WILLIAMS: Good afternoon, everyone, and welcome to the Banking, Commerce and Insurance Committee. Sorry, we're running just a little bit late. We were having a committee Executive Session. Otherwise, people could come in earlier and have, have found their seats. My name is Matt Williams. I'm from Gothenburg representing Legislative District 36, and I'm honored to serve as Chair of the committee. The committee will take up the bills in the order posted. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on a bill before us today. The committee members will come and go during the hearing. We have bills to introduce in other committees and are sometimes called away. It is not an indication that we are not interested in the bills being heard in the committee, it's just part of the committee process. To better facilitate today's proceeding, I ask that you abide by the following procedures. Please silence or turn off your cell phones. Move to the front row when you are getting ready to testify. The order of testimony on each bill will be the introducer, followed by proponents, opponents, neutral testimony, and then closing. When you come up, if you'd please hand your pink sheet to the committee clerk when you come up to testify. As you begin your testimony, if you would please spell your first and last name. And we also ask that you be concise with your testimony. We do use a five-minute clock for testifiers. You will see the light turn green when you begin your testimony. After four minutes, it will turn yellow. At the end of the five-minute period, it will turn red and we ask that you conclude your testimony at that time. If you will not be testifying at the microphone but want to go on the record as having a position on a bill heard before us today, there are white tablets at the entrance where you may leave your name and other pertinent information. These sheets will become part of the permanent record at the end of today's hearing. If you have written testimony or something that you want to hand out to the committee members, we ask that you have ten copies and hand that to the page when you come up to testify. If you do not have ten copies, the page will make those copies for you. To my immediate right is committee counsel Bill Marienau. To my left at the end of the table is committee clerk Natalie Schunk. The members of the committee that are with us today will introduce themselves 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 and Bennington.

AGUILAR: Ray Aguilar, District 35, Grand Island.

BOSTAR: Eliot Bostar, District 29, south central Lincoln.

WILLIAMS: And our page that is helping us today is Malcolm. And so if you need him, just raise your hand and he will help you with passing out materials. With that, we will begin our afternoon and ask Senator Wayne to join us. We will open the public hearing on LB1175 to prohibit a health insurer from removing a provider as an in-network provider under certain circumstances. Welcome, Senator Wayne.

WAYNE: Thank you, Chairman Williams and members of the Banking and Insurance Committee. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, encompassing north Omaha and northeast Douglas County. First, I want to say I fundamentally believe that healthcare and access to a high-quality healthcare is a fundamental right. We cannot pursue life, liberty, and the pursuit of happiness if we don't have some basic health needs being met at a basic level. I introduced this bill, LB1175, which would prohibit insurances from moving an in-work-- in-network provider to out of network purely for profit reasons. One, it goes back to what I just said. I believe that healthcare is a fundamental right. Two, most of our health insurance companies that I've seen are nonprofit, so they're not-- shouldn't be about making profits. So if they're not about making profits and healthcare is a fundamental right, then there should be no issue with this bill. However, if the majority of the people here are for this bill, I do know what priority bill I will have next year because I like to have big bills. I didn't think this was that big. So there are laws popping up around the entire country dealing with these kind of issues of in-network and out-of-network frustrations. This first came to my attention actually before I became a state senator and I was on the Omaha Public School Board, where we were part of a consortium of school members to provide health services to our employees. Around that same time there was this big fight, and I'm pretty sure some of you remember, where CHI moved out of network for Blue Cross Blue Shield. That disrupted things across the entire state where people could not go to their same providers. Well, this year I was contacted by, by three or four people who are going to a, a specific clinic in Omaha who are now being moved out of network and the justification that they seem to continue to get from their, their network provider is it's a financial reason for that reason. So that's the genesis of this bill. If people are moving doctors or providers

out of network for other reasons, such as quality of care or value care or whatever other term they want to use, that's fine. But if it is strictly a profit-- for a profit reason, I think at state law we should prohibit that. Again, I believe it's real simple. This year, or a couple of years ago, Senator Morfeld had a No Surprises Act that we passed federally. There's one going into effect in January or just went into effect that's saying that you can't do surprise billing for people out of network. Now there are some nuances into that. But at the end of the day, I fundamentally believe that healthcare and access to high-quality healthcare is a right, and if they're nonprofits then making profit-motive decisions should not be permitted underneath Nebraska law. And with that, I'll answer any questions.

WILLIAMS: Are there questions for Senator Wayne? I have one.

WAYNE: Yes.

WILLIAMS: Of-- it's a question of, you know, our, our insurance companies are private businesses. Is it up to them to disclose to us their business models and decide how they make those kind of decisions or is that a private business decision?

WAYNE: Well, it depends, if they're a nonprofit, the Attorney General currently has jurisdiction to ask all those questions. So if they're a nonprofit underneath in our Nebraska nonprofit law, we can ask those questions currently legally if we choose to do so. So I'm not changing that.

WILLIAMS: OK. Additional questions? Seeing none, thank you. Will you be staying to close?

WAYNE: I have three other hearings today, so I will waive my closing.

WILLIAMS: It's a busy day in the Legislature, a busy day in the Legislature.

WAYNE: Thank you.

WILLIAMS: We would invite the first proponent. Someone to speak in support of the bill. Seeing none, is there anyone here to speak in opposition? Welcome, Mr. Blake.

JEREMIAH BLAKE: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake. For the record, that is spelled J-e-r-e-m-i-a-h B as in boy -l-a-k-e. I'm the government affairs associate for Blue Cross and Blue Shield of

Nebraska, and I'm testifying in opposition to LB1175. At Blue Cross, we take pride in the fact that our network includes 90 percent-- 96 percent of Nebraska doctors and more than 1,500 medical facilities. In a typical year, we respond to more than 200,000 inquiries from providers, process approximately 15 million claims, and pay $3 billion in member benefits. Our success as a health insurer depends upon the success of healthcare providers across Nebraska. In recognition of the need to support our partners in the provider community, we have prioritized efforts to improve their interaction with Blue Cross by creating an efficient and-- efficient contracting and credentialing process, designing easy, understandable patient benefits and pre-authorization processes, quick-- quickly and accurately processing claims and reimbursement, and building reliable relationships through world-class customer service. This reflects our commitment to work collaboratively with our partners in the provider community to meet our shared responsibility to Nebraskans. LB1175 would prohibit a health insurer like Blue Cross from removing a provider from our network for financial reasons, but it's unclear from the language of the bill what would constitute a financial reason. The bill, the bill appears to allow health insurers and providers to negotiate contracts for reimbursement rates. However, it's unclear what happens if the two parties cannot agree to the terms of the contract. A more extreme interpretation of the bill would prohibit us from removing a provider who conducts financial fraud, waste, and abuse. I'm confident that's not Senator Wayne's intention, but the plain reading of LB1175 raises serious questions about how we would respond in those situations. In that rare occasion where we must terminate a contract, there is a dispute resolution process in the provider contract and state law requires health carriers and providers to provide at least 60 days written notice to each other before terminating a contract without cause. As a Nebraska-based insurer providing healthcare coverage to Nebraska families, we have every incentive to see our partners in the provide-- provider community thrive. However, this bill is introduced as overly broad and interferes with our right to contract with providers. For this reason, we oppose the bill and I would be happy to answer any questions you have.

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

JEREMIAH BLAKE: Thank you.

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

ROBERT M. BELL: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l, and I am the executive director and registered lobbyist for the Nebraska Insurance Federation, the State Trade Association of Insurance Companies, Nebraska Insurance Companies. I appear today in opposition to LB1175. I'm not going to repeat what Mr. Blake had to say. Senator Wayne posed a question as to why we would care. I would tell you with my health insurers, half of them are, are nonprofits, half of them are for-profit stock companies. But the reason that we care, and this is going to be a theme probably for today, is that rates matter to our policyholders. And at the end of the day, insurance can be quite complicated, but it also can be quite simple. We use those rates to pay out claims. If you increase the amount of claims that are paid or the, the cost of those rates or a cost of those claims, there is going to be a direct impact on premium. So in this case, I think Senator Wayne brought up the CHI, Blue Cross Blue Shield dispute, which was about rates, I believe, about one facility. And they-- there was a removal of all of the, the hospitals, which removed the CHI system from the Blue Cross network. If, if, if there are cheaper and better alternatives available or hospitals available or facilities available, certainly our policyholders kind of demand that, that we, that we renegotiate that contract and provide, provide them with the best product at the cheapest price possible so that their premiums may go down or perhaps not go up as much as, as they would. I would also point out something that's in the legislation that was not mentioned earlier. It does have a private right of cause of action for a patient or a provider if they're, if they are removed from the in-network or from the network. And obviously, to be frank, you know, we don't, we don't want patients necessarily suing insurance companies because we removed a provider. We have contractual relationships both with the provider and our insurance, and these things are spelled out. Also, state insurance law spells out what happens when in-network or participating provider is removed from a network. There has to be notices that go out. If you were involved in-- or if you have private insurance, you've probably seen these notifications from your insurer before, that a doctor has been removed or a facility has been removed. Those are all spelled out in existing law currently. So for, for many reasons, the Nebraska Insurance Federation opposes the passage of LB1175, and I appreciate the opportunity to testify. Thank you.

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

ROBERT M. BELL: You're welcome.

WILLIAMS: Invite the next opponent. Seeing no one else, is there anyone here to testify in a neutral capacity? Seeing none, Senator Wayne waived closing, so that will close the public hearing on LB1175. We do have-- excuse me, clerk, we did have one letter as a proponent.

LINDSTROM: OK, we'll now open the hearing on LB943 introduced by Senator Bostar.

BOSTAR: Good afternoon, Vice Chair Lindstrom and fellow members of the Banking, Commerce and Insurance Committee. For the record, I'm Eliot Bostar, E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29. I'm here today to present LB943, a bill to prohibit certain provisions in a health plan related to the administration of medication by a clinician, a practice also known as white bagging. I introduce LB943 on behalf of the Nebraska Hospital Association, as well as the countless healthcare professionals that are concerned about this practice. Health insurance companies have adopted new policies that limit patient choice and reduce the timely access to care for critical specialty medications administered at Nebraska hospitals. This insurance practice, called white bagging, requires that certain medications be dispensed by a separate pharmacy outside of the hospital, often owned by the insurance company. Patients do not get to choose if their medications are white bagged, as this practice is wholly determined by a health insurance company. During this process, medications may be required to be dispensed by a distant pharmacy at a remote location from the hospital on a patient-by-patient basis. While some insurance cost-saving schemes can benefit consumers, the real-world impacts of white bagging can negatively impact hospitals, providers, and patients. White bagging has caused delays in patients getting their medications and has even resulted in hospitals being sent the wrong dose or the wrong medication. In some instances, hospitals don't receive the shipment on time, if ever, and are forced to cancel and reschedule patient procedures until the next dose arrives. This leaves many hospitals in Nebraska at risk of liability and costs associated with this process. White bagging can cause serious, potentially harmful disruptions to patient care. This disruption to care resulted in insurance companies making decisions that belong to doctors and their patients. Lawmakers in 11 states across the country have introduced bills that address white bagging. Three states: Louisiana, Arkansas, and Virginia passed legislation to end the practice. Nebraska should follow suit. With that, thank you for your time. Please support patient choice and advance LB943. Also, there are a number of individuals who are, I think, eager and excited to speak to the committee more about the specifics related to white bagging and, and talk about some of the

incidents that have been occurring that this legislation is trying to resolve. Thank you very much.

LINDSTROM: Thank you, Senator. Any questions from the committee? Seeing none, thank you. Have our first proponent. Good afternoon.

LORI MURANTE: Good afternoon. Good afternoon-- well, Chairman Williams, Vice Chairman Lindstrom and members of the Banking, Commerce and Insurance Committee. My name is Lori Murante, L-o-r-i M-u-r-a-n-t-e, and I'm the director of pharmacy and nutrition care at Nebraska Medicine and the Fred and Pamela Buffett Cancer Center. We're a nonprofit integrated healthcare system affiliated with UNMC. Our 1,000 providers perform over 1 million outpatient visits, administer over 122,000 IV medications in our infusion centers and over 50,000 medications in our clinics. Administering complex medication therapies in these settings and in our inpatient environment is a vital part of delivering healthcare to our patients. I'm here on behalf of our organization to testify in support of LB943. This important bill addresses payer-mandated models of prescription drug delivery, such as brown and white bagging that jeopardize optimal, timely, safe, and effective medication administration. You have a graphic depiction in your, in your materials there that shows the difference between white bagging and our normal procurement processes. As health systems, we are required by the drug safe-- the Drug Supply Chain Security Act, DSCSA, enacted by Congress in 2013 to protect patients from exposure to drugs that may be counterfeit, stolen, contaminated, or otherwise harmful. DSCSA requires that pharmacies and hospitals purchase medications from certified distributors, along with strict stipulations, validating procurement and chain of command. We are expected to be able to track a medication all the way from the manufacturer to the patient. Requiring a hospital or clinic to administer medications supplied outside of our normal supply chain should be considered a violation of that act. Brown and white bagging allows insurers, rather than healthcare providers, to mandate where, when, and how drugs are purchased, prepared, and administered to patients, often leading to weeks or month-long delays in patient care, unwelcome patient and family stress, erosion of the patient and provider relationships, and the potential for creating significant waste. Today, you will hear and receive written testimony from across Nebraska describing just such incidents. It's not uncommon that a patient's treatment may need to be altered on the day of administration for a variety of reasons. Normally, we can easily pivot for dosing or use of other medications already within our organizations. Current payer mandates require that we wait for new product to be shipped through an unapproved third party, resulting in

more delays, likely wasting of the original product, and increased stress and frustration for the patient and provider. These practices effectively tie the provider's hands when it, when it comes to providing care. You have a letter in front of you from doctors Julie Vose, Rana Zabad, and Susan Swindells, sharing examples of delays in care resulting from these practices. As noted, these payer-mandated practices interrupt our existing DSCSA compliant processes and require duplicate parallel processes for storage and also for tracking within the patient's healthcare record. Many of us can attest that this adds unnecessary overhead and personnel costs to a system that was designed to be safe, effective, and efficient. I can also tell you in layman's terms or in nonmedical terms, this is akin to me wanting to go down to Farmer Browns and order a steak and being unable to do so because I have to get it from a mail-order place in Wyoming. They send the steak to Farmer Browns, and he tells-- and tells them to keep it safe there for Lori Murante, for when I come in, in two weeks from Friday to get my steak and baked potato, and then it has to be cooked to perfection. And at the end of my meal, I'm only going to reimburse them for the baked potato. In summary, I would say that payer-mandated models jeopardize optimal, safe, and effective medication use. LB943 provides guidelines for payers while preserving patient choice. On behalf of Nebraska Medicine and the Fred and Pamela Buffett Cancer Center, I respectfully ask for your support of LB943 and request that the committee advance this important bill to General File. Thank you. I'm happy to answer any questions.

LINDSTROM: Thank you. Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom. The insurance companies would contend that we're going to end up with increased cost because of the change that, that you're advocating. Is that true?

