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WILLIAMS: Well, good afternoon, everybody, and welcome to the Banking, Commerce and Insurance Committee. My name is Matt Williams. I'm from Gothenburg and represent Legislative District 36. And I'm honored to serve as Chairman of this committee. The committee will take up the bills in the order posted. Our hearing today is your part of the public process. This is your opportunity to express your position or opposition on a position before us today. Committee members may come and go during the hearing. We will have to introduce bills in other committees and are sometimes called away. This is not an indication that we are not interested in the bills being heard in the committee. It's just part of the process. To better facilitate today's proceeding, we ask that you abide by the following procedures. Please silence or turn off your cell phone. Seating is limited, therefore, we ask that you only maintain a seat in the hearing room when you have an interest in the bill that is being heard. We will pause between bills to allow people to come and go. While exiting the hearing, we ask you to use the doors on the east. We request that you wear a face mask while you're in the hearing room. Testifiers may remove their face mask during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. Public hearings for which the attendance reaches the seating capacity will be monitored by a Sergeant at Arms who will allow people to enter based on the seating availability. The order of testimony today will be introducer, followed by proponents, opponents, neutral testimony, and then closing by the introducing senator. Testifiers, please sign in, fill out a pink sheet and turn it in at the box on the testifiers' table when you go up to testify. As you begin your testimony, we ask that you spell your first and last name for the record. It is our request that you limit your testimony to five minutes. We use a light system. The light will be green for four minutes. It will turn yellow with one minute remaining and will turn red at the conclusion of your testimony. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white tablets at the entrance where you may leave your name and other pertinent information. The sign-in sheets will become exhibits in the permanent record at the end of today's hearing. We ask that you please limit or eliminate handouts. Written materials may be handed to the committee clerk only while testimony is being offered. To my immediate right is committee counsel, Bill Marienau. To my left at the end of

the table is committee clerk, Natalie Schunk. The committee members with us will introduce themselves, starting with Senator Pahls.

PAHLS: Thank you, Chair. Rich Pahls, District 31, southwest Omaha.

McCOLLISTER: Tom McCollister, District 20, central Omaha.

SLAMA: Julie Slama, District 1: Otoe, Johnson, Nemaha, Pawnee, and Richardson Counties.

LINDSTROM: Brett Lindstrom, District 18, northwest Omaha.

AGUILAR: Ray Aguilar, District 35, Grand Island area.

FLOOD: Mike Flood, District 19, Madison and just part of Stanton County.

WILLIAMS: And our pages this afternoon are Caroline and Ashton. Thank you for helping us today. And that-- with that we will begin our first public hearing today. Introducing LB20 will be Senator Carol Blood to provide for insurance coverage of and Medicaid access to prescribed contraceptives. Welcome, Senator Blood.

BLOOD: Thank you, Chair Williams, and good afternoon to Chair Williams and the entire Banking Insurance Committee. My name is Senator Carol Blood, spelled C-a-r-o-l B as in boy -l-o-o-d as in dog, and I represent District 3, which is western Bellevue and southeastern Papillion, Nebraska. And I do appreciate the opportunity to speak with you today on LB20. The intent of LB20 is to create a more consistent access to birth control, which then reduces unwanted pregnancies in our state, which unfortunately can lead to an abortion that ultimately could have been avoided. It would also provide equitable access to healthcare for people who experience additional barriers to regularly visiting a healthcare provider or pharmacy because they may live in a rural area when resources are far away or they depend on public transportation, travel for their careers, maybe a person with a disability, or maybe studying abroad to name only a few of the potential inequities that are currently problematic. LB20 provides for insurance coverage, both private and Medicaid of up to 12 months of self-administered hormonal birth control to be provided at one time. The bill provides an exemption for the first prescription of any birth control method requiring insurance coverage for three months of a new method. This exception is to ensure that it is-- that its continuation

is appropriate and desired by the patient before providing an entire year supply and also allows their care provider the opportunity to monitor that patient's health to make sure it is the right birth control choice for their personal health goals. Now I want to be really clear, this bill does not mandate a provider to prescribe 12 months at a time, although many do that already. It only requires that insurance covers the full supply of the prescription to be provided to a patient at one time for up to 12 months. It does not mandate any new benefits to be covered. It only changes the schedule at which those benefits are to be provided and covered by insurance. This is also an additional choice for the consumer, and not all women will take advantage of the programming, but it will be available to those who choose to utilize this option. Insurance typically only covers one to three months of birth control at a time requiring patients to refill such prescriptions several times in a year. As mentioned before, multiple trips to the provi-- their provider or pharmacy creates unnecessary barriers to pregnancy prevention, especially for those who work long or unusual hours, for those who then have to care for children or other dependent family members before and after their workday. It creates additional challenges for women who do not have a pharmacy nearby or those who do not have adequate or dependable transportation, especially in rural areas. It is especially problematic during a global pandemic when we're asking people to reduce unnecessary community exposure. It should be noted that existing parental consent laws are not affected by this bill when it comes to teens and birth control. This bill, again, only changes the insurance coverage structure. Research and other states' experience with extended supply supports-- support this policy as a method to prevent unwanted pregnancy. A study of over 84,000 women in California who received oral contraceptives of varying supplies: 1, 3, and 12 months found that dispensing a one-year supply was associated with a 30 percent reduction and the odds of conceiving a pregnancy in the subsequent year. The Medicaid program in the state of Washington found that dispensing a one-year supply of birth control for Medicaid recipients was associated with a 12 percent reduction in Medicaid-funded births, saving the state $1.5 million, an average of $226 per client on maternity and infant care. A 2019 study for the U.S. Department of Veterans Affairs, and I'd like to point out that that is the largest health system in the United States, concluded that adoption of a 12 month dispensing of contraception would result in the VA cost savings-- a VA cost savings of over $2 million annually. So

access to contraception remains a major cause of unintended pregnancies, like we didn't already know that, an unintended pregnancy is a major cause of abortion. Research has shown that dispensing a one-year supply was associated with a 46 percent reduction in the odds of an abortion, according to the Nebraska 2019 statistical report on abortions, no contraception used was the most common reason provided for seeking an abortion, 43 percent or 889 abortions, and socioeconomic reasons were provided for an additional 5.7 percent or 118 abortions. This bill will help to, to support uninterrupted access to birth control to prevent unintended pregnancy, ultimately reducing abortions here in Nebraska. Lastly, you may be asking yourself, well, why don't we do this for all prescription medications? Well, I'm not sure that I would disagree that it shouldn't be that way. But I'd like to point out that not all medications have an immediate response when missed. In other words, there's an immediate action that happens, a reaction that happens when you miss a dosage of oral birth control or that can happen, I should say. By enacting LB20, Nebraska would join 21 other states, including the District of Columbia, to require insurance coverage for an extended supply of birth control. And I'd like to address some of the opposition that's been raised during this debate in other states. Some have just suggested that limited supplies are necessary to monitor for side effects of birth control. It's very important to note that currently many providers are already writing those prescriptions for 12 months of birth control, but patients are only provided 1 to 3 months at a time due to the limits of insurance coverage. It's also important to note that there is nothing in this legislation, nothing in this legislation that would stop a physician from writing a prescription for a shorter duration if they are concerned about potential side effects, especially. The extended insurance coverage is only required when an extended supply is recommended and prescribed by the medical provider. Additionally, side effects of self-administered-- start over. Additionally, side effects of self-administered hormonal contraceptives are minimal. In fact, the American College of Obstetrics and Gynecology has recommended that birth control is safe enough to be offered over the counter, and several states and countries are moving to this option. Well, that is not the intent of LB20. The fact that foremost experts on women's health support over the count-- support over-the-counter birth control is strong evidence to support the safety of allowing women to pick up a 12-month supply of contraception with a doctor's prescription. Concerns in other states have been raised about proper storage of

birth control. Both pills and patches should be stored at room temperature away from sunlight, and the ring is kept in the refrigerator. While proper storage is important, there's nothing about birth control that requires extraordinary measures for storage. Women are highly capable of meeting these very ordinary storage requirements and do so currently with a three-month supply that they are often provided. Frankly, many of the women who reached out to me on this bill find it really insulting that anyone would think that they're incapable of being able to do this properly. Finally, some have raised concerns about potential costs because both private insurance plans and Medicaid already cover contraception and because existing coverage is for a 12-month period, regardless of when the contraceptives are dispensed, this bill does not require a new cost. To say otherwise is simply false. There is a potential cost associated with unused birth control with the provision of an extended supply. But research shows that women who received a one-year supply were less likely by 7 percent to switch to another method of contraception than women who receive smaller amounts of birth control at one time. And perhaps most importantly, the potential fiscal impact of this policy pales in comparison to the potential savings. For Nebraska Medicaid, the average annual cost per person for all family planning services is $360 compared to the capitation rate for birthing services at $4,700. Our state could pay for the average annual cost of family planning services 13 times over, that'd be 360 times 13, and it's still less than the cost of a Medicaid birth. This does not include additional costs for Medicaid once that child is born into poverty. It is appropriate for us as policymakers that we govern policy that is for the safety and convenience of Nebraskans for both rural and urban areas. It's going to help protect taxpayer dollars, prevent unwanted pregnancies that can lead to an abortion, and use science and clear data that supports these actions. So in conclusion, this bill provides an opportunity to support Nebraska families in preventing unintended pregnancy. It is an opportunity to support equitable access to healthcare and reduce barriers for rural Nebraskans and for those with additional barriers to transportation. We can implement a commonsense policy that will generate cost savings in our Medicaid program by reducing an unintended pregnancy. And all of this can be done at really no cost for Nebraskans. I'd urge your thoughtful consideration and advancement of this legislation. I do want to add that I've handed out a few documents that includes a letter from Dr. Maureen Boyle of the Methodist Physicians Clinic. She sent her little-- letter a little

bit past the deadline, but I thought it was important enough to enter into the record. We also gave you all a handout that gives us a sort of a quick synopsis on the benefits of this bill. And finally, I'm offering an amendment that you should have in your packets that came after conversations with the Department of Health and Human Services. This amendment offers the same three month trial period to the department that the bill offers to insurance companies in Section 1 of the green copy. With that, I will close and I will add that I believe there are some testifiers behind me who can offer more details about the cost benefit, health benefits, and the benefits when it comes to equity in the state. And with that, I thank you for your time.

WILLIAMS: Thank you, Senator Blood. Are there questions for the Senator? Senator Slama.

SLAMA: Thank you, Mr. Chairman. And thank you, Senator Blood, for being here today. I appreciate the chance to have this conversation. I, I just had a couple of technical questions about the bill itself. So this bill is intended to cover all birth control options with a monthly supply. So like pills, patches, rings, is that correct?

BLOOD: That's correct.

SLAMA: OK. Would it have any other impact on the other forms of birth control?

BLOOD: Such as Plan B?

