**HOWARD:** Welcome to your Health and Human Services Committee. I'm Senator Sara Howard. I represent District 9 in midtown Omaha. Today we'll be continuing our series of briefings with different department heads and agency heads at the Department of Health and Human Services. And today we'll be hearing from Sheri Dawson with the Division of Behavioral Health. Welcome, Sheri.

**SHERI DAWSON:** Great. Thank you, Senator. And thank you to the HHS Committee for taking time. I certainly think that the behavioral health conversation is an important one. We know that we have 1.9 million, approximately, in Nebraska, and one in five individuals have a mental illness or a substance use disorder. So we're talking about 380,000 people in Nebraska that are impacted in varying degrees. And so, you know, if we think about the conversation in healthcare, people that have chronic illness don't pretend generally to not have their chronic illness. But people with mental health and substance use disorder, because there is a stigma still although we've made some strides, are sometimes reluctant to access services. And so these kinds of moments and opportunities help senators and communities really normalize the healthcare conversation about behavioral health. So thank you again for this opportunity. I'm just going to give you an overview, and certainly Senator Howard indicated I'll have questions at the end. So our Division of Behavioral Health is one of five divisions. And you've probably heard with Medicaid they have a federal agency, CMS, that drives a lot of their regulations and so forth. We receive about $11 million for mental health and substance abuse block grant, which are federal funds from SAMHSA, which is the Substance Abuse Mental Health Service Administration [SIC], and we also have about $11.5 million per year in discretionary grants. And our role is to serve as the chief behavioral health authority for the public behavioral health system. We have, for community-based services, about $105 million for both mental health and substance use and prevention and recovery services. And our dollars are intended to serve individuals that typically aren't Medicaid-eligible and don't have insurance, so those folks with pretty limited resources that fall in between. And we do try and make sure that we have prevention, treatment, and recovery, so we have a well-rounded continuum of services. And we work through contracts for services. Most of our funding is through our Regional Behavioral Health Authorities, which I'll talk a little bit more about. And then we also have direct funding, and I gave some examples, such as our four federally recognized tribes. We sponsor the Nebraska Family Helpline, family

organizations, and the rural voucher farmer hotline, as well. We also have Web-based access for services. I think that's one of the challenges that we continue to identify is people say they don't know where to go for services. And so we're continually trying to educate people and provide tools so they can access service. I do like to make the comparison that if you were diagnosed with cancer or heart disease by your primary care physician, you may not know where your oncologist is or where that cardiac doctor is, but you get referred. And so what we want to have happen in the healthcare system is that people that are providing healthcare really understand, for people with limited resources, where those services are. And so we continue to do a lot of education. One of the other responsibilities we have in our division is to do the Mental Health Board commitment training. And so we have a manual that is posted on our Web site, and anybody that becomes a board of, or a member of the Board of Mental Health, they are responsible for getting that training. And then we also do some annual in-person training related to that. I think it's important that, when we talk about behavioral health services, we really talk about recovery for people, both on mental health and substance use. And in order for people to really be successful in recovery, we talk about having four components. We talk about having a home, a place to live. We talk about having, you know, maximizing health, so home and health. And community, being as involved and engaged in the community so they have that community of support helps them be successful. And the last one is purpose. So home, health, community, and purpose. And purpose really speaks to the opportunity to work, the opportunity to be educated, the opportunity to volunteer, just again depending upon. But we'd like to think that people, though they have a mental illness or substance use disorder, can be engaged in work. Our regional system, again because recovery is broad, we have set the regional system up so that we have a youth system, so that there is activities that are happening with our system of care, engagement with schools and with families. We have prevention; we always want to try and get out in front as much as we can for mental health and substance use. Housing, our emergency system network, which means that we have, each of the regions have a network, if you will, of mental health and substance use providers. And then one of the most important, I think, components of our regional system is having a consumer specialist. So each of the regions have a person with lived experience that has experienced the system and is an active part of the regional planning. And in our division, we also have the Office of Consumer Affairs, which are served by people that have experienced the system, and they help engage and have voice from a person that's experienced an illness as

we do service planning. Another opportunity that we have is-- work force is an issue. We're a low-employment state, and work force just in general is a challenge at times, and certainly folks in behavioral health are going into behavioral health. And so we try to really grow the existing work force, community capacity, and understanding of mental illness and substance use disorders. We have the emergency and Mental Health Board commitment system. We have crisis response teams for both adult and youth. And I just kind of gave a snapshot of trying to coordinate the system and the number of partners that we have in this system, in terms of contracts and, and coordination. On the next slide, I have a map of the Regional Behavioral Health Authorities because they receive a majority of our community-based funding. They are established in Statute 71-807. Each region is governed by a regional governing board which is made up of a county commissioner in each of the counties in the region. And the regional governing board is actually the body that hires, for example, the regional administrators, makes approval and decisions on the regional budget planning and those kinds of things. Our contract is actually with the regional governing board, and the governing board chair signs those contracts. In each county, in statute, there is a match requirement, and so for every three general fund dollars, the counties provide a dollar. The last thing I would say is that, in addition to the very detailed contract that we have with each of the Regional Behavioral Health Authorities, but the contract components and expectations are the same across; the dollar amounts vary. We're also governed by Title 206, which is our rules and regulations that we have for our division. And the funding allocation for those regions is based on a formula that involves both census and poverty level. Eligibility for our services is based on income and family size. So sometimes people refer to those services as a sliding scale, so it depends on where you fit with that income and family size. And then we also have clinical authorization, if you will, so those higher levels of care-- hospital and residential services-- in our centralized data system there is the algorithm that looks at the authorization and continued stay for those services, and others can just be registered, in other words, the comers. We still want data so we can look at outcomes. I mentioned our federal block grants earlier, and just of interest is the target populations that the federal SAMHSA identifies individuals with substance use disorders, severe and persistent mental illness, serious mental illness for youth, serious emotional disturbances. And then, in terms of priority populations, it's important because of the health risk that we prioritize those four that are on there over other people. For example, a person that, a woman that's pregnant and

injecting-- drug user-- has some significant challenges and we want that access to service perhaps before somebody that isn't in those priorities. Let's see here. One of the things I wanted to highlight-- in our system we talk about the amount of opportunity and work we have with stigma and just the work we have to do to coordinate the system amongst payers. But we really do want to build on our strengths, and so what I'm sharing with you is accomplishments. That's not just for the Division of Behavioral Health and our team in Behavioral Health, but really the great partners and providers that we have across Nebraska. We have had a strategic plan since 2011. We did pretty detailed needs assessment through the University of Nebraska Medical Center in 2016. So we're operating from the 2017-2020 strategic plan and proud to say that we have accomplished not all, but 87 percent of the activities and strategies are on track or completed to continue to move our system forward. U.S. News and World Report in 2018-- best studies. There was a number of different indicators. Mental health was one of them, and Nebraska was ranked number five. Our division has-- we serve 32,000 individuals a year, and we serve 2,400 more individuals than we had the previous year. On the annual Behavioral Health Consumer Survey, 87.8 said they would recommend the service to another friend or family, 86 percent were generally satisfied, and 80 percent said that the service improved their quality of life. Individuals with mental illness are employed at a higher level than the national average. And again, I think that's really important that we, at that first conversation with people that are newly diagnosed, is not to go down to the Social Security and apply for disability, but really explore that opportunity of their strengths and the ability for the person to work. Nebraska received a B4Stage4 Leadership Award related to the children's System of Care and the crisis response services. We're seeing some good initial outcomes in that. About 77 percent of the young people are able to remain in their home and get connected to services. We also developed a behavioral health resource for schools in collaboration with the Nebraska Department of Education. I actually had a number of times where I went to talk with school nurses, and one of the things that nurses don't always have is behavioral health training in general. And so for them to have the opportunity to learn not only about how to access service, but understand that if you take first aid and you take CPR, you should be taking mental health first aid and you should be taking QPR, which is a question, persuade, refer. I did a kind of starting-off exercise with the school nurses, and I asked them if they had a student that came to their office and it was their first day back from hospitalization for being newly diagnosed as diabetic, and how they

were comfortable with interacting with that student and developing a plan. And everybody-- there was over 200-- 230 nurses could raise their hand. And then I asked if you had a student that had lost a parent traumatically, suddenly, how many would be prepared and feel comfortable again in dealing with that young person and having a plan? And it was less than half of the room. And then I said, so how many of you, if you had a young person that came back from a psychiatric admission or out of substance-use treatment, would feel comfortable in knowing how to help that young student be successful? And again, there was about 230 people and probably six of those nurses raised their hand. And so the resource guide that we provided is for schools, whether you're a nurse, a counselor, just working in school to be really able to find out where you can access services, different screening tools, and really, again, to, to make that connection from a healthcare standpoint. We also have a federal grant that Nebraska Department of Education received, but the partnership needed to be with SAMHSA single state authority, which is us. And so we have three sites in Project AWARE-- Chadron, Hastings, and South Sioux City-- that are involved in this grant, and it's mental health in school. And we're really excited about the opportunity to see what those three sites do, and help us connect, and have lessons learned that we can use across the state. Let's see here. I talked a little bit about mental health first aid. We have over 58 trainers across the state, and it's not just through the regions and Behavioral Health. We've had local health departments and other partners be trained. Mental health first aid and, really, question, persuade, refer can save a life, just like CPR and first aid. And so we're excited about the continued growth. And 48 percent of the people trained have been in rural Nebraska. We think that's important that we, we reach across the state. Binge drinking is still higher than the national average, but over time we're seeing a nice decrease. But we still have lots of work to do, especially with 18- to 25-year-olds, which is that college age, so we still have some, some work going on. Housing related assistance-- we serve over 900 individuals a year. Every time somebody buys a house in Nebraska-- so we like when the market is good-- there's 30 cents from that stamp tax that comes into the Housing Related Assistance fund. And so we're able to serve individuals in transitional housing where they have a voucher-- it's up to $6,000 a year-- to help them get set up. And again, remember that home is part of that opportunity for recovery. In Synar compliance checks, that's really looking at a partnership. There's a variety of partners in the state. We receive federal funds to really look at the sale of tobacco to young people. And there's a retailer violation rate which, at the

national standard, is it needs to be below 20 percent. And Nebraska is at 9.6 percent, so our retailers are doing a pretty nice job. Peer support-- that is service as well as we have a certification process, and that's changing over this next year. So we're excited about that. Peer support is really for people that have that lived experience with mental illness or substance use and they bring value to others that are maybe at a different place in their healthcare journey. I'm just highlighting the $2 million opioid grants. There's a lot in the news about opioids and there's some great work going on in Nebraska, but I want you to have context. Alcohol is still number one in Nebraska. Methamphetamine is number two. Marijuana is number three. Cocaine is number four. And opioids are number five. And so, while we appreciate the attention and the opportunity to make a difference here in Nebraska related to opioids, we still have to focus on the other drugs of use. I wanted to highlight just a few things that we've accomplished through some of the federal dollars that, in grants have been focused on opioids. There's an awareness campaign, and some of you may have seen some of that if you go to a movie and see the "Dose of Reality," the little 30-second snippet. The impact-- there's been 3.5 million views from that media. There's been 125,000 individuals that have received opioid prevention education, 1,332 pounds of medication in Drug Take-Back Days, 2,200 prescription lockboxes, about 900 Naloxone distribution kits. And we're also training the existing work force through Project ECHO to learn more about pain management and substance use disorders. Lastly, I have mentioned here that we have, under the Division of Behavioral Health, the regional centers internal to DHHS. All the facilities are organized under Mark LaBouchardiere, who is the DHHS facilities director. For just perspective, the regional centers, which are listed below, their budget is about $67 million. And there's a regional center in Hastings that serves up to 24 young men with substance use or co-occurring disorders. It is a psychiatric residential treatment facility by Medicaid standards. Lincoln Regional Center: general psych beds, forensic beds, also serves individuals there for sex offenses and psychiatric transition. Also here in Lincoln there's 16 beds at the Whitehall campus which are for males who have sexually harmed adolescents, and that is also a PRTF. And then in Norfolk, up to 96 beds for individuals there that usually come from Corrections and are committed under LB1199, and are there for the first phase of their sex offender services. So again I want to-- perfect timing, it's the red light-- thank you for this opportunity, and happy to answer questions.

**HOWARD:** Thank you so much. Are there questions. Senator Cavanaugh.

**CAVANAUGH:** Thank you. You just, at the end here, mentioned the, the various beds, and I was reading: the 16 beds at the Whitehall campus for adolescent males who sexually harm. So it's for, it's for adolescents.

**SHERI DAWSON:** Correct.

**CAVANAUGH:** OK.

**SHERI DAWSON:** Correct.

**CAVANAUGH:** I wasn't sure. So is that a juvenile-- could you tell me more about Whitehall? I don't know the Whitehall campus area.

**SHERI DAWSON:** Sure. So it's a psychiatric residential treatment facility, so it falls under the treatment guidance of Medicaid. And it is specifically for young men that have been adjudicated and have sexually harmed another person.

**CAVANAUGH:** OK.

**SHERI DAWSON:** Most of those young men have experienced the trauma and experienced that in their younger life, as well. It is the only level of PRTF for juveniles that sexually harm in the state.

**CAVANAUGH:** And those children don't have to be from Lincoln. Do they come from across the state?

**SHERI DAWSON:** Correct.

**CAVANAUGH:** OK.

**SHERI DAWSON:** Um-hum.

**CAVANAUGH:** Thank you.

**SHERI DAWSON:** Um-hum.

**HOWARD:** Other questions? Senator Walz.

**WALZ:** A couple questions. Thanks for coming today. I'm excited about that grant that was received. The Department of Education applied for the grant and received the grant?

**SHERI DAWSON:** Yes, and they had to-- the condition of Project AWARE, because it touches on mental health, had to be with the state mental health authority.

**WALZ:** Um-hum, um-hum. How, how's that going to be used?

**SHERI DAWSON:** I will have to get back to you, Senator Walz, on all the specifics, but certainly some of them have engaged education and training for their teams. They've engaged connections, providers. And having to have that actual happening in their school, it's going to look different in Chadron, in that it is in Hastings, that it is in South Sioux City. But I'll get that update as to where they are. I know they were even still working on hiring like a coordinator for the grant, together with NDE.

