation to protect our patients who choose to work with pharmacies and community pharmacies-- or pharmacists and community pharmacies that are vital in providing medication and patient care services particularly in our rural economies. LB316 creates a Pharmacy Benefit Fairness and Transparency Act. LB316 would require that all Pharmacy Benefit Managers, or PBMs, doing business in Nebraska obtain certification as a third-party administrator under the Third Party Administrator Act with oversight by the Nebraska Department of Insurance. Violation of these acts shall be considered unfair trade practices pursuant to the Unfair Insurance Trade Practices Act. This language gives the Nebraska Department of Insurance the necessary tools to monitor the activities of the PBMs that do operate in Nebraska. It is important to understand what PBMs do. PBMs or third-party administrators are contracted by health insurance plans, employers, and government entities to manage prescription drug programs on half-- on behalf of health plan beneficiaries. While PBMs originated several decades ago as processors of prescription drug claims for health plans, they earned a flat fee for each claim processed. Some PBMs have evolved, though, into behemoth corporations that affect nearly all aspects of the prescription drug marketplace. For example, three large companies, Express Scripts, CVS Caremark, and OptumRX, control as much as 89 percent of the market. CVS Caremark and Opt-- OptumRX are the PBMs that administrate our Medicaid managed care drug benefit. CVS Caremark administers the University of Nebraska drug benefit and Optum administers the state of Nebraska drug benefit. PBMs determine which pharmacies will be included in a prescription drug plan network and how much said pharmacies will be paid for their services. Some entice plan sponsors to require plan beneficiaries to use a mail-order pharmacy, often one owned and operated by the PBM for certain medications. They also determine which medications will be covered by the plan or formula-- or plan formulary, and the drug manufacturers often pay rebates to PBMs to get their drugs onto those formularies. While their role was largely unnoticed, the transparent nature of the traditional PBM business model can add hidden costs and

lead to higher prices. LB316 establishes transparency provisions for the PBMs to follow in contracting with pharmacies. PBMs are not allowed to include in their contracts with pharmacies any language that allows pharmacy benefit managers to claw back payments for pharmacies or overcharge for copayments for patients. These clawbacks result in higher costs for patients, and pharmacists lose money when PBMs claw back payments. PBMs will not be allowed to restrict the pharmacies from sharing pricing information with patients for their medications. The PBM contracts do not allow pharmacists to tell their patients that the medications may be cheaper if they paid cash rather than the copayment. This bill lists restrictions on pharmacies mailing medications to patients at the request of the patients or mandating the use of the PBM owned mail-order pharmacies. And the contracts will prohibit restrictions on pharmacies being allowed to participate in specialty and other pharmacy networks. Especially-- specialty drugs are really just expensive drugs most of which can be provided to patients by any pharmacy. Mandating mail-order and denying a patient the right to choose their pharmacy is just not good policy. LB316 allows the Department of Insurance to promulgate rules and regulations to carry out the act. On Friday, the fiscal note was posted for LB316. I have to say I was somewhat dismayed and shocked at the number. When I introduced LB324 in 27-- in 2017 which was a much more comprehensive and expensive bill with many more requirements, the fiscal note was about $8 million less than it is now. I don't believe the information provided in the fiscal analysis is accurate, and be will-- and we'll be working with the Fiscal Office to revise the fiscal note. But I do believe it's time for the Nebraska Legislature to take a look at the business practices of E-- PBMs operating in our state. As healthcare costs continue to increase, particularly in drugs spent for Medicaid and other state-funded plans, we need to shine a light on the PBMs and ask why-- why they do not want transparency in their practices and how that impacts Nebraskans, our pharmacies, the healthcare system, and our tax dollars. There will be several representatives from the Nebraska Pharmacists Association that'll be following me, and will-- and they will provide greater clarification on the details and the need for this legislation as it affects them in their everyday practices. With that, I thank you, and I'll be open to any questions you might have.

WILLIAMS: Thank you, Senator Kolterman. Questions for the senator? Seeing none, I'm assuming you'll be staying.

KOLTERMAN: I think I'll stay.

WILLIAMS: We'll invite you to stay. Would invite the first proponent.

TREVOR BERTSCH: I'll be here, I guess. All right. Thank you, Senator--

WILLIAMS: Welcome.

TREVOR BERTSCH: --Williams, and thank you for the committee for hearing me out on my testimony. My name is Dr. Trevor Bertsch, T-r-e-v-o-r B-e-r-t-s-c-h, good old German spelling. I'm here testifying-- I'm an independent pharmacist that practices in Norfolk, Nebraska, at U Save Pharmacy, and I am also the independent chairperson for the Nebraska Pharmacists Association. So I-- I-- I am basically here, I would say, to represent a special interest group called my patients. I'm down in the trenches every day. I wish I was making these things up. I wish the things that Senator Kolterman was telling you were make believe, but they're not. We are subject to mafioso tactics. I feel like I should almost be shadowed out and have my voice changed being here because I've had several of my constituents receive letters from the PBMs saying if they continue to disclose pricing or talk to the state, that they will be kicked out of their network. So to say that we don't have gag clauses is-- is not true. We do. I often have patients come in that their copay through their insurance is actually higher than my cash price. Per my PBM contract, I am not allowed to say, hey, if you, you know, just buy it cash, it'll be cheaper for you. And, you know, it's a big issue when, as you heard, 89 percent of all of the prescriptions we process go through three PBMs, OptumRX, Express Scripts, CVS Caremark. So if we get kicked out of one of those, depending on your area, if let's say you get kicked out of one of them, they may constitute 50 percent of your business. And as-- as it is right now, we have no recourse. There's nobody we can file a grievance-- grievance to, so it is important that we have our gag order removed, that we are allowed to talk to the Department of Insurance and have someone to hear us. You know, another thing that is a huge issue is the PBMs incentivizing, telling patients, mandating that they have to use a mail-order facility. You know, I will use the example of our state Medicaid. Year one rolled out with the MCOs. I could dispense any medication, specialty. Specialty is just a fancy word for expensive. And all of a sudden two years later, now I'm not qualified to dispense those medications? And doesn't it seem prudent that we should send multi-thousand dollar drugs in the mail, so they can sit in the back of a UPS truck that maybe has 90 degrees back there or is below

