

Transcript Prepared by Clerk of the Legislature Transcribers Office  
Banking, Commerce and Insurance Committee February 18, 2020

**WILLIAMS:** Welcome to the Banking, Commerce and Insurance Committee. My name is Matt Williams. I'm from Gothenburg and represent Legislative District 36, and I'm honored 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 legislative process. It is your opportunity to express your position 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 called away. It is not an indication that we are not interested in the bills being heard, it's just part of the legislative process. To better facilitate today's procedure, we 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 first, followed by those in support of the legislation, then those opposed to the legislation, followed by neutral testimony, and then the senator introducing the bill will be asked to close. Testifiers, please sign in and have-- you have pink sheets when you sign those and come up to testify, please hand them to our clerk. And when you testify, if you would please spell your name for the record as you're beginning your testimony. We request that you be concise. It is my request that you limit your testimony to five minutes and we do use a light system. The light will be green for the first four minutes, followed by one minute of a yellow light, and then the red light will come on, and we ask that you conclude your testimony at that time. If you will not be testifying at the microphone, but want to go on record as having a position on the bill being heard today, there are white tablets at each entrance where you may leave your name or other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being given. Hand them to the page for distribution to the committee and the staff when you come up to testify and we'll need ten copies. If you don't have ten copies, the page would be happy to make those for you. To my immediate right is committee counsel, Bill Marienau, and to my left at the end of the table is committee clerk, Natalie Schunk, and the committee members are with us today and we will have self-introduction starting with Senator Gragert.

**GRAGERT:** Thank you. Good afternoon. Tim Gragert, District 40, northeast Nebraska.

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**La GRONE:** Andrew La Grone, District 49, Gretna and northwest Sarpy County.

**LINDSTROM:** Brett Lindstrom, District 18, northwest Omaha.

**QUICK:** Dan Quick, District 35, Grand Island.

**KOLTERMAN:** Mark Kolterman, District 24, York, Seward, and Polk Counties.

**McCOLLISTER:** John McCollister, District 20, central Omaha.

**WILLIAMS:** And our page today-- oh, Senator Howard.

**HOWARD:** I'm Senator Sara Howard from District 9 in midtown Omaha.

**WILLIAMS:** Now Senator Howard thinks she chairs the best legislative committee and we're gonna prove her wrong today. [LAUGHTER]

**HOWARD:** Are we gonna do this today?

**WILLIAMS:** Today.

**HOWARD:** All right.

**WILLIAMS:** And our page today is Lorenzo, and he is a student at UNL. And we are pleased to have him. Our first bill that we will open the hearing on now is LB948, introduced by Senator Crawford, to change provisions relating to insurance coverage for mammography. Welcome, Senator Crawford.

**CRAWFORD:** Thank you. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Senator Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County, and I'm here today to introduce LB948 for your consideration. LB948 is a bill about insurance coverage of the central breast cancer screenings for women considered to be a high risk for cancer. This summer I saw media coverage about surprise medical bills that some women are receiving for breast cancer screening services. Upon researching this issue and examining current Nebraska law on the subject, have identified several areas in need of an update and LB948 is a product of that research. One needed change was that language in our current law must be updated to better reflect the current federal mandate for preventive breast cancer screening services under the Affordable Care Act. The other

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necessary change is that we do not currently adequately cover higher level screening services that are required for women with dense breasts or who have other risk factors for cancer. All women over the age of 40 are recommended to have regular breast cancer screenings, and the Affordable Care Act provides that insurance coverage-- insurance must cover mammograms at no cost every one to two years for this age group. An estimated 40 percent of women have dense breast tissue. For these women, traditional mammograms do not effectively screen for breast cancer. Breast density is a measure of the makeup of the breast or refers to how the tissue appears in the mammogram, which often changes with age. Women with high breast density have a greater amount of breast and connective tissue compared to fat. Mammograms of dense breasts are harder to read than mammograms of fattier breast, because the dense breast tissue and cancers both show up as white on a standard mammogram. There is evidence that in women with dense breasts, standard mammograms miss more than 50 percent of the cancers present. This is why a higher level of screen technology is needed. Additionally, evidence shows that women with dense breasts are at a four to five times higher risk of breast cancer further increasing the need for more accurate picture of these women's breasts. Exams, such as supplemental MRIs have been demonstrated to be more effective at detecting cancer in women with dense breasts and result in as many as 50 percent fewer missed cancer diagnosis. The currently recommended gold standard screening modality for women with dense breasts is a digital breast tomos-- tomosynthesis, also known as 3D mammogram, because it is more accurate than traditional mammograms, results in fewer misdiagnosis than a breast ultrasound, and is more cost effective than MRI. LB948 would require that insurance companies cover 3D mammograms referred to in the bill language as digital breasts tomosyeth-- tomosynthesis at no cost for women with dense breasts or who are at higher risk for cancer due to previous cancer diagnosis, immediate family member with a breast cancer, or a positive genetic testing. The bill further requires coverage of MRI for those groups, though it allows the application of copayment are deductible because the MRI is a more expensive screening tool. The CDC recommends that MRI or 3D mammogram annually for those at high risk groups. The other changes in the bill are to up-- update outdated language to match what's required by the Affordable Care Act. I would venture-- I would venture a guess that all of us have a loved one who's been affected by breast cancer. Breast cancer is the most common cancer in women and the second most common cause of death from cancer among women. Since the ACA mandates that preventive screening services for breast cancer be covered for women over 40, women with dense-- dense breast and

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those with otherwise high risk for breast cancer should be entitled to coverage of a level of preventive care that they need. LB948 brings Nebraska statute in line with the existing federal mandate and ensures coverage of the necessary medical screening services for women at a high risk of breast cancer. Over the weekend, we received communications from the radiologists arguing that 3D mammograms are now the standard of care to be covered for all women, not just those with dense breasts or high risk women. The intent of LB948 is not to remove other women's access to these screening services, but to ensure that those women at highest risk receive the coverage they need. Our research-- our research stressed the importance of more effective screening modalities for these high-risk women and those with dense breasts. However, setting a statutory minimum does not legally prohibit coverage of free mammograms for all other women. Major insurance-- insurers in the state have shared they're already providing this service for women over 40. With LB948, we would simply be setting a minimum standard for these groups of women that medical literature indicates need these services the most. I believe that Blue Cross Blue Shield is here today to testify in neutral capacity and Medica has chosen not to take a position on the bill because they're both amenable to changes in LB948 and have shared that they're already providing coverage for breast cancer screening services consistent with the language in LB948. Two other notes. The fiscal note is-- is confusing because it notes a-- a cost for screening for those who are 35 to 40 for their screening mammogram, which is already in statute. We just added the word, screening, and so it's odd that they picked up that as something that's a new service which is-- has something that we've already been requiring in statute. So we haven't had a chance to follow up with the Fiscal Office on that front, but it seems an odd service that they have picked up as something that's added to the bill when actually that part of the bill is something that was already in statute before the-- the mammogram for women who are 35 to 40 was already there before. So we follow up with the committee as we follow up with Fiscal Office on that. So with that, I will take any questions now and I'll be here for closing too.

**WILLIAMS:** Thank you, Senator Crawford. Questions for the Senator?  
Senator La Grone.

**La GRONE:** Thank you, Senator Williams. Thank you, Senator Crawford, for bringing the bill. As I was looking at the bill, I'm just trying to get a full understanding. So it looks to me like it's simply an

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update to an existing requirement and brings that into line with modern practices rather than a new requirement, is that correct?

**CRAWFORD:** That is correct.

**La GRONE:** OK. Thank you.

**WILLIAMS:** Additional questions? Seeing none,--

**CRAWFORD:** All right. Thank you.

**WILLIAMS:** --thank you. We would invite the first proponent to testify. Anyone wishing to testify in support of the legislation? Seeing none, is there anyone here to testify in opposition? Seeing none, is there anyone here wanting to testify in a neutral capacity? Welcome, Mr. Dunning.

**ERIC DUNNING:** Thank you, Mr. Chairman. Sorry for my delay getting up here. I'm a little surprised to be leading off in a neutral capacity. Mr. Chairman and members of the Banking, Commerce and Insurance Committee, for the record, my name is Eric Dunning, E-r-i-c D-u-n-n-i-n-g. I'm a registered lobbyist for Blue Cross and Blue Shield of Nebraska, appearing today on behalf of Blue Cross and Blue Shield of Nebraska in a neutral capacity. Since 1939, we've worked very hard to encourage the health and wellness of all Nebraskans of all ages, and we think that this bill is an important step in that direction. We understand that concerns have been raised that by setting a minimum standard, you're going to allow companies to drift down to a minimum standard. We don't believe that to be the case. In fact, Blue Cross voluntarily moved forward on 3D mammograms for dense breast tissue and others, and we believe that's the current state of the science. And I said we're-- we're-- we believe that LB948 is merely setting the minimum standard on the floor and we don't think that that means that coverage as a practical matter is going to drift down to-- to meet the minimum level in the statute.

**WILLIAMS:** Any questions for Mr. Dunning? Seeing none, thank you for your testimony.

**ERIC DUNNING:** Thank you, sir.

**WILLIAMS:** Additional neutral testimony? Seeing none. Before Senator Crawford comes up, we do have letters in support from Todd Hlavaty from the Nebraska Medical Association, Andy Hale from the Nebraska Hospital Association, Amy Behnke from the Health Care [SIC]

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Association of Nebraska, Carol Dennison from the League of Women Voters, Tiffany Joekel from the Women's Fund of Omaha, and Scout Richters from the ACLU of Nebraska. All those letters are in support of this legislation. Senator Crawford,--

**CRAWFORD:** Thank you.

**WILLIAMS:** --you're welcome to close.

**CRAWFORD:** Yeah, so don't really have much else to add, but I will just ask for your consideration of the bill and be happy to answer any questions and work with the committee on any other concerns that you have.

**WILLIAMS:** And if I understood your testimony right on the fiscal note, you will be working with the Fiscal Office--

**CRAWFORD:** Right.

**WILLIAMS:** --and reporting--

**CRAWFORD:** Right.

**WILLIAMS:** --back to us on that also.

**CRAWFORD:** Yeah.

**WILLIAMS:** Thank you. Questions?

**CRAWFORD:** All right. Thank you.

**WILLIAMS:** You bet. Thank you for your testimony. That will close our public hearing on LB948. We are now going to open the public hearing on LB970 and LB949. We are going to be doing a joint hearing on these two bills dealing with limit on the amount of insurance individual pays for prescription insulin drugs. We have two bills, one by Senator Wayne and one by Senator Bolz on very, very nearly an identical issue. We will be asking you when you come up to testify, our assumption will be that if you are a supporter, you are a supporter of both bills. If you're in opposition, you are opposed to both bills. And if that is not the case, please let us know when you come up to testify. That way, we will not have people having to testify twice on what is essentially the same issue. So with that, Senator Wayne, you are here. We would appreciate if you would open on LB970.

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**WAYNE:** Thank you. Good afternoon, Chairman Williams and members of the Banking Committee. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, which is north Omaha and northeast Douglas County. LB970 will limit out-of-pocket expenses for individuals with insulin prescription to \$100 per thirty days, regardless of the type of insulin or the amount of the individual needs during that 30-day time frame. This bill is part of a national conversation to protect those from predatory pricing. Since healthcare companies and insurance companies aren't doing it to what I would consider the right way, I believe the state must act. America is in what is supposed to be a country with the best healthcare system on earth. As far as-- as far as I can tell, it's also one of the most expensive systems, by some estimates as high as 60 percent of all bankruptcies in this country are from medical-related expenses. This system requires both ration-- people to both rationalize-- ration their food and their insulin, and we should not have to choose between either one of those. Over the last two years, there has been ten confirmed deaths because individuals were forced to ration their insulin. This is from the sources that I've also seen and talked to, that one-in-four insulin independent diabetics-- insulin dependent diabetics have resorted to rationing their insulin at one point in their lives just because of costs. This bill will address the outrageous rising costs of insulin and protect Nebraskans from runaway pricing. Insulin has been mass-produced since 1930s yet the costs to consumers have more than doubled since 2012 alone. Profit margins should not become before people's lives. And in this case, when insulin was found, it was actually only sold to the university for a dollar because the founders or the people who discovered it decided that it was too important to charge. It is important that we address these types of questions regarding insulin and how caps work. And I think this is just one step towards the right direction of dealing with-- particularly insulin costs, which is a lifesaving drug. And with that, I'll answer any questions.

**WILLIAMS:** Are there any questions for Senator Wayne? Seeing none, will you be staying to close?

**WAYNE:** Yes.

**WILLIAMS:** Thank you. I would then invite Senator Bolz to come up and open on LB949. Welcome, Senator Bolz.

**BOLZ:** Thank you, Senator Williams. I have a few handouts for the committee. Forgive me if-- if I'm a little repetitive from Senator

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Wayne, I just slid over from Appropriations. Our bills are similar, but there are a few specific differences. For the record, I am Senator Kate Bolz, that's K-a-t-e B-o-l-z, and today I'm introducing LB949. LB949 proposes to cap patient out-of-pocket expenses for prescription insulin drugs to no more than \$100 per month. The bill provides that beginning January 1, 2021, and any individual or group sickness and accident insurance policy subscriber contract delivered or renewed in Nebraska, hospital, medical, surgical expense incurred policy, or self-funded benefit plan that provides reimbursement for prescription insulin drugs will limit the total amount that a covered individual is required to pay for covered prescription insulin drugs to no more than \$100 per 30-day supply of insulin regardless of the amount or type of insulin needed to fill the covered individual's prescription. A policy contractor plan can reduce a covered individual's cost sharing by an amount greater than the \$100 amount specified if issues. I want to clarify that I recognize that this does not apply to Medicare or other policies that are federally managed for which this requirement may be preempted by federal law. LB949 is modeled after Colorado legislation placing the same caps for prescription insulin copays on insurance providers. A study conducted by the Milliman Research Group estimated the cost impact on premiums as a result of their cap to be less than \$1 per subscriber annually. The executive summary of that report is being shared with you now and I'd be happy to provide the full report to this committee if it's of interest to you. In order to ensure that the impact of the cap does not have a negative impact on Nebraska providers and subscribers, our bill does include a provision that would protect insurance premiums. Similar to Senator Blood's bill LB15 in 2019, which provided hearing aids to children, this section would not apply to any contract plan or policy. If using a calculation method approved by the Department of Insurance, the cost of implementation of the provision would likely exceed 3 percent of all premiums collected under the contract plan or policy for the contract plan or policy year. In other words, we recognize that it is also important to limit the impact of premium payers, and we don't believe that there will be a significant impact based on the analysis of the Milliman report. But our bill-- this is one difference between our bill and Senator Wayne's bill is that we do provide kind of a-- a safety net for that piece. If you're-- if you're more comfortable with the 1 percent limitation, we've passed around an amendment for you to consider at 1 percent. That's-- that's more of a decision for the Banking, Commerce and Insurance Committee, but I think there's room for flexibility, if that's a concern. This issue was brought to my attention over the interim when our office received some calls from

