SLAMA: Good morning and welcome to the Banking, Commerce and Insurance Committee. My name is Senator Julie Slama. I represent the 1st Legislative District in southeast Nebraska and I serve as Chair of this 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 the proposed legislation before us today. Committee members will come and go during the hearing. We have to introduce bills in other committees and are called away for that reason. It is not an indication that we are not interested in the bill being heard. It's just part of the process. To better facilitate today's proceedings, I ask that you abide by the following procedures. Please silence or turn off your cell phones. Move to the front row when you're ready to testify. The order of testimony will be as follows: introducer, proponents, neutral-- no, wait-- introducer, proponents, opponents, neutral and then a close. Testifiers, please sign in. Hand your pink sign-in sheet to the committee clerk when you come up to testify. Spell your name for the record before you testify and be concise. It's my request that you limit your testimony to three minutes. Given how packed the room is, we, we need to be kind of strict on that rule today. If you will not be testifying at the microphone, but want to go on the record as having a position on a bill being heard today, there are white tablets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We'll need ten copies. If you have written testimony, but don't have ten copies, please raise your hand now so the page can make copies for you. To my immediate right is committee counsel, Joshua Christolear. To my left, at the end of the table, is our amazing committee clerk, Natalie Schunk. The committee members with us today will introduce themselves, beginning on my far right.

BALLARD: Beau Ballard, District 21.

JACOBSON: I'm Senator Mike Jacobson, District 42. I represent Hooker, Thomas, McPherson, Logan, Lincoln, and three-quarters of McPherson-- or Perkins County.

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

von GILLERN: Brad von Gillern, District 4, west Omaha.

BOSTAR: Eliot Bostar, District 29.

SLAMA: All right. Also assisting us today are committee pages, Quinn and Luke. The committee will take up bills today in the following order: LB32, LB145, and then a joint hearing on LB142 and LB779. And with that, we will kick off our hearing on LB32. Senator Jacobson. Oh, yes. Senator Dungan has just joined us for the record.

DUNGAN: Happy to be here.

SLAMA: Happy to have you.

JACOBSON: Good morning, Chair Slama, members of the Banking, Commerce and Insurance Committee. My name is Mike Jacobson, M-i-k-e J-a-c-o-b-s-o-n. I am before you today to introduce LB32. In years past, the Nebraska Comprehensive Health Insurance Pool, NECHIP, has been an option for Medicare beneficiaries under age 65 to receive a policy that would pay secondary to Medicare. This program is phasing out and plans to close when the last remaining enrollees reach age 65. It has not accepted any new enrollees for quite some time so it is no longer an option. I have introduced LB32, which would allow Medicare recipients under the age of 65 who are disabled or have end-stage renal disease, ESRD, to enroll in supplemental Medicare insurance plans within the first six months of becoming eligible for Medicare or during the 63-day period following termination of group coverage. The bill also provides a special enrollment period for those already enrolled in Medicare Part B. Such policies would be issued on a guaranteed renewable basis. The rate for such policies could not be more than the weighted average-aged premium rate. This weighted average premium rate is based on Missouri's law. In Missouri, a person under age 65 who has been approved for Social Security disability also has the guaranteed right to purchase a Medigap plan when he or she enrolls in Medicare Part B. Missouri has used the weighted average age premium rate since 2009. There have been no changes in the Missouri approach since that time. It is working. Thirty-four states now require Medigap insurers to sell at least one Medigap plan to persons under age 65 with disabilities. Twenty-three of those-- of these 34 states require Medigap insurers to make all of their Medigap plans available. Our 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 Kansas statute and South Dakota regulation become effective in 1990-- became