SLAMA: No-- well, I mean, sure.

BLOOD: That's been one of the questions that's supplied. That's the first, what other types of birth control.

SLAMA: Like, Plan B, the IUDs, any other options.

BLOOD: So IUDs are not something that you usually get a 12-month prescription for--

SLAMA: Yes.

BLOOD: --unless-- I mean, I'm 60 this week, so. But if memory serves correct, IUDs are something that you would put in and you would keep that for a year and then you would go in and, and have that checked.

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SLAMA: Yep.

BLOOD: And then Plan B is not a 12-month prescription. So that would not-- this bill would not apply to that.

SLAMA: OK. I was just wondering about if there would be any other wide arranging effects with the other forms of birth control.

BLOOD: Good question.

SLAMA: And then do we have any other medication that's provided-- you mentioned this briefly in your opening. I didn't know if we had, to your knowledge, any other medication that we allow to be prescribed and given to patients in one-year supplies?

BLOOD: Yeah, to, to my knowledge, they might prescribe it for a year, but you certainly wouldn't receive it for a year. I know that, again, 21 other states do this only for birth control. And to be really frank, I think it has to do, and, and you're right, I did touch down on this in my introduction, is that it, you know, there are other countries that are moving to you being able to walk into a pharmacy and buy oral contraception without a prescription. And that's because it has become much safer over the decades to utilize because of science. And so it's, it's hard to compare it to something like if I, if I don't take my heart medication, I'll likely die. If I miss-- excuse me, I won't likely die. I can go ahead and take-- that was the wrong-- let me rephrase that. If I, if I take my heart medication and, and I miss one, I'm not going to likely die because I missed one pill and I have the benefit of taking it as soon as I remember, usually depending on the type of medication that I take. But with birth control, if I actually miss a pill and then I have intercourse, it is likely that I could become impregnated. So I think that we are comparing apples to oranges because of the type of medications, prescriptions that we're talking about. And it's so much more complicated when you're talking about the other types of pharmaceuticals. Birth control is really not as dangerous as the high blood pressure medication you might take or the heart medication or the insulin that you take.

SLAMA: Well, I think if you miss some insulin that might have some pretty quick repercussions.

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BLOOD: That's true. But at the same token, that is an ongoing thing that you wouldn't want to do--

SLAMA: Sure.

BLOOD: --necessarily a 12-month prescription without a doctor saying that it's OK to do so.

SLAMA: Yep.

BLOOD: And then that's another valid point, too, is that this is only if the doctor says it's OK for you to do so. I mean, say that you were a person that experienced DVTs or PEs from your birth control. Your doctor would most likely want to see you every three to six months. And so this would not be the prescription for that patient, which is why it's the doctors who write the prescriptions.

SLAMA: OK, great. Thank you, Senator.

BLOOD: Thank you for the questions.

WILLIAMS: Additional questions? Seeing none, thank you.

BLOOD: Thank you.

WILLIAMS: We would invite the first proponent. Welcome, Miss Joekel.

TIFFANY JOEKEL: Chairperson Williams, members of the committee, my name is Tiffany Joekel, T-i-f-f-a-n-y J-o-e-k-e-l, and I am testifying in support of LB20 on behalf of the Women's Fund of Omaha. I want to thank Senator Blood for her very thorough opening. I'm not sure that there is much that I can add that she hasn't already covered. But I'd like to add a little bit of our perspective from the Women's Fund. So contraceptive-- contraception requires very strict compliance to be effective. And as Senator Blood said, even a minor disruption in the birth control regimen missing just one pill can result in pregnancy. Nationally, about 30 percent of women report difficulty accessing birth control prescription or refills. So this is a real problem that I think the bill seeks to try to address for those who lack access to dependable transportation, those who live in rural communities and may experience great distance from their pharmacy or their medical provider, for those experiencing reproductive coercion, which I'll talk about a little bit more in a minute. And quite frankly, for those

struggling to balance work, family, they work long hours, they work unusual hours. They have family commitments, responsibilities, getting kids to and from childcare, soccer practice, all sorts of things. I mean, I think there are all sorts of reasons to reduce medically unnecessary barriers for families who would like to properly time pregnancies should they choose to have one. I want to speak a little bit about reproductive coercion, because I think that's important. That is something we see in domestic violence relationships where an abuser may try to control access to birth control. The thinking being that if I get my partner pregnant, they will never leave me. And so this is not uncommon. And what we think this could do is provide increased safety for folks so they aren't having to make regular calls to their provider, regular trips to a pharmacy to try to keep themselves safe if they're not ready to-- not ready or able to leave an unsafe relationship. And so that's something I want to lift up as well. Providing extended supply of birth control is best practice, the CDC recommends that the more pill packs given up to 13 cycles, the higher the continuation rates, quote, restricting the number of pill packs distributed or prescribed can result in unwanted discontinuation of the method and increased risk for pregnancy. I also just want to name what I think is obvious, which is having a child is a life-altering event, intended or otherwise. And I think any of us who have had children on this-- in this room can attest it can be particularly difficult for someone who is not ready to have a child yet. There is-- or not ready to have a child at all, there is significant evidence that it disrupts a woman's educational course, her career course. And so I think it is wise to implement policy that supports family stability by helping and, and promoting the efficacy of birth control if families are not ready to have children at this time or ever. We also know that unplanned pregnancies result in health impacts for both mom and baby, because unplanned pregnancies may not have been something that a family had, had planned on. We often see reduced access to prenatal care, which leads to increased premature birth and low, low birth weight births, which has long-term implications for health costs and for healthcare and for the child's health. Unintended pregnancy also has direct costs to the state. So Medicaid in 2016 paid for approximately 30 percent of all births in Nebraska. The fiscal note says that paying for a month of birth control in Medicaid is $38. So that means a year is $457. I'll do the quick math for you. At $457 a year, when you compare that to the capitation-- the Medicaid capitation rate for a birth is $4,700. That

is just the birth cost. That does not take into account when a child is born on Medicaid, they're eligible for the first 12 months of their life. So that is just the birth, not the ensuing costs. So essentially the math works out that the state could pay for ten years of supply of birth control and it would still be cheaper than one unintended pregnancy. As Senator Blood indicated, the state of Washington in 2014 indicate-- implemented this exact policy and did an extensive research study following the year-- in the years following. What they ultimately found was a 12 percent reduction in Medicaid-funded births for those who received an extended supply of birth control compared to those who received a lesser one to three months supply and a state savings of $1.5 million a year in maternity and infant care services. Additionally, as Senator Blood indicated, the VA found a similar result with their study. There was a very extensive study as Senator Blood said of 85,000 women in California that found a 30 percent lower unintended pregnancy rate. So there is evidence that this would have-- has had an impact in other states. I would just say that I know there will be some concern from opponents about what if we provide a year of birth control and the patient decides to switch. So I think to Senator Blood's point, that's why the three-month exception is important. Right? So you have three months to ensure that the method is appropriate for you and then, then an extended supply is provided after that. Additionally, I would say in the Washington and California studies, they found a lower rate of switching for those who did receive a 12-month supply, which makes a lot of sense. Right? If you only get it one month or three months at a time, you sort of have an opportunity to reevaluate at every, every refill. Whereas, when you have 12 months, you have 12 months and you tend to stick with that supply. So I think the, the impact of switching and waste is real, but it is very small and it is easily outweighed by the extensive potential savings by preventing unintended pregnancy. So with that, I'd be happy to answer any questions.

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

TIFFANY JOEKEL: Thank you.

WILLIAMS: Invite the next proponent. Good afternoon and welcome.

MEG MIKOLAJCZYK: Good afternoon, Chairperson Williams and members of the committee. My name is Meg Mikolajczyk, M-e-g

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M-i-k-o-l-a-j-c-z-y-k, and I'm the deputy director and legal counsel for Planned Parenthood North Central States here in Nebraska. Nebraska is home to two Planned Parenthood health centers, one in Lincoln, one in Omaha. And we also deliver some limited care via our app PP Direct. Annually, we provide care to about 9,000 unique patients in the state, and about 37 percent of our practice is dedicated to prescribing and providing birth control to patients. Birth control methods that are the subject of this bill, as you heard, oral contraception, the patch and the ring make up about 19 percent of all of our visits and half of the methods that we prescribe. And currently we do prescribe a 12-month supply to our patients. Unfortunately, they're not able to access more than typically one-month supply at a time, sometimes three- month supply. So I also provided some information, what that really looks like for our patients, 2,618 visits for supply pickup and delivery in Lincoln and another-- or I'm sorry, in Omaha, and another 2,063 in Lincoln. So people having to come pretty regularly to get their supply if they're getting it through our pharmacy. Thousands of our patients and also tens of thousands of Nebraskans would greatly benefit from the passage of this bill for the reasons Senator Blood so clearly laid forth. So the studies have shown that when patients don't get their one-year supply, one in three patients will actually fail to fill that prescription, which, of course, as you've heard, leads to unintended pregnancies or a higher risk of unintended pregnancies. Planned Parenthood is invested in making sure our patients don't have anything happen to their bodies that they don't want to. And we do also want to prevent those unintended pregnancies where we can. In addition, when you have an unintended pregnancy, it leads to increased costs to insurers, including Medicaid, as Miss Joekel mentioned earlier, and the risks created by the unnecessary barriers erected by insurance companies, the increased likelihood of discontinued or inconsistent use is greater than any risk associated with the hormone methods. Doctors agree with this position. It's standard practice as Planned Parenthood and other women's health clinics, you know, prescribe an annual supply at the time of visit. Once a patient is counseled in what methods are available to them, a complete medical history is taken, anticipated side effects are discussed, and sufficient education, and this is really key, sufficient education is provided regarding both use and when to seek medical assistance so that there is that dialogue about, you know, what symptoms would be problematic that you would want to either reevaluate your method or seek other care. As mentioned, ACOG believes that the risk of hormonal

birth control, irregular bleeding, headaches, potentially weight gain, that's a little unclear, and in rare events, blood clots are so minimal that these methods should be available over the counter. And again, these risks can also be further mitigated during that consultation between patient and prescriber. As you've probably already heard from people that went before me, some opponents may claim patients should have a follow-up appointment with their physician one month after prescription. That is not standard practice, but certainly there's nothing precluding a patient and a physician from determining a follow-up appointment would be necessary. Birth control is not like other prescription drugs and, therefore, it should not be covered or constrained in the same way. And it's true that some reasons insurance companies do limit the availability, availability of supply include things like dosage inconsistencies, or I believe Senator Slama mentioned insulin and how that dosage may change. Birth control static, it is one dose every day for, you know, the prolong taking of the pill. So the dosage issue is, is not present with birth control. In addition, there's also a very low or unknown risk of abusing birth control. That is just not something we hear about. So unlike something like a, a prescription drug that's used for pain, there's no risk here. Another critique of this policy could be the idea that giving a 12-month supply would result in undue risk or waste to insurance companies. And in other words, that women are so fickle with their method that if they get a 12-month supply, say, in month six, they would change to a different method and the company would have to cover that method as well. But as it's been mentioned, that's actually not what the studies show, that when a person gets a 12-month supply, they actually use it more consistently. And it's about 12 percent of women in one study who actually changed their method over the course of that year. And of that 12 percent, most of them change their supply because they want to get pregnant. So it's really not a real risk that we're seeing in the data. Finally, some folks indicate a concern about the long-term storage of these medications. This has been discussed, but oral contraception and the patch are stored very similarly at room temperature away from extreme moisture or humidity. The ring is to be kept under certain temperatures, I believe under 88 degrees. So a refrigerator is a great place to keep it. And coincidentally, these same temperature and moisture rules apply to myriad over-the-counter medications that people possess and use all the time for long periods of time. And for what it's worth, condoms, the main method of male birth control, needs to be kept in cool, dry