**WALZ:** All right, thank you.

**SHERI DAWSON:** But I can get back to you.

**WALZ:** Thanks.

**HOWARD:** Other questions? Senator Williams.

**WILLIAMS:** Thanks, Senator Howard. And thanks, Sheri, for being here today.

**SHERI DAWSON:** Um-hum.

**WILLIAMS:** You mentioned, in your opening remarks, the reluctance to seek service sometime. What are we doing to try to break down that barrier? And does that barrier exist the same in rural areas as it does in urban areas?

**SHERI DAWSON:** Well, there's a, there's a few things just nationally in terms of access. On our needs assessment in 2016, of the people-- if you look at that big prevalence number that I gave you, that 380,000-- on the mental health side, only about 40 percent of those people actually access treatment. And on the substance use, it's pretty sparse. It's 16 percent, and that's typically nationally. And so part of the work that we have to do is to get that access out there. I have gotten calls from practitioners that say there's no services; I'm really frustrated. And so I may say, you know, where are the, where do you, where are you located? And they may have services in the area but, again, they didn't know and they didn't know if the person that was providing that service might take Medicaid or, you know, the

region funding versus private insurance. So we have the network of care, which is that Web-based access that people can look. If you're just, you know, again in your own home trying to find, you can click on the county where you live. And you know, resources will be there. We have the Nebraska Family Helpline, and we try to advertise that, if you want anything from just a parenting question all the way up to how do I access service, that that Nebraska Family Helpline is an opportunity to also get connected. We also are really pushing the regional behavioral health contacts like in our school resource guide on the Web site, so that people could just call the Region 2 and be, be connected. But we have to continue to do and train the existing healthcare work force so that they know where that is because, like I said, if it was cancer, you may not know only what your primary care doctor may tell you-- I'm recommending you go here-- and we need to make that connection a regular part of healthcare for mental health.

**WILLIAMS:** Thank you.

**SHERI DAWSON:** Um-hum.

**HOWARD:** Any other questions? I just have one. Would you care to comment on any impacts that you see from, from Medicaid expansion, because we know that this population is one that you're most likely already serving through the regions and for some of your other grants. How do you, how do you see that population's continuum of care shifting or changing?

**SHERI DAWSON:** Um-hum. Well, I think there's going to be a lot of moving parts so-- because Medicaid in our regions provide a similar set of services, right? But as some become Medicaid eligible, they will then be served or paid by Medicaid instead of the region. But what we know in looking at other states is there's still a lot of churn, and that eligibility may vary, you know, income changes, seasonal work, they've been at a provider, they're not paying, their healthcare premiums lapse. So there's a lot of churn between those populations, and so we're still-- and my colleagues in other states-- you're still going to serve a significant number of people. And keep in mind that we also provide those things that Medicaid doesn't pay for right now. So that's, you know, the housing and the prevention and those kinds of systems aren't, you know, currently funded by Medicaid. And so we're-- and the emergency system and the commitment. So we're still going to, you know, need to provide those kinds of services, regardless.

**HOWARD:** Thank you.

**SHERI DAWSON:** Um-hum.

**HOWARD:** And I know we've heard before that the EPC issue is, is an incredibly important issue. And you mentioned that you do the Mental Health Board commitment trainings. Have you seen any trends in regards to where emergency protective custody is, that you would care to comment on with the committee?

**SHERI DAWSON:** Sure. So in Nebraska I think the work with law enforcement and our regional emergency system coordinators and other community partners is, does, does work really, really well. Over time, if you look at a trend, we will see a decrease in our emergency protective custodies. One of the things that we're tracking is those individuals that might have repeat EPCs, so that we can know who those people are and get connected with our emergency system coordinators, our service providers, and what's working or what's not working for this individual that we have to have a repeat. There's training that goes on with law enforcement, so-- and the percentage, I can't give that to you right off the top of my head, but the number of EPCs, compared to those that actually get committed, is quite low. You know we're talking some thousands in the EPCs and, really, hundreds that actually have the Mental Health Board commitment.

**HOWARD:** That's wonderful. All right, any final questions? Thank you so much for visiting with us today.

**SHERI DAWSON:** OK. Thank you for the opportunity.

**HOWARD:** We really appreciate it. All right. This will conclude the briefing for the Division of Behavioral Health. Sherry, when you're ready-- all right. Good afternoon, and welcome to the Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as chair of the Health and Human Services Committee. I'd like to invite members of the Committee to introduce themselves, starting on my right with Senator Murman.

**MURMAN:** I'm Senator Dave Murman from District 38: Clay, Webster, Nuckolls, Franklin, Phelps, Kearney, and part of Buffalo County.

**WALZ:** Lynne Walz, District 15: Dodge County.

**ARCH:** John Arch, District 14. Papillion, La Vista-- Sarpy County.

**WILLIAMS:** Matt Williams, District 36: Gothenburg and Dawson County, Custer County, and the north portion of Buffalo Counties.

**CAVANAUGH:** Machaela Cavanaugh, District 6: west-central Omaha, Douglas County.

**HOWARD:** And we are joined by our legal counsel, Jennifer Carter, and our committee clerk, Sherry Shaffer, and our committee pages, Maddy and Erika. Thank you. A few notes about our policies and procedures. We ask that you turn off or silence your cell phones. This afternoon we'll be hearing three bills and we'll be taking them in the order on the, listed on the agenda outside the room. On each of the tables near the doors to the hearing room you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearings. If you are not testifying at the microphone but want to go on record as having a position on the bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note, if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m., on the day prior to the hearing. Any handouts submitted by the testifiers will also be included as part of the record. We would ask that, if you do have hand handouts, please bring ten copies and give them to the page. We also ask that you try to collate them if you have multiple handouts; that would be very helpful. We do use a light system in the Health and Human Services Committee. Each testifier has five minutes: that's four minutes on green, one minute on yellow and, when it's red, we will ask you to wrap up your thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening, we'll hear from supporters, opponents, and anyone wishing to testify in a neutral capacity. Then the introducer of the bill will be given an opportunity to make closing statements, if they wish to do so. We have a strict no-prop policy in this committee. And with that, we will begin today's hearing with LB556, and I will hand it over to my Vice Chair, Senator Arch.

**ARCH:** Thank you. Welcome, Senator Howard, to the Health and Human Services Committee today.

**HOWARD:** Thank you, Senator Arch.

**ARCH:** You may begin.

**HOWARD:** Good afternoon, Vice Chairperson Arch and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I'm presenting to you LB556, a bill that changes provisions relating to data, interstate sharing, and other general clean-up language within our Prescription Drug Monitoring Program statutes. Before we talk about the bill, I always sort of, I try to give you some context as to why this is important to my family. So--Jeez Louise-- whole day I was totally fine. OK. So ten years ago in March my sister passed away. She had been in a series of car accidents; she wasn't actually a particularly good driver. And she really enjoyed singing along to music and so she would get into these accidents. They would be like fender benders. And from those accidents she actually ended up getting whiplash, which led to a lot of back pain. And the doctors couldn't figure it out. She was really young, and she was too young to be having the kind of back pain that she was having. She was in her 20s. And they finally suggested that she have a spinal fusion. They thought this would be the only thing that could fix what had happened with her. And so they took her in for a spinal fusion. It was the year I graduated from college. And she was given morphine in the hospital and then, when she left, she was given this enormous bottle of OxyContin. And my mom and I talk about it because we feel like that's the moment when-- that was the moment when we knew that we lost her, when she was absolutely gone. We went through rehab. She would get better; things would get worse. And then when we finally lost her, she had gone in for some oral surgery for like her teeth were bothering her. And she had been clean for a while, and then the dentist sent her home with more OxyContin. And she thought, because the doctor had given it to her, that she should take it. And five months later she was gone. It went so fast, and even now I think about if we could have done something differently, if we had known more about what this was. So in 2011, when my mom was serving, she passed the first Prescription Drug Monitoring Program in the state. It might have been one of the first in the country. It was before anybody was talking about opioids, before presidents were making them part of their platforms. And so she actually had to put in a prohibition on receiving any state funds for

the PDMP. And so in 2014, Senator Lathrop actually removed that prohibition. And so we kept building. But there were a couple things that my mom did that were really smart. She embedded our Prescription Drug Monitoring Program into a broader system called the Health Information Exchange where, if we think about where we're at in 2019, imagine 2011. We're talking about a time where not all providers were using computers. And it was, it was revolutionary for us to think about an electronic health record highway like the Health Information Exchange. For years I did not want to talk about Carrie on the floor. And then when Senator Lathrop left, he was like, you have to, you have to deal with this because there's a lot more for us to do. And so in 2015, I passed a comprehensive change to our Prescription Drug Monitoring Program. We addressed all of the issues that my mom didn't know were going to come up. These were things like allowing somebody to opt out, right? A drug seeker would absolutely say, I don't want to be in the Prescription Drug Monitoring Program because you'll figure out that I'm a drug seeker. And she had included a provision that the Prescription Drug Monitoring Program captured all prescriptions, not just narcotics, which was revolutionary and remains so, but provide, gives our providers the ability to do medication management and therapies, and talk to patients about how their medications interact in a way that is completely unique to our state, which is wonderful. We started picking up cash-pay prescriptions and, essentially, our PDMP is, is completely fueled by our pharmacies. So everything that is dispensed in this state goes into our Prescription Drug Monitoring Program, which is embedded into our Health Information Exchange. What we want and what I think-- the reasons why we've been so successful is that we have always looked at this program and at this work as though opioid addiction is an illness. And if providers have more information, then they will, they will be able to help their patients in a more effective way. We have never looked at it as though it was a criminal act. Carrie was sick; she wasn't a criminal. So we've been working on this but, as you'll find, anytime you take on something like this, your work is almost never done, right? Technology is changing, there's more to do. And so this year we've got-- this bill is a clean-up bill. So we're cleaning up some of the language within the PDMP. But there are also some really important things that I want to make sure the committee understands that we're doing. One of the challenges when-- so say, OK. So for instance, my father-in-law has been kind of sick. We moved him into a nursing home. He keeps getting these incredible nosebleeds. And we had to take him to the Med Center, to the ER. And they said, well, what meds is he on? We've just taken him from the nursing home because he had this nosebleed. And we said,

oh, we don't have a med list for him. He's on a statin. He takes Melatonin at night. Like this was not very helpful. And I said, would you mind terribly checking NeHII and checking the PDMP to see what meds he's on? And they said, absolutely, no problem. But what this bill allows them to do is actually allows the PDMP data to dump directly into the electronic health record. So instead of the physicians saying-- or the nurse most likely-- looking at their electronic health record and then looking at a separate screen, they'll be able to interface directly, which is really exciting. The other thing that's really important is a lot of states-- well OK. Every state but Missouri has a prescription drug monitoring program, and they're most effective when we allow them to talk to each other so that people aren't crossing state lines and picking up a medication in Iowa and then running over to Nebraska. And so this allows for that interstate operability, which I think will be incredibly critical, not just as the state of Nebraska fights opioid overdose deaths and opioid addiction, but also as the entire country tries to fight it. So this allows for our PDMP to state, to share with other states. You have a white copy amendment, or you will have a white copy amendment, because, as you know, when new things come up to you, there are, there are new issues. One of the things that I would like to consider, the committee to consider and think about for next year is I don't think that we should be, we should keep coming back and revising our statutes for things that I think should be in policies for NeHII. And so one of the conversations that I think we should start having is, is allowing there to be an advisory board to start building these policies, kind of take some of the need to be constantly revising these statutes out of our hands and put them in the hands of the people who really understand the technology, who really understand the providers. We did have one issue that we will try to figure out if it comes up in the hearing. Right now it has an emergency clause. This emergency clause helps us align with some of our CMS expectations, in terms of interstate operability. And so I know there are some providers who are worried that, with an emergency clause, they won't be able to meet some of the newer requirements, including some of the personal data for the prescribers when things are dispensed. But I know that NeHII will work with them to find a time line that, that is most effective for them. So with that, I'm happy to try to answer any questions you have. I know that's a broad-strokes explanation of how this bill came about and what's in it, but I'm really happy to try to answer any questions.

**ARCH:** Any questions? Senator Cavanaugh.

**CAVANAUGH:** Thank you, Vice Chairman. Thank you, Senator Howard. First, thank you for sharing Carrie's story. I know, knew her, as well, and I would just like to say I think it'd be fun to celebrate "Galentine's Day" with her. But also, thank you for bringing this really important legislation over the years, and to your mom, as well. This is something that is hugely problematic in this country and, having been through multiple procedures myself, I've been prescribed a lot of things. And it is actually because of Carrie, and because of that you've shared that story with me, that I've been proactive in my life in asking the pharmacy for those bags that you can ship those things back when you don't need them. And that's such an important thing that has been accomplished that people don't know about. So thank you for doing that. I do actually have a question. So when I go to the doctor's office with my kids, which is an extraordinarily frequent, they're always asking me-- the nurse always asks me at the intake about drugs, medications, etcetera. And I might forget which kid gets what drug, when or whatever. So they're always pulling it up in the system, which is great and makes me feel like everything is taken care of. But they do have to kind of draw from like this is what we have in our system. So this is, in my understanding of what you said, this would be making it easier for that conversation to happen so that, when you have aging parents or small children that are on multiple medications. Is that correct?

**HOWARD:** That's absolutely correct. And it should also make it easier for that provider. So when you're, when you say, oh, I don't remember what they're taking and what they're on, they have to actually go into a separate screen in a separate system. So if we allow the, the NeHII PDMP to interface directly with the EHR, they can, they should be able to see them in very close to real time with dispensing. The directions-- that's an interesting issue because that is something that was in the green copy, so we had asked for the directions on the medications, as available. And the Pharmacy Association asked for that to be removed, and so we have removed it. But it is a broader conversation. How do we-- it's not just about what meds are dispensed, but how are you taking them? And so thank you for asking that question.

**CAVANAUGH:** Yeah, thank you.

**ARCH:** Senator Williams.

**WILLIAMS:** Thank you, Senator Arch. And thank you, Senator Howard. And thank you for your continued passion on this issue. I would like to have you make some comment about the fiscal note and the federal grant and that process with the grant that's terminating, I think, or running out, and then the likelihood of receiving the additional grant money to continue the process.