LORI MURANTE: I don't believe it is. I'm not sure how they pass along their, their, their cost savings to their, to their insured or to their stockholders. I'll be honest with that. I don't know enough about that. What I can tell you is that my job and my organization is to be able to contract and negotiate for the lowest-priced medications possible. And we do that day in and day out. Furthermore, we, we work with our med-- our physicians to create what's called our drug list. Those drugs that are approved to be able to be given in our hospital and that helps streamline our formulary, is what we call that drug list, further controlling costs associated with medications. Overall in my organization, I'm held to keeping drug costs low.

McCOLLISTER: In those states that have approved this, this statute, is there any anecdotal information to show that costs have increased?

LORI MURANTE: I don't have that information, but I would be happy to look into that and provide it at a later date, if that's what you would like.

McCOLLISTER: Thank you.

LORI MURANTE: I can tell you that some states, it sounds-- 11 doesn't sound like that many states that are doing it because some states already had strong enough language in their Pharmacy Practice Act to allow-- to disallow the practice.

McCOLLISTER: Thank you.

LINDSTROM: Any other questions from the committee? Senator Flood.

FLOOD: Thank you for your testimony today. In your role at Nebraska Medicine, what do you do?

LORI MURANTE: I'm the director of pharmacy.

FLOOD: OK.

LORI MURANTE: So I'm responsible for the overall procurement systems, the overall storage. I'm responsible for everything from when the drug comes into my hospital to when it's given to a patient. I have to--

FLOOD: Are you responsible for the patient's bill for what they're charged for the drug that's administered?

LORI MURANTE: Well, there's, there's two different ways to handle that.

FLOOD: But no, no, no, is that--

LORI MURANTE: No.

FLOOD: --so that's not your responsibility?

LORI MURANTE: No, it's not.

FLOOD: So do you regularly review the profit and loss statements of the hospital?

LORI MURANTE: I, I have some oversight to that, but not a lot of detail.

FLOOD: OK. Are you familiar with what the markup may be on these?

LORI MURANTE: We have formulas that we use for the markup.

FLOOD: So you are responsible for pricing as to the patient.

LORI MURANTE: To a certain extent. It is-- it's a, it's a combined decision-making process. But there are formulas that are used to, to calculate that.

FLOOD: So I think what Senator McCollister was asking you, and, and, and I-- anytime we see two very powerful institutions fighting each other in the Legislature, it's usually about money. And so my question for you is, are you confident in your testimony that says, we, you know, this is not a money issue for the hospital. This is not a profit motive. This isn't, this isn't about a margin. This is about patient care. Is this 100 percent patient care or is this 50 percent patient care, 50 percent margin?

LORI MURANTE: This is-- my-- from my perspective, this is 100 percent about patient care. This is about me knowing exactly what we are putting into the veins of those patients. I have to be able to track that all the way through the system.

FLOOD: OK. And I, and I appreciate that and I think patients appreciate that. I think the burden for the proponents of this legislation is to make a case that, that isn't rooted in financial gain, but patient care. And I-- I'll look forward to hearing the testimony that follows you to see if it goes that vain because my-- I suspect a lot of this has to do with, with money, and I'm not saying one side should make money or one side shouldn't make money. But that's been my experience as a member of the Legislature. So thank you very much for your testimony.

LORI MURANTE: Appreciate your comments, Senator.

LINDSTROM: Any other questions? Seeing none, thank you.

LORI MURANTE: Thank you.

LINDSTROM: Next proponent. Good afternoon, how are you?

ELIZABETH BOALS-SHIVELY: Good afternoon. Members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in favor of LB943. My name is Elizabeth Boals-Shively, E-l-i-z-a-b-e-t-h B-o-a-l-s S-h-i-v-e-l-y. I'm the pharmacist in charge at Henderson Health Care Services. Henderson Health Care Services is a 13-bed critical access hospital that's associated with two rural health clinics and a 40-bed long-term care facility. Our health system also contracts with several specialty providers that provide care to our patients on a regular basis. I have been practicing as a critical access hospital pharmacist for the past ten years. During this period, the number of patients needing outpatient services, including infusions and injections, has grown significantly. Prior to COVID-19, outpatient services from 2016 to 2018 grew at my facility by almost 10 percent, and the trend seems to be continuing. LB943 is key legislation to preserving access to outpatient medications for my patients. LB943 will ensure that patients are able to receive the right medication at the right dose at the right time. The medications being addressed in LB943 are often very expensive. Our health system has a patient receiving a medication once a month to manage his cancer. One year of therapy, 12 doses, equates to almost 40 percent of my entire drug budget for the hospital. If white bagging would be required for that patient, the patient's treatment would have to be delayed when, when the designated specialty pharmacy shifts an incorrect dose, or when the medication doesn't arrive on time for a variety of reasons. LB943 guarantees that I can buy and stock medications and get reimbursed when they are administered. Perhaps the most important thing that LB943 does is guarantee access to care for my patients. Many critical access hospital patients have to travel 15 miles or more to reach care. Then additional restrictions or incentives by their insurance may require them to drive an additional 50 to 100 miles to receive a medication that they could have gotten closer to home. Other patients are being required to use home infusion services. My colleagues in areas with colleges are reporting that their college students are being required to coordinate times with home infusion service to get their infusion in their dorm room. LB943 means that patients can receive their injections and infusions when and where it is most accessible to them. Thank you for your time today. As an advocate for access to high-quality healthcare, I encourage this committee to advance LB943 to the General File for full consideration by the Legislature.

LINDSTROM: Thank you. Any questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom. And thank you for being here. How often does it occur that the drug sent down from the drug company is wrong or needs to be changed?

ELIZABETH BOALS-SHIVELY: I think that depends on the volume. If you're looking for a percentage of the time, my volume is so small that it could be 50 percent of the time. I might have one to three to five patients. In larger facilities, they would have to answer that question for you.

McCOLLISTER: So I, I don't want to ask you your volumes, but so they sometimes send the wrong formulary or is it necessary to change it because of the patient's condition had changed?

ELIZABETH BOALS-SHIVELY: It comes from a variety of reasons. Sometimes the actual drug is changed and that drug change didn't occur at the specialty pharmacy. They didn't process that change for some reason. So sometimes it's the completely wrong drug. Other times, it might be the wrong dose. A lot of these medications are weight-based, and especially when you're talking about kids and pediatrics, they tend to grow. And so then that dose change doesn't happen at the pharmacy because they're not weighing the patient. Other examples that I can think of is just that it doesn't show up at all because it got-- the address for my facility is the long-term care at the clinic and the hospital all have the same address, so the drug got shipped to the long-term care facility instead of coming into my hospital because of the address that is the same. So we work really hard to go and find those drugs when we know they're coming. But things like that do happen as of course of business process.

McCOLLISTER: Just so I understand the process, the, the doctor orders the drug, correct?

ELIZABETH BOALS-SHIVELY: Correct.

McCOLLISTER: And, and then he submits the order to the pharm--

ELIZABETH BOALS-SHIVELY: Yeah.

McCOLLISTER: --the drug company?

ELIZABETH BOALS-SHIVELY: Yep, to the-- and specialty and a pharmacy. That specialty pharmacy then ships the drug to me in my facility. Now there are several places where that communication can break down. One, the physician sends the order and the order isn't, isn't received or isn't processed. Maybe it's not proc-- they sent it on Tuesday, and

they're shipping the drug on Wednesday, so they don't process it in time. Things like that happen, you know, on a regular basis.

McCOLLISTER: From the time the doctor orders the drug until the time you receive the drug, how long is that typically?

ELIZABETH BOALS-SHIVELY: I wouldn't be confident answering that with my volumes. The patients that I've done, usually from the order to when I get it, if it's-- usually takes at least a week.

McCOLLISTER: A week?

ELIZABETH BOALS-SHIVELY: Yeah, to make sure that all the checks and-- are done appropriately. But by the time the doctor sends it to the time it reaches my door, I would say a week, usually, for a brand new patient.

McCOLLISTER: So you don't have an inventory of these drugs that you typically buy from the drug companies?

ELIZABETH BOALS-SHIVELY: As a critical access hospital, I can't afford to keep extra drug on hand. And even if I did have extra drug on hand, I can't administer it because I wouldn't get reimbursed for it.

McCOLLISTER: So it's patient specific, you don't have an inventory?

ELIZABETH BOALS-SHIVELY: Yes,--

McCOLLISTER: I understand.

ELIZABETH BOALS-SHIVELY: --very patient specific. Yes.

McCOLLISTER: Thank you for your testimony.

LINDSTROM: Any other questions from the committee? Seeing none, thank you. Next proponent.

KORBY GILBERTSON: Good afternoon, Vice Chair Lindstrom, members of the committee. For the record, my name is Korby Gilbertson, it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n, appearing today as a registered lobbyist on behalf of Boys Town National Research Hospital in support of LB943. Andrew Raduechel, which for the transcribers is R-a-d-u-e-c-h-e-l, intended to be here today. He's the director of pharmacy at Boys Town, but he found out late yesterday afternoon that he was going to have to be quarantined today. So you're stuck with me. Boys Town National Research Hospital operates a hospital on the Boys

Town campus and includes pediatric inpatient hospitalization, surgical services, and inpatient and residential care for children and adolescents with severe behavioral health disorders. Our medical clinics include primary pediatric care with five Boys Town pediatric locations in Omaha area and specialty, specialty care clinics for link-- for children and adults across Nebraska, Iowa, and South Dakota. Boys Town supports LB943 and you've heard many of the reasons already, but, Senator Flood, to go directly to your question, in this incident it's specifically about patient care, and I'll tell you one story that I think will make, make sense to you. Recently, they had a delivery made by the U.S. Postal Service, delivered to the wrong building and left on a dock. They did not receive notice that there was a delivery made. By the time it was found, they had to just destroy all the medication. So that, in turn, affected their ability to then treat numerous patients. So that kind of goes in the same vein of what the other proponents talked about, that there are issues with shipping, it being logistically being able to receive the drugs. There are also instances of wrong doses, things like that, and then specifically to Senator McCollister's question. There was a, a specific example of a patient that needed an infusion regularly, and they come-- they came to the clinic. The dosage was wrong, so they ended up using some of the biologic that they had in their own pharmacy stash and-- or shouldn't say stash-- inventory, and because they used their own inventory in that instance, the insurance company that they were dealing with for that patient would not reimburse them. So they were forced to change their policy so that they would no longer do that. So since then, there have been numerous instances where patients have shown up for treatment and then they were-- had to be turned away for the treatment because either the shipment was not there, the dosage was incorrect, or the medication was incorrect. So these issues and the issues that they wanted to make sure you knew were specifically about patient care, more so about logistics and making sure that those patients get the appropriate medications that they're supposed to be getting. I realize that you'll-- you're already aware of the opposition testimony you will hear, and I think there's validity in that as well. But I think back to the Pharmacy Benefit Manager bill that has took years to go through, and I hope Senator Bostar will bring all of the stakeholders together to continue to discuss this because obviously there are issues with patient care that need to be addressed. With that, I'd be happy to answer any questions.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you.

KORBY GILBERTSON: Thank you.

LINDSTROM: Next proponent.

JEROME WOHLEB: Good afternoon, Vice Chairman Lindstrom and senators. My name is Jerome Wohleb. I am the pharmacy director at Bryan Health Medical Center. And my name is J-e-r-o-m-e W-o-h-l-e-b. I've been a practicing pharmacist for 42 years and 11 years at Bryan as the pharmacy director. Bryan represents communities across the state of Nebraska, critical access hospitals, and the large hospital here in town, and we service inpatients for pediatrics, infants, adults, geriatrics, surgical, oncology, and other center of excellence. And we provide, hopefully, the quality of care that you have grown to expect across our great Nebraska. Insurance companies' white bagging practices compromises our ability to do so, and you've heard other testifiers witness that by telling providers how and what medications they can order and where the patients can receive that care. Our patients deserve a safer alternative than what's being mandated by insurance companies and PBMs. Access to lifesaving medications are in the balance of this discussion today. One of the issues with white bagging is the disruption of the medication distribution process for the patients. Normal distribution is for the medication to come via the distributor to a courier to the hospital allowing the medical center to have control over the medication once it's received to ensure high-quality delivery of that product. White bagging intervenes with this process and having medication distributed by a third-party pharmacy and/or insurance companies' vendor of choice. Waiting on the supply chain resulting in delays in care is a concern these days, you see it in the news. It's also present here. However, if a provider chooses to order the medications onsite to avoid the delay, the insurance company will not reimburse that provider or hospital to do so. That is called white bagging, and that's the problem. Can you imagine coming to your provider or hospital expecting to receive your cancer treatment and then find out the insurance company sent the wrong dose, the product delayed or worse, wasted due to shipping errors? Who carries the burden for this? The patients do. This practice may require them to drive a significant period of time to meet their insurance carriers' needs. In summary, Vizient, our group purchasing organization, has done a review. To Senator McCollister's question, how often does this happen? They looked at 142 responses and 92 percent of them had delays for care. So it's a concern not just here at Bryan, but across Nebraska. Who else shares this burden? The patient does. Synagis is a medication that we use for infants to prevent serious infection. Currently, 28 patients receive white bagging patients-- white bagging medications for their-- for these patients. Unfortunately, we're the only place in Lincoln that provides

that service. The question is why? No other agency will do this, and we think it's a patient-care issue, so we do it. Who else shares the burden? Our providers. Our providers, and I gave a copy of the Cancer Partners of America [SIC] testimony of ten physicians indicating that they do not have the insurance coverage needs to cover the medications. And so their ability to take, take care of patients in the environment best suited for care doesn't necessarily happen. And finally, our hospitals, they carry the burden. Again, you've heard testimony about why that's important. In conclusion, safe, quality patient care and access to treatment are significant impacts that the insurance companies are forcing via white bagging. It's in our best interest to allow local providers and hospitals to continue servicing our own patients. LB943 protects the many sick children and adults from insurance practices that disrupt important life-saving therapies. I ask for your support of LB943. If you have questions, I'm happy to answer those.

LINDSTROM: Thank you. Any questions from the committee? Seeing none, thank you. Next proponent.