freezing on a day like this which could end up sitting in the patient's mailbox before they even get it. I don't believe that's wise. And now if that drug is damaged, who pays for it? You'll-- you'll-- I think you can kind of guess where the money is coming from. I-- I often see that my patients are sent to these mail-order pharmacies regardless of their needs. I have an example of a patient who had a traumatic brain injury. We provide compliance packaging for her. Essentially we set up her morning, noon, evening, bedtime meds, and set them up throughout the week. She does not, at this point because of her injury, have the intellectual ability to manage her own medications. Recently, her husband's employer mandated that she use mail-order pharmacy or go use one of our competitors down the street, a large corporation. She-- I am going to be looking in the newspaper to see if there is an obituary or to see if something bad has happened because I've seen it happen so, so many times. You know, I-- I don't just dispense medication. Sometimes I am the only person that somebody trusts for their healthcare needs. You know, I benefit that I'm in Norfolk where we have a robust medical community, but some of the patients out west in some of the western states, they-- the pharmacists may be their only healthcare provider within 50 miles. And, you know, I also use this instance is that because we are being pinched financially as a pharmacy, I'm not a-- I don't have the time, I don't have the ability now to go talk to my patients about complicated health issues. You know, I had a patient come in, this is also another true story of how this may actually be something that I could not be able to talk to my patient about. She came in, I see her every month. All of a sudden she came in last month, and she just did not look right, and I asked her, what's going on? You don't seem like you feel well. She goes, my-- my blood sugars have been all over the place. I have low blood sugars. My physician can't figure it out right now. My endocrinologist can't figure it out right now. We're trying different things, adjusting my insulin. I spent 20 minutes with her and found out she started a natural supplement that was lowering her blood sugars. And I told her to stop, and guess what? Everything resolved and fixed herself. Now you tell me, can a pharmacist sitting in New York State mailing their prescription provide that level of service? I think not. We're so much more than just a product. We are someone that sees the patient on average 31 times a year, and it provides opportunity for us to catch things. And I see my time is almost up. I want to leave you with one other piece. My patients are paying more for their premiums. They're paying higher deductibles. They're paying higher copays. I'm losing money on a lot of prescriptions that I fill. Independent pharmacies are struggling. The

state is paying more for their healthcare than they ever have. Our country is paying more for our healthcare than we ever have. Yet PBMs post record revenues. I saw a state from the Nebra-- from the National Community Pharmacists Association that since 1984 to 2014, PBMs, their business has increased 1,010 percent. Let that sink in. The U.S. economy has only expanded 127 percent. I thank you guys for listening to me, and happy to take any of your questions.

WILLIAMS: Thank you, Dr. Bertsch. Questions? Senator McCollister.

McCOLLISTER: Yeah. Thank you, Senator Williams. And thank you, Dr. Bertsch--

TREVOR BERTSCH: Yeah.

McCOLLISTER: --for appearing here today. Would a complaint system work in lieu of some kind of work-- registration system under the state of Nebraska?

TREVOR BERTSCH: I would probably say, no, because it doesn't provide any type of teeth.

McCOLLISTER: How do you think we could get around the price conundrum that you spoke of? What-- is there a way we could do that that--

TREVOR BERTSCH: Well--

McCOLLISTER: --would help you and your business?

TREVOR BERTSCH: --well, that was in the bill the last time it came around. So right now, basically transparency, allowing me to talk to the person that's actually paying for the plan. Right now, if I fill a medication and I'm reimbursed one cost, they can turn around and bill-- let's just use Medicaid, for instance, or an employer, they can turn around and bill them a higher amount. I'm not allowed to talk to the employer to ask how much they're getting charged. They're not allowed to talk to me about how much I'm getting paid. To open that up and allow us to have discussions to see what type of spread pricing we're dealing with would be huge. But, you know, that was more or less in the bill the last go around. And I-- I-- I just think eliminating the gag clause would just allow pharmacists to speak up to some of the things that we hear and see.

McCOLLISTER: What happens when you do-- do give customers advice? Is there some-- something that the PBMs can do for you--

TREVOR BERTSCH: Well--

McCOLLISTER: -- or against you?

TREVOR BERTSCH: --if they hear about it, they can remove me from their network for violating their contract. You know, several of the-- several, you know, testimonies that may come after me, they may say that there aren't gag clau-- clauses, but there are. It's been brought up on a national level even on a federal level that it does exist.

McCOLLISTER: Maybe you don't know, but how many laws or how many states have similar laws like we're contemplating here?

TREVOR BERTSCH: Well, I will leave that to my colleague after me. She has the actual stat.

McCOLLISTER: OK.

TREVOR BERTSCH: It's substantial, and there's quite a few. And it's a huge issue that has been raising the costs in our healthcare. It really, really has. And I-- I-- I can't even stress enough. It just makes me angry. You know, trying to come up with a testimony that was five minutes long, let alone three, was very difficult because the issue was so large. And trying to remain calm, and see, you know, the stuff that we deal with on a day-to-day basis and seeing how my fellow independent pharmacy colleagues are just struggling. We're at risk of losing pharmacies in several small towns located in many of your guys' districts. It's a scary thought that that corner drugstore isn't going to be there in the next ten years if we don't do something about it.

McCOLLISTER: Well, thank you for coming today, Mr. Bertsch--

TREVOR BERTSCH: Thank you.

McCOLLISTER: --or Dr. Bertsch, and-- and what you do.

TREVOR BERTSCH: Thank you.

WILLIAMS: You mentioned the three PBMs. Do you contract with each one of those three P-- PBMs?

TREVOR BERTSCH: We do. How it works is we have to go through what's called a PSAO. They're an organization, usually through our wholesaler, that negotiates on our behalf. The PBMs, as a whole typically, don't-- don't like us to contract with them on an individual basis. We have to contract with them through this group. Now we are given take-it-or-leave-it contracts. It's-- this is-- this is what you need to follow. If not, you can't be a part of it. So we are constantly trying to negotiate better things through that PSAO, but it-- it just gets worse every year.

WILLIAMS: And those are written contracts?

TREVOR BERTSCH: Written contracts.

WILLIAMS: So your-- your testimony is that in that written contract, there is a gag clause?

TREVOR BERTSCH: Right.

WILLIAMS: OK. Do you know of anyone that has actually had their-- been kicked out of the network for violation of the gag order?

TREVOR BERTSCH: I don't know about kicked out. There have been several letters sent to the Nebraska Pharmacist Association, well not letters, but, you know, notification to them that-- they did receive letters if they did not cease and desist, that they would be removed from the network.

WILLIAMS: OK. Do you know if they-- any have been kicked out after receiving a cease and desist?

TREVOR BERTSCH: I do actually know of one, but it was Medicare.

WILLIAMS: OK.

TREVOR BERTSCH: He discussed with his patient about the costs, and he actually did get kicked out because he was telling them that he was losing money on their prescription that they were-- that he was dispensing.

WILLIAMS: Thank you.

TREVOR BERTSCH: Yeah.

WILLIAMS: Any further questions? Seeing none, thank you, Doctor--

TREVOR BERTSCH: Thank you, guys.

WILLIAMS: --for your testimony. Invite the next proponent. Welcome.