**HOWARD:** Absolutely. And I, and I may defer that question to the department because they are the agency that--

**WILLIAMS:** That'd be fine.

**HOWARD:** --is focused on that grant. But I will say when we were first starting this process, it was one of the first years that they had released those grants. And so we were sort of an early, early adopter of these PDMP enhancement grants. And so some of the indications that I've seen are that we will be able to continue receiving these funds. That doesn't mean that we shouldn't try to find a source of revenue to pay for the PDMP for its continued-- to ensure that it will be sustainable long term. And I, and I've persistently said, do we look at a dollar on provider rates, for providers who are able to look at, use, utilize the PDMP? Do we look at some other type of assessment or something creative like that? But I will let Director Dawson speak to the grants in particular. And if she forgets, we also got an extra grant that pays for autopsies so that we can actually know how, how many people are actually dying of overdose. So sometimes a person will die but the county doesn't have enough money to perform an autopsy. So this will help us really understand our rate of overdose deaths.

**WILLIAMS:** Thank you.

**HOWARD:** Thank you.

**ARCH:** Other questions? I just have one. The, the, this bill deals only with the PDMP, not NeHII. Is that correct?

**HOWARD:** Not NeHII. Well, so the PDMP is housed within NeHII.

**ARCH:** Right.

**HOWARD:** And so I think it is confusing because we tend to, I tend to use them interchangeably because the PDMP lives inside of--

**ARCH:** HIE.

**HOWARD:** --the HIE. And I want it to be as seamless as possible for providers. But yes, this deals specifically with the Prescription Drug Monitoring Program--

**ARCH:** OK.

**HOWARD:** --under DrFirst, housed within NeHII.

**ARCH:** NeHII-- that piece of it has a voluntary aspect to it. PDMP-- mandatory?

**HOWARD:** PDMP is not mandatory, but the access is free to all, all, all prescribers and dispensers, as well as members of the medical team; it is free for them to look at. NeHII, on the other hand--

**ARCH:** Right.

**HOWARD:** --is not free.

**ARCH:** Right, OK.

**HOWARD:** That was part of the grant. The grant really helps to make sure that it's free for everybody, which makes a huge difference.

**ARCH:** Good, yeah. Yeah, OK. Thank you very much.

**HOWARD:** Thank you.

**ARCH:** We'll now begin with proponents for this bill. Welcome.

**KEVIN BORCHER:** Good afternoon, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Kevin Borcher, K-e-v-i-n B-o-r-c-h-e-r, and I'm testifying in support of LB556 today. Although I'm a member of the Nebraska Board of Health, I'm testifying here today as the Prescription Drug Monitoring Program director at the Nebraska Health Information Initiative, or NeHII. Thanks to the hard work of Senator Howard and the Health and Human Services Committee, the Prescription Drug Monitoring Program, or PDMP, was greatly enhanced in January of 2017 with the passage of LB471 in 2016. The bill required dispensers, such as Nebraska pharmacies, as well as outstate pharmacies with a mail service pharmacy permit, to report all dispensed controlled-substance prescriptions on a daily basis. This allows authorized prescribers, pharmacists, and their authorized designees to query the PDMP, at no cost, to view all opioid and other controlled-substance prescriptions that have been dispensed in order

to help prevent opioid misuse or abuse. In 2017, the PDMP collected approximately 3.9 million unique prescription records. LB471 was a major achievement for Nebraska and quickly became a shining example for other states as being the first state to require pharmacies to report all dispensed prescriptions, not just controlled substances. This allows providers to review a patient's entire dispensed prescription history to make better informed decisions for the care and treatment of their patients. In 2018, the PDMP collected over 31 million unique prescription records, or over eight times the volume of prescriptions compared to 2017. Since then Nebraska's PDMP has gained national attention, with several other states inquiring and expressing interest in Nebraska's success with the reporting of all prescriptions. LB556 helps to align the Nebraska PDMP with federal policy and increases the capabilities of the PDMP to make it even more effective and efficient in three main ways: one, while we were the first state to require reporting of all dispensed prescriptions, Nebraska is, unfortunately, one of the last states that does not participate in the interstate data sharing of PDMP information. This bill allows Nebraska to share PDMP data with other states for those patients who may cross state borders to have prescriptions filled. For our residents who work in neighboring states, and for those workers employed in Nebraska who come from just across our state borders in Iowa, Missouri, South Dakota, and Colorado, this data sharing component becomes so crucial to the continued success of the PDMP. Number two, LB556 allows for the PDMP information to be integrated into the clinicians' workflow in their electronic health record or pharmacy dispensing software system. This is meant to reduce the burden and improve the clinical workflow for providers. This will become increasingly important for providers who, beginning in 2020, will be required by CMS to check the PDMP for Medicare patients and, in 2021, for Medicaid patients. The third point is that LB556 includes adding some additional data fields such as telephone number, if it's available, and a patient identifier such as a driver's license or other form of identification. This provision will help improve the patient-searching capabilities for the interstate data sharing and the workflow integration of the PDMP, as well as enhance patient-matching capabilities for providers to have a more complete and accurate information. I thank you for allowing me to speak today. I am honored and fortunate to be Nebraska's Prescription Drug Monitoring Program director and, in keeping with Nebraska's name and reputation, noticed across the country. With your help we can continue to build on the

strong foundation the Nebraska Legislature has created for the PDMP. With that, I would be willing to answer any questions you may have.

**ARCH:** Questions.

**WILLIAMS:** Thank you, Senator Arch.

**ARCH:** Senator Williams.

**WILLIAMS:** And thank you for being here. Just a quick question so I'm, I'm sure that I understand the interstate data sharing. Are our people today able to access the PDMP directories in other states?

**KEVIN BORCHER:** Currently they are not able to access that.

**WILLIAMS:** And they're not able to access ours either?

**KEVIN BORCHER:** That's correct.

**WILLIAMS:** So this bill would at least open it up so they can access ours.

**KEVIN BORCHER:** That's correct. With this bill, Nebraska could query any other state and, vice versa, other states could query Nebraska for some of the [INAUDIBLE].

**WILLIAMS:** So it opens it up both ways.

**KEVIN BORCHER:** That's correct, Senator.

**WILLIAMS:** That answers my question; thank you.

**ARCH:** Other questions. Senator Hansen.

**B. HANSEN:** So I'm trying to think of this from a clinician's standpoint. Will this affect like the everyday workflow of a clinician? Will this hinder them in any well, in any way, trying to check some of this information? Is it fair, do they need more software to check this kind of stuff? Like even like a, like a small clinic by themselves, do they have to, do they have to buy, spend thousands of dollars get more software? Or is this, so is this going to be accessible easily?

**KEVIN BORCHER:** What we're anticipating is, with the passage of this bill, the clinician could use their existing electronic health record software or, for pharmacies, their pharmacy software, and just with a

couple of clicks-- and we're hoping to get that down to a minimal number of clicks because every click a provider has to make is a waste of their time. I've been read into that so well. And so the goal is to reduce the amount of burden on the provider.

**B. HANSEN:** Good. All right, 'cause I'm-- you know, I deal with federal and state. State's a lot easier than federal. Federal just takes forever, it seems like, so good. Thank you; appreciate that.

**KEVIN BORCHER:** Thank you.

**ARCH:** Other questions? I have a couple.

**KEVIN BORCHER:** Yes, sir.

**ARCH:** So your testimony says LB550, LB556 allows the information to be integrated. So the building of the interfaces would be at the cost of the provider--

**KEVIN BORCHER:** The interfaces--

**ARCH:** --if there's a cost.

**KEVIN BORCHER:** And at this point, there would be a cost on the PDMP side, which will be funded through grants-- federal funding. And the interstate data sharing should be at no additional cost.

**ARCH:** OK. As you know, there's a wide variety of EMRs out there that, that would need to be interfaced with the PDMP. Or does it go through the electronic prescription, the prescribing module?

**KEVIN BORCHER:** This would most likely go directly through the electronic health record of the facilities. On the PDMP side, there's no cost. There, we're unsure of what the cost may be on the hospital side or the HR side.

**ARCH:** But, but it allows. So that could still go to the PDMP and look up. They don't have to integrate with their EMR.

**KEVIN BORCHER:** That's correct, Senator.

**ARCH:** OK. All right. And then, if they integrate with the EMR, what, what's the patient identifier that links the two systems, the PDMP and the EMR?

**KEVIN BORCHER:** That's one of the challenges across the country with every PDMP. Unlike electronic health records where you may have a vast amount of data on that patient-- Social Security number, their insurance card information-- and that can that can all be matched together, with PDMPs It comes from pharmacies, and they have a much more limited amount of data. It may be patient name, address, date of birth. And so it's not as vast. And so with getting more data, we can use that to better identify the different patients. If, if one patient moves to an address, those are two distinct patients in that PDMP. Maybe one pharmacy lists a patient's name as John, J-o-h-n, another may do it as John, J-o-n.

**ARCH:** Right.

**KEVIN BORCHER:** And so we need a way to match those patients together so they're a single person. And these identifiers will help to accommodate that.

**ARCH:** I would think as well, one of the challenges would be that, with the, with the PDMP being fed by pharmacies, sometimes the active prescription list on, on the physicians' side, may not match up.

**KEVIN BORCHER:** That is a possibility.

**ARCH:** They'll know, they'll know what they prescribe, but they will not necessarily know what somebody else prescribes, and it may not be on their list because the patient didn't tell them.

**KEVIN BORCHER:** That is correct, and that's the importance of the PDMP. With Nebraska having the most comprehensive medication history in the country, we can identify all prescriptions, not just from a single EHR or a provider, but from anyone who has had a prescription dispensed in Nebraska or from mail service pharmacy permit holders dispensing into Nebraska.

**ARCH:** Right. Whether they're continuing to take the medication or not is another question, but at least it would be on the list of having been, having been prescribed and actually picked up?

**KEVIN BORCHER:** This would primarily be for those prescriptions that have been dispensed.

**ARCH:** Dispensed.

**KEVIN BORCHER:** Meaning they were prepared from the pharmacy. And then there's additional data fields that may show if it was picked up and when it was picked up.

**ARCH:** OK, all right. Thank you.

**KEVIN BORCHER:** Thank you, Senator.

**ARCH:** Seeing no other questions--

**B. HANSEN:** Can I, can I have one more question?

**KEVIN BORCHER:** Senator Hansen.

**ARCH:** Oh. Senator Hansen.

**B. HANSEN:** I'm sorry, I'm sorry if this is going to be a [INAUDIBLE] question.

**ARCH:** That's all right.

**ARCH:** So how does, how does this work like with law enforcement?

**KEVIN BORCHER:** Law enforcement does not have access to the PDMP.

**B. HANSEN:** OK. That's what I was wondering. OK, thank you.

**KEVIN BORCHER:** Thank you.

**ARCH:** OK, thank you very much.

**KEVIN BORCHER:** Thank you.

**ARCH:** Other proponents. Welcome.

**MICHAEL WHITE:** Thank you. Good afternoon. Thank you, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Michael White, M-i-c-h-a-e-l W-h-i-t-e, and I currently serve as the chief academic officer for CHI Health and current chair of the board for the Nebraska Health Information Initiative, commonly referred as NeHII. CHI Health is a regional health network consisting of 14 hospitals, two stand-alone behavioral health facilities, a freestanding emergency department, 136 employed physician practice locations, and more than 11,000 employees in Nebraska and southwest Iowa, serving communities from Corning, Iowa, to Kearney, Nebraska. And an, and NeHII is a 501(c)(3) nonprofit organization that serves as

a statewide health information exchange designed to share clinical and administrative data among providers in Nebraska and neighboring states, while protecting the security and privacy of medical information. My testimony this afternoon is in support of LB556, on behalf of both CHI Health and NeHII. And I want to thank Senator Howard for the bill's introduction and for her work on the issue of prescription drug abuse and prescription drug monitoring programs in general. Several months ago we participated in a large collaborative effort between interested stakeholders and Senator Howard to discuss the Prescription Drug Monitoring Programs, the sharing of prescription data across state lines, and Nebraska's eligibility for federal funding to fight the opioid addiction epidemic. Additionally, we discussed implementation concerns with last year's successful opioid prescription restrictions. I am pleased to see that all of these issues are getting positively addressed today in the context of LB556, as well as LB557, introduced by Senator Lindstrom, which we also support. Nebraska's Prescription Drug Monitoring Program has continued to evolve and improve since it was first established in 2016, making the state of Nebraska a leader among the states, with respect to improving patient safety. Federal guidance on opioids and PDMPs are ever changing. However, there is a need to revise parts of Nebraska's statute to address interpretations of current law prohibiting the alignment with federal guidance of interstate data sharing. The most urgent need, which LB556 addresses, is the ability to share data with other states and integrate the PDMP into our clinicians' workflow. This requires data to be incorporated into electronic health records and shared across state boundaries to facilitate an integrate, interstate data sharing model. In doing so, Nebraska would be eligible for federal funding to help fight the opioid epidemic across the country. Today Nebraska is only one of a small number of states not participating in interstate data sharing. This lack of participation in interstate data sharing threatens the sustainable future of the PDMP, as this is a requirement through many competitive grants and federal funding mechanisms. These are all convincing reasons for us to support LB556. I can tell you that NeHII and its private and public partners are confident these changes will continue to improve our PDMP and patient safety while preserving the security and privacy of medical information, which is our mission. I thank you very much for your time and your service, and I'd be pleased to answer any questions that you have this afternoon.

**ARCH:** Questions from the committee? Senator Hansen.

**B. HANSEN:** Just to kind of-- thank you for coming, sorry.

**MICHAEL WHITE:** Absolutely.

**B. HANSEN:** To kind of play off of Senator Arch's question previously, do you expect any costs on your facility with the implementation of this bill?

**MICHAEL WHITE:** So we, for CHI Health, we participate in the Nebraska Health Information Initiative now, with interfaces that are built there today. So we will continue to use those interfaces as they exist.

**B. HANSEN:** Oh, excellent. Great, thank you.

**ARCH:** I'll ask you the question about the patient identifier. How have you solved that issue?

**MICHAEL WHITE:** I think that it's, it becomes a very complex issue as we've done with patient identification. I think we need to, you know, collect as much information as we can and be protective of that information to make it unique amongst our patients. It is a challenge that we have in healthcare to make sure we are truly treating that unique individual. I'm not sure I have a great answer for that yet today.