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constituents who shared that they were having difficulty affording insulin. The American Diabetes Association reports that nearly 175 Nebraskans, or 11.6 percent of the adult population have diabetes. Diabetes, like many chronic manageable diseases, is expensive and the costs of insulin have increased as much as 45 percent since 2013. According to the ADA, that increase contributes to people with diabetes having medical expenses approximately 2.3 times higher than those who do not have the disease. Colleagues, diabetes is growing and without the financial means to purchase secure prescription insulin, many of our neighbors with diabetes are forced to ration their doses or forgo the medication completely risking dangerous and even life-threatening results. An additional handout that I have for you is a summary of just a sample of some of those constituent stories that have come into our office. I do want to ask for your patience for just a few more minutes while I address a few questions that have come up on this bill just to share my perspective before you hear further testimony. One question is, why are insulin prices so high? And a number of factors contribute to the rising costs of insulin. Insulin has no generic competitors and only brand name products are produced. It's a biologic compound and it can be difficult to produce, but historically pharmaceutical companies have controlled those formularies, and even though the formula has not changed significantly over time, those minor changes have led to increases in costs. And there are a few testifiers today who can speak a little bit more specifically to the drug, how it's produced and how the costs are managed. I also want to address the question of why shouldn't people simply purchase a different plan or a plan that better fits their diabetes diagnosis if they know that they're going to need this medication? I want to share a couple of thoughts about that. One is from personal experience and I don't have diabetes, but I do pay for my health insurance out of my pocket. That's what makes most sense for me. A couple of years ago, Blue Cross Blue Shield stopped offering individual health insurance. And so I had to purchase insurance from Medica because that was the only provider in the state at that time that provided an individual health insurance product. So I did not have choices. I had one insurance company from which I could buy that product and I had a budget of which I could afford, because in the two months in which I needed to change my plan, I couldn't find a new job or find a way to get more money. And I bring that up not to talk about myself, but to say I think that it's one thing to argue that there should be people should make different choices, practicality and individual experience is a little bit different than that. The last question I wanted to mention is we did put a

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sunset on this bill. And the reason for that is simply that we understand and recognize that \$100 per month may need to be adjusted over time. There are probably a couple different ways you could draft a bill to do that, but the sunset seemed to be an opportunity for us to both have a five-year period where we could understand the impact of this change on individuals with diabetes and the insurance market, while also recognizing that the amount may need to be changed over time. OK, I've-- I've opened for too long. I am happy to take your questions.

**WILLIAMS:** Thank you, Senator Bolz. And before we open it up to questions, I just want to be sure that I understand and the committee does, the-- the distinction between your bill and Senator Wayne's bill is primarily with the increase, the either 3 percent or the amendment with 1 percent of the-- of the insurance. That's the primary difference between the two.

**BOLZ:** I-- I believe so. I would have to cross-check with Senator Wayne's bill to be certain, but I think-- I think Senator Wayne's bill also does not include the sunset. There are similar ideas. I-- I think we both care about this issue. There's multiple ways to-- to put a package like this together. Those two additional provisions are options on the table for this committee to consider.

**WILLIAMS:** Yes. Questions? Senator McCollister.

**McCOLLISTER:** Yeah, thank you, Chairman Williams. As one of the 11.6 percent of the population diabetics, I have just a couple of questions. There is a cost shift with this bill. Who bears that extra cost, the pharmaceutical companies or the insurance companies?

**BOLZ:** Um-hum. I think under our bill, the idea is that more negotiation would have to occur between those two stakeholders. And under our bill, we included a provision to try to limit the cost to make sure that an individual premium payer does not bear an undue proportion of that cost. So our intention is that the-- the person purchasing insurance doesn't unnecessarily bear too much of a burden for this change. And I think the Milliman report that shows in the other state in which we have an example that the cost of an insurance premium went up less than a dollar for those payees helps justify that this is something that can be done.

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**McCOLLISTER:** That was my second question, is that-- did that report come out of Colorado based on their experience?

**BOLZ:** Yeah. And at the risk of getting into the weeds just a little bit, the Colorado bill has not been fully implemented, but the analysis has been done regarding existing plans and what they think can be projected in terms of the impact it costs. So I don't want to misrepresent that it's been fully implemented and that everything was easy-breezy, but what I do want to represent is that based on the Colorado experience and looking at those gold, silver, bronze plans, they were able to predict that the impact on the premium payer would be minimal.

**McCOLLISTER:** Have any other states implemented such laws in their statutes?

**BOLZ:** Illinois recently passed similar legislation, but that's fairly new. So I'm not sure we have any additional information from Illinois.

**McCOLLISTER:** Thank you.

**BOLZ:** Um-hum.

**WILLIAMS:** Additional questions? Seeing none, thank you.

**BOLZ:** Thank you.

**WILLIAMS:** We will now invite the first proponent for both LB970 and LB949 to testify. Come on up and welcome.

**CHRISTINE FALLABEL:** Thank you. For the record, my name is Christine Fallabel, C-h-r-i-s-t-i-n-e, Fallabel, F as in Frank, -a-l-l-a-b as in boy, -e-l. OK. Thank you. Good afternoon, Mr. Chair and members of the committee. Thank you so much for hearing this important bill today. My name is Christine Fallabel and I'm the director of State Government Affairs and advocacy for the American Diabetes Association. And I cover both Colorado and Nebraska, so if you have questions about the Colorado bill, I'm also happy to answer those as well. Additionally, I've been living with type 1 diabetes for 20 years. So this is near and dear to my heart. We support both bills addressing insulin cost and we urge you to as well. So as we've heard a little bit today, people with diabetes are facing a national crisis. A vial of insulin in 1996 cost \$21, and today, that same exact vial of insulin is over \$300. Advances in research and development and technology have been lifesaving, but the chemical formulary for insulin has not changed in

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over two decades. People with diabetes are sometimes forced to choose between insulin and rent or insulin and food to survive. For a chronic autoimmune disease that is not preventable and has no cure, that seems unnecessarily excessive and dangerous. Now the majority of Nebraskans have access to affordable health insurance, but we need to do better for people with diabetes. Concurrently, the rates of high deductible health plans have skyrocketed from adults 10 percent in 2007 to up to nearly 25 percent in 2017. The CDC has found even higher rates of these high deductible plans in the entire population with over 43 percent of Americans having a high deductible health plan. So these high deductible health plans offer a way for people to have some sort of coverage that costs less per month, but they have a higher bar to reach before full coverage for their medicine, like insulin kicks in. Insulin is a chronic disease management medicine and without it people with diabetes die and very quickly. People with diabetes also require a lot of it, averaging anywhere from two to eight vials a month. So when these deductibles are so high, people, even with insurance, end up paying thousands of dollars per month simply to live or they're rationing their medicine like we heard before, which quickly leads to complications and even death. This bill would alleviate a lot of strain for people by cop-- capping the copay of insulin, ensuring access to their life sustaining medicine while longer term policy solutions are investigated at both the state and federal level. Studies have shown that cop-- capping copays on insulin would not increase the monthly health insurance premiums like the Milliman study that was referred to before. Strategies like this work well to help those living with diabetes achieve better health outcomes in the long term, and not only save the state money, but it will also save lives. The ADA stands with patients, and we believe no individual in need of life sustaining insulin should ever go without due to prohibitive costs. We support both LB949 and LB970 and urge you to vote yes. Thank you.

**WILLIAMS:** Thank you, Ms. Fallabel. Questions? Seeing none, thank you for your testimony. Invite the next proponent. Welcome.

**BOB LASSEN:** Thank you, Chairman Williams and members of Banking, Commerce and Industry [SIC] Committee. My name is Bob Lassen. I'm a semi-retired pharmacist and volunteering-- testifying in support of LB949 and LB970 on behalf of AARP and our families of those who are 55-plus. With the rising unaffordability of insulin, Nebraska needs to take an action to ensure our residents are able to access this lifesaving medication. Diabetes affects people from all walks of life.

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It doesn't discriminate between those who can afford medications and unconscionable cost of those who cannot. Roughly 171,000 Nebraskans living with diabetes have to buy insulin at a pharmacy because their pancreas no longer produces the insulin that they need to survive. Insulin needs vary by patients as do-- do the cost often depending on their insurance coverage. On average, people with diabetes require two to four vials of insulin per month. Diagnosed diabetics cost an estimated \$1.4 billion in Nebraska each year. Monthly expense of Nebraskans average between \$450 and \$500. Over the last 14 years, the out-of-pocket expense for many insulin brands has jumped 555 percent. Due to these skyrocketing prices, many insulin users have been forced to alter their medications by substituting lower quality products, seeking other options outside the country, or even having to ration their supply and some dying by so doing. A Yale study showed that 25 percent of people with diabetes, both type 1 and 2, have reported using less insulin than prescribed as directed as a result of high prices. Insulin is not new. It was discovered as a treatment many years ago. Very little about the way insulin is produced has changed, yet the prices continue to skyrocket. Approximately 90 percent of the insulin is sold and manufactured by three companies, which limits competition and therefore results in higher cost to patients. State lawmakers from 15 states have introduced legislation that would place a cap on monthly insulin copays for diabetics. The bills are at state level response to a halt in Congress' overall efforts to rein in pharmaceutical cost and a growing awareness that insulin prices have surged dramatically in the past decade putting the health of millions of diabetics at risk. We have heard heartbreaking stories from Nebraskans struggling with the cost of prescription drugs. As one example, we heard from a 63-year-old female resident of Antelope County employed at a local nursing facility. She has health insurance through that facility. She writes, I have skipped doses many times due to cost. My doctor tried to supply me with the insulin, but due to not having the right dosage or the right kind, I went without. He also would try to find coupons for me to use to lower the cost, but often they don't work because the insurance plan that I have. He's even tried to switch insulins I have, to find a cheaper alternative for me. Most of the time I get one shot a day instead of the four that I'm supposed to take. Thankfully, the local pharmacy will allow me to make payments. My monthly costs range from \$500 to \$800 a month. This is difficult for me while also trying to pay my rent, my health insurance premiums, my utility bills, and other costs to pay for food to eat. I have had to even ask family to help me paying for the cost of my insulin. This issue is also personal to me in this instance, not as a

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pharmacist, but as an uncle. I am here today to talk about my nephew, Steve, my sister's son. I received a call from my sister on July 3, 2008. She had had a local police come to her door at 4:00 in the morning to tell her that her son had died. Steve had moved to Palm Springs two years earlier to help with the care of his father with early dementia. My sister was understandably shaken by the news, so I went with her to make arrangements to bring Steve home to bury him. Steve had been dead for about two days before he had been found. He had been working at a Sprint kiosk at a local mall for minimal hours. What we found in his apartment was devastating. I knew that he had type 1 diabetes and I was-- and was dependent on insulin to survive. When we looked in the refrigerator, there were two empty insulin vials. Scattered throughout the kitchenette were orange juice containers, which I thought was odd until I realized that he couldn't afford his insulin and he was trying to bandage his symptoms with orange juice. I thought, how could this be possible in our society today, a lifesaving insulin could be denied to anyone? A very complicated drug distribution system has developed in this country over the last 50 years. It's now time to start to uncomplicate it. LB949 and LB970 are the first steps needed to fight for Nebraskans who are forced to decide whether to pay for medicine or other basic necessities. These bills are the stepping stones to addressing ways to lower the cost of prescription drugs for everyone. Thank you, Senator Bolz and Senator Wayne, for introducing these important pieces of legislature. And I would ask you for your support in advancing these bills. I'd be happy to answer any questions.

**WILLIAMS:** Thank you, Mr. Lassen. And I forgot to have you spell your name at the beginning of your testimony,--

**BOB LASSEN:** And I forgot to do it. I'm sorry.

**WILLIAMS:** --if you do that for me, please.

**BOB LASSEN:** Bob, B-o-b, L-a-s-s-e-n.

**WILLIAMS:** Thank you. Are there questions for Mr. Lassen? Senator McCollister.

**McCOLLISTER:** Yeah, thank you, Chairman Williams. We were given a-- some data here on Humalog--

**BOB LASSEN:** Um-hum.

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**McCOLLISTER:** --and in 1996 it was \$21 dollars a vial, right?

**BOB LASSEN:** Right.

**McCOLLISTER:** And now in 2016 it's \$255, right?

**BOB LASSEN:** That's-- that's correct.

**McCOLLISTER:** What's happened in the price of this particular grub-- drug in Canada and Mexico?

**BOB LASSEN:** The last statistics that I saw in researching a little bit of this, show that what we were paying about \$5,000 for, Canada was paying a little over \$2,000 for.

**McCOLLISTER:** Mexico?

**BOB LASSEN:** Same drug. In Mexico I don't know about, but that was the Canada figure.

**McCOLLISTER:** Thank you.

**WILLIAMS:** Additional questions? Mr. Lassen, as-- as a pharmacist, could you help us understand as I understand it, under this legislation it's a \$100 cap per month on all insulin drugs for that 30-day period. Tell me about what different types of insulin drugs there would be that--

**BOB LASSEN:** Typically, and-- and there may be somebody that's following that may have more information on it, but typically you'll have a long-acting insulin drug, maybe like once a week, and then you'll have a shorter acting drug that you take like two or three times a day, depending for meals. And the way that I understand this bill is that it would cover the cost of both of those insulins.

**WILLIAMS:** OK. Also, based on your experience as a pharmacist over the years, I'm having trouble connecting the dots of how this legislation will actually control the cost of insulin, the underlying cost of the product. I see it shifting who's gonna pay for it, but is there a way that this does potentially reduce the costs?

**BOB LASSEN:** You know, and I thought about this, too, and I thought, well, maybe by doing this, you know, we're taking the responsibility off the manufacturers to-- to lower their prices. But then I rethought the insurance industry as a whole and the purposes of insurance

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companies, as I understand, is to aggregate and bring all of the costs together and to make it affordable for everybody. And I don't think that that's happened with the insulin and the diabetics in particular or people who particularly have specialty drugs. I think they're being penalized because they have a-- a disease that is different than everybody else.

**WILLIAMS:** And also with-- with your experience as a pharmacist, this is one drug, insulin. Are there other drugs that would fall into the same type of category as lifesaving that we would be--

**BOB LASSEN:** I--

**WILLIAMS:** --asked in the future to do the same?

**BOB LASSEN:** Yes, Pennsylvania. And-- and again, there's 15 states that have bills similar to this. And in Pennsylvania's bill, it not only specifies insulin, it uses specialty drugs also. And that's another category that, you know, if we don't address this year, at some point we should, because it's a-- a very big burden for a lot of people.