CONNIE BOLTE: Thank you. Good afternoon, Senator Williams, members of the committee. My name is Dr. Connie Bolte, and it's C-o-n-n-i-e B-o-l-t-e. And I'm a pharmacist at Charlie's U Save Pharmacy in York, Nebraska. I actually work with my father who is a pharmacist. On behalf of the members of the Nebraska Assoc-- Pharmacists Association, I'm here to testify in support of LB316, and I would like to personally thank my senator, Mark Kolterman, for sponsoring this legislation. Two years ago I was here, and testified before this committee about the pharmacist's day-to-day interactions with the Pharmacy Benefit Managers. Since then, the situation has not improved, and in fact, patients are still feeling those burdens of the unfair practices. And now that Nebraska Medicaid is part of managed care, this affects even more patients across our state. This legislation would benefit the patients, the pharmacists, and because it affects Nebraska Medicaid, the taxpayers of our state by giving oversight to the PBMs to the Department of Insurance. I don't want to overlap too much what Trevor said, but the calendar year brings new deductibles which often means full cost out of pocket for many patients, so they're paying 100 percent of the prescription price. Again, that cash price that I have is probably lower than what they're paying out-of-pocket costs. And I recently had a patient who stood at my cash register with his cell phone and had to transfer money from one account to another just to be able to cost-- cover the cost of his prescription. That wouldn't have happened if I could tell him the cash price. He wouldn't have had to transfer money. There was plenty of money if he'd been able to pay just my own regular price. And then to add the insult to the injury, once the deductible's met, the PBM reimbursement to the pharmacy is much lower, often, than the actual cost of the drug. And this isn't a rare occurrence, to be paid below cost, either. My father, as I mentioned, is a pharmacist. He often spends an hour or more each week on the phone with our contracting organization, the PSAO, reporting these underwater claims. In fact, he told me this morning he spent an hour and a half yesterday afternoon entering information on-line for those type of claims, so it's a time consuming process. Over a span of time, he recently reported 500 claims for below-cost pricing. Not one of those had the pricing adjusted after it was reported, 500 claims. As we reviewed reports for December, 2018, two B-- two PBMs showed that 17 percent of the claims that we submitted to them were paid below our drug cost, 17 percent.

Those happened to be the two PBMs processing the claims for Nebraska Medicaid patients. So what are the PBMs doing with the taxpayer dollars? Where are the dollars going? As legislators, I encourage you to give the Department of Insurance this much-needed oversight for the PBMs. That would give some teeth to these issues. And we experienced the same thing as Dr. Bertsch mentioned. When the patients for Medicaid were placed into managed care, specialty drugs were no longer allowed to be dispensed by us after that first year. Again, expensive medications, and while we had been providing these for basically much of the patient's life, suddenly after one year we were no longer good enough to do that. These patients don't know this. They come to the pharmacy, and now they can't get their medication. And in instances they had to wait several days. So now you have a patient with a chronic condition, in this case cystic fibrosis, who went without medication for several days. That's not appropriate. It causes more harm than good. And in 2019 dual-eligible patients, so patients who have both Medicare and Medicaid, are now paying copays. PBMs told us that the recipients were notified, but we have many patients who were shocked and angry when we informed them that they had an amount due. As an independent pharmacy who provides services over and above filling prescriptions, we offer delivery services. We offer compliance packaging. We offer one-on-one counseling. We offer vaccinations. We build relationships with our patients and we care for them as individuals. Having to fight for every penny of reimbursement of those drug costs takes away from our time to pro-- provide care. And in rural areas, this can decrease access to the most accessible health care provider a patient has, the local pharmacist. And this isn't just a Nebraska issue. The National Community Pharmacists Association reports 194 bills have been introduced in 40 states relating to pharmacy benefit managers. So that's just at the state level. There's national legislation being proposed as well. So here in Nebraska, this legislation will protect patients from the unfair practices and requirements of the Pharmacy Benefit Managers. It will give patients the right to choose where they have their prescriptions filled, not be forced into an option they don't want. LB316 will give pharmacists the ability to help patients to save money on needed medications without fear of retribution. It will give pharmacists the freedom to care for their patients without the concern of losing money on every prescription filled through a PBM. Thank you for the opportunity to comment, and I'd be happy to answer any questions.

WILLIAMS: Thank you, Dr. Bolte. Questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. And thank you for coming here again. Your pharmacy as compared to a Walgreens or CVS, is the pricing similar, would you guess, your pricing compared to their-- their supply chain?

CONNIE BOLTE: OK. Supply chain pricing should be fairly similar. They probably are able to buy drugs for less than we are able to just because they're much bigger corporations even with us being as part of a buying group. That being said, I do know that if I have patients who call me and ask a cash price, our cash prices are most often lower than a national pharmacy chain.

McCOLLISTER: Why is that? I don't want to get you in trouble, but--

CONNIE BOLTE: I feel that we want to take care of the patient and so focus on making medications affordable because if you can't afford to take a medication, it has no benefit for you.

McCOLLISTER: I can't believe that a patient can't go in and ask-- ask cash price, and that is currently against your--

CONNIE BOLTE: A patient can come in and ask, but I cannot offer the price.

McCOLLISTER: Wow.

CONNIE BOLTE: And that's-- that's the difference with the gag clause.

McCOLLISTER: And that's the rub.

CONNIE BOLTE: And that's the rub.

McCOLLISTER: OK. Thank you so much.

WILLIAMS: Can you explain in a little more depth the specialty drug issue with-- with an example or something that I might under-- understand? Now you mentioned cystic fibrosis, but are specialty drugs for unusual or very-- more serious kinds of diseases or ailments?

CONNIE BOLTE: Specialty drugs may be considered for-- like, say, an oral cancer medication would often be considered a specialty drug. In this instance, the one for the cystic fibrosis patient was breathing solutions as well as some medications to replace enzymes that the patient's own body doesn't produce to help digest food. And up until last January, we had been able to supply those medications for the

patient without any problem. We could order them from our supplier, receive them overnight, and have them ready the next day.

WILLIAMS: What's the justification for the change in that?

CONNIE BOLTE: You know, I'm not really sure. I have my thoughts.

WILLIAMS: I'll ask that of somebody else then. Thank you, Doctor. Any further questions? Seeing none, thank you for your testimony.

CONNIE BOLTE: Thank you.

WILLIAMS: Next proponent. Welcome.