locations and not be exposed to friction. Failure to comply with these storage methods may result in method failure. And there's no limit on the number of condoms a person can purchase or have in their possession despite storage risks. And often this less effective method is the one that is actually used if a gap in birth control coverage exists. And I, I guess I'd point that out to say that this, this concern about people being able to safely and efficiently store this seems less rooted in the data than it does in problematic gender stereotypes about women being unable to take care of their own bodies and their own health. So prescription birth control is safe. It's already being prescribed for 12 months at a time with regularity and lack of insurance coverage is the only reason people cannot currently have their entire supply at once. And we know that when people do have their full year supply, they're more successful in consistent use and preventing pregnancies. And for that reason, I would respectfully request the committee advance LB20 to General File. And thank you so much, Senator Blood.

WILLIAMS: Thank you, Miss Mikolajczyk. Senator Slama.

SLAMA: Thank you, Mr. Chairman. And thank you, Miss Mikolajczyk, for being here. I'm interested that you referenced the alternative method of birth control and condoms, those aren't covered by insurance though are they?

MEG MIKOLAJCZYK: No, they're not. And to the point that ACOG makes, birth control should be over-the-counter and easily available to folks, too, which is not what you're dealing with today.

SLAMA: No.

MEG MIKOLAJCZYK: But I, I do bring it up to say it is readily available. We don't worry about men storing condoms. We shouldn't be worried that a woman couldn't figure out how to store her birth control pill outside of a humiditive-- humidity-laden environment. It's just like Tylenol. It just seems like maybe the problem is that we don't trust women to store their medication correctly.

SLAMA: OK, well, I think the bigger issue at hand is the insurance part, but we just disagree on that one.

MEG MIKOLAJCZYK: That's fine. Yeah.

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

MEG MIKOLAJCZYK: Thank you.

WILLIAMS: Invite the next proponent. Good afternoon and welcome to Banking, Commerce and Insurance.

SCOUT RICHTERS: Good afternoon. Thank you. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s. I am legal and policy counsel at the ACLU of Nebraska here in support of LB20. I'd like to thank Senator Blood for bringing this legislation as access to contraception is consistent with longstanding constitutional principles guaranteeing individuals' personal liberty decision-making with respect to their own reproductive decisions. Not only is LB20 consistent with those constitutional guarantees central to individual autonomy, access to contraception is critical to the ability of women to participate in the social, economic, and political life of Nebraska and the country as a whole. And we know that there are significant barriers to contraceptive access, particularly for low- and middle-income women, as has been mentioned. And LB20 removes one barrier to access. By enabling women to access a full 12-month supply of contraceptives in one visit to the pharmacy, this bill reduces the chances that women have a gap in contraceptive use and, thereby, reduces the risk of unintended pregnancies. In summary, constitutional guarantees relating to contraceptive use and access and the numerous benefits of reducing barriers to continuity and birth control use all support the advancement of LB20. And that-- for that reason, we would offer our full support. And I would be happy to answer any questions.

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

SCOUT RICHTERS: Thank you.

WILLIAMS: Invite the next proponent. Good afternoon.

KAREN BELL-DANCY: Good afternoon, Chairperson. My name is Karen Bell-Dancy, K-a-r-e-n B-e-l-l hyphen D-a-n-c-y, and I serve as the executive director for the YWCA in Lincoln. The mission of the YWCA in Lincoln is the elimination of racism and the empowerment of women and girls. We seek to promote peace, justice, freedom, and dignity for

all. We have been engaged in this movement for over 135 years in the state of Nebraska alone. Nationally, the YWCA boasts more than 227 local associations across the United States. And our programs serve over 2 million individuals in the U.S. and over 25 million worldwide. I am here to support LB20, whose intent is to close health inequities in rural Nebraska, those who are relying on public transportation, and women who must travel for work. I would like to thank Senator Blood for introducing this bill and express my sincere gratitude to the committee for your time and consideration. Rural communities face several medical issues, shortages of medical workers, lack of consumer awareness, and transportation issues. Women have to travel miles and miles for healthcare. There are a few healthcare centers in rural communities where women face disparities, low health, screenings, and poor reproductive health outcomes. Nebraskans can close the inequities of access to contraceptives. Prescribing a 12-month supply of contraception would reduce barriers to basic reproductive care. Women need access to contraceptives to be covered by insurance. Insurance can be a luxury, and many times there are many items that are covered by insurance that are very expensive for women, specifically. The choice to use contraceptives for women is there, but not the luxury of insurance coverage. Insurance can be tied to employment. Women who travel for work would like the right to have contraceptives easily accessible with their benefits. There are only 30 states who cover prescription contraceptives through insurance. It is now time for Nebraska to join these states and take a stand. This legislation will be beneficial to all women in the state of Nebraska. And we urge you to advance this the General File.

WILLIAMS: Thank you, Miss Bell-Dancy. Are there questions? Seeing none, thank you for your testimony.

KAREN BELL-DANCY: Thank you for your time.

WILLIAMS: Invite the next proponent. Seeing none, we will move over to opponents. We invite the first opponent. Welcome, Mr. Dunning.

ERIC DUNNING: Hello, sir. Good afternoon, Mr. Chairman and members of the Banking, Commerce and Insurance Committee. For the record, my name is Eric Dunning. That's spelled E-r-i-c D-u-n-n-i-n-g. I appear before you today as a registered lobbyist for Blue Cross and Blue Shield of Nebraska in opposition to LB20. Blue Cross and Blue Shield absolutely respects that the sponsor's intent is to make essential women's

healthcare services more available and easily accessible. We share that goal as well. Birth control coverage is heavily regulated under federal rulemaking with required coverage at little to no cost sharing as a federal minimum standard. Many Blue Cross and Blue Shield of Nebraska policies cover prescriptions on a 90-day basis. And in addition, we have significant numbers of our members covered under policies that allow for six-month fills of birth control prescriptions. We don't see a significant number of women who take advantage of that option. Last year, out of more than 43,000 prescriptions filled for 8,000 women who were eligible to take advantage of the, of the six-month prescription, we only saw 39 women who chose to do so. In addition, we believe that there are a few, there are a few issues the Legislature would want to consider before requiring coverage for a year at a time. Policies are written on a one-year basis. This bill would require insurers to extend coverage for prescriptions beyond that coverage period. Also, as these pills become more and more sophisticated, we believe that mid-coverage adjustments to prescriptions will become more common. We see significant issues with disposal, disposal of unused prescriptions, as is. Although, we, pharmacies, and our competitors all fund prescription disposal efforts, as a society, we're seeing increased issue with pill disposal. A requirement that pill-- birth control pills be issued for a one-year minimum will only make that issue worse. Because we're not seeing much member demand for an even six-month birth control filling, we do not believe that there's a need to have a one-year prescription minimum added to Nebraska law. While we absolutely respect Senator Blood's intent is to make essential women's healthcare services more available and easily accessible, we don't agree that an additional coverage mandate will necessarily accomplish that goal. Sitting in the audience, I heard a few, few arguments made that one of which I want to address in particular. There's been concern about disparities for women who live in rural parts of our state and their access to these pills and other methods of contraception on a, on a-- on the same basis that women who live in urban areas have. I would point out that tomorrow you will hear extensive testimony on mail order pharmacies and their operations in our state. Mail order pharmacies are a real option for people who want to fill prescriptions at a reasonable cost. And those services are not only available in our urban parts of our state, but in our rural parts as well. So with that, I would be happy to answer any questions, Mr. Chairman.

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WILLIAMS: Thank you, Mr. Dunning. Questions? Senator McCollister.

McCOLLISTER: Yeah. Thanks for appearing, Mr. Dunning. If those people given the option to get their birth control pills, pills for six months, don't usually follow through on that. What's the opposition to 12 months if you think very few people will want that option?

ERIC DUNNING: Well, in general, we believe that the market should be allowed to work and that employers should be able to buy insurance policies that fit the needs of their employees as they move forward. So while if we have employers who want to fill on a, on a six-month basis or even as the University of Nebraska does, according to the fiscal note, on a one-year basis, that, that seems appropriate. However, as a minimum standard, we just disagree that there, that there needs to be lawmaking in this particular space.

McCOLLISTER: Thank you.

WILLIAMS: Senator Slama.

SLAMA: Thank you, Mr. Chairman. And thank you, Mr. Dunning, for being here today. I, I just wanted to follow up on a point that you made and you're right has been made several times about access and disparate access for folks in rural areas, folks who struggle to take off of work to get their prescriptions. So you mentioned mail order birth control pills that someone can be prescribed and then they show up in their mailbox in the three-month supply. It's just a matter of walking down to your mailbox and getting your birth control pills, is that correct?

ERIC DUNNING: Correct.

SLAMA: And you provide coverage for those as well?

ERIC DUNNING: Yes, ma'am.

SLAMA: Fantastic. Thank you.

ERIC DUNNING: Thank you.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah. Forgot the second question, but here it comes. Do Blue Cross companies provide year coverage for some birth control pills in the country?

ERIC DUNNING: Around the country, Senator, I would point out that Nebraska-- Blue Cross and Blue Shield of Nebraska is a standalone company. We provide coverage only in Nebraska. In terms of how our sister companies cover this, I could not answer. However, I would note that there are a number of states that have passed a mandate that looks like this. States like Washington or, or that sort of thing. And we would presume that our sister plans would be in compliance with state law.

McCOLLISTER: Are there other companies besides the Blue Cross Blue Shield companies that provide year coverage for birth control?

ERIC DUNNING: Honestly, Senator, that's not a point that I have investigated. I know what we do.

McCOLLISTER: Thank you.

WILLIAMS: Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, Mr. Dunning. So you describe this as a mandate.

ERIC DUNNING: Um-hum.

BOSTAR: And I think, I think I'm trying to understand. So tell me, tell me in, in this narrative where I'm, where I'm getting mixed up. If a, if a physician prescribes birth control and they prescribe it for a year, that is covered by your company, but the, the distribution of it is segmented into nonannual dispersions.