MELVIN CHURCHILL: Thank you for letting me come and talk with you, gentlemen and ladies, about my role in medical care. My name is Dr. Melvin Churchill. I'm a native Nebraskan, grew up in Seward, did all the-- a lot of my training in Nebraska as well at the Mayo Clinic. My name is spelled M-e-l-v-i-n C-h-u-r-c-h-i-l-l. I'm here to testify in support of LB943 on behalf of Nebraska Medical Association, as well as Nebraska Rheumatology Society. I'm an active rheumatologist, having practiced in Lincoln since 1980. The Arthritis Center of Nebraska was-- has been in existence for that entire period of time. We care for patients with autoimmune disorders, including rheumatoid arthritis, lupus, gouty arthritis, spondylitis, psoriatic arthritis, and others. Over the past two to three decades, we've seen a renaissance in the management and treatment of rheumatic diseases. We now have biologicals that are available that allow us to literally stop these diseases in their tracks if are used appropriately and early in the course of their treatment. We improve the quality of life, their comfort, of course. Reduction in the mortality rate has actually been proven to happen with proper treatment. There are mortality rates associated with rheumatic diseases. In my capacity as director of clinical research, I've had firsthand involvement in development of these agents. We've had remarkable success. These are phenomenally better than what we had in the past. In the old days, we had aspirin, gold shots, and lots of prayers, none of which worked very well. We can now protect these patients from disability, loss of function, reduce their joint damage, and reduce their-- and maintain

their-- and, and not to reduce their life expectancy as a cause associated with these illnesses. During this time, it's been clear that our infusion center, which we developed in our office many years ago, has provided profound continuity of care. And that's a key word, continuity. We have direct supervision within our office, literally a few feet from my examination rooms where I can supervise everything that's done. We can monitor them very successfully. We have clinical staff and nurses trained-- who have been trained to do this and they do a great job. Given the fact that we're able to order these drugs directly, we have complete control over their chain of custody. We're able to provide these agents knowing full well they've been handled appropriately and come from, from reliable sources. We have days when patients need to reschedule. Having our own source of these supplies allows us flexibility to change the schedule and allow the patients to be seen when they're well. Lots of things change their schedules, just like you and I, people get sick, people have family issues, things that delay their treatments, occasionally. It's very important, however, that these drugs be delivered timely and on time. They do improve their patients' quality of life and we're able to control their disease. These inflammatory diseases increase the risk of cardiovascular events, and so by controlling this disease, we reduce their risk of early death. We presently provide approximately 150 fusions per week. We have these products-- if these products were delivered individually would be a nightmare for our staff to try to keep them, keep them straight. If they're not there on time, the dosage isn't correct, it would be a really incredible disaster for us. The drugs are designated for a given individual and if they weren't there, we can't give it to someone else. It's like a prescription you pick up at your pharmacy. They can't take it back. You're stuck with it, whether it's right or wrong. In summary, we provide increased access in a very comfortable environment. With staff, these patients are rec-- recognized as their caretakers day in and day out, month after month. And we service not only just southeast Nebraska, but Greater Nebraska. Some patients come from many miles because they're comfortable in the setting. At the same time they're there, they can see the, the rheumatologist they have and one of the providers in our clinic. We have to make these clinical decisions quickly and promptly on a daily basis, and changes are constantly happening. Every day, infusion nurses interrupt my day, thankfully, to ask me appropriate questions. This patient has a problem, what should we do? We have to change the dosage, change the treatment date, delay it. Patients have emergencies, they have surgery. There, again, all sorts of things can delay treatments. So we have to make these timely decisions quickly and efficiently. It would be almost impossible if they weren't

underneath my roof. I couldn't do it otherwise. Unfortunately, practices addressed in this bill by insurers and PBMs threaten this type of care in my opinion, personal opinion. For these reasons, we ask the committee to support and advance this bill, LB943. I thank you for your time. It was my pleasure to be here.

LINDSTROM: Thank you. Thank you for coming. Senator McCollister.

McCOLLISTER: Yeah, thank you, Senator Lindstrom. Thank you for your testimony. When a drug company sends the wrong product, the wrong drug, sends it to the wrong address or the patients' needs change, what recourse do you have with the drug company?

MELVIN CHURCHILL: Well, I think my business manager would probably have better answers than I have for that, but it's, it's a disaster. If we get drugs that aren't appropriate, we can be stuck with them. Once in a while with our personal relationship with these wholesalers, we're able to sometimes exchange them, but it's really, really difficult to get that done. It just doesn't happen. I can certainly provide you with some, with some additional answers to your questions if you like. My business manager is sitting in the back room-- back of the room, and she probably has a quicker, more appropriate answer than I do.

McCOLLISTER: Thank you, Doctor.

LINDSTROM: Any other questions from the committee? Seeing none, thank you.

MELVIN CHURCHILL: Thank you, Senator.

LINDSTROM: Next proponent.

MANDY OGLESBY: Senators and members of the committee, my name is Mandy Oglesby, M-a-n-d-y O-g-l-e-s-b-y. I have been a registered nurse for almost 22 years and fortunate enough to have spent the last 19 years in rheumatology at the Arthritis Center of Nebraska as an infusion nurse. I'm here to testify in support of LB943. It is extremely important that we continue to have access to our medications that we provide to our patients in our office. We need to be able to adjust a dose of the patient's medication on the same day of an infusion and be able to have our own supply of drug available to use. This is needed if the patient is not doing well, otherwise, we would only have drugs available for that specific patient, which would create unnecessary waste. This would be very costly for everyone involved. Having our own supply of drug that we order ourselves allows us to have full control

of purchasing from one supplier. This ensures that patient-- that the drug is safe for the patient because we know it has been handled and stored properly at the correct temperatures. By ordering drug in bulk, this ensures that the patient's drug is here on time for their appointment, as many of our patients come from all over the Midwest to receive care in our office. If we would have to order a drug by requirement of the insurer or PBM for each of our approximately 4,000 infusion patients by who mostly are infused monthly, it would be a logistical nightmare. We would have to keep track of over 150 patients weekly to ensure that the drug is here on time, calling each patient's individual pharmacy, tracking and logging each patient's drug. This would take valuable time away from monitoring and caring for our patients. Our office would not have the staff or the extra time it would take and would be very costly. In fact, it would be devastating-- a devastating increase in administrative burden. I have experienced on a smaller scale what this practice would look, look like asked-- being asked of us, having just a few patients utilize free drug assistance programs. I have had to monitor and keep track of their individual drug for each monthly appointment. More times than not, I've had to make several additional phone calls per patient after already having completed and faxed forms to follow up as to why shipments have not been received for patients' scheduled appointments. This is very time consuming with just a few patients, and I can't imagine the amount of time this would involve with 4,000. Time taken away from patient care, which is always our number one priority. We need to be free to assess our patients to make sure that they can receive these complex drugs. If they receive one of our drugs, when they have an infection, illness, surgery, or other unexpected problem, it could be deadly. We need to be free to monitor our patients constantly during an infusion as they could have severe reactions at any time. That could also be deadly if not caught and treated immediately. I have heard from patients that have received infusions administered in other settings. They report to us that they are frustrated because they have received larger bills, significantly more than when receiving an infusion in our office. Patients also report it takes roughly twice as much time out of their day to be infused elsewhere. They are also not being monitored by specialized nurses who are trained to monitor patients receiving biologic therapies that could have a potential life-threatening reaction at a moment's notice. We also have direct access to our providers who are close by for any emergencies or questions that may arise during the infusions. As you can see, it is safer and more cost effective to allow us to continue the current process that we have in place. Therefore, it is essential that these practices by insurers and PBMs be limited so that the focus

remains on the care of the patient. I ask you this, if I were taking care of your family member, would you want me to be monitoring them or making unnecessary phone calls and filling out unnecessary forms trying to get drug into our office for the next week's patients? For these reasons, I ask that you support and advance LB943. Thank you for your time.

LINDSTROM: Thank you. Any questions? Senator Flood.

FLOOD: Just a logistical question. Well, maybe just a broad question first. What is more concerning to you, is it the having these patients go to a specialized infusion center in the PBM network or is it having the insurance companies' pharmacy, for lack of a better word, send the prepackaged dosage for, you know, send two IVs for each patient. Which of those two is a bigger deal?

MANDY OGLESBY: Well, we don't want to have insurance companies involved in just sending prepackaged drugs because there are so many instances where that drug, like everybody else has said, that it can come and it's not-- it has to be refrigerated between two and eight degrees Celsius. How do we know that that drug's been kept in that time that--

FLOOD: So just logistically, and I'm not very familiar with what you do for a living, if, if you have drug ABC, do you buy it in bulk from your supplier and then you take the appropriate dosage out versus a patient that has the, the white bagging going on, each individual dose is already sent?

MANDY OGLESBY: What we do in our practice is we order a drug for a week at a time--

FLOOD: OK.

MANDY OGLESBY: --so that we have it--

FLOOD: For all patients?

MANDY OGLESBY: --for all patients. So that we have it available. So that we can make those necessary changes or we can use it for somebody else if that patient is unable to get it because they have surgery or they're sick, and it's a lot easier to manage. It's individual.

FLOOD: So if Mr. Smith has a prescription and it comes in for Mr. Smith and it's prepackaged and let's say he doesn't show up for his

appointment, can you use that dosage for anybody else or is it then discarded?

MANDY OGLESBY: That would be his drug only.

FLOOD: So it's not--

MANDY OGLESBY: We would not be able to use it for anybody else.

FLOOD: So what do you do then, you throw it out?

MANDY OGLESBY: It's-- we could keep it, if he'd come back another time, maybe we could give it.

FLOOD: But it's only for him?

MANDY OGLESBY: But it's only for him. So we would have to keep track of each individual's drug in our refrigerator and find that drug when they arrive. And we have 150 infusions a week. That's a lot of drug to manage for each patient.

FLOOD: What, what would be an infusion for at your place? What would you be--

MANDY OGLESBY: What do we infuse? We infuse over 12 different things for rheumatoid arthritis, gout,--

FLOOD: Like pain.

MANDY OGLESBY: --lupus,--

FLOOD: OK.

MANDY OGLESBY: --pain and swelling.

FLOOD: Thank you. Thanks--

MANDY OGLESBY: Yeah.

FLOOD: --for your testimony.

MANDY OGLESBY: Yes, thank you.

WILLIAMS: Any additional ques--

MANDY OGLESBY: Oh, I'm sorry.

WILLIAMS: Senator McCollister.

McCOLLISTER: Sorry.

MANDY OGLESBY: That's OK.

McCOLLISTER: If we outlaw this practice, will consumers see a savings?

MANDY OGLESBY: I think they would because we are in control of the drug. There would be less waste. There would be-- we would be in control of the drug, which would help lower costs for patients.

McCOLLISTER: Thank you so much--

MANDY OGLESBY: Um-hum. Thank you.

McCOLLISTER: --for your testimony.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony. Invite the next proponent. Any additional people to speak in support? If not, we'll invite the first opponent. Good afternoon.

DAVID ROOT: Good afternoon. My name's David Root with Prime Therapeutics, that's D-a-v-i-d R-o-o-t. Thank you very much for letting us be here this afternoon. It's my, my second time this year back in, in this-- in front of this committee. I want to go over a couple of things that's sort of difficult places to start, but I think-- let's focus on, on the legislation and go over a couple of items that we've heard that are identified in this as well. This ban-- this bill bans an insurer or employer benefit choice that is used when it's the right situation for the, for the care that is needed. Couple of important words, this bill bans that choice. This bill's objective is to create a mandated, anti-competitive, high-cost clinician administered drug market. That's what its purpose is. We just heard a moment ago a, a, a question of where, you know, if this bill passes, will the consumer save? No. The consumer will not save. The markup for our book of business that we see in this state is the minimal markup for these products at the buy-and-bill stage is 38 percent. These drugs are incredibly expensive. We're talking, you know, hundreds of thousands of dollars in many cases, anywhere from $65,000 up to, you know, sometimes a million dollars, a little bit less. Very expensive products. The idea that we as PBMs are going to simply waste that spend, frankly is, is insane. Couple of things to address. We use nationally accredited specialty pharmacies, whether the PBM owns that accredited pharmacy, or in my case, we don't own a pharmacy, but we use nationally accredited specialty pharmacies to deliver these products. This very body had conversations, extensive conversations two weeks ago around the necessity and importance of that

accreditation. We are not reaching into some bag behind a counter, giving away whatever drug we happened to pull out of, out of that bag. These pharmacies are subject to the same federal supply chain requirements that you heard about previously today as the pharmacies that were up here testifying. The DSCSA, or the Drug Supply Chain Security Act, hospitals are administers of the product. They're not dispensers. They have an exception from the ped-- the drug pedigree, pedigree issues in the Supply Chain Act. Even still through white bagging, that pedigree is available if the hospital so chooses that they want to see that pedigree. And that pedigree is the drug as it travels through the supply chain. When a pharmacy sends that product, it is the same product that is then that would be purchased through a buy-and-bill. It is the same product from the same wholesaler. It is the same drug. And in many cases, in a rural, in a rural area like Kansas, in a rural state like Kansas, it is even delivered under the same common carrier, with the same driver going to the same place. The idea that we've heard today that a facility will receive a product and not know what to do with it or how to catalog it, they're receiving that product every day from their-- from the wholesaler that they are buying it from. They're receiving that product every day. It's the same product only this product has Mrs. Jones's name on it. They're all already, when they receive their buy-and-bill products, they are already keeping track of-- having to keep track of who's going to get what doses, when and how. Those shipments are carefully orchestrated. These therapies are done through the administration of therapy, the protocol of that therapy. You don't wake up tomorrow and say you have RA and show up at a doctor's office to get treated. You've gone through a regiment to determine what kind of RA you have and what the best treatment is and what the best drugs are. That process takes weeks to months. Once that-- and part of that process is understanding what your insurance requirements are, what the drug-- what drugs are covered under your insurance, and what sites of care are the best places for you to receive that. And again, these products, every instance of people needing these infusions is not a white bagged instance. It is when it is the best appropriate care for the best cost for both the patient and the payer of the benefit. As I said before, these are expensive treatments. You are not showing up for these products, it is, it is a-- you are in a course of treatment following protocols, our pharmacies reach out to the consumers and the doctors making sure that everyone is scheduled. And if there are delays because the patient is sick, then the medicine is withheld until the time is scheduled to be there. Are there delays? There quite possibly could be because of a shortage of a supply. The hospital or the clinic may experience that same delay. The only difference is in that

situation, they reach out to the consumer and they say, don't come in today, come in on Friday. That doesn't get categorized as a delay, but it's still a delay.

WILLIAMS: Mr. Root, your, your red is on.

DAVID ROOT: Yes.

WILLIAMS: Thank you.

DAVID ROOT: Thank you.

WILLIAMS: Are there questions? Senator Pahls.

PAHLS: You know, after listening to what you're saying, the people before you must have been a group of liars or not understanding their job. That's how I'm interpreting what you're telling me is they're, they're incompetent.

DAVID ROOT: Committee, Mr. Chairman, I'm not saying that they're incompetent by any stretch. What I am referring to is the fact that we are addressing a sizable revenue stream for all of the people that have spoken today prior to myself. As I said, our experience in our book of business, the markup is-- starts at 38 percent for these products. They're--

PAHLS: Have you ever worked in a clinic or a hospital?

DAVID ROOT: No, I have not.

PAHLS: So you probably don't know what they're experiencing, whether it's right or wrong. It seems to me that you-- I, I just-- two different worlds I've listened to.

DAVID ROOT: Um-hum.

PAHLS: I'm trying to figure out which world is the direction I should go in.

DAVID ROOT: I would agree with that. I think that it is important to figure that out. I would point to the bill and say that this bill makes absolutely no attempt to figure that out. This bill is an outright prohibition.

PAHLS: Yeah, I've, I've read--

DAVID ROOT: Which to me begs the question, what are we protecting? There's nothing in this bill that addresses patient safety. There is everything in here that addresses how the facility is reimbursed and how much.

PAHLS: Thank you. I'll, I'll, I'll listen to other opponents. Thank you.

WILLIAMS: Additional questions? Senator Flood.