BOB LASSEN: Welcome. Thank you, Chairman Williams, members of the Banking, Commerce and Insurance Committee. My name is Bob Lassen, and I'm also a pharmacist. That's B-o-b L-a-s-s-e-n, and I'm here today as a retired pharmacist and an AARP volunteer testifying in support of LB316. Thank you, Senator Kolterman, for bringing this to the Legislature. AARP sup-- supports increased transparency in the prescription drug benefit as to access of care and transparency in the pricing process. It is our policy that federal, state, and local governments should ensure that prescription drug prices and subsequent pricing decisions are reasonable, justified, and support improved consumer access and affordability. There's no reason for consumers across America to pay more for prescription drug pricing than anywhere else in the world, but we often do. This hits older Americans especially hard. Skyrocketing prices are pushing lifesaving prescription drugs out of reach of many who need them including people suffering from cancer, asthma, and diabetes. Prescription drug prices in America are among the highest in the world and remained at the top of the list of concerns Americans have regarding their healthcare. According to the August, 2018 AARP Bulletin, the average cost for a year's supply of medication for someone with a chronic illness has more than tripled since 2006 to over $13,000. That's about four-fifths of the average Social Security retirement benefits and almost half of the median income of people on Medicare. AARP surveyed 50-plus Americans in 2015 to learn about their prescription drug use and any struggles that they had in regard to their prescription drugs. Some of the key findings of the 50-plus group were that 81 percent think prescription drugs are too expensive, 87 percent say that it is important for politicians to support efforts to make prescription drugs more affordable, 44 percent are concerned about being able to afford medications, 76 percent report that there are not enough

regulations when it comes to limiting the price of prescriptions, and 84 percent think that drug companies should be required to publicly explain how they price their products. Tackling the cost of prescription medications in America is like trying to eat an elephant, you cannot do it all at once. Because of the important role that PBMs play in the delivery system, LB316 is a good place to start. By requiring registrations, Nebraska has some oversight into PBM practices. Additionally, LB316 does four things that would further assist consumers in tackling the high cost of prescription and access. It restricts the PBMs from implementing a surcharge to the cost of a prescription in addition to the normal copay. It also requires that any amount paid by the insurer is applied to the plan deductible. It removes the ability of the PBM to require plan beneficiaries to only access specialty medications through the PBM's pharmacies. This process can cause needless delays in getting medication and requires the beneficiary to navigate through an outstate pharmacy provider. Under this bill, any licensed pharmacy in Nebraska can fill the prescription pursuant to their license. This bill also requires the PBMs to allow Nebraska pharmacies to precipitate-- participate, excuse me, in the same beneficiary cost savings program that they provide through their mail-order pharmacies. And lastly, it would allow pharmacies-- pharmacists to consult regarding cost, price, and copayment options regarding the beneficiary's prescription. This is currently not permitted by contract with some PBMs. As you consider this bill please keep in mind, the cost of prescriptions are increasing but incomes are not. People are going without medications or cutting back on taking them because the prescriptions are too costly. It doesn't matter whether someone has insurance or not, costs are going up either way. And many people are having to choose between medication and other needs like food, housing, and utilities. No one should be forced to jeopardize their health because they can't afford proper medication. Thank you for the opportunity to comment on this important legislation. And please, if you have any questions, I'd be happy to answer that.

WILLIAMS: Thank you, Mr. Lassen. Senator McCollister.

McCOLLISTER: Yeah. Thank you, Chairman Williams. And thank you for your-- coming here this-- on this cold day. Is there any prohibition against advising a patient to use a generic drug rather than some expensive brand name?

BOB LASSEN: The, as I understand it, Joni can correct me if I'm wrong, the-- to talk to-- or counsel the patient regarding changing to another particular prescription has to be initiated by the patient. We cannot do it, as I understand it.

McCOLLISTER: So once again, we-- we have the gag order.

BOB LASSEN: Right.

McCOLLISTER: Thank you, Doctor.

BOB LASSEN: Um-hum. Anybody else?

WILLIAMS: I'd like to ask one quick question--

BOB LASSEN: Um-hum.

WILLIAMS: --about your testimony. You-- and this was specifically about counseling regarding cost, price, and copayment options. You make the statement there that this is currently not permitted by contract with some--

BOB LASSEN: With some.

WILLIAMS: --PBMs.

BOB LASSEN: Yes, there's some PBMs that do.

WILLIAMS: There's-- there's three. Can you tell us which are which?

BOB LASSEN: I can't, but that'd be a good question for them.

WILLIAMS: OK, thank you. Any further questions? Seeing none, thank you, Mr. Lassen. Next proponent. Welcome, Miss Cover.

JONI COVER: Thank you, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Joni Cover, it's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association. I'm here on behalf of the Nebraska Pharmacists Association to support LB316, and I want to thank Senator Kolterman for his continued effort to work with us on this bill and get this passed. So thank you, Senator Kolterman. Connie and Trevor and Bob did a great job kind of giving you the perspective of the pharmacist, and I'm happy to answer questions about that. But I wanted to talk to you about sort of my experiences as the CEO of the Nebraska Pharmacists Association. I feel like I've been there a really long time so, even longer than some of

you have been sitting in this Legislature. And I'll tell you that over the years we've had different pharmacy issues pop up, but there hasn't been one consistent issue that I've dealt with like I've dealt with this one, and not only on a state level but a federal level, too. And it continues to get worse. I'm very, very concerned about the viability of some of our pharmacies across the state. We are very lucky in the fact that we have chain and independent pharmacists that serve communities across Nebraska. We currently have 19 counties that do not have any pharmacy located in that community. And I will tell you that while there are CVS and Walgreens and Wal-Mart in many of your districts, there's a lot of districts that don't have those particular pharmacies. So they rely on their community pharmacies and their community pharmacists to take care of them. And we're afraid that the viability of those particular small businesses are going to-- they're going to go out of business. I want to touch briefly on the fiscal note. Senator Kolterman mentioned that in his opening, and I'm not going to walk through the fiscal note with you. But I was taken aback when I saw it, and then I read it, and then I was surprised. I kind of expected what the Department of Insurance had put forward because we figured that there would need to be staff. But the information that came from the university and from DAS, I felt like there's a real opportunity there for us to sit down with those folks and talk to them about some cost-saving measures that they could employ in their Pharmacy Benefit Management contracts. So we'll be meeting with Fiscal because we believe that we can come back to you with a much more reasonable fiscal note. So I just wanted to bring that up. Federally, there has been federal gag-clause legislation that has been passed and will go into effect in 2020 that is in Medicare only. So that won't impact Medicaid or any other of the state governed plans. I passed out-- or I had the pages pass out two documents just to highlight some of the information that's going on in other states. The state of Ohio has done quite a bit of investigating due to a newspaper, The Columbus Dispatch, doing some investigative reporting. That particular newspaper, and because of the investigations done in Ohio, have uncovered that the state of Ohio was overcharged $16 million in their state workers' comp program, and they were overcharged $224 million in their Medicaid managed care program. I provided some information about the Pennsylvania Auditor General, the announcement that they're going to be doing some investigation as well. I know that my colleagues I've heard from in West Virginia and Kentucky and other states are doing some similar-- some similar investigations. I also know the Department of Insurance has been working on a national level on some federal model legislation, and

we've had conversations with the Department of Insurance and so welcome their input and feedback and continued dialogue. I do also want to suggest there's a, Senator McCollister, you had asked about sort of what's going on in other states, and NCSL has done a very good job of doing sort of an overview of what's going on in other states, who's been successful and in what areas, and so the-- it was like-- I think, a 20-some page document that I didn't feel like you'd probably want to read. So at your leisure if you-- if you're interested in the-- in the topic and want more information, we had a speaker come to one of our national meetings from NCSL, and he was very, very informative. And so I would encourage you, if you-- if you have time, to go check out that resource. So really what I want to just point out is that I'm hopeful that this committee will, as the Banking, Commerce and Insurance Committee, look to our state as to how can we do some more oversight investigation of what's going on in Nebraska as far as the PBM practices. In healthcare, hospitals are regulated, pharmacies are regulated, even our own, you know, many of the insurance carriers in this room are regulated. And the only entity that's not really regulated at a state or federal level are the Pharmacy Benefit Managers. So we would just ask this committee to assist us in trying to shut-- shed some light and some transparacy-- transparency on that business practice. So for that, I'll stop talking and answer your questions.