ERIC DUNNING: Um-hum.

BOSTAR: So the bill isn't asking you to cover something you aren't already covering, you're, you're, you're currently-- you're covering the year, the prescription for this medication. But it's just about when the, the customer can receive it?

ERIC DUNNING: I see the road you're going down, Senator, and, and understand the point you're trying to make, but because our policies

are typically written on a one-year basis and because employers and, and, and members move from company to company at sometimes at the end of that year, the extent to which we're required to pay for the, the-- those physical pills or what have you for a, for a period of time that extends beyond the period of time in which we have coverage, I think would best be described as a mandate.

BOSTAR: OK, so, and out of my own ignorance, because I don't work in this industry, I want to explore that just a little bit. So if you were to-- if I were to get a prescription for a year's worth of medication and it was a year's worth of medication that you were willing to give me up front, but I'm six months away from the termination of my policy and, and I go to a different company and so you gave me a year's worth of medication, the idea is that you would be at a loss for what you'd already, you'd already given me for that-- the, the final six months?

ERIC DUNNING: The, the discrepancy here, sir, is that in, in the situation you're describing, that would be a decision that was made by the employer in, in terms of the coverage that they wanted to buy. Right? And not as something that was driven by an external compulsion such as the law. And, and it's that part that I think is the mandate.

BOSTAR: And so I'm, I'm going to go out on a limb here and assume, please correct me if I'm wrong, that there are medications that are given in year-- yearly allotments. Does that exist or does it really not exist at all?

ERIC DUNNING: Senator, I would hesitate to speculate in that way.

BOSTAR: OK.

ERIC DUNNING: But granting your point, sure, for the sake of argument, let's grant your point.

BOSTAR: I was just curious, you know, what happens in those cases, right? I mean, do we just-- does the, does the insurance provider just accept the loss and--

ERIC DUNNING: Absolutely, we would do so. Yeah.

BOSTAR: You talked about disposal issues.

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ERIC DUNNING: Yep.

BOSTAR: Can you talk to me a little bit about concerns around disposal?

ERIC DUNNING: So we have significant concerns as a country with prescriptions that are-- that, that cease at one point or another and pills that are left in bottles. What do you do with those pills? In particular, there's been a huge problem with opioid disposal, for example, but the problem doesn't end there. I mean, these are, these are strong chemical compounds. Hopefully, people are not just flushing down-- flushing them down the stool, but we understand that that happens. And so we do, as a society, fund take backs on, on a pretty regular basis. I think that's a legitimate concern.

BOSTAR: So I, I, I completely agree that it's-- there is concerns around having these pharmaceuticals end up in our, in our water system. In the states that have annual coverage and distribution, are you aware, and I understand you don't work in other states, but are you aware of any water quality concerns that relate to an increase in water quality contamination after, say, a, a bill like this has passed?

ERIC DUNNING: Senator, I'm going to defer to your much more extensive knowledge of water quality issues. But we would say that drug take back or drug disposal issues aren't just restricted to, say, water quality issues. But again, what do you do with these prescriptions when people move on and they move to a different form of, of treatment or something isn't working quite, quite right?

BOSTAR: And, and, and I-- if this was covered before I came in, I apologize, I was introducing another bill. But what, what is currently-- what are you required to distribute as far as a prescription? So if someone gets an annual prescription for birth control, I'm assuming you can't dole it out one day at a time or maybe you can, can you?

ERIC DUNNING: You know, I don't know that anybody would have explored that option. I would tell you, Senator, that there are some--

BOSTAR: Please don't.

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ERIC DUNNING: --I would tell you, Senator, that there are some employers that prefer to structure their, their coverage as, as 30 days, some at 90, some at 6 months, and some at a year. And we respond to the demand of the market in that space. And no, we are not looking to-- we've, we've not proposed breaking that down to a year-- or a day, excuse me.

BOSTAR: So since, since the, the insurance policy is, is an annual one and it can change year to year, and I can understand some of that, would there be-- would there still be objection if, say, LB20 was a-- pertained to six months of, of dosage versus a year?

ERIC DUNNING: Yes, Senator, we believe that the employers who pay for the majority of the insurance coverage in, in our society ought to have the ability to structure their contracts in ways that make most sense for them to meet the needs of their employees.

BOSTAR: Thank you, Mr. Dunning. And thank you to the committee for indulging my questions.

WILLIAMS: Senator McCollister.

McCOLLISTER: One more. Currently, responding to Senator Bostar's question, you can extend coverage for six months, correct?

ERIC DUNNING: Yes.

McCOLLISTER: All right, and you're--

ERIC DUNNING: And we could do a year, too, sir.

McCOLLISTER: Yeah. And you're fully paid by Medicaid for-- you're fully reimbursed for that cost?

ERIC DUNNING: Sir, I'm-- can I ask you to restructure your question?

McCOLLISTER: Under Medicaid coverage,--

ERIC DUNNING: Yes.

McCOLLISTER: --you're able to receive birth control benefits. Correct?

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ERIC DUNNING: Again, we don't provide coverage in the Medicaid space, so I'd better not answer questions on, on Medicaid issues. I'm sorry to dodge your question, I just--

McCOLLISTER: OK, let's, let's, let's leave Medicaid out of the--

ERIC DUNNING: OK.

McCOLLISTER: --question. But somebody makes a claim against Blue Cross for birth control pills for six months and, and you will compensate either the person or the doctor, correct?

ERIC DUNNING: Typically, that, that reimbursement will go to the pharmacy. Yes.

McCOLLISTER: OK. What difference does it make to Blue Cross whether it's a year or six months? You're going to be fully compensated anyway.

ERIC DUNNING: Again, our policies are going to, are going to line up on a yearly basis. And unless those-- and unless that prescription is timed directly with the inception of the policy, we're going to be extending coverage from beyond our policy period in all likelihood.

McCOLLISTER: Well, some folks would consider that to be arbitrary and capricious. But thank you for your, your answers.

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

ROBERT M. BELL: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, spelled R-o-b-e-r-t, middle initial M, last name spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies. I appear today in opposition to LB20. First, the members of the Federation certainly appreciate Senator Blood's attempt to remove this possible impediment to women's healthcare. And we also appreciate her reaching out to the Federation just before the session to inform us of her intent and her openness to any suggestions that we had on language. However, our opposition is more philosophical than, than technical at this point. As you have heard, LB20 would require health insurers and the state regulated-- in the state-regulated

market to pay for dispensing of the first 3 months of prescription for birth control for our first prescription, then up to 12 months a prescription afterwards. Typically, as you have already heard, most prescriptions are dispensed on a three-month supply or less. And I was listening and interesting, I think most of the proponents have already told you most of the arguments that maybe we had thought of as an insurance industry. But I want to share really the three main kind of issues that I wanted to bring to the attention of the committee. One is, is, is cost, to be frank, this is a financial transaction, right? Insurance is a financial transaction. And what we don't hear-- what we hear from our constituents or from our constituents-- from our policyholders is we want reduced costs for healthcare, nothing that would possibly increase the cost. And I understand this would be relatively minor in the grand scheme of things. However, what we, what we ask of legislators is not to remove the tools that we use to keep costs down. And certainly there are medical reasons for the three-month prescription. There are, there are also financial reasons if you change in the middle of the year to a different plan, you know, we lose the premium cost and that goes on to a different insurer, etcetera, etcetera. There, there are financial considerations here. Two, is which Mr. Dunning was expounding upon, you know, we-- there should be some market flexibility in the fact that, that insurers have the ability to compete against one another with various market design or benefit designs that exist. So if, if I was Aetna and maybe I wanted to have an advantage over UnitedHealthcare, maybe I would write in a six-month prescription, not just to apply, of course, to birth control, but perhaps many other prescriptions that are out there. I mean, we lose that flexibility when, when the law hammers in, you must do this for this amount of time. And so please don't take away our flexibility there and help us keep our costs down, really the healthcare. And then third, an issue that has not been pointed out today. But I need to point out to the committee so any legislative bill that imposes a mandate will not apply to most federally regulated, self-insured, large group plans governed by the Employee Retirement Income Security Act of 1974, also known as ERISA. And according to research I have read, ERISA plans cover about 50 percent of the privately insured Nebraskans out there. So those are your large employers' health plans. You can't, as a legislator touch those particular benefit plans, according to federal law, you've been preempted. And so for these reasons, the Nebraska Insurance Federation

opposes the passage of LB20. And I appreciate the opportunity to testify. Thank you.

WILLIAMS: Thank you, Mr. Bell. Questions? Senator McCollister.

McCOLLISTER: Thank you, Chairman Williams. You're aware the scope of this bill only concerns birth control. Is that correct?

ROBERT M. BELL: I am, yes.

McCOLLISTER: So fairly narrow.

ROBERT M. BELL: Very narrow.

McCOLLISTER: Understand that. And you are citing cost as an issue, correct?

ROBERT M. BELL: I am, yes.

McCOLLISTER: OK. If you were to fill that prescription once a year rather than four times a year, isn't there less cost?

ROBERT M. BELL: To the insurance company or to the, the person that's paying for that prescription?

McCOLLISTER: [INAUDIBLE]

ROBERT M. BELL: No, it would be the same. I, I would think. I would hope it would be the same unless that prescription changes. Right? So if-- let's say there's some sort of adverse reaction to the prescription, you know, four months down the road, the, the policyholder has to go back to see her doctor and they prescribe something different. And then we're-- we have another 3 months and then a 12 months after that. And so when before they're still going to be-- they're still-- you're still going to lose even in a three-month situation under my example. But, yeah, there could be increased costs.

McCOLLISTER: I don't think so. If you're filling that prescription once rather than four times, you would think that would be less cost. Correct?

ROBERT M. BELL: I, I don't see why it would be. I would, I would say-- see it as the same cost.

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McCOLLISTER: One versus four?

ROBERT M. BELL: Well, I mean, so we're going to charge the same amount of money, right? So let's say it's a-- it's $100 prescription for three months and you get it four times. That's what, $400. If you only get it for 12 months, that's going to be a $400 prescription.

McCOLLISTER: But it takes time for the druggist to fill the prescription, mail it, things like that. So I, I just don't quite understand why you can make the contention. If there's--

ROBERT M. BELL: Well, there are certainly going to be cases where that prescription needs to change. And so if you dispense it on a 12-month period, you know, maybe that only happens 10 times out of 100. But in those 10 times, it's going to be more expensive than it would be otherwise.

McCOLLISTER: And the third point you made is about competition, saying that your company would be disadvantaged if we made this. But of course, if the Legislature were to pass this bill, every company would be subject to it. So there'd be no competitive disadvantage, correct?

ROBERT M. BELL: Well, yeah, we'd all be treated the same and that's my argument. My argument is we don't want to all be treated the same. We want the ability to maneuver within our policies and provide our customers what they want and perhaps have an advantage of one member over the other.