FLOOD: Thank you, Chairman Williams. Thank you for your testimony. You know, it's a pretty high bar for this committee to involve itself in contractual disputes, you know, between payers in a health insurance situation. But this committee has already voted once this year because we found that the behavior of PBMs has violated some of the trust of Nebraskans. That said, how do you respond to the questions or to the concerns raised by pharmacy folks from across Nebraska about the delay in care jeopardizing patient care and not getting drugs to the places on time or sending it to the wrong address. What is your response to that?

DAVID ROOT: Mr. Chairman, members of the committee, my response to that is that, as I said before, our pharmacies are accredited, they're nationally accredited by national accrediting organizations. Our standard of delivery is 24 hours. In new therapies, in other words, a patient that is new to the therapy, that, that period of time may be two to three days. That is an acceptable period of time under those standards. I would say that we are not in the business, nor is it in our-- the insurers', the health employers' best interest to have us be in the business of delaying anyone's therapy. Delayed therapy causes additional problems. Additional problems require additional hospitalizations. Our goal is to see to it that you get the best quality care at the best sustainable price. This is a mechanism to do that that fits some situations. It does not fit all situations. As I said before, every one of these in-- every instance of infusion is not a white bagging situation.

FLOOD: So one last question then I'll be done. Your-- you basically said that the markups start at 38 percent. So in this white bagging effort that PBMs are engaged in or, you know, a third-party pharmacy, what are some of the examples of cost that you've seen passed on to the patient via their health insurer? Is there been anything egregious that you've seen from the behavior of these hospital pharmacies?

DAVID ROOT: I'm not sure I understand it.

FLOOD: Well, you said 38 percent markup. That's where the markup starts. You've seen 50 percent markup, 75 percent markup.

DAVID ROOT: Yes.

FLOOD: OK, so let's say the drug costs the wholesaler a thousand bucks and then you mark it up. The, the third-party pharmacy marks it up, and maybe not you, but are you saying that hospitals are marking that $1,000 drug up to $1,750 and selling it or delivering it to the patient? Like, what kind of markups are egregious?

DAVID ROOT: Well, the, the, the hospital facility is protecting that revenue stream. There is no markup from the third party. When the, when the drug is white bagged, that's an, that's an agreed to negotiated price that's already understood before there's even a script that that's what the pharmacy will be when the pharmacy-- when the claim sits against the, the, the drug benefit. So there's no markup on that side, it's an agreed to price.

FLOOD: So the PBM doesn't bill any--

DAVID ROOT: No.

FLOOD: --margin into that.

DAVID ROOT: No.

FLOOD: It's clearly a pass-through.

DAVID ROOT: That's correct.

FLOOD: Now that is hard to understand, because I-- our experience has been that PBMs have been writing that margin somewhere in there. And you're saying there is no margin that the hospital would add a markup and that-- that's your financial benefit is that you get drugs cheaper for your patients [INAUDIBLE].

DAVID ROOT: That's correct. That's correct because we've negotiated the price of those drugs before the first script comes into play because the drug's on a formulary. So, you know, and we can talk later, if you'd like about the alleged markup that you talk about with respect to the PBMs, that that's not relevant to the situation. And I would argue, as I did two weeks ago, doesn't actually take place.

FLOOD: There's a lot of money in play.

DAVID ROOT: Hundreds of millions of dollars.

FLOOD: And so I'm just trying to figure out where the money's going. And, and, and right now you're saying that the hospitals are marking this up so much that it's forced health insurers to find a cheaper path?

DAVID ROOT: That's correct.

FLOOD: Thank you.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. Thank you for being here. The channel of distribution seems awfully strange. Why can't hospitals order in bulk like they do other drugs?

DAVID ROOT: Typically, these drugs are very-- have very particular care instructions. They have to be kept frozen. Some of them have to be warmed up, whatever the case may be. And so you don't stockpile these products, it's-- that would, that would truly be wasteful.

McCOLLISTER: So I'm sure they, they take similar care to other drugs that they currently dispense. Why would this be different?

DAVID ROOT: I'm not sure I understand the question.

McCOLLISTER: You're contending that every patient is specific and they send the drug to the hospital when the doctor orders it. And we've heard from some of the proponents that they would rather order in bulk because many of their patients take the same drug. Why wouldn't that be more efficient?

DAVID ROOT: Well, in some cases, and, and perhaps in an RA case where you're on a maintenance dose. But again, there you're on a maintenance dose, so your dose isn't changing, it's a maintenance dose. So the, the-- there shouldn't be a problem if the health benefit require-- or if the health benefit has a white bagging component and it ends up being cheaper for both the consumer and, and the, the employer group paying for the benefit, there shouldn't be a problem with that. What, what's-- then why-- I would turn the question upside down and I would say why, why can't the white bagging take place if it's cheaper for the employer group and the patient?

McCOLLISTER: Well, I'm not sure it is, but thanks for the answer.

FLOOD: I have one more question.

WILLIAMS: Senator Flood.

FLOOD: All right, just trying to probe and understand this. Who-- so you work for Prime Therapeutics?

DAVID ROOT: Yes, sir.

FLOOD: And who owns that?

DAVID ROOT: We are owned by 22-- the 22 not-for-profit Blue's plans, of which Nebraska is one.

FLOOD: So you're kind of a PBM.

DAVID ROOT: No, we are a PBM.

FLOOD: OK, you are a PBM.

DAVID ROOT: We are the only stand-- arguably, we are the only stand-alone PBM left. The other ones have become fully vertically integrated with their health plans.

FLOOD: OK. I think-- and so you're wholly owned by those 22.

DAVID ROOT: Yes, we-- that is, that is correct. We're not, we are not a for-profit organization. We are not publicly traded in any capacity or anything like that.

FLOOD: Thank you.

WILLIAMS: Any final questions? Seeing none, thank you, Mr. Root.

DAVID ROOT: Thank you.

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

MICHELLE MACK: Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Michelle Mack, M-i-c-h-e-l-l-e M-a-c-k, and I'm a senior director, state affairs at the Pharmaceutical Care Management Association, also known as PCMA. PCMA is the national trade association representing America's Pharmacy Benefit Managers, or PBMs, which administer prescription drugs for more than 270 million Americans. Thank you for the opportunity to provide testimony to LB943, a bill which would prohibit plans from the specialty drug delivery practice known as white bagging. PCMA

respectfully opposes LB943. PBMs and their health plan, and employer clients use specialty pharmacies to deliver high-quality, accessible pharmacy services while promoting product affordability. Flexibility to continue contracting with these select pharmacies is the key to ensuring access and promoting affordability in Nebraska. When an employer or health plan decides to contract with a PBM to administer the pharmacy benefit, they maintain authority over the terms in the benefit plan design, including how drugs should be obtained by or delivered to beneficiaries. The employer or plan, not the PBM, makes decisions regarding cost-sharing requirements, formularies, and networks, including the use of mail delivery or of a drug to a patient or provider. While the vast majority of prescriptions do not require special handling or packaging for those that do, mail service pharmacies use U.S. Pharmacopeia guidelines to determine handling needs and leverage proprietary software to map out the ideal packing-- packaging journey, which accounts for the acceptable temperature range, forecasted weather conditions, and destination temperatures. Specialty prescription drugs, including injectable drugs with special handling requirements, are usually shipped through commercial mail and shipping carriers such as UPS and Federal Express. Specialty drugs requiring refrigeration are typically shipped for overnight delivery, often through common carriers other than the United States Postal Service. The safety and efficacy of mailed prescriptions is of the utmost importance and is well-reflected in the level of precision and planning undertaking by those mail service pharmacies in the mailing of the prescription drugs, including those with special handling requirements. The precision also reflects the needs and preferences of consumers not only for safe, high-quality products, but also to know when their prescription-- prescriptions will be shipped and received. For example, as required by CMS, Medicare Part D plan sponsors require their network mail service pharmacies to provide enrollees an approximate shipping date range of within two to three days prior to delivery. Mail service pharmacies offer enhanced safeguards for safety and accuracy. Specialty pharmacies and mail delivery are tools used in pharmacy networks because they ensure high-quality drug service, avoid waste, and ensure appropriate use of the medications. In limiting a plan's sponsors' choices to allow white bagging, this bill will substantially increase costs for Nebraska consumers and plan sponsors. As a matter of fact, our research shows that in the first year alone, restricting white bagging will cost Nebraskans $59 million in excess drug spending and $733 million over the next ten years. It is for these reasons we respectfully request that you oppose LB943. Thank you, and I appreciate your time and attention to our concerns and am available for questions.

WILLIAMS: Are there questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. What documentation can you give us on the numbers you just cited?

MICHELLE MACK: I have-- Chair, Senator McCollister, I have a, a one-page document that I can share with the committee.

McCOLLISTER: That'd be great.

MICHELLE MACK: And it has-- it was PCMA research and it has the-- all of the formulas and everything as to how we came up with those numbers.

McCOLLISTER: That'd be great. Thank you.

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

MICHELLE MACK: Thank you.

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

JEREMIAH BLAKE: Good afternoon again, Chairman Williams and members of the Banking, Commerce and Insurance Committee. For the record, my name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B as in boy -l-a-k-e. I'm the government affairs associate for Blue Cross and Blue Shield of Nebraska, and I'm testifying in opposition to LB943. The rising cost of specialty medications, such as those used to treat cancer, hemophilia, rheumatoid arthritis, and multiple sclerosis, is one of the largest drivers of healthcare spending for Blue Cross members. We use a variety of tools, including white bagging, to manage these costs for-- by working with facilities, pharmacies, and specialty pharmacies to obtain these high-cost medications, resulting in more affordable premiums and out-of-pocket costs for our members. From the patient's perspective, these tools are a safe and effective way to get the same medication administered by a healthcare provider with the same therapeutic outcome, but at a lower cost. Our goal is to strike a delicate balance between the health and well-being of our patients, our obligation to hold down costs for our members, and the needs of providers across Nebraska. We strike to-- we seek to strike this balance through the limited use of white bagging where it is safe, effective, and appropriate. For example, we have heard from providers who want medications to be available via white bagging. We have also been in discussions with providers who have questions and concerns about white bagging. This communication with providers allows us to

respond, respond to the needs of both our members and providers regarding the appropriate use of this procedure. We oppose LB943 because it would make it more difficult to offer high-quality, lower-cost services and benefits that are safe and effective for our members. In addition to effectively banning white bagging, this bill limits the opportunity for us to work with members to find lower-cost providers that deliver similar service-- similar services and therapeutic outcomes. Our members have found considerable savings from such programs and-- that have reduced their healthcare expenses for these exact same medications. And finally as has been alluded to earlier, I would point out that this committee advanced LB767 to regulate Pharmacy Benefit Managers. LB767, which now sits on Final Reading, was the result of extensive negotiations between all the parties. That bill will make significant changes to the way Blue Cross must manage our network in terms of specialty pharmacies and how we reimburse providers for certain medications. This bill would upend and conflict with certain provisions in that bill that all the parties worked hard to resolve. I would encourage the committee to take a similar approach on this bill, that is to bring all the parties together. We've heard a lot of great testimony on both sides, and that would allow us the opportunity to discuss those issue-- those issues and respond to the concerns raised by proponents. We participated in good faith in the discussions on PBMs, and I can assure you we would do that on this issue as well. With that, again I would close by just saying we oppose the bill and be happy to answer any questions you have.

WILLIAMS: Questions? Senator Pahls.

PAHLS: Thank you, Chair. So what I'm gathering from what you told us that the bill that we did pass-- or it's on the floor, a lot of these issues would be resolved by that bill?

JEREMIAH BLAKE: No, I'm not going to say a lot of the issues would be resolved by that bill. But what that bill does is it requires insurers like us to include specialty pharmacies that dispense these specialty medications in our network if they're accredited and agree to the terms and conditions of, of a contract. And what this bill does, LB943, is it really guts that provision and it says that any provider who wants to provide these specialty medications, we can't deny that and look for a lower-cost alternative.

PAHLS: OK.

JEREMIAH BLAKE: OK.

PAHLS: Thank you.

JEREMIAH BLAKE: Um-hum.

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

JEREMIAH BLAKE: Thank you.

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

ROBERT M. BELL: Thank you, Chairman Williams. Chairman Williams and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell. Last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation appearing today in opposition to LB943. The Nebraska Insurance Federation, as you know, is the state trade association of Nebraska insurance companies, including many, many of the health insurers that write in Nebraska who would be impacted by the passage of LB943. I, I don't plan to elaborate much more on what has already been said by other opponents. But I would like to make a, a couple of points first. I, I do want to express my appreciation to Senator Bostar for reaching out to the industry prior to session to see if any opportunity existed to compromise. Unlike a few other bills where insurers and others have found consensus, the costs associated with banning white bagging are too great for insurer policyholders and other ratepayers to find consensus without further significant study. Insurers believe white bagging practices save policyholders significant costs without sacrificing care. Second, as I mentioned to the committee on several other bills this session already, according to the Centers of Medicare and Medicaid Services, healthcare spending amounts to 19.7 percent of the national gross domestic product. One of my ongoing themes and speaking with the Legislature is finding ways to shrink the cost of healthcares and to fend off attempts by other parties who seek to limit the ability of payers of healthcare, whether individuals, employers, or the government and create new-- to create new and implement creative ways to limit healthcare spending while still providing first-class care. White bagging has proved to be a successful tool for health insurers to mitigate costs without sacrificing care provided to policyholders. It would be unwise to eliminate this valuable tool for insurers, policyholders, and other ratepayers, such as employers, without further understanding of the rate increases and identification of the problems in the marketplace. For these reasons, the Insurance Federation respectfully opposes the passage of LB943. Yeah, just a couple of other kind of off-the-cuff comments from, from what I heard, you know, and obviously there's

concerns from the provider community about the care of the patient, and I, I think that's a goal of, of both the, the insurers and the medical providers. Certainly, we do not want to, as, as the health insurance industry, have our policyholders ill. We, we care about them, we do care about them, we care about them. Also, we're financially incentivized to care about them, right? If-- we're talking about some pretty high-level, high-cost medical situations that are going on when we're talking about injectable, white bagging type of drugs. And I mean probably in most cases, these individuals have been through-- burned through their deductibles, through their coinsurance, through all of their policy limits. And those costs that are occurring behind the scenes are, are just between the medical provider and, and, and the insurer. And you know, if, if our policyholder ends up in the hospital, that, that is obviously a, a, a major cost for health insurers. In fact, in that 19.7 percent, I can't remember the exact percentage, its hospitalization that is the highest percentage of that 19.7 percent, the, the payments to hospitals. And this is obviously some high-stakes financial-- it's a high-stakes financial piece of legislation here. And then I would also just point out if, if an insurer makes a decision and that care is not provided to an individual, there are protections in the law that, that would be under, under Nebraska state law right now. That would be an adverse determination by the health insurer. And there are internal processes that must occur within the health insurer, and there are external processes that must occur that go through the Department of Insurance if it's a state-sponsored plan, through the Department of Labor if it is a, if it's an ERISA type of plan that an outside pair of eyes has taken a look at that, and their "expediated," "expediated," you know, external review determinations, etcetera, etcetera. It's a complicated issue and, and there's a lot of money at stake, and I think you already know that. So with that, I appreciate the opportunity to testify. Thank you.

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

ROBERT M. BELL: You're welcome.

