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WILLIAMS: Well, good afternoon, everyone, and welcome to the Banking, Commerce and Insurance Committee. My name is Matt Williams. I'm from Gothenburg, regis-- represent Legislative District 36, and I'm proud to serve as Chairman of this committee. The committee will take up the bills in the order posted. And as I announced to you, we have two bills this afternoon and we will be doing a joint hearing on LB270 from Senator Morfeld and LB375 from Senator Kolterman. And we will ask that when you do come up to testify, that you let us know if you're testifying in support of both bills or opposition to both bills or however you are testifying. Committee members may come and go during the hearing. We have to introduce bills in other committees and are sometimes called away. It's not an indication that we are not interested in the bills being heard here today, it's just part of our process. To better facilitate today's proceeding, we ask that you abide by the following rules. Please silence or turn off your cell phone. As we have discussed, seating is limited. We ask that you only maintain a seat in the hearing room when you have an interest on this bill. We do have more proponents waiting outside to come in and testify in favor, so when you are-- have completed your testimony, we're going to ask you to exit and the exit-- entrance on this side, exit on that side. Then after we are finished with the proponents, we will take a short break and the opponents will be allowed to come in and occupy the seats and we'll go forward. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering to assist committee members and the transcribers to clearly hear and understand your testimony. Pages will sanitize the table and the chair between testifiers. And we do ask that you move as quickly as you can up front so that we aren't delaying time between testifiers. Public hearings for which attendance reaches seating capacity-- we don't need to do that. You know that Lois, the sergeant-at-arms, will kick you out of here if, if necessary and she'll kick me out of here if necessary also. So the order of testimony will be introducer first, followed by proponents, followed by opponents, followed by neutral testimony, and then the introducing senators will have an opportunity to close. And we will be asking Senator Morfeld to open on his bill first and Senator Kolterman will be opening on his bill next. Senator Kolterman, as we speak, is introducing a bill in the Education Committee, so hopefully he will get here as quickly as he can to make his introduction. Testifiers, please sign in and use the pink sheets and turn them in at the table

when you come 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 when you have one minute remaining and when it turns red, we ask you to conclude 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, but if you have written testimony, bring it with you and it will be passed out by our pages. We ask in your testimony that you try not to be repetitive from what other people are saying in front of you. To my immediate right is committee counsel Bill Marienau. To my left, at the end of the table, is committee clerk Natalie Schunk and our committees with us-- committee members with us today will do self-introductions, starting with Senator Pahls.

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

McCOLLISTER: John 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, Grand Island.

WILLIAMS: And our pages that are with us today are Caroline and Ashton. And thank you for your help and, and this is our last hearing day for the year, so I want to thank them for being with us this entire year. And Senator Flood, would you like to introduce yourself, please?

FLOOD: Yes. My name is Mike Flood. I'm from District 19, which is Madison and part of Stanton County.

WILLIAMS: Thank you. With that, we will open the joint hearing on LB270 and LB375 and ask Senator Morfeld to provide us with his introduction. Welcome, Senator Morfeld.

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MORFELD: Thank you, Chairman Williams, members of the Banking Committee. For the record, my name is Adam Morfeld. That's A-d-a-m M-o-r-f-e-l-d, representing the Fighting 46th Legislative District here today to introduce LB270. LB270 is similar to LB1196, which I introduced at the request of the Nebraska Pharmacists Association last year to continue to shed light on the pharmacy benefit managers or PBMs and their unfair business practices. Pharmacy benefit managers are middlemen that were originally designed to reduce administrative costs for insurers, validate patient eligibility, administer planned benefits, as well as negotiate costs between pharmacies and health plans. Over time, PBMs have taken advantage of their strategic position between the insurer and provider to assert control over these prices in most aspects of the prescription drugs' transitions and have become extremely profitable. The three largest PBMs, Caremark, Optum, and Express Scripts, manage drug benefits for approximately 95 percent of Americans with prescription drug coverage and each of these companies has an annual revenue exceeding $15 billion. In spite of these facts, PBMs are virtually unregulated at the state or federal level, even though they manage numerous prescription plans funded by taxpayer dollars. In my time in the Nebraska Legislature, I've worked tirelessly on healthcare issues, always putting patients and their interests first. When I learned about how patients are often penalized with higher copayments for getting their prescription medications from their local pharmacy or required to use PBM mail-order or specialty pharmacies, I thought it was important to bring this legislation. Since then, I've also learned that they have a lot of other negative impacts on pharmacies and, and other industries and providers. Like Senator Kolterman's bill two years ago that put prohibitions on gag clauses and clawbacks, LB270 continues the efforts to level the playing field for community pharmacists and patients across Nebraska. Nebraska pharmacies are struggling because of the policies of the insurers and their PBMs. LB270 would remove specialty networks and mail-order requirements so that patients have a choice of where to get their medications. It is a daily occurrences in pharmacies across the state that patients come to pharmacies asking for help, as their lifesaving, as their lifesaving medications did not arrive in the mail and they need medication that day. This is unacceptable. The bill add-- will add provisions to pharmacy contracts that require PBMs to pay pharmacies a fair price on medications they dispense to the patients. Pharmacies are often required to dispense brand name because of the rebates they get from the manufacturers. Those rebates are not

passed on to the patients or pharmacies. We are told that those rebates help lower the premium for policyholders. I haven't heard of many premium decreases on health insurance benefits for patients recently. In the last 18 months or so, several states have audited their Medicaid drug benefits, specifically their managed care programs and-- that PBMs manage the drug benefits on their behalf of the managed care program. LB270 includes language that provides funding for our State Auditor to audit the Medicaid prescription drug program. I think as legislators, it's our job to ensure state tax dollars are being spent appropriately. Recent findings by the state auditors and attorney generals in Ohio, Kentucky, Florida, and West Virginia caused me concern and why including the audit provision in LB270 is important. While Nebraska's MCO contracts were amended in November 2019 to say that spread pricing is not allowed, it, it was in fact a part of the original contracts and should therefore be examined nonetheless. I'd be happy to answer any of your questions. I urge your favorable consideration of LB270 and as you can see, there's a lot of people behind me to come and talk. And in fact, I think that goes to show the seriousness of this issue because I don't know about Senator Kolterman, but I didn't ask anybody to come to the hearing and testify, although I'm glad that people did. They came on their own because it's an important issue and it requires reform. I'd be happy to answer any questions.

WILLIAMS: Thank you, Senator Morfeld. Questions for the senator? Seeing none, thank you.

MORFELD: Thank you.

WILLIAMS: Where is Senator Kolterman?

NATALIE SCHUNK: He's, he's done opening.

_____: Where's Waldo?

WILLIAMS: You said he's finished opening?

NATALIE SCHUNK: I can see if he's still in there.

WILLIAMS: We're just going to wait a few minutes for Senator Kolterman. Senator Kolterman, as you are coming up to introduce LB375, Senator Morfeld has given his introduction and we are, are ready for

you. Welcome to Banking, Commerce and Insurance, a friend-- friendly place for you.

KOLTERMAN: Thank you, Senator Williams. Good afternoon-- and members of the Banking Committee- Banking and Insurance Committee, excuse me. My name is Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n. I represent District 24. Today I'm here to introduce LB375, which will adopt the Pharmacy Benefit Manager Regulation and Transparency Act. LB375 would require any ben-- pharmacy benefit manager doing business within the state to obtain a certificate of authority as a third-party administrator under the Third-Party Administrator Act. The bill prohibits pharmacy benefit managers from charging or collecting from a covered person a cullment-- a copayment for a prescription or pharmacy service that exceeds the amount retained by the network pharmacy from all payment sources for filling the prescription and providing the service. LB375 stipulates that pharmacy benefit managers cannot exclude a Nebraska pharmacy from participation in its specialty pharmacy network as long as a pharmacy is willing to accept the terms of the pharmacy benefit managers' agreement with its specialty pharmacies and they cannot prohibit a pharmacy or a pharmacist or a contracted pharmacy from mailing a prescription drug to a covered individual at any location requested by covered individuals. The bill also provides for auditing standards, pricing transparency, and fairness and it creates a formal appeals process. Others following me will have the ability to explain why these reforms are necessary. However, we all agree this bill is and continues to be a work in progress. I've had an opportunity to work with Senator Morfeld and, and the Chairman Williams and I look forward to continuing to work with the stakeholders in the coming weeks to make sure that this is, is the right piece of legislation and I'm looking forward to the hearing today. With that, I would try to answer any questions you might have.

WILLIAMS: Thank you, Senator Kolterman. Are there questions for the senator at this point? Seeing none, thank you for your opening.

KOLTERMAN: Thank you.

WILLIAMS: We will now invite the first proponent to come and testify. We have somebody coming from the back. Welcome to Banking, Commerce and Insurance and if you would please spell your first and last name? Thank you.

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MARCIA MUETING: Certainly.

WILLIAMS: Go ahead.

MARCIA MUETING: Good afternoon, Chairman Williams and members of the committee. My name is Dr. Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g. I've been a pharmacist in Nebraska for 30 years this year and I currently serve as the chief executive officer of the Nebraska Pharmacists Association. I'd like to thank Senators Kolterman and Morfeld for introducing legislation to regulate pharmacy benefit managers also known as PBMs. I am here on behalf of the Nebraska Pharmacists Association and the Nebraska Retail Federation. I'm testifying in support of both bills, LB270 and LB375. When pharmacies began submitting claims electronically for prescriptions, PBMs were a really important partner. They were positioned as the conduit between the pharmacy and the insurance company for prescription claims. Prescription claim data were, were standardized such that every pharmacy sent the same data in the same format to insurance companies or the PBMs. When a pharmacy submits a claim electronically, it receives a message from the PBM within seconds to confirm that the claim has been received, that the patient is eligible, the medication is covered, and what the patient's cost is, the amount of money that the pharmacy will be reimbursed, or the pharmacy receives a rejection message. This instant adjudication of claim was the original purpose of a PBM. PBMs collected a fee for this service from the insurance company. Over the last 30 years, the role of PBMs has ballooned to much more than processing pharmacy claims. What's more interesting is that nearly 80 percent of the prescription claims processed in the United States are handled by just three PBMs. Even more interesting, many insurance companies own their own PBM. Pharmacies are contracted for reimbursement for the acquisition cost of the medication and then a cost to dispense the medication known as a dispensing fee. Two years ago, Nebraska Medicaid adopted the cost of dispensing survey done in Iowa, determining that the cost to dispense medication, just to provide the medication, is $10.15. This is the amount to cover the label, the bottle, the staff time and overhead, not the medication, just what it costs to-- just to provide the medication and that's cost, no profit. Today, the claim is less-- is paid at less than $10.15. The pharmacy is losing money on the dispensing fee alone. Now today, PBMs collect rebates from drug manufacturers. They conduct predatory audits, which have become a profit center, reimburse pharmacies at below-cost rates, and offer contracts to pharmacies,

which are not negotiable. Pharmacies are receiving underwater reimbursements and PBMs are posting record earnings. The dollars generated for rebates, audits, and below-cost reimbursements are not being passed along to the patient. In December 20, 2020, the United States Supreme Court issued a landmark ruling in the Rutledge vs. Pharmaceutical Care Management Association case. Rutledge is the attorney general in Arkansas and the Pharmaceutical Care Management Association, also known as PCMA, is the national organization who represents PBMs. This case was about the ability of a state to regulate PBMs. PCMA challenged the Arkansas law, which regulates audit practices, transparency, and the calculation of the acquisition cost of medications and lost the Supreme Court case in a unanimous vote. While this Supreme Court ruling does not dictate which state PBM laws are to be enacted, it does highlight the areas where protections need to be provided: audit practices, transparency, and the calculation of the acquisition cost of medications. In the past, opponents of a bill like this in Nebraska have stated that their companies don't do any of these things, so a, a law isn't needed. In this case, I would think that if their company didn't do these things, they would be in favor of this bill to even the playing field against their competitors who are the bad actors. I think it's important to note that 21 states already have legislation in place to regulate pharmacy benefit managers and their practices. Without state statutes in Nebraska to allow oversight by the Department of Insurance, patients and pharmacies have nowhere to turn when a PBM ignores their pleas for help. Do these bills mandate a profit for pharmacies? No. The bill ensures pharmacies have a fair appeals process when they're reimbursed at a rate, which is below their cost. It's time for Nebraska to regulate PBMs and these bills are a first step to preserve patient care provided by Nebraska pharmacies. That's the end of my, my remarks and I'd be happy to take any questions.

WILLIAMS: Thank you, Ms. Mueting. Are there questions for Ms. Mueting? I have one.

MARCIA MUETING: Sure.

WILLIAMS: You mentioned in your testimony that predatory audits have become a profit center. Can you explain how that becomes a profit center?

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MARCIA MUETING: Sure. You know, if a, if a pharmacy is committing fraud, that should be discovered and that, and that pharmacy should suffer consequences, but what we're finding-- and we've got some people behind me that will-- they will actually give you some really great examples of audits that they have received. But we're finding that PBMs are issuing audits on random, mostly expensive drugs, looking for anything and everything in an almost a phishing-type process and we're, we're also-- it is also widely known that many of the, the companies that are hired by PBMs to perform these audits are paid by a percentage of the amount of money recouped from the pharmacy. So there's an incentive for them to keep digging until they find something that, that-- even a small error or a clerical error can, can lose all of the cost of the, of drug and the dispensing fee for the pharmacy.

WILLIAMS: Thank you. Any additional questions? Senator McCollister.

McCOLLISTER: Thank you, Chairman Williams. When an audit does occur, occur--

MARCIA MUETING: Um-hum.

McCOLLISTER: --it's pretty expensive for the pharmacy, isn't it?

MARCIA MUETING: Well, it, it is because it, it takes an incredible amount of labor, often-- and people will-- behind me will talk about this, but they might get a 76-page audit where-- or on 76 prescriptions, 100 prescriptions, 200 prescriptions where the documentation, just one piece of documentation that's being asked to be provided, is the original copy of the prescription. You know, unless, unless you're, you're-- you've got electronic copies, you physically need to dig through boxes and boxes of prescriptions because-- and some of these audits are as, as many as two years back-- and make a photocopy of that prescription. So you're right, Senator, it takes a lot of time and labor, without a doubt, just to provide the documentation that's being requested.

McCOLLISTER: Thank you.

MARCIA MUETING: Sure.

WILLIAMS: Seeing no other questions, thank you for your testimony.

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MARCIA MUETING: Thanks for the opportunity.

WILLIAMS: We'll invite the next proponent. Good afternoon and welcome.

KIM BERLOWITZ: Good afternoon. Hello, Chair-- Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Kim Berlowitz, spelled K-i-m B-e-r-l-o-w-i-t-z. Thank you for giving me the opportunity to speak today. I'm a 46-year-old mother of four and a wife. In November of 2020, what started as an emergency appendectomy turned into an appendix cancer diagnosis, metastatic goblet cell adenocarcinoma to be exact. I know it's a mouthful. This is a rare and aggressive cancer and I would need another surgery to remove it all and then, of course, chemotherapy. It was scary, but we had good ben-- good benefits through my husband's work, so I thought the worst part would be the treatment. I was wrong. I was scheduled for eight treatments that consisted of I.V.-- of an I.V. infusion, infusion and a two-week course of pills at home, repeating every three weeks, and the first went off without a problem. I received my pills from Optum Pharmacy in plenty of time and because I had reached my out-of-pocket maximum, the pills were free. January rolled around and I called to get my meds and found out I had to pay over $800 for two weeks of pills. I was surprised and I knew my husband and I would need to look at our budget to sustain this. We do have a health savings account, but it would not take long to deplete it at this rate. Nevertheless, we had enough in there to cover it, so went ahead. Fast forward to February's refill. I was grumbling to the lady at Optum about paying over $800 last time and she proceeds to tell me she would have to see what they did last time because it was more this time. When I asked how much more, I was floored to hear $1,700. Come to find out, someone at my insurance company saw that the percentage payout on the generic drug I was on wasn't as good as the percentage payout on the name brand, as in they paid 80 percent for the name brand drug, but only 50 percent for the generic. The person at my insurance company, not my doctor, chose to change my medication. Unfortunately, they didn't do simple math to see that while the benefit was better on the name brand, it was much more expensive. To fix this, I had to call my oncologist who had to call my insurance company, who had to call Optum, who then had to call me to get it all fixed. This took a few days and by the time it all got fixed, we were cutting it close to when I would need my pills. I was promised they would be here on Thursday, the day I had to start them, with the understanding that I would miss a dose if they didn't show up. Thursday came and went and

my pills were not here. I received a notification they would be here Friday. Friday, I received no-- notification they wouldn't be here until Monday. When I called to express my displeasure and to begin the process of removing Optum so I could use the pharmacy at my oncologist's, magically my pills showed up two hours later. The problem was it was a day and a half after I needed it and my doctor had changed my dose on Thursday because of my side effects. So I now have an entire bottle of medication I paid for that I don't need. When I asked my insurance company to remove Optum from the equation so I could receive the right dose of medication at the right time for the right price from the pharmacy in my oncologist's office, I have received nothing but push-back and transferred calls. My oncologist is battling this for me as well. Why? It doesn't make sense to order a medication a week before you know what your dose is going to be and possibly pay for meds you don't need and that is the position my insurance company has me in. My husband intentionally got a good job with good benefits for our family to be covered and we pay good money for those benefits. As it stands, if I can't get my insurance company to work with me, I will have to pay the cash price through my oncologist's pharmacy, which, by the way, is less than $200. It makes me wonder why I have insurance when I paid more than four times that amount through my insurance. And while I will be saving money on the medication, the cash I will pay won't go towards my out-of-pocket maximums or deductibles. I have cancer. I have four kids and a husband that need me. We are in the middle of a pandemic and I have everything to lose. I shouldn't have to deal with these issues receiving my lifesaving medication when we work hard and pay good money to make sure we're covered. This should not be where the stress is in my life. The time for change is now so that people like me are not put in this position. Cancer is more than enough to deal with. Thank you for your time and for listening. If you have any questions, I'd be happy to answer them.

WILLIAMS: Thank you for coming and telling us your story. Are there questions? Seeing none, thank you for your testimony.

KIM BERLOWITZ: Thank you.

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

TIM REDLINE: Thank you. Good afternoon, Chairman Williams, members of the Banking, Commerce and Insurance Committee. My name is Tim Redline,

spelled T-i-m R-e-d-l-i-n-e. My wife and I own Redline Specialty Pharmacy in Hastings, Nebraska. I appreciate your time today and allowing me to speak on these important issues affecting independent community pharmacies, pharmacies and your friends and neighbors who are not, not able to choose their pharmacy. I am in support of both LB270 and LB375. I want to speak to you about how PBMs limit patient choice with regard to specialty medications. Many PBMs create limited networks of pharmacies that are able to fill what are called specialty medications. Most of these pharmacies are out of state and in many cases, include PBM-owned specialty pharmacies. That's right, the PBM owns the pharmacy that they force patients to use. So what is a specialty medication, you might ask? There is no standard definition of a specialty drug, but as a general rule, they are expensive medications that might require special handling, patient training, or ongoing monitoring. Some PBMs require a special accreditation to participate in their limited specialty drug pharmacy network, but can still deny a pharmacy access even with that accreditation. Many PBMs will allow any pharmacy to fill the first few doses of a specialty drug, then require that it be filled at a PB owned-- PBM-owned or a limited network mail-order specialty pharmacy. They say this is so patients can get the medication faster, but this is the most critical time for a patient needing a specialty drug. It is at the beginning that the pharmacy collects medical records, helps submit the prior authorization, and trains and educates the patient on the proper use, storage, and side effects. These are all things that Nebraska pharmacists are well qualified to do. Why would they allow a nonaccredited pharmacy to take care of these patients at such a crucial time, yet not allow us to continue their care? Requiring burdensome accreditation requirements or arbitrarily refusing access for an accredited pharmacy simply allows the PBMs to create artificial barriers to entry and limit competition, which makes it easier to steer patients to their PBM-owned companies. This patient steering creates tremendous disruption in patient care, countless hours of pharmacy and physician staff time to coordinate the transfer of care, and usually results in the medication being mailed into Nebraska from an out-of-state pharmacy. Ask any physician if they would rather work with a local pharmacy or a mail-order pharmacy. Additionally, it sends jobs and tax dollars to other states. We have two patients recently whose PBMs are forcing them to use an out-of-state specialty pharmacy. Both have been patients of ours for many years. One gets a medication for immune deficiency and the other a medication for a severe

neurological condition. These are life-sustaining medications. Both patients and their physicians are now having to navigate the transfer of their treatment to an out-of-state pharmacy, which is not going well. It is likely that both of their treatments will be dislayed-- excuse me, will be delayed and disrupted. One patient was planning to testify here today, but was-- called this morning and said she was too ill and didn't feel safe since she's-- her treatment has been delayed by at least a week already. In both cases, the pharmacy of choice is owned or affiliated with the PBM and one of them is a Nebraska Medicaid managed care organization sending our tax dollars out of state. I don't typically like government intrusion into private business and you may not either. I'm a big believer in the free market. However, it is the government's role to step in when markets are broken. When you have companies approaching monopolistic power control the supply, demand, and the price and when information between buyer and seller is not equal or transparent, then it is appropriate for the government to step in. The big three PBMs control 75 percent of all prescription claims in the United States. PBMs control which drug your doctor can prescribe, how much you pay, how much they pay the pharmacy, what the plan's sponsor pays, and which pharmacy you have to use. There is no negotiating in this environment. The contracts we are presented with are take it or leave it. The PBMs will tell you they need this power to control drug costs, which is not true. Drug costs started their steady climb when PBMs arrived on the scene and continue to go up along with their profits. We're not asking for special treatment. All we're asking for is fairness and transparency so that community pharmacies can compete on a level playing field and can continue to serve the healthcare needs of the people of Nebraska. LB270 and LB375 will accomplish these goals. Thank you. I'm happy to answer any questions.