**WILLIAMS:** Thank you. Additional questions? Senator McCollister.

**McCOLLISTER:** Yeah, thank you, Chairman Williams. Are there any bills that you've seen in the other states that actually are directed toward the pharmaceutical companies rather than the insurance companies?

**BOB LASSEN:** Right now, what we're seeing and what I saw on a-- the states that are addressing it are caps. You know, that's what they're doing. And some states are doing like \$30, some are doing \$50, \$100 seems like it's a standard cap that's being applied at this time. As far as other issues surrounding that, it's cap issues really what they're working with right now.

**McCOLLISTER:** But those affect the pharmaceutical companies, not--

**BOB LASSEN:** It does not directly. And now where it may have some interplay is between the PBMs and the pharmaceutical companies. And in-- in response to the criticisms that pharmaceutical companies are getting, again, there are only three major ones that are supplying 90 percent of the insulin in the United States. But the response from Eli Lilly and Novo Nordisk has been that they are coming out with \$99 programs, and they are increasing their-- the amount of drugs that they're allocating for in needy areas. So they're responding, but they aren't responding to the major problem. Lilly is also coming out with

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some generic versions of the same product. So I think that they're-- they're moving towards that direction, and I think when we start putting caps on, it's going to be-- start putting some new pressure on the PBMs to interact directly with the manufacturers.

**McCOLLISTER:** Thank you.

**WILLIAMS:** Senator Kolterman.

**KOLTERMAN:** Thank you. Thank you, Bob, for coming today. So you-- you alluded to the fact that other types of insulin, would that be including things like Trulicity and Ozempic?

**BOB LASSEN:** Yes, uh-huh.

**KOLTERMAN:** So this-- they would fall under the same caps?

**BOB LASSEN:** Yes, as I understand the bill.

**KOLTERMAN:** OK. Thank you.

**WILLIAMS:** Additional questions? Thank you, Mr. Lassen, for your testimony. Invite the next proponent.

**MATT TORCZON:** I thought everybody would like to do some more reading, too, on this highly enjoyable topic, so.

**WILLIAMS:** Thank you. Welcome.

**MATT TORCZON:** Thank you, Senators. My name is Matt Torczon, M-a-t-t T-o-r-c-z-o-n. I'm coming to you today and thank you for allowing me to support LB949 and LB970. The copies that are going around right now, on the second page of those handouts, I have provided a cost of all insulins that I need to pay for every month. Now these are the cash pay costs that you're seeing. Fortunately, I do have insurance through my spouse that does help cover that, but as I will get into a little bit later, that wasn't always the case. The cost of those medications, just for those four medications that you're looking at right there, \$4,979.93. That's essentially what my life's worth. If I were unable to afford those costs, I would be dead without these prescriptions. This is the reality that is facing over 120,000 Nebraskans every month. I, like most Nebraskans who are afflicted with this disease did not ask to be given diabetes. We did not do anything to bring on this disease. We-- we did not want this disease. We were simply the lucky ones, I guess you could say, so this disease is not

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that simple to live with. It requires massive lifestyle changes. It requires having you inject yourself with needles. It requires constantly having to poke your fingers so you can check your sugars to make sure that your blood levels are appropriate. Making this disease even more difficult is the rising costs of the treatment. I'm hopefully you've all seen the price increases that insulin has taken over the last ten years. Some forms of insulin have risen by over 500 percent with minimal changes to the actual drug itself. I don't know how we can sit back and allow the few corporations that manufacture these drugs to exploit people's dependence on them so their stock prices may rise a few points or their CEO and executives can get a higher bonus. Imagine if a few corporations manufactured the air that all people of this world breathe, if you couldn't pay for air, you would die. That is essentially what 120,000-plus Nebraskans and millions across the United States face, pay or die. That example may be a little bit extreme, but I'm willing to bet that as you think about this bill, hopefully you remember the paying for your air just like diabetics have to pay for their insulin. We're hearing reports far too frequently of people dying across the country because they were rationing their insulin or they simply could not afford it. One of the arguments that I have heard against the proposed bills that are before you today is that we cannot do much at the state level. And to that, I completely disagree. I believe that is the job of the people, the people sitting behind you, the constituents to make their voices heard to the Senate, to the Unicameral, to you, Senators, and allow you to start helping make these changes so then the changes can be brought forth on a federal level. We can start doing this in-- in lending Nebraska's voice with Colorado and Illinois to make our voices collectively louder so that there is changes that are gonna start to be made then federally. We cannot continue to suffer these price increases as-- as you see before you, in my examples. On even a more personal note, I told you before that it was not always the case where I was covered by my spouse's insurance. I was recently married just over a year, and prior to that I was on the Affordable Care Act to cover my insurance. Due to the fact that-- that it was costing me a lot of money to afford the prescriptions under that plan, I was actually hospitalized twice on two different issues because I had to ration it. My ketones were so out of whack that in one time I was hospitalized for two days and a different time I was hospitalized for three days. So because of my rationing, and granted I was lucky that I still pulled through, but we just added even more costs on top of what I was already having to deal with to suffer because of the fact that I was trying to ration my insulin before it could be readily available

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to me. That's another point to this whole bill. This doesn't affect just these 120,000-plus Nebraskans, it affects their families, it affects their friends. My wife and I, we have two daughters. We have to worry about, you know, how are we gonna be able to pay for dad's insulin if-- before I was married, how are we gonna be able to pay for this insulin? It's-- it's-- it's affecting more than just those with the disease itself. The other thing that is not taken into consideration when you look at just the prescription prices, you have to also consider the supplies that go into it. We can't get access to free needles that we need to make the injections ourselves or the caps that go on the end of our insulin pens that we have to-- that we need to inject ourself, or the supplies that go in for those people that wear the pump. We don't have access to the test strips. Those are extremely expensive considering what you get for those. I'm not here to-- to ask for free insurance or free prescriptions or anything like that, what I would ask for is that they are made fair. Give us a fighting chance. At least let it be fair to everybody. We didn't ask for this. I don't think that the pharmaceutical companies have the right to allow this to go. With that, thank you for allowing me to speak.

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

**MATT TORCZON:** Thank you.

**WILLIAMS:** Invite the next proponent.

**KAMERAN ULFERTS:** Good afternoon.

**WILLIAMS:** Welcome.

**KAMERAN ULFERTS:** I have provided my testimony. I don't know if you want to pass it out or not. Well, good afternoon, everybody. My name is Kameran Ulferts, K-a-m-e-r-a-n U-l-f-e-r-t-s. I currently reside in Kearney, Nebraska, where I'm-- where I'm an educator for 4-H Youth Development. And I've worked there for about two years now and I traveled up here to read my testimony to you guys today. And I also brought an empty vial of insulin because for obvious reasons, I can't bring myself to throw them away. Kind of just keep them in a bucket in my room, and I'm-- I'm thinking maybe I can create some kind of piece of artwork with them later. I've turned them into earrings as well. But if you also look inside, you'll notice there's a small little-- probably about five units that you can't extract from the vial once

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it's all gone. And so I want you guys to kind of take a look at that. Maybe one day I'll figure out how to get the-- the last couple units out. I don't know if you guys want to look at that if you're familiar what a vial of insulin looks like, so I just wanted to bring that along. I am here representing myself and hundreds of other families affected by diabetes in Nebraska. I'm here to support passage and possibly further amendment of LB949 and LB970 regarding the limitation of the amount of insulin an insured individual pays for prescription drugs. I was diagnosed with type 1 diabetes in 2009, in rural Nebraska when I was 13 years old. I'm here to represent 13-year-old me and 23-year-old me. Although I was diagnosed ten years ago, I still remember the indescribable feeling of my body when it began to waste away as this autoimmune disease attacked me, leaving me without this hormone insulin. Without insulin, I would have no chance at life. I am here not only to represent myself, but also to represent my brother. One year after my diagnosis, my brother Jared [PHONETIC] was also diagnosed with type 1 diabetes at age 11. Today I am choosing to tell the stories of several people I know with diabetes to further explain the scope of diabetes and show that diabetes does not discriminate. I'm here to represent my Uncle Doug and my Aunt Tammy, who were both diagnosed with type 1 diabetes in the 1970s. I'm here to represent Lizzy, Maddy, Zoe, Franny, Emaleigh, Abbie, Alex, and Clare. The 8 teenagers with type 1 diabetes that I've worked with over the past years at Camp Floyd Rogers, a camp for children with diabetes. I also represent the hundreds of children ages 8 to 18 and the adults with type 1 diabetes that I've met over the years at this camp in Gretna, Nebraska. Thanks. I'm here also to represent my friend, Jordan, with type 1, who at age 21 was recently diagnosed with advanced diabetic retinopathy. I'm here to represent my friend Reilly, who at age 17 for the past 5 years has traveled with her family to Mexico to purchase affordable insulin for her. I'm here to represent my friend Blakely, who was diagnosed with type 1 diabetes at age 2 and now at the age of 6 has finally got the diabetic alert dog after years of her family fundraising. I'm here to represent my father and my mother, who both have worked tirelessly for the past ten years to provide financially for the high cost of insurance to ensure the safety and health of my brother and I. I'm also here to represent Jordan, Dane, Christine, Mark, Lauren, Melissa, and Vanessa [PHONETIC], just a fraction of the champion caretakers of these children and adults who live with type 1 diabetes, as the burdens of diabetes affect so many aspects of life directly and indirectly. Out of the specific stories I have mentioned, this is just a fraction of the people in Nebraska with diabetes. As I mentioned earlier, type 1 diabetes does not discriminate. According to

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the statistics published by a study in the Journal of the American Medical Association, one in four patients ration their insulin. Based on that study, we could easily assume that from these 15 people that I just mentioned with type 1 diabetes, there's a possibility that 3 or 4 of those 15 children, adults or caretakers, have rationed insulin. There's a possibility that they have struggled financially to afford that one prescription that keeps them or their child alive. This is absolutely unacceptable. These people I know deserve to live. They deserve happiness. They deserve good health. They deserve to have access to affordable insulin. I believe that access to insulin is a human right, insured or uninsured. Thank you for your time.

**WILLIAMS:** Thank you, Ms. Ulferts. Questions? Seeing none, thank you for your testimony.

**KAMERAN ULFERTS:** Thank you.

**WILLIAMS:** Invite the next proponent. Welcome.

**BEN FEITEN:** Thank you. Hello, and thank you for providing me with the opportunity to testify this afternoon. My name is Ben Feiten, that's B-e-n F-e-i-t-e-n, and I'm a second year occupational therapy student at Creighton University. Type 1 diabetes is a condition that is very near and dear to my heart as I've had it for over 23 years and both of my brothers also have it, one of them for 23 years, and one of them for 30 years. My brothers and I will be the first to tell you, diabetes is nonstop, and it dictates every single aspect of our lives. As a young adult with type 1 diabetes, my daily life is filled with many extra decisions, every day to be sure I am at a level to be able to participate in the activities that are meaningful to me, whether that's learning in occupational therapy school, helping patients on my clinical rotations, or just playing in my recreational basketball league. While technology has progressed and made it easier to make these decisions, diabetes is still a constant in my-- a constant stressor in my life, one that I cannot take a vacation from. Though diabetes has forced me to constant-- constantly make these decisions, it is the costs of type 1 diabetes management that has caused me to make the most dramatic, life-altering changes. I absolutely loved my high school theology courses and I thought long and hard after graduating about becoming a high school theology teacher. However, when I brought this up to my parents, I began to learn about the shattering reality of how diabetes would dictate my life. My parents, who are very loving and supportive, responded to my consideration of theology by telling me about the drastic costs they had each year for

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my diabetes care. I decided that I would study something different to be able to insure myself the healthcare coverage and the salary that I felt I needed to be able to provide for my care and my insulin and all of the other costs associated with type 1 diabetes. I chose to study healthcare administration and policy. I was not nearly as passionate about this field, but I did it because I had to. And fortunately a few years after graduating from undergrad, I found occupational therapy, something that I am super passionate about in a field where I feel I will be guaranteed a salary and an insurance plan that will meet my needs and be able to fulfill the financial burden of type 1 diabetes. Insulin is a large contributor to the high costs of type 1 diabetes and that cost continues to rise. In a 2019 brief, which I have attached for all of you to my speech, the Health Care Cost Institute found the average per person spending on insulin to be approximately \$2,864 per year in 2012. By 2016, that amount had nearly doubled, with the average per person spending on insulin coming in at \$5,705 per year. Just let that sink in. The cost nearly doubled in four years and as we've heard from other people, there wasn't really much of a change in the actual medicine itself. I find that sickening since the creators of insulin sold the patent for \$1, believing it should be affordable and accessible to everyone. As a young adult who's a year out from graduating from professional school, I should not have to be concerned about spending thousands of dollars per year on something I need to live. I ought to be looking at paying for my wedding, buying a house, and paying off my student loans. I'm originally from Colorado, where a similar bill was recently passed. Unfortunately, I was unable to take advantage of that bill because I turned 26 just last December and was forced onto my school insurance policy. Though my current plan is providing me with actually a pretty good insulin benefits, I worry about the future and whether future plans will provide me with this security. If this bill passes, it will provide me with the peace of mind of knowing what to expect for my future insurance plans. Passing this bill will keep young professionals like myself in Nebraska. If it is not passed, young professionals like myself will have to leave Nebraska for states like Colorado or Illinois, where our insulin costs are more closely regulated and guaranteed. I commend Senators Bolz and Wayne on bringing this bill to you all today, and I ask you all to consider moving it forward to decrease the cost burden on people with diabetes so that we no longer have to worry about the varying costs of something that we need to live. And I also have brought-- I attached just one page of that Health Care Cost Institute pamphlet, but I

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brought the entire document for you all as well, so I can hand that out.

**WILLIAMS:** Thank you, Mr. Feiten.

**BEN FEITEN:** Yes.

**WILLIAMS:** Questions? Senator Gragert.

**GRAGERT:** Thank you, Chairman Williams, and thank you for your testimony. I'm interested-- interested in the-- your insurance. You say you got good insurance benefits, insulin benefits, right now.

**BEN FEITEN:** Yes. So--

**GRAGERT:** You mind saying what those be?

**BEN FEITEN:** Yes. So I actually ordered insulin the other day. It was my first time this year. And I have a high premium plan, but a low deductible, and so it cost me \$20, but I have friends who have spent over \$600 per month. So I'm here for future me, who might not have a plan like that in the future, but I'm also here for those many friends who have those plans that are spending well over \$100 a month on their insulin.