**ARCH:** OK, thank you. Any other questions? All right, thank you very much.

**MICHAEL WHITE:** Thank you.

**ARCH:** Other proponents.

**SHANNON NELSON:** Hello.

**ARCH:** Welcome.

**SHANNON NELSON:** I am Shannon Nelson. S-h-a-n-n-o-n N-e-l-s-o-n. I am the pharmacy director for WellCare, one of the Medicaid managed care plans here in Nebraska. I want to thank Senator Howard for her dedication to the PDMP because it's really been invaluable to the pharmacists of the state. I also want to thank the folks at NeHII and Kevin Borcher for their partnership because they really made a great program out of the PDMP. WellCare has been interested in the PDMP since go-live in 2017. This new federal law, H.R.6, has recognized the

importance of the access to the managed care plans. It's really been an invaluable tool for us. Nebraska has a program. It's called the Restricted Services Program [SIC], where we have Medicaid members that are restricted to certain providers and pharmacies due to, usually, overutilization of medical services. Right now we can see what we have, just what we have paid for in the Medicare managed care plans. We can see exactly what, what WellCare has paid for, but we aren't able to see what the members are getting outside of the Medicaid system. If a Restricted Services member is getting medication by paying cash, we have no visibility into that right now. And that visibility is invaluable for us to manage those members. If you think about the overutilization problem for a member, they are restricted to one prescriber, maybe a specialist and a pharmacy. We can manage that member by making sure that they, you know, stick to one person that's managing their care. But once they start going outside that system, it's very hard for us to manage them. We can't see it; we don't have any knowledge of it. So it's really important that we be able to see their whole picture just to be able to manage that, that member. We also use the PDMP to decide if a member is ready to be released from the, from the Restricted Services Program. If they have been following the rules, we can see everything that they, they've taken. We can see that they are doing much better on utilization of medical services, but we can also make sure that they've been managed by their primary care physician. When we go to release them, we have to base our release on what we can see. But if they're not playing by the rules, and they are getting things outside the Medicaid system, we can't see that. So we release them and then they become a problem and they bounce right back into the Restricted Services Program. And you know, it would be a lot easier if we could just keep them inside the system, based on full knowledge of what's going on with that particular member, and really coordinate and manage their care. This cash perspective is really just crucial in managing those members. In a nonrestricted services example, NeHII and the PDMP are really crucial just to coordinate care across all of their providers for any member that has multiple disease states or multiple chronic illnesses. Just to give you an example of a case where it was, was absolutely crucial, we had a young, very young child that had been hospitalized for seizures. Well, we received a request for a, for a prior authorization for one of the seizure medications. Well, based on our claims history, we didn't have any recent hospitalizations, we didn't have any recent treatments. They were fairly new to us. By accessing the PDMP, we could see what they'd tried before. We weren't aware that they had just recently been hospitalized because we hadn't received the

hospitalization claim yet. But by accessing NeHII, we could see-- hey, this this poor child has just been, you know, severely ill with the seizures, they had just been hospitalized. We were able to use the consultant that saw her in the hospital to provide the information that wasn't provided on the original PA request, and we were able to get the child the medication. It's the partnership with the information in NeHII and the partnership with the PDMP that we were able to see the entire picture for this child and make sure that they got the medication that they needed. So it's really been crucial for us in managed care. As far as the PDMP, that pharmacy data is about 80 percent of the information we need to manage anybody. If you think about medical claims, they're usually about two weeks behind, but the PDMP is instantaneous. We, we have that medication record right away, and that provides invaluable information as we try to manage our, our members. We're really unique here in Nebraska, not just to see the opioids, but to see the entire record for these members. That's something that my partners in other states drool over, so I really appreciate the ability to see all of the medications. That's really all I have today. If you have any questions-- I really appreciate you're giving me the opportunity to speak to you all today.

**ARCH:** Questions. I have a question. So at this, at this point the MCO does not have access to the PDMP?

**SHANNON NELSON:** We have access to the PDMP but we don't have access to the cash portion. So we have access to just what we pay for. So it's, it's a limited amount of information.

**ARCH:** All right, OK. Thank you. All right. No other questions. Thank you very much.

**SHANNON NELSON:** Thank you.

**ARCH:** Next proponent.

**ANN POLICH:** Good afternoon.

**ARCH:** Welcome.

**ANN POLICH:** Vice Chairman Arch and the members of the Health and Human Services Committee, my name is Ann Polich, A-n-n P-o-l-i-c-h, and I, too, am testifying in support of LB556, for both NeHII and for the Nebraska Medical, Methodist Healthcare System [SIC], of which I am vice president of quality. And I am testifying today in favor of the

enhancements for the Prescription Drug Monitoring Program. I use the PDMP as both an internal medicine provider, as well as in the oversight of quality in our healthcare system. So my remarks are mainly that of the clinical side of the house. The PDMP that exists today has improved our ability to review the medications our patients have been prescribed outside of our healthcare system, but only in the state of Nebraska and very limited to western Iowa. We know our patients are mobile and seek care in many different locations and across the United States, often outside of our state borders. Prior to the PDMP, we were reliant really on patients to keep a very current list of their drugs when they were accessing care outside of our system. Given that many patients have multiple diagnoses requiring multiple drugs to treat their medical conditions, having an incomplete medication list can be a source of errors that can lead to patient harm. Being an internist, I will see patients who have 20 to 25 diagnoses and as many pills, and many subspecialists and those who-- it would be rare to see a patient 100 percent within our own system. Today healthcare providers can access the PDMP to reduce the likelihood of medication errors, but is external to the electronic medical record, as you have heard repeated time. Timeliness to access the PDMP can be troublesome for the provider in that they are waiting for the PDMP to open, oftentimes a couple minutes per patient. And if you're seeing 25 to 30 patients a day, that's a significant waste of time for the providers. As well as the completeness of the data can be an issue as well, due to patient matching like we've talked about, incomplete data, as well as out-of-state care. The first step towards clinical integration has been started by the PDMP, but much work remains to ensure the improvement of the health and safety of our patients. Enhancements of the PDMP integration into the electronic medical record and allowing interstate data sharing addresses the need to have the ability to have a complete, accurate, timely medication reconciliation with each patient that we serve very efficiently and effectively. Any questions?

**ARCH:** Thank you. Any questions? All right, thank you very much.

**ANN POLICH:** Thank you.

**ARCH:** Next proponent.

**MATTHEW VAN PATTON:** Good afternoon, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Dr. Matthew Van Patton; that's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n, and I serve as director for the Division of Medicaid and Long-Term Care in the

Nebraska Department of Health and Human Services. I'm here to testify in support of the Medicaid provisions of LB556. And thank you, Chairperson Howard, for introducing this bill. LB556 will allow the Division of Medicaid and Long-Term Care, MLTC, medical and pharmacy directors, and the medical and pharmacy directors of Nebraska's Medicaid managed care organizations, the state's Medicaid Drug Utilization Review Board, and any other state-administered health insurance program to access state health information exchange, which includes the Prescription Drug Monitoring Program, or PDMP. Monitoring, quantifying, and improving the care delivered to the patient served by Nebraska Medicaid is a high priority for me, and I appreciate the additional functionality this bill provides in working towards this goal. Permitting Medicaid to have access to PDMP data will allow MLTC to better track the care delivered to Medicaid members. This is an important step forward in building the state's health management program and enhancing population health information. In addition, recently passed federal legislation, H.R.6, provides for state Medicaid programs and their contracted managed care organizations having access to this information. The advancement of this bill provides MLTC with the ability to comprehensively align data wells and access for true studies of cost utility, benefit, minimization, and effectiveness studies. And full economic evaluation uses one of these methodologies, and a full economic evaluation is the only type of economic analysis that provides valid information on efficiency. I therefore support LB556. Thank you for the opportunity to testify. This concludes my remarks.

**ARCH:** Thank you. Any questions? Seeing none, thank you very much.

**MATTHEW VAN PATTON:** Thank you, Mr. Chairman.

**ARCH:** Next proponent? Welcome.

**ALEX DWORAK:** Good afternoon, members of the Health and Human Services Committee. My name is Dr. Alex Dworak, A-l-e-x D-w-o-r-a-k. I am here on behalf of the Nebraska Medical Association, testifying in support of LB556. I'm a practicing physician and medical educator, raised and trained here in Nebraska. I am associate medical director of family medicine at OneWorld Community Health Centers in Omaha and assistant professor of family medicine at UNMC. I am here today with the NMA, speaking as a private citizen to express my views, which are not the official views or positions of my institutions. The NMA and I would like to personally thank Senator Howard for her tremendous work on Nebraska's PDMP, and all of you on the committee, and all state

employees who have been part of this, and also for bringing this to allow interstate data sharing. This would specifically allow Nebraska to share and receive PDMP data from other states. This would be an important step in providing patient, in providing for and improving patient safety, and would let people like me get a truer picture of what our patients are receiving. As some stated, patients are mobile. And for those of us practicing along the borders of our state, or really anywhere, it can be very difficult to know what our patients are actually getting. And per the Brandeis Training and Technical Assistance Center, it's six states that don't allow this; and we're one of them. So the NMA and I also support the portion of the bill that gives us an opportunity to integrate PDMP information into the electronic records directly. Right now either I or my clinical pharmacist or my nurses usually has to log out to go to another system, identify that, and you print it out or type it in, which does give another chance for errors with miskeying the dose or maybe even getting the name of the patient wrong. And that's also more time that we could spend taking care of patients instead of taking care of the computer. This would make things more seamless. It would improve our efficiency and would improve our quality. And speaking personally as a physician practicing along the Missouri River, I do see patients from Nebraska and Iowa, as well as from South Dakota and other places occasionally. I also treat chronic pain and I treat substance use disorders, and I can't overstate the impact that having accurate information provides. I can think of many stories, both from previous years before we had a PDMP at all, where patients could have had their problem diagnosed faster and we could have gotten them effective treatment. Even now this week I've been looking at a case, a friend who was seeing a, another clinic that was closed, and now they're coming to us, asking for help with their medication, who's been in South Dakota. And so I, and other people like me, will sometimes use the Iowa Prescription Monitoring Program, which I am allowed to access and which also provides interstate data sharing. That's yet another step and yet more extra effort and time that's required. And so I think that if Nebraska could add that and share with Iowa, as well as other states, clearly that would help practitioners like me provide better care, diagnose the problem if someone has a substance use disorder, especially with opioids, and then give them effective, evidence-based treatment. And really, I think that's, if we don't have this objective information, we have the Hobbesian [SIC] choice of either enabling disorders that can be, and are, deadly or looking at patients and treating them like criminals, and sometimes both at the same time, which is not good medicine. I, as the committee is very

aware from the testimony that's already been given, lives are at stake. I think this is extremely important and, as a practicing physician, I cannot support it more strongly. I thank you for your time and I'm happy to take any questions that I can answer.

**ARCH:** Thank you. Questions? Seeing none, thank you very much. Welcome.

**ANDY HALE:** Thank you. Good afternoon, Vice Chair Arch and members of the HHS Committee. My name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president for advocacy with the Nebraska Hospital Association. The NHA has always been a supporter of the PDMP, and we appreciate Senator Howard's willingness, and her staff, to discuss ways to improve the PDMP. In fact I'd like to acknowledge Senator Howard's mother, as well, Senator-- former Senator-- Gwen Howard, who got us started down on this road. And I appreciate Senator Howard's passion for this issue. Nebraska continues to have one of the lowest rates of opioid deaths in the United States, and one of the reasons is the PDMP. The PDMP was not just created to prevent the misuse of controlled substances that are prescribed, but the PDMP also allows prescribers and dispensers to monitor the care and the treatment of patients and to ensure that such prescription drugs are used medic, for medically appropriate purposes. We really look at it from a patient safety issue. If my hospitals have all the data on prescriptions, not only can we help prevent abuse, but can it also allow us to provide better patient care by knowing what prescriptions the patients have been prescribed and have had picked up. Some of our members have had issues in regards to the H.R.-- or the electronic health records-- the H.R. We were part of the shareholder group and we believe that those issues have been taken care of and are eliminated with LB556. I would also like to echo Senator Howard's initial comments to see as the PDMP is a living and breathing entity, I think it's always changing and always changing for the better. It would be ideal if we could not have to come in front of this committee and the Legislature to address all those concerns, but there are other similar ways we could do it. So on that note, again, I want to thank Senator Howard and her staff, and I ask that you advance LB556.

**ARCH:** Thank you. Questions? I see none. Thank you so very much.

**ANDY HALE:** Thank you, Senator.

**ARCH:** Other proponents.

**BRENNEN MILLER:** Good afternoon, Vice Chair Arch and members of the Health and Human Services Committee. My name is Brennen Miller, B-r-e-n-n-e-n M-i-l-l-e-r, appearing before you today representing our client, Nebraska Medicine. On behalf of Nebraska Medicine, we wished to have a member of the leadership team here today who has been involved in the discussions on this bill, but, due to scheduling complications and the time to travel to Lincoln to testify, today just didn't work out. With that said, the leadership of Nebraska Medicine wishes to convey their deepest thanks to Senator Howard for her work, last year and over the interim, on PDMP. We also want to convey our thanks for her bringing stakeholders together to move this legislation forward. We support LB556 and echo the comments made in previous proponent testimony today. Again, our thanks to the senator, her staff, on this important issue. And with that, thank you for the opportunity to testify.

**ARCH:** Thank you. Any questions? All right, thank you.

**BRENNEN MILLER:** Thank you very much.

**ARCH:** Welcome.

**JONI COVER:** Thank you. Senator. Arch, members of the committee, for the record, my name is Joni Cover; it's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association, and I'm here today in support of LB556, the white version of the bill. I want to also say thank you to Senator Howard, and her staff, and the other stakeholders who worked with us to address the concerns that we had on the green copy of the bill. We know that there are some very important issues, some important issues in the bill which we support. One of them is the interstate data sharing. That's something we have been a proponent of from the very beginning so we're glad to see that. We're also excited to see the fact that you can integrate the data into EHRs or pharmacy systems, so we're excited about that. We did have concerns with the E clause, but I believe that there's been a way, through conversations with NeHII and DHHS, for our folks to be able to, to meet the promise of the bill with maybe not being able to hit the deadline, because it may take some time for us to be able to change our software systems, but we'll work hard to be able to do that. One of the things that we asked Senator Howard to remove from the bill, so it's, it's in the green copy but it's not in the white, were the directions of use. And I think, Senator Cavanaugh, you had, had asked about that. We asked for that to be removed for a couple of reasons. No pharmacy, very few pharmacies report the same kind of data, so the e-prescribing data or

regular data that comes through the physician prescription may come into your software system. And yours may say one thing, and yours may look one way, and yours may look one way, but when they go into the PDMP they can still all be jumbled. It's my understanding that there won't be a national standardized format for that directions field until at least 2021. So we just ask that that be sort of taken out until we have some standardized language so that, when you read it, you won't see gobbledegook-- I don't know a better way to say it. There's probably a better term, but that's the one I could come up with today. I also don't believe, even if we did report it, it would be something that the prescribers and the dispensers would see right away because, again, you wouldn't necessarily be able to read it. So I think that there are probably going to be pharmacies that do report it. And so we can sort of test which methods work the best so that, when we do implement that, that's, data field, then everybody will be able to read it and it'll make more sense. With that, I'm going to stop talking, and I would be happy to answer any questions.