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

McCOLLISTER: Yeah, thank you, Chairman Williams. Do you have a choice of the PBMs that you, that you work with? I mean is there any competition between the various PBMs that are available?

TIM REDLINE: Not necessarily. Like, like I said and others have said, 70-- depending on the numbers you look at, 75 to 90 percent of all prescription claims go through three. So if you choose not to work with one of those PBMs, you're eliminating about one-third of your patients.

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McCOLLISTER: So do you deal exclusively with one PBM or do you--

TIM REDLINE: No, most pharmacies contract with, with all PBMs.

McCOLLISTER: I see, thank you.

TIM REDLINE: Yep.

WILLIAMS: Mr. Redline, you talked in your testimony about patient steering. In your judgment, does patient steering save money?

TIM REDLINE: In my judgment, it does not. I have not seen any studies to show that it does save money.

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

TIM REDLINE: Thank you.

WILLIAMS: We'd invite the next proponent. Good afternoon and welcome.

ANGIE SVOBODA: Thank you. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Angie Svoboda, S-v-o-b-o-d-a. I have co-owned Good Life Pharmacies in Ord, Albion, and Loup City for over 25 years. I appreciate your time today allowing me to speak on the important issues that affected the community pharmacies across Nebraska. My pharmacies are a very vital part of these small rural communities. I am talking today about how wasteful and unnecessary pharmacy PBM audits can be. I am support of both LB270 and LB375. Rural independent pharmacies have been extremely stressed this last year. With the pandemic ongoing, pharmacies are doing more curbside and home deliveries and we've dealt with staffing issues due to COVID. Of course, we're frontline workers. During October, rural independent pharmacies were busier than I've ever been. We did the majority of all flu vaccinations in our community based on CDC recommendations. We also did a majority of the Medicare Part D Plan evaluations for our elderly patients in our community to keep them in our pharmacies. This after one of the major PBMs in our community sent letters to our elderly patients, to about one-fourth of our patients, telling them that they would have to go to mail order or drive 64 miles away to get their prescriptions with low copays. So we had to help try to get these patients back into our pharmacy. During the busy time-- during this busy time is when I been-- began to

experience an abundance of PBM audits. To be clear, I do support legitimate efforts to prevent fraud, waste, and abuse in healthcare, but since October, I've had up to five audits at a time on my desk. Unfortunately, the audits to my pharmacy had nothing to do with patient care. These audits were simply looking for an easy way to recoup money for issues such as technical and clerical issues. The two big audits from-- I've had two big audits from two of the three major PBMs since October. The first audit had a value of $57,000 and this audit came from our own state Medicaid program. The second audit was valued over $76,000. The notification of the audits was sent in the pharmacy-- was sent to the pharmacy via fax, not a phone call, not a certified letter, a fax. And as you can imagine, a busy pharmacy getting a fax, that could easily get lost. The $76,000 audit, the fax, simply stated the pharmacy needed to respond within a determined short time frame with all the documentation requested. If the deadline was not met, a penalty of 25 percent would be assessed on the audited claim value. The audits went back over two years, included hundreds of prescriptions. Combined together, it took over 25 hours of time to collect the requested prescriptions and signature laws-- logs requested. One of these audits was sent back in early December and I still have yet to hear back on the response from the PBM. And what do I say-- mean when I say clerical and technical errors? A technical error is as simple as misspelling a patient's name or missing, missing a home address on a prescription. Otherwise, that prescription contains all the correct information. This can result in loss of money and then any associated refills that can result in loss of money. What's happening to independent pharmacies across Nebraska is the equivalent-- if you go into a mechanic, getting your car fixed, and then two or three years later-- your car is still working-- the mechanic get slammed with thousands of dollars in fines because he spelled your name wrong in the bill. A bit-- as a small business owner, it's hard to stay in business when money can be taken away at any time. A loss of $133,000 to any small business would potentially close that door and a small rural town, this would have a great economic effect on the community. Sure, there are some appeal processes in place for these audits to-- but to reach a live person to discuss the findings is impossible and these appeals are rarely won without legal representation. Again, the profession of pharmacy accepts audits to support legitimate efforts to prevent fraud, waste, and abuse if there's any evidence, but unnecessary audits take away a-- time a pharmacist can be spent use-- doing patient counseling,

giving flu vaccinations, and currently giving COVID lifesaving vaccinations. Under the proposed bill, LB375, technical, technical errors no longer would carry heavy financial fines. Insurance companies must audit pharmacies for prescriptions filled within the last few years and pharmacies must be notified within a written notice of an audit at least 14 days before the audit is scheduled to take place. I thank you for your time and I do have examples of medications and medications that have been targeted because of technical and clerical errors that I can share with you if you're so interested.

WILLIAMS: Thank you, Ms. Svoboda. Are there questions? I have one. So your testimony is that the, the two audits that you're talking about, the total-- the $133,000, which was money that you lost--

ANGIE SVOBODA: No, that I could lose.

WILLIAMS: That could you could lose, OK.

ANGIE SVOBODA: I could lose. The $76,000 audit was sent in first part of December and I have yet heard back--

WILLIAMS: Not heard back on that yet.

ANGIE SVOBODA: --not yet heard back. And this are-- these are the audit values. I had a pharmacy student with me and I set the pharmacy student down with all the records they requested, all the prescriptions that were documented and requested, and I had them calculate what the value of that prescription was and the refills thereafter because if they take money from one prescription, everything thereafter goes.

WILLIAMS: OK. Have you experienced loss based on an audit?

ANGIE SVOBODA: Unfortunately, I have, based on a clerical error.

WILLIAMS: OK.

ANGIE SVOBODA: And situation would be an insulin. Insulin is quite frequently written for in a-- what they call a sliding scale, where it's based on the patient's glucose levels and if their glucose levels are a certain range, they have to give a certain dose of that insulin. And if we're not given that sliding scale and don't show our calculations on the prescription we provide to that PBM-- we have to

show our calculations and we have to show that potential day supply, which can change-- then we can lose all of our money from that insulin and it's-- insulins are very expensive.

WILLIAMS: Has any loss that you have, have taken related to fraud, waste, or abuse?

ANGIE SVOBODA: No, they have been all based on clerical or technical errors.

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

ANGIE SVOBODA: Thank you.

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

DAVID KOHLL: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is David Kohll, D-a-v-i-d K-o-h-l-l. I'm a pharmacist and member of the Nebraska Pharmacists Association. My family owns Kohll's Pharmacies in the Omaha-Lincoln area and have served Nebraskans for over 73 years, including some of your own families. The lack of any type of regulation and oversight of pharmacy benefit managers has negatively impacted patient care in Nebraska so much that PBMs are a danger to the public. I'm going to give you two-- just two examples that occur daily from all pharmacies across the state. The first example from just last Friday, a patient was prescribed colchicine because of an acute gout attack. The PBM negotiated a contract with the branded drug for colchicine and would not cover the generic drug. The branded drug had a patient copay of $398. The insurance did not cover generic colchicine, which have-- which would have resulted in a much lower patient copay. The PBM would only cover the branded drug. These shenanigans resulted in the patient choosing to suffer his acute gout attack to avoid paying the $398. Second example also happened last Friday. A patient was prescribed dexmethylphenidate extended release, a drug indicated for attention deficit disorder. The PBM of the patient's primary insurance is a commercial plan and the secondary insurance PBM is a Nebraska Medicaid plan. The PBM primary insurance would not cover the much less expensive generic drug. They only would cover the much more expensive brand drug. The brand drug coverage, under the PBM's primary commercial plan, mostly went to a deductible.

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Therefore, Nebraska Medicaid was required to pay most of the cost of this prescription. The savings to Nebraska taxpayers would have been huge if Nebraska Medicaid could have just paid for the generic drug. So in that-- in the chart that I provided each of you, I wanted to explain how the PBMs-- why and how they're doing this. So the first example is the colchicine. The cost of the drug-- for the branded drug is $450. The rebate is $90. I happen to have information that gives me what general rebate amount the PBMs are paid. The generic cost of the drug was $100. There's no rebates on generics, so the PBM had a profit of $90. The second example, the dexmethylphenidate, the branded drug is $1,300. The brand rebate is $90 to $800. Well, why the difference? Well, if the drug is a specialty drug, then the PBM is paid a higher rebate than if it's just a brand drug. But what's odd is PBMs can decide what's specialty and what's not specialty. So if they consider this a specialty, the rebate is $800. The generic cost is $150. Of course, no generic rebate, so the PBM either made $90 or $800, plus other ways they make money. So it's kind of like a credit card. The more you spend, the credit card companies-- the more they make. That's the same way that these PBMs are operating. The more, the more branded names, the higher the branded drug, the more rebate they're going to get, the more money they're going to make. And that's why the manufacturers have to pay these PBMs the rebate and so then they turn around and raise their price. So the PBMs are causing these manufacturers to raise the prices. You would think that a PBM, which is owned by many insurance companies, would just make their money based on premiums. So if nobody goes to the hospital and they're just paying in premiums, they had a great year. Well, that's not the way it is for drugs. The more branded names that are dispensed, the more money they're making. So these rebates are either passed on partially to-- so self-insured companies may be able to get some of these rebates back, but definitely not all of them. Companies that are fully insured do not get any of the rebates. They aren't passed onto the patient. They aren't lowering the premiums. This rebate is all profit directly to the PBM. In either example, the generic would have significantly saved Nebraskans the most. There are many other ways PBMs are profiting at the expense of the public and in doing so, they're lowering the level of healthcare, just like Angie said. Spending-- we're spending too much time with working around these PBMs' rules, but please protect the public by regulating these PBMs and I welcome any questions that you have.

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

McCOLLISTER: Thank you, Chairman Williams. Mr. Kohll, can you describe the relationship you have with the PBMs and, and negotiation of the pricing and communication that you have--

DAVID KOHLL: Sure.

McCOLLISTER: --from those companies?

DAVID KOHLL: Sure. Thank you, Senator McCollister, for the question. So when your, when your contract is running out, the PBM will introduce maybe a three-year contract and you'll-- you look at the pricing that they're going to give you and say well, that-- many drugs are going to-- they're going to pay me less than what I buy it for. So then you say, OK, let me contact them to negotiate pricing. Well, you can't call them. You can't even email a person. You can't meet with them face to face. They have a portal. You send the question in for a portal, how can we work this through? This isn't right. You might get a response back two weeks later. In that response, it's usually-- they usually don't even answer the question. It, it, it's-- at some point, you know, we may decide to not work with 90 percent of what these PBMs are doing, so but--

McCOLLISTER: OK.

WILLIAMS: Any additional questions? Mr. Kohll, I've been driving by your pharmacy for over 50 years and I'm glad to know there's really a Mr. Kohll.

DAVID KOHLL: Thank, thank you very much, Senator Williams.

WILLIAMS: Thank you for your testimony.

DAVID KOHLL: Thank you.

WILLIAMS: We'd invite the next proponent.

DAVID KOHLL: I'd like to invite my, my patient who came here, Pat and Gary Spanel.

PAT SPANEL: Thank you.

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WILLIAMS: Good afternoon and welcome.

PAT SPANEL: Good afternoon. Members of the Banking, Commerce and the Insurance Committees, my name is Pat Spanel, S-p-a-n-e-l. We are Gary and Pat and we are asking for your support for LB375, adopt the pharmacy benefit manager program. PBMs are a third-party administrator of prescription drug programs that currently are reporting record profits and sending prescriptions to be filled at out-of-state pharmacies that significantly contribute to pharmacy waste and provide substandard pharmacy advice. Their practices limit my choice of a pharmacy. LB375 would allow patients' choice. The PBM requires me to get a 90-day supply of prescriptions. Recently, my doctor went ahead and prescribed seven of my prescriptions, but due to my changing medical condition, one of the other doctors discontinued all seven prescriptions. Ninety-day supply wasted, my copay money wasted. Where does this money go to, coming out of my pocket? So this needs to go ahead and be looked at, not just by myself that it's happening to, but to other Nebraskans that are forced to go ahead and use these types of PBMs. When I would call the PBMs to talk to them, I would be put on hold for 15, 20 minutes and then once I would get there, I would be transferred from one pharmacist to another, trying to go ahead and answer my questions, which wasn't helpful at all. And when I finally got to a pharmacist, then I couldn't understand the language very clearly. That's very hard to do when you have a hearing loss also and you're trying very hard to get your instructions straight because your life depends on it. What we place in our bodies is very important, the drug therapy. I am not going to belay something in my body that is not right and neither should either one of you. So I ask that you need to trust someone, to be able to talk to someone that will go ahead and give you the correct advice and go to a recommended pharmacy like Kohll's. Even Gary used to have to get his prescription needles for his insulin, three-month supply, and he takes three shots a day. That would be 300 pin needle. They're little. They would come-- all the boxes would be smashed. The covers on the needles would go ahead and be off and we would have 300 loose syringes, the needle parts, in a bag that we would have to deal with each time. Loss of money. Nebraska, to me, is the good life, but Nebraska is also the quality of life and we need to provide that to each and every citizen here. And I thank you, so please consider approving this bill today. Thank you.

WILLIAMS: Thank you. Are there any questions? Seeing none, thank you for coming and telling your story today.

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PAT SPANEL: Thank you very much.

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

MARCUS SNOW: Good afternoon. Thank you. Chairperson Williams and members of the committee, my name is Dr. Marcus Snow, M-a-r-c-u-s S-n-o-w, and I appreciate the opportunity to speak today. I'm speaking today on behalf of myself, the Nebraska Medical Association, the Nebraska Rheumatology Society, and the American College of Rheumatology in support of LB270 and LB375. I'm a rheumatologist who has been in practice in Omaha for over 11 years and currently serve as the president of the Nebraska Rheumatology Society and as chair of the American College of Rheumatology's committee on rheumatic care. The use of PBMs has created an extra layer within the healthcare delivery system and PBMs lead to inefficiencies in providing care to patients. PBMs often have an impact on which prescription drug a, a physician may provide to a patient, even if the physician believes that a different drug will be more beneficial. This can lead to additional follow-up visits with the patient, additional administrative work on a physician's office behalf, and unnecessary delays to get the proper medication in the patient's hands. PBMs also take away from the local economy, as they circumvent the local pharmacy. They have the ability to restrict the quantity of drug a patient can get through their local pharmacy, often requiring patients to receive their medication through the mail. By making patients wait for their medication, this negatively impacts the streamlining and timeliness of delivery of care for the patient. PBMs claim to lower costs by negotiating discounts of high-priced drugs, but many note their role in rising drug costs through their opaque rebate system. There is no transparency available to the patient, to the provider, or to any involved in the care of the patient. It is not clear where the benefit of this lower cost goes. Let me give you a brief example of how a PBM impacts care from, from my point of view. I take care of patients with multitude of conditions, but probably most often rheumatoid arthritis. I prescribe many different medications. Some of them are 50 years old and relatively cheap, some of them are relatively new and very high priced, some often "inaccessless" price of $70,000 a year. After I write a prescription for this medication, after a multitude of thought with the hope that I can prevent long-term damage for my patient, I submit the prescription to the pharmacy. It ultimately makes its way and the pharmacy benefit manager decides and lets me know what their formulary would allow. Most of the time, I will agree with their

change, depending on the situation. They will give me a handful of options and if I think that they're adequate, I end up changing my prescription at their request. If I would not, my patient would have to pay exorbitant amounts of money to get that medication. So once this happens, the drug is mailed to the patient and is taken. And if the patient responds favorably to the medication, we still get letters later on asking us to prove that this medication is needed. And what happens, a year later, if they change their formulary? I get a letter saying the drug that, that I wanted you to take last year is no longer preferred by us. We want you to move to another medication. So now I have a patient who's responded, is doing well, and they're asking me to move them to a different medication, putting their health at risk. This is not appropriate in my mind. I would also like to point out that LB270 addresses a significantly disturbing trend employed by PBMs and insurance carriers. As you are likely aware, copayments are significantly increasing yearly. This means that even if there is coverage for a medication and it is preferred by the carrier and it is approved by the carrier, the copay can be in the hundreds of dollars and the deductible can be in the thousands of dollars. Some manufacturers have stepped in and they have provided assistance for patients in this regard to help pay for their copayments so they can get their medication. As a means to discourage the use of these costly medications, some insurers have instituted accumulator plans where they essentially do not allow this, this practice to happen and they continue to charge deductibles in excess. This is a means to take patients and to, to reduce the number of patients on medication by making it too expensive for them. This is inappropriate in my mind. The origin for the money of the copay for the deductible is none of their business. If it comes from their parents or if it comes to the manufacturer, it, it basically is being-- the, the deductible and copay is being met. Again, I, the Nebraska Medical Association, the Nebraska Rheumatology Society, and the American College of Rheumatology urge you to support both of these pieces of legislation. I'm happy to answer any questions you may have.

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

MARCUS SNOW: Thank you.

WILLIAMS: Invite the next proponent. Good afternoon.

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SARAH KUHL: Good afternoon. Thank you, Chairman Williams and the members of the Banking, Commerce and Insurance Committee. I appreciate you holding this important hearing today. I am Sarah Kuhl, S-a-r-a-h K-u-h-l, director of community-based pharmacy services for Nebraska Medicine. Nebraska Medicine is a nonprofit integrated healthcare system affiliated with the University of Nebraska Medical Center. We have over 9,000 employees and 1,000 affiliated physicians. Our providers perform over 1 million outpatient visits and about 100,000 emergency visits every year. A vital part of our health delivery to our patients is our pharmacy department and 340B program. Nebraska Medicine is in support for LB270 and LB375. As director of community-based pharmacy services, my job is to ensure patients have access to their medications by removing barriers to care, whether that be clinical, financial, or logistical reasons. Nebraska Medicine, along with many other hospitals in Nebraska, are able to purchase drugs at a discounted price for their in-house pharmacy or partner with pharmacies serving their patients because of a program called 340B. The 340B program legislation passed with bipartisan support in 1992. The program lowers the cost of outpatient prescription drugs purchased by eligible hospitals, health centers, and clinics by required drug-- by requiring drug manufacturers to discount their prices as a condition of participation in Medicaid. The savings generated from the discounted drug prices are passed along in many ways, such as helping low-income patients afford their drugs and investing in clinical programs to provide more care for patients, especially those living in underserved and rural communities. With the 340B savings, Nebraska Medicine has been able to provide reduced-cost medications to more than 10,000 patients every year. This means patients being able to obtain things like insulin and cancer treatment without going broke. My written testimony has a sampling of many recent examples in line with many other-- of the testimony today. Just to be respectful of your time, I'll defer to the patients and my colleagues for further examples. I would like to talk about the discriminatory pricing practices from PBMs. In recent years, many of the largest PBMs have started reimbursing our pharmacies for prescriptions at a significantly lower rate while still charging patients the same high copay because they know we are able to purchase the drugs at a 340B discounted price. Instead of the 340B savings going back to help our patients and community, the 340B savings are being recuperated by the PBMs. PBMs will say that they do not like the 340B program because some drug manufacturers will not give them a

rebate on the drugs purchased at the 340B price. As of last week, Express Scripts, one of the largest PBMs, is now requiring pharmacies to submit additional documentation at the time of dispensing to let them know when a prescription is 340B eligible. This policy by PBMs will likely discourage some pharmacies from dispensing 340B drugs because the process will be too cumbersome, making dispensing 340B prescriptions nearly impossible for many pharmacies. PBMs often say they are here to help keep costs down from patients-- for patients and employers. I am in a unique position because I also help Nebraska Medicine's benefit team manage the pharmacy insurance for our own employees. Policies implemented by PBMs often lead to a lack of patient choice and provider choice and treatment based upon coverage restrictions as well as restrictions placed on where a patient can obtain medications. I've seen PBMs audit and take back money for arbitrary reasons on employee prescriptions filled through our own pharmacy. They then keep the money they took back and not pass it-- the money back to Nebraska Medicine's own self-insured plan. The PBMs are making formulary decisions based on nondisclosed rebates from drug manufacturers for having their product preferred on the formulary and driving business to their PBM-owned pharmacies. These decisions are for the benefit of the PBMs' bottom line and shareholders and not in the best interest of Nebraska. Throughout all this testimony today, you're going to hear one overarching theme. PBMs run a complex and nontransparent business. We're asking for the legislation to be taken up in order to help-- for our healthcare providers to provide unrestricted care to their patients, uninhibited by unfair policies laid forth by PBMs. If these discriminatory prices-- practices from PBMs are not stopped, the funding for critical healthcare programs across the state will be gone. Thank you. I'm here for any questions.