effective in 1999, more than 20 years ago. The Colorado regulation, Kansas statute and South Dakota regulations are working. This-- there is no evidence that I know of that premiums have risen in states that have implemented Medigap for those under 65 Medicare population. In fact, with respect to those states of Kansas and Missouri, you have been provided with a copy of a Wakely report, "Medigap Reform for Medicare Enrollees with ESRD Under Age 65," dated July 22, 2022. This report concludes using published reports and observing annual rate changes. We did not observe significant rate increases following legislative changes as compared to national averages in Kansas or Missouri. The Health Management Association, HMA, report, "Medigap Reform for Medicare Enrollees with ESRD Under Age 65," dated February 16, 2022, notes quote if all Medigap carriers are required to offer-- were required to offer policies to the under 65 population with ESRD and set the premiums at the weighted average charge to all enrollees over the age of 65, we estimate the overall average Medigap premium in Nebraska would increase by 0.3 percent, from $194 per month to $195 per month. For enrollees over the age of 65, the actual premium would continue to vary based upon a variety of factors, although we would expect most plans to include the same average 0.3 percent increase. It should be pointed out that in Nebraska, the pool of persons under age 65 who may choose to purchase a Medigap plan would basically be those who have worked and have assets which would be subject to spend down. Many of the disabled or ESRD patients under age 65 are covered by Medicare and would not need to purchase a Medigap plan. Others may have coverage from another source, such as health insurance from a spouse's employment, and would not need to purchase the Medigap plan. In addition, having the option to purchase a Medigap plan would keep people from having to spend down and go to Medicaid, resulting in savings to the taxpayers of Nebraska. Medicare Advantage plans are a Medicare replacement plan, not a Medicare supplement. They are not a good option for disabled and ESRD patients under age 65 in Nebraska, particularly for those living in rural areas. For example, in Columbus Community Hospital, website indicates it has not signed a contract with any Medicare Advantage plan. A November 1, 2022, Community Hospital-McCook and McCook Clinic press release notified the public that neither the hospital nor the clinic are in-network with any Medicare Advantage products being sold in the area. Community Hospital operates clinics in Curtis, Nebraska, and Trenton, Nebraska. Brodstone Healthcare operates the hospital in Superior, Nebraska. Its website states Brodstone is not a contractor provider for Medicare Advantage or similar-cost products. Now is the time for this situation to be rectified in Nebraska. The disability-- the disabled and ESRD patients

under age 65 in Nebraska should have the opportunity to purchase a Medigap plan without the exorbitant premium, just as those 65 and older do. The disabled and ESRD patients under 65 do not choose to have their disability or ESRD. When approved for a Social Security disability, they are forced to go to Medicare. This is a matter of justice, equity and fairness. Disabled and ESRD patients under age 65 in Nebraska should not be forced to move to other states to purchase the Medigap plan or have their assets subject to spend down if they choose to remain in Nebraska. In addition, the current situation will certainly discourage the disabled and ESRD patients in other states from moving to Nebraska. This is the message-- is this the message we want to send? And with that, I'll stop and ask for any questions. I would also tell you that there are, as you can see, many testifiers behind me who have significant knowledge and expertise in the subject matter. So I'd refer any specific questions about the bill to them, but I'd be happy to entertain any questions now.

SLAMA: Thank you very much, Senator Jacobson. Are there any questions from the committee? Seeing none, thank you.

JACOBSON: Thank you.

SLAMA: We'll open it up to proponent testimony for LB32. Good morning.

STEPHEN W. KAY: Good morning. My name is Stephen W. Kay, S-t-e-p-h-e-n W. K-a-y. My wife, Jean [PHONETIC], planned on testifying in support of LB32 this morning. However, she is ill and not able to attend the hearing. Her ADA accommodation written testimony has been submitted through the Legislature's online portal. I am testifying in support of LB32. On a personal note, I practiced law in North Platte, Nebraska, for 40 years. In 2018, at age 64, I had to find a job with health insurance because my wife was faced with the resulting disability of multiple sclerosis. I applied at Wal-Mart and Menards since health insurance benefits would have been offered. However, I did not receive 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 was 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 assisting my wife. It was hard leaving home on the morning of October 10, 2018. Under-age-65 Nebraskans found to be disabled by the Social Security Administration receive Medicare benefits. They 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 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 is time for Nebraska to do the same. Thank you and please vote yes to advance LB32 to General File. Thank you very much.