**GRAGERT:** Thanks.

**BEN FEITEN:** Yeah.

**WILLIAMS:** Additional questions? Seeing none, thank you for your testimony.

**BEN FEITEN:** Thank you so much.

**WILLIAMS:** Invite the next proponent. Welcome.

**JULIE HOPP:** Thank you. My name is Julie Hopp, J-u-l-i-e H-o-p-p. I am here as a proponent for both bills. I very much appreciate them being introduced. I'm also here because I've been married to Mark Hopp for 40 years. I was five when we got married [LAUGHTER], and counting. We continue counting thanks to insulin. Mark has been insulin dependent diabetic for 64 years. I like to tell him longer than I have been alive. Mark was diagnosed two months before his third birthday in 1955. He is alive today because of insulin and his support group. His support group includes his mother, father, brother, doctors, nurses,

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medical facilities, emergency medical technicians, our children who learned at a very young age what an insulin reaction looks like. Come home from work, my kids are going mom, the ambulance came today. They're all sitting there, so I'm figuring someone, it survived, but they learned from the ages of five and seven something's wrong with dad. It could be a complete stranger who sees him at the downtown post office here in Lincoln looking like something's wrong and calls an ambulance for him. And our son's best man from his wedding happens to be the EMT on the squad that picks him up. The line that stands out to me in the bill is an amount not to exceed \$100 per 30-day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription. I pay to cover my husband on my workplace health insurance and we pay to have him on Medicare, part A and B, because nobody can tell me whether doing double coverage is good or not. And the times when I haven't had a job where I could cover him and had to get him back on Medicare, it was like moving heaven and earth, so I pay for both. Whether he's on Medicare due to disability and my work status or on my workplace coverage, we fight at least annually to justify the brand of insulin that works for him. Insulin that is in network with most insurance providers causes frequent insulin reactions, a dangerous low blood sugar. Annually or more often, his doctor writes a letter and states his need for another brand of insulin. We were forced to change doctors as one office was not able to help us in the fight for the insulin that works for him. Without this annual fight, we would pay a significantly higher copay for the brand of insulin that causes fewer hospitalizations. I very much appreciate your time and the opportunity to testify.

**WILLIAMS:** Thank you, Ms. Hopp, and Mark is a lucky person, and I don't think you listed yourself as part of his support group in that list. But if you didn't, you should have listed it at the beginning and the end, so thank you. Questions for Ms. Hopp? Seeing none, thank you for your testimony. Invite the next proponent. Welcome.

**ASHLEY RYAN WOLFE:** Hello. My name is Ashley Ryan Wolfe, A-s-h-l-e-y R-y-a-n, Wolfe, W-o-l-f-e. Thank you for this opportunity. Ten years ago, I graduated from college at age 22. I was lucky enough to get a job in my field of study right out of college. I excitedly moved across the state for this new job. But reality hit when I found out that between my pay and less than amazing health benefits, I didn't have enough money to cover the cost of my diabetes supplies. So I got an additional part-time job. When I was offered a higher level position in Lincoln with a significant raise, I jumped on it. However,

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I quickly learned that not even with a raise, the increased cost of living combined with the cost of my diabetes supplies was still too much. With my new insurance, each bottle of insulin was about \$75 and I needed two different kinds and I used multiple vials a month. Still, I needed to buy test strips and additional diabetes supplies like ketone strips, lancets, syringes, and glucagon. I was easily spending over \$300 a month on supplies. The numbers just didn't add up for me. Rent, food, diabetes supplies, something had to give. I started eating less and skipping my long-acting insulin and only checking my blood sugar occasionally. I avoided my doctor because not only could I not afford that additional expense, I was scared to know the effect of playing a repeated guessing game with my blood sugars and the effect that had on my A1C. Sorry. Eventually my savior was a primary care physician. You see, I quit going to my endocrinologist due to the cost, but I still needed someone to write the scripts for my supplies. My primary care doctor would provide me with supply prescriptions-- prescriptions in exchange for getting a lab drawn every six months. He also offered me sample vials of insulin whenever I would come in. I didn't even have to confide in him about my struggles, he just offered because he knew he could help and he knew that the cost was out of control. He encouraged me to call his office and to check in to see if they had extras whenever I was running low. I could always request the vials rather than the more convenient insulin pens because they would last longer and so I wouldn't have to go back as often. I would make trips across town to pick them up whenever they were needed and I was always incredibly grateful. I felt ashamed that I couldn't afford my supplies. I felt that because I was in a decent paying, full-time job, I shouldn't have been in that situation. Through a series of job changes, getting married, and better health insurance, I was eventually able to be self-sufficient again, but it took a long time. Since then, I've been in my doctor's office and I have seen other people come in and pick up insulin samples. So I'm not-- I know that I am not alone in being helped out by this provider. I never really shared my story because as an educated and independent woman who grew up with a family in healthcare it was really hard for me to admit to myself that I had to ration my life-sustaining medication for a long time because I could not afford my copays. I am one of the lucky ones though. I was able to recover from my hard times without any long-term complications and many cannot-- are able to stay-- say the same thing, so thank you.

**WILLIAMS:** Thank you, Ms. Wolfe.

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**ASHLEY RYAN WOLFE:** Yep.

**WILLIAMS:** Questions? Seeing none, thank you for your testimony. Next proponent. Welcome.

**MARK FEIT:** Thank you, Mr. Chairman. Senators, thank you for your time today. My name is Mark Feit, M-a-r-k F-e-i-t. I was diagnosed with type 2 diabetes in 2011 with no family history. Type 2, if you're not familiar, is insulin resistance. Your body produces insulin but has become less able to use it to get glucose or energy to your cells and that glucose builds up in your blood, and without treatment will eventually long-term damage your organs. I managed my diabetes with oral medication until July of 2019 when I became insulin dependent and about-- excuse me, and a month ago, I was diagnosed with late onset type 1 diabetes, still obviously very new to me, which is a very serious, life-threatening autoimmune disease where your pancreas produces little or no insulin so you have to inject it in order to metabolize the food that you eat to live. Initially, I was given sample injection pens to try out two different medications that were insulin combination meds, once daily injections. And when it became time to price those for a refill, my cost with my health insurance for the first was \$220, the second was \$316 every three weeks for the rest of my life. That was sticker shock. And I wondered, how are we going to afford this? What are we gonna have to change in our budget in order to afford this huge, unexpected increase in prescription costs? Why is this decades old drug so expensive? The medicine and my insulin pens, as you have heard, costs about \$5 to manufacture, and it's been largely unchanged since the 1990s. So the fact that we're talking about setting an upper limit of 20 times that amount is testimony to how out of control drug prices are. The average cost of insulin in the U.S. with insurance is \$350 a month. Since I shared that I would be testifying in support of this bill, I've heard from other Nebraskans that are living with this disease, like my best friend from high school, Tom, who lives in Kearney with his family. His son, Alex, was diagnosed two years ago with type 1 diabetes as a sophomore at Kearney High School. They have a high deductible HSA and he shared with me that they only pay \$95 a month for his insulin with that. The problem for him and for me, and for the others you have heard from today, is everything else you have to buy in order to manage this disease. Test strips to manage-- to check my glucose level four times a day, which I buy on eBay because it is cheaper than my insurance. That's \$75 a month. Needle tips, because the insulin pen that I use is completely useless without a way to get that insulin into my body, 4 per day,

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\$7.50 a box. By the way, on Amazon, because-- because it is one-tenth the price of buying it through my insurance company, that box lasts me 25 days. And, of course, meter, lancets, alcohol, cotton balls, glucose tablets, and everything else. And those on insulin pumps have a much higher cost. Alex's family has a \$6,750 out of pocket that they met last year in August because of their son's diabetes. His insulin would be \$620 a month without insurance. Another longtime friend of mine lives in Philly and he's on an injectable combination insulin drug and told me in the past he's had to decide whether or not to buy his insulin or pay his mortgage. It was \$365 the first time he went to the pharmacy to refill it for a drug that costs \$5 to manufacture. We haven't even mentioned the mental health cost of dealing with diabetes, obviously not just for the person that is living with it, but their family who has to share in the nausea, the dizziness, the confusion, the lethargy, the mood swings, and the highs and lows. This disease is hard. In closing, a type 1 diabetic will die in as little as one day without insulin. You have an opportunity to literally help Nebraskans more easily afford to live. Thank you very much for your time.

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

**ALEXANDER REGAN:** I have extra-- take this one. Thank you, appreciate it. Chairman Williams, members of the Banking, Commerce and Insurance Committee, my name is Alexander Regan. That's A-l-e-x-a-n-d-e-r R-e-g-a-n. I am a pre-med, masters student at the University of Nebraska at Omaha. I work at Nebraska Medical Center's Emergency Trauma. I also work as the medical staff at the Camp Floyd Rogers, the camp that Ms. Ulferts had mentioned before as well. I'm here to support LB494 [SIC] and the other one as well, which is to cap insulin prices, no matter the type nor amount at \$100 a month. I was diagnosed with diabetes April 27, 2004. I was ten years old, a month before my birthday, was almost 11, and it was the first time I saw my mother cry. She cried because she is an emergency nurse. She has been her whole life. In fact, she works at-- she used to work at Nebraska Medicine with the ER where I work now. She cried because she saw what a life of uncontrolled diabetes would lead, and she feared that for me. She knew how it would affect the body and what it could lead to. The nurses, always compassionate and caring at Children's Hospital where I was diagnosed, gave us comfort in the knowledge that diabetes is treatable. With good education, one can manage the disease well

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enough that it wouldn't encumber one's life too much, at least. The good news to accompany this comfort was that the sole drug that I would need for the rest of my life to keep me alive was cheap to make and affordable, about \$5 to make, and at the time it was \$30 a vial. A study by BMJ Global Health in 2018 said that the cost to produce insulin-- human insulin is between \$2.28 and \$3.42. The cost to produce analog insulin, which is the main insulin that we all use, novolog, novolin, humalog, humulin, etcetera, lantus, is between \$3.69 and \$6.16. So it on average it is about five bucks to produce a vial of insulin. So while a nurse at Children's today could say that to a newly diagnosed diabetic that insulin is cheap to make, they can no longer say that it is affordable at the prices, per vial, gravitate around \$270 to \$300. So working in the same ER as my mother once had, I now see those patients, those who have lived a long life with uncontrolled diabetes, but now I see a new type of patient my mother never had. I see patients who are around my age who come in, who are in between jobs, who are unable to afford the high price of insulin, they come in as a last resort. They generally fall back into an 1800 style practice of self-starvation and rationing their diabetes, on a diet of low carbohydrates, low calories, high fat, high protein, at least for a couple of weeks until they can get their next paycheck to help hopefully pay for their insulin. Capping insulin prices at about \$100 a month would mean that those with the disease wouldn't have to fear between if they could afford to survive until their next paycheck. I would likely see less of those patients coming into the ER, those in between jobs or not well-established in the work force. And without sounding too dramatic and without hyperbole, this bill could literally save lives. So thank you for your time.

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

**VANESSA JEWELL:** Thank you. My name is Dr. Vanessa Jewell. It's V-a-n-e-s-s-a, Jewell, J-e-w-e-l-l, and I'm here in favor of both LB949 and LB970. Just a little background on myself. I am a resear-- a diabetes researcher, and I am a professor at Creighton University and have a background as an occupational therapist working in rural clinics. And I'm also a mom of a daughter who has type 1, and she'll, she's gonna come up here with one of our students because I can't read her testimony without crying, so. All right. So I am again here in support of both bills, but what I really want to talk about is a grant that we received from the Patient-Centered Outcomes Research Institute about a year and half ago. So you've already heard from some of my

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team members from across the state. So we have stakeholders from across the state that have been involved in this project. And one of our primary objectives was to conduct focus groups across the state trying to find out what are these challenges and barriers that individuals have who have type 1 diabetes. And so we interviewed people who have type 1, their caregivers, any kind of connection, healthcare providers. And the number one thing that came out, and I have a handout that our marketing team created for us, but on the bottom of the first page, I have some of the statistics which you've already heard so I won't read the stats again. But at the bottom, the first theme that we heard from everyone was these dramatic family and lifestyle changes that happen after diagnosis. And with-- and not-- the one thing that we really, really heard was these costs. These medical costs that all these families just absolutely were not prepared for. And they just shared over and over again about how expensive this disease is and that they didn't know how to navigate the insurance system. They didn't know how they were gonna pay for all the medical costs that they now had. And so I just want to read a few quotes that we-- just again because I'm trying to represent people from across the state of Nebraska. So one person said having diabetes is like hitting a brick wall at 100 miles per hour, then trying to put all the pieces back together. Life changes very quickly. Another said, every January my deductible resets and the costs really impact my family's financial decisions. I was not prepared for this. Another said, living with diabetes causes me to consider an employer's insurance plan before choosing a career or a job. Another talked about having to get pre-authorization every single year from their insurance companies even knowing that this disease never goes away. People said repeatedly and repeatedly, it's just so expensive. Another said, I don't know how people manage without good insurance. Another mentioned that they asked a family member who travels to Canada to get insulin for their daughter because they couldn't afford it. And another said, that my first trip to the pharmacy after my child was diagnosed was a huge jolt. So those are just some examples of things that we have heard across the state. We did focus groups in Kearney, North Platte, Lincoln, and then we hosted one virtually for those to kind of capture people from other parts of the state that couldn't travel. Though-- and then just on a personal note, I just last weekend, everyone's kind of sharing about costs. I have an amazing job and I still struggle paying for healthcare for all of my daughter's expenses. Just last week, I paid \$608 out of my own pocket to cover my daughter's 30-day supply of insulin because she has type 1 and that's just insulin. And we have test-- test strips, which are-- which other people have shared

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as well, which I know is not included in this bill, but up until a couple years ago I was paying over \$600 a month for test strips as well. Her insulin pump-- pump is \$5,000. Her continuous glucose monitor is thousands as well. I mean, I think I calculated it one time. It's probably a couple thousand dollars a month that I pay, and as a single mom who's responsible for 100 percent of healthcare costs, and I will happily pay those for my daughter and I will do anything I can. I just really urge you guys to seriously consider this bill. Again, I have a great job and it's still hard. So I can't imagine what the people do who don't have the same opportunities that I've been blessed with. So I just want to thank you again for considering these two bills. Any questions?