**ARCH:** Any questions? Yes, Senator Hansen.

**B. HANSEN:** Similar question as before, so do you foresee any additional costs on pharmacies or pharmacists, maybe, in this bill?

**JONI COVER:** If we have additional costs it'll just be with our software providers, to be able to make sure we're reporting the, the new fields in a correct manner. So I mean there could be some costs. There have been the few costs along the ways as we've, as we've each year, we've added new fields. But overall it's, it's not a big, it's not bad. And for us to be able to use it, the law says that the pharmacists, the dispensers, and the prescribers have free access, which we really appreciate. Since we're the ones supplying the data, it's kind of nice to be able to see it for free. So--

**B. HANSEN:** Cool.

**JONI COVER:** Thank you.

**B. HANSEN:** Thank you, appreciate it.

**ARCH:** Other questions? I have one.

**JONI COVER:** OK.

**ARCH:** So, so the pharmacists not only are required to report--

**JONI COVER:** Yes.

**ARCH:** --to provide that information, but then they also check the information--

**JONI COVER:** Yes, yes.

**ARCH:** --before they, before they dispense. They, they also are using that, not just, not just uploading it someplace.

**JONI COVER:** Correct.

**ARCH:** But they're, they're in the system themselves--

**JONI COVER:** Correct.

**ARCH:** --checking.

**JONI COVER:** Correct. We have pharmacists that are checking both in retail settings, so I know that there is a lot of pharmacies in Nebraska that are requiring their pharmacists to check it before-- particularly with controlled substances--

**ARCH:** Right.

**JONI COVER:** --before they dispense it. Some of them are required-- don't, don't send one out the door until you've looked at it. Others, it's sort of a we'd like you to do it. As far as on the hospital side, I know that many of them use it for medication reconciliation. I know some of them still aren't quite there yet because-- I get frustrated with community pharmacies that call me and say, I wish the folks at the hospital would just check the PDMP; they wouldn't have to call me. So we'll get there, you know, we'll get there; it's, it's going to take some time. But I really do believe it's been a good tool, particularly with our pharmacists being able to reach out to the physicians and say, hey, did you really mean to prescribe this? You know, if you look at the PDMP you'll see that maybe that's not the best option or it's not the right dose. Or did you know? Or they already got it. So it's been, it's been a tool then to allow for open communication between the prescribers and the dispensers.

**ARCH:** Well, you would anticipate that integration into the EMR would significantly eliminate some of the barriers to looking, to looking that up.

**JONI COVER:** I would hope so. I am probably the last person you should ask about techy things, especially in a hospital. But I have been told from our pharmacists and, and the folks in the hospitals that it would, it would make a big difference, and at the community pharmacy level, too. The, the interesting thing will be-- some of our community pharmacy software systems block outside Web sites, if you will. So well, you know, they'll have to adjust to that. But hopefully, I mean, I think it makes sense to be able to do that.

**ARCH:** OK. Thank you.

**JONI COVER:** Thank you very much.

**ARCH:** Other proponents. Seeing none, there are, we did receive some letters: Dr. Aaron Lanik from the Nebraska Academy of Family Physicians; Dr. Travis Teetor, Nebraska State Board of Health; Dr. Richard Azizkhan, Children's Hospital and Medical Center; and Joel Kurzman, the National Association of Chain Drug Stores. Opponents. Are there any opponents to this bill? We had one letter from Kathy Wilmot, and it came under her personal name. Anyone want to testify in a neutral capacity today? Seeing none, Senator Howard, you may close.

**HOWARD:** Thank you, Senator Arch and members of the committee. OK, there are just a couple of things that I want to circle back to and clarify, just for the record. One is that for providers we don't mandate a check. We don't mandate it on the pharmacy side and we don't mandate it on the provider side. Other states do. And I think I've been reluctant to say let's mandate a check until we know that the system is working seamlessly for providers so that we're not creating a burden within their own practice. The question about law enforcement is timely and important. I know that the Attorney General is very interested in having access to the PDMP. Part of our original conversations, when we revamped it, was we put together a very aggressive privacy provision within this. So all of this is [INAUDIBLE], is protected health information. And so we made sure that it was really only HIPAA-protected providers who would be able to see it. That being said, if a law enforcement agency has an issue or has reason to suspect that there's misuse or fraud, they can file a warrant and, and get that information from NeHII. What the Attorney General was interested in was having a team that would have full access to the information. But without really clear parameters around what type of access they were going to get, that isn't something that I would be able to support. And it sort of goes back to we either treat this as an illness or we treat this as a crime. And we have been

incredibly successful in treating opioid addiction as an illness, and so successful, in fact, that when we talk about how low our rates are, when, when Director Dawson comes in and says, listen, opioids aren't our issue, right? It's alcohol, it's meth. Part of that is because of the work that we've been doing. We are an anomaly in this country because of this work, in the sense that our opioid overdose deaths have gone down. For the MCO, I did want to clarify. They pay for NeHII, which is why they are not actually considered a provider in the sense that they could access the PDMP. So we had to grant them access, same with Medicaid and Long-Term Care. So they do pay for NeHII. But for the patient IDs, so trying to figure out how best to make sure that we're identifying patients appropriately, if you look at page 2 on the white copy, so we were already getting name, address, date of birth, which is kind of what we are already-- those are kind of your basic things. What is new is that we're going to try to capture phone number which, with people keeping their own cell phone number for a really long time, that should really help. We can also capture now a state ID number, so if there's a driver's license or a military ID number, and those are all if they're available, they try to capture those. So that should really help with some of that patient, aligning that patient data so that you actually know you're talking to John Smith versus, versus another John Smith. With the issue of directions, so making sure that those directions are included because the whole idea of this is that we want to improve patient care. We want providers to have the most information so that they can do the best job for the patients that are in front of them. Because we know that the issue of patient directions is going to come and it's maybe not something necessarily that we want to keep putting into statute, I go back to the idea of that advisory board who really looks at the rules and regulations within our PDMP and how we're managing technology and interfaces and privacy, and sort of not take it out of our purview, but really treat it like the Board of Health, where it's like you are going to do something for us and make recommendations to us on those regulatory changes because I think there's a lot in our statute around PDMP that is very technical and very prescribed. And I think an advisory committee or a board would really help with that. Finally, I just want to say I'm really grateful that you were very patient with me in telling my story and talking about my sister. It is so important, as you go on in this work, to share the things that are important to you and your own experiences. That's why your constituents sent you here. And so having that kind of bravery and having your patience for that, I really do appreciate it. So with

that, I'm trying, I'm happy to try to answer any questions you may have.

**ARCH:** Any questions? Senator Hansen.

**B. HANSEN:** I don't know if it's so much a question as it is a comment. I do appreciate you mentioning that law enforcement, because I've had actually a couple members in law enforcement that have to deal with prescription drug investigation. Tell me about their frustration about trying to do investigations without having certain access to PDMP or going to the [INAUDIBLE] process.

**HOWARD:** Well so this is what's interesting--

**B. HANSEN:** But--

**HOWARD:** --is that-- oh, sorry.

**B. HANSEN:** But it's about tethering patient-protected information with trying to accomplish something, too, and so--

**HOWARD:** You always want to make sure, when somebody is accessing private information, that they have good cause and that they can show that good cause to a judge who would issue a warrant for that information, that it's not just me saying, I'm super curious about what Ben Hansen is up to. You want somebody to be able to show good cause to a judge. The suggested law enforcement access that was proposed was unfettered access without that good cause; and that's concerning. Prior to the PDMP, when law enforcement wanted access to drug information, they would have to go to a pharmacy and ask for their DEA binder, and they would read the pages. This is considerably more efficient. Calling NeHII, sending your subpoena, and getting that drug history is incredibly more efficient because you're not visiting multiple pharmacies. So while, yes, I'm certain they would enjoy more access to the PDMP, what they're getting now is far more comprehensive than what they were getting even three years ago, four years ago. So we've made incredible strides in the in the amount that they can get for the subpoena that they have.

**B. HANSEN:** Thank you.

**HOWARD:** Thank you.

**ARCH:** Just one other question.

**HOWARD:** Yes.

**ARCH:** We didn't talk about the, about the research purposes.

**HOWARD:** Oh, yes.

**ARCH:** So, so is, is the PDMP regulated by HIPAA rules?

**HOWARD:** Yes.

**ARCH:** OK. So they have to be HIPAA compliant, so--

**HOWARD:** Everything.

**ARCH:** Whatever, whatever comes out for research is--

**HOWARD:** Deidentified.

**ARCH:** Anonymized and deidentified and all of that.

**HOWARD:** Um-hum, absolutely.

**ARCH:** OK. All right.

**HOWARD:** That's a great question. I'm actually really glad you asked it.

**ARCH:** All right. Thank you.

**HOWARD:** Thank you.

**ARCH:** Thank you very much. And this closes the hearing for LB556.

**HOWARD:** All right. This will close the hearing on LB556 and open the hearing on LB557, Senator Lindstrom's bill to change provisions relating to prescriptions for controlled substances. Good afternoon.

**KRISSA DELKA:** Hi. Thank you. Good afternoon, committee members, Madam Chair. My name's Krissa Delka, K-r-i-s-s-a D-e-l-k-a, and I'm introducing LB557 on behalf of Senator Brett Lindstrom, who represents the District 18 in northwest Omaha. Senator Lindstrom does send his apologies; he's a little under the weather today. And as his legislative aide, I've been asked to introduce this bill. LB557 is a bill to change the provisions relating to prescriptions for controlled substances. This is a clean-up bill to LB931 that was passed during the 2018 legislative session. Among other things, that bill required a

patient notification and/or a conversation with the patient, on the first and third prescription of any opioid, regarding the dangers and addiction risks of opioids. It was brought to our attention that there were certain issues in workflow, workflow within the healthcare settings, and this bill seeks to address those concerns. First of all, LB557 amends the definition of a practitioner to include a prescriber or healthcare provider who's substituting for another prescriber or healthcare provider, so long as that member of the patient's care team and under the direct supervision or in consultation with the primary prescriber. For example, if a doctor is out of the office and another doctor is covering their shift, they would not be required to have the conversation with the patient if they are authorizing a refill of the prescription. The second adjustment changes the first and third prescription to a 60-day look back. Instead of on the first and third incidence of a prescription request, the provider looks back to see if the patient has had a prescription in the last 60 days. This was recommended because prescriptions aren't always given in person and, therefore, it would be more efficient to look back on the patient's chart to indicate dates of refill rather than the number of times the medication had been prescribed. The 60-day look back aligns more simply with the patient's electronic health record and aligns with the federal definition of what constitutes an opiate, opioid-naive patient or someone who is more at risk of addiction and could benefit from additional education provided in LB931 from 2018. The next change occurs on page 4, line 24, and that includes an exemption for hospice and palliative care or for a cancer diagnosis. This was at the request of doctors treating these patients. And lastly, LB557 moves these sections of statute to the Uniform Credentialing Act and out of the criminal code. You also have an amendment in front of you, AM246. The amendment strikes from the definitions to exclude veterinarians and facilities that do not prescribe medications to humans. There will be several testifiers behind me to follow up and answer any questions you may have regarding the bill, and Senator Lindstrom would encourage this bill to be moved, moved up to General File, and thank you for allowing me to testify on his behalf.

**HOWARD:** Thank you, Krissa.

**KRISSA DELKA:** Thank you.

**HOWARD:** We'll now invite our first proponent testifier to speak. Good afternoon.

**ANTHONY KUSEK:** Good afternoon. Chairman Howard and members of the Health and Human Services Committee, my name is Anthony Kusek, A-n-t-h-o-n-y K-u-s-e-k. I'm testifying on behalf of the Nebraska Medical Association for, in support of LB557. I'm a family physician in Albion, Nebraska. I'd like to thank Senator Lindstrom and Senator Howard for working with us to bring this update to last year's LB931 opiate package. In LB931 the prescriber was required to notify the patients of the risks of opiate addiction, the reasons why the prescriptions were necessary, and alternative treatments, which are very good requirements. Many times these patient interactions happened with physicians, but other times they can occur with other members of our staff that don't necessarily refill those prescriptions or when we're not available, such as our physician assistants or our nurse practitioners. And it allows them, any member of the patient's healthcare team, to actually notify them of these risks. We usually have written notifications and answer questions for these in a more seamless patient, patient interaction, and they ensure that the information is communicated. So we have protocols so they are-- that we check off to make sure that we don't miss that communication. And LB557, it also changes requirement to, to the 60-day look back which is, which is in, and, and our workflow much better. Instead of the first and third prescription, we can look back to see when these prescriptions were prescribed, were prescribed. Our, our health information systems have that information readily available. Rather than trying to look back at prescriptions, we may have somebody who comes in three or four times in that 90-day period for other things, not to get a prescription filled. So it allows us to go to the 60-day look, look-back period, based on some implementation problems that came into light with prescribers. Electronic medical records easily track, don't easily track the first and third, but they do the 60 days. The 60-day also has an alignment with the federal guidelines, such as the DEA, the CDC, the CMS, what constitutes an opioid-free or opioid-naive patient. The patient is considered to be opioid-naïve and have it out of their systems if they're not-- if they're 30 days beyond their, their prescription, they would be considered opioid-naïve, sixty days after their 30-day prescription was filled, so if it was filled on December 1st, they took it for 30 days, 60 days after that they would be considered naïve, and this would restart the, the 60-day look back. The Nebraska Medical Association worked with the Department of Health and Human Services to write the Pain Management Guideline [SIC] Document which we all use and we have access to. It's, it's a resource that provides information for us, as well as the general public, to advise in the national standards of narcotic

prescription. It educates the opioid-naïve patients so that they can, they can look back to the-- or the opioid patients, they can look into this guide, the guideline, and to see exactly what we're, we're trying to do with our, with our prescriptions and how we're trying to treat their pain. Finally, we'd like to thank the senators, Senator Lindstrom and Senator Howard again, for moving these items out of the Uniform Controlled Substances Act into the credentialing act, Uniform Credentialing Act. These, this makes the most sense in relationship to licensure and the action, rather than criminalizing the practice. We again thank them for their change. Overall we see it as a practical implementation and clean-up bill of LB931 from last year. And we're grateful to the senators for engaging in this conversation with us for LB557. We'd like to support this and advance it through the committee. And I thank you and would be happy to answer questions, if I can.