WILLIAMS: Invite the next opponent. Is there anyone else here to speak in opposition? Seeing none, is there anyone to speak in a neutral capacity? Seeing none, Senator Bostar, as you are coming up, we have four letters: two proponents and two opponents. You're welcome to close.

BOSTAR: Thank you, Chair Williams and members of the committee. I think this was a good hearing. I think we uncovered a lot of issues. A few things that I want to respond to. Mr. Bell talked about how there's a lot of money on the line. I think that's true. But I think that we should think about that in certain ways. One, I will say that I applaud and support the insurance industry for consistently taking steps to limit and lower healthcare spending. We rely on them to do that. It's important that they do that. However, in their pursuit of that sometimes the system will break, and that's our job, is to find the areas that aren't durable enough to withstand the rigorous pursuit of cost saving and address it. And that's what we're talking about. If you are an insurance company subject to the Affordable Care Act, since the passage of that legislation, you now have to deal with something called the medical loss ratio, which is what we have heard about in this committee before. It means you're limited on your profit, profit you're limited on what your premiums that are paid to your company can be used for. I'll be more clear. So if you are restricted by law on what you can do with your premiums, you're incentivized to find other places for revenue that do not contain those kind of restrictions. It should be of no surprise, committee members, that we keep hearing about issues revolving the pharmacy side of the business, PBMs, they have no restrictions there. Insurance companies own them, they are curtailed in what they can do with their premiums. They are not curtailed in what can happen with revenue generation and profit within the PBM market and that business. This is why we keep hearing about this. So we need to ensure that while we are all interested in lowering healthcare costs, that we aren't doing that at the expense of the very care that Nebraskans and our constituents rely on. With that, I'd be happy to answer any questions the committee may have.

WILLIAMS: Senator Flood.

FLOOD: Thank you, Chairman Williams. Thank you, Senator Bostar, for your eloquent summation of this. Have you chosen a pretty severe remedy here where something less than an outright ban would accomplish, progress as opposed to using the heavy hand of government to weigh down the scale?

BOSTAR: Thank you for the question. I, because Mr. Bell brought it up, I don't feel I'm out of line in saying that I approached the industry about finding a middle ground here. They did not take me up on that. So if it seems like this is aggressive, I'm at the table, and I'd be happy to talk to anyone who'd be willing to sit down at that table with me.

FLOOD: One of the testifiers made the statement that your efforts here, as proposed in LB943, would frustrate or even completely render useless the PBM resolution that you helped craft earlier this session. Is that true?

BOSTAR: Well, I certainly, I certainly take anything that Mr. Blake comes and, and speaks to seriously, and that certainly deserves attention. I'll say a few things. One is I don't think that it would render a great deal of this moot in any way. The other thing that Mr. Blake talked about how-- is how they're currently going through the process of transitioning within their market and business space to accommodate the legislation that this committee worked on and came to an agreement on. What I would say is, that's actually a really good time while they're working on this all, while they're modeling what they need to do to go forward. This is actually the right time to incorporate some other adjustments because, because they're going through it. So if there are tweaks that need to be made to ensure that the intent of the legislation that we all worked on as a committee previously is maintained, I certainly welcome that. But I would say that actually for their business, this is the right time to get it right so that they don't have to come back to the table in the future, a year from now, two years from now, three years from now, and, and do it all over again. Right? Let's get this right, right now.

FLOOD: Thank you.

WILLIAMS: Senator Pahls.

PAHLS: Thank you. I'm just going to add onto that, it does just seem pretty rigorous, because I'm just going to read the first nine. I'm just going to read the first word of your nine statements. And just the first word: refuse, impose, interfere, require, limit, reimburse, condition, require, require. Those are some pretty tough words. I'm not going to address this to the sentences, but you are really pushing the envelope, don't you think?

BOSTAR: I, I suppose-- if you were to go back and look at the PBM legislation that the committee heard last year, I think you're going to find similar things.

PAHLS: OK.

BOSTAR: And I don't want to speak for you, and I'm not in the role in this place to ask questions of you. I feel good about what we did as a committee there. I would hope you do, too. And so the words are words,

the words can be changed. The issue is real and that's what I want to solve.

PAHLS: I appreciate that. Thank you.

WILLIAMS: I would remind all of us that the PBM legislation that we worked on and advanced to the floor that's now on Final Reading had five primary ingredients: it addressed MAC pricing, the appeals process, the audit process, the 340B process, and finally, the specialty pharmacy process. I think Mr. Blake was testifying as concern to that last one, the specialty pharmacy issue.

BOSTAR: I think that's right.

WILLIAMS: And I'd ask you, do you have a response to that? Just so--

BOSTAR: I, I think that's similar to-- if I understand your question, I think that's essentially what Senator Flood was asking was if--

WILLIAMS: I'm just pointing out that, that I don't think anyone was talking about the entire PBM legislation that we advanced being subject to being changed completely by what [INAUDIBLE] white bagging,--

BOSTAR: I'm sure that wasn't what, what they were.

WILLIAMS: --we're narrowing it down to the specialty pharmacy aspect of the PBM legislation,--

BOSTAR: Yeah.

WILLIAMS: --not the other four things that we talked about.

BOSTAR: I think that's right.

WILLIAMS: Any additional questions or final comments from the senator? Seeing none, thank you.

BOSTAR: Thank you.

WILLIAMS: And that will close the public hearing on LB943. The committee is going to take a very short ten-minute break and we will start at exactly quarter after three.

[BREAK]

WILLIAMS: All righty, we are back together and we will open the public hearing on LB1190 introduced by Senator Lathrop, change requirements for issuers of Medicaid-- Medicare supplement insurance policies or certificates relating to the coverage. Senator Lathrop, welcome to Banking, Commerce and Insurance.

LATHROP: Well, I'm pleased to be back, Mr. Chairman and members of the committee. My name is Steve Lathrop, L-a-t-h-r-o-p. I represent Legislative District 12. I'm here today to introduce LB1190. LB1190 would require insurers providing, providing supplemental Medicare insurance in Nebraska, also known as Medigap coverage, to guarantee issuance of those policies to individuals under 65. Current federal law provides these protections to individuals who become eligible for Medicare when they turn 65. It also requires that they charge the same price to everyone purchasing a policy at 65, regardless of any preexisting conditions. This bill would extend those same protections to adult Medicare recipients under the age of 65. After I introduced this bill, I was made aware that we accidentally carved out one population from the protection of this bill, individuals with end-stage renal disease who were made eligible for Medicare through a different legal mechanism than receiving Social Security disability insurance benefits. That was not intended. So I've introduced AM1706, which becomes the bill and which I'll direct the balance of my comments to at this time. I'm sure this committee is aware that there are significant costs that Medicare does not cover and that Medicare has no annual out-of-pocket limit. Individuals who turn 65 are offered a wide variety of Medicare Advantage and Medigap policies that cover these additional costs. There are so many options, and the options are so complex that we have SHIIP navigators to help individuals understand the market and determine the best options for themselves. The option-- options are much more limited for an individual under 65 who become eligible for Medicare because they are receiving Social Security disability benefits or they have been diagnosed with end-stage renal disease. These individuals have a narrower range of options, and often those options don't fit their needs because they're either too expensive, have too many out-- too many out-of-pocket expenses, or they don't have an adequate provider pool, especially in rural parts of the state. Medigap is technically available to this population, but because it is subject to medical underwriting, disabled individuals are frequent-- frequently denied coverage, and the coverage that is available can be prohibitively expensive. People who speak after me will explain why Nebraska comprehensive high risk pool and Medicare Advantage often do not meet the needs of Medicare recipients under the age of 65. I was first made aware of this issue

by Steve and Jean Kay of North Platte, who have traveled here today to testify. Jean was diagnosed with MS and eventually became eligible for Social Security disability and, subsequently, Medicare. After working with SHIIP volunteers, the Kays realized that their share of cost for Jean's care would be financially devastating. So Steve closed his law practice on very short notice and took a job that provided group coverage until Jean turned age 65. His law practice had been in operation for 40 years. The job Steve was able to find was in North Dakota, 12 hours away from home. Had a Medigap policy been available to them, this would have been avoided. The situation was such a hardship to them that they've since dedicated themselves to making sure other people don't face a similar outcome. Their situation struck me as fundamentally unfair. My office has since been made aware that there are many individuals in a similar situation. SHIIP navigators who work with this population encounter these issues regularly. Across the state, there are many Medicare recipients under age 65 who could afford to purchase Medigap insurance if a policy was available to them. However, because no one will issue them a policy, they either have to forgo appropriate care or spend down their assets and income below the federal poverty line in order to qualify for Medicaid. LB1190, LB1190 would reduce the number of people who, despite having the means to pay for insurance, need to qualify for Medicaid in order to receive care. The majority of states have already addressed this issue, 34 states require Medigap providers to issue plans to individuals under age 65. These include nearby states of Kansas, South Dakota, Colorado, Missouri, Oklahoma, and Texas. LB1190 provides protections effectively identical to those that have been provided in Kansas since 1999. The two most recent states to pass these protections, Indiana and Virginia, passed them by unanimous votes in both committees and on the floor, except in one single no vote on the floor in the, in the Indiana Senate. This isn't a partisan issue. Any family in Nebraska could face-- could be faced with the same challenge of disability, and it's important that we provide protections so that they can receive the care they need, they need without having to spend down their income and assets in order to qualify for Medicaid. I provided the committee with copies of a 2016 study done by the Kaiser Family Foundation entitled: Gap in Medigap. Their analysis found that since the introduction of Medicare Part D, which now covers medication costs separately, there's no longer a clear rationale not to guarantee issuance of Medigap policies to individuals under 65 because it is not significantly more costly to provide coverage to this population compared to the over 65 population. The study concludes, and I'm quoting, In light of the data, it's not clear what the justification for treating younger adults with disabilities different from older

adults when it comes to buying a Medigap policy, end quote. You'll find a chart summarizing the data on page three of that study. Individuals who testify after me will be able to provide more detail about this complicated issue than I'm able to. As Professor Valarie Blake, an expert on healthcare law, wrote to the committee in her letter for the record, health insurance has two purposes. One is to provide for day-to-day health needs, and the other is to insulate us from financial ruin for those who suffer rare but catastrophic health events. Our working families in Nebraska facing the challenge of disability deserve equal access to both forms of protection. They don't need a catastrophic health challenge to be compounded by a financial disaster. This issue could affect any one of us, and I urge you to support LB1190. Thank you.

WILLIAMS: Questions for Senator Lathrop? Senator, is, is the idea that those that are under 65 qualifying that way would be issued a separate type of policy that would be underwritten for that particular group or is the idea that that particular group come into the other larger group that is already qualifying for this?

LATHROP: I think it's the latter.

WILLIAMS: It's the latter. OK.

LATHROP: In other words, we're not creating a separate pool. And part of the problem is right now, they-- that's the only way they can get it, and there's separate underwriting, and it's-- they can have preexisting limitations, and it's cost prohibitive. What we want to do is put them in the pool with the rest of everybody on Medicare over age 65 and allow them to pay the similar rates--

WILLIAMS: OK.

LATHROP: --for their coverage.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. Senator Lathrop, the CHIP program, that does not work in this case?

LATHROP: It does not, and somebody behind me is going to have to tell you why that is.

McCOLLISTER: OK.

LATHROP: I, I, I know that I-- I talked to-- I know that someone told me that why that doesn't work and to be honest with you, I'm not remembering it right now.

McCOLLISTER: Thank you.

WILLIAMS: Seeing no additional questions, thank you.

LATHROP: Thank you.

WILLIAMS: We invite the first proponent. You want to watch that chair.

JEAN KAY: Yeah, I was going to say.

WILLIAMS: Welcome, Miss Kay.

JEAN KAY: Thank you. Good afternoon. And my name is Jean Kay, J-e-a-n, last name K-a-y, and I'm testifying in support of LB1190 because Medicaid-eligible beneficiaries under 65 should not be discriminated against based on age. Individuals should be able to purchase a Medigap plan, which is going to reassure being able to see a specialist, as well as being proactive in one's health and preventing emergency room visits and hospitalizations. In 20 years following my MS or multiple sclerosis diagnosis, the progression of the disease has caused changes in my employment as a registered nurse. I went from a clinic nurse, then working for a public health district, more of a sedentary position of what I was doing to going to a completely sedentary position of reviewing Medicare charts for a, a government contractor. The disabling effects of MS were apparent with changes in my ability to walk, fatigue, and cognition. And people often ask, what do you mean by cognition? And I always give them this example. I'm driving and I see this car in front of me, it has these big black letters on the back of it. And this is true, this happened. And I'm thinking, why does anybody have foliage written on the back of their car? That's what I saw it as. It said police. So that's how it can affect cognition in case if you're wondering. I started receiving SSDI benefits in April of 2016 and enrolled in the original Medicare before reaching age 65. I was still responsible for paying the 20 percent co-pay that original Medicare does not cover and the $1,556 that Medicare Part A in-patient hospital deductible, which is the first night charge for each 60-day benefit. In a year's time, that could be six times, so every time you're admitted during-- after the first 60 days until the next 60 days, so that's six times a year. Irrespective of having Medigap coverage, there are other additional expenses such as Medicare B and D, with, with payments of $170.10 and $97 per month,

respectively. Now my husband's-- my Medicare Part D is $97 a month, my husband's is $10. So that's a big difference. The-- my, my costs increase with additionally yearly co-pay of $7,000, so my medicine co-pay is $7,000 a year. The medicine that I take right now is $8,000 a month. And that's, I guess, just a drop in the bucket compared to what they were talking about before on some of the other medications that people receive. But it's still, the $7,000 a year just for the medication out-of-pocket is expensive and then plus other medications that I take for the MS symptoms. Our retirement savings would be used to pay all of these expenses, and that would just deplete this through until I would reach 65. After much, after much discussion during early 2018, it was decided my husband, Steve, would need to secure a job with health insurance benefits since I wasn't able to purchase a Medigap plan in Nebraska. And I was the carrier for our insurance, my husband was self-employed, so I, I carried the insurance. Well, when I became disabled, we had no health insurance then. So that's why it was decided we would need to find something for that. And once Steve left for Fargo in 2018, his assistance for me was gone at home, so the everyday activities were challenging to accomplish by myself. I had to rely on friends and employ people to do cleaning, mowing, leaf raking, physical activities, and that added another expense to our budget. We called each other daily; morning, noon, and night, and more often than that. That way he was rest assured and I was rest assured if I fell and couldn't get up, I knew he was going to be calling. If he couldn't get a hold of me, then he'd send somebody over for kind of a welfare check. And I was kind of getting to the point that I was going to have to get a medical alert just for my own peace of mind and for safety, and I always kept my cell phone in my pocket. Once I turned 65 a year ago, I had access, access to affordable Medigap plan, which helped defray my medical expenses. And then the Medigap plan is $121.30 a month. And actually, the total yearly cost is $1,456, and that's actually less than the $1,550 that I would have had to pay for hospital for a one-night stay without a Medigap policy. So-- and I also have the peace of mind of 20 percent being paid, that I don't have to worry about that. No one plans to have a disease process leading to a disability. Whether MS, ALS, Parkinson's, end-stage renal disease, or any other disability, we should be treated equally as those age 65 and over and allowed to purchase a Mediset-- Medicare gap-- Medigap plan. I hope those who have been elected to serve in the Nebraska Legislature do not have a loved one who becomes disabled and has to face this situation.