**WILLIAMS:** Thank you. Dr. Jewell.

**VANESSA JEWELL:** Yeah.

**WILLIAMS:** Senator McCollister.

**McCOLLISTER:** Yeah, thank you, Chairman Williams. Thank you, Dr. Jewell,--

**VANESSA JEWELL:** Yeah.

**McCOLLISTER:** --for being here and what you do. To what extent have people been able to take advantage of these so-called drug discount plans that we--

**VANESSA JEWELL:** Yeah.

**McCOLLISTER:** --heard about earlier?

**VANESSA JEWELL:** Sure. So this is interesting. So Dr. Knezevich is here as well and she's gonna talk a little bit more about that. She's a pharmacist on our team. And as we were walking in, I was just telling her I paid \$608 last month. And she said, well, there's these \$99 plans. But why is nobody telling me about this. I, as a patient, that's the first I've heard of it. My healthcare providers have said nothing to me. So if it's-- I mean, and I'm well-educated and can look into these things and so I-- I'm just gonna leave it at that. If people aren't aware, how do you take advantage of it?

**McCOLLISTER:** Thank you very much.

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**VANESSA JEWELL:** Yeah, of course.

**WILLIAMS:** Additional questions? Seeing none, thank you for your testimony.

**VANESSA JEWELL:** Yes, of course.

**WILLIAMS:** We will be taking a short break at 3:00, give or take, so everybody can plan on that. And I would invite the next proponent.

**VANESSA JEWELL:** Sure, and I did ask one of our students to read for my daughter.

**WILLIAMS:** Absolutely.

**VANESSA JEWELL:** OK.

**SHELBY HOFFMANN:** Hi, everyone. My name is Shelby Hoffmann, S-h-e-l-b-y H-o-f-f-m-a-n-n. I'm a second-year pharmacy student at Creighton University. Also on the team with Dr. Jewell and a few other students that talked today, and Dr. Knezevich. And I'm speaking on behalf of Norah Jewell, N-o-r-a-h J-e-w-e-l-l. Imagine a two year old crying on the floor telling their mom and dad they wanted to kill themselves because of all the needles and pokes she had to go through on a daily basis just to stay alive. No one chooses to have diabetes. For me, a 12-year-old kid, it's \$608 for 30 days of insulin. For me, it feels like putting a price on death. I've heard so many cases where not just adults, but kids have died because the price of insulin was way, way too high. They'd store and save their insulin, causing them to end up in the ER with a higher medical bill in which they started. Diabetes affects an incredible amount of people, yet there is no cure, not even a vaccination. I hope that sometime soon we can help everyone with insulin costs and maybe even find a cure. Thank you.

**WILLIAMS:** Thank you, Ms. Hoffmann. Norah, have you got something you'd like to say?

**NORAH JEWELL:** No. [LAUGHTER]

**WILLIAMS:** OK. I just wanted to be sure you had your chance. Thank you for coming. Any questions for Norah or Shelby? Thank you for your testimony. Invite the next proponent.

**EMILY KNEZEVICH:** I don't know how I'm gonna follow that, but my name is Emily Knezevich, and thank you for hearing my testimony today. I'm

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here to speak in support-- oh sorry, I should of spelled my last name because it's a--

**WILLIAMS:** Yes, please.

**EMILY KNEZEVICH:** Yes, it's E-m-i-l-y, last name is K-n-e-z-e-v-i-c-h. I have to teach my kids a song to remember how to spell it, so. It's a toughie. I am here to speak in support of both bills, LB949 and LB970. I'm representing Creighton University's School of Pharmacy and Health Professions. I'm a professor there. I'm also on Dr. Jewell's [INAUDIBLE] research team as well, and I serve as a faculty member and also a clinical pharmacist and diabetes educator at the CHI Dundee Clinic in Omaha. There, I collaborate with endocrinologists and internal medicine physicians and nurses to ensure patients' medications are optimized and that they're educated on their disease and its treatment. I want to take time to thank Dr.-- Senators Bolz and Wayne for their support of this bill and its recognition of-- of its relevance in today's healthcare environment. My role as a clinical pharmacist and diabetes educator has exposed me daily to the difficulties that patients have in affording their insulin. In our clinic, I have-- fortunate enough to have pharmacy students there with me to help me out with-- with our patients. And we utilize the state's wonderful prescription drug monitoring program to review each diabetic patient's medications when they come into the clinic. What we found when we review those, unfortunately, is that adherence to insulin is very poor. Often, typically less than 50 percent of patients that come into our clinic take their insulin as we have prescribed it. And when we talk about adherence, when we talk about barriers, why-- why aren't you taking your medications? What we find nine times out of ten is the cost is the-- is the driver for that. So as a result, we see patients get poor control of their diabetes, and-- and some of the testifiers today have talked about the consequences of that, but it could include vision loss, kidney failure, neuropathic pain, and even amputations that can occur secondary to infection. I truly believe that this bill in capping the costs of insulin for patients each month will begin to address the very significant barrier that we as clinicians have in trying to improve outcomes for our patients with IBDs. In healthcare, we often look at things like laboratory measurements, hospitalization rates, or other financial implications of chronic illnesses like diabetes, and all of which would be very significantly improved through improving adherence to insulin through cost reduction. Additional outcomes though that we need to take into consideration is a lot of what you've heard today. Quality of life in those with

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dealing with the day-to-day challenges of the disease. And with diabetes, there are so many. So being able to improve this, and-- and eliminate hopefully one challenge would be such a significant leap in the right direction for many with this very costly and burdensome disease. I truly believe that my patients want to be adherent to their medication regimen and want to get better control of their diabetes, but the unaffordability of their medication is one more barrier in them doing so. In moving forward with this legis-- legislation, I do think it is very important that-- and we can learn from our neighbors in Colorado. In speaking with some colleagues in similar positions to me out there that we need to ensure that the insulin cost cap should be inclusive of all insul-- insulin prescriptions prescribed in one month versus each component of their insulin. We've heard that many patients are on two different types of insulin. Typically, a once daily, long acting and then a three times daily mealtime insulin. And we need to ensure that all of those insulins will be covered at a maximum of \$100 out of pocket versus each individual component. Additionally, some patients are on very high doses of insulin as they're considered insulin resistant. And again, it's just important, I think, to make sure that their entire insulin cost is at that maximum capped of \$100 per month. Currently, for patients with commercial insurance, as there are discounts offered through insulin manufacturers that do reduce the costs to \$100 per month, as Dr. Jewell had alluded to, but the major limitation in that is that patients do have to know about these programs. They have to enroll with the insulin manufacturers. And there are limitations on how much is allowed with that total \$99 cost. Additionally, I think it is worthwhile to mention that there are lesser expensive insulins that are available at \$25 a vial, but they are far inferior to the more expensive insulins that many require. I would also think it's worthwhile to mention that with our current system, insurance providers switch formulary insulin products annually, sometimes every six months depending on the contracts negotiated with the pharmaceutical company and the Pharmacy Benefit Managers or PBMs. And what this means to patients is their preferred insulin project-- products are interchanged nearly every January 1. This can be a very difficult transition for many to make. It can compromise access and disease control. It's a potential risk for adverse effects to the patient if they're not clear, clear about their new medication instructions. It also provides a significant time restraint and workload issue for providers and pharmacists each January 1. So my hope is that through putting all insulin costs on a more level playing field that the required formulary change might be minimized. So

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lastly, I would just be remiss if I did not mention that although this is a significant issue for all patients with both type 1 and type 2 diabetes, there is a significant number of those individuals who do not have commercial insurance and will not see the benefit of this change in legislation. This insulin cost capping should be expanded to those with Medicare and those who are uninsured as well to truly help open access to this vital medication. Thank you for your time.

**WILLIAMS:** Thank you for your testimony. Any questions? Senator McCollister.

**McCOLLISTER:** Thank you, Chairman Williams. We all know the personal cost of noncompliance with a disease like diabetes. Do you have any idea what the social costs are of noncompliance nationally or in Nebraska?

**EMILY KNEZEVICH:** Speaking of like loss of productivity and-- and things like that?

**McCOLLISTER:** Yeah.

**EMILY KNEZEVICH:** I am not sure about statistics. I know it's definitely significant. They have direct costs primarily related to days off work, or I would say just a lack of productivity across the board, but I'm-- I'm not sure about numbers. I'm sorry.

**McCOLLISTER:** Thank you for being here.

**WILLIAMS:** Seeing no more questions, thank you--

**EMILY KNEZEVICH:** Thank you.

**WILLIAMS:** --for your testimony. We'll do one more testifier before we break. Welcome, Ms. Stiffler.

**KRISTEN STIFFLER:** Good afternoon, Chairman and members of the committee. My name is Kristen Stiffler, it's K-r-i-s-t-e-n S-t-i-f-f-l-e-r, and I am the state government relations manager for the National Psoriasis Foundation. The National Psoriasis Foundation is the leading patient advocacy group for more than 8.3 million Americans and over 46,000 Nebraskans living with psoriasis and psoriatic arthritis. I'm here today to express our support of LB949 and LB970. Patients with psor-- psoriatic disease are at a heightened risk for developing other chronic conditions, including diabetes and hypertension, cardiovascular disease and stroke, as well as depression

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and anxiety. LB949 and LB970 will help individuals with diabetes who may also be managing other chronic diseases such as psoriasis. And this allows for them to have affordable access to insulin. Numerous studies have demonstrated that individuals with psoriatic disease face a higher risk of diabetes, even when controlling for risk factors such as obesity and hypertension. One study compared over 100,000 individuals with psoriasis, with matched patients without psoriasis, and found that those patients with mild psoriasis had an 11 percent increased risk of diabetes and patients with severe psoriasis a 46 percent higher increase for diabetes. Another study found that after accounting for diabetes risk factors, diabetes risk increased by 20 percent with every 10 percent increase in psoriasis body surface area. It is critical that patients with psoriatic disease, diabetes, and other chronic conditions have the tools that they need to effectively manage their disease. While facing high out-of-pocket costs, patients often do not use their medications appropriately, skipping doses as-- as you've heard, in order to save money or abandoning treatment altogether. Furthermore, according to several studies, prescription abandonment rates increased significantly when the cost sharing exceeds just \$100. In regards to Section 1, subsection (3) of LB949 and AM2292, the NPF is still reviewing the original bill language and the amendment to determine the effects on patients with psoriatic disease and are also managing diabetes in Nebraska. The NPF would be happy to follow up with committee members after the hearing regarding additional findings about premiums and insulin costs for psoriatic patients. By limiting the cost of insulin prescriptions to \$100 per 30-day supply, LB949 and LB970 will help reduce patient costs and thereby improving patients' ability to access insulin. We appreciate your attention for this important matter. And if you have any additional questions beyond the hearing, I'm always available.

**WILLIAMS:** Thank you, Ms. Stiffler.

**KRISTEN STIFFLER:** Thank you.

**WILLIAMS:** Questions? Seeing none, thank you for your testimony. We are going to take a very short ten-minute break. Can I get a showing of hands [RECORDER MALFUNCTION]-- and then we will take our break.

**LAURA EBERLY REINER:** Hi.

**WILLIAMS:** Thank you.

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**LAURA EBERLY REINER:** No, thank you. My name is Laura Eberly Reiner, L-a-u-r-a, Eberly, E-b as in boy -e-r-l-y, Reiner, R-e-i-n-e-r. And so I am here to support the two bills. I was diagnosed with type 1 on June 15, 2010, my senior year of college, and I went to school at UNL to get a degree as event planning and public relations. After my diagnosis, my dad said I hope you find a good job with health insurance to cover the bills that were costing for insulin and all my other medical supplies. Like Dr. Jewell said, there's a whole lot more on the outer scopes that occurs, the costs, and everybody has really giving their testimony about that. So what happened was I interned for JDRF here in Lincoln and I was hired as the development assistant in 2012 and recently just left JDRF, but support them immensely in what they're doing. They have changed so many lives here that have been affected by type 1 diabetes. And I've gotten to know so many more people across the state and given so much support and resources, you know, trying to help them, hear their stories, figure out how they can manage this cost, giving them supplies that others have donated, just-- it's tremendous. And so basically, I guess I'm just really speaking from the heart here. It-- it's just crazy, and JDRF is a resource for these families to come to to get help. Nationally, JDRF is working to fight the costs of-- the high costs of insurance and everything too. And I know that's probably one of your guys's questions as well as what nationally they're doing. But I think it's great for us here in Nebraska to make a stance on that and to really provide support and know that, you know, we're making a difference here locally. But then also, you know, helping support nationally this difference, so I think the steps we're doing here today are huge, and I would just really appreciate your support in that. Any questions?

**WILLIAMS:** Thank you, Ms. Reiner. Questions? Seeing none, thank you for your testimony.

**LAURA EBERLY REINER:** Thank you.

**WILLIAMS:** We will be taking a short break. We will start promptly at 3:15.

[BREAK]

**WILLIAMS:** [RECORDER MALFUNCTION] begin our hearing on LB970 and LB949. And we would invite the first opponent testifier and welcome.

**JEFF HUETHER:** So good afternoon, Mr. Chairman and members of the Banking, Commerce and Insurance Committee. My name is Jeff Huether,

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J-e-f-f H-u-e-t-h-e-r. I'm the director of pharmacy of Blue Cross Blue Shield of Nebraska, appearing in opposition to LB949 and LB970. In listening today's testimony, I want to share that this is an issue we've been working on for a long time. We share our members concern about access to insulin and we have worked hard to balance all of our member interests to bring cost effective solutions. As background, even though insulin was developed decades ago, there isn't a real generic option for our members. Constant small improvements to manufacturing, formulation, and delivery methods-- methods have acted to extend patents over and over again. Ever increasing costs for insulin have been a factor for several years, even as we manage to keep our cost sharing relatively consistent. These bills strike at our primary method of managing insulin costs, one of which is being a formulary system that balances major insulin providers against each other for lower costs from the pharmaceutical companies. We do this by providing our members access to a preferred insulin. Brand insulin category has significantly reduced cost sharing, while keeping a higher cost sharing for nonpreferred brands. As part of the negotiation, preferred brand, we'll seek the highest difference between the two options to incentivize our members to use one option over the other. Pharmaceutical companies have worked hard to circumvent this work as well by offering and promoting copay coupons that steer patients away from lower cost insulin options, and a plans preferred insulin product driving up overall costs. As you can see, the negotiation process is very fluid and we need to the ability to react to evolving pharmaceutical company negotiation techniques. By limiting payer freedom of contracting between brands this will inevitably increase costs. We've had studies provided to us to claim that a bill that passed in Colorado will have minimum impact on premium. We would point out that those studies based on 2013 data are not exactly on point. One study examined exempting insulin from deductibles without a cap on the copayment. Another 2015 study examined the impact on California's market of capping copayments. The earliest this bill has been in effect was July 1 of this year. And while there are reports from Colorado on premium increases, we believe that over time the erosion of our negotiation position will yield sustained premium increases. Further because the bill is capped-- as drafted so the cap is at \$100 for all insulins, this bill goes far beyond legislation adopted in Colorado. While we appreciate that Senator Bolz would seek to short circuit the bill if the premium impact was more than 1 percent, we'd point out that individual market premiums for a family of 4 can easily exceed \$20,000 per year. So to say that the bill doesn't take effect if a family that doesn't use

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insulin sees increases of \$200 per year is OK, seems like a problem to us. As I mentioned earlier, we offer members preferred brand insulin options with lower cost shares. We offer a range of deductible options. We offer a range of copayment options. In our case, copayments for a 30-day supply of insulin vary from \$30 to a percentage that we believe is about \$125 per month. To put that number into context, by the way, since 2011, the retail price of insulin has increased from \$200 to more than \$500. The flexibility in how a member wants their coverage structured does have price impacts based on how much of the risk the member assumes. Some people prefer a lower premium and a higher copayment. Others prefer the opposition. We don't make the choice, they do. But the important thing to remember is that the member or the small or medium-sized employer makes the choice, not us. To reduce the impact of increasing premiums while still providing health insurance benefits to their employees, high deductible health plans have been an attractive option for employers. We believe that the way the bill is structured, it would not allow the deductible to apply as we saw with the recent hearing aid mandate. Eroding high deductible health plans will remove one more option for employers struggling with increasing premium costs. Further, because these bills go beyond a price per prescription model, these claims will be very difficult to administer, leading to unnecessary compliance costs. While the bill will not impact insulin costs for the uninsured, it also won't affect roughly 50 percent of insured Nebraskans whose employer self-fund benefits whose plans are regulated by the federal government. And while advocates may focus on individual coverage and while roughly 140,000 Nebraskans get their coverage through the individual market, a significant percentage of those individuals have their coverage subsidized by the federal government. The deepest impact will be on small and medium-sized businesses who will see higher costs for the coverage that they buy for their employees. Moving back to the overarching problem, which is the high cost of insulin. While we work to offer affordable insulin products to members, there are several external factors outside of our control. Price increases are completely under the discretion of the manufacturers and the aggressive pricing strategies are particularly harmful to patients who are uninsured. Neither of the bills included anything like the Colorado language requiring the Attorney General to investigate the cost of insulin. As we move forward, insulin costs will not decrease because we've undercut payor ability to negotiate. Neither of these proposals lower the cost of insulin for Nebraskans.