WILLIAMS: Thank you, Miss Cover. Questions? I have one question or I would like to get your reaction.

JONI COVER: OK.

WILLIAMS: We have a letter in-- in opposition to LB316 from Matthew Van Patton--

JONI COVER: OK.

WILLIAMS: --Department of HHS, and in part he says, "By preventing the health plans from selectively contracting, this bill could raise drug prices by limiting the plans' ability to negotiate for lower rates in a larger marketplace. This bill would also limit the plans' ability to ensure their providers meet safety and quality standards. Ultimately, this bill could unintentionally increase costs and lead to inferior results."

JONI COVER: And you would like me to respond to that?

WILLIAMS: That was my question.

JONI COVER: That was your question.

WILLIAMS: That's why you're sitting in that chair.

JONI COVER: All right. All right. Well, my-- my comment would be Nebraska pharmacists, since the beginning of time with Medicaid and the drug benefit, have done an exceptional job of managing that benefit. There have been cost-saving measures that have been put in-- been put into the pharmacy benefit at the request of pharmacists. So, for example, tablet splitting was one that saved the state money. Putting together a cough-and-cold drugs products list was something that our members came together and said, we're paying for too many expensive cough-and-cold products, let's narrow this list down and let's put something together that will save the state money. As far as the quality of what is being provided by our pharmacies, if there are pharmacies in Nebraska that aren't providing quality care and quality patient services, I believe Medicaid has the ability to go and tell them they can't be a part of the Medicaid program anymore. So I sort of take exception to that comment. If there's fraudulent activities going on, sick patient safety issues that have-- have come about, then by all means the state of Nebraska needs to take action. But I'm not aware of any right off the top of my head. So that's my comment to that. As far as saving the state money or costing the state money with Medicaid, I would just point, again, this committee to-- to the state of Ohio and have you look at what they've done in investigating their Medicaid managed care program. Same PBMs, and they found that $224 million was overcharged the-- the Medicaid program and underpaid to pharmacies. Now I know we have a budget deficit. So really that $8 million price tag on this bill looks like peanuts compared to the $224 million they found that they were being overcharged in that program. So I-- I believe that the-- that the Medicaid program is doing an exceptional job. But I believe that they can probably do a little investigating and maybe find some of these same dollars that are on the table that are being discovered in other states. So I think the Medicaid program in Nebraska does a great job in-- with the tools that they have. So that's my-- my reaction to that comment.

WILLIAMS: Any further questions? Thank you, Miss Cover.

JONI COVER: Thank you.

WILLIAMS: Would invite the next proponent. Welcome, Mr. Schaefer.

MATT SCHAEFER: Thanks. Chairman Williams, members of the committee, my name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, appearing today on behalf of the Nebraska Medical Association in support of LB316. The NMA echoes the testimony you've already heard today in support of the bill. Specifically, the NMA supports Section 6 which prohibits the PBM, or provides that the PBMs may not prohibit pharmacies from sharing pricing information with patients for their medications. LB316 furthers the concept of patient-centered care and empowers patients to be knowledgeable healthcare consumers. The NMA supports LB316 and urges the committee to advance it to General File.

WILLIAMS: Thank you, Mr. Schaefer. Questions? Seeing none, thank you for your testimony. Invite the next proponent. Welcome, Mr. Mueller.

WILLIAM MUELLER: Thank you, Senator Williams, members of the committee. My name is William Mueller, M-u-e-l-l-e-r. I appear here today on behalf of the Pharmaceutical Research and Manufacturers of America in support of LB316. The page is handing out a statement from PhRMA. I will not read that. PhRMA does support this bill. We've supported and testified on past bills. PhRMA does support meaningful transparency in this area. We believe that the provisions of LB316 do provide that. Our concern is that the significant rebates and discounts that brand name drug manufacturers are providing to Pharmacy Benefit Managers and health insurers are often not realized by patients. Unlike physicians or hospital expenses where patients pay based on the discounted rates negotiated between the health plan and the provider, case and-- patient costs are often based on the medicines full list price. Patients may not realize that they are not benefiting from the negotiated rebates and discounts provided for the medicine especially when a patient has not fully met his or her deductible. During that time, patients may pay the full list price for a drug even when a manufacturer is paying the PBM or the insurer a rebate. This bill will ensure that a pharmacist can tell patients if there's a less expensive way to obtain their medicine such as buying the medicine without using insurance. Historically, some PBMs have prohibited pharmacists from telling patients that a medicine may be less expensive if the patient paid out of pocket for a drug instead of using their prescription drug benefit. We believe that the provisions of this bill are-- if you-- if you go back and compare this year's bill to past year's bill, this is a slimmed-down version to get at

what the Pharmacy Association believes are the real issues here. Be happy to answer any questions that the committee may have.

WILLIAMS: Thank you, Mr. Mueller. Questions? Seeing none, thank you--

WILLIAM MUELLER: Thank you.

WILLIAMS: --for your testimony. We'd invite the next proponent. Seeing none, we would switch to opposition testimony. Is there anyone here to testify in opposition? Welcome.

DAVID ROOT: Thank you. The paperwork issues first. Chair, my name's David Root, R-o-o-t. I represent Prime Therapeutics. We are the PBM that operates Pharmacy Benefit Management for Nebraska Blue Cross Blue Shield. Nebla-- Nebraska Blue Cross Blue Shield is under our ownership model, also a part owner in our organization. We are owned by 18 other nonprofit Blue Cross Blue Shield plans across the country. Very quickly, I came here today to discuss LB316. In the course of listening to the testimony, we've wandered far afield. So I'm going to go over the issues with respect to LB316 and then would invite the committee to ask questions, some of which went unanswered previously. So PBMs contract with health plans, employer groups, states, unions, including state Medicaid programs and government programs like Medicare Part D. We create pharmacy networks. We negotiate drug prices from manufacturers. We help plans and employer groups design drug formularies. We adjudicate pharmacy claims as well as implement drug utilization programs to ensure safe, effective use of low-cost, appropriate products in the treatment of various therapies. This bill is-- is a little confusing largely because it goes over a number of activities that it cites as new when, in fact, they're existing law. It requires pharmacies to be registered-- PBMs to be registered as TPAs. Under 44-5802, Section 6: Third-party administrator shall mean a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents in this state or another state from offices in this state. That is clearly one of the things-- adjudication of claims is the core of-- one of the core fundamental programs that PBMs utilize. We are registered as TPAs already. The other issue in-- in the-- is business parlance of this law we call the one section you heard about mail-order parody. In other words, you have to treat mail order-- the consumer going to mail order is not-- we are not able to incentivize a consumer going to mail order as opposed to going to a retail pharmacy. That is already existing law. The ex-- only exception in your existing law for that program is for, what is defined by the