WILLIAMS: Thank you, Miss Kay. Are there questions? Seeing none, thank you--

JEAN KAY: Thank you.

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

STEPHEN W. KAY: Thank you very much. My name is Stephen W. Kay, S-t-e-p-h-e-n W. K-a-y. I am also testifying in support of LB1190. On a personal note, I practiced law in North Platte, Nebraska for 40 years. In 2018 at the age of 64, I had to find a job with health insurance because my wife was faced with resulting disability of multiple sclerosis. [RECORDER MALFUNCTION] Menards since health insurance benefits would have been offered because I wanted to stay in North Platte. However, I did not receive interview-- any interviews. I was able to secure a job in Fargo, North Dakota, which resulted in the closing of my business and moving to Fargo. It was difficult having to tell clients and friends on short notice I was moving. The drive from North Platte to Fargo is 10 to 12 hours. Weekend trips home were not possible. If Medigap plans would have been available for purchase in Nebraska by those with disabilities under age 65, I would have been able to continue practicing law in North Platte and assisted my wife. It was hard leaving home on the morning of October 10, 2018. Thirty-four states now require Medigap insurers to sell at least one Medigap plan to persons under age 65 with disabilities. Twenty-three of these 34 states require Medigap insurers to make all of their Medigap plans available. Across the country, this is a widely supported, bipartisan effort. Indiana and Virginia are two states that passed this issue into law in recent years. Neighboring states Colorado, Kansas and South Dakota require Medigap insurers to make all of their Medigap plans available for purchase by those with disabilities under age 65. The Colorado regulation became effective in 2003. The Kansas statute and South Dakota regulation became effective in 1999, more than 20 years ago. Under age 65 Nebraskans found to be disabled by the Social Security Administration receive Medicare benefits. They certainly do not choose to become disabled and should not be discriminated against as a result. All Medigap insurers doing business in Nebraska should give those with disabilities under age 65 the same opportunity to purchase Medigap plans as those aged 65 and older. This is an issue of justice, equity and fairness. Colorado, Kansas and South Dakota took care of this inequity years ago. It's time to do-- for Nebraska to do the same. Thank you, and please vote yes to vote this bill out of committee. Thank you for letting me speak today.

WILLIAMS: Thank you, Mr. Kay. Are there questions? I have a question.

STEPHEN W. KAY: Yes.

WILLIAMS: And thank you for your advocacy on this issue. Clearly, the group of people that would be insured under this are a high-cost, high-risk group. What will that do, do you think, to the overall situation, the cost of the problem?

STEPHEN W. KAY: Well, I-- I-- I'd refer you specifically to that study that was done by the Kaiser Foundation. You know, I'm not an expert on that, but that is answered in that Kaiser Foundation study. And then Professor Valarie Blake, a law professor at West Virginia School of Law, for this hearing, prepared a report, and it's in exhibit in evidence, and I would recommend that you look at that. She discusses these insurance issues. And of course, I hate to say this. I've been sitting here all afternoon, but, you know, we have to think of the disabled in Nebraska. We have to think of the taxpayers, too. You know, if we-- if people can buy this coverage, they don't have to go on welfare, that's going to save the taxpayers money. So, I mean, there's two issues here, but I think we really need to start thinking about how we're treating the disabled, whether they're treated equally and, you know, not worry so much about the insurance companies so much. I'm sorry to say that and I hate to do that, but I just-- I feel strongly about that. And I-- and I think Nebraska has to join these other states that are doing it. You know, we need to do this. So I-- that would be my answer.

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

STEPHEN W. KAY: Thank you.

WILLIAMS: Invite the next proponent. Is there anyone else here to-- oh, come on up. Good afternoon and welcome.

SHAUNA DAHLGREN: Good afternoon. Thank you. Thank you for the opportunity to be here and speak today. For the record, my name is Shauna Dahlgren, which is spelled S-h-a-u-n-a D-a-h-l-g-r-e-n, and I am the work incentive and community outreach specialist at Easterseals Nebraska, and I'm here in support of LB1190. I'm a certified community partner work incentive counselor, which means I'm counseling individuals, Social Security disability beneficiaries, on how work in-- income will impact SSDI and SSI cash benefits, healthcare options, and other public benefits. I've been doing this work for 20 years and I serve beneficiaries throughout the state of Nebraska and mentor a team of professionals doing the same. Excuse me. In addition,

I'm a certified SHIIP counselor or volunteer, as Senator Lathrop mentioned, which means I'm trained to assist individuals in navigating Medicare eligibility, enrollment and coverage options, so discussing Medicare with beneficiaries is part of our daily work, including individuals who are just becoming eligible for Medicare due to disability or age, and those who remain eligible for Medicare while working due to disability or age. Individuals with disabilities often experience extremely high medical expenses, as you mentioned, Senator Williams, but not every beneficiary with a disability does so. Some individuals, they may have severe or significant disabilities or health conditions. It doesn't necessarily mean they have extremely high costs, but some individuals do and as a result out-of-pocket expenses can become unaffordable. So I just want to describe a couple of considerations. As an alternative to original Medicare, Medicare Advantage and Nebraska CHIP programs supposedly offer other coverage options. Acknowledging that there have been improvements to Medicare Advantage plans and availability in recent years, a number of issues remain: lack of options for certain counties; lack of providers, or at least in-network or close, in-their-community providers; providers changing acceptance of plans from one visit to the next, even within the same year; listed out-of-pocket maximums for the plan may not include all of the out-of-pocket expenses, therefore, costing the individual much more than they would expect. Choosing a Medicare Advantage plan can be based on drug coverage, or it may-- might be based on provider coverage, but not always both, so one plan may not actually fit an individual's full needs. Secondly, people consider secondary coverage to help reduce out-of-pocket costs, and some of this have-- has also been previously mentioned, but hopefully, maybe, a little more insight. Many beneficiaries consider Medicaid coverage as the most viable option for secondary coverage, but there are obviously challenges here as well. Beneficiaries most often consider reducing income and/or resources in order to meet eligibility guidelines. Doing a spend-down on qualified insurance premiums or a share of cost is common to reduce countable income for a Medicaid budget. It's common enough in practice that any insurance agent is likely to know what types of policies someone can purchase in order to meet spend-down eligibility. Agents, as a result, are sometimes regular attendees at disability-related networking groups and market this as something they regularly help people with. Medigap plans, again, as mentioned, may technically be available, but plans are limited and individuals under 65 go through underwriting, may be denied coverage, and charged high premiums. If Medigap plans were more accessible and affordable, original Medicare, combined with a Medigap plan, could offer better coverage and access to providers and medical

services. In closing, we come across beneficiaries every day who face challenges with current Medicare coverage options. Deciding to further reduce income and resources to the federal poverty level to qualify for Medicaid is burdensome but often necessary. For many, Medigap coverage would be the only viable option to preserve income and assets, including work income, while still meeting their healthcare needs. Thank you, and I am happy to answer any questions.

WILLIAMS: Thank you, Miss Dahlgren. Are there questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams.

SHAUNA DAHLGREN: Yes.

McCOLLISTER: And thank you for being here. We were talking about CHIP, and that is a viable way to go with people with these kinds of difficulties?

SHAUNA DAHLGREN: Actually, somebody testifying behind me will probably be able to give you more information on that. I was not aware. I did look into that a little bit more recently. I've worked with individuals in the past that have utilized that. They experienced some of the same issues that people with Medicare Advantage plans do with providers, you know, not adequate provider pool, some of those kinds of things, and the premiums that they were being charged were pretty high. So I don't have, like, current within the last year experience with that, but now it's my understanding that it's not even an open pool, so.

McCOLLISTER: Thirty-one states provide Medigap coverage to people with disabilities.

SHAUNA DAHLGREN: Right.

McCOLLISTER: What's been the impact on rates in those 31 states, if you know?

SHAUNA DAHLGREN: I don't actually know what the impact on rates has been. I can only speak to my experience with some other related plans. Some Medigap plans, when they close the pool of insured, then your rates tend to go up because, as those-- for individuals over 65 or those that tend to have higher medical costs, if they close the pool of insured, then rates tend to go up because those costs tend to get higher, but I don't know of anything where they've expanded the pool of insured where the rates have actually gone up.

McCOLLISTER: Well, just reading the document that Senator Lathrop provided, it says on a per capita basis, the rates don't really differ for those people below 65 versus those above. Is that-- did I read that correctly?

SHAUNA DAHLGREN: You mean currently--

McCOLLISTER: Yeah.

SHAUNA DAHLGREN: --like if they get it in Nebraska, or in other states?

McCOLLISTER: No, in other states.

SHAUNA DAHLGREN: In other states, that could be true. In Nebraska, again, just from my experience, I don't have statistics on it, but the few people that I've worked with that actually were able to obtain Medigap coverage under 65, their rates were significantly higher than what they would have been charged at age 65.

McCOLLISTER: Really? OK. I misread it, but thank you.

SHAUNA DAHLGREN: So.

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

SHAUNA DAHLGREN: Thank you.

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

MADELINE HENDRIX-JONES: Good afternoon. My name is Madeline Hendrix-Jones. I am a community partner work incentives counselor with the Mental Health Association of Nebraska. And I don't want to--

WILLIAMS: Ma'am, would you spell your name, please?

MADELINE HENDRIX-JONES: Oh, I'm sorry.

WILLIAMS: Thank you.

MADELINE HENDRIX-JONES: M-a-d-e-l-i-n-e H-e-n-d-r-i-x, hyphen, J-o-n-e-s. I don't want to repeat anything that anybody else has said, so I wanted to focus a little bit differently on my testimony today. The individuals that we serve are impacted primarily by behavioral health issues. Many that we work with are on SSI due to disability, SSDI due to disability. For them, not having access to certain aspects

of healthcare, for example, dental, vision, and hearing, that are provided in Medicare Supplemental Insurance plans impact them negatively and place barriers to them achieving their wellness goals and utilizing natural supports. For example, someone who has no access to dental care may find it harder to reenter the workforce, or someone who cannot hear and/or see very well may find it keeps them isolated from others and exacerbates existing mental health symptoms. These type of health issues also greatly affect self-esteem, which impacts an individual's entire health. Having access to Medicare Supplemental Insurance for disabled individuals under the age of 65 would be of great benefit not only to those individuals, but to our communities themselves, as though-- those comprehensive healthcare benefits, people may become more active members of the communities they live in by being able to access employment supports, transportation for themselves, instead of relying on others or funded programming to help them live independently. With access to healthcare for these types of conditions, individuals may be more likely to seek out community resources, expand their support systems, and need less crisis intervention when isolation is a key factor. Access to dental care can also improve diet, lifespan, as well as quality of life. Thank you for your time and consideration.

WILLIAMS: Are there questions? Seeing none, thank you very much for your testimony. Invite the next proponent. Welcome, Mr. McDonald.

EDISON McDONALD: Hello. Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for The Arc of Nebraska. We're a nonprofit that advocates for people with intellectual and developmental disabilities. We're here today in support of LB1190 because our members have struggled with access to proper healthcare in the holes between Medicaid and Medicare. LB1190 helps families who fall into some of these gaps or struggle with the cliff-effects impact. This is an issue that we regularly have families call on us to-- to help them to navigate through. Families struggle through the complexities between our Medicaid and Medicare systems. There are a number of gaps. This is a smart strategic tool that can help to eliminate some of those gaps. Many states have already addressed this, as Senator Lathrop talked about before. One of the key issues that really brought me into this work with The Arc of Nebraska was that I was a private employer and I had an employee from Senator Aguilar's district who was a young lady with a disability who was an amazing worker. She showed up early. She stayed late. She worked harder than anybody else. And so one day I said, I want to give you a promotion, and she said no. I was shocked, just the idea that somebody who, you know, worked so hard would not want to have that sort of raise or

increased responsibility. And she said, I can't risk losing the $60,000 a year in benefits that helps to keep me alive for the couple of dollars an hour extra that you're offering. This really opened my eyes, and I think we see this in a number of spaces within our disability support systems, you know, these jobs where, you know, it doesn't matter if you're making $30,000, $40,000, $50,000, a little bit extra isn't going to make a whole bunch of difference if you've got, you know, an individual with $100,000-plus a year worth of expenses where they do have that really huge need for a program like Medicaid or Medicare. So we really encourage the Legislature to help us to figure out how do we deal with some of these issues, how do we navigate these. This is a smart, targeted way to go and help deal with a specific population who faces that sort of barrier. LB1190 helps to address this for a number of circumstances, in particular, for those who may have an income that's just over the threshold, they may have too many resources. Medicare Advantage plans also aren't available in their geographic area. They lack-- their area lacks providers, which is a huge issue that we see, especially across rural portions of the state; or they work, but they don't have employee coverage available. We need to create equity in this program for people with disabilities and make this shift similar to those who qualify based upon age. We encourage you to support LB1190. And any questions?

WILLIAMS: Any questions? Seeing none, thank you, Mr. McDonald. I'd invite the next proponent. Good afternoon and welcome.

WENDY SCHRAG: Good afternoon. Thank you. Chairman Williams and committee members, my name is Wendy, W-e-n-d-y, Schrag, S-c-h-r-a-g. I'm testing-- testifying today on behalf of Fresenius Medical Care, which is a dialysis company, and I'm here to support LB1190. And I want to specifically thank Senator Lathrop for adding in the amendment, which-- which adds in people with end-stage renal disease, or ESRD. Our company operates nine dialysis clinics in Nebraska. We serve Omaha, Kearney, Grand Island and North Platte communities. We take care of 589 Nebraskans with kidney failure. Out of that 589, 327 of them are under age 65, and you'll see on your testimony the first set of bullet points talk about that. One hundred and forty-one of those have Medicare as their only insurance. They have no option for secondary insurance, and that leaves them unable to access critical medical services, the most important being a kidney transplant. People under age 65 are the prime candidates for kidney transplant, but without comprehensive insurance you are not going to end up on a transplant list. We do have some patients who have spent down their resources because of a lack of secondary insurance, and so they have Medicaid. You've mentioned the state high-risk insurance pool several

times. We used to have some patients who were able to get secondary insurance through that pool. When the exchanges came into being in 2013, quite a few of the risk pools phased out because then there were the exchanges as options, and so Nebraska ended up closing their pool eventually. But there's still a gap; there are still these people who don't have comprehensive insurance, who are Medicare beneficiaries under age 65. So then we were excited because in 2021, through the implementation of the 21st Century Cures Act, people with ESRD could start accessing Medicare Advantage plans. Prior to this, there was a specific carve-out for insurance companies that they didn't have to sell MA plans to people with ESRD. So we do have 82 of our patients who have taken advantage of MA plans and do have them. However, the 141 of our patients who still have Medicare as their only insurance have given us a number of reasons why they've chosen not to enroll in MA. Some were concerned about the personal co-pay amounts. Some told us that the MA medication plans were not as robust as Part D, and our patients tend to have a lot of comorbid conditions, and so they take a lot of medications. Some MA plans only cover dialysis at 80 percent, so they still have the 20 percent co-pay. It's just like Medicare Part B, basically, and other side issues with in-network and out-of-network coverage with their multiple Medicare medical providers. And some do not have the opportunity to enroll in them, depending on where they live. And finally, fee-for-service Medicare does not have an annual maximum out-of-pocket, so that is important to some folks. Some say that implementing this legislation will cause premiums to rise for those already insured or who are over age 65. We operate in every state except for North Dakota, and I did check with our national insurance coordinator and they said that we have not seen the difference in premiums in states that offer the plans for under age 65, we haven't seen insurance premiums rise for the over 65 population, and so I'm just happy to be here today. I do live in Kansas and our-- our state has been been-- been mentioned several times today. I'm a licensed master's-level social worker. I've worked in the industry for over 30 years, and half of that time I spent working directly with patients. And, yes, it was easy to access those plans for my patients under age 65 in Kansas, and we really have appreciated having that coverage for our patients.