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They require people to buy more insurance-- insurance to pay for it. With that, I'd be happy to answer any questions.

**WILLIAMS:** Thank you, Mr. Huether. Questions? Senator La Grone.

**La GRONE:** Thank you, Chairman Williams. Thank you, Mr. Huether, for being here. You mentioned the patents in the original part of your testimony-- testimony. If you don't know this, that's-- that's fine. I was just curious. We heard earlier about the lack of competition in the-- in the insulin manufacturing area. Is that due to the extension of these patents?

**JEFF HUETHER:** It's hard to answer that question necessarily. As we've heard, there's predominately three major manufacturers that manufacture versions of insulin or the types of insulin that are available. In terms of-- if-- if that is just because they are the only ones with patent, that can lead to limited competition, obviously. The more players in a market speaking on economic principles would make sense that there would be more competition, which would hopefully be lower costs.

**La GRONE:** And in that same vein, and the patent issue really struck me as an interesting one. Are these-- so are these-- and you may not know this either-- are-- are these the same patents that they're operating under and have been operating under for a while? Is that what--

**JEFF HUETHER:** No, no, my understanding is they're different patents.

**La GRONE:** OK.

**JEFF HUETHER:** As new manu-- or as new insulins come to market, they're under different patents than what they've been on before.

**La GRONE:** So could more manufacturers enter the market under what was a previously patented method?

**JEFF HUETHER:** I would believe it is possible, but without knowing kind of the background of those patents in particular, it's hard to say.

**La GRONE:** Fair enough. Thank you.

**WILLIAMS:** Additional questions? Senator McCollister.

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**McCOLLISTER:** Yeah. Thank you for being here. Would you encourage those people buying or having your policies to obtain their-- their necessary diabetic drugs from either Canada or Mexico?

**JEFF HUETHER:** It's hard for me to answer that, considering we're federally and state regulated in terms of where that is, not something that we can cover drugs from other countries.

**McCOLLISTER:** But many, many people do it, do they not?

**JEFF HUETHER:** I think we've heard testimony today that some do. I'm not familiar with any that do that today.

**McCOLLISTER:** Thank you.

**WILLIAMS:** Additional questions? Mr. Huether, I have one. In your testimony, you talked about this legislation going far beyond the Colorado legislation. Could you compare those two for me?

**JEFF HUETHER:** Without having the bill in front of me, I know of one in particular is around, I believe, it's-- my understanding the Colorado bill is a cap on each prescription per month. And my understanding of the bills presented today is that this would cover all insulins regardless of the number of prescriptions and the like.

**WILLIAMS:** Thank you.

**JEFF HUETHER:** You're welcome.

**WILLIAMS:** Senator Kolterman.

**KOLTERMAN:** Thank you. So Blue Cross and Blue Shield, do you know what percentage of the market they have in-- in Nebraska?

**JEFF HUETHER:** I don't have that number off the top of my head. I know looking at various others in the market, we are a significant portion of that.

**KOLTERMAN:** And you indicated, I think if I heard you correctly, this wouldn't pertain to self-insured programs. And yet I believe, at least in Senator Wayne's bill, he has included self-insured programs in the bill. Are you-- are you familiar with that?

**JEFF HUETHER:** I'd have to go back and look at the bill in particular to make sure. But we can get back to you on that.

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**KOLTERMAN:** Thank you.

**JEFF HUETHER:** You're welcome.

**WILLIAMS:** Any additional questions? Seeing none, thank you, Mr. Huether, for your testimony.

**JEFF HUETHER:** Thank you.

**WILLIAMS:** I'd invite the next opponent. Good afternoon.

**JAY McLAREN:** Good afternoon, Mr. Chair and members. My name is Jay, J-a-y, last name McLaren, M-c-L-a-r-e-n, and I'm the vice president of public policy and government relations of Medica. Medica is an insurance company based in the Twin Cities, but we offer coverage throughout the Midwest in nine states. We cover just about a million people or just under a million people in the Midwest, including approximately 90,000 Nebraskans. So the coverage that we offer in Nebraska, we offer Medicare coverage, group coverage, but also we are the primary care in the individual health insurance market. So, Mr. Chair and members, again, I'm here to testify in opposition to LB970 and LB949. First and foremost, the concerns that I heard from the proponents are not-- or that are addressed in this bill are not necessarily the cost of insulin. The price of insulin is not addressed in this bill. It's the predictable cost of what they're gonna pay out of pocket for insulin through the health insurance coverage that they acquire through us or others. So for us in the-- in the individual market products that we offer throughout this date, so again, those are people who don't have coverage available through Medicare or through their employer. So for us, we offer two different types of coverages in the individual market. So one of them is a high deductible health plan where you need to meet the deductible before the benefits kick in. And we also offer a choice of copay plans where for insulin, people would have the choice of products where that copayment is either \$70 or up to \$160 and anywhere in between there, not anywhere but \$70, \$120, or \$160. And the reason that we do that is because, again, these folks do not have the option-- or these folks do not have coverage available-- available to them elsewhere. So we want to make sure that for folks with diabetes and other debilitating conditions that require these maintenance medications, that they have a copay plan available to them so that they do have predictable out-of-pocket costs for those medications on a monthly basis. So we do offer these type of options in the market. I would to that point, though, and to your question, Mr. Chairman, earlier, share the concern

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from Blue Cross as well when it comes to-- this does not necessarily place a cap on the copayments. It places a cap, as we understand it, from the description on the aggregate amount that someone would pay per month for all the different types of insulin that they may be on. So this is administratively burdensome for us to and comp-- really complicated in how we'd be able to pull that off. So that's one of our concerns with the bill as well. So again, the cost of insulin is the actual underlying problem. This addresses a symptom, which is the cost sharing that people pay for it. According to Indianapolis Business Journal, over the last 20 years, milk has gone up about 23 percent. Dodge Caravan has gone up about 21 percent in terms of its cost. Humalog has gone up almost 1200 percent over the last 20 years. And again, this bill does not address the underlying cost of insulin, and I do have a lot of sympathy for those who have to pay for that out of pocket. And this bill does not also address people who are not insured either. So one-- one more thing, Mr. Chairman, to your question that you got or that you asked earlier about that add-- the mandates that may be applied to cost sharing and perhaps its cumulative effect over time, whether that may be you from others. But we have a broader concern of, if you and the Legislature goes down this path of applying and capping cost sharing for our health insurance products, it puts insurers in the precarious position of trying to decide where else we increase cost sharing. The coverage that we offer in the individual market has to meet the metal level. So I think some people have heard the bronze, silver, gold plans that we have to offer. Well, those products have to meet certain actuarial values, meaning for a bronze plan on average, it has-- we have to pay about 60 percent of the typical cost that someone would incur in that plan and the member would have to pay about 40 percent on average. So if the Legislature goes down this path of instructing insurers to limit cost sharing and different things, because of those actuarial values, we'd be forced to increase shot-- cost sharing elsewhere in order to reach that equal-- equilibrium of 60, 70, or 80 percent. So that's the broader concern that we have on this bill and other bills if we start going down this path. Mr. Chair, those-- those conclude my remarks and I'd be happy to answer any questions.

**WILLIAMS:** Thank you, Mr. McLaren. Senator Kolterman.

**KOLTERMAN:** Thank you. Thanks for being here. So when the Affordable Care Act came out, there's compliant policies and then all of a sudden we saw the industry starting to sell these short-term policies, which are limited in scope of what they're covering, what they aren't going

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to cover. And they-- they are even subject to preexisting conditions and things of that nature in many cases. And they're typically limited to one or two years. Would those be affected by this type of a mandate or the cost sharing as well, or would those-- would you see those come underneath this or--

**JAY McLAREN:** Great question, Senator Kolterman. So I think, first of all, to your point, no, this wouldn't apply to short-term limited duration policy because from the beginning they can underwrite and-- and deny coverage to people who have diabetes in the first place. So that's one way that they would be able to limit their exposure to this. Secondly, in reading the bill and I could stand corrected, but in my reading of the bill, even if someone acquires coverage and then they would be diagnosed or a loved one on that policy would be diagnosed, in my reading of the bill, it doesn't apply. But again, I could stand corrected.

**KOLTERMAN:** OK. Thank you.

**WILLIAMS:** Senator McCollister.

**McCOLLISTER:** Yeah, thank you, Chairman Williams. You've indicated that we're really treating the symptom rather than the cause of this, these high drug costs. Should the state of Nebraska be dealing with these pharmaceutical companies in some kind of different way? Have you seen progressive legislation that states can enact to deal with the drug companies and the pharmaceutical companies for these high costs?

**JAY McLAREN:** Senator McCollister, believe me, my team and I have been trying to think of ways to address the broader issue, which is the actual cost of prescription drugs, particularly insulin and others that have gone up so much over the last several years. I think this is a question you asked earlier. What have other states been doing? In Minnesota, where we're headquartered and where there's been an intense debate on this for-- for the last year, they have-- then they are moving forward with a bill this year that would apply a fee on pharmaceutical companies to try to help pay for insulin that would be available for people that need it on an emergency situation in pharmacies when they-- when they show up there and they don't have coverage. So that's one thing that other states have looked at. Again, that's not something that necessarily we support. We don't have a position on that, but that's an example of what some other states are doing.

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**McCOLLISTER:** But you didn't oppose it, correct?

**JAY McLAREN:** That's correct, Senator. That's correct.

**McCOLLISTER:** OK. Thank you.

**WILLIAMS:** Additional questions? Seeing none, thank you, Mr. McLaren. Invite the next opponent. Welcome, Mr. Bell.

**ROBERT BELL:** Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Robert Bell. Last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, which is a state trade association of insurance companies domiciled in or with us in ethican-- economic presence in Nebraska. I appear today in opposition to LB949 and LB970. Health insurance deductibles, copayments, and coinsurance are all utilization tools used by health insurers to share the costs and risks with consumers. Consumers who agree to pay higher amounts of these cost sharing measures typically have lower premiums. With continuing the-- continuing rise in the cost of healthcare services, both healthcare premiums and cost sharing amounts have also risen. So it is very understandable that in these times of higher premiums and higher cost sharing amounts, that when lifesaving drugs costs are nearly exponentially increasing, that advocates for consumers will seek governmental mandates to lower the consumer share. Unfortunately, this does not actually get to the root of the problem, which is the high costs of these pharmaceuticals. Instead, it merely shifts these costs to the insurance company who must increase its premium-- premiums and cost sharing limits to stay solvent. Contrary to popular belief, insurance companies are not making large amounts of profit off these high costs of pharmaceuticals. Many health insurance companies are mutual companies which exist to benefit the policyholders. They do not make profits. Stock companies are different and there are insurance companies that are stock companies. However, both stock companies and mutual health insurers are subject to limitations placed into law by the Affordable Care Act called medical loss ratio. For every dollar of premium received, at least 80 cents must be used to pay medical claims. The remaining 20 cents can be used to pay for expenses such as marketing, salaries, administrative costs, and commissions. And the insurer must still maintain a level of financial solvency determined by the Department of Insurance to stay in business. Any state legislative bill that caps a cost sharing measure or impose a mandate will not apply to most federally regulated self-insured large group plans

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governed by the Employee-- Employee Retirement Income and Security Act of 1974, also known as ERISA. According to a research I've read, ERISA plans cover at least 50 percent of privately insured Nebraskans. I tell the committee this for two reasons. First, the legislative bills will have a more limited impact than most realize. Many people are not aware that if their employer provides our plan, it is likely that a state mandate will not apply, especially if that employer is a large employer. Just yesterday, the Denver Post ran an article about how many Coloradoans were surprised that a similar bill passed last year in Colorado did not apply to their plans. Second, ERISA preemption could lead to adverse selection, meaning that people that need insulin may switch off their employer plans to state regulated plans for their coverage needs. This shift, while understandable and beneficial for the individual, could lead to higher risks and costs within the state regulated pool with accompanying higher premiums. For these reasons, the Nebraska Insurance Federation opposes the passage of both LB949 and LB970. I appreciate the opportunity to testify.