statute as, long-term maintenance medications. And so what-- you may ask what does incentivization look like? Incentivization would look like if you went to mail, you could get a 90-day supply and only pay a 60-day copay. So you'd be-- you'd be one less copay; that would be incentivizing a consumer to go to mail. That's already a prohibited practice in the state. So if we have understandings that that's taking place, we would encourage the people who have the proof to that information taking that forward to the requisite authorities. It's already a violation of Nebraska law. The other item which is in the bill which was slightly confusing to me as well is the notion of the gag clause. And that is the prohibition on informing a customer of a cheaper alternative product which may or may not be through their insurance. First of all, let me state that Prime Therapeutics has never had a gag clause in their contracts. In fact, Prime's contracts encourage the pharmacist to have a discussion with the consumer with respect to cheaper alternatives. If the patient is taking their medicine, they are adherent and they are less likely to have an adverse effect, an adverse outcome as opposed to not taking the medicine. However, the federal government at the end of last year, Congress passed and the President signed a nationwide prohibition on gag clauses that took effect 1-1-2019. There now can be no contract in the United States that's legal between a PBM and a pharmacy that prohibits a pharmacy from counseling a patient about a cheaper alternative therapy be it in their insurance program or outside of their insurance program. So, again, if there are people who have information to the effect that those contracts are in existence, to the extent that they may be in existence, that section is null and void. They cannot be held to it. And if they are, they're violating federal statute already. One of the things, and this is a bit of a nuance, but one of the things, and it is contained even in our contracts, one of the things that is prohibited is this notion of having the pharmacy be able to share with the consumer the pharmacy's reimbursement or the terms of the pharmacy's reimbursement contracts with the PBM or the health plan. That language is still there. That is prohibited. That is a contract between the PBM or the health plan and the pharmacy. And it has absolutely no bearing whatsoever on what the consumer pays at the counter, whether they pay the cheaper of the cash price or the cheaper of their insurance price, whether it's a copay or coinsurance. So the end of this, we had a lot of conversation about Ohio and Pennsylvania. So what those places are talking about is a thing in the business we call spread-pricing arrangements. And the spread-pricing arrangement in its simplest term is the PBM will charge the health plan one price, and will pay the pharmacy a lesser price.

Typically, the PBM then keeps that delta, the difference between what they charge the health plan. Now in the Medicaid space, Medicaid plans will frequently ask for a spread-pricing contract for very specific price certainties in the relation-- in the fee that the PBM charges the Medicaid--

WILLIAMS: Thank you, Mr. Root. We do have a red light--

DAVID ROOT: --I see that.

WILLIAMS: --but would you continue with that discussion. I'm interested in hearing--

DAVID ROOT: Sure.

WILLIAMS: --what you were just saying.

DAVID ROOT: Sure. So one of the things that they will do is they-- a Medicaid department-- so first to understand what happens is the Medicaid department decides how much-- well, you all decide how much money the Medicaid is going to have to spend on a drug benefit. And then they create an RFP for that service. That RFP goes out to the PBMs. The PBMs then compete to provide that service for the-- for the Medicaid program. The Medicaid program is interested in price certainty because they-- they only have what you give them. And they have difficulty when they come back, and there's a shortfall. So what they say is, I tell you what, this is-- price certainty is very important to us as the PBM. We want price structure on these things; we'll allow you to create whatever kind of discounts you can get out of the pharmacies, and you can keep the difference. But we want to make sure that we don't pay any more, and I'm making up numbers, we don't pay any more than $6 a claim, OK? But if you can get the pharmacies to do it for $3 or $2 or $4 or $1.50, then you can keep the difference. And that's sort of an offset to what they negotiate the lower fee to.

WILLIAMS: In your judgment, that issue that you're just talking about there, does that create an environment where the large pharmacies, CVS, Walgreens, have an advantage over our community pharmacies?

DAVID ROOT: I don't believe that does because that's a negotiation. And I would say to you, if you do believe that it does, you have the ability to direct your state Medicaid program to not issue a spread-pricing contract. If-- if you feel that way, you can-- you can

direct your state Medicaid program to not issue spread-pricing programs. It is a fallacy and a shortcoming on behalf of the Ohio Medicaid department to act demure and say, oh, I had no idea CVS was doing a spread contract. CVS was doing exactly what they were contracted to do by the Ohio Medicaid department. The only thing that the Ohio Medicaid department had the right to be demure about was the fact that they did not know the size of the spread. And as it turned out, according to that report, if you take that report for what it is, the average across all of the pharmacies in the state of Ohio, the spread was about 8 percent.

WILLIAMS: Thank you, Mr. Root. Are there questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Mr. Chair. There's three PBMs in Nebraska, is that correct?

DAVID ROOT: No, sir. I have no idea how many PBMs there are operating in-- in the state of Nebraska. You'd have to look to see how many have signed up for their TPA license.

McCOLLISTER: There's more than one?

DAVID ROOT: Yes

McCOLLISTER: OK. So we could do competitive pricing and give all the business to the winner, could we not?

DAVID ROOT: Yes, you could [INAUDIBLE].

McCOLLISTER: And that open market would probably get the best price.

DAVID ROOT: That's the plan. Yes.

McCOLLISTER: OK. Thanks for being here, Mr. Root.

DAVID ROOT: Thank you.

WILLIAMS: Couple of questions. I want to be sure I understood the-- the mail-order priority. Is there an exemption in the mail-order priority for, I think you called it, long-term maintenance medication.

DAVID ROOT: As I understand your existing law, yes, sir. There is a-- an-- an exemption for mail order par-- for not requiring mail-order

parody for long-- what is-- what is statutorily defined as long-term maintenance medications.

WILLIAMS: So that would be things like insulin.

DAVID ROOT: I'd have to look at the code, but, yeah, I think you're in the ballpark.

WILLIAMS: OK. A question we asked earlier, there was some discussion that may or may not be totally relative, but I want to know anyway about specialty drugs and the justification for taking specialty drugs out of the ability of pharmacies to dispense.

DAVID ROOT: Sure. One of the things, and I understand, it was very difficult to follow a lot of the testimony to this, and I think it's very important. It was very confusing to determine when we were talking about the commercial market and when we were talking about state Medicaid programs. State Medicaid program is something that you control as-- as a leg-- as a legislator. The bottom line, and this is-- it's the ugly truth of the fact, but the bottom line is that PBM's mail-order pharmacies because of their size and their ability to buy drugs can provide those specialty drugs cheaper to consumers. We are also able to obtain the vast majority of those specialty drugs even in situations where those drugs are through-- are produced through manufacturers in limited dispensing arrangements. Many times the FDA, in order to get a promising drug to market especially in the specialty space, will say to the-- will say to the manufacturer, we're going to give you a conditional approval. You need to keep collecting data, and you need to submit that data on a regular schedule to the FDA to ensure that the drug is actually acting the way it was told to the FDA that it would act. Those are called REMS programs. That means that the pharmacy who is distributing that material has a tremendous amount of paperwork that has to be done to be sent back in each dispensing to the manufacturer. It has to be the doctor, the diagnosis, what's happening to the patient, all those-- those types of things. So in many instances, through those limited distribution networks a-- a run-of-the-mill local pharmacy is not equipped to access that information. And frankly, the manufacturers simply won't sell it to them. And they may not even have a-- a patient that requires that product.