SLAMA: Thank you very much, Mr. Kay. Are there any questions from the committee members? Seeing none, thank you very much--

STEPHEN W. KAY: Thank you very much.

SLAMA: --for being here.

SLAMA: Additional proponent testimony for LB32.

HRANT JAMGOCHIAN: Good morning.

SLAMA: Good morning.

HRANT JAMGOCHIAN: My name is Hrant Jamgochian. I'll spell that for all of you. That's H-r-a-n-t, last name, J-a-m-g-o-c-h-i-a-n. I serve as the CEO for Dialysis Patient Citizens. I submitted testimony, but just want to highlight a couple of key points on why this is so important to our members in the state; one, for financial stability. Medicare covers 80 percent of the cost of care. There's still 20 percent that patients have to come up with out of pocket. There are over 2,100 residents under the age of 65 in Nebraska who are on dialysis and there are actually about 600 of those who are not, who are not eligible-- dual eligible and do not have access to Medigap. And as I mentioned, not just the financial stability, but also the critical part that it could be actually life saving for some of these individuals. There are 137 who are currently on the transplant list and without secondary insurance or significant financial resources, often-- you know, oftentimes, those individuals are moved from active to inactive. And while some do well on dialysis, not everyone does. And I just want to make a couple of real quick points. Thank you, Senator Jacobson, for leading this effort. You know, one of the things that it's a misnomer is that, you know, legislation like this is potentially challenging, you know, insurers. On the contrary, we've seen where there isn't this kind of legislation in place. For example, in Rhode Island, some insurers have tried to cover disabled or

dialysis patients. And in fact, last year, we were last testifying on this issue, one of the committee members said this is why he ran for office. His wife was on one of those plans that-- because that was the only plan in the state. That insurance actually had to discontinue the plan. And so his wife was actually forced off of the transplant list until legislation was introduced that would allow for, you know, basically the sharing of these costs. Secondly, one of the things that I think is really striking is the fact that this language includes Missouri Compromise kind of language. In other words, it's not, you know, requiring community rating, it's not requiring the-- that the premiums be the same for 65 and everyone under. It's a compromise language that, you know, acknowledges that it's going to be a little more expensive for individuals who are on disability or who have dialysis. But at the same time, Missouri has done quite well. This past year, they had 34 insurer-- or 37 insurers that offered 245 plans. If it wasn't, you know, an effective way to address these issues, then plans wouldn't be offered. And so, you know, I just want to thank you for your time, your consideration of this issue and thank Senator Jacobson for his leadership.

SLAMA: Thank you very much. Are there--

HRANT JAMGOCHIAN: Any questions?

SLAMA: --any questions from the committee? Seeing none, thank you for your expertise. All right. Good morning.

WENDY SCHRAG: Good morning, Chairperson/Senator Slama and committee members. My name is Wendy Schrag and that's S-c-h-r-a-g and I'm here representing Fresenius Medical Care. We're a dialysis company nationwide and we have nine clinics in Nebraska. We serve 623 Nebraskans with kidney failure or end-stage renal disease, ERSD, and these-- most of these patients come to our clinics three times a week and we're in the following communities: Omaha, Kearney, Grand Island and North Platte. Under federal law, people who have ESRD can qualify for Medicare regardless of age as long as they have work history requirements. And most, most people over age 65 have secondary insurance to help with these costs. However, those with ESRD or other disabilities like we'll hear today under the age of 65 are often unable to access critical medical services such as kidney transplant unless they have comprehensive health insurance. The Nebraska risk pool was mentioned by Senator Jacobson. A year ago when we had a bill similar to this, I contacted the pool and verified that there are just a handful of people left in it. And as soon as those people age to 65,