McCOLLISTER: But in insurance policies, there are other mandates that you follow. Correct?

ROBERT M. BELL: Absolutely.

McCOLLISTER: So this would be simply another mandate.

ROBERT M. BELL: It would be another mandate, correct.

McCOLLISTER: Thank you.

ROBERT M. BELL: You're welcome.

WILLIAMS: Additional questions? Seeing none, thank you, Mr. Bell.

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ROBERT M. BELL: You're welcome.

WILLIAMS: Invite the next opponent. Welcome, Mr. Miner.

MARION MINER: Good afternoon. Thank you. Excuse me. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r. I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here today to express the Conference's opposition to LB20. So I've not seen the proposed amendment, but LB20 appears on its face to be a state contraceptive insurance mandate. That is what the plain language seems to indicate to me. But I would be willing, of course, to, to take correction on that and get some explanation. My read of the bill is that it would, in fact, force group health insurance plans, including private plans held by objecting religious employers and closely-held corporations to pay for hormonal contraceptives for their employees. So there are a few different reasons that the Conference opposes this policy. First, numerous studies from sources across the ideological spectrum illustrate that greater access to contraception does not reduce unintended pregnancies and abortion, but in fact tends to increase both. Second, studies purporting to show that increased contraception available decrease abortion are largely estimates and projections with little or no supporting empirical data. I did note in proponent testimony and, and in Senator Blood's introduction citation to a couple of different studies, one from California, one from Washington, one from the VA. And the California study did purport to show a 30 percent decrease in unintended pregnancies. I would be interested in reading that. I have not seen that one. The Washington study, I will point out, talked about 12 percent fewer births. I believe that was recorded under Medicaid. And that, of course, is a very, very different question from whether there are fewer unintended pregnancies and fewer abortions. Third, the third reason we are opposed is that some studies have concluded that a rise in contraceptive use has been a significant factor in the breakdown of marriage, which comes with a high social cost that falls disproportionately on the poor. And fourth, a state contraceptive mandate would potentially involve the state in legal action, similar to several cases including Hobby Lobby and Little Sisters of the Poor that have roiled the country for several years following the imposition of a federal mandate. And I

would point out too that when with regard to federal-- a federal contraceptive mandate, we at least have the protection of RFRA, the Religious Freedom Restoration Act, that gives people with conscientious, conscientious objections to providing this coverage some refuge under federal law. We don't have a state level RFRA in Nebraska so that, that, that protection would not exist. And then onto just some of the social science studies here, two studies by the Guttmacher Institute, which receives significant funding from Planned Parenthood and was formerly affiliated with Planned Parenthood until just recently, found that 48 percent of women with unintended pregnancies and more than half of women seeking abortions were using contraception in the month they became pregnant. In addition, numerous studies examining sexual behavior and STD transmission have demonstrated a greater willingness to engage in sexually risky behavior when a person believes the risk has been reduced through the use of contraception. Researchers in Spain examined patterns of contraceptive use in abortion from 1997 to 2007 and found that a 63 percent increase in the use of contraceptives during that time over 10 years coincided with a 108 percent increase in the rate of elective abortions. In July 2009, results were published from a three-year program in the UK conducted at 54 sites, which sought to reduce teenage pregnancy through sex education and advice on access to family planning, contraceptives, beginning at ages 13 to 15. Quote, No evidence was found that intervention was effective in delaying heterosexual experience or reducing pregnancies, end quote. In fact, young women who took part in this program were more likely than those in the control group to report that they had been pregnant 16 percent versus 6 and to have had early heterosexual experience, 58 percent versus 33. Finally, a study published in 2019 which analyzed whether oral contraceptives played a causal role in the rise of nonmarital births in the United States during the 20th century, concluded that access to the pill significantly increased both nonmarital births and demand for abortion, and that the effects are especially concentrated among less educated families and among minority women. And these studies are all cited in the footnotes. In conclusion, the hard data available shows that increased contraception access does not tend to result in fewer unintended pregnancies or fewer abortions, but tends instead to increase both. LB20 would advance bad policy by pushing for expanded contraceptive usage. In addition, what I read to be a mandate on business owners, closely-held companies, and religious organizations who object to paying for the contraception used by

others is in itself contemptible and a gross violation of religious liberty. We ask that you indefinitely popone-- postpone, therefore, LB20. And I'm happy to take questions.

WILLIAMS: Thank you, Mr. Miner. Are there questions? Seeing none, thank you for your testimony.

MARION MINER: Thank you.

***NATE GRASZ:** Chairman Williams and Members of the Banking, Commerce and Insurance Committee, my name is Nate Grasz, and I am the Policy Director for the Nebraska Family Alliance (NFA). NFA is a non-profit policy, research, and education organization that advocates for marriage and the family, life, and religious liberty. We represent a statewide network of thousands of individuals, families, and faith leaders who are dedicated to upholding religious freedom and protecting human life from conception to natural death. Mandating all private and public health insurance plans cover hormonal contraceptives is a serious violation of the religious freedom and conscience rights of employers and forces taxpayers to pay for other people's contraceptives that in many cases cause early abortions. Hormonal contraceptives can prevent not only ovulation or fertilization, but also the implantation of an already formed embryo - a human being in its earliest form of development - into the uterine wall. This occurs after conception and causes the demise of unique, living human being. Further, many researchers and family planning studies have demonstrated that expanded or increased funding for contraceptives may actually lead to a higher rate of unintended pregnancies and abortions, not less. LB20 directly undermines the sanctity of human life by expanding the use of our tax dollars to pay for contraceptives that can cause abortions, and would force churches and religious organizations to pay for drugs and devices that violate their sincerely held religious beliefs. Due to the severe religious liberty violations and forced funding of contraceptives contained in this legislation, NFA opposes LB20 and respectfully asks the committee not to advance the bill. Thank you for your time and consideration.

***RON SEDLACEK:** Chairman Williams and Members of the Banking, Commerce and Insurance Committee: My name is Ron Sedlacek and I am testifying on behalf of the Nebraska Chamber of Commerce & Industry. LB20 would provide requirements for insurance coverage of prescribed contraceptives. In application, the bill proposes to mandate

additional insurance coverage for group and individual health insurance plans. The Nebraska Chamber would like to register its opposition to LB20. Many trade association members and local chambers of commerce, in addition to our business and industry members, offer either group insurance coverage or federal, ERISA-based plans. In this regard, we represent those businesses and trade associations that are consumers of insurance products which do not offer ERISA plans and that will be directly affected by this proposed legislation. We maintain that the addition of further mandates for non-ERISA plans can only serve to price many Nebraskans out of the group health insurance market or result in some reduction of other benefits of value to the employee. The Nebraska Chamber shares in the concerns of other consumers attempting to find and obtain reasonably priced, affordable health insurance products. We continue to find that the escalating costs of health insurance benefits for employees remain high on the list of business concerns. Historically, Nebraska had remained a relatively lower cost, health insurance state, due in part to the fact that the Nebraska Legislature has been vigilant when it comes to adding on layers and layers of additional health insurance mandates that would exceed federal ERISA standards. While each new proposal for additional mandated coverage may be well intentioned, it is a fact that additional mandated coverage will increase health insurance rates and will affect both the affordability and availability of health insurance for employers and employees. In many cases, the result of increased health insurance costs means higher deductibles or copayments for employees. In some cases, increased health insurance costs may result in the employer and employee being required to reduce or eliminate other benefits that may be more appropriate to their work environment. In a few cases, the aggregation of increased mandates may ultimately result in an employer providing payments in lieu of insurance benefits or the migration of more employers to a VEBA, MEWA or other self-insured ERISA plan. The State Chamber would urge the members of the Banking, Commerce, and Insurance Committee to not advance LB20.

WILLIAMS: Invite the next opponent. Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Blood, while you are coming up, we have drop-off testimony, Nate Grasz from the Nebraska Family Alliance and Ron Sedlacek from the Nebraska Chamber of Commerce, both as opponents. And we have letters for the record in support from Molly McCleery, from Appleseed, Mary Sullivan from the

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National Association of Social Workers, Michelle Walsh from the Nebraska Medical Association, Amy Behnke from the Nebraska Center for Association of-- Nebraska Health Association of Nebraska, and in opposition from Tom Nebelsick from himself. Senator Blood, you're invited to close.

BLOOD: Thank you. So I think we need to drill some things down. So I apologize. I know it's already been a long hearing. I would like to point out that we, we purposely didn't fill this room with folks that wanted to testify in favor of this bill. Instead, we asked that they go online and write comments. You notice that there are 45 proponents in support of this bill on your Uninet. There are actually only four that opposed it. And for the vast majority of those who opposed it, they obviously didn't read the bill because their letters of opposition show that they didn't have a clear understanding of what it did. Senator Slama has stepped out of the room, unfortunately. I wanted to make sure that she looks at page 2, line 7 through 8, that the bill specifically only applies to "self-administered hormonal contraceptive." So page 2, line 7 through 8, which includes pills, patches, and the contraceptive ring. And it's not a standard of care to prescribe emergency contraception for long periods of time because it's not effective as birth control. So she also raised some interesting ideas that perhaps condoms should be covered by insurance and this bill doesn't do that. But that's an interesting concept. So let's talk a little bit first about something that I looked up while I was sitting over there. So according to the AMA, prescriptions that are noncontrolled substances in other states are often prescribed for more than 12 months: Idaho allows up to 15 months; Illinois allows up to 15 months; Iowa up to 18 months; Maine up to 15 months; South Carolina, 24 months; and Wyoming, 24 months. To put things into perspective. So I appreciate the fact that my friends, Rob and Eric testified today. Rob pointed out that I did reach out to the insurance industry because I'm a glutton for punishment prior to bringing my bill forward and did give them the opportunity to work with me. And they chose not to. And I appreciate that. And I understand that anytime there's a mandate, it's their job to come in and testify against it, much like they did with our hearing aid bill. But we also learned through that hearing aid bill and I know, Senator Williams, you were on the committee at that time and I'm not sure if anybody else on this-- in this room was at that time. But we know already that it doesn't approve-- it doesn't apply to the federal insurance