WILLIAMS: Thank you, Dr. Kuhl. Are there questions? I have a question concerning the 340B program that's been in existence, as you said, since 1992. And, and as you mentioned, that program has been used to help a lot of people needing help. And so your-- is your testimony then that the, the PBMs are now trying to divert that money for their own profit?

SARAH KUHL: Yes.

WILLIAMS: Can you explain that just a little more for the committee?

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SARAH KUHL: Sure. So when we purchase our drugs, it's at a lower price and the PBMs now understand that we're able to purchase at a lower price. So rather than reimbursing at us-- our pharmacy and the contract pharmacies we work with at the normal range, they now have a lower payment that they give us. So they have, they have been able to take that margin that we're supposed to get for those 340B drugs that we could use for things like helping with COVID response and now they-- all the PBMs now have that additional margin.

WILLIAMS: Thank you. That's helpful to understand. Senator McCollister.

McCOLLISTER: Thank you, Chairman Williams. Are PBMs publicly held companies?

SARAH KUHL: Yes, they are, so they have shareholders, yeah.

McCOLLISTER: And they've been doing rather well?

SARAH KUHL: Very well.

McCOLLISTER: Thank you.

SARAH KUHL: Very well.

WILLIAMS: Additional questions? Seeing none, thank you, Dr. Kuhl.

SARAH KUHL: Thank you.

WILLIAMS: Invite our next proponent. Welcome to Mr. Randolph.

DAVID RANDOLPH: Thank you. Good afternoon, Chairman Williams and other members of the Banking, Commerce and Insurance Committee. My name is David Randolph, D-a-v-i-d R-a-n-d-o-l-p-h. I am the pharmacist and owner of Dave's Pharmacies in Hemingford and Alliance, Nebraska. I am here representing myself, the Nebraska Pharmacists Association, and rural pharmacy in Nebraska. My fellow colleagues has testified over several areas in which PBMs hurt local pharmacies, decrease healthcare access, and hamper patient care. I wish to, wish to discuss with you a couple of other areas, including their appeals process, which lacks any transparent-- no transparency whatsoever. When I fill your prescription today, I will submit a claim to the PBM. They will then send it back to me at the point of sale, right there, how much they're

going to pay me. However, we recently learned that up to a month later, they will come back and change that. For, for the sake of this argument, they will tell me how much they'll pay me. So if the drug costs me-- for a blood pressure medication, it cost me $10. They will submit that claim back to me and tell me they're going to pay me $12 or whatever it may be. A lot of the times what they actually will submit back will be less than what I am paying my wholesaler. So I submit a drug for $10, they will pay me $5, below my cost. Don't forget, as Ms. Mueting alluded to earlier, it cost me $10-plus just to dispense that drug, not regarding the cost of the medication. However, I do have an appeals process for this. I can get on their website, enter in all the information, the medication, the patient information, everything on their website. And in one to two weeks, I will get a response. Ninety-nine percent of the responses that I receive in the appeals process are negative responses, meaning too bad, appreciate your effort. With one of the major PBMs, in seven years, 100 percent negative response. What is the point? The highlight of it is when we get the negative response, we get no reason behind it. Why am I getting paid less than the drug costs me? Can you explain this to me? No, because everything is done by computer, no human interaction whatsoever. If you have a drug, any drug-- you think of a drug. If you have-- I'm going to use Tylenol because everybody knows what Tylenol is. It has something called an NDC number on it, which is called the National Drug Code. There's several different makers of generic Tylenol. Each different maker is assigned a different National Drug Code for that maker and for the size of the bottle, OK? If I submit this appeal to PBM "X," the least they could do is tell me we're paying you less than what you should be paid because we can buy this NDC code cheaper. Great. I've got a place to go. I can go back to my wholesaler and say I want this in NDC. This is what I'm getting paid. We don't get that, so for all I know, the amount that they're paying me is based on a drug they got in Zimbabwe. There's no way to know what they're paying that for and why. Part of this also lies with the fact that they do not update their price list. They will tell you they do. I'm here to tell you, as a small pharmacy owner, every day we update our price files. They have the capability and ability to do it. They choose not to. In March and April, at the start of COVID, drug prices went through the roof, two to ten times the price went up. On generic drugs, it used to be pennies. Now they're worth several dollars. They still reimbursed on the old price list clear into June and July, meaning that I was appealing, on a daily basis, several

claims, all with the no response. If I have the ability, they have the ability. You're going to have several PBM lobbyists come in here to refute our claims with fancy contract language and talk of saving money. To that point, please ask these questions. Ask them about Shirley Jones [PHONETIC] and her Combivent inhaler that was mailed to her along with a book. She came in to me to ask for help. I saved them money by saving her a trip to the E.R., didn't get a dime, or how Bob Smith is doing since his wife passed away. She set up his medications for him. Oh wait, they don't even know what language he speaks. He has to press 1 at the 800 number. Then ask these representatives of the billion-dollar monopolies that have posted record profits during this pandemic, how many people they plan to hire in Nebraska or how they help-- plan to help the local economies? Ask them how many youth sports teams they plan to sponsor or if they're going to buy an ad in the local annual? Maybe help donate something to the benefit auction for that poor person who just found out they have cancer in town. Finally, ask them when the local pharmacy is forced to cut hours or even close, who's going to be there for these patients when the mail-order prescription doesn't come in, when the new prescription is started, when the antibiotic is started that they have to wait a week or two to get in? Ask them who is going to come out? Are they going to send their mail-order pharmacists and technicians out to vaccinate for COVID? In the fall, will we see them to help vaccinate for flu or whatever pandemic is next? In 1994 in Scotts Bluff County, there were 11 pharmacies--

WILLIAMS: Mr. Randolph, you've got your light on.

DAVID RANDOLPH: Yes, I'm sorry.

WILLIAMS: Could, could you--

DAVID RANDOLPH: Thank you, thank you.

WILLIAMS: --make your final comment please? Make your final comment.

DAVID RANDOLPH: OK. In 1994 in Scotts Bluff County, our most populous county in the Panhandle, there were 11 pharmacies, seven of which were independent. Today there are five, one of which is independent. Two towns have health clinics in them with no convenient access to medications because there's no pharmacies in town. If nothing is done,

this trend will continue to happen, so please take this bill forward. Any questions?

WILLIAMS: Thank you, Mr. Randolph. Are there questions? Senator Flood.

FLOOD: Mr. Randolph, you said you operate two pharmacies. Is that in-- what towns?

DAVID RANDOLPH: OK, one is in Hemingford, which is roughly about 900 people-- it's 60 miles northeast of Scottsbluff-- and one is in Alliance, Nebraska.

FLOOD: And how many pharmacists do you have to run those two pharmacies?

DAVID RANDOLPH: Me and one other one.

FLOOD: So who's working today?

DAVID RANDOLPH: I, I have a stand-in gal that comes in, thankfully, and she helps me out.

FLOOD: And how many hours did it take you to get here?

DAVID RANDOLPH: It took me seven and a half.

FLOOD: So how many days of work are you missing this week?

DAVID RANDOLPH: I missed-- well, I'll miss two.

FLOOD: OK. This is pretty important to you, isn't it?

DAVID RANDOLPH: It's very important to me.

FLOOD: Thank you.

WILLIAMS: Are there additional questions?

PAHLS: Chair.

_____: Senator Pahls.

WILLIAMS: Senator Pahls.

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PAHLS: The questions that you've asked-- a few, I noticed-- I hope the other side is listening because I want them to answer some of those questions. Don't come up here and give me a lot of garbling. I'm just telling you guys, if you're going to come up, answer these questions that were posed. Thank you.

DAVID RANDOLPH: Thank you.

WILLIAMS: Mr. Randolph, to, to follow up on Senator Flood's question of you taking time to be here, who's filing those appeals while you are here--

DAVID RANDOLPH: Senator, one of my other pharmacists--

WILLIAMS: --and will they get the same response?

DAVID RANDOLPH: They, they are going to get the same response, but honestly, when I get back there tonight-- hopefully I'll get back there tonight because I have to give COVID shots tomorrow-- but there will be a stack at each pharmacy that I'll have to go through and do.

WILLIAMS: Thank you, Mr. Randolph. Thank you for your testimony today.

DAVID RANDOLPH: Thank you.

WILLIAMS: We'd invite our next proponent. Thank you for being here.

TREVOR BERTSCH: Thank you, thank you.

WILLIAMS: Welcome.

TREVOR BERTSCH: Thank you, Chairman Williams and members of the Banking, Commerce and Insurance Committee. I want to thank you for your time for me to voice my support for both of these legislative initiatives, LB270 and LB375. My name is Trevor Bertsch. It is spelled T-r-e-v-o-r, last name is spelled B-e-r-t-s-c-h, and I'm a pharmacist who works at U Save Pharmacy in Norfolk, Nebraska. So a key provision of these two legislative bills is to address PBMs steering their insurance to a PBM-owned pharmacy or big-box retail chains whom they have an exclusive contract. We touched on this with specialty. This is happening in your normal run-of-the-mill community pharmacies. In some cases, patients in rural areas may not have a preferred pharmacy in their close area, so they may drive several miles, even up to an hour

away in some cases to get their, get their medication. And when they get there, that medication may not be in stock or it may be out of refills, so some patients make the decision to skip doses because they can't make that trip. This practice by PBMs is not only anti-competitive, but it also-- it is also anti-patient choice and in some cases, dangerous for public health, patient health, and their pocketbooks. So for example, I'm going to tell you a story about a patient of mine who has a traumatic brain injury. She was in a horrific car accident. She doesn't have the cognitive abilities anymore to manage her own medications. We've been filling her medications for the last year and then all of the sudden, her pay-- her, her husband's insurance decides that they have to go to a big-box retailer and they can no longer use our pharmacy. We provide her medications and compliance packaging, so all she has to worry about is morning on Sunday, evening on Sunday, and she gets all of her meds packaged for her. They don't provide the services that we do. Her husband can't manage her medications and she can't. Now she is stuck at the-- that pharmacy and I'm-- I, I-- it regrets me to tell you that I've been watching the obituaries because I'm afraid that's the next time I'm going to see her name. Another story that affects my patients is one of my patients has a high deductible plan. His PBM, through his insurance, through work, forces them to use another big-box retail chain. When he runs his medication through his insurance at that chain, one month costs the same amount as three months if he didn't use his insurance at my pharmacy. So I'll repeat that. He can buy three months of medication not using his insurance at my pharmacy versus using his insurance at the PBM-preferred pharmacy for one month. Now when he comes to me, it's not applied to his deductible. He gets no credit for that. And lastly, another story that I'd like to share is I had a patient-- this actually happened last week. Every day since January, she has received harassing phone calls from her PBM saying you need to switch pharmacies, you need to go use our preferred pharmacy. Every day, phone calls, emails, texts, letters. She's been with us since 2006. She has hearing problems. She can't really respond over the phone, so we have to text her. And when she comes in, we work with her. We also package her meds because she has cognitive ability issues, but she can't manage her own medications. She finally gave in and came in tears saying, I have to switch pharmacies because I cannot take these phone calls anymore. And the owner of our store went up to her and said, what-- is it something we did? What happened? And she was in tears. She goes, no, you guys are like family to me. You have

changed my life. You have created a life so that I can live and function at the most optimal health and optimal ability that I can. So sadly, these examples are not really the norm-- they're not the exception, they are the norm. These abusive practices have put my patients and other Nebraskans in hospitals, wasted our healthcare dollars, destroyed our local economies, and caused dollars to leave our state. Studies have shown that when an independent pharmacy leaves a downtown in a small community, that is pretty much the last straw. That community will die. Next thing you know, you're going to have maybe a gas station and a couple of bars. The PBM representatives will reference their insurance as patients, yet they provide very little value to them or know their faces. The main reason I'm up here-- I'm solely up here to defend my patients who have a name and face to me. I know their families. I know their joys. I know their suffering. They aren't just patients. They are like family. We aren't asking for hand-- handout, we just want an even playing field. I leave you thanking you for your time and ask you to remember that all the pharmacists that are testifying up here today are doing so because there's a systemic problem that inhibits our ability to take care of our patients. Our patients are our priority, not shareholders of the C Suite. This legislation would allow us to continue to be the most accessible healthcare provider. I would be happy to answer any questions that you may have. I thank you for your time and I hope you guys have a good afternoon.

WILLIAMS: Thank you, Mr. Bertsch. Senator Slama.

SLAMA: Thank you, Mr. Chairman, and thank you, Mr. Bertsch, for being here from Norfolk today. I, I wanted to give you the chance to go into a little bit more detail-- I was pretty disturbed by your third example of the patient being harassed by the PBM, receiving calls, texts, letters. Do you find that happens often and do you find them targeting elderly patients when that happens?

TREVOR BERTSCH: Absolutely. It is especially rampant in Medicare and it's starting to happen in even our own Medicaid program. Our managed care organizations are trying to steer patients to use mail-order facilities and other entities that may package meds that don't exist in our state.

SLAMA: Um-hum.

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TREVOR BERTSCH: So they're having our tax dollars leave our state. I don't know about you, but when I get my paycheck, I tend to buy things in our state and so it really stimulates our local economy. And sadly, even people who have cognitive disabilities or developmental issues who maybe don't have someone helping them, they're often tricked or misled into switching before they even know it.

SLAMA: Sure. Elderly, those with cognitive disabilities being targeted by those calls, those letters, those contacts.

TREVOR BERTSCH: They are.

SLAMA: OK, thank you.

TREVOR BERTSCH: As well as, as well as people who have--

SLAMA: Sure.

TREVOR BERTSCH: --good cognitive abilities and everything, but--

SLAMA: Yep.

TREVOR BERTSCH: --sadly, I bet our pharm-- our pharmacy is fairly busy, but I bet we would have way more business if we could just be on a level playing field and our charm is that we do take care of patients. That is our normal goal. I'm not told you have to fill this many prescriptions an hour or whatever. It's just-- the owner says be a good pharmacist.

SLAMA: Thank you.

TREVOR BERTSCH: Yeah, thank you.

WILLIAMS: Additional questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, sir. As a follow up to Senator Slama's question, you mentioned that patients receive, on occasion, letters encouraging them to change pharmacies. Would examples of those letters be something that you could send to the committee?

TREVOR BERTSCH: Absolutely. I will talk to some patients and see if they still have them. It happens-- tends to happen more-- a lot more

so in January and you'll see probably a slew of them in March. The PBMs will allow us to fill maybe one or two months and then they will actually lock it at our point of sale and not allow us to process the prescription. And I'd basically have to tell the patient you can't get your prescription here, so it does delay care. I can give you screenshots of those rejections. I could provide letters. It-- the evidence is out there. You know, PBMs are a difficult thing to understand and they like it that way. You've maybe never heard of them and that's what they want.

BOSTAR: Well, I would certainly encourage you to-- if you can come across some of those things--

TREVOR BERTSCH: Yeah.

BOSTAR: --to send them our way. I would appreciate it.

TREVOR BERTSCH: You bet.

BOSTAR: Thank you.

WILLIAMS: Additional questions? Senator McCollister.

McCOLLISTER: Thank you, Chairman Williams. That's a restraint of trade practice. Do you have any recourse--

TREVOR BERTSCH: No.

McCOLLISTER: --in that regard?

TREVOR BERTSCH: No.

McCOLLISTER: Why not?

TREVOR BERTSCH: Well, because there is no oversight of them currently that we are aware of. There's no place for us to appeal. We are-- we passed-- you, this committee, did let, let through the, the gag order clause a few years back, but we are locked in contractually. That-- we aren't allowed to basically fight back and much like our-- several of my colleagues have said, if you decide that you're not going to take a PBM, well, you lose three-- one-third of your patients at the minimum and we are forced to accept those contracts because we want to take care of our people. So there really-- at this point, there really

isn't any recourse. I don't have anybody to file a complaint with. If I file a complaint with the PBM, it gets filed in the paper shredder.

McCOLLISTER: Thank you.

TREVOR BERTSCH: Yep.

WILLIAMS: Mr. Bertsch--

TREVOR BERTSCH: Yeah.

WILLIAMS: --just before you, Dave Randolph was up here talking about the appeals, the appeals process.

TREVOR BERTSCH: Right.

WILLIAMS: Have you had the same experience with that process--

TREVOR BERTSCH: Yes.

WILLIAMS: --as he testified to?

TREVOR BERTSCH: Absolutely. Before we switched to the managed care organizations, the-- when we were a fee for service, our appeal process worked for Medicaid. We were successful at times in reversing some of the underwater claims. Now it's, it's just flat out impossible. It goes into an abyss or you get a negative, negative response. It really doesn't even behoove you to appeal. You swallow the loss and move on.

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

TREVOR BERTSCH: Thank you, guys. Have a good afternoon.

WILLIAMS: Invite the next proponent.

TRAVIS COVEY: Hello.

WILLIAMS: Welcome this afternoon.

TRAVIS COVEY: Feels good to get that off.

WILLIAMS: You can go ahead.

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TRAVIS COVEY: OK. Chairman, Chairman Williams and members of the Banking, Commerce and Insurance Committee, my name is Travis Covey, T-r-a-v-i-s C-o-v-e-y. My wife and I are part owners of U Save Pharmacy in North Platte and members of Nebraska Pharmacists Association. I've been with U Save for over 20 years and in North Platte since 2010. I thank you for giving your time and allowing me to speak to you about the unfair and elusive issue of PBM contracting. I'm in favor of both LB270 and LB375. I'd like to share a couple examples of the challenges retail pharmacies are experiencing just trying to survive. These, these PBM contracts are meant to be so complicated and confusing that the average person can't understand them, let alone figure out if they're followed as we sign them. As an example, the hospital in my community employs over 1,000 employees. The contract that, that they have on paper says we will not be filling prescriptions at a loss. It doesn't say we're going to make any money or a significant amount of money, but we're not going to be losing money and so we can, we can look at what a-- what the contract says and what our cost of goods are and we can reasonably say, OK, we should make money on this. That's not, that's not reality. So in, in 2020, we filled prescriptions for these patients, for these employees overall at, at a loss. After, after trying to get ahold of the PBM and to figure out what is going on, if we're billing something wrong, if there's some issues there, it, it, it was weeks before we finally got some information back that said they have two different plans, an exclusive plan and a national plan, and they intermingle these plans. So they, they tell me that if I'm losing money on one plan, I'm making money on the other one. These, these are completely different groups and so it's impossible to try to figure out where I actually stand on that and I don't think anybody could figure that out. Another example of these practices involves the, the way that they are now doing it, which is BER, which is-- it's brand effective rate and GER, which is generic effective rate. And it's, it's a way to retroactively callback dollars after the fact. So rather than pay a set rate for a prescription every month for that patient-- you've got the drug and you've got this calculation that you come up with-- they, they finagle these numbers all year long. And so what it leads to is that, that patient may have a different copay every single month and we have different reimbursement every single month. And, and remember it-- too that you-- now you've got these two different plans, so there's zero way to track any of this. And, and then-- and to further confuse the issue, as, as some, some other guys have talked about here, they have

this mandatory dispensing of brand name drugs when there's a much less expensive generic. So if I'm trying to meet all these parameters, they're absolutely impossible to, to know where you even stand. You know, I'm sure all of this sounds a little confusing and that's what it's meant to be. That's, that's how they want it. It's, it's-- the average guy who can't figure it out. Now they're going to come in here and say that these contracting issues are between us and our, our PSAO, which is a, a pharmacy service administration organization. What a PSAO does is it's a co-op of independent pharmacies usually and they, they, they negotiate and sign the contracts for you. Without that backstop, we wouldn't, we wouldn't be able to do this at all. And so the-- these PBM contracts are, are ever-changing and the only negotiating, as several guys have said, it's take it or leave it. There's, there's no negotiating and there's only the three PBMs. So there's decisions to be made here. If I, if I leave this contract, I potentially lose one-third of my customers and I lose that relationship that, that I and my pharmacy staff has with all of these, these employees, which-- I have a child in school with these people. I, I go to church with them. I see them at community events, so do I lose those patients and potentially friendships or do I potentially lose-- bleed my pharmacy out of business? Neither, neither one of these are good options, but, but that's what we're left with. And, and I think that is the end goal of these PBMs, to, to get rid of all independent pharmacies. So as many of you here, I, I am normally against overregulating anything, especially regarding private business. But the, the PBMs have been allowed to do anything that they want, as far as healthcare stands. From what a doctor prescribes to what I get paid, from the beginning to the end of the process, the PBMs have complete control here. My, my reimbursement also is affected simply by how adherent a patient is to a medication. If you skip a dose, I-- my reimbursement is negatively affected. I have no control over whether you miss that dose or not.

WILLIAMS: Mr. Covey, your red light is on. Could you give us some final comments?

TRAVIS COVEY: OK. No, I'm-- just-- so I am just-- as PBMs have increased control of the market, drug costs have gone up and I feel now, as many other states have already done, is the time for Nebraska to, to get something done here. That's it.