WILLIAMS: Did that process change then?

DAVID ROOT: I--

WILLIAMS: Did they all of a sudden become not capable of doing that in 2017 or some-- whatever that date was?

DAVID ROOT: --I think-- I think the problem was, and again, here's where I think we have a disconnect, I think the issue was that previously your state Medicaid program was in a managed Medicaid program-- I mean, excuse me, was in a fee-for-service program. And it transitioned to a managed Medicaid program to save money because PBMs are able to work with the health plans and the MCOs in the state to actually save money. One of the ways they do that is by utilizing their ability to get the drugs cheaper to get the drugs to those populations. So to that effect, if that is considered change, I would say that that is probably where the change comes from. And I would also say that there's been some question about the dollar value being far greater than what it was. I am, you know, I'm a liberal arts graduate so I'm delving into math now, so I apologize for that. But generally speaking, you know, the-- we have seen massive increases in specialty drugs, the costs of specialty drugs. So I can see where that would be a result of some of the increase over that fiscal note between the last time some semblance of this bill came forward. Specialty drugs now are-- are-- are approaching 50 percent of the drug distribution chain, and they are a large percentage, if not the majority percentage, of the actual drug spend, the cost of the products.

WILLIAMS: Thank you, Mr. Root. Any further questions? Seeing none, thank you for your testimony. Invite the next opponent. Welcome back, Mr. Dunning.

ERIC DUNNING: 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 for Blue Cross and Blue Shield of Nebraska testifying in opposition to LB316. Since 1939, we've worked hard to encourage the health and wellness of all Nebraskans of all ages. Our mission is to lead the way in supporting patient-focused care, to achieve a healthcare world without confusion that adds more good lives-- good years to people's lives. We don't believe LB316 will accomplish most of those goals and are here in opposition. LB316 covers a wide range of subjects. David's covered many of them, so I'll try to skip over as much as possible the duplicative parts of my testimony. Again, going back to clawbacks and gag clauses, we've seen

action from the federal government when it comes to the issue of the gag clauses. Interestingly, the bill in front of you today, the language in the bill doesn't look like it's consistent necessarily with the federal gag-clause language that was actually adopted. And so that'd be some-- that would give us pause about supporting what we would otherwise come in, in support of. The-- let's see-- moving to the mail-order copayments, again, as David mentioned, 513.02 is existing Nebraska law. It's been in place for 20 years. And it's not cross-referenced in this bill, so it's hard to know how this new standard relates to the old standard. But we abide by the standards in existing Nebraska law. If insurers are offering state-regulated products that don't meet the standard, we have an enforcement issue not necessarily a statute issue. As regards to the TPA registration, we seem to have another sort of drafting- ish issue. Under existing Nebraska law, it looks like the functions that a PBM undertakes on our behalf are within the existing TPA law. Now that said, the bill would, you know, double down on that principle, but then go on to subject them to examination standards in the Unfair Insurance Trade Practices Act. However, existing Nebraska law already subjects TPAs to examinations as well as the Trade Practices Act and the Unfair Claim Settlement Practices Act. So there seems to be a redundancy, and you'd need to be able to read all those statutes together. Section 4 of the bill is also troubling. One of the-- Section 4 of the bill requires the exercise of good faith and fair dealing by PBMs under their contracts. However, those obligations are not, under this statute, reciprocal. So the implication is-- is that pharmacies may be statutorily released from any similar obligation of good faith and fair dealing to PBMs as well as the insurers on whose behalf they work. We can't believe that's what intended, but it's certainly implied by the bill. As we look at the bill as a whole, we have significant concerns about not only some of the policy but just the basic how do we read this bill together with existing Nebraska law?

WILLIAMS: Thank you, Mr. Dunning. Questions? So you would support language in the bill, though, that would mirror the federal language on a gag clause?

ERIC DUNNING: Yes. And, Senator, I would remind you that a few years ago-- the last couple of times we've heard this issue, that conduct, that-- that gag clause con-- conduct is not widespread in our state. I mean you-- we heard several representatives of-- several of the PBMs stand up and say we don't do this a few years ago. So it looks like

we've got a small hole with maybe a bad actor out there that needs to be told not to do that.

WILLIAMS: As Mr. Root testified, there are a number of PBMs. They're not all here today.

ERIC DUNNING: That's correct.

WILLIAMS: Thank you for your testimony.

ERIC DUNNING: Thank you, sir.

WILLIAMS: Are there any additional opponents? Welcome back, Mr. Tabor.

NOAH TABOR: Thank you, Mr. Chairman and members of the Committee. And for the record, Noah Tabor, N-o-a-h T-a-b-o-r. Seeing that the hour is late, I'm going to be very brief. Would echo the comments raised by my fellow opponents on the substance of the bill. We take particular issue with Section 5 on specialty pharmacies. We see that section as eroding our ability to develop and maintain the specialty pharmacy network which we see as critical to protecting patient safety. Some things in terms of process and logistics I want to raise. As what I think brought forward from a proponent, the federal government released proposed rules last month that will dramatically alter the way that PBMs and manufacturers deal with rebates and that federal regisla-- regulation will be dealing with Medicare and Medicaid. But as often is the case, regulations that start with Medicare and Medicaid often find their way quite quickly to the commercial market especially the ACA market sort of looking for federal activity on the rebate issue. The NAIC, the National Association of Insurance Commissioners, is also looking at model legislation around PBM transparency, licensure, and registration. We understand that model legislation is forthcoming. We would encourage the committee to hold off any action until the federal rules have had a chance to be finalized and that model bill has come forward. Would also raise for the committee in the past PBM transparency bills have had issues passing ERISA preemption tests, and the Eighth Circuit has held now several times that bills similar to LB316 are preemptive and the bills are then-- fall flat. So we'd kind of make sure that the committee is going to be keeping those ERISA issues in mind. I was also-- I was struck by the proponent from the AARP raising a very important issue of the price of drugs, and certainly our members who are 50, 55, their price of drugs is significant. And we remind the committee that while you consider legislation, some impact in drug pricing at the federal

level, that the cost of healthcare and the costs of prescription drugs is inordinate. The list price of prescription drugs has gone through the roof, and Nebraskans in your districts are feeling that sting, I am certain. So we kind of look at ways to address healthcare costs. Let's remember kind of top-stream issues as well. And I want to keep my comments brief, and I'm happy to answer any questions, Mr. Chairman.