policies. And that's not something that we expected that it would. I want to talk a little bit about-- I have a lot to unpack. I'm trying to go as fast as I can here. So I want to talk a little bit about the mail order pharmacies, because that is definitely not a panacea. So, first of all, a lot of the mail order pharmacies are-- require the utilization of the Internet. And we know about the broadband issues throughout the state of Nebraska. And so that could be a hurdle in itself if they have to utilize the mail order pharmacies. But more importantly, we talked really specifically about storage. Remember how I talked about how heat or extreme cold can be detrimental to medication? So if you work eight to ten hours a day or more and your mail comes in the morning and it's a typical Nebraska summer, putting that birth control in a mailbox is not something that would be productive, is not something that you would want to do. So I like the fact that there may be mail and pharmacy choices, but I think we need to, we need to think about the hot and the cold that we experience, the extreme heat and cold we experience in Nebraska and how, again, that might not be an option for people that utilize certain birth control methods. And then, you know, we all know that low-income families have a tendency to move more frequently as well. And the one thing that I really want to point out, too, is that this is about a doctor prescribing for a patient. This is about a relationship. Right? If the doctor decides that it's not the right thing for their patient, they're not going to write a 12-month prescription. And to intimate otherwise is misleading. So I don't fault insurance companies for saying that they want to be able to compete and, and have their own benefit designs, but that's not what this is about. What this is about is about access to healthcare. And I do appreciate the fact that Blue Cross Blue Shield has basically stated that it's not going to be a financial burden for them. And I want to talk about disposal and unfortunately now Senator Bostar has left. You know, I don't know if you know this, but in Nebraska, every day is disposal day, is take back day. Did you know that? Every single day. Nebraska has a program, you can find it on the Department of Health and Human Services website. And there are locations throughout Nebraska. So if you need to dispose of your birth control, you need not flush it down the toilet or put it in coffee grounds and put it in your garbage, in your garbage can, you can take it to your area pharmacy, to your area law enforcement agency, whoever participates in this program and turn in any remaining medication that you choose not to use. And that's not just birth control. That's all medications. So I want to let you know

that there is already something in place. We talk about the word mandate a lot like it's a dirty word. But, you know, if you sit on this committee, you know full well that we have to do a mandate because of the ACA, we don't have the option to change insurance without making it a mandate. I wish they'd change the word because mandate means we're forcing people, but what we're really doing is our job, which is to amend policy so we can better serve Nebraskans. And again, I can't stress enough that there are 21 other states that are doing this. And if you follow the data, it's not been a financial burden to any of the insurance companies. And they've already stated that for the ones-- for the women that have the benefit to take three to six months of, of birth control when they have the option, that there aren't a lot taking advantage of that. Yet, another, another expression of how this is not a financial burden was said by both of our insurance companies. It's not a burden. It's going to be for a small percentage of women. So now I have to unpack. The last person who came forward, so I'm Catholic and I have to say that it's been really interesting bringing bills like this forward, but I want to put this in perspective. And if I make people uncomfortable, I apologize in advance. So the Catholic Church also bans masturbation, bans masturbation. Indeed, masturbation is a dualistic, self-indulgent activity that uses the body as a means for personal gratification according to what I've been taught in my church. However, I never see the church pushing legislation about this. When I see over 300 bills across the United States in just this last year alone that pertain to women's bodies and health equity, and as usual, I couldn't find any bills that pertain to men's bodies. So what is it about policymakers that makes them so interesting in telling us what we can and cannot do with our bodies? And I wonder sometimes if you-- if those people, and I'm not saying you, if they don't believe that we already know what's in our own best interests between ourselves with our doctors. Shouldn't we be trusted to do what's right, especially when we all know that the main cause of unwanted pregnancies is irresponsible ejaculation. You know, this isn't about religion. I'm Catholic and I choose to follow what I've been taught. However, I'm also a senator who makes laws for all Nebraskans, and it is not the job of my church to be in everyone's bedroom. It is their job to keep their flock in the fold. And frankly, when I go to Mass and I see the vast majority of families in the pews with two or three children, it's clear that there are many in the flock that are utilizing birth control. Upon looking at available data, I found nearly 70 percent of Catholic women

use sterilization, the birth control pill, or an IUD. And that's just a little less than evangelicals and Protestants. And only 2 percent of Catholic women are using natural family planning. I don't like the fact that I had to address this, but it's been brought to the table today in our discussion. We cannot keep making bad laws that pertain to women's bodies based on feelings. We have to do good laws based on facts. And by the way, I stole that, that from Senator Slama that she said in Government last week. We make laws based on facts, not feelings. And if you listen to, listen to the testimony today, a lot of what was brought forward was more about impressions. And not data or not good data. I think we've done a very effective job today sharing with you what the data says. And with all due respect, our friends in the insurance industry actually kind of shored that up for us. It's not going to be an expense, and if that is their concern, I would be happy to bring forward a mandate-- excuse me, an amendment, not a mandate. We said that word so much as in my head now. I would be happy to bring forward an amendment just like we did for the hearing aid bill, that if they could show that it caused them some sort of financial burden and that it could potentially raise the rates of their members, that they would have the opportunity to go to the Department of Insurance and say, we think that this is a burden and we can prove it. And here's the numbers. I'd be happy to do that, just like we did for the hearing aids. But you know what happened with the hearing aids that we were told also was going to raise premiums and be a big burden. It wasn't. Because, again, we use data and we use facts. And so I just really hope that you listen to the data, you listen to the facts, and that you put yourself in the position of the student that's going to travel abroad next year from UNL, or the IT person who travels all over the United States because that's part of her job. And she's not going to have the opportunity to come back to the doctor, come back to her pharmacy. She's going to be traveling and working 12-, 14-hour days. And birth control shouldn't be something she should be worried about. I want you to think about those people who have to get on a public-- on public transportation or take a Uber. There is no reason that we can't make birth control accessible. And with all due respect, I'm going to say this again, and I know that there are other Catholics in this room. We make laws for Nebraskans. We can choose not to utilize birth control. I always point out that my oldest has ten children. We believe what we believe, but it's not my job to shove that down the throats of other Nebraskans. And that's not good policy when you do that. And if, if the Catholic Church thinks I'm wrong to

do that, then that's going to be between me and God. And when I die, I'm sure God will deal with me. But right now, I'm a Nebraska state senator and I represent everybody. And the women in Nebraska are telling me that they want this bill to move forward. And so with that, hopefully I've, hopefully I've drilled down everything that was talked about and I apologize for the long hearing, but I do appreciate your time today.

WILLIAMS: Thank you, Senator Blood. Are there questions for the Senator? Seeing none, thank you. And that will close the public hearing on LB20. We're going to take a very short ten-minute break as people change in here and we will start back at-- right at 3:00 on the dot. Thank you.

[BREAK]

WILLIAMS: Welcome, Senator Wayne. We will open the hearing on LB30 to limit the amount an insured pays for prescription insulin drugs. Welcome, Senator Wayne.

WAYNE: Good afternoon, Chairman Williams and members of the Banking Insurance Committee. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, which is north Omaha and northeast Douglas County. LB-- we literally took the script from last year and it says LB970, so that's the wrong number, would limit out-of-pocket expenses for individuals with insulin and prescriptions to $100 per 30-day period, regardless of the type of insulin, the amount of individuals during the 30-day time frame. We know insulin is very important for those who are diabetic and people are dying every year for rationing it out. I do appreciate the committee Chairman for allowing this to be on the last day. The reason is, is there are some data coming from Colorado that I think it's important that we look at as we craft this bill moving forward. So I would ask the committee to not IPP it, but to hold it. But if they want to IPP it, I'll bring it back next year. But with that study where it's been a couple of years now under Colorado, it'll either support or go against what this bill might actually do. You'll hear from opponents that this bill will actually raise the cost for everybody else. All the proponents who testified last year loved this bill because many of them have seen $1,300 bills on insulin monthly or more. And we've got to remember that insulin was first founded and was given to the government for free and giving it to corporations for free. The idea was to save

lives, not necessarily to make profit. And over the last ten years, roughly, you've seen almost it increase for around 400 percent in some market areas. So, again, this is a bill that I introduced last year. It's definitely needed in the community I represent and across the state. But I know this committee is driven off of data. And so because of that study was ongoing, I asked the committee Chairman to give me a late hearing hoping it would be out. But it's not. And I'd rather have that information before it goes to the floor.

WILLIAMS: Thank you, Senator Wayne. Are there questions for the Senator at this point? Senator Flood.

FLOOD: Senator Wayne, what, what is the, the study that you're waiting on from Colorado?

WAYNE: So Colorado passed a similar bill that capped it and so the insurance industry and the government has done a joint analysis to see if the, if the rate actually went up, if the insulin was actually capped and it didn't had any other cost. It's, it's a cost-benefit analysis of kind of where things are. And so that was one of the biggest critics last year of the bill that both myself and Senator Bolz introduced. And so we were trying to get that data before-- just either counter their argument or to at least have a better understanding.

FLOOD: Thank you.

WILLIAMS: Additional questions? Seeing none, thank you.

WAYNE: Thank you.

WILLIAMS: We'd invite the first proponent.

WAYNE: I waive my closing.

WILLIAMS: OK, thanks, Senator Wayne. Miss Bell, welcome back.

KAREN BELL-DANCY: Thank you. Good afternoon again. I am Karen Bell-Dancy, K-a-r-e-n B-e-l-l hyphen D-a-n-c-y. And again, I am the executive director of the YWCA in Lincoln. And I am here to express our support for LB30. And we thank Senator Wayne for introducing this bill. We know that diabetes is an epidemic in the United States. Over 34 million Americans have diabetes and face the devastating

consequences. In Nebraska, approximately 127,000 people, or 8.8 percent of the adult population have diagnosed diabetes. Alarmingly, an additional 44,000 people in Nebraska have diabetes but don't know it greatly increasing their health risk. Every year, an additional 10,000 people in Nebraska are diagnosed with diabetes. The incidence of diabetes in adults vary significantly by socioeconomic status, race, and ethnicity. This is most likely due to the inequities in the healthcare system. Percentages are 14.7 percent of Native Americans, 12.5 percent of Hispanics, 11.7 percent of African-Americans, and 9.2 percent of Asian Americans. Complications from diabetes are grave and life changing. Common health challenges are loss of vision, kidney failure, and damage to the nervous system, leading to neuropathy. And I won't go into the history of the discovery of insulin because Senator Wayne just spoke to that or the Colorado bill. But I do want to express as an individual being diagnosed with diabetes and coming from a family that we have a, a number of members of our family with diabetes and both of my parents did as well prior to their death. The cost of insulin is so prohibiting. I have paid as much as $400 a month for insulin alone when I was insulin dependent. Reducing the cost of insulin is imperative, and I just urge the committee to consider this bill and push this bill forward. And that would be the sum of my comments. And I would entertain any questions at this time.

WILLIAMS: Questions?

FLOOD: I have two questions.

WILLIAMS: Senator Flood.

FLOOD: Just maybe more general.

KAREN BELL-DANCY: Yes.

FLOOD: There's Type 1 diabetics that, that take-- that give themselves shots and then there's the pump that automatically does it. Is the pump more efficient than the manual application of the shots? I mean, has that improved?

KAREN BELL-DANCY: I don't know that exactly, you know the, the pump versus the needle. So Type 1 or Type 2 can be self-injected.

FLOOD: Sure.