**HOWARD:** Thank you. Are there questions? You sure?

**B. HANSEN:** Yeah.

**HOWARD:** Senator Hansen.

**B. HANSEN:** It's just again, probably, I may have been reading this wrong. How do we know somebody's had a discussion 60 days ago?

**ANTHONY KUSEK:** How do we know-- pardon?

**B. HANSEN:** The, like if somebody's prescribing the medication that-- somebody else in a patient's care team has had a discussion with them 60 days ago?

**ANTHONY KUSEK:** Of course we act, we access the PDMP when we get a narcotic.

**B. HANSEN:** Sixty days to put it in the PDMP, OK.

**ANTHONY KUSEK:** Yeah, yeah.

**B. HANSEN:** And that's [INAUDIBLE].

**ANTHONY KUSEK:** The access.

**B. HANSEN:** Where was that in the file and how that works.

**ANTHONY KUSEK:** Yeah, that's, that's all consistent with this. So this really--you know, when we prescribe narcotics, we access PDMP to make sure compliance is there.

**B. HANSEN:** OK, cool. Thanks.

**ANTHONY KUSEK:** And I, I don't know if everybody does that, but I think it's the standard that most people use now.

**HOWARD:** Other questions? Seeing none, thank you for your testimony today.

**ANTHONY KUSEK:** Thank you.

**HOWARD:** Our next proponent. Good afternoon.

**JONI COVER:** Good afternoon. Senator Howard and members of the committee, my name is Joni Cover; it's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association, here in support of LB557. I just wanted to lend our support on the record and also to lend our support to the amendment. Appreciate Senator Lindstrom and Krissa and Senator Howard's help in kind of narrowing down the list of those folks who are the most appropriate to do the counseling in the, in the record and things on the opioid prescriptions. So with that, I'll stop and answer any questions.

**HOWARD:** Are there questions? Thank you.

**JONI COVER:** Thank you.

**ANDY HALE:** Hello, Chairwoman Howard and members of the HHS committee. My name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president for advocacy at the Nebraska Hospital Association, and we are in support of this bill. We supported it, supported Senator, Senator Lindstrom's efforts last year in regards to LB931, and we support the work here today. As mentioned previously in my testimony earlier on, on the other bill, we are very fortunate that we're one of the lowest, if not the lowest in the nation, for opioid deaths. But I think we all can agree that one death is one too many. I appreciate Senator Lindstrom's efforts in regards to this bill, as well as Senator Howard and, really, this legislative body's ability to be proactive when it comes to this. The Nebraska Hospital Association last year convened a group of stakeholders in regards to the opioid epidemic, and we produced an opioid tool kit that I believe all of you senators should have received probably in the last couple of weeks. It is a very good tool

to use. We will provide that to anyone who requests that at no cost to them. And if you have not received it or would like another copy, please contact myself and we can provide that. So I just would like to voice our support for LB557 and hope that you advance the bill.

**HOWARD:** Thank you. Are there questions? Seeing none, thank you for your testimony.

**ANDY HALE:** Thank you, Senator.

**BRENNEN MILLER:** Good afternoon again.

**HOWARD:** Good afternoon.

**BRENNEN MILLER:** Chair Howard, members of the Health and Human Services Committee, my name is Brennen Miller B-r-e-n-n-e-n M-i-l-l-e-r, appearing again on behalf of our client, Nebraska Medicine. We just want to say thank you to Senator Lindstrom and his staff for bringing this forward and for bringing stakeholders together to move this legislation forward. We appreciate the resolution to the workflow issues in healthcare settings, including amending the definition of a practitioner to include those filling in during an absence; that is very helpful. So with that I conclude my testimony, and thank you again.

**HOWARD:** Any questions? Seeing none--

**BRENNEN MILLER:** Thank you.

**HOWARD:** Thank you for your testimony today. Any other proponent testifiers? Seeing none, is there anyone wishing to testify in opposition? Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Lindstrom waives closing, and this will conclude the hearing for LB557. And we will take a brief break. We will come back at 3:00.

[BREAK]

**HOWARD:** All right. Good afternoon. We will reconvene the Health and Human Services Committee, and we will open the hearing with LB567, Senator Morfeld's bill to adopt the Prescription Drug Cost Transparency Act. Senator Morfeld, you are welcome to open.

**MORFELD:** Thank you, Chairwoman Howard. Members of the Health and Human Services Committee, my name is Adam Morfeld, for the record A-d-a-m

M-o-r-f as in Frank-e-l-d, representing the fighting 46th Legislative District, here today to introduce a noncontroversial bill [LAUGHTER], LB567, a bill intended-- actually I at least have one proponent-- a bill intended to create transparency and reporting on the rising cost of prescription drugs. I do have two handouts, if the page would be willing to come over here while I talk a little bit about this. The bill requires that a manufacturer of a prescription drug with a wholesale acquisition cost of more than $40 for a course of therapy shall provide notice to certain parties if the increase of such cost is more than 16 percent. Wholesale acquisition, or WAC, means that a manufacturer sells a drug for-- of what the manufacturer sells the drug for prior to any rebates or discounts. The prescription drugs that this act applies to are those which are purchased or the price is reimbursed by the following: a state purchaser, including DHHS, DAS, or Corrections, or any entity acting on behalf of one of these; an HMO; a health insurer who is authorized to transact business in Nebraska; a fraternal benefit society such as Woodmen; or a pharmacy benefit manager. The notice is required in this-- the notice that is required in this act shall occur in writing at least 60 days prior to the planned effective date of the increase and shall include the date of the increase, the wholesale costs at the time of the notice, the dollar amount of the increase, and the wholesale acquisition cost, and a statement regarding whether or not the increase is necessary to a change or improvement in the drug. The bill also assigns reporting requirements and publishing of such cost increases to the Department of Administrative Services. I want to thank Senator Howard, who introduced this bill last session, and I've sent you the handouts with the definition on some of these terms for your review. I've also-- have a handout that talks about some of the success in California. After that law was passed, which is a little bit more stringent than this law-- I haven't read the whole thing. In terms of California law, they actually canceled some cost increase, increases there. This bill is based in part on a measure that passed in California in 2017. Although that bill went farther than LB57 [SIC], so far it has shed light on the rising costs of prescription drugs. I have an article here that I just handed out that talks about that. I introduced this bill because I truly believe that our citizens deserve to know why a drug that they rely on significantly increases in cost. Through LB567, I'm attempting to address the high cost of prescription drugs by requiring transparency from manufacturers and information on why prescription drug costs increase. You have all heard of increased costs of insulin, EpiPens, and other life-saving drugs that a few years ago were actually fairly affordable. In fact, many people are

now rationing these life-saving drugs because they cannot afford them, even those with insurance that have high copays. I understand the costs of research and development are quite high for these companies, some of whom are small startups, and don't, we don't want to quash creativity and innovation and science in developing these new medications. That being said, I think as policy makers, we need to start somewhere to get information on the cost of these drugs and I think LB567 is a reasonable step forward just to do that. I ask that you strongly consider this bill, and I'd be happy to answer any questions.

**HOWARD:** Are there questions? Senator Hansen.

**B. HANSEN:** So I'm trying to approach this from the standpoint of a, the owner of one of the companies, I guess, is-- do you feel like this legislation would, in any way, infringe upon their ability to make money?

**MORFELD:** Well, I would think that behind me there's going to be some folks that think that it would. There are going be some administrative costs on their end to report some of this. And I know that, because California's already done this, these state, these companies which operate in almost, always in many states already have to comply with those types of regulations, particularly in California. So yeah, there is going to be some cost and I'm sure that there'd be some people that would say that that will inhibit some innovation. That being said, this also has a high cost on the consumers and the consumers are the ones that I'm particularly interested in. And regardless of their margin of profitability, you know, my constituents, you know, they're having a hard time just making ends meet. And I, it's not just my constituents; it's everyone's. So I think it's a reasonable measure. I know that there's some folks that think that there should be transparency in some of the other industries, like PBMs and things like that. I'm open to that, but I think this is a good first step in the right direction.

**B. HANSEN:** OK. I'd just like to make sure in the, in the essence of transparency we do not infringe upon somebody else's right to run a business or trade secrets or-- you know, that's, that's the only reason I kind of asked that question.

**MORFELD:** Yeah.

**B. HANSEN:** That's the main thing. I'm just curious about it to make sure we're not kind of infringing upon their ability to run a business or, you know-- I don't want to sound cold.

**MORFELD:** Um-hum.

**B. HANSEN:** But their bottom line, you know, because--

**MORFELD:** Yeah, yeah. I mean they have a bottom line and the consumer has a bottom line. And not only does the consumer have a bottom line, being as though that healthcare is now-- and by most assessments-- covered by half in terms of taxpayers' federal, state subsidies and other costs, I think that we also have a bottom line as a state, and a responsibility as legislators to be good stewards of that taxpayer funding which is going, in many cases, to these prescription drugs.

**B. HANSEN:** Thank you; appreciate it.

**HOWARD:** Senator Williams.

**WILLIAMS:** Thank you, Chairperson Howard. Thank you, Senator Morfeld. You mentioned California several times. Are they the only state that have passed legislation like this?

**MORFELD:** That's a good question. They're the one that stands out. I can look into that and get back to you a little bit more.

**WILLIAMS:** Thank you.

**MORFELD:** I might contact NCSL.

**WILLIAMS:** Thank you.

**HOWARD:** Any other questions? Seeing none, will you be staying to close?

**MORFELD:** Yeah, I'm planning on it, depending on how many people are testifying. I've got a work meeting in 0maha at 6:00.

**HOWARD:** Okay. Thank you, Senator Morfeld. Our first proponent. Good afternoon.

**BOB LASSEN:** Good afternoon. Chairman Howard, members of the Health and Human Services Committee, my name is Bob Lassen; that's B-o-b L-a-s-s-e-n, and I am a retired pharmacist and a volunteer today, testifying on behalf of AARP Nebraska, in support of LB567. AARP is a

nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to the families of those 55 and over, such as healthcare, employment, and income security, retiring planning, affordable utilities, and protection of financial, from financial abuse. AARP supports increased transparency in the prescription drug development and pricing process, particularly in the case of drugs manufacturers that benefit from taxpayer-funded research. It is our policy that federal, state, and local governments should ensure that prescription drug launch prices and subsequent pricing decisions are reasonable. They're also justified and support improved consumer access and affordability. There's no reason for consumers across America to pay more for prescription drugs than anyone else in the world. But we often do. As prices continue to soar, more and more families struggle to pay for the medicines that they need every day. Some even choose between buying food and buying medicine. This hits older Americans especially hard, hard. Skyrocketing prices are pushing life-saving prescription drugs out of reach of many of those who need them, including people suffering from cancer, asthma, and diabetes. Prescription drug pricing in America is, are among the highest in the world. They remain at the top of the list of concerns Americans have about healthcare. According to the August 2018 AARP Bulletin, the average cost for a year's supply of medication for someone with a chronic illness has more than tripled, since 2006, to over $13,000. That's about four-fifths of the average Social Security retirement benefit for almost half of the median-income people on Medicare. Too many adults, 50 and older, report struggling to pay for their prescription drugs, delaying or deciding not to fill a prescription due to the cost, or by taking less medication to make it last longer. With this trend continuing, those 50 and older will not be able to afford the prescription drugs that they need, leading to poorer health, higher healthcare costs in the future. Confusion, anxiety, and anger over the cost of medication has been on the rise for many Americans for decades. According to a 2017 AARP Bulletin, reports-- this reports: Consider the following. The cost of-- and these are just a few medications that have come out-- the cost of Bavencio, a new drug, a cancer drug approved March 2017, is about $156,000 per patient per year. A new muscular dystrophy drug came on the market in late 2016 for a price of about $300,000 annually. A new-- in, in 2016 the FDA approved a new bladder cancer treatment for the cost of $12,500 a month, or $150,000 a year. Even older drugs that have been on the market for a long period of time are not immune from these price, price increases. The cost of insulin has tripled from 2002 to 2013, despite no changes in formulation or

manufacturing. A four-decade-old EpiPen that we've all heard about, a life-saving allergy medication, has seen an increased price of 500 percent since 2007. Public outrage over this price tag has brought down the cost by a generic, which I understand is still owned by the same company. AARP surveyed 50-plus Americans in 2015 to learn about their prescription drug use and any struggles that they faced in regarding prescription drug costs. The survey also examined their views on how prescription drugs and pharmaceutical companies are regulated and what should be done to help reduce prescription costs. Some of the key findings for this group was that 81 percent think prescription drugs are too expensive, 44 percent are concerned about being able to afford their medications, 76 percent report that there is not enough regulation when it comes to limiting the price of prescriptions, and 84 percent think that drug companies should be required to publicly explain how they price their products. AARP is supportive of, to ensure those over 50-plus have affordability in their medication. As you consider this bill, please keep in mind the following: the cost of prescription drugs are increasing, but the incomes are not. People are going without their medications, are cutting back on taking them as prescribed, trying to conserve their resources. It doesn't matter if someone has insurance or not. Costs are going up either way. For many people, they are having to choose between medications and other needs, like food, housing, and utilities. No one should be forced to jeopardize their health because they can't afford proper medication. To answer one of your questions-- and this is really what prompts-- this is from Senator Hansen.