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

TRAVIS COVEY: Thank you.

WILLIAMS: Invite our next proponent. Welcome to the Banking, Commerce and Insurance Committee.

JEFF KILBORN: Good afternoon, Chairman Williams and other members of the Banking, Insurance and Commerce Committee. My name is Jeff Kilborn, spelled out J-e-f-f K-i-l-b-o-r-n. I apologize if my voice cracks because like some of the other gentlemen, it's kind of an important deal. So with that being said, I'll try to finish. My wife Laura and I have owned and operated Elmwood Pharmacy located in midtown Omaha for almost 25 years, in the same neighborhood where we lived and have raised our three children. I appreciate your time and the opportunity to speak about the important issues affecting independent community pharmacies, your friends, your neighbors, your coworkers of the do-- due to the inability of freedom of choice of their local pharmacy because of the business practices of pharmacy benefit managers. I am in support of both LB270 and LB375. I would like to speak today about how the anti-competitive business practices of pharmacy benefit managers do more than negatively affect fellow Nebraskans' healthcare, as has been eloquently addressed by others speaking here today. In addition to these issues raised by others, I would like to-- I would also like the committee to seriously consider how these practices legal-- negatively affect local economies, as well as the overall economy in Nebraska. As others have testified about the many hardships placed on the pharmacies and patients, as Pat previously spoke of, by PBMs making it more difficult-- it's making it more difficult to maintain a viable independent pharmacy, which provides high-quality health services to Nebraska cit-- to citizens of Nebraska. These practices will ultimately lead to the demise of independent pharmacy. Unlike the pharmacy benefit managers, independent pharmacies provide a positive economic impact on their respective communities and to the state of Nebraska as a whole. Independent pharmacies positively impact the local economy by utilizing other goods and services provided by other fellow Nebraskans. These services, which locally owned pharmacies like myself, like David Kohll and some of the other gentlemen that speak-- or spoke earlier today, are provided by other fellow Nebraskans. These services range from accounting, insurance, marketing, legal, lawn

care, snow removal, janitorial services, just to name a few. These services are provided by Nebraska-owned companies and/or individuals, just like the independent pharmacy who pay for other local goods and services, which further benefit the local economy and tax base, in contrast to the Nebraska residents who are forced to choose a national pharmacy chain or mail-order owned by PBMs. Those dollars leave the state and benefit the non-Nebraska economies. According to the Better Business Bureau, local businesses spend on average $68 out of $100 benefiting their local and state economies. In addition to the economic multiplier effect provided by independent pharmacies, they also provide hundreds of jobs to Nebraskans. These jobs-- these weld are high-paying jobs that also provide a positive effect on the economy because these individuals also spend their wages for other local goods and services and, and paying local and state taxes. I, I went through this way too fast and I apologize, but in closing, I would like to thank everyone on the committee for their time and attention today and like to consider leveling the playing field by supporting LB270 and LB375. And I guess since I need-- running out of time, so independently owned pharmacies can continue to have a positive impact on the economy as well as their health services of fellow Nebraskans. I support-- I feel that supporting LB270 and LB375 will accomplish these goals. Thank you and if there are any other questions?

WILLIAMS: Are there questions? Seeing none, Mr. Kilborn, thank you for being here today and testifying. Invite our next proponent. As you're coming up, could I see a showing of hands of how many are left in the room to testify? OK, thank you. Good afternoon and welcome.

ELIZA HENDERSON: Thank you. Hello, Chairman Williams and members of the committee. My name is Eliza Henderson, spelled E-l-i-z-a H-e-n-d-e-r-s-o-n, and I am in support of both LB375 and LB270. I am a pharmacist at Nebraska Hematology Oncology or NHO here in Lincoln, where I work at a pharmacy within the oncology clinic. I am here to discuss the ways in which PBM mandates negatively impact the care provided to patients. I am also here as an advocate for my patients to share the ways in which PBM mandates cause unnecessary waste, stress, and increase the burden for patients already struggling with a cancer diagnosis. My goal is to demonstrate that allowing patients the choice to fill medications at their local pharmacy and not at designated specialty pharmacies as mandated by PBMs provides the best patient care with the least potential waste. PBM mandates to specialty

pharmacies impact the majority of prescriptions filled at NHO Pharmacy, as most oral chemos are designated as specialty medications by various PBMs. When a prescription is mandated to a specialty pharmacy, the majority of the high-level pharmacy services, which we provide for each prescription, such as drug-drug interaction screening and management recommendations and patient follow-up for adverse events and management, are not provided, as specialty pharmacies do not have access to the patient's medical record and they do not have a relationship with the patient or prescriber. We estimate that approximately 40 percent of our time is spent dealing with issues surrounding mandated oral chemo prescriptions. These issues include treatment delays, lack of ability for same-day dose changes and prescription billing, and increased waste. Utilizing specialty pharmacies is also extremely complicated for non-English speaking patients, as well as those who are housing insecure. Finally, there are issues surrounding financial assistance not being applied by specialty pharmacies to patients' prescriptions. I will share some patient stories highlighting these issues. KB is a 46-year-old woman whose oral chemo was mandated to Optum. Before the third refill, the patient contacted us to say she was unable to refill her prescription. After four calls to Optum, the patient insurance and initiation of a new prior authorization by our pharmacy, we assisted in-- Optum in resolving the issue. The patient presented to NHO the next day for an office visit prior to starting her next chemo cycle and due to a side effect, the provider reduced the dose of her oral chemo. The patient received her prescription two days later from Optum, a delay in therapy at the incorrect dose, as her refill at Optum had been processed prior to her office visit, deeming a dose reduction was necessary. We could have filled the prescription for the appropriate dose reduction on the day of her office visit, therefore preventing her treatment delay and medication waste. As shown in this case, medication waste is a common issue with specialty pharmacies in the oncology setting. Another patient recently presented to a local hospital with significant neurologic complications related to recurrence of breast cancer in her brain. We spent over one hour and 20 minutes on the phone attempting to obtain an emergency override to urgently fill her medication. Despite the severity of the patient's clinical status being explained numerous times, we were unsuccessful. Before our request for the override was approved, the patient was placed on comfort care. We could have-- we keep the medication prescribed to the patient in stock in our pharmacy at all times and

could have filled and delivered it to the local hospital the same day it was prescribed. Even when we are successful in obtaining an override for a one-time fill, it is not uncommon that we could be hundreds or even thousands of dollars underwater. This forces us to choose between taking care of our patients or keeping our pharmacy doors open. Recently, a patient called to state he had been trying to get his refill for two weeks and had been out of the medication for four days with delivery issues surrounding the extreme cold weather across the U.S. He requested an override to allow us to fill his medication, as he knows we keep it in stock. AllianceRx told the patient that no overrides were being approved because the cold weather was, quote, affecting everyone the same. The patient ended up out of his meds for five days, his oral chemotherapy. If we had been able to fill his prescription, he would not have missed a single day of treatment. Another patient called to state she was told by Avella that the copay for her oral chemo would be over $3,700. When she expressed her shock, the rep stated, maybe we should look into assistance for you so you don't have to refinance your house. It turned out that Avella had the copay card information, which our pharmacy had previously obtained and provided to Avella, on file the entire time. They just hadn't applied it to her prescription refill. Finally, we recently contacted IngenioRx twice to alert them of the need for a Karen interpreter for one of our non-English speaking patients. Despite our calls, IngenioRx still used the incorrect interpreter, Korean, which ended up causing an entire week's delay in prescription delivery to the patient. The examples of issues surrounding PBM mandates to specialty pharmacies that I presented today scratch the surface of the burden placed on patients to navigate a complicated system to obtain affordable and timely oncology treatment. These mandates consume valuable healthcare resources and hours to resolve the patient care issues they create. In the time that I have worked at NHO, we have had multiple patients express their extreme frustration in dealing with their oral chemo prescriptions being mandated to specialty pharmacies. In another instance, a patient brought in a mislabeled Pomalyst prescription from a specialty pharmacy, pharmacy, which has now prompted investigations by two separate state health departments. I hope I have provided persuasive testimony that the boast-- best, most efficient and most cost-effective option for patients to receive their medications in a timely and safe manner is to be allowed to fill medications at the local pharmacy of their choice. I thank you for your time.

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WILLIAMS: Thank you, Ms. Henderson. Are there questions? Seeing none, thank you for your testimony. Invite the next proponent. Good afternoon and welcome.

BRAD BOWDINO: Good afternoon. Thank you. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Brad Bowdino, spelled B-r-a-d B-o-w-d-i-n-o, and it's a pleasure to get the opportunity to talk to you about LB375 and LB270 and how the Unicameral can help pharmacies and patients across the state. As an independent small business pharmacy owner in north-central Nebraska, it's a constant struggle to hold our ground in today's medical environment controlled by large billion-dollar companies. In my role, I run into problems this bill could prevent constantly. Every day we run into instances where a patient is required by a PBM to pay a much larger copay than we would charge that same patient as a cash price. A few examples of this are a 58-year-old female with a kidney transplant having to pay over $500 as a copay for her generic anti-rejection medication. Another is a 71-year-old female with a history of heart disease having to pay almost $100 as a copay for her generic cholesterol medication. In both instances, due to the policies of the PBM, our patients were required to pay five times more for cheap generic medications than we would have charged that same person as a cash price. While in these examples I stand to benefit, it comes as a direct additional cost to my patient. Whether it's an attempt to drive my patient to a PBM pharmacy or just because of a complete lack of oversight, this practice is making Nebraskans decide every day whether or not to receive their lifesaving medication. Another issue our patients deal with constantly is receiving misleading letters and communication addressing our pharmacy's relationship with the PBM. Whether it's a notice of a preferred pharmacy change or a patient no longer being able to fill a 90-day prescription towards the end of the year, we have found most of this communication to be completely false. However, there is no number to call and no office to visit to correct these attempts of a PBM trying to push patients to their pharmacies. This creates a huge workload on our staff, as our pharmacy-- as our pharmacists are left trying to decipher and explain why a PBM won't let a patient choose their pharmacy rather than spending time counseling for the best possible outcome in our value-based healthcare system. Here are three provisions in the bill that could help prevent these examples I just talked about. Section 5 (1) would prevent big PBMs from charging their

insurer more for the same drug we sell to non-PBM-insured individuals. Section 5 (3) would prevent big PBMs from prohibiting us to send scripts to wherever the patient requests and Section 6 allows us to turn misleading letters of any kind my patient receives into the state. Thank you.

WILLIAMS: Thank you. Are there questions? Senator Flood.

FLOOD: Thank you for your testimony today. How far did you drive to get here today?

BRAD BOWDINO: I actually was in Omaha, so it wasn't as far.

FLOOD: It seems to me, like, OK, we can't exercise our authority, our police powers essentially, to regulate PBMs. And if we do exercise that power, the, the cost could go up based upon the savings the PBM claims that they are generating for the premium payers or the, the entity that it contracts with, like the State of Nebraska Department of Administrative Services.

BRAD BOWDINO: Sure.

FLOOD: What could pharmacists do in Nebraska to help us make this the most efficient system in the state? And I ask that because it seems to me you're at the front desk of the-- and seeing everything go out the door.

BRAD BOWDINO: Sure.

FLOOD: Would there be things that you could do and be rewarded for, finding that savings that would, that would still help us deliver the same cost savings back to the insured corporation or company or what, whatnot?

BRAD BOWDINO: Yeah, absolutely. I think, you know, as a direct result, those examples I gave where we, we see a patient copay. It's not the amount the insurance company reimbursed, but rather the copay. They've paid their premium and now they're in our store having to pay a copay to receive that medicine. We know what that medicine costs when it goes out the door. Every single one of my pharmacists and technicians know that amount and then they see that copay. We know if someone walked in as a cash-paying patient, we would charge them "X" number of dollars and in many instances, many, many times, you know, because we

know that, I guess. The-- we want to send that patient out with the cheapest medication. We want that customer to keep coming back to us. We run a front store program. You know, we want to retain that person. Obviously, charging someone $500 for a monthly prescription is, is unsustainable. So you know, from our standpoint, to answer your question, we could identify things like that where right now, we don't have anywhere to go to report that and we're contractually not able to send that prescription out for our cash price for that patient.

FLOOD: It seemed like that is, that is very good for the consumer, which I think-- but I-- what I'm looking for is how could the pharmacists aid in reducing the cost for the state of Nebraska public employees? Because we-- the state of Nebraska itself, through DAS--

BRAD BOWDINO: Sure.

FLOOD: --we actually employ a system that takes business out of your pharmacies at times because we have a PBM that is forcing people into the mail or into-- I think we have a, a deal-- we have a-- the University of Nebraska anticipates it would lose 6 percent discount it currently receives by partnering exclusively with CVS Caremark on specialty pharmaceuticals. So I-- the reason I'm saying this is we have a duty not only to the consumer, but so the university is saving 6 percent that it spreads across all of its insurers.

BRAD BOWDINO: Sure.

FLOOD: How could pharmacists-- independent pharmacists in Nebraska help us to make it more cost effective for the University of Nebraska? Because those are the two-- we have to do two things here. We have to help the consumer and we have to help the pool that is-- our public employees, for instance. Does that make sense?

BRAD BOWDINO: Yeah.

FLOOD: And, and I-- my sense is if we sat down with all the pharmacists in the state, we could figure out things in our formulary to make it better, but I-- the question is could we get and deliver the same kind of savings back to these large insurers?

BRAD BOWDINO: With, with the help of the pharmacists?

FLOOD: Right.

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BRAD BOWDINO: Yeah, I mean, I, I think as many people have testified, there's, there's a lot of waste that goes on with things like a mail-order pharmacy or a PBM, you know, forcing-- if the University of Nebraska were to sign up exclusively with someone and save that 6 percent, I don't know that that really ultimately saves-- maybe the entity 6 percent, but then ultimately their insurers are having to pay 90 to-- 90-day copays on things that they maybe change--

FLOOD: Good point.

BRAD BOWDINO: --more often, right? So I guess the pharmacists, from my standpoint, are, are the ones that-- you know, they, they see the drug costs, they see what's being reimbursed. They're really at the front line a lot of time. Although we work with physicians very closely on switching patient medications to try and make it more affordable, not even-- I mean, always with their health and health interest, but I mean, we're trying to combat two things. The pharmacist ultimately sees, I guess, both sides of the equation as far as the, the drug cost and what's being paid by the, the customer and the insurance companies.

FLOOD: Thank you.

BRAD BOWDINO: Yeah.

WILLIAMS: Senator McCollister.

McCOLLISTER: Thank you, Chairman Williams. You described a situation where a patient comes into the pharmacy and if he or she had been willing to pay a cash price, they would ultimately have saved money over the deductible. Is that a common occurrence?

BRAD BOWDINO: It is, yeah. I would say that we, we see examples of that every single day.

McCOLLISTER: So it does happen frequently.

BRAD BOWDINO: Yes, yes.

McCOLLISTER: So me going into the pharmacy, I should offer to pay cash for all my, you know, pharmacy needs?

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BRAD BOWDINO: Yes, depending on the pharmacy. It won't-- you know, a lot of times it wouldn't count towards your deductible, obviously, if that was something you're trying to meet because it wasn't run through insurance. And then secondly, if-- we have no, no knowledge-- contractually, we're obligated to run that claim through your insurance and not offer you a cash price, depending on the contract we signed with the PBM.

McCOLLISTER: Do you have that option with some of the contracts you have--

BRAD BOWDINO: Do--

McCOLLISTER: --to offer your customer cash price?

BRAD BOWDINO: No, typically that's, that's not an option. That's, that's not something that's negotiable.

WILLIAMS: And that's a contractual matter, right, with your contract with the PBM?

BRAD BOWDINO: Yeah, correct. In most of our--

WILLIAMS: I want to be sure that--

BRAD BOWDINO: Yeah.

WILLIAMS: --I understood that. Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, sir. If someone asks you for what the cash price would be, in that case, can you inform them?

BRAD BOWDINO: Yes, I guess it, it, it comes down to whether or not we think the insurance company is going to come audit us and show that we superseded-- you know, we-- because essentially, they don't know how expensive it is. The insurance company may cover all of it, right, so you always run it under their insurance plan. We're not-- contractually, many times when we sign up with the PBM, they're not then supposed to advertise, hey, we can offer a cash price. Of course, we have patients, you know, explain-- exclaim their discomfort and many times, we will try and work with them on switching that medication, seeing if we can get them into something. But technically on many times, we're not supposed to offer them the cash price.

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BOSTAR: I just want to be, I, I want to be clear. So if they come in with insurance, is it that you can't-- the contract stipulates that you can't offer a cash price or that you, you can't volunteer it or you can't tell them what the cash price would be no matter what? What, what is sort of-- what's the language in the contract?

BRAD BOWDINO: Yeah, I'm-- I, I would have to sort of review it again. I don't believe that it, it states specifically that I'm not supposed to volunteer and I believe that we're supposed to honor the contracted reimbursement price for that patient for that drug.

BOSTAR: Thank you.

BRAD BOWDINO: Yep.

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

BRAD BOWDINO: Thank you.

WILLIAMS: The committee is going to take a short ten-minute break and we will be back in-- at the--

[BREAK]

WILLIAMS: All righty, we'll get started again. We'd invite the next proponent. Good afternoon.

MICHAEL LOGSDON: Good afternoon and thank you. Hello, Chairman Williams, members of the Banking, Commerce and Insurance Committee. Thank you for hearing our testimony this afternoon. I am Michael Logsdon, M-i-c-h-a-e-l L-o-g-s-d-o-n. I'm the director of Pharmacy Services for Thayer County Health Services in Hebron, Nebraska. I'm here to testify in support of both LB270 and LB375. Thayer County Health Services is a critical access hospital. We're located in Hebron and serve patients in many capacities across southeast Nebraska. The pharmacy department consists of a hospital pharmacy, a community retail pharmacy, as well as a long-term care pharmacy, and have an interesting perspective on the relationship of PBMs with patients, providers, and caregivers, as well as our community as a whole. And in the spirit of saving redundancy with previous testimony, I may skip ahead to an example that I'd like to share with you today that maybe tells a different tale. S. L., she's an 84-year-old woman that lives

outside of Byron, Nebraska. For those of you don't know, Byron is a tiny agricultural-based community in Thayer County. She lives independently as a vibrant woman and has a number of medical conditions that requires a monthly injection, in addition to four maintenance medications. And after open enrollment this last fall, realized our local pharmacy would no longer be a preferred pharmacy and would impact her copayments if she were to continue using us versus going with a standard pharmacy 90 minutes away or using mail order. So based on S. L.'s driving limitations, suggestions from her family, they chose the mail order option. And this is a story you've heard before. And the difference is that I'm about to share is the bullying and communication barriers PBMs put up pretty ubiquitously. And this is a common, yet untold tale. In February, as everyone knows, in the seemingly endless snow and cold, she did not receive her mail order medication, which would have been the first cycle after moving to the mail order process. She left messages, called her insurance plan and didn't have answers. So she called me and reached out to the local resources and I suggested she come to town for a regular appointment, because I happen to know that she also was to receive her injection and to stop by the pharmacy before getting groceries and other supplies. I called the same number she did. We requested an emergency supply of medication, and only after being transferred a few times and left-- leaving a message, then getting called back, did we get this accomplished at about 6:00 p.m. on a Friday, which took around an hour and a half of my time. And here is the financial summary for this encounter. For a 14-day supply that we received emergency override for, our pharmacy charges $38. And I'll share with you, our drug cost was $26.33. And the PBM took this information, sent back to us that they would, they would pay us $17.31. The copay for the patient-- again, in an emergency situation was the full $17.31. They would pay nothing and we were required to collect that fee at the point of sale. This is one patient. There are many other examples. Pharmacies do not get reimbursed for helping patients navigate their own insurance plans. And not only do PBMs fail to provide meaningful value to patients, especially in a serious situation, and in rural Nebraska, they create a complex web of processes difficult to navigate for everyone and are truly choking our business. Luckily, the injection that she received was eligible for 340B pricing, which you heard about earlier, and offset our costs slightly. But as you also may know, the program is directly in the rifle scope of PBMs as well because of, of the program's value to our community. And yes, I didn't

misspeak. The 340B is a revenue source for qualified pharmacies that PBMs are not capturing. So now the attempt is being made to dismantle the program altogether from a national level. So once this occurs, what are we left with and who is left to care for S. L., my 84-year-old in Byron? To Senator Flood's question earlier, I would like to throw out there that there are a huge group of motivated pharmacists in this state that are dedicated to patient care, that are dedicated to solving this problem. And we do it one step, step at a time. And in fact today, we could maybe do with two steps with these two bits of legislation. PBMs do not have a patient's best interest in mind. The legislation would be a powerful step to protect Nebraskans from an unregulated industry taking advantage of the masses. And the legislation will offer safeguards to help support pharmacies to allow us to continue to serve patients. Thank you. I'd be happy to take questions. And as I said, I'm sure the NPA would be very motivated to put together some sort of a resource group to help battle this continued problem.

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

MICHAEL LOGSDON: Thank you.

WILLIAMS: Invite the next proponent. Welcome.