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

**ROBERT BELL:** You're welcome.

**WILLIAMS:** Invite the next opponent. Welcome, Ms. Nielsen.

**COLEEN NIELSEN:** Thank you. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Coleen Nielsen. That's spelled C-o-l-e-e-n N-i-e-l-s-e-n, and I'm the registered lobbyist for the American Health Insurance Plans, or AHIP, testifying in opposition to LB949 and LB970. AHIP members are committed to ensuring that patients with diabetes get affordable insulin to help control their blood glucose levels. Health insurance providers have a strong history of advancing innovative approaches to help enrollees successfully manage and control diabetes, prevent complications, and improve their quality of life. We understand that for many diabetes patients, the rising cost of insulin has created an affordability crisis that threatens their health and well-being. Capping copays only masks the problem because the problem, as you've heard, is the price-- out of control. Prices for insulin products and other prescription drugs are a direct consequence of drugmakers taking advantage of a broken market for their own financial gain at the expense of the patients. The lack of competition, transparency, and accountability in the prescription drug market has created extended price dictating monopolies with economic power that exists nowhere

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else in the U.S. economy. The obviousness of a broken prescription drug market is particularly evident in the context of prescription insulin. The price of insulin, just like the price of countless other pharmaceutical products, has increased sharply over the past-- the past decade. At the same time, the prevalence of diabetes has risen across the U.S. population. Since 2006, while the number and supply of insulin products has grown, the list price of insulin products has increased exponentially, as you've already heard. Our members support market-based solutions that hold drugmakers accountable for high list prices and put downward pressure on prescription drug prices through competition, consumer choice, and open and honest drug pricing. These-- this includes solutions that would promote competition by removing barriers to the availability of generic drugs, create a robust and competitive marketplace for biosimilars, and increase transparency around pharmaceutical prices. Due to our concerns about the impact that this bill would have on health insurance premiums for Nebraska consumers and business and the bad precedent the bill would set, we oppose the legislation. Thank you, and I'd be happy to answer any questions.

**WILLIAMS:** Thank you, Ms. Nielsen. Questions? Senator McCollister.

**McCOLLISTER:** Thank you, Chairman Williams. Wondering if you would make a commitment to work with this committee on ways that we could increase competition and-- and methods to deal with some of these pharmaceutical companies.

**COLEEN NIELSEN:** Absolutely, Senator.

**McCOLLISTER:** Thank you.

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

**RON SEDLACEK:** Good afternoon. Good afternoon, Chairman Williams and the 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. You've already heard this several times now, and I'm gonna try not to be as repetitive, but in application, I think we can all agree, the bill proposes the mandate insurance cost shifts. And many of our members of the Nebraska Chamber, our trade association members, local Chambers of Commerce, and obviously individual business employer members who offer either group health insurance coverage or they offer-- and which are

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regulated by the state-- or federal ERISA plans. In this regard, we're representing the consumers of those state-regulated insurance products that would be affected by these legislative bills. And I can't emphasize it enough and be clear that about 50 percent of those covered employees are under federal ERISA plans. So this will not affect about half of the work force, whether it's enacted or not. So we want to make everything clear in that regard. We represent those consumers that-- most of them are small employers, small businesses or the self-employed. Now we share the concerns of other consumers as well, attempting to find and obtain reasonably priced and affordable health insurance products. We continue to find the escalating costs of health insurance and benefits for employees remain high on the list of business concerns. We poll our businesses quite regularly, still top-- one at the top of the list. Historically, Nebraska has remained a relatively low-cost health insurance state due in part to the fact that the Nebraska Legislature has been vigilant when it comes to adding layers and layers of additional health insurance mandates or cost shifts that would exceed federal ERISA standards. While each new proposal that is heard before this committee for additional mandates or shifts, they're well-intentioned. We understand that and we have sympathy for those who bring these issues before you. But it is a fact that additional mandates will increase health insurance rates. It will affect both the affordability and availability of health insurance for employers who offer those plans and their employees. In many cases, the result of increased health insurance costs means higher deductibles or copayments for employees. In some cases, increased health insurance costs may result in the employer and employee being required to either reduce or eliminate other benefits that may be more appropriate to their work environment. And in a few cases, the aggregation of increased costs, increased benefits may ultimately result in an employer providing payments in lieu of health insurance benefits, essentially saying you're on your own, or maybe they will migrate to-- more-- more employers may migrate to a VEBA or a MEWA or another ERISA-- self-insured ERISA plan and then escape state mandates. So in representing our members, again, most of them who are consumers of employer provided health insurance products, we believe that the addition of further mandates or cost shifts can only serve to price many Nebraskans out of the group health insurance market or result in some reduction of other benefits of value to the employee. And it's for these reasons that we oppose this legislation.

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

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to testify in opposition? All righty. Anyone here to testify in a neutral capacity? Come on forward. Welcome.

**ROD REGALADO:** Thank you. Forgive me if I'm too loud. I'm half deaf, an old Marine. So my name is Rod Regalado. I live up in Tekamah, Nebraska. And my baptism started on 9-6 when my 13-year-old son was diagnosed with type 1 diabetes. So I'm fairly new to this. So when 9-6--

**WILLIAMS:** Mr. Regalado, would you please spell your name for us?

**ROD REGALADO:** Oh, sure.

**WILLIAMS:** Thank you.

**ROD REGALADO:** Yeah. It's Rod, R-o-d, last name Regalado, R-e-g-a-l-a-d-o. So on 9-6, they took him into Children's and kept him all weekend because his A1C was off the charts, his ketones were off the charts, and he was not doing very well. I'm here because I didn't know anything about LB979 or the other bill in front of you folks. Don't know anything about it. I know you want to cap the price of insulin, that's fantastic. They let him out on 9-8, but I had to buy insulin. My out of pocket after insurance was like three hundred fifty bucks. In two months time-- two months time my insurance was north of \$5,000 and my out of pocket was \$1,700. Seventeen hundred in two months-- two months. It's a travesty. People are rationing their insulin. And if-- and if you are in a position where you don't have the means or you don't have a good job or a young man, your opportunities are limited. So you go into the world and you don't have a good insurance plan and you're married to that bill every month just to stay alive, just to breathe. That's all we want to do. Want to live. My son is 14 now. He turned 14 in December and he is married to that invoice for the rest of his life. So it's not sustainable. So I'm looking at this and looking at this and I'm trying to make my son's life just a little bit better. That's all I want to do. I'm just a dad at the end of the day with a young son. So I started calling and I called my Senators, called Senator Ben Hansen, called my Congressman, called Congressman Fortenberry. And in two months-- in two months, I got a bill on the floor of the House of Representatives. It's called H.R.5382. It's named after my son. It's called Matt's bill, 5382. And these fellows over here kind of gives me a little bit of a warm feeling to know that the insurance guys are against these two bills because they have been robbing us and fleecing us and they will do so forever until somebody does something about this. H.R.5382 is Matt's

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bill. It's named after my son, and what it does is what you guys are all trying to achieve. It allows type 1 diabetics or diabetics in general-- bear in mind, there's 3 million type 1 diabetics that have to have insulin. They will die without insulin. Three million in this country and somebody earlier mentioned there's 100,000 in this state. I don't know if that's accurate. I don't know. Can't dispute it, whatever the number is. It's a lot. They will die without it. H.R.5382 will allow these patients to bypass these insurance folks and their PBMs that negotiate the price of insulin and buy it direct. And I've heard testimony a couple of times today, insulin's \$3, \$5, \$10. I've-- I've always been of the impression it was \$30 to \$50. I'm-- I'm sure it's a fluid number regardless. I don't know what this bill does, but it caps the price at a hundred, and that's fine. That's fair if you don't have insurance. We do and I'm fortunate-- Matthew's fortunate, but I'd like to retire some day. Who doesn't want to retire some day? And that isn't gonna apply to him. I mean, right now we get insulin less than \$100 a month because what we do is we go past the insurance companies and we buy from the PBMs, CVS Pharmacy, and I get the same-- the same insulin for \$180 for 3 months. Now, I don't know if this bill raises that price. I don't know. I don't know what I don't know. I was-- I was agnostic until I walked in here. Really, I didn't know one way or the other. I wanted to hear what all you guys had to say and I'm still sitting on the fence. But the issue is PBMs and insurance companies, if they're producing this stuff at, let's call it \$50 a vial and they're willing to sell it at \$100, that's a pretty nice markup in my world. Not too bad. But what they do is they charge-- they are charging \$282 and \$276. That's \$500 a month. I don't know what the answer is, but if these guys are against these bills, I'm pretty comfortable saying it ain't a bad bill. [LAUGHTER] That's my two cents on it.

**WILLIAMS:** Thank you, Mr. Regalado. Questions? Thank you for your testimony.

**ROD REGALADO:** You're welcome.

**WILLIAMS:** Are there any additional neutral testifiers? Seeing none, Senator Wayne, you're invited to close. And while you're coming up to close, let me read on LB970 we have the following letters of support: Rodrigo Lopez from Children's Hospital and Medical Center; Todd Hlavaty from Nebraska Medical Center [SIC]; Joni Cover, Nebraska Pharmacists Association; Andy Hale, the Nebraska Hospital Association; Amy Behnke from the Health Care [SIC] Association of Nebraska; Lisa

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Schoenberger from herself; Deb Gokie from the Arthritis Foundation; Angela Thomas from herself; and Carol Dennison from the League of Women Voters of Nebraska. Senator Wayne.

**WAYNE:** Thank you, and I'll be brief. I'll save the-- I guess you'll be saving the best for last with a colleague, she'll-- she'll close out a lot better than I will. But I just want to bring up a couple of things. What I'm passing out is a bill that was introduced in Utah. Utah has already passed similar legislation, but this bill is even going farther to say that it will be \$30, capped at \$30 a month. And to the individual who just spoke a second ago, we keep hearing about PBMs and insurance companies versus manufacturers. Well, this bill also allowed the state to direct buy from the insurance-- from the manufacturers in Utah. So they're saying they're just gonna cut out the middle person. If the middle person keeps saying it's too hard and too encumbersome upon it, administratively they're just gonna cut him out and allow their public employees to directly purchase insulin directly from there. There's also another bill working through Indiana that allows it to be capped in the rebate. And this is what nobody has talked about, the rebate to go back directly to the individual. To how the game is played, and I have another bill that deals with transparency that I hope will move this year, is that they'll charge you \$400 for insulin, \$500 a month for insulin, and they'll put a rebate on it, some magic rebate that the consumer never really gets to see. But somewhere between insurance companies and the manufacturer, somewhere in there, the consumer might hear about a rebate and it's worth \$300. It's the rebate scheme that's part of the problem. And the only way to get rid of that is directly buy or to make sure the rebate goes to the consumer. And we can legislatively do that. I just chose not to this year. But if they want to fight a basic bill capping at a hundred and which most of them are already at a hundred or less, then let's just go all the way. Let's remove the middle person if that's the problem. If it's too hard for Blue Cross to administer, well, let them buy direct. Let them buy directly from the manufacturer and see what happens. They'd be totally against that bill too, because somewhere in the rebate is where the money is being made, and let's not ignore that. And I understand most of these corporations are nonprofits or mutual beneficiary companies, but at the end of the day, their CEOs and their executive team are not-- not short on cash. They're making some decent money. And it's through this whole process of health insurance that we've got to change. I do want to mention that there is a-- talked about a study on diabetes. I think it's critical with Chairwoman Howard being here that we look long term at

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diabetes from a Medicaid standpoint. And at the end of the day, I'm also cochairing every ER visit that happens in my premium and I'm cochairing that cost because somebody couldn't control their diabetes, most of the time because they can't afford it. Those costs are three to four times higher than this \$100 that we're talking about. I am diabetic. I am not insulin dependent. I take medication and I typically work out except for when I'm not-- or when I'm in session. Typically what happens is if my sugars go out array, the only answer I can go to is to the ER. And that ER cost everybody knows is higher than simple insulin or what I should have been doing at the right place, but I'm not gonna lie, my medicine is expensive. Not my Metformin, that's cheap, but the specialty drugs are extremely expensive. And if I didn't have my wife working for the state of Nebraska, I don't know how I'd pay for it. And if I can't control it, then you guys are paying for my ER visits. So when we talk about share cost and premium going up, you also got to talk about the share cost of the current value of what a ER visit costs when somebody's diabi-- diabetes in the 800 and their sugar level is that high, or their sugar level is that low. That is three to four times higher than the cost of what we're talking about, \$100 per month. So to me, I actually see it as a cost savings across the system, not a-- not an input that's gonna increase the costs because you will level out, especially for those who are diabetic the first year. The first year, the average person averages two to three ER visits. They're type 1 diabetic and recently diagnosed. They're trying to figure out how to-- how to do it. And they may be out and order a-- a Diet Coke and then one day forget and order a regular Coke. They still have the same meal and end up in the ER, because they're still trying to figure it out. And if you talk to anybody who was recently diagnosed with diabetes, it is that first year to two years that are critical, and if you're a type 1 and you can't afford insulin, we're already cost sharing people. We're paying for it in our premiums. It's called the ER visits. So I look at this as a way to be cost neutral, if not save money in the long run, and we have to do something to protect our-- our consumers. And with that, I will answer any questions.

**WILLIAMS:** Thank you, Senator Wayne. Questions? Seeing none, thank you. And we would invite Senator Bolz to come up and close on LB949. And, Senator, as you're coming up, we have the following letters in support: Rodrigo Lopez from the Children's Hospital and Medical Center; Todd Hlavaty from the Nebraska Medical Center [SIC]; Joni Cover from the Nebraska Pharmacists Association; Andy Hale from the Nebraska Hospital Association; Amy Behnke from the Health Care [SIC]

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Association of Nebraska; Lisa Schoenberger from herself; Angela Thomas from herself; and Carol Dennison from the League of Women Voters of Nebraska. Welcome back, Senator Bolz.

**BOLZ:** Thank you, Chairman Williams. I do want to take this opportunity to follow up on some of the issues and points that have been brought up today regarding LB949, which is a bill that caps copays for insulin dependent individuals in our state. One thing I heard is that this is an insurance mandate. Well, I think there are certain circumstances in which mandates protect consumers and actually lead to change. And so I think that painting with too broad of a brush and saying that any mandate is bad is not appropriate in this case. This is a focused bill to address a specific problem in which a particular medication has increased significantly and dramatically over time. The second thing I want to address is the concern regarding the erosion of the negotiation position. I guess the question that I would ask you as the Banking, Commerce and Insurance Committee would be, how well is that negotiating position serving consumers now? Those costs have gone up and we have seen them continue to go up over time. This isn't an issue that came up recently. This is an issue that has been evolving over time, and I think something needs to change. One of the things that I think needs to change is to put stronger state statute into place to tell insurance companies and those drug manufacturers what states expect from their insurance products and-- and from the producers of lifesaving medications. The next thing I want to mention is that there was a comment that-- that the insurance companies don't make the choices about the products, that the purchasers of those products make those choices. As I said in my opening, not everyone has the luxury of a choice. And when you can only purchase from one company and you only have a certain budget to work with, then you cannot say that an issue like this should fall back on the choice of a consumer. A couple of other things that I want to share are that if you refer back to the Milliman report that I referenced to you, five out of the six plans analyzed in their study, the benefit design changes-- changes resulted in-- in plans that remain compliant under ACA actual value requirements without requiring the plan to make any further changes to the benefit design. One remaining plan, a standard bronze plan, could be made compliant through offsetting increases to the PCP specialist copays and prescription drug copays. The information that we have from the Milliman report says that this can be done. Moreover, that it can be done with a very minimal impact on the premium payers, less than a dollar according to the information that I have provided to you. When I was deciding to bring this bill, and someone told me that this would

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be an uphill battle, and others told me that others have been working on this for a long time, and I would say the time has come for this change and some things are worth fighting-- worth fighting for. And I would ask this committee to-- to fight uphill with me on behalf of the individuals that you heard testify today about the importance of the affordability of this lifesaving medication. Thank you.