**HOWARD:** Mr. Lassen, actually [INAUDIBLE].

**BOB LASSEN:** Oh, I'm sorry, red, yes, I am sorry.

**HOWARD:** So let's see if the committee has any questions.

**BOB LASSEN:** Okay, good.

**HOWARD:** Thank you. Are there questions?

**BOB LASSEN:** Thank you-- open for questions, yes.

**HOWARD:** Senator Hansen.

**B. HANSEN:** I'd like you to answer the question I asked previously.

**BOB LASSEN:** Good, because I have an answer to that, or at least some information for you.

**B. HANSEN:** Funny you should ask.

**BOB LASSEN:** This talks-- yeah, it's nice of you to offer, 'cause that was my next comment. We're talking about profits, how pharmaceutical companies earn comparing to other companies. All right, and we have specific examples here. This was from a survey done in 2016. This has to do with the operating profit margins, OK, of various organizations. And Amgen's profit margin was 42.6 percent. AbbVie was 36.6, Johnson and Johnson was 29.4, Roche Laboratories was 27.8, Pfizer was 26. Then we get down to some other things that you may be more familiar with. Coca-Cola operates at a 20.6, General Electric operates at a 14.4, American Airlines operates at a 13.2, General Motors operates at a 5.7, Exxon operates at a 3.7. We don't want to deny anybody or any innovation and medications, but we do want to have responsible billing and, by these manufacturers. And this is really what we are doing in endorsing Senator Morfeld's bill.

**B. HANSEN:** Can I ask one more question, if that's OK?

**BOB LASSEN:** Sure.

**B. HANSEN:** Do you think it's OK for the government to tell a pharmaceutical company to lower their prices, or force them to?

**BOB LASSEN:** I think the government, as a, the party responsible for paying for a lot of things, has some options available that they haven't done before. If there were a life-saving medication for you and it cost $1,500 a month, OK, should you be denied that medication because you can't afford it? So I think that's the thing that presents to everyone is, is can you afford these costs if you are the one needs this medication?

**HOWARD:** Other questions? Senator Williams.

**WILLIAMS:** Thank you, Chairwoman Howard. And thank you, Mr. Lassen, for being here and representing AARP; I barely qualify in that age category. And you talked a lot about drugs that are, are very expensive. I want to get your take, as a pharmacist dealing with this stuff, some things you've seen. This bill starts down at the level of a prescription of $40 for one course of therapy. I'm, I'm assuming that might be interpreted as a 30-day supply probably or--

**BOB LASSEN:** Probably, like an antibiotic, it would be a ten-day supply.

**WILLIAMS:** OK. I don't know if this is even a fair question, but what kind of percentage of medications that would be prescribed might fall above and below a $40 watermark?

**BOB LASSEN:** I think, with the current pricing structures and the copays and everything, most of the medications that you see are going to be above that $40 rate. Now this is-- well, you know, the insurance company is paying their part and you're paying your part.

**WILLIAMS:** So--

**BOB LASSEN:** And it, and if this level is, is artificially low, then maybe there should be another level for this bill. But what we are, are advocating for is for the cost of medication to be down in some form to where our people can get the same medications as somebody who has unlimited, you know, resources.

**WILLIAMS:** OK. So the majority of medications that would be subscribed would fall under that $40--

**BOB LASSEN:** That's my opinion, yes.

**WILLIAMS:** -- would be your take. Thank you.

**BOB LASSEN:** Yeah, I mean you're--

**WILLIAMS:** I just wanted to get a kind of a--

**BOB LASSEN:** By the time you've done the copay and everything else.

**WILLIAMS:** -- benchmark.

**BOB LASSEN:** I think what, what's happened in the pharmaceutical industry is we've become calloused to the actual costs of things. And we're so used to the third parties picking up the cost that even on the pharmacy level, you know, what we're looking at and what we are facing with the customer is the copays. And so if the medication costs $1,500 a month, and the insurance company is picking up $1,400 of that, you know, we see a $100 copay that individuals paying for it. So we lose sight of that actual total cost because of the way that the

billing takes place. We put the figures in, the insurance company kicks back what we have to collect.

**WILLIAMS:** Thank you.

**HOWARD:** Other questions? Seeing none, thank you for your testimony today.

**BOB LASSEN:** Um-hum.

**HOWARD:** Our next proponent testifier? Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

**ZACHARY POSS:** Good afternoon. My name is Zachary Poss, Z-a-c-h-a-r-y P-o-s-s, and I'm a senior manager of state advocacy, the Pharmaceutical Research and Manufacturers of America. Today I'm here to voice our opposition to LB567, a bill that would require pharmaceutical manufacturers to provide 60 days advance notice to state purchasers if a manufacturer plans on increasing the wholesale acquisition cost, or WAC, by 16 percent over the course of two years, or a three-day notice after introduction if a manufacturer introduces a medicine to the market at a WAC equal to or greater than the Medicare Part D threshold for specialty drugs. This legislation would place a significant burden on the Department of Administrative Services, collecting a large volume of information that can be misleading because it does not draw information from the entire pharmaceutical supply chain and, rather, singles out pharmaceutical manufacturers. Most importantly, this legislation will not help patients understand their cost of medicine or better afford their medicine. First, discussions about the costs and affordability of medicines are important, but legislation like this will not help patients for the state. The advance notification of WAC price increases creates financial incentives for secondary distributors to enter the pharmaceutical supply chain, thus creating a gray market. Gray market distribution networks consist of a number of different companies, some doing business as pharmacies and some as distributors, that buy and resell medicines to each other before one of them finally sells the drugs to a hospital or other healthcare facility. As the medicines are sold from one secondary distributor to another, the possibility of counterfeit medicines augmenting the supply of legitimate medicines increases, thereby threatening patient safety. Furthermore, the constitutionality of advanced notification requirements is questionable and is currently the subject of litigation in California. Second, this legislation inappropriately

targets only one part of the healthcare continuum and doesn't examine the entire pharmaceutical supply chain. As you can see from the-- one of the handouts in front of you has a lot of circles on it. There are a lot of players in the pharmaceutical supply chain and it's very complex. Specifically, the notion that medicines are the primary driver of healthcare cost growth is false. In fact, retail medicines in Nebraska were actually less than 5 percent of the Medicaid spend in 2017. And a report issued in 2017 by the Berkeley Research Group does look at the entire pharmaceutical supply chain. It examines the complexity of drug spending and the many entities that make up the drug supply chain, including wholesalers, pharmacies, pharmacy benefit managers, or PBMs, and payers that impact the net price of a medicine and the price the patient pays at the pharmacy. The report states that brand biopharmaceutical companies realized just 39 percent of total gross drug spending, or the amount paid by payers and patients to a pharmacy, which is based off the list price or WAC before rebates, discounts, and fees were calculated. Specifically in 2015, brand manufacturers paid more than $130 billion in the form of discounts and fees, with nearly $60 billion going to PBMs and health plans. In 2017 the manufacturer rebate had jumped to $153 billion. And in the Nebraska Medicaid program alone, brand manufacturers paid $121 million in rebates in 2017. It's also important to note that even though manufacturers pay these substantial discounts and fees, many manufacturers provide copayment assistance to the tune of $7 billion yearly, and because of these rebates that manufacturers give to PBMs, CBS Health stated that it's drug spending growth was kept to only 1.9 percent in 2017, which is down from 5 percent in 2015 and 11.8 percent in 2014. Additionally, Express Scripts recently announced that their prescription spending only grew 0.4 percent in their commercial plants and projects similarly low growth over the next three years. These trends reaffirm that after a spike in 2014, increases in drug spending are stabilizing and are projected to remain in line with increases of other healthcare services. Finally, it's important to understand that there is no formula for setting a drug price. For example, a manufacturer could consider past research and development, including failures, the needs of future research and development, and the value of treatment to patients, payers, and society. And you've heard, and will hear, a great deal of information today, and I want you to know that we are a resource to each of you and look forward to working with the committee on these very complex issues. One thing that is irrefutable is that patients, your constituents, are not seeing the savings that are being paid by pharmaceutical manufacturers to PBMs, insurers, and others in the supply chain. It's time to figure out how

patients can benefit from these significant discounts and rebates. Thank you, and I'd be happy to take any questions.

**HOWARD:** Thank you. Are there questions? Senator Hansen.

**B. HANSEN:** I think I might ask this, also, of Senator Morfeld, but I'm going to ask it of you. I'm assuming, or I think the intent of trying to, in the name of transparency and saving the patient money on their medication, is that then manufacturers, manufacturers would be able to see the price of each other's medications, whereas they weren't able to before. Then would we create competition and then they might lower their prices?

**ZACHARY POSS:** So the way that this bill is written is really that purchasers will get the notification of price increases. We believe that a competitive market is central to bringing down price increases. We know that when a brand first comes on to market, it will face competition from other brands within two to three years. And then at the end of its patent lifecycle, generics will come on and further reduce the price significantly.

**B. HANSEN:** Thank you.

**HOWARD:** Senator Cavanaugh.

**CAVANAUGH:** Thank you, Chairwoman. So I guess I'm a little confused about what your issue is with the bill, because it's-- you talked about the complexity of the pricing in this chart, which I appreciate a good visual. But this bill is asking for-- that the price change is coming from here; it's not asking about all this other stuff. So it's not actually as complicated as all of that. It's this piece right here and the notification just of this origination piece.

**ZACHARY POSS:** So there are a couple of things. The notification piece is constitutionally questionable right now, and that's under litigation in California. It also requires a lot of reporting of information that we don't believe will actually help patients: A) understand what they're paying when they go to the pharmacy, and B) it won't, this information wouldn't help patients better afford their medicines. We're in search of real solutions that will help patients better afford their medicines when they're picking them up the pharmacy counter; and we don't think this bill does that.

**CAVANAUGH:** But it does inform healthcare companies that they can expect an increase and prepare for that.

**ZACHARY POSS:** It gives a 60-day advance notice, which could create a gray market. So if the distributors are aware that a price increase is coming, they can buy up or advance purchase a large quantity of medicines they expect to see a price increase, which could cause shortages, can introduce counterfeit medicines into the supply. It's challenging and potentially harmful to patients.

**CAVANAUGH:** And drug wholesalers are allowed to buy things that far in advance, because don't they expire?

**ZACHARY POSS:** It depends on the types of drugs.

**CAVANAUGH:** There's-- doesn't every type of drug have a certain, the expiration and how long you can [INAUDIBLE]?

**ZACHARY POSS:** Yes, and an expiration date can vary from drug to drug. For example, biologics. It creates a-- because of the way biologics are produced, it's an even more difficult logistical supply chain issue.

**HOWARD:** Thank you. Senator Murman.

**MURMAN:** I'm probably the only one-- and thanks a lot. I'm probably the only one in here that doesn't know the answer to this question, but how long is the patent life cycle?

**ZACHARY POSS:** Patent life is 20 years, however it can be a little misleading. So when a new molecular entity is discovered, a company will file a patent and, from that point in time, the 20-year clock starts. But that 20-year clock encompasses all the research and development, bench, clinical trials, etcetera. So by the time a company gets the drug approved by the FDA and it gets to market, there might only be eight-ten years maybe left on the patent.

**MURMAN:** OK. And also, you mentioned the spike in drug prices in 2014. What would you attribute that to?

**ZACHARY POSS:** Twenty fourteen was an unusual year with the passage of the Affordable Care Act. You saw a significant increase in the amount of people who had insurance. There was also a record number of approvals at the FDA of new drugs, and there was a, again, record

number of drugs that were not coming off patent, so the generic entry that year was lower, as well.

**MURMAN:** OK, thanks.

**HOWARD:** Other questions?

**B. HANSEN:** Can I have one more?

**HOWARD:** Oh, Senator Hansen.

**B. HANSEN:** OK. I want to just make sure I wrap my head around this, right? So the manufacturer would have to report pricing plans used around the world, right? That's what this would require?

**ZACHARY POSS:** Um-hum.

**B. HANSEN:** This bill would require the manufacturers to report their pricing plans used around the world?

**ZACHARY POSS:** Yes.

**B. HANSEN:** And then could that result then in reporting an estimated volume of patients that use the drug?

**ZACHARY POSS:** Yes.

**B. HANSEN:** So then this would, would this bill then require drug manufacturers to reveal just about how much profit they stand to make off the result of international and national sales?

**ZACHARY POSS:** I believe that's the language of the bill.

**B. HANSEN:** OK, thank you.

**HOWARD:** Senator Cavanaugh.

**CAVANAUGH:** So is there a problem with that?

**ZACHARY POSS:** Again, it falls into this reporting that we're not sure how this actually helps patients. It's onerous reporting requirements and none of this information will actually tell a patient, when they go to the pharmacy counter, this is how much they're going to pay. And it won't help the patient better for their medicines when they're picking them up at the pharmacy counter.

**CAVANAUGH:** But if their healthcare provider who's negotiating the costs of these drugs has this information, it will help them infinitely if they know that these drugs are being sold significantly lower rates in other countries.

**ZACHARY POSS:** The challenge with trying to do price comparisons with the U.S. and other countries is that it's really an apples-to-oranges comparison. Other countries have a significantly different style of healthcare.

**CAVANAUGH:** But they still have human beings that are receiving medication and dosages based on weight, age, etcetera. So it's not apples-to-oranges 'cause they're still people-to-people.

**ZACHARY POSS:** Their system of healthcare is different. And oftentimes we'll see that other countries do not receive access to medicines at the same time that the U.S. does. In the cancer space we've seen--

**CAVANAUGH:** But we're talking about the cost of the medicines; we're not talking about the delivery of the care. We're talking about the cost of the medicines, allowing healthcare providers access that they don't currently have to how much a manufacturer is receiving for a specific-- let's say Amoxicillin-- how much that manufacturer is receiving for Amoxicillin here versus in the U.K. versus in Uganda. We want to know those prices as a healthcare provider so that we can actively negotiate an appropriate price for our clients who are the patients or, in some instances, the government. So the people, that's what we're looking for. We don't, we're not talking about how that Amoxicillin is distributed or administered.

**ZACHARY POSS:** And I think one of the challenges, though, is that some of these other countries have government-imposed price controls in their healthcare systems which mandate what the price of a drug could be.

**CAVANAUGH:** But just companies still operate there, which means that they still make a profit. They wouldn't do it out of the goodness of their hearts. So even if there is a government-mandated cap on that, we want to know that information. And we do understand that other countries have different ways of administering their healthcare. So that's not the issue. The issue is that we still want to know that information as to what the cost is.

**ZACHARY POSS:** And again, we don't think that this information will actually help patients when they're picking up their medicine at the pharmacy counter.