OLIVIA LITTLE: Thank you for having me here today. My name is Olivia Little, O-l-i-v-i-a L-i-t-t-l-e. I am here today on behalf of Johnson County Hospital and the Nebraska Hospital Association. I am here in support of LB270, which would prohibit discriminatory practices by PBMs on 340B qualified pharmacy claims. The 340B Drug Pricing Program was signed into law in 1992 and critical access hospitals were allowed to participate in the program with the signing of the Affordable Care Act in 2010. The 340B Program requires manufacturers that are in the Medicaid program to sell to safety-net hospitals at discounted prices. The intent of the 340B Program is to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Johnson County Hospital participates in this program, and we are located in Tecumseh, Nebraska. In the fiscal year of July 1 of 2019 to June 30 of 2020, Johnson County Hospital had a 340B benefit of $875,000. This benefit is a combination of 340B savings, and in part with our contract pharmacies, as you've heard here today from others. The following are only some of the ways our

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340B benefit allows us to do great things for our patients and our communities. Our 340B benefit is used to help serve-- fund services through the hospital that do not generate enough revenue to offset the expenses, offset the expenses like a licensed DME, durable medical equipment business, and Lifeline. We have provided almost half a million dollars of community benefits in that time period, which include a subsidized, subsidized emergency and trauma care, charity care, free monthly blood pressure checks, toenail cares, and community outreach like stop the bleed events, to name a few. Our 340B benefit also allowed us to install 3D mammography, which is now considered the standard of care in breast imaging. The Johnson County Hospital's population for mammograms, over 31 percent of our patients have dense breast tissue. 3D mammography is a standard of care and we would have to refer away 31 percent of our patients to a facility that does 3D mammography. With our benefit, we were able to purchase 3D mammography so our patients can receive care in our hospital in our town. In 2019, revised federal regulations went into effect that caused us having to upgrade our equipment and our compounding suite in our pharmacy so we could keep compounding chemotherapy. Our patients, if they can't get chemotherapy in our hospital are driving 50 to 75 miles to receive a chemotherapy treatment. In order to do this, they have to line up a ride, which puts a burden not only on the patient, but friends and family. A lot of times when they're done with the chemotherapy treatments, they're not in any shape to drive home as they're feeling ill. With our 340B benefit, we are able to make this upgrade and to keep our patients close to home and work with our oncologist in getting that service in our community. I could continue to go on with the many positive effects the 340B Program has had on Johnson County Hospital, our patients, and our community year after year. But the time I have today does not allow. You have heard the positive effects of the 340B Program, particular to the Johnson County Hospital. But I want you to know we are not alone. In Nebraska, 64 hospitals participate in the 340B Program, including 91 percent of our critical access hospitals in Nebraska. These hospitals have similar stories to tell about their 340B Program. To lose or reduce our 340B benefit would force the loss of services, community benefits, and for some, even the ability to keep their doors open. I ask you to please protect the 340B Program so that we may continue to serve our patients in our communities. I think you've heard here today, many of these pharmacies are also contract pharmacies in the 340B Program with hospitals. They

use it to do great things in their community, too. So thank you very much for your time here today.

WILLIAMS: Thank you, Miss Little. Are there questions? On the 340B Program, what type of, of accountability does a hospital have to be sure that you're using those funds that you're receiving for those kind of benefits?

OLIVIA LITTLE: So in the regulation, and when I-- from earlier when I said it, the intent of it was to stretch scarce federal resources. For most critical access hospitals like in Nebraska, you can put together our uncompensated care and it's going to cover it.

WILLIAMS: That'll--

OLIVIA LITTLE: It's going to cover--

WILLIAMS: --cover most.

OLIVIA LITTLE: --a lot of hospitals that are in the black-- or excuse me, in the red. They use it to keep their doors open. And without this program, if we take $875,000 away, we would not be in a positive of margin, not even close.

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

BRENT GOLLNER: Good afternoon. Hello, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Brent Gollner, spelled B-r-e-n-t G-o-l-l-n-e-r. My wife Patty, also a pharmacist, and I have owned two local independent pharmacies in Hastings since 1992. I also happen to be the 2021 Nebraska Pharmacy Association president. So I thank all the pharmacists who have been here today to testify and appreciate all your comments and thoughts and questions that you've had for us. We've seen major changes in the PBM landscape since the early 1990s, and that's exactly why I'm asking for your support of LB375 and LB270. PBMs were originally seen as conduit between pharmacies and the insurance company to coordinate benefits and payments to pharmacies. PBMs have since evolved into a vertically integrated conglomerate, oftentimes promoting their own mail order pharmacies to the detriment of patient care and support from their local healthcare providers. I'm going to speak a little bit today about the course of tactics that many PBMs use today to force

patients to use the PBMs own mail order pharmacies. You've heard some of these comments from others. While this ultimately does impact my, my pharmacies bottom line, it also challenges the way healthcare today should be about patient care and lessening the total healthcare cost to Nebraskans. Mail order pharmacy, by its very name, does neither of those things. When a prescription is shipped to a patient here in Nebraska, that face-to-face patient care component does not exist. How is it possible for the patient to ask questions, seek advice, or simply be reassured that the correct medication has been prescribed for the right diagnosis? In addition, those healthcare dollars and in turn local taxes are disappearing to out-of-state mail order facilities. That obviously affects our state's bottom line as well as those tax dollars the local pharmacies provide that no longer exist in our local communities. Let me give three examples of what happens. During this last cold spell, two separate individuals came to my local pharmacy to see about getting a few days of their maintenance medications for blood pressure and heart disease as their mail order service had not been able to ship them in a timely manner. Of course, I took care of their needs, as many of our-- my colleagues here have said they've done the same thing. The wife of a veteran in our community came in needing to make sure that this was the right med as it looked totally different than what her husband had traditionally gotten through the mail. I researched the identity of the med and realizing it was not correct, contacted the doctor and provided the appropriate med to keep Mr. Jones out of the hospital. Finally just yesterday morning, I had a developmentally challenged individual come into my store and ask why his insurance was going to make him use mail order. He told me they had called him to set that up and he was totally confused. He told me he didn't want to get them in the mail. He stated, and I quote, I can now remember to take my meds at the right time since you put them in the correct spots in those packs I like. I assured him that we would continue to get his meds and memory blister packs that we provide. I helped him cancel what would have become quite challenging for him in order for him to take his medications at the appropriate time. Not only do these examples show the difficulty patients feel when forced to use mail order, but also directly affect our local economy here in Nebraska. The PBMs will tell you mail order saves money, but numerous studies have shown that simply is not true. In fact, there is oftentimes mail order waste that occurs when medications are shipped without the patient's knowledge. I have a couple photos that I've given to all of you showing thousands

of dollars worth of meds that were sent to a patient who had been taken off of these medications. Fortunately, the patient knew enough not to take them, even though they kept coming in the mail month after month. The second photo shows insulin pens that were shipped to a patient whose type of insulin had been changed by the local physician. How can this occur, you may ask? Remember, the PBMs often own their own mail order pharmacies and ultimately benefit from medication being shipped to the consumer. Is this good healthcare for Nebraskans and does it save money? I don't think so. We're not here asking for special treatment, but rather the opportunity to provide first-rate quality healthcare to Nebraskans. If given an equal choice, most patients prefer to get their medications filled by someone they know and trust. Someone in their community, someone they can ask questions of and know they will get an answer. Mail order regulation of the kind found in LB375 and LB270 needs to occur not only for the health of Nebraskans, but also the health of our local economies. Thank you all for the opportunity to try and give a little insight into what mail order pharmacies impact on our patients and our pharmacies, but all of us here in Nebraska. Thank you.

WILLIAMS: Thank you, Mr. Gollner. Questions? Mr. Gollner, you, you mentioned that-- and you've been in this business for a number of years, it, it sounds like maybe when the PBMs first started in the ‘90s, there was a different purpose for them than there is now.

BRENT GOLLNER: Yes.

WILLIAMS: Do you remember who owned the PBMs when they first started?

BRENT GOLLNER: Typically, the Pharmacy Benefit Managers were owned by a local group of businessmen that worked between the insurance company and the pharmacies. They worked together to coordinate benefits and payments back and forth.

WILLIAMS: When did it happen that that changed and that the PBMs became owned by the insurance companies themselves?

BRENT GOLLNER: Really in the last probably I'd say 10 years, the vertical integration has occurred where that the big companies like a CVS Caremark or OptumRx, UnitedHealthcare, have bought their own PBMs in order to coordinate those benefits. They say it's obviously to save money, easier for them to coordinate those things. But in my opinion,

that's only made things more difficult for us to negotiate, to deal with things that-- typically, patients need access to quality healthcare. And when you enter in-- first-- PBMs into the mix, it makes it much more difficult.

WILLIAMS: Thank you. Additional questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams.

BRENT GOLLNER: Yes, sir.

McCOLLISTER: I talked about restraint of trade here earlier today.

BRENT GOLLNER: Yes.

McCOLLISTER: The model that they've established is a restraint of trade practice, wouldn't you say?

BRENT GOLLNER: Yes, I, I would agree with that. The frustration that we have is that, as you heard from one of my patients, you know, he was just told you're going to get this through the mail and this is the way it's going to be. He came in and was totally frustrated and said, I can't do that. I, I just can't do that. So, yeah, they're trying to coerce patients into-- to losing that freedom of choice, and that freedom to go where they want to go and be serviced by the kind of patients-- or the kind of pharmacies that can do that. So yes, I, I think it really is.

McCOLLISTER: Thank you.

BRENT GOLLNER: Yes, thank you.

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

BRENT GOLLNER: Thank you. Appreciate it.

WILLIAMS: Invite our next proponent. Good afternoon.

CHARLES MOORE: Good afternoon and hello, Chairman Williams and members of the Banking, Insurance and Commerce Committee [SIC]. My name is Charles Moore, spelled C-h-a-r-l-e-s M-o-o-r-e, and I'm a member of the Nebraska Pharmacists Association and the owner of Charlie's U-Save

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Pharmacy in York. I'm asking for your support of LB375, the adopt a Pharmacy Benefit Manager Regulation Act [SIC]. And while I support that entire bill and its companion bill, there are some specific provisions in LB375 that address the negative impact the PBMs have on my pharmacy's ability to provide the care my patients deserve. The first of these is the provision for adjustments in the medications on the PBM's maximum cost list or MAC list. Retail pharmacy has traditionally priced medications to the patient based on the cost of the medication to the pharmacy and a dispensing fee based on the overhead costs involved in filling the prescription. The overhead cost identified by both independent and chain pharmacies is currently $10.15 as notified earlier. And what we're seeing in the contracts offered to us by the PBMs is the cost of the medication based on their MAC list and the generous dispensing fee of 50 cents, if we're lucky. But most of them now have a fee of zero. When the costs on their MAC list are below what we can purchase the product for from a Nebraska license supplier, we're forced with a daily dilemma, do we provide the medication the patient needs now and lose money each time that we do. We can currently appeal the medication-- I'm sorry, we can appeal the MAC price, but have to do it through the PSAO, which was previously defined, who contracts for us with the PBMs. And there's a response from the PBM's MAC price committee is most of the time the MAC price will not be changed because of products available in the marketplace at the MAC we have set. My pharmacy was recently notified by one of the PBMs that we've been overpaid by $8,000 in the time frame from May through November of 2020, in spite of them not paying us enough to cover our medication costs during that same time frame. PBM provisions in LB375 allowing patient access to local pharmacies would also clarify what can happen when that access is limited by the PBMs. As recently as last Saturday, my pharmacy had a patient who had five medications ordered by her prescriber. We were able to fill three of the prescriptions, but the other two, the PBM instructed the patient they had to go to mail order or to the pharmacy owned by the PBM. Closest to those pharmacies is 50 miles away from York, and the time to receive the medication from their mail order facility is measured in weeks, not days, and certainly not hours. When I purchased my pharmacy in York 37 years ago, it was 1 of 5 independent pharmacies in town. I'm now the only independent pharmacy remaining. Currently, 90 percent of the prescriptions we fill are done under contract with a PBM, and the patients not only are covered by Medicare and Heritage Health Medicaid, but also by insurance through the local school

system, city government, county government, and by private employers. To be able to take care of all of these patients, we have to accept the predatory contract terms offered to our pharmacy or have the patients go elsewhere. From July 2018 to July 2019, the number of pharmacies nationally has decreased by 3.8 percent or 2,284 closures. Rural pharmacies have been impacted tremendously with a 16 percent or 1,231 closures, reduction since the introduction of the Medicare Part D program. Nebraska currently has 18 counties without a pharmacy and 41 counties with only 1 or 2 pharmacies. Fewer pharmacies lead to significant restricted access and convenience issues for patients who live in areas with closures. We'd like to think that we built a loyal patient population during the time we've been in York, but too often we're faced by patients who tell us they can no longer come to our pharmacy because their insurance tells them they have to go to a different pharmacy that their Medicare D or other insurance prefers. LB375 would allow more options for patients to choose local pharmacies to provide their medications. By utilizing a local pharmacist, patient care can-- patients can ask questions about their medications, share concerns, and identify potential interactions. To encourage healthy innovation and competition in the pharmacy market, LB375 and its companion bill, LB270, must be passed. Thank you for your consideration of these two important pieces of legislation and I would entertain any questions.

WILLIAMS: Thank you, Mr. Moore. Questions? I'd like to explore MAC pricing a, a little bit more, if you could help me understand how much transparency there is to you as a pharmacist of knowing what those prices are and how often they change and--

CHARLES MOORE: OK, thank you. So the PBMs do provide some lists which we can access. Nebraska Medicaid has, has a list. But strangely enough, under Nebraska Medicaid, there are three different PBMs and there is also a fee for service component to the Medicaid program. The fee for service component does have a MAC list which is published. The other three PBMs, it's not near as, as accessible. What we often find is that they may set a MAC price, but again, depending on market conditions and we all know what's happened in the last year with accessibility and the fact that a big portion of our medications comes from outside the United States and the prices have increased. But once again, the MAC pricing has not caught up with what the actual market conditions are. We can appeal that. And I should have brought along my three-inch stack of yesterday's claims, which were claims where once

again we need to do the appeal process. You know, it's very time consuming. Some of my other colleagues have also mentioned that, too, that it involves a lot of after hours time to, first of all, file the appeal, to wait for a response, and then to, to come back and find that 90-plus percent of the time the response is we think you can buy that product in the market somewhere so we're not changing that pricing.

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

CHARLES MOORE: Thank you.

WILLIAMS: --Mr. Moore, for your testimony. Invite the next proponent. While you're coming up, how many additional proponents are going to be testifying? OK, would notify anybody that happens to be outside the room that following Miss Stiffler, we only have two more proponent testifiers. Go ahead, introduce yourself. Thank you.

KRISTEN STIFFLER: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Kristen Stiffler, spelled K-r-i-s-t-e-n S-t-i-f-f-l-e-r, and I'm the state government relations manager for the National Psoriasis Foundation representing more than 46,000 Nebraskans living with psoriatic disease. I want to start off by thanking Senator Morfeld and Senator Kolterman for their work to try-- to, to seek to adjust-- to address healthcare reform. The National Psoriasis Foundation is testifying today in support of Section 10 of LB270. The NPF does not wish to weigh in in any capacity on LB375 or in any other sections of LB270. Section 10 of LB270 very simply ensures that all payments made by or on behalf of a patient are counted towards their deductible and out-of-pocket maximum. When faced with high out-of-pocket costs, patients do not use their medications appropriately, skipping doses in order to save money, or abandoning treatment altogether. In an effort to maintain their health and quality of life, many patients use financial assistance programs, also known as copay assistance. In a 2020 NPF survey, it showed 80 percent of patients with psoriatic disease who take a biologic medication and have commercial insurance utilize copay assistance programs. Historically, when a patient paid for their out-of-pocket cost, they use their own money alongside of patient assistant-- copay assistance payments. Every dollar that was paid was counted to the cost-sharing requirement. However, there is a rise in an insurance program called Copay Accumulator Adjustment

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Programs that are harming patients by excluding copay assistance from out-of-pocket cost-sharing calculations. This is a discriminatory practice that allows our-- that allows the payers to shirk their fiduciary responsibility. Under an insurance plan, patients owe a deductible and out-of-pocket maximum before their insurance coverage fully kicks in. Copay assistance dollars help patients reach their out-of-pocket costs. When health plans choose to exclude copay assistance dollars, patients have to pay that deductible all over again. I can't imagine going to a pharmacy counter knowing that I've been paying a copay consistently for a few months and then all of a sudden I get there and they tell me that my drug now costs $3,000, $4,000, $5,000 when a month before it was $25, and finding out that my copay assistance was not being attributed to my deductible or my out-of-pocket maximum. Unfortunately, this is the reality that many patients, chronic disease patients, and our patients with psoriatic disease face. This is an unfair practice and in the end payers are shirking their fiduciary responsibility. Some may say that copay assistance increases healthcare spending by incentivizing patients to use brand name drugs. However, for patients with chronic diseases like psoriatic disease, diabetes, cancer, arthritis, there are no cheaper alternatives or generics. In fact, a 2018 IQVIA study revealed that a 99.6-- sorry, 99.6 percent of copay assistance is for medication that do not have generic alternatives. Let me repeat, nearly 100 percent of all copay assistance is for medication that do not have generic equivalents. Therefore, it's unfounded that there are cheaper generic alternatives for patients that use copay assistance. As of now, five states, including Arizona, have passed similar legislation to protect patients from this discriminatory practice. Over a dozen states this year have introduced legislation regarding this specific practice, and we anticipate over 20 states will also address this issue this year. In the end, NPF agrees that healthcare reform is needed and appreciate the thoughtful discussion surrounding third-party administrators. That said, Accumulator Adjustment Programs are not a solution to the healthcare reform puzzle. These programs leave patients in the middle of this debate by punishing patients for using copay assistance to afford their necessary treatments. The NPF respectfully request the committee include Section 10 of LB270 as a standalone option or within any PBM reform package that moves forward from the committee. Section 10 of LB270 is simply about ensuring that all copays count. And we're asking the committee to protect patients against this discriminatory practice known as Copay Accumulator Adjustment Programs. Thank you.

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WILLIAMS: Thank you, Miss Stiffler. Questions? Senator Slama.

SLAMA: Thank you, Mr. Chairman. And thank you, Miss Stiffler, for being here. I was hoping on your handout you could speak a bit towards the graph. I'm having issues deciphering it. I get the smileys and the "frownies," but not necessarily the data that's behind it.

KRISTEN STIFFLER: Of course. So this, this graph is-- sometimes when addressing how the out-of-pocket maximum, the deductible are met, it's easier to see it in a, in a graphic like this. So what we've put together is explaining our orange patient is a patient that has the opportunity where all copays count and the blue patient is a patient where a Copay Accumulator Adjustment Program has been placed on that patient. So you will see in January for the orange patient, they're able to use their manufacturer assistance to reach their deductible and out-of-pocket maximum. So in January, in orange, they are using-- they have a $25 copay and then their manufacturer assistance copay assistance here is utilized to help them reach their deductible and a portion of their coinsurance. And that continues for February and March. So by the time that they reach their out-of-pocket maximum, the patient is-- still has manufacturer assistance left over, but has reached the cost-sharing requirements that are required of that patient. The blue patient, as you can see in January, they are also paying their $25 copay and then their, their manufacturer assistance is also being utilized, real money being paid for the cost of that drug, but is not being counted towards the patient's deductible and not being paid towards the patient's out-of-pocket maximum. So then you see in February that $15,000 of the copay assistance is now almost depleted. And by March, the patient is left with what we call the spring surprise, where in March, they are-- they go to the pharmacy counter and they find out that to, to obtain the drug, their manufacturer assistance has run out. And now the patient has to cover their entire deductible and whatever's left of their, their coinsurance [INAUDIBLE].

SLAMA: So are-- is this data based on real patients or are these just two comparisons of hypothetical situations for patients?

KRISTEN STIFFLER: We know that in Nebraska, both on the individual market, there is language in both plans for patients that plan documents that state that they can and will use this Accumulator Adjustment Program.

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SLAMA: OK, thank you.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony. Invite the next proponent. Welcome, Mr. Mueller.