WILLIAMS: Thank you, Mr. Tabor. Any questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Williams. And thank you for your appearance here, Mr. Tabor. The contract that you have with Nebraska, is that a spread market, or a so-called spread contract?

NOAH TABOR: You know, I'm not sure. We are-- our PBM is CVS. And I'm not sure of the spread contract-- contracted practices, sir.

McCOLLISTER: You do have a contract with Nebraska?

NOAH TABOR: We have a contract. So we offer-- we don't have-- we don't-- we do not contract with Nebraska, the state. We offer ACA compliant plans here in Nebraska in the individual market, so we don't have a direct contract with state of Nebraska.

McCOLLISTER: OK. Sorry, I must--

NOAH TABOR: No, you--

McCOLLISTER: --have been confused.

NOAH TABOR: --no, you're just fine, sir. A moment of levity, Medica and Medicaid, often kind of get thrown together, so you're just fine, Senator.

McCOLLISTER: I just needed somebody to blame.

NOAH TABOR: Yeah. I'm usually a good person for that.

McCOLLISTER: [INAUDIBLE]. All right.

NOAH TABOR: Thank you, Mr. Chairman.

WILLIAMS: Thank you, Mr. Tabor. Invite the next opponent. Welcome back, Mr. Bell.

ROBERT BELL: Thank you, Chairman Williams and members of the Banking, Commerce and Insurance Committee. It's been a very long day. My name again is Robert Bell, last name is spelled B-e-l-l. I'm executive director and registered lobbyist for the Nebraska Insurance Federation, and I am here today to testify in opposition to LB316. I think I'll just make a couple of points real fast again. And it's been brought up, by Miss Cover and then Noah as well, that the NAIC has just moved forward with the process of creating a model in this area, and the hope is that there would be some sort of national consensus. And one thing that the National Association of Insurance Commissioners is very good at doing is bringing all parties to the table, whether or not they're insurance companies or Pharmacy Benefit Managers or pharmaceutical companies or pharmacists themselves, to sit down and come up with solutions that work for all 50 states to the best of their ability. You know, whether or not they'll complete that work I guess we'll see. But the hope is that they would be able to pass a model at their level and then bring it to the various legislatures for adoption on this very important issue so we can keep drug prices down which I think everybody wants to do, make healthcare more affordable for everyone. And with that, thank you for the opportunity to testify.

WILLIAMS: Thank you, Mr. Bell. Questions? Seeing none, thank you for your testimony. Anyone else in opposition? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Kolterman. And while you're coming up, we do have four letters in support from Jim Otto, Kathy Siefken from the Grocery Association, Matthew Kubat from Kubat Pharmacy, Peggy Reisher from the Brain Injury Alliance, and as I mentioned earlier, we have one letter as-- in opposition from Dr. Matthew Van Patton from the Department of Health and Human Services. You are welcome to close, Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Interesting afternoon. I brought this bill-- I-- I've been-- I was work-- I worked all summer with the-- I've talked to the PBMs. I had the Department of Insurance, the pharmacists, insurance companies. We all got together at times and talked about what can we do, what can't we do. That's why I was encouraged when the-- the NAIC told me or the-- the Nebraska State Department of Insurance told me that they're working on model legislation that will come probably next year. We talked about that. We decided to bring this bill anyway. A couple of things I want-- I-- I think there's a couple of things that concern me. First of all, this bill's not going away. As you've heard today, there's a lot of trouble with-- there's a lot of trouble with the Pharmacy Benefit Managers and

how they work and how they control the business. And, you know, I can't-- I can't condemn insurance companies because I made a pretty good living with them over the years. But on the other hand, I've always wondered why an insurance company who gets a premium dollar and makes money off that premium dollar should also be entitled to take the profits off of the PBM. Because as an example, Blue Cross and Blue Shield owns Prime. Well, there's a margin there and then there's a margin with Blue Cross and Blue Shield. Optum owns-- or UnitedHealthcare owns Optum, another example. I don't know who-- who owns Express Scripts or CVS Caremark, but those are-- those are probably the largest players in the marketplace. And there are a lot of other PBMs, many smaller. If you're an independent-- if-- if you've got your own group, you can contract with a PBM on your own and work through them if you're a self-insured program. Many companies do that. When the NAIC gets together, they're going to have insurance companies, Big Pharma, PBMs, and pharmacists all in the same room. And they're going to hammer something out, and they're all going to have to agree to it. And then perhaps that's our answer. I'm going to take you back a few years, though, because it-- I'll tell you why I really carry this legislation. And maybe it's-- maybe it's because I'm a softie, but my family owned a small retail business in a-- in a community of Seward for 85 years. It was Ben Franklin store. Some of you, like Williams and McCollister, are old enough to remember that. But the Ben Franklin stores were independently owned businesses and were franchises, then Walmart came along. And I can't-- I don't have to tell you what Walmart's done to the small communities in this state, how it kind of ruined the downtowns and moved out on the outskirts and cut the prices and put people out of business. I've got constituents sitting right behind me here that are-- that are the old Ben Franklins because the Walmarts, the CVSs, the Optums, the Primes, they're trying to put them out of business. What concerns me the most is these are people that talk to you-- the guy from Norfolk was talking about how he works with his patients. I could sit down and talk with him. You know how my-- how my company works with me? I'm with Humana because I'm over 65. I get my prescriptions from my local-- my local pharmacy. Humana calls me up after-- aft-- after I get it filled and says we don't want you doing that anymore. They leave me a voicemail. Don't-- don't do it there. We can cut the costs. Send-- send it in to us. We'll do mail order and get back to you. I pretty much told them to pound sand. But irregardless I don't want-- I don't want to see-- in my district there are 10 independent pharmacies left. There used to be probably 15. We are already starting to see consolidations and as people get older, they're closing them up and

sell and selling their customers off to someone else. It's already happened in Seward several times already. I don't want to see that happen. I believe in this state and I believe in small businesses. They're the backbone of this state just like the farm economy is the backbone of this state. So when I brought this legislation, you think I really care about UnitedHealthcare or Blue Cross and Blue Shield? They're-- they're good companies, but they don't mean anything to me as much as our constituents mean to us, the people that work hard. They volunteer in our local communities. I don't see many Walgreen people doing that. They-- they contribute financially to the small communities. They sit next to us in the church pew. They're people in our communities that we need to continue to support so that we can keep them in business. And I don't think for a minute they're going to take advantage of us. So with that, I'd-- I'd try and answer any questions. As I said, this bill's not going away. We might not get it through this year. Maybe we'll get parts of it through, I don't know. It's going to be up to all of us to talk about that. But it's going to be there, needs to be there to protect our state and our constituents. With that, I'll answer any questions you might have.

WILLIAMS: Thank you, Senator Kolterman. Are there any final questions for the senator? Seeing none, that will close the public hearing on LB316. And we will not be having--