WILLIAMS: Thank you, Miss Schrag. Are there questions? Senator McCollister.

McCOLLISTER: Yeah. Thank you, Chairman Williams. And thank you for your testimony and the trip to Nebraska. How many of your 589 patients are undocumented for end-stage renal disease?

WENDY SCHRAG: That's a great question, and thank you, Senator McCollister, for your other bill, which we support. We have-- I know we have 12 patients right now that are undocumented, and I'm not sure if we have more than that, but I-- I do know that we have at least a dozen.

McCOLLISTER: And how is that being financed for those particular people?

WENDY SCHRAG: We have individual contracts with hospitals that we set up for those 12 patients. So the pa-- the hospitals would rather contract with us to provide regular outpatient dialysis than have those patients end up on their doorsteps once a week or once every two weeks when they're very, very sick.

McCOLLISTER: So the hospitals are currently absorbing that cost?

WENDY SCHRAG: Yeah, they-- they basically pay us to-- we-- we do individual contracts for every patient with the hospital, and they basically-- the hospital pays us so that they don't have to have the high cost of taking care of a very sick patient when they come in for-- when it has to be an emergency.

McCOLLISTER: Would it surprise you if I said that the state would be better off going ahead and providing that, that level of care, for the undocumented, rather than having them come into the emergency room and get care that way?

WENDY SCHRAG: It would be very, very conducive for the state, and there are at least 12 states that do that. They have emergency Medicaid, or a few states still have their high-risk pools that offer policies for undocumented. So those are the two options that are available in probably-- I would say, between emergency Medicaid and the risk pools that still exist, it's probably a third to almost half of the states have some sort of coverage that you can access for people who are undocumented.

McCOLLISTER: And perhaps save the state money?

WENDY SCHRAG: Oh, yes.

McCOLLISTER: Thank you very much.

WENDY SCHRAG: Um-hum. Thank you.

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

WENDY SCHRAG: Thank you.

WILLIAMS: Invite the next proponent. Welcome, Miss Ragland.

JINA RAGLAND: Good afternoon, Chair Williams and members of the Banking, Commerce and Insurance Committee. My name is Jina Ragland; that's J-i-n-a R-a-g-l-a-n-d. I'm here today testifying on behalf of AARP Nebraska in support of LB1190 and AM1706. AARP Nebraska is a nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to families and those aged 50 and older. Medicare Supplement Insurance is a form of supplemental insurance that helps pay for gaps in Medicare payment. Given the high costs of healthcare and Medicare cost sharing, Medigap policies are key to affording care for individuals in traditional Medicare, eliminating the cumbersome 20 percent co-pay for services generally every time they seek medical attention or services. Unfortunately, younger beneficiaries with disabilities face significant obstacles to purchasing these policies. These hurdles in Nebraska come in the form of denying access to supplemental insurance coverage if the beneficiary is under the age of 65 and on Medicare due to a disability. It is our policy that Congress and state legislatures should keep Medicare Supplement Insurance, also known as Medigap or Med Supp policies, affordable and available to those who need it, one of those being by requiring Medicare Supplemental insurers to provide Medicare beneficiaries with disabilities under age 65 the same guaranteed access to supplemental coverage given to those beneficiaries age 65 and older. In Nebraska, the concern remains that we're not providing that access to those beneficiaries. People who aren't yet 65 can enroll in Medicare if they're disabled and have been receiving disability benefits for at least two years. As with end-stage renal disease, or ESRD, which you've heard about today, or if you have a disability happ-- that happens to be ALS or Lou Gehrig's disease, you do not have to wait that 24 months for Medicare coverage. You can acquire Medicare as soon as you become entitled to Social Security Disability Insurance, and again, as noted, federal legislation was enacted in late 2020 that ended that waiting period, allowing ALS patients to get Social Security Disability Insurance and Medicare immediately after diagnosis. In Nebraska, there's more than 375,000 residents who are enrolled in Medicare. As of July of 2021, 47 insurers offered Medigap plans in Nebraska, and about 181,000 people on Medicare were enrolled in Medigap plans in Nebraska. However, roughly 12 percent of Nebraska Medicare beneficiaries are under age

65, and our state's rules do not guarantee access to Medigap plans for this population. Thirty-four states now have some sort of "guaranteed issue" requirements for Medigap when a disabled Medicare beneficiary is under the age of 65. You've heard a couple of new states-- Indiana is one of those-- Tammy's Law became law in July of 2020, and most recently legislation was enacted in Virginia, in 2021, that would ensure at least some access to private Medigap plans for disabled enrollees under the age of 65. Outside of enrollment into a Medicare Advantage program, there really are no other options for disabled Nebraskans under the age of 65 who are enrolled in the Medicare program. A Med Supp policy has no provider limitations if the medical treatment is being performed by someone who accepts Medicare, which most providers do. This removes the barriers we currently have with Medicare Advantage plans. Medicare Advantage plans are not offered in all Nebraska counties and have limitations on provider access, along with having larger co-pays and deductibles. Individuals who are under the age of 65 who qualify for traditional Medicare due to their disability or have ESRD or ALS are among those with the greatest healthcare needs. We've known that and we've established that today. But they are greatly in need of affordable Medigap policies to supplement Medicare cost sharing. Those who obtain Medicare because they're under 65 and are disabled should be afforded the same or similar access to care as those aged 65 and older. Medical bills are reported to be the number one cause of U.S. bankruptcies. Studies claim that 61.2 percent of bankruptcies were caused by medical issues, while another claims that over 2 million people are adversely affected by their medical expenses. In closing, and in the spirit of compromise, we would encourage the committee to consider looking at all the options that are available to provide some relief for supplemental coverage to those under 65 on Medicare. There's not a one-size-fits-all model, and in a number of states insurers are required to offer some but not all of their Medi-- Medigap plans to people under 65. There are also states that require Medigap insurers to offer all their plans to newly eligible Medicare beneficiaries, regardless of their age, and some of those including restrictions of premiums, while others have no restrictions. AARP Nebraska supports LB1190 and the amendment and thanks Senator Lathrop for introducing the legislation. We would encourage your support and advancement of the bill to General File. Thank you for the opportunity to comment, and I will do my best to answer any questions.

WILLIAMS: Thank you, Miss Ragland. Are there questions? Seeing none, thank you for your testimony. Invite the next proponent. Good afternoon.

KELLY GOSS: Good afternoon. Phew, could have used that. Good afternoon, Chairman Williams and members of the committee. My name is Kelly Goss; that's K-e-l-l-y G-o-s-s, and I'm with Dialysis Patient Systems, or DPC for short. DPC is a national nonprofit, patient-led advocacy organization working to improve the lives of dialysis patients through education and advocacy. Our membership consists of dialysis and kidney disease patients and their families, and our board is comprised entirely of end-stage renal disease patients who are either on dialysis or have received a transplant. Today, I'm testifying in support of LB1190 as amended, AM1706, to include end-stage renal disease patients, and my testimony will focus largely on the ESRD patient population. This bill, as amended, would provide access to Medicare Supplemental Insurance, or Medigap, for disability and ESRD patients under the age of 65, providing key consumer protections and giving greater financial security and stability to these patients who need it most. Currently, 30 states, and this is as of 2022 data, require at least one Medigap plan for ESRD patients under age 65; and 17 states limit the premium differences that insurance carriers can charge for individuals under 60-- age 65, compared to Medigap enrollees age 65 and older. Unfortunately, Nebraska is not among the states in either of these categories, since Nebraska does not require any Medigap plans for ESRD patients under age 65. There are more than 3,000 ESRD patients who live in Nebraska today. Nearly 1,100 of them are under the age of 65, and these patients comprise an extremely vulnerable patient population, as evidenced by the fact that nearly half of them are on state Medicaid. ESRD patients either require multiple dialysis treatments per week or a transplant just in order to survive, so access to healthcare is absolutely crucial or they will die within a matter of weeks. So we support this bill because it will provide patients with greater financial security to receive the medical-- medical care that they need. As you know, patients become eligible for Medicare in either two ways: either turning age 65 or having a disability or diagnosis with ALS or ESRD, which is kidney failure. But even with Medicare coverage, these patients are still responsible for 20 percent of all out-of-pocket costs, and that is unaffordable for most of these patients. Moreover, there's no annual limit on the expense of that 20 percent, so we know that patients, their out-of-pocket-- ESRD patients' out-of-pocket cost is as much as $20,000 or more annually, and that's simply unaffordable for most healthy Americans, let alone somebody with a serious chronic disease. Medigap coverage helps pa-- patients pay for these expenses so that less people struggle having to decide between paying their rent or paying for which medical procedure, dialysis being the most crucial that they receive on a

regular basis. It also prevents patients from having unnecessary emergency room or hospitalizations because they're not having to pick and choose which one they afford. And lastly, it may also explain why so many dialysis patients are forced to spend down their assets in order to be eligible for the Medicaid program that will help pick up that 20 percent cost. We also know that Medigap coverage saves lives. While dialysis provides critical lifesaving therapy to more than half-- or nearly half a million patients nationwide, the optimal therapy is a kidney transplant whenever possible, as it adds years and provides a higher quality of life. Currently, there are 185 Nebraskans on the kidney transplant waitlist and 116 of them, or 62.7 percent, are under the age of 65. If a patient does not have access to supplemental insurance or the financial resources to cover the 20 percent coinsurance, or they're not personally wealthy, most transplant centers, in fact, more than 80 percent of transplant centers nationwide, will not waitlists these patients. Although Medicare Advantage plans are now accessible to Medicare enrollees under the age of 65, as you have heard in other testimony today, many MA plans charge the same 20 percent co-pay for dialysis as original Medicare does, which is no net benefit to a dialysis patient. Also, the provider networks are often limited, and both network coverage and plan costs vary year to year, providing less security and stability for ESRD patients that they can continue to receive the coverage that they depend on. Medigap coverage can help lower healthcare costs by preventing unnecessary expenses that patients can't afford. Of the-- there are nearly a 1,062 ESRD patients who are under age 65 here in Nebraska. This legislation would positively impact 561 ESRD patients without increasing overall premiums by more than a fraction of a percent. Thank you for your time, and I'm happy to answer any questions that you may have.

WILLIAMS: Thank you, Miss Goss. Are there questions? Senator McCollister. You've almost reached your limit.

McCOLLISTER: Yeah.

KELLY GOSS: Hello, Senator.

McCOLLISTER: Thank you, Chair Williams. Let me ask you the same question. Of those 3,000 Nebraska patients with end-stage renal disease, how many are undocumented?

KELLY GOSS: That is a good question. I do not know the answer, but I can try to get back to you on that-- on that.

McCOLLISTER: Thank you. I quit. [LAUGHTER]

KELLY GOSS: I-- yeah, that is-- that is a good question. I can tell you that in my home state of California, there are several more than any other state probably combined, but-- but I will get back to you on that information.

McCOLLISTER: Thank you.

WILLIAMS: Additional questions? Seeing none, thank you for your testimony. Invite the next proponent. Anyone else here to testify in support? Seeing none, we'll invite the-- anyone here to testify in opposition? Welcome, Mr. Bell.

ROBERT M. BELL: Good afternoon. Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell; last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today testifying in opposition to LB1190. As you know, the Nebraska Trade Insurance Federation is the state trade association of Nebraska insurance companies. Many of the federation member companies are active in the Medicare Supplemental Insurance marketplace and have policyholders that would have-- would be impacted by the passage of LB1190, which would mandate that issuers of Medicaid-- Medicare supplement insurance to offer such policies to individuals who are eligible for Medicare by reason of disability and, with the amendment, by reason of end-stage renal disease. The legislation would prohibit issuers from rating this new population in excess of the population who already qualifies for Medicare because of age. Medicare supplemental policies, commonly referred to as Medigap policies, are plans sold by private insurers to provide coverage for some of the cost original Medicare does not cover. According to information from America's Health Insurance Plans, or AHIP, over 180,000 Nebraskans had Medigap policies in 2018. These plans provide important financial protections to Nebraskans 65 years of age or over. The members of the federation who sell these important products are concerned that LB1190 would lead to increased premiums for Nebraska seniors, leading to disruption and dislocation in the marketplace. The Medicare Payment Advisory Commission, MedPAC, is an independent congressional agency established by law to advise Congress on issues affecting the Medicare program. According to a MedPAC report, beneficiaries younger than 65 account for a disproportionate share of Medicare spending, as do individuals with end-stage renal disease. I handed out a couple of charts from MedPAC showing this impact. I would highlight that ESRD population on-- has on average six times higher costs than the average

senior population. MedPAC data shows that the average spending for original Medicare beneficiaries in 2017 was $10,000, or just about $11,000 per person for age 65 and older; $15,529 for under 65 and disabled; and $54,905 with those with end-stage renal disease. The federation members are certainly sympathetic regarding difficult-- the difficult financial plight of disabled individuals under 65 and that ESRD population. Fortunately, both populations have access to Medicare Advantage, as you've already heard, in 87 of the 93 Nebraska counties. Medicare Advantage is an option used-- utilized by over 80,000 Nebraskans-- Nebraskans, including all three Medicare-eligible populations. Medicare Advantage is similar in many ways to commercial insurance, such as those offered by employers, and utilizes more of a managed-care approach to coverage. The federal government recognizes Medicare Advantage is useful in managing chronic diseases in the population, and its risk adjustment programs reflect the increased cost and provides incentives for Medicare Advantage carriers to effectively manage this population. Unlike Med--Medicare Advantage plans, private Medigap plans cannot manage chronic disease. This is really Medicare's job. Most importantly, no risk adjustment payments are available for Medigap plans. Medicare Advantage plans also receive subsidies from the federal government for extra service to the disabled and the end-stage renal disease beneficiaries. And as you already heard, there is a comprehensive health insurance pool. I don't believe there are very many Nebraskans left in that statutory pool at this time. And of course, there are a small number of Medigap policies also offered to Nebraskans under 65 that would qualify for Medicare, though these are, as you have already heard, subject to underwriting, and certainly not all people would qualify for those. Several other states do require guaranteed issuance of Medigap policies to both the under 65 eligible population and the ESRD population. While some states do prohibit rate differential between the populations, many states do allow a rate differential between the under 65 population, the ESRD population, and seniors. Also, some states limit the type of Medigap policies available. One note on this is Oklahoma, who in 19-- 19-- 2017 capped rates on Medigap under 65 population. Currently, the Oklahoma-- Oklahoma Department of Insurance is promulgating a regulation reversing this previous rule that capped rates for the disabled to help, quote, reduce the high cost for those eligible for Medicare due to age. Because the passage of LB1190 would have an adverse effect on Nebraska seniors and because other insurance products are available to both the under 65 disabled and ESRD populations, the federation opposes respectfully the passage of LB1190. I appreciate the opportunity to testify. Thank you.