BILL MUELLER: Thank you, Mr. Chairman. Senator Williams, members of the committee, my name is Bill Mueller, M-u-e-l-l-e-r. I appear here today on behalf of the Pharmaceutical Research and Manufacturers of America, or PhRMA, which represents the country's leading biopharmaceutical research manufacturers. I appear here today in support of LB270. I want to thank Senator Morfeld and Senator Kolterman for their work in this area. I think that Senator Kolterman, this must be at least his, his third PBM bill. I think that today we, we maybe have, have reached the tipping point on this subject. For many patients, having health insurance is not enough. It is what their insurance actually covers that is most important. Insurers and PBMs are increasingly shifting more healthcare costs to patients through deductibles and coinsurance. Since 2006, what patients pay for deductibles has increased 300 percent. Not only has the cost of deductibles for patients increased, but more plans are also using deductibles for prescription drugs. Between 2012 and 2017, the percentage of health insurance plans that employed deductibles for prescriptions more than doubled. Patients would also benefit immediately by requiring that insurers cover patient-- cover medicines from day one without subjecting patients to deductibles. And in LB270, this is Section 11 of the bills. As I mentioned, the cost of deductibles which require the patients pay the full deductible before any benefit is received for their medicines has risen dramatically over the last several years. Deductibles usually reset at the beginning of the year. For patients in high deductible plans, this means when they walk into a pharmacy to pick up their drugs in January, they may have to pay a deductible of $8,550, the federal limit in 2021, before their insurance coverage kicks in. To give you an idea of how burdensome these requirements are, nearly half of Americans say that they could not cover emergency expenses costing $400 or more without selling something or borrowing money. By eliminating deductibles for prescription drugs, LB270 would ensure that health insurers still have the flexibility to offer different plan designs to meet patients' needs. And patients would have more predictable expenditures over the calendar year. Compounding this increased burden of cost sharing the patients are expected to assume, insurers and PBMs are also restricting the use of payment assistance

programs, which is what Miss Stiffler was talking about. By not counting copay assistance that are provided by pharmaceutical manufacturers or nonprofits toward patients deductibles or out-of-pocket costs as they have historically, health plans extend the time it takes a patient to meet their out-of-pocket requirements, and the plan can collect both the copayment assistance from the manufacturer and the full deductible paid by the patient. As you can imagine over the years-- over the year, this leads to patients paying significantly more at the pharmacy. In fact, studies have shown that insured patients that are subject to these policies are at a much greater risk of not taking their prescriptions as directed or not picking them up from the pharmacy at all. The PBMs and the health plans will argue that copay cards drive patients toward more expensive therapies when a generic equivalent is available. But the reality is that these copay cards are helping patients with limited alternatives. Studies have shown cost-sharing assistance is overwhelmingly used for brand name medicines with no generic alternative. In closing, policies that count third-party discount programs toward patients out-of-pocket limits and provide first-dollar coverage, make drugs more affordable and accessible for patients. PhRMA respectfully supports the passage of LB270 and ask that the legislation be advanced to the floor. I'd be happy to answer questions. I have a letter from 16 patient groups that I can provide to the page. Thank you. I'd be happy to answer any questions that the committee may have.

WILLIAMS: Thank you, Mr. Mueller. Are, are there questions? Seeing none,--

BILL MUELLER: Thank you.

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

SARAH HUNTER: Good afternoon. Chairman Williams and members of the committee, my name is Sarah Hunter, that's S-a-r-a-h H-u-n-t-e-r, and I'm the project coordinator at the Nebraska Pharmacists Association. And I would like to testify in support today of both LB270 and LB375. In my capacity at the NPA, I have been able to visit almost every single pharmacy in the state of Nebraska. I don't know how many other people that have the opportunity to say that. The reason why I visit these pharmacies is to educate our pharmacists and our communities about the Nebraska MEDS Drug Disposal Program. When visiting, I have

the opportunity to meet with the pharmacist and discuss issues that-- or barriers that they see on a daily basis. I can easily say the barriers that we heard in testimony from pharmacists today are consistent across the state. Pharmacists have emphasized the need for pricing transparency, protection from unfair auditing practices, and overall regulation of PBMs to keep community pharmacies around as a healthcare resource in Nebraska. It may be argued that on a national level, the amount of community pharmacies has increased. However, in Nebraska specifically, we have not seen that statistic to be true. In 2018, as you see on the back page of the handout I sent or handed out, there were 514 community pharmacies. In 2020, when I accumulated my list to determine eligible community pharmacies for the Drug Disposal Program, there were 489. We have 19 counties in the state without a community pharmacy. And patients are a considerable distance from healthcare services. Despite a great opportunity for mail order, these patients are missing out on other valuable services that pharmacies provide, such as vaccinations, diabetes education, medication therapy management, smoking cessation, and much other. It may be argued that these bills and past bills were too complicated or unenforceable and the role of Pharmacy Benefit Managers is complicated. And as a nonpharmacist, I tend to agree, health benefits are complicated, but many other complicated things are regulated. When attempting to address steep costs of medications in areas where Nebraska programs may be overspending, an audit should be welcomed to ensure compliance and the best use of taxpayer dollars. As we have seen through the auditing of other PBMs with state-run programs, we may find some areas for improvement in areas that can better benefit Nebraskans. What is not beneficial for Nebraskans is shifting the blame of increased pricing for manufacturers to PBMs and so on. Instead of blame shifting, let's focus on increasing transparency and providing patients with a local option for their medication needs. People are going to oppose the bill and state how PBMs do not do these harmful practices. We have heard testimony that says contrary from pharmacists. However, increasing transparency regardless would help determine bad actors that are causing these medication prices to increase and help level the playing field between PBMs as well. LB270 and LB375 are small steps to help lawmakers and the public understand why the cost of medications are so high and to help address these discrepancies. These bills will ensure the survival of essential community pharmacies by enabling price transparency, protection to the

pharmacy from unfair auditing practices, and encourage transparency of taxpayer spending. I'd be happy to answer any questions you may have.

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

SARAH HUNTER: Thank you, all.

WILLIAMS: Invite the next proponent. Are there any more proponents that would like to testify on LB270 or LB375? Seeing none, we will switch to opponents and invite our first testifier in opposition. Welcome, Mr. McLaren.

JAY McLAREN: Good afternoon, Mr. Chairman. My name is Jay McLaren, first name, J-a-y, last name, M-c-L-a-r-e-n, and I'm the vice president of public policy and government relations at Medica, which is a nonprofit health insurer based in Minneapolis, St. Paul. We've been offering health insurance coverage in the state of Nebraska for five years. We currently cover approximately 100,000 Nebraskans in the individual group and Medicare markets. And I'm here, Mr. Chairman, to testify in opposition to LB375 and in opposition to LB270. I've spoken to both authors about the bill and about our concerns and appreciate the opportunity to share our thoughts on these bills with the committee. I'd like to pick up with some of the content of LB375, particularly where some of the previous-- immediate previous testifiers left off, particularly related to drug copay coupons. I have a great deal of sympathy, Mr. Chairman, and members to the patients that are caught in the middle of what's happening on this issue. So what happens with drug copay coupons is they are a tool for pharmaceutical companies to use to circumvent negotiations with PBMs. So the previous testifier was correct. I'm not going to beat up on pharmaceutical companies for diverting people away from generics. That's not the point of drug copay coupons. The point is getting all of those brand name pharmaceutical companies to compete for formulary position with the PBMs. And when they lose in that negotiation and they-- their patients are required to pay more, that's when they fight like crazy to keep their market share by using these copay coupons to keep that market share, to help those patients pay for the higher out-of-pocket costs that come from that negotiation they lost with the PBMs. Again, I have a great deal of sympathy for the patients that are caught in the middle. But that's the background on that issue and why we're opposed to that section of the-- of LB375. There are a couple

other components of LB375 that I'd like to highlight for the committee, both of them deal with specialty pharmacies and you heard this addressed earlier in testimony earlier today. The intent of these sections of the bill are to require PBMs to contract with every specialty pharmacy in the state of Nebraska. One of the problematic pieces is it prohibits PBMs from requiring pharmacies to be accredited. You are a specialty pharmacy by getting accreditation. Essentially, these two sections of the bill in combination allow any pharmacy to declare that they're a specialty pharmacy and then be required to be contracted with a PBM to perform specialty pharmacy services. Those two pieces in combination we have extraordinary concerns over. In addition to just requiring us to requiring PBMs to contract with any specialty pharmacy, we have concerns over that in and of itself as well as our company uses a competitive process to procure for specialty pharmacy services. So while I obviously don't dispute the testimony and the examples that were given earlier today, and I don't dispute the fact that good customer service often comes face-to-face, another element of customer service is expertise. The specialty pharmacy that we contract with has expertise in several locations around the country in different type of specialty drugs. For example, there's one location that has pharmacists who specialize in oncology so that they know what to look for in terms of drug interactions and making sure that patients are taking their drugs appropriately. So, again, that second component of customer service dealing with specialty or specialty of different types of medical conditions is incredibly important. And also, to your point earlier, Senator Flood, on, on the price component, that's why we like to use a competitive process to procure for specialty pharmacy services so that we're driving the best bargain for our members. Again, I have sympathy for a lot of the arguments that were raised earlier, but wanted to share why we're opposed, particularly to that section. On LB270, again, I appreciate Senator Morfeld made himself available as any member does. Your time is very valuable to, to hear our concerns on this bill so we have talked about this. One section I question is the section that prohibits deductibles from being applied to prescription drug benefits. I was just texting with some colleagues to understand this further. I want to look into this further. But in general, federal requirements on health insurance products that can be tied to an HSA that people can use an HSA for require, require individuals to pay every dollar before their deductible themselves. Otherwise, they can't use their HSA for those products. The Section 11 of LB270 has

the potential by eliminating deductibles of not allowing people to use their HSAs in the state of Nebraska for their health insurance coverage without facing some sort of tax consequence. So it has the potential to do that. The other element is-- or of the LB270 has to do with 340B pharmacies. So this runs counter to some things that we're doing in the market to offer products in collaboration with care systems in the state of Nebraska. For example, we offer products in collaboration with Nebraska medicine. And those, those individuals who buy that individual policy can use those pharmacies and that network through Nebraska medicine. Under this bill, those members would have to have access to the 340B Pharmacy at CHI, which defeats the whole purpose of trying to drive value for those members by having all their care coordinated under one product and one provider. So in the interest of your time, Mr. Chairman and members, I'll, I'll conclude my testimony.

WILLIAMS: Thank you, Mr. McLaren. Are there questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, sir. We heard in testimony that there were individuals who were being persuaded to change the pharmacy that they use. Can you tell me about that practice?

JAY McLAREN: So, Mr. Chair, Senator Bostar, that has more to do with a PBM practice I'm not as aware of. And I understand that it was more related to utilizing someone's mail order pharmacy benefit. And so I don't have similar background of what is the nature of that. Right? Is it informing someone and educating a member of their ability to use that, that benefit and what the cost sharing is or is it trying to, to steer that person to that? I don't know the nature of that, because that's what our-- those are the type of things our PBMs do.

BOSTAR: And does the insurance company have an ownership interest in the PBMs?

JAY McLAREN: Mr. Chair, Senator Bostar, my organization does not.

BOSTAR: Thank you.

JAY McLAREN: Thank you.

WILLIAMS: Senator Flood.

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FLOOD: Thank you, Mr. Chair. Mr. McCaren-- McLaren, what company is that you're with again?

JAY McLAREN: Medica.

FLOOD: And Medica does not have a PBM-- does not have an ownership interest in a PBM?

JAY McLAREN: No, we do not.

FLOOD: What PBMs do you contract with?

JAY McLAREN: We contract with Express Scripts for our PBM services. And we happen to also have Accredo, they're a specialty pharmacy for our specialty pharmacy network as well.

FLOOD: So do you have any ownership interest in the specialty pharmacy?

JAY McLAREN: No, we do not.

FLOOD: OK. I have nothing further.

WILLIAMS: Additional questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Could you just-- and, and I, I try to follow along with this, it's not a subject area that I'm, I'm used to. But with the, the coupons, what's happening there? That, that is, you know, you talked about patients getting put in the middle of a process. Could you walk me through that again?

JAY McLAREN: Absolutely, Mr. Chair, Senator Bostar. So what the PB-- what the-- part of what the PBMs do is sit down with the pharmaceutical companies and negotiate with them over where they're going to be placed on the drug formularies. Right? So there's a lot at stake for the pharmaceutical companies to get in the tier, the highest tier where there's the lowest cost sharing for consumers to actually buy and access their products. That helps drive market share for the pharmaceutical companies. And for some of the instances that they were talking about earlier, in instances where their drug copay coupons, it's where all these brand name drugs are competing with each other for drug formulary position. If they have a negative outcome, they meaning the pharmaceutical companies, in those negotiations and their

patients who would like-- who are using their drug have to pay more for their product, they have started to offer copay coupons to those patients to make them whole or to basically subsidize the fact that their product has moved down a tier and they have to pay more. So it is a tool used by the pharmaceutical companies to keep and grow their market share. And again, it gets pharmacies and patients caught in the middle.

BOSTAR: Thank you. Who's the-- do you know who has the largest ownership interest in the PBM that you contract with?

JAY McLAREN: Oh, goodness. Mr. Chair and Senator Bostar, I think I've lost track of all the different mergers, but I believe Express Scripts partnered up with Cigna.

BOSTAR: Why wouldn't Medica-- if there are these challenges that are happening at the PBM level and it seems like you're recognizing that, why wouldn't-- what would stop Medica from creating their own PBM to do this in a different way?

JAY McLAREN: So, Mr. Chair, Senator Bostar, I, I, I think you see this vertical integration among larger national for-profit companies that have the capital to do that type of thing. Our organization as a regional nine-state, nonprofit organization don't have the capital in general or the market clout of our own membership, which is about a million members total to get a better deal than what we're getting from the PBMs today, quite frankly.

BOSTAR: Do you think that vertical integration, let's say, an insurance provider, a PBM, and then a PBM having ownership over, say, pharmacies. That level of vertical integration, do you think that that would create distortions in the market as far as having a market operate outside of the normal constraints of supply, demand, price setting?

JAY McLAREN: Great question, Senator. I'd prefer to have individuals that are directly involved in the vertical integration answer the efficiencies that, that come with that. Given that we don't have direct experience, I'd rather have others be able to answer that who have greater expertise, Senator, to be frank.

BOSTAR: That's a good answer. Thank you very much.

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WILLIAMS: I've got a couple of questions, Mr. McLaren, and, and you documented through your initial testimony some concerns that Medica has with, with both of the bills. But there's a lot else in those bills. I'm assuming that there are things that you would agree with would be good changes in these two bills. And I'm going to request again, as you and I have talked before, your continued involvement with working with Senator Morfeld and Senator Kolterman for the future. Thank you for that. I'm going to divert for one minute. We had a bill here yesterday and your ears may have been burning. We were hearing LB30, a bill brought by Justin Wayne concerning the cost of insulin. And I asked a question that was unfair to ask because the wrong person was sitting in that chair. The right person is sitting in the chair today. It's my understanding that in the last year, Medica has brought a product to the state of Nebraska offering a, I believe, $25 copay on insulin for a 30-day subscription. Is that true, and could you expound on that just briefly for the benefit of the committee?

JAY McLAREN: Yeah, thank you, Mr. Chairman and members. Yeah, so 2021 is the first year in which we are in all of the products that we're offering in the state of Nebraska, Mr. Chairman, group, individual, Medicare, capping the copay, copayments for insulin at $25 for a 30-day supply. So, yes, you're correct and it does apply to products across the board. So, yes, we are offering a product on that and hope that it has positive results for our organization in terms of membership. And just note, too, it's, it's-- a lot of it has to do with the very difficult news reports that we've seen throughout our service area, people rationing and, and perhaps going without their, their insulin. And it was our organization's response to, to those things that we know happened throughout our nine-state service area.

WILLIAMS: Thank you for adding to this bill today. Thank, thank you, Mr. McLaren. Seeing no other questions, we would invite the next opponent. Welcome, Miss Nielsen.

COLEEN NIELSEN: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Coleen Nielsen, and I'm here today representing Prime Therapeutics, Pharmacy Benefit Manager owned by 18 not-for-profit Blue Cross and Blue Shield insurers, subsidiaries, or affiliates of those insurers, including Blue Cross and Blue Shield of Nebraska. And I'm testifying in opposition to LB270 and LB375. I've also handed out some testimony

from the Pharmaceutical Care Management Association. We had a couple of subject matter experts that were, were intending on coming here today. Unfortunately, the vice president of the PCMA contracted COVID or actually got a test before he came and found out he was positive. So he, he expresses his regret for not being here today, as well as the subject matter expert for Prime Therapeutics had some COVID restrictions as well. So here I am. I want to thank Senator Kolterman and Senator Williams and Senator Morfeld and the community pharmacists for the conversations we've had. We had a meeting a couple of weeks ago and we talked about these issues. And what we discovered is that this is a very, very complex area and we look forward to the continued discussions that we hope will occur during the interim. The purpose of PBMs is to ensure that patients have access to affordable prescription drugs by encouraging them and their physicians to select the safest and most effective drugs at the lowest possible price. They are-- their purpose is to keep drugs affordable for individuals and consequently keep their premiums for their insurance lower. Prime Therapeutics helps people get the medicines they need to feel better and live well, and live well by managing pharmacy benefits for health plans, employers, and government programs. Our company manages pharmacy claims for more than 30 million people nationally and offers clinical services for people with complex medical conditions, ensuring our members get the right medicine at the right time for the best possible value. Our business model relies on advocating for the simpler, lowest net cost pricing for drugs. This is Prime's focus, not driving profit margins. LB270 and LB375 touch on numerous issues regarding PBMs. They seek legislation regarding pricing, specialty pharmacies, mail order, 340B entities, reimbursement, audits, appeal processes, and the regulations of PBMs by the state. Both of these bills take aim at many of the tools Prime uses to drive quality, safety, and value for Blue Cross members in Nebraska. It's our position that if these two bills were to pass, they would harm Nebraska patients. These bills are complex pieces of legislation that require further discussion. By way of example in just a couple of instances, I won't talk about-- this paragraph was talking about accreditation. And I think that you heard that from Mr. McLaren. But in addition, restricting audit programs increases the likelihood of fraud, waste, and abuse in the prescription drug system. Prime's audit program ensures that payers and patients are getting the prescription drugs that they pay for. Our audits are not paid by commission or, or recoveries are not punitive. They serve to ensure that the healthcare

money is being spent appropriately and the patients are not being harmed. Pharmacies have the apple-- ample opportunity to appeal audit findings with Prime and desktop audits serve to identify potential problems before they cause serious, serious patient and/or financial harm while being minimally invasive to pharmacies. These bills would also cause serious financial harm for insured Nebraskans by, by mandating certain levels of reimbursement for the pharmacies. The state would be creating an entirely inflationary scheme of drug purchasing, where pharmacy owners would have zero incentive to be good buyers of the products they sell. PBMs drive value in the prescription drug space by helping people get the right medicine for the right price. In clu-- in conclusion, Prime uses a variety of tools to curb the rising drug prices set by drug manufacturers. We work to deliver the lowest net cost pricing for drugs to our health plans and, thus, lower cost to patients. But over and over the value of PBMs and the tools that we use has been affirmed. This bill would handicap a number of ways in which we provide the value. And as a result, increase prices in the drug supply chain. We-- we're asking that this committee not advance LB375 and LB270.

WILLIAMS: Thank you, Miss Nielsen. Questions? Senator Flood.

FLOOD: Thank you, Chair Williams. Hello, Miss Nielsen, nice to have you.

COLEEN NIELSEN: Thank you.

FLOOD: Help me understand, who is your principal today, and you appear as a registered lobbyist on behalf of whom?

COLEEN NIELSEN: Prime Therapeutics, which is the Pharmacy Benefit Manager for Blue Cross Blue Shield of Nebraska.

FLOOD: So they are the PBM for Blue Cross and Blue Shield?

COLEEN NIELSEN: Correct.

FLOOD: And where are they located?

COLEEN NIELSEN: They are located out of-- well, their main headquarters is in Minnesota, but they do have a number of employees working here in Nebraska. I believe about 236 people in Nebraska.

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FLOOD: And who would you-- if we were to use our authority granted to us as a branch of government, if we were to subpoena someone from Prime Therapeutics, who would that be to testify as their principal?

COLEEN NIELSEN: I don't know.

FLOOD: Would you get back to us on that?

COLEEN NIELSEN: I certainly will.

FLOOD: And where would that person most likely be domiciled? In Minnesota?

COLEEN NIELSEN: Most likely.

FLOOD: OK. You talked about the health-- or you talked about the, the safety-- the PBMs were working for the safety of the insureds.

COLEEN NIELSEN: Um-hum.

FLOOD: Were you able to hear the testimony that we heard today earlier of the proponents of these two bills?

COLEEN NIELSEN: Yes, I did hear some of it.

FLOOD: Did you hear all of it?

COLEEN NIELSEN: No, I was out in the hall.

FLOOD: Did you hear about the several cases where individuals were waiting for their drugs to arrive by mail and they didn't arrive? Did you hear anything about that?

COLEEN NIELSEN: I did hear some of that, yes.

FLOOD: Did that cause you concern?

COLEEN NIELSEN: Yes.

FLOOD: What was concerning about it to you?

COLEEN NIELSEN: Well, if, if they did need their drugs on time, that that, that would be a problem.

FLOOD: Has that been something that your, your client has worked to remedy?

COLEEN NIELSEN: I don't-- I, I am not aware that they've had any problems with mail order.

FLOOD: OK. Is this the first you've heard of it?

COLEEN NIELSEN: Yes. Well, in terms of Prime Therapeutics, I've not heard of it.

FLOOD: OK. Who regulates these PBMs in Nebraska?

COLEEN NIELSEN: They are third-party administrator, so regulated through the Department of Insurance.

FLOOD: Through the Nebraska Department of Insurance?