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KAREN BELL-DANCY: And so you have to be taught on the proper way to inject yourself personally. Typically, what a Type 1, a Type 1 is a small child or someone that get it in their youth. So they would be injected by a parent or caretaker. So they need to be taught. With the pump, that is usually just putting the correct number of the doses in and then issuing the doses. There's pros and cons to both, I would imagine.

FLOOD: Thank you.

KAREN BELL-DANCY: But I can't get any more specific to that because--

FLOOD: No, you're fine.

KAREN BELL-DANCY: --that's out of my realm and I've not had the opportunity to have a pump.

FLOOD: You do?

KAREN BELL-DANCY: No, I do not.

FLOOD: OK.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, as a diabetic for 33 years, I can answer your question. The pump generally gives the wearer better control than pricking your finger and, and doing shots.

WILLIAMS: Additional questions?

KAREN BELL-DANCY: And if I can respond?

WILLIAMS: Go ahead.

KAREN BELL-DANCY: You still have to prick your finger in order to test your blood sugar, which you ideally you test your blood sugar at least once, probably three or four times a day. So it's a lot of management for one individual and, and the cost is just so devastating for many. And we have so many millions that are insulin dependent.

WILLIAMS: Thank you very much for coming and testifying today.

KAREN BELL-DANCY: Yes. Thank you.

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***JINA RAGLAND:** Chair Williams and members of the Banking, Commerce and Insurance Committee: My name is Jina Ragland. I am here representing AARP Nebraska in support of LB30. LB30 requires health insurers to limit the copayments for insulin. Specifically, the bill requires state health insurers to limit the copayment that may be required for an insulin prescription to $100 per 30-day supply. We know that the high price of prescription drugs is a burden on many Nebraska residents. Every day, our relatives, friends, and neighbors are forced to choose between filling life-saving prescriptions or paying rent, buying food and affording other critical essentials. In fact, a recent AARP report showed that in 2017, 29% of Nebraska residents stopped taking prescription medication as prescribed due to cost. In the richest country in the world, no one should be unable to pay for their life-saving medications. The roughly 171,000 (11.2%) Nebraskans living with diabetes have to buy insulin at a pharmacy because their pancreases has stopped producing it and they have to have insulin to survive. Insulin needs vary by the patient, as do costs - often depending on their insurance coverage. On average, people with diabetes require two to four vials of insulin per month. Diagnosed diabetes costs an estimated $1.4 billion in Nebraska each year. Monthly expense to Nebraskans average between $450 and $500. Over the last 14 years, the out of pocket cost of many insulin brands has jumped 555%. Due to these skyrocketing prices many insulin users· have been forced to alter their medication by substituting lower quality products, seeking other options outside the country, or even having to ration their supply; some dying by doing so. Insulin is not new. It was discovered as a treatment for diabetes almost 100 years ago. Very little about the way insulin is produced has changed yet the prices continue to skyrocket. Approximately 90% of insulin sold is manufactured by 3 companies, which limits competition and therefore results in higher costs to patients. In 2017, the annual cost of Lantus, a form of insulin used to treat diabetes, was more than $4,700 per year. The cost of Lantus increased 62 percent from 2012 to 2017. That is unacceptable. For many of these individuals, insulin serves as the only drug to help them stay healthy. LB30 takes an important step toward lowering costs for consumers so that they can afford their medication as prescribed. Capping the amount that a consumer pays every month for drug, will lower consumer's prescription drug expenditures, making prescriptions more affordable and accessible. Medications don't work if people can't afford them. Thank you to Senator Wayne for introducing the legislation and for the opportunity

to comment. We would ask the committee to support the legislation and advance the bill to the floor.

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

ROBERT M. BELL: Thank you, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies. I appear today in opposition to LB30. Health insurance deductibles, copayments and coinsurance are utilization tools used by health insurers to share the costs and risks with consumers. Consumers who agree to pay higher amounts of these cost- sharing measures typically are rewarded with lower premiums. With the continuing rising costs of healthcare services, both health insurance premiums and cost-sharing amounts have also risen. So it's understandable that in these times of higher premiums and higher cost-sharing amounts, that when lifesaving drugs are increasing nearly exponentially, the advocates for the consumers will seek governmental mandates to lower the consumer's share. Unfortunately, this is-- this does not actually get to the root of the problem, which is the high costs of the pharmaceuticals. Instead, it merely shifts these costs to the insurance company and its policyholders who must increase its premiums and cost-sharing limits to stay solvent. Contrary to popular belief, health insurance companies are not making huge profits off the high cost of pharmaceuticals. Many health insurance companies are mutual companies, which exist for the benefit of the policyholder. They do not make profits. Stock companies can make profits, however, both stock and mutual health insurers are subject to limitations placed into law by the Affordable Care Act, called medical loss ratio. For every dollar of premium received, at least 80 cents must be used to pay medical claims. The remaining 20 cents can be used to pay for expenses such as marketing salaries, administrative costs, and commissions. And the insurer must still maintain a level of financial solvency determined by the Department of Insurance to stay in business. Any state legislative bill that caps a cost-sharing measure or impose a mandate that will not apply to most, will not apply to most federally regulated, self-insured, large group plans governed by the Employee Retirement Income Security Act of 1974, otherwise known as ERISA. According to research I've read, ERISA plans cover at least 50 percent

of privately insured Nebraskans. And why this is important is that legislative bills will have a more limited impact than most realize. Many people are not aware that if their employer provides a plan, it is likely that a state mandate will not apply. I know Senator Wayne mentioned Colorado, and the press coming out of Colorado today is talking about how the, the people of Colorado didn't realize many of their health insurance plans were not covered by the law that passed there because of the impact of ERISA. For these reasons, the Insurance Federation opposes the passage of LB30. I appreciate the opportunity to testify. Thank you.

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

ROBERT M. BELL: You're welcome.

WILLIAMS: Invite the next opponent. Welcome back, Mr. Dunning.

ERIC DUNNING: Thank you, Mr. Chairman. Good afternoon, Mr. Chairman and members of the Banking, Commerce and Insurance Committee. For the record, my name is Eric Dunning, E-r-i-c D-u-n-n-i-n-g. I appear today as a registered lobbyist for Blue Cross and Blue Shield of Nebraska in opposition to LB30. Senator Wayne is not alone in having to make sure that his testimony numbers were updated from last year. This seems like this is a very similar bill from last year. And my testimony is-- will be consistent with last year's. But I do want to begin by sharing that this is an issue-- cost sharing for insulin is an issue that we've been working on for a long time. We share our members' concern about access to insulin, and we have to work hard to balance all of our member interests to bring cost-effective solutions across the pool of our membership. As background, even though insulin was developed decades ago, there is no generic option for our members. There's no other alternative. Constant small improvements in the manufacturing, formulation, and delivery methods have acted to extend patents over and over again. Make no mistake, this is patented medication. Ever increasing costs for insulin have been a factor for several years, even as we have managed to keep our cost sharing relatively consistent. This bill today strikes at our primary method of managing insulin costs, which is a formulary system that balances major insulin providers against one another to extract lower costs from pharmaceutical companies. We can do this by providing our members access to a preferred brand insulin category at significant reduced--

significantly reduced cost sharing while keeping a higher cost sharing for nonpreferred brands who will not negotiate with us on the same basis. As part of that negotiation, the preferred brand vendor will seek the highest difference between the two options to incentivize our member to use one option over the other. Pharmaceutical companies have worked hard to circumvent these negotiations by, for example, promoting copay coupons that steer patients away from lower cost options and a plan's preferred insulin product driving up overall costs. As you can see, the negotiation process is very fluid, and we need the ability to react to evolving pharmaceutical company negotiation techniques. By limiting our freedom of contracting between brands, this will inevitably increase costs. Like Senator Wayne, we are interested in seeing what the new data comes out from Colorado. However, I think we should point out that that bill has been in place for about 14 months as of today. Over time, we believe that this erosion in our negotiation position will be shown up over time. We do not anticipate seeing something that's come in the last 13 months. As I mentioned earlier, we offer our members preferred brand insulin options with lower cost shares with a range of deductible options. We are-- in our case, copayments for a 30-day supply of insulin vary from $30 to a percentage that we believe is about $125 a month for nonpreferred brands. To put that number into context, by the way, since 2011, the retail price for insulin has increased overall from about $200 to more than $500. This flexibility in how a member wants their coverage structure does have some price impacts based on how much of the risk the member wants to assume. Some people prefer lower premium and higher copayments or deductibles. We don't make that choice, though. Our members make the choice. And the important thing to remember is that the member or the small or medium-sized employer makes the choice not us. To reduce the impact of increasing premiums while still providing health insurance to their employees, high deductible health plans have been a very attractive option for employers. But because of the way this bill is structured, it would not allow that deductible to apply as we did see with Senator Blood's hearing aid mandate that she mentioned in, in the earlier hearing. Eroding those high deductible health plans will remove one more option for employers struggling with increasing premium costs. While the bill will not impact insulin costs for the uninsured or people in ERISA plans-- let's see-- and moving back to the overarching, the deepest impact will be on small and medium-sized businesses who will see higher costs for the coverage that they choose to buy for their

employees. Moving back to the overarching problem, which is the high cost of insulin. While we work to offer affordable insulin products to our members, there are several external factors which are beyond our control. Price increases are completely under the discretion of the manufacturers, and the aggressive pricing strategies are particularly harmful to patients who are uninsured. Neither of the bills, again, as-- this bill does not include anything like the Colorado language that would have required their attorney general to investigate the cost of insulin. As we move forward, insulin costs will not decrease because of our-- if-- because if our ability to negotiate with pharmaceutical companies is undercut, this product-- this proposal will not lower the cost of insulin for Nebraskans. They just require people to buy more insurance coverage to pay for it. And with that, I'm happy to answer any questions.

WILLIAMS: Questions? Senator Aguilar.

AGUILAR: Thank you, Chairman Williams. You said that insulin itself is a patented product.

ERIC DUNNING: Yes.

AGUILAR: Does that mean there's only one pharmaceutical company making it?

ERIC DUNNING: No, they all have different formulations and different takes on, on insulin. And it's going to depend on their manufacturing process, the delivery method, that sort of thing. But the, the basic science was done 100 years ago.

AGUILAR: So there is an opportunity for different pricing?

ERIC DUNNING: There is a-- there is an opportunity for different pricing. And as-- and that has been the mechanism that we have been best able to use to, to keep those prices. I hesitate to say under control, but to keep those prices as under control as we could make it.

AGUILAR: Thank you.

WILLIAMS: Senator Flood.

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FLOOD: The pricing, obviously, is, is concerning going from $200 to $500. What authority does the federal government have to intervene in a, in a price gouging scenario or situation on, on something like insulin? Is there any action that can be taken at the federal level to investigate this?