**CAVANAUGH:** Sounds like it might help though, negotiating the costs. So thank you.

**HOWARD:** Other questions? I did want to ask-- you've mentioned this constitutionality question. Can you tell us a little bit about the litigation in California?

**ZACHARY POSS:** I-- unfortunately I can't tell that much.

**HOWARD:** Well, what is the constitutional issue anyway?

**ZACHARY POSS:** The constitutional issue, as it relates to the dormant commerce clause and interstate commerce, I think I would really have to defer to our legal counsel. But I think, in essence, these-- the reporting in California goes to state purchase, state purchasers in California. And there's a question of whether or not that reporting is protected, whether it could be mandated under the First Amendment, and whether or not that information can cross state lines.

**HOWARD:** Thank you.

**ZACHARY POSS:** Um-hum.

**HOWARD:** Anything else? Now are you visiting us from out of town?

**ZACHARY POSS:** I am.

**HOWARD:** Where are you visiting from?

**ZACHARY POSS:** From Washington, D.C.

**HOWARD:** Well, welcome. We're glad to have you in Nebraska.

**ZACHARY POSS:** Thank you.

**HOWARD:** Thank you so much for your testimony today.

**ZACHARY POSS:** Thank you.

**HOWARD:** Our next proponent testifier?

**WILLIAMS:** Opponent.

**HOWARD:** Opponent-- our next opponent testifier [LAUGHTER].

**WILLIAMS:** It worked a little to have that lunch break.

**PHIL KOZERA:** You feeling lonely, Adam?

**MORFELD:** Just a normal bill.

**HOWARD:** Oh, man. Good afternoon.

**PHIL KOZERA:** Good afternoon. Chairperson Howard and members of the committee, my name is Phil Kozera; it's P-h-i-l, last name's K-o-z-e-r-a, and I am the executive director of the Bio Nebraska Life Sciences Association. We have a statewide membership of over 80 members that are working on innovative products and services that are impacting human health, medical device, animal health, plant sciences, and bio-based materials. We respectfully oppose LB567, which would enact various reporting and notification requirements on biopharmaceutical manufacturers. As we've talked a little bit, modern biotechnology is a young industry. But just-- in over four decades the scientists, researchers and entrepreneurs working in this field have really established themselves on the forefront of medical innovation. What was likely a terminal or debilitating prognosis 30 years ago, today may be a curable or manageable disease, thanks to advances in medical research. Over 70 percent of the companies working on these innovations are small, prerevenue enterprises. Ninety percent of these companies involved in medical research do not earn a profit and focus solely on innovative research and development for future products. Their success in getting new cures and therapies to markets rests on the ability to attract enormous amounts of private capital required to fund these challenging and risky endeavors. If you've spent any time with our Nebraska biotech entrepreneurs, you know that they really have two concerns: one) Are they able to continue the evolution of their technology? And two) Do they have enough cash and reserves to hit those milestones? Bio Nebraska believes that the requirements in LB567 will have a negative impact on our innovative ecosystem in, in Nebraska by hindering these companies in the development of these new treatments and cures, and ultimately will fail to provide lower healthcare costs for Nebraskans. LB567 forces burdensome reporting requirements on small and midsize pharmaceutical manufacturers which, in turn, puts innovation at risk. And the industry itself has undergone significant changes over the last decades. A lot of the

large pharmaceutical companies no longer have significant R and D departments, and so they rely on the small and midsize companies to provide that innovation. They recognized years ago that these smaller companies were more nimble. And where Nebraska fits into this equation, our members are working on technologies that they hope to prove commercially viable. And then the relationship with the large manufacturers, they take a look at that technology and eventually acquire that technology. Therefore, you know, our small companies play a significant role in the development of new, new cures and must use their limited resources efficiently and effectively. And we think that the proposed reporting requirements on these small prerevenue companies will take precious capital and direct it towards additional FTEs to handle the reporting requirements in this legislation. We also don't think that the legislation will actually lower the out-of-pocket costs, which we feel should be the goal of this type of legislation. We heard a little bit before about the wholesale acquisition costs, but it doesn't accurately reflect the true costs of the plans. As the previous testifier noted that-- these large pharmaceutical companies pass along significant rebates to the PBMs and insurance companies, and these dollars are not getting-- they're not directed toward reducing those healthcare costs. So as a Nebraskan and a member of our state's biotechnology industry, LB567 raises several questions. How will this legislation impact our biotech company? We've worked hard on developing resources, provider innovative companies, a lot of those technologies coming out of the University of Nebraska and the Med Center, and our goal is to keep them here to commercialize. Will this legislation differentiate Nebraska so now that they look at other states to develop? And will it provide less access for Nebraskans to get the cures that they need? Will companies then limit the amount of drugs and treatments in Nebraska and require our Nebraskans to have to go to neighboring states to get the cures that they, that they need to treat the ailments that they have? And in closing, we're, we're happy to work with Senator Morfeld on legislation that we think would truly address the cost of drugs. And it's an opportunity, I think, really to do something in Nebraska that the rest of the country can look to as, as a model. With that I'll open for questions.

**HOWARD:** Thank you. Are there questions? Senator Cavanaugh.

**CAVANAUGH:** Thank you. It's my understanding from your testimony that your opposition is to the, not, not direct for the, the Bio Nebraska

Life Sciences, correct? It's more of the indirect effect, because you don't currently produce and manufacture and sell.

**PHIL KOZERA:** So I'm a, we're the trade association.

**CAVANAUGH:** OK, awesome.

**PHIL KOZERA:** So we have member companies.

**CAVANAUGH:** But your member companies don't. But do they manufacture and sell?

**PHIL KOZERA:** So they're-- they work on technologies that will--

**CAVANAUGH:** They're the research.

**PHIL KOZERA:** -- treat various-- yes, yeah. So--

**CAVANAUGH:** Right, OK. So this is an indirect implication to their business.

**PHIL KOZERA:** Yes.

**CAVANAUGH:** OK.

**PHIL KOZERA:** Yeah.

**CAVANAUGH:** Thank you.

**PHIL KOZERA:** Yes.

**HOWARD:** Other questions?

**WALZ:** [INAUDIBLE], I have a question.

**HOWARD:** Senator Walz.

**WALZ:** That, that helped me. So, so we live in like one of the most powerful, most "opportunic"-- we live in the, in the United States which is, we have the most abilities, we have the most opportunities, we have the best technology than any other country. And we are paying more than anybody else in the world for our medication. What ideas then do you have that would, that we could reduce the amount that people are paying for medication? Because you guys do an awesome job. But we have to let people be able to--

**PHIL KOZERA:** Sure, yeah.

**WALZ:** -- access that medication. So how can we reduce that cost?

**PHIL KOZERA:** I think there are opportunities. You're correct that we do lead the world in innovation. We certainly provide the most new technologies. We're leadership in a variety of disciplines, whether it's Parkinson's or cancer or Alzheimer's. A lot of that innovation is, is happening here. But we also, as you said, have high out-of-pocket costs. And I can't sit here and say, here is the specific answer. But we do feel very strongly that this focus simply on the, on the innovators and manufacturers, fails to incorporate significant players in this process. And so if we could see those rebates that the drug companies are passing along, and seeing those rebates actually passed along to the consumer, I can see that there would be a significant reduction in cost. What's happening now is those rebates-- there didn't used to be this middle section: pharmacy benefit managers and insurance companies. Typically you saw the, you had the manufacturers and they went to the pharmacy. But there's this huge middle group that has significant impact on the cost of drugs. And we think, to find a solution, we have to take a look at all the players that are involved in that drug pricing. And we also have to factor in the impact that innovation has on reducing costs. If you're looking at something before that would have been a lifelong-- Hepatitis B is an example of that-- the fact that you now have a cure for hepatitis B. And there are numerous examples of that.

**HOWARD:** Other questions. Seeing none, thank you for your testimony today.

**PHIL KOZERA:** Thank you.

**HOWARD:** Our next opponent testifier? Good afternoon.

**GREG HOKE:** Good afternoon, Madam Chair. And thank you, members, for taking up this, this issue. It's a tough one; we understand that. My name is Greg Hoke; G-r-e-g, last name is H-o-k-e, and I am the regional director of government affairs for the Biotechnology Innovation Organization. We are the international trade association representing really everything biotech, from food to ag to industrial and to human health, and we represent 1,300 member institutions: universities, research centers, biopharmaceutical research manufacturing companies, innovators, incubators, and state associations like Bio Nebraska and Mr. Kozera, who he represents. I

don't want to, to repeat things that have already been repeated or said, but let me just say this: ninety percent of our member companies on the human health side are prerevenue companies. They are three or four people, sitting around in a laboratory inventing stuff, and what they're inventing are the cures for diseases tomorrow that we're just treating today. And Mr. Kozera laid out some of those diseases. They are, they're: hepatitis C-- we have a cure; certain childhood cancers-- we have a cure; childhood leukemias-- we have a cure; blindness-- we have a cure. These are, these are diseases that would have harmed life or ended life just a few years ago, and we are literally on the cutting edge of explosive new therapies and treatments coming down the pike. But they're very, very expensive and, unfortunately for these 90 percent of our member companies that are prerevenue companies, they don't have a extending product line that they can fall back to, to help fund this research. They are completely supported by the angel investors and venture capitalists of the world to maintain and keep their operation going. And as you've heard earlier and you've heard from previous testimony in other years, this is the most risky business that there is. It's almost a 10,000-to-1 shot for a product that ever gets to the clinic, to the, to a, to a-- studies that will ever become a product on the market. And then it's even riskier if that product, once it hits the market, ever becomes profitable. It's an incredibly risky business, and anything that would enhance-- or rather, inhibit-- access to that capital to keep these operations going. And we feel that that would be something that would inhibit innovation and potentially stop the process that's bringing these-- excuse me-- these new products to, to the marketplace. For that reason we're very welcoming and helping to craft some kind of legislation that looks at means to expose, to have more transparency in this process. We don't believe that focusing on 14 percent of the healthcare spend, which is what pharmaceuticals are and have been for decades, we don't think that that's a fair assessment of what's happening in this marketplace. But we're very willing to work and look at other transparencies across the medical spectrum, how we can help bring down costs across the board. And one other reason that we oppose this legislation is it looks only at cost. It does not look at the offsets. If you take products-- recently for hepatitis C-- what is the cost of maintaining a patient with hepatitis C, or providing for a liver transplant at some point in the future, or for liver cancer? The cost of the medication, yes, was high, but the cost of the medication has dropped over the years by competition entering the marketplace. You passed legislation two years ago for accessing biosimilars, interchangeable biologic drugs; and we very much appreciate you doing

that. Those products will be on the market soon and, when those products come on the market, we'll also see a decrease in the cost, in the cost there-- excuse me. So we believe the market can work but we also understand that there are issues with transparency, and we're willing to work with the sponsor to look at these, these issues across the medical spectrum.

**HOWARD:** OK, thank you. Are there questions? Seeing none, thank you for your testimony today.

**GREG HOKE:** OK, thank you.

**HOWARD:** Our next opponent testifier? Anyone else wishing to testify in opposition? Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Morfeld, you are welcome to close.

**MORFELD:** Well, that wasn't so bad. Well, just a few different things. I've got a few notes; I won't go through all of them. In terms of the legal challenge, I was perusing the lawsuit and, in the words of my old constitutional law professor, when you have to start out with the dormant commerce clause as your legal argument, you're in trouble. So in terms your legal case, I, I-- you know, there's a lawsuit on just about every law and other thing that you can think of out there that particularly impacts big business, because they have resources to challenge those laws. So if we stopped or didn't implement a law because there's a lawsuit in some other state, we would probably never implement any law or regulation or program. So I don't think that should get in the way. And that's the job of our attorney generals, to defend our laws. Second, you know, short of cost controls, I'm not quite sure what else we can do to be able to provide transparency and be able to provide what I consider peer pressure essentially, peer pressure and justification for price increases so that the public can be more well-informed and that those price increases can be justified and, hopefully, a bit more reasonable. So anything short of cost controls, price controls, which is, you know, I think a lot more intrusive than what we're talking about here, which is transparency, I don't know what else we do. If we want to include the PBMs, then great; we can include PBMs. We can make everybody be transparent and report. And, you know, I need to learn a little bit more about the industry, and I think this has been helpful today. I'm going to sit back and talk to these folks after this and learn a little bit more. Maybe there needs to be a little bit more narrowing of the bill. But for these folks that are two- or three-person shops, my understanding-- and again, it could be wrong and I'll find out after,

I'm sure, or people will be shaking their heads behind me-- my understanding is that these two- or three-person, you know, research and development shops, they're developing the drug and then they sell it off to a larger manufacturer and pharmaceutical company, that then manufactures it and then would have the responsibility of reporting some of these price increases and these cost increases. And so-- and if it's 10,000 to 1, in terms of odds of these different drugs that are being developed and actually make it to the market, then that's, that's not very many people that actually have to report that in comparison to all the other people that they represent in the biopharmaceuticals industry. So the bottom line is, is the status quo is not working. I think we can all agree that status quo is not working, that there has to be some kind of change. And the thing that's frustrating for me with the healthcare industry is anytime you try changing something, everybody kind of points to somebody else and says, well, that's not our problem. We have to start somewhere. And if this needs to be expanded so it's broader, so it requires everybody to be transparent, then I look forward to all these folks behind me coming and testifying in support next year, and I'm happy to do that. I'd be happy to take any questions.

**HOWARD:** Thank you, Senator Morfeld. Before I forget, I forgot to read the letters. So there were two letters in opposition: Jason Jackson from the Department of Administrative Services, and Tara Ryan from the Association for Accessible Medicines. Are there questions for Senator Morfeld?

**WALZ:** I just have a quick question.

**HOWARD:** Senator Walz.

**WALZ:** You mentioned-- when you say peer pressure, do you mean competition?

**MORFELD:** Yeah, competition. I mean I think that transparency-- anytime you have transparency-- I think it creates incentives for, I think it creates a higher incentive to: number one, be reasonable; and number two, be more thoughtful about what you're doing.

**WALZ:** OK, thanks.

**HOWARD:** OK. Any other questions? All right. Seeing none, thank you, Senator Morfeld.

**MORFELD:** OK, thank you.

**HOWARD:** This will close the hearing for LB567. The committee is going to have an Executive Session so we'll ask that you clear the room.