COLEEN NIELSEN: Yes, they are registered with the Nebraska Department of Insurance.

FLOOD: Do they-- would they-- would, would your client object to regulation, you know, on this from the Nebraska Department of Insurance?

COLEEN NIELSEN: Well, at this point in time, there is a process going on at the NAIC.

FLOOD: What is that?

COLEEN NIELSEN: The Nebraska-- or the, the National Association of Insurance Commissioners.

FLOOD: Is that a governmental agency?

COLEEN NIELSEN: It is an association of all the insurance commissioners in the United States. They work on model legislation.

FLOOD: OK.

COLEEN NIELSEN: And currently they've been working on PBM regulation. I think Senator Kolterman has been very interested in that process, process at the NAIC. And through our discussions, we are waiting for the approval of that, that we expect fairly soon and are hoping that

that will be helpful to us in, in, in, in, in legislating PBM regulation.

FLOOD: And you recognize that ultimately it's up to this Legislature, this, this government body to decide?

COLEEN NIELSEN: I certainly, I certainly do.

FLOOD: Can you describe drug rebates and describe who gets the rebates?

COLEEN NIELSEN: Well, I will do the best that I can. There are different scenarios of rebates, but within, but, but within the PBM's position in the private area, not in Medicare or Medicaid. As I understand it, there are contracts between the, the insurers or the employers that, that do certainly include rebates at some, at some point in time. But that's-- and so sometimes rebates are used to pay Pharmacy Benefit Managers for their services. But that's not the only way that Pharmacy Benefit Managers are reimbursed. Sometimes they're reimbursed by administrative fees.

FLOOD: Right. But this would be a source of income for them.

COLEEN NIELSEN: It could be depending on the contract that they have.

FLOOD: You know what percentage--

COLEEN NIELSEN: I don't.

FLOOD: --it would be for your client?

COLEEN NIELSEN: I don't. I, I don't, I don't believe that that's how Prime Therapeutics is reimbursed.

FLOOD: I know it's been a long day, Mr. Chair. I have two more questions and I'll be done. Is a seven-day update of the maximum allowable cost price list acceptable?

COLEEN NIELSEN: I, I don't, I don't know, I don't know if it's acceptable or not. What I heard from the testimony is that the phar-- the pharmacists did not feel that that-- that, that said in some instances, that it was not, that they would prefer a daily update.

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FLOOD: But you don't have a position on that?

COLEEN NIELSEN: I don't have a position.

FLOOD: And the last question I have is I think it's very interesting that the local pharmacy is allowed to fill the initial couple of rounds of a prescription and then the testimony would suggest that the PBM requires it to go through the preferred pharmacy, through mail, for instance. Are you familiar with that practice?

COLEEN NIELSEN: No, I am not.

FLOOD: Well, I offer that question because it seems like to me, and this is something I'd like you to check on, it seems to me that they want the pharmacist in the local community to do all the work to on board the, the patient with all of the information and to do the health education and to check for interactions with other drugs. And after they do the work, then the PBM takes that prescription away from the pharmacist and then sends it through the mail for the course of the treatment. And if that's the case, it would seem almost predatory on the pharmacist's time in order to make money down the road. Can you see where that would be concerning?

COLEEN NIELSEN: I, I see your line of thought. But really the, the purpose, the purpose of Pharmacy Benefit Managers-- I mean, we've heard a lot of testimony here talking about punishing and predatory and all those sorts of things, but the purpose is to keep low prices for consumers and to help them be able to afford their insurance.

FLOOD: And our job is to balance that with the health--

COLEEN NIELSEN: I agree.

FLOOD: --and safety of our citizens. And I don't-- my sense is that if we don't exercise our authority as a branch of government to make your folks come testify so that the principals are here, we're not going to get to the actual answers. And we're waiting for some nonelected group of insurance commissioners to tell us what's happening. But we're the ones that sit here for three hours listening to horror stories from across the state. So I guess I would register with you my sincere disgust with some of the things that I've heard today.

WILLIAMS: Senator Pahls.

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PAHLS: Thank you, Chair. And what Senator Flood-- is I have to ditto that. And I don't mean to be picking on you, but you said there were a couple of individuals coming to talk to us today from your organization,--

COLEEN NIELSEN: Yes.

PAHLS: --but they couldn't, but they couldn't because of COVID.

COLEEN NIELSEN: Right.

PAHLS: How large is this organization that they could not have found at least two more people? I don't think they're showing us any respect. They should have had somebody here today, not the lobbyist, so we could have asked some really pointed questions because they would have that-- they live that. I'm, I'm amazed. I think they're just thumbing their nose at us to some degree, because in the organization, there has been more than two individuals who could come and make us a little bit smarter. I say shame on all those pharmacists who came up and the, the proponents. Shame on you guys. Shame on you two senators who are proposing these bills. Because nobody seems to care. And I'm not-- I'm talking to you, but I'm not putting you on the spot. They should have been here. This is a significant-- I'm, I'm assuming this is-- this has been in front of this committee in the past since I'm new to this year to this committee, some of this has been discussed. I, I just get irritated because I-- a lot of the stories that I listened to, I saw people who live here who are trying to make something work for the state of Nebraska. And I just-- seems like Big Brother up here is saying I'm going to pull the strings. That's what I was getting for some of these individuals. I'm not-- if, if you think-- I'm not irritated with you, I'm just irritated that, that they should have shown us a little bit more respect as I see it, because we're trying to find the answer, trying to find the answer. I mean-- and I'll, I'll get off my--

COLEEN NIELSEN: May, may I respond?

PAHLS: Sure.

COLEEN NIELSEN: I, I would just tell you that the two individuals that I mentioned in my testimony sincerely, sincerely wanted to be here. And so--

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PAHLS: I'm not doubting that.

COLEEN NIELSEN: Right.

PAHLS: But there has to be more than two in a company that size, you know.

COLEEN NIELSEN: I understand.

PAHLS: Thank you.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, yeah, thank you, Mr. Chairman. Thanks for being here in the hot seat. Sorry about that. But we've been hearing about the very troubled relationship between the PBMs and, and these, these druggists throughout the state. You know, talking about the abusive pricing arrangements, predatory contract arrangements, you know, that's something we need to fix. And I, I do not want to leave here in a year and a half without that being resolved. And I think the restraint of trade and a competitive activity, we're seeing a lot of that in this room today. And so let's, let's resolve and get this taken care of before Senator Williams and I leave the body.

COLEEN NIELSEN: We are looking forward to further discussions, Senator.

McCOLLISTER: OK.

PAHLS: Thanks.

WILLIAMS: Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you for your testimony.

COLEEN NIELSEN: Sure.

BOSTAR: It's a question I asked the gentleman from Medica, but it, it didn't quite apply. Are you aware of the, the, the company you represent engaging in activity to try to influence Nebraskans to change their, their pharmacy provider?

COLEEN NIELSEN: I am not aware of, of my employer doing that. Just from personal experience, I think that I've seen-- I have seen

advertisements or whatever about-- or, or actually, I've been learning more about preferred pharmacies and that, and that sort of thing. But I've not heard of any steering to a particular pharmacy or-- and as Mr. McLaren had testified earlier, about maybe, maybe this mail, mail order pharmacy, but I'm not aware of it.

BOSTAR: Would you look into that?

COLEEN NIELSEN: I surely, I surely will.

BOSTAR: And I guess the follow-up to that would be if you were to discover that the PBM was engaging in what I would describe as coercive influence of patients, and that would include-- what we heard was up to daily phone calls, letters. I think we even heard text messages. I mean, how would you feel about that?

COLEEN NIELSEN: Well, personally, I don't, I don't think I'd like it.

BOSTAR: OK, thank you very much.

COLEEN NIELSEN: You're welcome.

WILLIAMS: Miss Nielsen, I wanted to be sure about something that I think I heard in your testimony, and that is that Prime does not hire commission-based auditors.

COLEEN NIELSEN: That's what I-- yes, that's the information I have.

WILLIAMS: Are you aware of other Pharmacy Benefit Managers that do hire commission-based auditors?

COLEEN NIELSEN: I don't, I don't have any personal knowledge about it, Senator.

WILLIAMS: OK. I, I, I want to echo a little bit what Senator Pahls and, and others have talked about. I think it is troubling the testimony that we heard today. I also want to thank you and others for participating in the roundtable discussion that, that Senator Kolterman and Senator Morfeld scheduled last month. Not all the members of the committee know that that took place, but there was a large group that included Miss Nielsen, a number of the others that you have heard testify today. And I walked away understanding a couple of things and not understanding a lot of things, but understanding

that this is complicated, but it is very problematic and there have to be solutions found. I think looking around the room and recognizing that I don't see anybody else that's going to come up here and testify as a Pharmacy Benefit Manager, the questions about copay accumulation, harassment, MAC pricing, the 340B drug pricing program, the kicking higher copays, that's just, just really troubling. I have the opportunity, as Senator Kolterman did a few years ago, to currently sit on Health and Human Services. In 2017, was when Heritage Health was adopted, which became the Managed Care Organization for the state of Nebraska's Medicaid program. Many of the things that I have heard testified to at HHS Committee remind me a great deal of what I'm hearing now about Pharmacy Benefit Managers as that, as that system has changed from 1992 or whatever that date was till, till today. I, I think the right people need to sit at the table and find solutions to these things for Nebraskans. I, I guess I'm not sure there was a question in that for you anywhere. Are there any additional questions? Seeing none, thank you, Miss Nielsen,--

COLEEN NIELSEN: Thank you.

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

ROBERT M. BELL: Greetings, 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, middle initial M, last name spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here to testify in opposition to both LB270 and LB375. As a reminder, the Nebraska Insurance Federation is the state trade organization representing the domestic insurers of Nebraska and other insurers licensed to do business in Nebraska with an economic presence in our state. The members of the Federation certainly appreciate Senator Kolterman, Morfeld, and Williams for setting up the dialog that was just mentioned on Pharmacy Benefit Manager regulation. I believe we had a Zoom before that. And then also the in-person meeting set up by the senators has been helpful to me and some of my members hearing the concerns of the pharmacists. And I hope that the pharmacists also found the meeting productive. It is, again, my hope and hope of my members that perhaps some common ground may be found after further discussions. And I think that is possible. As you've already heard, as Miss Nielsen pointed out, the National Association of Insurance

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Commissioners has taken up the issue of regulation of Pharmacy Benefit Managers the past couple of years and has been working with a large group of stakeholders on creation of a model law which is hopefully nearly complete. The regulators on a working group created, created a new model, took comment from many trade associations, including insurers, pharmacists, doctors, other regulators, and, and other folks as well. It is anticipated that the new model may be approved at either the spring in the IC meeting, which, I believe, is in April or the summer in the IC meeting in August. With the model, states will have a model available for their-- if they want to pass it or not, for licensure and enforcement scheme similar to other entities regulated by the Nebraska Department of Insurance. I believe both pharmacists and insurance companies have the same goal being able to provide or finance care at a price that Nebraskans can afford. And make no mistake, PBMs have saved Nebraskans money. For the most part-- for most Nebraskans, healthcare is a top five monthly expense. According to America's health insurance plans, of every dollar spent on healthcare premiums, over 21 cents is spent on pharmaceuticals, outpacing inpatient costs, outpatient costs, doctor visits, emergency room visits, and other expenses. As drafted, both LB270 and LB375 would tie the hands of PBMs from using some tools that have helped keep costs down for Nebraskans. You've already heard what they do. They, they, they process drug claims. They operate mail order pharmacies. They audit pharmacies. They create specialty pharmacies to help control and manage chronic disease. And they, they allow health insurers to leverage the market power of its members to negotiate with pharmaceutical companies. We believe that PBMs are vital tools for health insurers and employers to keep health costs down. I'm going to skip around a little bit. One, one point I think I might want to leave the committee with is that healthcare is very, very, very, very expensive. It's very expensive. I think depending on your age and how the ACA markets work so forget about employer-sponsored healthcare for a second, but I think-- I, I ran my family through the healthcare exchange for a family of five. I'm, I'm 45, my wife's 43. I have a 16-year-old, a 13-year-old, and an 8-year-old. We would pay $26,000 in health insurance premiums with, I believe, a deductible in the range of about $5,000. I don't remember what the max out of pocket-- it was a couple of weeks ago. I was looking that up for a different committee. It's very expensive-- that-- if we were paying that and we didn't have employer-sponsored health coverage through my wife's work, that would be a significant portion of our, our monthly expense. And

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I, I, I just have to comment because the pharmaceutical companies got up here. Insurance is really simple at the end of the day, it's, it's claims equals premium. We have to pay those claims. We are regulated by the Nebraska Department of Insurance. We provide our rates to the Department of Insurance. They look at those rates. They make sure that not only are those rates fair, but that they can also keep us solvent when those claims come in and so that we can fulfill the promises that we have made to our policyholders. And that is driven by cost, the cost of healthcare, the cost of pharmaceuticals. And if you look at studies that are going on, the cost of pharmaceuticals are not going down anytime soon. I think I read that on that same graph from 21 cents, I think that will be approaching 30 cents by the end of this decade of, of our healthcare costs. And those, those pharmaceuticals do great things for people. I mean, obviously we have vaccines. There-- there's wonder pills all over the place that help prevent many things. And, and so-- I mean, we're doing a great job in the United States with that, but we're not doing a good job of controlling our costs. It's too much for our GDP. It is, it is honestly too much out of, of, of families' budgets right now. And we need the tools to be able to, to help keep those costs, costs down. And, you know, I think some of these wonder drugs get, get very, very, very expensive. I mean, we're talking thousands of dollars for a, a monthly dose. And that's, that's paid for in a number of ways, but some of that is by commercial insurance and private insurers. So with that, we look forward to further discussions. I think we did have a productive meeting. We would like to continue to have that productive meeting. We will certainly ask our members to bring those pharmacists and Pharmacy Benefit Managers that they work with to the, to the table. I think I heard this committee loud and clear that they need to be here and they need to talk and they need to talk with you and share their experiences as well. And just one final thing. I've-- I-- I've lost count of how many times I've testified in front of this committee this year, but I want to say thank you. It's the last time you'll see me at this table hopefully this year, unless we see an amendment on something I have to come testify. But anyway, I just wanted to say thank you for all the time that the, the committee has given the insurance industry this year, and I appreciate the opportunity to testify.

WILLIAMS: Thank you, Mr. Bell. Questions?

FLOOD: Real quick.

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WILLIAMS: Senator Flood.

FLOOD: Chair Williams. Thank you, Mr. Bell. So when you give your end of the session report to your principals,--

ROBERT M. BELL: OK.

FLOOD: --out of all the bills that you have spent time with us in here, would this one be the one at the top of your list to say, I have not seen the committee so upset about anything else?

ROBERT M. BELL: Yeah, it's going to be, it's going to be right there. I didn't, I didn't feel this kind of anger on aftermarket parts or annuities, but maybe I should have or birth control. But, yes, I-- it was-- it's been loud and clear and not to share too much inside baseball, but--

FLOOD: We are at a public hearing.

ROBERT M. BELL: Yeah, yeah, I know. So you know what, I'll let it lay there, Senator Flood. But yes, I, I understand the-- I understand, I understand it. And I understand-- you know, I want to understand more though. I want to understand where the pharma-- I don't walk in their shoes. I-- we need to talk more and we need to have a discussion, so.

FLOOD: And one thing I would also say is I, I do understand what you're trying to do. I mean, premiums equal costs. I mean, all of the things that you talk about, cost equal premiums. I, I do think if you brought the pharmacist in to the tent more and you said to them, what things could we be doing as a state? I think sometimes they're the last ones consulted.

ROBERT M. BELL: Sure.

FLOOD: And they could save the most money in our healthcare system.

ROBERT M. BELL: You know, you, you made that point earlier today and, and I heard it.

FLOOD: And I'm not saying it would, but I think if you had them at the table.

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ROBERT M. BELL: I think it's an interesting point. And I, I think there's opportunity to provide both better care to Nebraskans and cheaper care to Nebraskans. And that's really what we're all after I think at the end of the day. You know, the world is changing a little bit. I mean, there's, there's certainly-- I mean, the-- when we talk about-- a lot of times we talk about Insurtech. Insurtech is this movement of technology and how it helps distribute insurance. And there's a lot of issues going on and it's a very interesting subject. But one thing I always think about related to Insurtech is Amazon and the story of Amazon. And of course, they came up with Kindle. Right? The reader, so you could read the books online. And when they did that, they were the largest bookseller in the world. And, you know, you wonder, you wonder how, how the world is going to change and, you know, how we distribute products and things like that. And in the pharmacy world, that's part of it as well. You know, I, I miss going to the local bookstore store, but I order a lot of books off Amazon. Sorry.

FLOOD: I better have to stop answering or the entire committee is going to want to take me out behind the woodshed.

ROBERT M. BELL: OK, I'm sorry. I'm rambling at this point. I got a, I got a concert to go to tonight. So, yeah.

WILLIAMS: I, I do have a question. And, and you have exceedingly exceptional experience in this because of your previous work with the Department of Insurance. I'm, I'm concerned that we get sidetracked thinking the NAIC model will be the solution to this discussion.

ROBERT M. BELL: Right.

WILLIAMS: My concern-- and this, this turns into a question, is that that will address the regulatory issues surrounding the PBMs in that area, but that it may not get us to where it will address the-- some of the other issues that are really the boots on the ground issues that I'm hearing today from pharmacists. From your experience with the NI-- NICA [SIC] models, is that a fair assessment?

ROBERT M. BELL: Yeah, I mean-- so I've, I've read the, I've read the model, the latest draft of the model. And it-- it's very, very much regulation or licensure driven, right, that, that you have to license. It gives the department various examination powers related to Pharmacy

Benefit Managers, which they probably have now as, as TPAs, to be honest with you. But we're not talking about a financial, a financial model where the other states are relying on, on the Nebraska department to go look at the books of an insurance company as an example so they can sell there. Here, we're, we're talking about what we call a market model. And so states, and many states already have, have, have passed various PBM laws and the idea probably is not that it's going to be-- we would like to probably-- I mean, honestly, they've, they've dealt with some of these issues and they-- clearly, whatever we introduce could be amended. I guess, is what I'm trying to say. We're not, we're not so much worried about uniformity across the states. I mean, we always worried about uniformity. It makes, it makes business easier, to be honest with you, but states are always able to go into those models and make the changes that they feel are necessary.

WILLIAMS: Well, I think giving the department regulatory authority that's clear in these areas is important. And I think having uniformity is also, but I-- my fear is where, where there are some areas that will be left out of that legislation.

ROBERT M. BELL: Yeah, and it doesn't mean that, that could be part of the solution. You know, and I think we, we all in the insurance world realize that. One, one caution that I would give that are in both of these bills that I didn't hit on in my testimony and I probably should have, is that the ability of pharmacists to call the Nebraska Department of Insurance and lodge a complaint is certainly something that, that this committee should review very-- should be leery of. Right now, when the only people that call the department and file complaints are actually consumers. Right? And so there are certainly complaints that go into the department related to my, my insurance company told me I need to use this generic drug or whatever. They file, they file a grievance with the department and it's, it's adjudicated somehow. We talked about that quite a bit on step therapy. But the fact that, you know, doctors don't call auto shops, or if they do they're like, well, what does the consumer say? Right? Because it's a contract between the consumer and, and, and the insurance company. And so that-- that's something that gives me just a little bit of pause in all this. But certainly if, if the Legislature is willing to fund the additional folks at the department to, to do that, I mean, you know, that would be something, so.

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

ROBERT M. BELL: You're welcome.

WILLIAMS: --testimony and thank you for being here all these times this year.

ROBERT M. BELL: You're doubly welcome.

WILLIAMS: Invite the next opponent. Welcome, Mr. Dunning. And before you begin your testimony, I am going to ask, are there any additional testifiers in the audience? Just wanted to be sure that Mr. Dunning was last.