ERIC DUNNING: Not really per se. What we have seen in the past year was a rule adopted by the Trump administration, which requires people who have what are term-- what are deemed high cost-sharing requirements to be able to buy those-- to buy insulin at cost from the federally qualified health centers. And that's been the, the, the primary lever that they've been trying to pull so far. But this takes place in a, in a whole context of, of, of really significant increases in the amount of, of money that Americans pay for prescription drugs. Insulin is no different, but for the fact that, again, the basic science was done 100 years ago.

FLOOD: Has anybody tracked it down to find out who's making the money? I mean, is it the patent holder? Is it the manufacturer? Are they one of the same?

ERIC DUNNING: Yeah, it'd be a large pharm-- it'd be large pharmaceutical companies, right, and would be making the money on this deal. Now, you know, offsetting those costs are to be fair development costs as they engineer new and better versions of what they're doing. And I suspect that's one of the things it would point to.

FLOOD: You'd think that at somewhere in the market that there would be some competition that would bring this down and instead it's going the other way.

ERIC DUNNING: Well, and what we find particularly troubling about bills like this bill, Colorado's bill, a similar bill passed in Minnesota, is that to the extent that we have the ability to, to leverage competition as much as possible, bills like this, I think, really undercut our ability to do that. And that's what we're-- that's our, our largest concern over time.

FLOOD: Thank you.

WILLIAMS: Senator McCollister.

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McCOLLISTER: Yeah, thank you, Chairman Williams. Mr. Dunning, is there a big difference in cost between insulin in the United States versus some foreign country?

ERIC DUNNING: I am assuming that underlying your question is, it is reading stories in the media that talk about lower cost of prescription drugs as well as insulin in foreign countries. And I believe the answer to that, sir, is yes.

McCOLLISTER: Is it time for the federal government to start bidding out of coverage?

ERIC DUNNING: Senator, I don't know that I, that I, I have an answer for you from a federal perspective. I know, however, that the proposal in front of us today probably takes us in a direction we don't want to go on a state basis.

McCOLLISTER: OK, thank you.

WILLIAMS: Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, Mr. Dunning. So I-- my familiarity with patent law is limited at best. So I understand that these manufacturers get to maintain patents because they are-- will be generous and call it innovating, but updating their processes or formula or something else that allows them to maintain that patent, is that correct?

ERIC DUNNING: That is my understanding, sir.

BOSTAR: The previous way they were manufacturing it or the previous formula that maybe worked acceptably, why isn't someone able to turn that into a generic?

ERIC DUNNING: Honestly, Senator, I don't know the answer to that question. I do know that there is not a generic available for our members.

BOSTAR: Thank you.

WILLIAMS: Mr. Dunning, you and I have talked numerous times about the problems with what I'll call insurance mandates and taking away the ability for market forces to work in this area. We've also talked that

insurance companies have been somewhat innovative in trying to address these situations. And I think, I think you would answer that the products that you have available today versus the products that you had available two, three years ago or longer have moved the cost share, whether it's copay or whatever, to a lower level. Is that correct?

ERIC DUNNING: I think it would be more accurate to say, sir, that on certain lower cost options, we've been able to hold the line a little better on, on cost sharing rather than, you know, lowering that. I, I don't know that I could go so far as to say we've lowered it.

WILLIAMS: One of the people that apparently is not here to testify today is, is Medica. I know, and you may be able to confirm this, that they have now come into this market with a $25 copay that was not available a year ago when we had this same hearing. Do you-- and again, I know that's not your company, but since you're sitting there, has Mr. McLaren confirmed that with you?

ERIC DUNNING: Well, Senator, I'm thinking quickly to come up-- to see if I can come up with a smart-aleck response to your question. But it is my understanding that Mr. McLaren's company has, has come in with a, with a cap at $25.

WILLIAMS: My point being that market forces are at work and recognizing some of the things that are going on with this, this situation with insulin prices. Are there any other questions? Senator Pahls.

PAHLS: Well, I-- thank you, Chair. But that $25 cap, though, it depends how much insulin you're doing, because I know you can buy a pen. At one time, you could get a whole package. I could get a whole package of four or five for the same price that I get one now or two. I know that because I live that life. The same price, but somebody upstairs said we can't do that anymore. You have to break it apart.

ERIC DUNNING: Senator, I can really only respond about our policies and so the numbers that I use, $30 a month or $125 a month, that is per 30-day supply, that's per 30-day supply. So not per vial of insulin.

PAHLS: But 30-day supply may be three vials or one because they hold so much. One of the pens hold so much. So my 30-day supply compared to his 30-day supply may be significantly different.

ERIC DUNNING: But under our plan design, it would still be that flat $30 a month for the, for the preferred insulin, whether it's three vials, four vials, three pens, four pens. So--

PAHLS: So if he--

ERIC DUNNING: --that's how it's structured.

PAHLS: --so if he-- I'm just-- this is-- helping myself out. So if he gets three and I get one, we pay the same price.

ERIC DUNNING: Correct.

PAHLS: So I have to get my doctor to say that I need three.

ERIC DUNNING: Senator Pahls, as a man who has worked very hard in the area of healthcare finance for much of his career, I can only expect that you will be asking your provider for the most cost effective and responsible option possible.

PAHLS: Yeah, thank you. [INAUDIBLE]

WILLIAMS: Any additional questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Promise this is the last one. Thank you, Mr. Dunning. And Chairman Williams brought up Medica's $25 insulin, which is illuminating. Now if we don't pass LB30, we don't pass any of these mandates and we ensure that you all maintain the, the market flexibility, would you imagine that your company would reduce its prices in order to compete with Medica's pricing?

ERIC DUNNING: Senator, I would tell you that markets are powerful, powerful things, and market forces will drive us in whatever direction employers and individual customers want us to go.

BOSTAR: Thank you very much.

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

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ERIC DUNNING: Thank you, sir.

***COLEEN NIELSEN:** Good afternoon, Chairman Williams and Members of the Banking, Commerce and Insurance Committee, My name is Coleen Nielsen and I am the registered lobbyist for the American Health Insurance Plans (AHIP) testifying in opposition to LB30. AHIP members are committed to ensuring that patients with diabetes can get affordable insulin to help control their blood glucose levels. Health insurance providers have a strong history of advancing innovative approaches to help their enrollees successfully manage and control diabetes, prevent complications, and improve their quality of life. We understand that for many diabetes patients, the rising cost of insulin has created an affordability crisis that threatens their health and wellbeing. Capping copays only masks the problem. Because the problem is the price. Out of control prices for insulin products and other prescription drugs are a direct consequence of drug makers taking advantage of a broken market for their own financial gain at the expense of patients. The lack of competition, transparency, and accountability in the prescription drug market has created extended, price-dictating monopolies with economic power that exists nowhere else in the U.S. economy. The end result is that everyone pays more-from patients, businesses and taxpayers to hospitals, doctors, and pharmacists. Steps are needed to ensure that people can get affordable insulin and other medications. With solutions that deliver real competition, create more consumer choice, and ensure open and honest drug prices, we can make prescription drugs more affordable-while protecting and supporting innovation that results in new treatments and cures for patients. Since 2006, while the number and supply of insulin products has grown, the list price of insulin products has increased exponentially-in direct violation of the economic laws of supply and demand. For example, the price of Lantus increased from $88.20 per vial in 2007 to $307.20 per vial in late 2017, while the price of Levemir increased from $90.30 per vial to $322.80 per vial during the same time period. These sharp price increases harm patients who rely on insulin and reduce the affordability of coverage for all consumers and payers who must bear the cost through higher insurance premiums. AHIP believes that truly addressing this situation requires looking for the root cause of rising insulin prices and identifying ways to address market behavior that values pharmaceutical profits over patients. Unfortunately, legislation such as LB30 will only mask the symptoms of dramatically

increasing prescription drug prices without taking steps to address the cost of insulin. As the committee continues to explore these issues, we would like to note that the entire pricing process is driven entirely by the original list price of a branded drug-which is determined solely by the drug company, not by the market or any other participant in the pharmaceutical supply chain. Lawmakers need to address this reality-the problem is the price-as part of any strategy for reducing pharmaceutical costs. Due to our concerns about the impacts that this bill could have on health insurance premiums for Nebraska consumers and business and the bad precedent this bill would set, we oppose this legislation. Please do not advance LB30.

***RON SEDLACEK:** Chairman Williams and Members of the Banking, Commerce and Insurance Committee: My name is Ron Sedlacek and I am testifying on behalf of the Nebraska Chamber of Commerce & Industry. LB30 would limit the total out of pocket costs to patients with insulin drug prescriptions to $100 per each 30-day supply, regardless of the amount or type that is needed to fulfill the prescription. In application, the bill proposes to mandate additional insurance coverage for group and individual health insurance plans. The Nebraska Chamber would like to register its opposition to LB30. Many trade association members and local chambers of commerce, in addition to our business and industry members, offer either group insurance coverage or federal, ERISA-based plans. In this regard, we represent those businesses and trade associations that are consumers of insurance products which do not offer ERISA plans and that will be directly affected by this proposed legislation. We maintain that the addition of further mandates for non-ERISA plans can only serve to price many Nebraskans out of the group health insurance market or result in some reduction of other benefits of value to the employee. The Nebraska Chamber shares in the concerns of other consumers attempting to find and obtain reasonably priced, affordable health insurance products. We continue to find that the escalating costs of health insurance benefits for employees remain high on the list of business concerns. Historically, Nebraska had remained a relatively lower cost, health insurance state, due in part to the fact that the Nebraska Legislature has been vigilant when it comes to adding on layers and layers of additional health insurance mandates that would exceed federal ERISA standards. While each new proposal for additional mandated coverage may be well intentioned, it is a fact that additional mandated coverage will increase health insurance rates and will affect both the affordability and

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availability of health insurance for employers and employees. In many cases, the result of increased health insurance costs means higher deductibles or copayments for employees. In some cases, increased health insurance costs may result in the employer and employee being required to reduce or eliminate other benefits that may be more appropriate to their work environment. In a few cases, the aggregation of increased mandates may ultimately result in an employer providing payments in lieu of insurance benefits or the migration of more employers to a VEBA, MEWA or other self-insured ERISA plan. The State Chamber would urge the members of the Banking, Commerce, and Insurance Committee to not advance LB30.

WILLIAMS: Any other opposition testimony? Is there anyone here to testify in a neutral capacity? Before-- and you know Senator Wayne waived closing. We do have drop-off written testimony in support from Jina Ragland from the AARP of Nebraska; in opposition from Coleen Nielsen from the American Health Insurance Plans, and from Ron Sedlacek from Nebraska Chamber of Commerce. We also have four letters of support from Barbara Petersen, the Nebraska Nurses Association, Sarah Hanify from the National Association of Social Workers, Michelle Walsh from the Nebraska Medical Association, Andy Hale from the Nebraska Hospital Association. And Senator Wayne has close-- or has waived closing. So that will close the hearing on LB30, and close our hearings for today.