WILLIAMS: Thank you, Mr. Bell. Are there questions? Mr. Bell,--

ROBERT M. BELL: Yes.

WILLIAMS: --we-- we had testimony that-- from one of our testifiers that talked about implementing this legislation in other states has not pro-- proven to increase the cost to those that are already in the program. Can you respond to that?

ROBERT M. BELL: Well, I haven't read that report, so I guess I'll need to review that report and comment further, but I will say this. If-- and I think I've said this on maybe all three of these bills. If-- if there's an increase in claim amount on a population, the premiums will have to increase. I mean, insurance-- insurance is highly regulated. I mean, the insurers have to stay solvent. They have to meet certain criteria that the Department of Insurance will set out for them financially. And so they can't just say, well, you know, there is no increase here, even though our claims are going to go up. I think if you look at the MedPAC data, you'll see that this population-- I mean, and honestly, and you understand, they're just more expensive to insure. If you throw that population in with seniors, there is going to be an increase in-- in the amount of premium that will need to be required to be collected from these individuals in the pool as a whole. I think what you've seen in some other states, you know, I think California's an example where ESRD has been carved off from Medigap; or other states have-- have instituted some sort of capping of the rates for or-- or have some-- put in a different rating for the individuals that are under 65 or even a separate rating for those with ESRD in the Medigap if they decided to go. That's-- they've-- they've put some sort of guide rails around this, as I think Miss Ragland from AARP mentioned. And so I think other states are doing that because there is-- there is an impact. How much does that impact? I don't know. Maybe a testifier behind me will have a better idea.

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

ROBERT M. BELL: You're welcome.

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

APRIL AYRES: Good afternoon, Chair Williams and members of the Banking, Commerce and Insurance Committee. My name is April Ayres, A-p-r-i-l A-y-r-e-s, and I am vice president of actuary at Mutual of Omaha, responsible for Medicare supplement products. I'm here today-- today to testify in opposition of LB1190. Mutual of Omaha is the

third-largest Medicare Supplement carrier in the United States, with over 1.3 million policyholders nationwide and 32,000 of those residing in our state of Nebraska. I'd like to offer a quick reminder of how Medicare supplement plans work. Med Supp adds additional coverage on top of Medicare-eligibles' traditional Part A and B benefits. When purchasing a Medicare Supplement plan, seniors pay a premium in exchange for coverage of some healthcare costs not paid by Medicare, including co-payments, co-insurance, deductibles and excess charges. The benefits we offer in each of our Medicare Supplement plans are standardized by the federal government and regulated by State Department of Insurance. In Nebraska, most carrier's Medicare Supplement premium rates are distinguished by attained age of the policyholder, allowing the rates to align with the average claim costs of a particular age. Under this bill and amendment, individuals who qualify for Medicare because of disability or end-stage renal disease would join the rating system for seniors already in a plan and pay the same premium as an age 65-year-old. In our experience, in other states, when those populations are lumped in with already enrolled seniors, everyone's premium rates increase. This is due to the fact that individuals with disabilities and end-stage renal disease have average claim costs that are up to six times higher than Medicare seniors. The language in LB1190 would lead to seniors with Medicare Supplement plans subsidizing the claim costs of these new populations, with seniors' now-higher premium payments. Keep in mind that anybody who qualifies for Medicare, whether by age, disability or end-stage renal disease, is entitled to all the healthcare coverage Medicare offers. Under current law, if Medicare eligibles with disability do not end up with a Medicare Supplement plan, they are by no means going without coverage for their health needs. The federal government pays for their care under Medicare's Parts A and B, and individuals can seek coverage by Medicare Advantage plans that help manage their care and can provide additional coverage benefits. For these reasons, we would ask the committee not to advance LB1190. I'm happy to respond to any questions you may have. Thank you for your consideration of Mutual of Omaha's perspective on this bill.

WILLIAMS: Thank you, Miss Ayres. Are there questions? I understand in your testimony that, in your other states that you have that have passed different legislation that we have, that your testimony is that if this population is brought in, that would actuarially-- that increased the premium cost.

APRIL AYRES: Yeah. And so, like-- like other people have-- have said before me, that each state is different in how they are handling--

WILLIAMS: Right.

APRIL AYRES: --the disabled and ESRD. I know a couple individuals prior to me--

WILLIAMS: Here-- here's my question.

APRIL AYRES: Oh. Yeah.

WILLIAMS: We-- we have a large population of people that are currently covered with Medicare.

APRIL AYRES: Um-hum.

WILLIAMS: And we have a small population of people under 65 that have a disability that are-- we're dealing with. When-- when you say that that cost will increase or has increased, can you tell us in some definitive term how much that's increased?

APRIL AYRES: You--

WILLIAMS: Are we talking a small increase? Are we talking a major increase?

APRIL AYRES: I-- it really depends on how much the-- the carrier is selected against, right? So Mutual of Omaha is a fairly large carrier, so we-- we could probably handle a influx of these individuals where the premium rates for our current cohort of seniors wouldn't increase that much. But you have smaller--

WILLIAMS: So you would blend that together--

APRIL AYRES: It--

WILLIAMS: --for you with your large amount of coverage.

APRIL AYRES: Yes. We-- we would--

WILLIAMS: As-- as an actuary, you would not suspect that to change.

APRIL AYRES: It would change the premiums, so the premiums would increase. So, for example, I can give you, like Wisconsin, we-- we currently looked at the differential between what are the claim costs that we incur for the under 65 population and compare to the 65-year-old, and their claims were four times higher in that under 65 population. Their-- their regulation includes ESRD and does allow us to rate them up to that amount, so when we went to the state to

justify the amount that we need to charge that pool, that we had justification for that. I know they had mentioned Virginia and Indiana. Both of those states do not allow ESRD because those, as have been mentioned before, are the-- the most--

WILLIAMS: OK.

APRIL AYRES: --costly individuals, and in both of those states, that we are able to, again, rate for that population. We have to justify that rate to the Department of Insurance, but we're able to-- to-- to increase that block of business so the-- the senior age population doesn't have to pay more. And like I said in my testimony, seniors do pay currently the rate that's associated with their claim cost, right? So a person who's 65 pays less than someone who is 85 because, as you age, your claim costs on average increase, right? And so currently seniors are paying more in-- in relation to what their claim costs are, and that's what a lot of states allow us to do with the disabled and ESRD population. And they also carve out so, you know, we can select one plan, so not-- not-- not everyone is, I guess, impacted, all the seniors.

McCOLLISTER: Sorry, Mr. Chairman.

WILLIAMS: Well, that's only because you just heard that your cost, since you're older than I am, is higher than mine. [LAUGHTER] So we'll all--

APRIL AYRES: Sorry if you didn't already know this.

WILLIAMS: We'll allow you to ask one more question.

McCOLLISTER: Half a year. But the states have policy options when they implement this, do they not?

APRIL AYRES: So-- so you mean like the standard plans that we have to offer?

McCOLLISTER: I mean, you know, states offer a variety of these kinds of plans. You know, some absorb the cost in the-- in the-- in the older population; sometimes they carve out a section. How many different options are there that we could look at?

APRIL AYRES: So I think I might be able to share. So AHIP does have a under 65 document. I would probably need to make sure that it's OK that I share that with you guys, but it lists all the states out, what-- what their-- a link to their-- their regulation, and then what

are the-- the key differentiators, so does it include ESRD, are you able to-- to rate differently, is it only one plan or is it-- do you have to offer it on all plans? So that information is in a nice format, and I don't know if, like I said, I can see--

McCOLLISTER: But do states that legislatively or does the insurance department in a state typically enact the-- establish the regulations that the state uses?

APRIL AYRES: I believe it's the state would establish-- establish the regulations. The Department of Insurance would-- would then enforce those, right? So as we are filing our-- our plans, they would make sure that-- that we are following whatever is required--

McCOLLISTER: Thank you.

APRIL AYRES: --in that regulation.

WILLIAMS: Senator Pahls.

PAHLS: I just have a question. I live in the state of Nebraska. I pay this. Believe it or not, I have-- I'm older the-- over 65. I know it's hard to believe.

APRIL AYRES: I wouldn't have guessed.

PAHLS: Thank you. Good salesperson. The insurance I buy in the state of Nebraska, if I would move to Texas, chances are my insurance rate would go up or down?

APRIL AYRES: It does. So-- so how-- how that works when you get a Medicare Supplement plan, there are area factors associated with that plan, so depending on where you live, the premium rates would adjust--

PAHLS: OK.

APRIL AYRES: --where you reside in.

PAHLS: So in other words, it would-- when I retire, I ought to take a look at that, plus a state that doesn't have any income tax. My goodness, state of Nebraska, we're in trouble.

APRIL AYRES: Maybe.

PAHLS: OK.

APRIL AYRES: I think the area factors are a little higher, though, in Texas, I'd say.

PAHLS: OK. OK. Thank you.

APRIL AYRES: Yes.

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

APRIL AYRES: OK. You're welcome.

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

JEREMIAH BLAKE: Good afternoon, Mr. Chairman, members of the committee. Again, my name is Jeremiah Blake, J-e-r-e-m-i-a-h B as in boy -l-a-k-e. I'm the government affairs associate for Blue Cross and Blue Shield of Nebraska, and I am testifying in opposition to LB1190. Given the hour and the good conversation we've had today, I won't repeat myself. You know, again, Blue Cross operates in Nebraska so, unfortunately, we don't have the claims history to look at other states and how it would impact rates. But, you know, again, given the-- the-- the-- the high cost that this population-- these populations have to cover, we have a reasonable belief that this would increase rates for our members. So for that reason, we're opposed to the bill. Be happy to answer any questions you have.

WILLIAMS: Any questions for Mr. Blake? Seeing none, thank you for your testimony. Next opponent. Anyone else to testify in opposition? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Lathrop, as you're coming up, we have letters. We have ten letters in support and two letters in opposition. Welcome back, Senator Lathrop.

LATHROP: Thank you. And I appreciate everyone who came here to testify today on this bill. I think this is an important topic. And while I was sitting and listening to the testifiers, this-- this occurred to me, that it's important for the committee to understand who we're talking about. So apparently, 12 percent of people on Medicare in Nebraska are disabled Nebraskans. So if you have that pool of-- pool of people who are on Medicare, the greatest share of them are-- 88 percent of them are going to be over 65, and they're on Medicare because of their age; 12 percent of them are going to be disabled, so we're talking about some of the people that are in that 12 percent. Of the people that are in that 12 percent, some of them are going to be people who are poor. They are totally disabled and they're poor. Maybe they got in some kind of terrible accident that was-- that left them

disabled and they qualify for Medicare and they're poor. Those people are not-- we're not talking about them because they're on Medicaid, right? They're already going to get Medicaid because they're not going to want one of these gap policies. They'll have Medicare and they'll have Medicaid, and the taxpayers will pay everything Medicare doesn't pay. The people we're talking about today are the people that have done the things that we expect Nebraskans to do: work hard, save money, like the-- like the Kays did, and have something. When something happens to you, the people we're talking about are people who have worked hard and saved. Otherwise, they're going to be on Medicaid to take care of everything that's not covered by Medicare. So these are-- today you saw a couple that came before you that's a lawyer and a registered nurse. Right? Their options right now are to-- they can try to get a-- if they-- if they can get a plan, one of these supplemental plans that everybody thinks they should go get, or the opposition does, they-- they don't-- they have network problems. They have pricing problems. You can get on one, but since they rate those plans, they're very expensive if you are disabled. It's not a-- it's not a practical option. And so what people are left with-- these are the ones that have saved money, worked hard, saved money like the folks that you heard from today. They now have to spend down their assets and become poor and have the taxpayers pick up the balance. That's fundamentally wrong. That's fundamentally wrong. These are people that have worked hard and saved, and now we're saying you really don't have any options, but you will when you get poor enough. And then-- then, instead of sharing the cost among people that are Medicare eligible, we're going to have the taxpayer pick that up with Medicaid. That strikes me as is fundamentally wrong. I want to talk about that 12 percent too. The-- when we talk about the-- the 12 percent who have something to lose financially. The poor are over here. Now we're talking about that population, whatever that percentage is. Some of them aren't expensive people. You can be disabled because you have mental illness, and Social Security, you qualify for Social Security at, we'll say, hypothetically, 50. You go see your psychiatrist once a year or twice a year. You get some medications. You're not an expensive person. You're probably not as expensive as the 65-year-old. So in that 12 percent of the people who have something are people who aren't going to be expensive. But what we talk about when we oppose the bill are there's this group that's six times more expensive than a 65-year-old, but that's not all 12 percent of them. Right? And when you hear them say it will raise rates, it's going to raise rates perhaps nominally. I think that handout that I showed you is the people that are totally disabled and under 65 aren't that-- they're marginally more expensive than a

65-year-old person coming in, so what we're doing is bringing more people into the pool. I always find it interesting when I come before this committee and I introduce a bill that might help get somebody coverage that the-- the opposition comes up with all the resources of all these great big insurance companies, and they say premiums will go up. And you asked the question properly. Well, what are you talking about, a big amount, a huge amount? You would-- you would think that, if they're-- if they're concerned about it, they come-- come and tell you they're going to go up by 12 percent or 2 or a percent and a half. I mean, they-- they're the ones with all the actuaries. And I will just suggest to you that this is, as Steve Kay said, fundamentally about fairness, about bringing these people into the-- into the pool of the Medicare insured, and allowing them to get a plan that they can afford so they do not have to go into financial ruin or move to North Dakota or someplace where their legislature has been thoughtful enough to allow these plans at a reasonable price. And, you know, I was contacted by Steve Kay, I think, over the summer. I didn't know anything about this issue until I got an email, and Sean, my LA, who's spent a lot of time working on this, we started to look into this and I'm like, this really is unfair, and it's unfair to people who have worked hard and accumulated something and who want to pay a premium. They want to pay a premium instead of getting on Medicaid. This is an important issue, and I hope you will move the bill to the-- to General File. If you want to try to make some kind of a-- these things don't all come out like a uniform bill from the--- whatever uniform model law place you guys look at over here. It has-- it has-- some states have done things to it to try to control costs or to do-- have certain limitations. I'm happy to talk to you about that if we can get it out and help this population of hardworking Nebraskans that have done everything the right way, they just happen to have somebody in the family that becomes totally disabled, as any of us could, before age 65. With that, I'd be happy to answer any questions.

WILLIAMS: Thank you, Senator Lathrop. Are there questions? Seeing none, thank you very much.

LATHROP: All right. Thank you, guys.

WILLIAMS: And that will close the public hearing on LB1190 and close the [RECORDER MALFUNCTION]