ERIC DUNNING: Oh, cool. Shoot, it's not every year you get to be the last testimony before such an august body. OK, good afternoon, Senator Williams and members of the Banking, Commerce and Insurance Committee. My name is Eric Dunning. For the record, that is spelled E-r-i-c D-u-n-n-i-n-g. I'm a registered lobbyist appearing today for Blue Cross and Blue Shield today-- Blue Cross and Blue Shield of Nebraska here today to testify in opposition to LB270 and LB375 as complete-- as currently structured. I think that's an important part of my messaging for today. Since 1939, we've worked hard to encourage the health and wellness of Nebraskans of all ages. And to the extent that we fall short in that goal, we're not happy about it any more than you certainly would on behalf of your constituents. We are a company that is ultimately owned by our member policyholders. We only do business in Nebraska. We sink or swim in Nebraska. So we share many of the concerns that I've heard today from our part-- from our pharmacy partners. I-- two weeks ago, Senator Kolterman and Senator Morfeld and Senator Williams pulled together a group of stakeholders in this space. We heard from PBMs. We heard from insurers. But most importantly, we heard from pharmacists. This is not the first year that this committee has heard this bill. And typically the way that this bill has come in has been sort of at the last minute, late December, early January, so the, the, the ability to talk back and forth on either side of the table just hasn't been there. I think Senator Kolterman has done a, a masterful job trying to encourage those communications. And we're really excited to see potential results from that. We approached those meetings with an open mind. And while we can't necessarily agree with all of the solutions in the bill

as they're currently structured, we feel like we have a much better understanding of some of those challenges faced by our pharmacy partners. We hope that those conversations continue so we can find a solution that works here in Nebraska. Now as I understand from colleagues around the country, the PBM issues are usually teed up as a contest between the interests of community pharmacists and PBMs. And it's implied that PBMs are these big entities that pull profits out of the pharmacy system without providing any benefit to people who buy insurance. It's important for me to pull back a little to discuss the context in which these entities operate for us. PBMs exist because they negotiate better pricing with extremely large pharmaceutical companies on behalf of smaller insurers like Blue Cross and Blue Shield of Nebraska. They also work on pharmacy network issues. But in most of, in most of those instances, about 80 percent, that's not a negotiation that's happening between our PBM and community pharmacists, but actually between the PBM and an entity called the PSAO, which we heard referred to earlier. And typically those PSAOs are sponsored by drug wholesalers who have some control presumably over the cost of wholesale drugs. Our PBM was founded originally to meet the needs of smaller insurers, and we're proud to have been a founding owner of Prime. Prime drive savings for our insureds, which are all passed on in one form or another back to those insureds because of the, the ownership relationship between us and our PBM. There's no other money, there's no other way for that money to, to, to leak out, whether that be to shareholders or others. We are concerned about some of the solutions that are in the bill and that they might restrict our ability that are-- that's going to increase the cost of insurance for Nebraskans. I'm-- you have heard testimony on a whole range of subjects and all of which obviously I'd love to answer questions on. But I'd like to point out a few things that I think are important to note. Nebraska Revised Statutes 44-513.02 has for the last 20 years governed the conduct of mail order pharmacy in our state. It says that we can't provide extra incentives for people to move prescriptions to mail order. Right? But that law is not going to apply to, to Medicare, which is governed under federal law. It's-- and I don't know how it, how it interacts with, with laws governing Medicaid, but there are laws on the books that restrict our ability to use Medicaid-- or excuse me, to use mail order, particularly if it's a-- not a, a, a six-month prescription. So I'd encourage the committee to take a look at that, see what protections are already in Nebraska law. With that, I'd also like-- last but not least. Look, we've heard

some of the testimony today. Over the years, we have worked with the committee to develop responses to clawbacks and gag clauses even before that was a factor in, in federal law. And that was, and that was something that, that happened as a result of sitting in hearings just like this. So we're very interested in hearing from our pharmacy partners. We are not interested in seeing them abused. And we look forward to a conversation that starts hopefully sooner rather than later so we can develop a decent response that has a Nebraska solution for Nebraska problems. And with that, Mr. Chairman, I'd like to wrap.

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

BOSTAR: Thank you, Chair Williams. Thank you, Mr. Dunning. I'm going to ask you the question that I asked previously. You know, we've-- you and I in this room, we've talked a lot about markets over the last few weeks and the power of markets and the importance of markets. So if an insurance company owns a PBM and PBMs own pharmacies, that level of vertical integration, do you feel, do you feel like that could create distortions in the market?

ERIC DUNNING: Senator Bostar, I think that is absolutely something that you're right to focus on. However, I would also say that I'm aware that the FTC and others have said, you know, vertical integration at, at some level can drive efficiencies. And so I think that's a fairly complicated conversation that I'm not sure I'm prepared to give you a yes or no answer. Boy, was that a long answer for that. Sorry.

BOSTAR: The requirement that an insurance company like yours has to have, I believe, it's 80 percent of their premiums go to providing service.

ERIC DUNNING: Um-hum.

BOSTAR: What's that called?

ERIC DUNNING: That is a minimum loss ratio that's established under the Affordable Care Act.

BOSTAR: Minimum-- that-- minimum loss ratio was what I was looking for.

ERIC DUNNING: Yes.

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BOSTAR: Does--

ERIC DUNNING: And, and I would point out, sir, that we would love to be able to get to those numbers. Anyway.

BOSTAR: Does, does a PBM have any kind of similar requirements?

ERIC DUNNING: Funny you should mention that. Not only do the PBMs not have a similar regulation based on minimum loss ratio, but neither do pharmaceutical companies, which is why the PBMs exist.

BOSTAR: So if, if a-- if regulations have been put in place in order to ensure that an insurance company isn't spending too much money on administration and overhead, but it owns a PBM that doesn't have the same constraints on the extraction of profit, does that create a scenario where an insurance company gets an entity to work around the distribution of revenue for itself?

ERIC DUNNING: Well, you're unpacking a few subjects in there. One-- and I-- the, the minimum loss ratio standard is applicable to fully insured groups, large employer-sponsored groups. It's not, it's not an issue for them. So those, those, those payments, and I believe as a matter of practice, Prime returns the, the, the rebates to the, to the, to the employer-sponsored group. But I don't know how-- I don't-- honestly, sir, I don't know how the accounting works in terms of whether or not, whether or not that the-- how the accounting works for the, the, the fully insured group. I, I honestly don't know. But I'm more than happy to get back to you on that.

BOSTAR: Thank you very much.

WILLIAMS: Senator McCollister.

McCOLLISTER: One quick question, Mr. Dunning, your PBM is wholly owned by Blue Cross and Blue Shield?

ERIC DUNNING: By a consortium of, of 16, I believe of Blue Cross and Blue Shield plans. We, in, in conjunction with another Blue plan actually provided the seed capital to start this in the early '90s.

McCOLLISTER: No other outside investors?

ERIC DUNNING: No other outside investors.

McCOLLISTER: And your earnings aren't reported?

ERIC DUNNING: I don't know. Sir, I don't know the answer to that, that question. But at the end of the day, if there are earnings, they flow back up into our organization, which allows us to, to offset the premium costs.

McCOLLISTER: So you contend your PBM is entirely different than the other investor-owned PBMs?

ERIC DUNNING: Yeah, I, I would say that.

McCOLLISTER: OK, thanks.

WILLIAMS: Senator Flood.

FLOOD: Thank you, Mr.-- or Chair Williams. Thank you for coming, Mr. Dunning. Were you here earlier or did you have the opportunity to hear the testimony of that pharmacist from Box Butte County who traveled seven hours here from Alliance and Hemingford?

ERIC DUNNING: I did. I did. It was sort of in and out, but.

FLOOD: Right.

ERIC DUNNING: Yeah, but I am aware that he came from, from Alliance.

FLOOD: What, what did you take from his testimony? My-- and I will give you my sense. I'm interested in your sense. Here's a guy that's out there trying to solve problems and people come in and they don't know what to do. And he's putting these pills in the boxes and, and somebody comes in with a mail order system and takes the business away from him. The more situations like that, the less likely he is to be able to provide that level of service to the people that don't understand it.

ERIC DUNNING: Um-hum.

FLOOD: Do you, do you share that concern?

ERIC DUNNING: Well, again, I want to go back to the fact that there is an existing statute on the books that governs-- that got-- an existing state law on the books, that governs the ability to direct people to

mail order. We, Blue Cross and Blue Shield does not have, as I understand it, a particularly heavy take up of mail order. So I'm not sure to what extent that testimony relates directly to us. But again, that's part of the conversations that I've-- that I alluded to earlier.

FLOOD: Is it possible that while everyone's looking at the spreadsheet, the very infrastructure of our system is at stake because we're eroding the ground that everybody stands on? By that, I mean, they're lucky to have a pharmacist in Neligh. And, yeah, they can do a lot of things, by, by mail. But when it all hits the, the fan, where do they show up? They show up at Wanek Pharmacy. Is it possible that looking at the spreadsheet too much could actually disintegrate the, the people that are solving the pharmaceutical challenges of the day in people's lives?

ERIC DUNNING: Senator, I, I think that's absolutely possible. And again, I'm going to go back to the conversation that Senator Williams, Kolterman, and Morfeld have sponsored, and we'll be looking for opportunities to address some of that. I would also tell you that under network adequacy standards, we do need to have pharmacies in all of our state, right, if we're going to, if we're going to have a reasonable network. So we are interested in making sure that our community pharmacies continue to exist and to thrive.

FLOOD: Now, Miss Nielsen, she ended up getting all of the questions because she was representing a PBM. But it's important to note that PBM she's representing is wholly owned and started by your company.

ERIC DUNNING: Yes, sir.

FLOOD: So do you think-- I mean, if, if we're going to-- my sense is, if this doesn't get better, we're going to use every power in the Legislature we can to compel not only witnesses, but information and answers to come here. What message will you send to the board of directors of Blue Cross about the Legislature's Banking Committee's concerns?

ERIC DUNNING: Well, Senator, no one has ever had to subpoena Blue Cross and Blue Shield of Nebraska. Again, since 1939, people just like me have sat in this chair and come in.

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FLOOD: No one in the Legislature, but you've been subpoenaed before, just not by a branch of government like us.

ERIC DUNNING: Right. Right. So we are committed to being at the table. And again, while I can't sign off on everything in these two bills or anything in particular, I am-- we are looking at ways to address valid concerns.

FLOOD: Thank you.

ERIC DUNNING: Thank you, sir.

WILLIAMS: Any additional questions? Seeing none, thank you, Mr. Dunning, our last testifier. I, I will ask, is there anyone here to testify additional in opposition?

***KEVIN BAGLEY:** Good afternoon, Chairperson Williams and members of the Banking, Commerce and Insurance Committee. My name is Kevin Bagley (K-E-V-I-N B-A-G-L-E-Y), and I am the director of the Division of Medicaid and Long-Term Care (MLTC) within the Department of Health and Human Services (DHHS). I am here to testify in opposition to LB270 and LB375, which would create new requirements for Pharmacy Benefit Managers (PBMs) and their pharmacy networks. LB270 also provides for an audit of pharmacy benefits. Both bills change rules around PBMs' regular pharmacy networks. LB375 requires PBMs to enroll any interested pharmacy in their regular pharmacy networks, as long as they accept the terms of the agreement. LB270 limits the managed care health plans' ability to create a pharmacy network. This prohibits PBMs from defining participation in their specialty pharmacy network. Both of these changes would lead to increased costs. They could also lead to program integrity issues, as PBMs would not be able to exclude from their networks pharmacies suspected of fraud. Regarding the audit provision in LB270, Medicaid still has concerns that the audit would not provide a useful comparison of fee-far-service pharmacy claims to pharmacy claims in the Heritage Health managed care model, which are administered through PBMs. This audit would not provide useful information, as 99% of Medicaid pharmacy claims are paid via managed care. This audit would likely produce skewed results due to the variance in volume and mix of claims. To be clear, Medicaid is not opposed to audits, but we have doubts this one would provide a clear comparison of managed care to fee-for-service pharmacy claims. While the division welcomes discussion on how to improve the member

experience related to pharmacy benefits, LB270 and LB375 could lead to increased cost. We respectfully request that the committee not advance these bills. Thank you for the opportunity to testify today.

WILLIAMS: Anyone here to testify in a neutral capacity? Seeing none, we will ask Senator Morfeld to come up. And as you're coming up, Senator Morfeld, we have drop-off testimony from Kevin Bagley from the Division of Medicaid and Long-Term Care as an opponent. And we have 16 letters for the record in support of these two bills. Senator Morfeld, welcome.

MORFELD: Thank you, Senator Williams, members of the committee. I want to thank everybody for their time. I've sat on the Judiciary Committee and the Education Committee for the last seven years, and we had a lot of long hearings. And this is probably the longest hearing that I've seen on an issue, particularly one where I haven't asked people to come. And so I think it, it shows the gravity of the issue and the fact that we need to take action and not just-- we need to have discussions, but we've had discussions now for two years. I'd like to point out, Mr. Dunning noted that these get introduced at the last minute or the month before. We don't have time to talk. My bill has been on the table for the last two years. And I think if anybody knows me behind me, knows that I don't take an issue and just simply drop it. So I introduced basically the identical bill, with an exception of the 340B section that I introduced last year. So if we're serious about making good faith efforts to actually find solutions and not just have discussions, I'm here, I'm ready to go. And I appreciated the, the meeting that I joined Senator Williams and, and Senator Kolterman with. I hope we have that meeting again. I am very skeptical of an industry regulating itself. I'm sure that something good will come out of the, the National Association of Commissioners, but I don't think it will probably go far enough, quite frankly. So that's where we're going to need to come in and, and do what we think is in the best interest. The 240-- the 240B [SIC] section, I'm, I'm a little confused as how that can increase costs. It's simply saying, if you read the language, very simple in terms of how this type of language goes, that the PBMs can't pay them any less than what they're paying for other non-240B [SIC] federal type of program reimbursement. So I'm confused as to that. I have some folks looking into it. I'll talk to Mr. McLaren about it as well. I would-- well, I'll leave it at that. I think there's going to be a lot more discussion on this. I could talk a lot longer, but I teach a con law class for three hours at 6:00. And

if I don't eat, I'll be angry and we'll have some students that might have a bad three hours, too. And so with that, I'll be happy to take any questions and I'll be working with Chairman Williams and, and Senator Kolterman to get something across the finish line.

WILLIAMS: Thank you, Senator Morfeld. Questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, Senator Morfeld. Your bill last session was LB1196. Is that correct?

MORFELD: Correct.

BOSTAR: What's different?

MORFELD: What's different is we added the, the nondiscrimination clause for 340B entities. That's, that's the difference.

BOSTAR: OK, so looking through the fiscal note of LB1196 and your bill today, LB270, they look significantly different.

MORFELD: Yes.

BOSTAR: Do you have any thoughts about that?

MORFELD: I was surprised by, I believe it was the $13 million fiscal note from the Department of Administrative Services in LB270, the bill before us right now. Last year, I believe it was zero. I'm looking through the fiscal note for LB1196. It was zero from DAS, so I'm, I'm confused by that-- the section that they refer to for that has not been changed unless I'm missing something.

BOSTAR: Would you, would you try to look into that and get back to the committee, if you are able?

MORFELD: Yes, I will try to look into that. I was hoping DAS would, would testify today and we could ask them some questions, but they're not here. I'll look into it.

BOSTAR: Thank you, Senator.

MORFELD: Yeah, thank you.

WILLIAMS: Any additional questions? Seeing none, thank you, Senator Morfeld. And we'll ask--

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MORFELD: Thank you.

WILLIAMS: --Senator Kolterman to close on LB375. Welcome, Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. And committee, thank you for bearing with us today. Well, I don't know where to start. I, I know you want to get out of here, but I have a lot to say. And I think it will put a little perspective on why I'm involved in this legislation. I think this is my, I think-- Mr. Mueller indicated this might be my third PBM bill in six years, and I think it is. I didn't carry any PBM bills last year because I made a commitment to the Nebraska Department of Insurance. And I, and I had worked with the Pharmacy Association and told them it was time to sit out a little bit and try and let the NAIC do their work. And they didn't get that done last year. But in the meantime, Senator Morfeld had brought some legislation. But we were-- we have been able to nip away at this a little bit, piece by piece with gag orders and clawbacks, and allowing the pharmacist to divulge what the drug actually costs and allow people to pay for them directly, if that's what-- if it's cheaper to do that than go through your insurance. So we've made some forward motion on that. I had made a commitment to Bruce Ramge, the director of insurance, said that I would carry the NAIC legislation, the model legislation, which really, it's not going to be the answer to everything, but it would fit into this bill because we are going to need someone to regulate PBMs going forward. And I think that the, the Nebraska Department of Insurance has a tremendous reputation in being fair with people, and I think that's where it belongs. For those of you that have not been around a lot, they are nationally known, nationally respected. And I think that if we do have to have a regulator, they're the people to do it. And you will see on my bill that if they were to do this, there's, there's close to $300,000 more per year that they're going to need to administer a program like this. A reason that I agreed to bring it this year, even though that wasn't complete, was we thought it might be complete by now and, and we'd have that, we could roll it in. There's been some legislation, Arkansas was, was one of the states that passed some early, hard legislation, and especially after the Rutledge case this summer was another reason we decided to bring it. As has been indicated today, on February 12, Senator Williams and I and Morfeld tried to bring as many people together as possible. We brought insurance companies, pharmacists, managed care organizations, PBMs. We brought them all to the table and, and really started talking

about this. Because of COVID, we didn't work on it this summer. We should have. But the reality is we were somewhat reluctant to bring that many people. I think we had 30 people in a room and we tried to social distance them, but it was very, very well-attended and we did get some good results. So I think obviously there's a lot of work to do in the area of deductibles, copays, MAC pricing. Some of it we're not going to be able to tackle because it's federal legislation. As an example, when we talk about Medicare, my, my-- I have a 91-year-old mother who gets a call once a week asking her to move her prescriptions from a local pharmacy to a, to a another pharmacy that's mail order. And they keep hounding her about how much she can save. And she finally-- you got to know my mother, she finally told them she was going to keep her business right where it belonged in her local hometown and quit calling me. Three forty-- 340B programs, that's not in my bill. That's in Senator Morfeld's. So there's a lot of work to be done yet to merge maybe the two bills and ideas in each of the bills together. But at the end of the day, Senator Flood, I, I really like where you're going with all this, and I'm got to tell you a little story. On February 12, David Randolph drove down from Hemingford to come and test-- and to work with us. It meant that much to him. On February 15, his house burned to the ground. Burned to the ground. He doesn't have a home right now. Fortunately, they were able to salvage some of the, some of the personal belongings. But who was here today? David Randolph from Hemingford. That's commitment. At our meeting on the 12th, and if I get emotional, there's a reason for it. At our meeting on the 12th, I made the remark that I take Ozempic. You know, I'm, I'm on Medicare and I, I buy a prescription drug policy. You have to. You're forced to. I could get it cheaper through mail order. Fortunately, I'm-- I've been blessed enough that I can afford to pay a little bit more and get it through my local pharmacy, but they are trying to push everybody to mail order. For me, at the end of the day, and I said this publicly at that meeting on the 12th. We have people here today from Lincoln, Stromsburg, Ord, Hastings, Milford, York, Seward, Omaha, Hemingford. Those are the people we have to deal with. These pharmacists out here are just trying to make a living. And we have to help them survive. Because it's not right that you get pushed to mail order, but at the end of the day, when you can sell a week's worth of pills while you're waiting on your mail order and get them from our local pharmacist. Something wrong about that. People say, why do you care? Well, you know, for 85 years, my family owned a business in Seward, Nebraska. It was a Ben Franklin store. Now, some

of you don't know what a Ben Franklin store is. They aren't around anymore. You know why? Walmart put them out of business. But my folks and my grandparents and my brother, when somebody came to them, and somebody alluded to this earlier today, when somebody came to them and said, we're having an after prom party, can you contribute? They contributed. Or can you help with the local scholarship program in town? They contributed. The local businesses made that contribution. And you're right, somebody talked about it. You don't see the mail order pharmacies throwing money into the coffers of our small communities. So my folks aren't in business any longer, but they didn't quit contributing to the community and my mother is 91 years old and she still leads a couple of committees in the community, even though Walmart put them out of business. So I say to you, it's important that we support the people that are behind us. At the same time, I would like to thank the four people that came in here and took a, took a hard hit today because they oppose this bill. Those people came here because they knew that we're willing to work with them and they're willing to listen. There are some companies that didn't show up. And they are in it for the buck. And they need to be reprimanded and they need to have more controls put on them. But I will tell you that Blue Cross and Blue Shield and Prime Therapeutics have been very straight forward. Robert Bell has worked with us. And I think that they need-- Jay McLaren from Medica. Rather than criticize them, we need to, we need to have them in the fold working with us. I know that they've been willing to work with Senator Williams and I and Morfeld. And so at the end of the day, we need, we need a third party administrator, we need new legislation, but we have to work through this together and people that know me know that I will continue to work on this. We had a bill this morning that we advanced to Select File. It was a, it was a step therapy bill, dealt with prescription drugs. We brought everybody to the table and we got that worked through and even HHS came, didn't come in and opposition, they, they just didn't testify against it. So we need everybody involved and I'm, I'm going to make the commitment again to work with people. That's how we do it. And I appreciate your time today. I know it's long and it's time for, for us to quit. That's why I'm here, and that's what we're trying to accomplish, and I hope we can continue to move this bill forward.

WILLIAMS: Thank you, Senator Kolterman. Are there questions for the Senator? Seeing none, as we are closing the hearing, I would like to

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say a special thank you to all the committee members for your work this year and for committee counsel Bill Marienau. For those of you in the room, this is Bill's 35th year as being legal counsel to the Banking, Commerce and Insurance Committee. And a special thank you to Natalie Schunk, our committee clerk, and she has been with me my entire time in the Legislature. And we set a new record, so Senator Flood's bill that we heard a few weeks ago is not the longest bill we had in hearings this year. That will--

FLOOD: You mean that we need priority?

WILLIAMS: That will close our public hearing on-- and I would also like to thank all of you for being here and--

McCOLLISTER: Let's thank our pages.

WILLIAMS: So that will close LB270 and LB375. And you're right, thank you to our pages.

McCOLLISTER: Come on let's-- round of applause for the pages.