**WILLIAMS:** Thank you, Senator Bolz. Any final questions for the Senator? Seeing none, thank you for bringing the bill. And that will close the public hearing on LB970 and LB949. And we will now open the public hearing on LB804 brought to us by Senator Wayne to provide for insurance coverage for epinephrine auto-injectors. Welcome back, Senator Wayne.

**WAYNE:** Thank you.

**WILLIAMS:** Let's wait just a second while the-- those who want to leave so we can hear. OK. I think we can go ahead. Welcome, Senator Wayne.

**WAYNE:** Good afternoon, Chairman Williams and members of the Banking Committee. My name is Justin Wayne J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, which is north Omaha and northeast Douglas County. LB804 is pretty straightforward. The bill would mandate insurance cover the cost of an EpiPen for those who are under 18. Like the previous bill, this is not a trailblazing legislation. I don't even think this one is controversial. What you'll probably hear for as many insurance companies already do this, but there are some that don't. I think this is a serious enough issue that we should mandate it like other states do. There is some of the-- soaring and pred-- predatory pricing of this product needs to be dealt with and consumers and patients must be protected. In 2007, when Mylan brought-- purchased a device from a competitor, is that a dual injector was about \$94. But since then, again, that's 2007, the cost has since increased 600 percent to a point where two injectors was over \$600. This does not sound right, doesn't sound functional, especially when we're talking about things that our children need all the time if-- if they are required to have it, buy them. It is also important to address that insurance plans don't consider EpiPens a complete necessity or a lifesaving drug. As essentially, this is my belief a lifesaving drug, and that's basically it. I don't have a long opening. I don't have a whole lot of witnesses. These are one of these bills that I really think is simple.

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**WILLIAMS:** Thank you, Senator Wayne. Questions? Senator Wayne, would you like to address the fiscal note?

**WAYNE:** What about it? What do you want me to address, which part of it? Do I think their numbers are a little high? I do, but-- and the reason I think they're high is because I believe right now one of the major providers for the state insurance already covers one. So I was really confused by the fiscal note, but I--

**WILLIAMS:** OK.

**WAYNE:** --I don't have a direct reasoning for it. I have reached out for the-- to the office and haven't-- haven't had a conversation yet with them.

**WILLIAMS:** Any additional questions? Seeing none, will you be staying to close?

**WAYNE:** Sure.

**WILLIAMS:** Thank you.

**WAYNE:** Thank you.

**WILLIAMS:** Invite the first proponent of LB804. Welcome.

**KARLA LESTER:** Thank you. Thank you, Mr. Chairman and members of the committee. I am Dr. Karla Lester. For the record, that's Karla, K-a-r-l-a, Lester, L-e-s-t-e-r. I'm a community pediatrician and mom of three children, two of whom have life-threatening food allergies. I've been an advocate for almost two decades. Lots of-- I'm old. I'm an old pediatrician. So for many years on addressing the issue of life-threatening food allergies in children, I've worked with Lincoln Public Schools to develop a district wide food allergy policy. I've also done a lot of statewide work in advocacy and also within my clinic. And I'm in full support of LB804. As you know, as Senator Wayne just voiced, cost often prohibit access to epinephrine auto-injectors which are often not covered by insurance. In 2016, the American Academy of Pediatrics called for urgent action to reduce the cost burden of epinephrine auto-injectors for children with life-threatening allergies. Unfortunately, even generic epinephrine auto-injectors are still too costly for many Nebraska families. Currently, epinephrine auto-injectors is a two-pack, and I brought my son's, range from \$300 or over \$300 to over \$600 for a two-pack. Children simply won't be able to have their need in medica--

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medications if a family cannot afford them. Anaphylaxis is a rapid and severe allergic reaction. It's also a life-threatening emergency. It includes a wide range of symptoms that can start quickly within seconds to minutes or several hours after exposure to an allergy trigger. Epinephrine is the only lifesaving medication for anaphylaxis due to allergic reactions. Epinephrine-- epinephrine helps to quickly reverse the life-threatening symptoms of anaphylaxis. Children at risk for anaphylaxis should carry at least two auto-injectors with them at all times. So that means that families need at least a couple of two-packs so they can have something up to date at schools, in the childcare centers and after school programs, and then on them at all times as well. All Nebraska youth with life-threatening allergies deserve to be safe and have access to lifesaving epinephrine auto-injectors. So my husband and I are both physicians. We can easily afford EpiPens for our two children. Every time we go, we think of all the families who I take care of, who have reached out to me and who I know either have to go with an expired epinephrine auto-injector or have to go without. Parents should not have to choose between lifesaving medications for their child in providing for their family's basic needs. I support LB804 because it will allow children diagnosed with life-threatening allergies access to lifesaving epinephrine auto-injectors. Thank you.

**WILLIAMS:** Thank you, Dr. Lester. Senator Kolterman.

**KOLTERMAN:** Thank you. Thanks for being here.

**KARLA LESTER:** Sure.

**KOLTERMAN:** There's-- I think in recent months there's been a newer product that's been delivered to the marketplace that's quite a bit less expensive. Are you familiar with that and how effective is it?

**KARLA LESTER:** There have been several different products that have come up. There's like Auvi-Q and then that was recalled. I think that's been put back on the market. Then they've had the generic and the generics have been still too expensive. And I'm not familiar with what the most recent one is and what the cost for that is.

**KOLTERMAN:** OK. Thank you.

**WILLIAMS:** Senator McCollister.

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**McCOLLISTER:** We recently learned about the high cost of insulin. This particular drug has gone up unbelievably high as well.

**KARLA LESTER:** Yes.

**McCOLLISTER:** Is that correct?

**KARLA LESTER:** Yes, uh-huh. And like Senator Wayne referred to, it skyrocketed. It had the-- you know, they had the monopoly on it. And so then that was in 2016 when the AAP came forward and urged urgent action. So then they developed the generics, which are still high priced. So families are still struggling in Nebraska to get those covered.

**McCOLLISTER:** Can you document those cost increases?

**KARLA LESTER:** I can get that information for you, but-- yeah.

**McCOLLISTER:** That would be great. Thank you. Thanks for coming.

**KARLA LESTER:** I just have an example of my son's, Andrew, who's a seventh grader at Lefler Middle School, and our out-of-pocket cost was, I think, \$263 for this one. And then our insurance covered \$112. So that's for one two-pack. So about \$375 total for that EpiPen two-pack. And then, you know, we have two kids. So you think about those families and then they do expire pretty quickly. So, I mean, you're probably looking at that.

**McCOLLISTER:** You must live in District 20.

**KARLA LESTER:** I live in Patty Pansing Brooks's district.

**McCOLLISTER:** Lefler School.

**KARLA LESTER:** Um-hum. Yeah, Lefler.

**McCOLLISTER:** Thank you.

**KARLA LESTER:** Thank you.

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

**KARLA LESTER:** Thank you.

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**WILLIAMS:** Invite the next proponent. Seeing none, is there anyone here to testify in opposition? Welcome back.

**JEFF HUETHER:** Good afternoon, Mr. Chairman, members of the Banking, Commerce and Insurance Committee. If you can't recall how to spell the last name that I-- looks exactly like it sounds. My name is Jeff Huether, J-e-f-f H-u-e-t-h-e-r, director of pharmacy of Blue Cross Blue Shield of Nebraska appearing in opposition LB804. My testimony, very-- will be very brief on this bill. Blue Cross Blue Shield of Nebraska pays for epinephrine whether or not the member is 18 or older. We have no plans to discontinue coverage and we believe our competitor is covered as well. Therefore, we don't believe there's a need for this bill as Nebraskans will continue to have this available to them. With that, I'd be happy to answer any questions.

**WILLIAMS:** Any questions for Mr. Huether? Seeing none, thank you for your testimony.

**JEFF HUETHER:** Thank you.

**WILLIAMS:** Invite the next opponent. Welcome back, Mr. Bell.

**ROBERT BELL:** Thank you, Chairman Williams. Again, my name is Robert Bell. Last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation, the insurance federation and state trade association of insurance companies domiciled and economic presence in Nebraska. We are opposed to LB804 for many of the same reasons you just heard is that we believe all the members cover this coverage already. You know, again, this is-- this is a true mandate in that it's-- it's requiring coverage as opposed to just putting in cost sharing limitations like you heard on the insulin bill, just now. There's a-- there's a slight difference there. And so, and-- and, in fact, the-- the sole proponent on this which was, you know, compelling testimony that these things are very expensive. Again, there was insurance coverage there. It existed and that was-- it was expensive coverage because the-- the pharmaceuticals are, again, very expensive and it sounds like there's again a monopoly. And I don't think anybody-- insurance companies would love to see that reduction in-- in those costs as well. And, you know, when we look at our pharmaceutical companies who provide this and we look at the regulations that apply to insurance companies, the financial solvency regulations, the regulations on how much of a-- of a dollar premium can be used for claims versus administrative costs, these things do not apply to pharmaceutical companies. They have--

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they have other regulation that's out there about when drugs can come on markets, things like that. But it-- it-- it does get, I mean, obviously, our-- our members are frustrated members being the people that hold our policies, that they're frustrated at the costs of things like this and, you know, so are insurance companies. I would point out, I could believe in the fiscal note, it's not so much related to the costs related to the Department of Administrative Services or University of Nebraska. I think that's a reflection that this is a mandate doesn't-- that does not exist in current law. So it triggers portions of the Affordable Care Act related to states having to share the costs related to what the federal government pays for subsidies for individuals that get coverage on the exchange. So anyway with that, thank you.

**WILLIAMS:** Thank you for that explanation. Any questions for Mr. Bell? Seeing none, thank you for your testimony.

**ROBERT BELL:** You're welcome.

**WILLIAMS:** Invite the next opponent. Welcome back, Ms. Nielsen.

**COLEEN NIELSEN:** Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Coleen Nielsen, spelled C-o-l-e-e-n N-i-e-l-s-e-n, and I'm the registered lobbyist for the American Health Insurance Plans, or AHIP, testifying in opposition to LB804. From the proponent's testimony in-- on this bill, it-- it appears that the problem again is the price not set by insurance companies, but by pharmaceutical companies. But AHIP is also opposed to this legislation because it is a true mandate and mandates increase the cost of health-- health insurance premiums especially for small employers and the individual. And mandated benefits do not apply to self-funded, employer-sponsored groups or ERISA plans. And so for these reasons, we respectfully ask this committee not advance the bill, and I'd be happy to answer any questions.

**WILLIAMS:** Thank you, Ms. Nielsen. Questions? Seeing none, thank you for your testimony. Next opponent? Welcome back, Mr. Sedlacek.

**RON SEDLACEK:** Thank you, Chairman Williams and members of the business-- or 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, representing the Nebraska Chamber of Commerce and Industry. What I'd like to do is extend the remarks from the previous bill that was heard-- bills heard today, LB949 and LB970, and in regard to those issues in our

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discussion on-- on mandating benefits, I'd like to incorporate that for the record, at least for this hearing and be respectful of the committee's time. Again, briefly, we are representing a number of consumers of health insurance and we are concerned about affordability and availability of that insurance that is offered to employers-- by employers to their employees, particularly the smaller employers, as well as the self-- the self-employed. And although it appears that there is coverage in this regard, it is a mandate, and we've been trying to be consistent with our-- with our policy and with the Legislature in representing those interests, those consumers who say each and every mandate has a cost. And we just want to keep insurance affordable and available to the work force. And with that, I'll conclude my remarks.

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

**RON SEDLACEK:** Thank you.

**WILLIAMS:** Any additional opponents? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Wayne, while you're coming up to close, we have letters of support from Russell Hopp from Children's Hospital and Medical Center; Todd Hlavaty from the Nebraska Medical Association; Joni Cover from the Nebraska Pharmacists Association; and Andy Hale from the Nebraska Hospital Association. Welcome back, Senator Wayne.

**WAYNE:** So it's just interesting that it's already covered, but we don't want a statute to say keep doing what you're doing. Now normally that doesn't bother me, but the fact of the matter is, is an insurance company can decide to drop their plan, change their plan every October or November you sign up. We don't have bills until January, February. So if they decide not to cover this anymore, there could be thousands of kids without EpiPens because they're doing it now. It makes business sense. Let's be honest, it's business. But what happens if it doesn't become business sense? Are we gonna have 33 people sign up a letter, a special session, making sure we cover kids who are in school with EpiPens, because that's really what we're talking about? Probably not. So the closest we can get a bill done is a six-month, seven-month period. By then, you have our most vulnerable who can't afford it. And really those who are in the gap because if you're on Medicaid, you already got it covered, like four. You get four of them, four to six of them. So we're talking about working families who will lose their coverage. I don't think it's something we can waste our time to figure

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out, let's hope they keep doing it. When, as everybody says, the insurance market keeps shifting, tomorrow they could decide to get out of it and leave thousands of kids uncovered. If they're already doing it, the cost is only beared by us the state dealing with the Affordable Health Care Act because our plans already provide for it. So it shouldn't be any more increase costs to our members who are already a part of the system using Blue Cross Blue Shield or whoever else that the government gives them to or gives the choices to. So I don't think it's really a cost issue. We're not increasing premiums. It's the matter of whether the state wants to kick in \$200,000 over the next year to meet the ADA requirements, but to make sure that they just can't arbitrarily decide in October, we don't want to carry it anymore because that's their right as a business. We heard the last testimony from Senator Bolz, who Blue Cross cut one of their plans and she had to figure out a different option. That's their business model. What-- they wouldn't do it if they didn't make money. What happens if this becomes obsolete and we have to wait six, seven months to cover EpiPens for kids? That just doesn't make sense for us. If they're already doing it, then this bill won't hurt them at all. And with that, I'll answer any questions.

**WILLIAMS:** Thank you, Senator Wayne. Questions for Senator Wayne?  
Seeing no questions,--

**WAYNE:** Thank you.

**WILLIAMS:** --thank you, Senator Wayne. And that will close our public hearing on LB804, and that is the last bill we have scheduled for today. The Banking Committee will be going into a--