they're going to close the pool completely and they haven't accepted new enrollees for a few years now. So that pool is just no longer an option for our patients. However, in 2021, there was federal legislation through the 21st Century Cures Act that mandated that Medicare Advantage plans could no longer turn down people with ESRD. So we were excited about MA plans. We thought that those would be an option, especially in states like Nebraska that don't have a Medigap available for under 65. However, the MA plans to have some barriers and, and we've heard from our patients the following, the following things. Although we have patients who have signed up for MA plans, they con-- continue to be concerned about personal copay amounts. Some MA plans only cover dialysis at 80 percent, so that leaves a 20 percent copay. And in fact, most of the plans that our patients have in Nebraska follow that model. I checked with our billing department to see what the average amount of out-of-pocket for a patient in Nebraska with an MA plan is. It's $965 a month before they meet their out-of-pocket expense, which is often, you know, $6,000, $7,000 a year. So then they might-- may be covered 100 percent for a few months of the year, but then the next year that starts all over again. Some patients also told us that they wanted to stay on original Medicare because they felt that their Part D plan was a better medication option than the medication coverage in an MA plan. Others had issues with in-network, out-of-network or just didn't have an MA plan available. I live in Kansas and I've worked in dialysis for over 30 years. We have always had plans for under 65 in Kansas. They've worked well and we would really like Nebraska to consider this.

SLAMA: Thank you very much, Ms. Schrag. Are there any questions from the committee? Seeing none, thank you so much for being here today.

WENDY SCHRAG: Thank you.

SLAMA: Additional proponent testimony.

EDISON McDONALD: Hello. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm here representing the Arc of Nebraska. We're Nebraska's largest organization representing people with intellectual and developmental disabilities and their families. We support LB32 because many of our members have struggled with access to proper healthcare in the holes between Medicaid and Medicare. LB32 helps families who fall into some of these gaps or struggle with a cliff-affect impact. This is an issue that we regularly have calls on from families. As families struggle to navigate the complexities between Medicaid and Medicare, there are numerous gaps. This is a

smart, strategic tool that can help to eliminate some of those gaps. Many states have already addressed this, including Colorado, Kansas, Missouri, South Dakota, Oklahoma and Texas. And other states such as Arizona, Kentucky and Rhode Island are looking at this. I wanted to go and read, read a part of some comments from Shauna Dahlgren from Nebraska Easterseals that I think really kind of digs into this issue well. Individuals with disabilities may experience high medical expenses so out-of-pocket expenses can be much more than affordable. As an alternative to original Medicare, Medicare Advantage offers another coverage option. Acknowledging that improvements to Medicare Advantage plans and availability in recent years, a number of issues or challenges remain: (1) the lack of Medicare Advantage options for certain counties; (2) difficulties of understanding the coverage and steps needed to avoid out-of-network charges, (3) the lack of providers within a reasonable distance; (4) providers changing acceptance of plans from one visit to the next; (5) out-of-pocket maximums not including all out-of-pocket expenses, therefore costing much more than the individual sometimes expects; and (6) sometimes an individual chooses a Medicare Advantage plan based on drug coverage or sometimes for provider coverage, but not both. So one plan may not fit an individual's need where original Medicare with a drug plan and a Medigap plan may offer much better coverage and access to providers and medical services. With that, we just want to urge you to support LB32 and I'll take any questions.

SLAMA: Thank you. Mr. McDonald. Are there any questions from the committee? Senator Kauth.

KAUTH: About how many people with developmental disabilities would need this?

EDISON McDONALD: That's a good question. I don't have a good answer for you.

SLAMA: Thank you, Senator Kauth. Additional committee questions? Seeing none, thank you very much. Good morning.

JINA RAGLAND: Good morning. Good morning, Chair Slama and members of the Banking, Commerce and Insurance Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d, here today testifying on behalf of AARP Nebraska in support of LB32. AARP Nebraska is a nonprofit, nonpartisan organization that works across the board to strengthen communities and advocates for the issues that matter most to families of those 50 and older. Medicare supplement insurance is a form of

supplemental insurance that helps pay for gaps in Medicare payments. Given the high costs of healthcare and Medicare cost-sharing, Medigap policies are key to affording care for people in traditional Medicare, eliminating the cumbersome 20 percent copay 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 of the beneficiaries under the age of 65 on Medicare due to a disability. It's the policy of AARP that Congress and state legislatures should keep Medicare supplemental insurance, also known as Medigap, policies affordable and available to those who need it. One of those being by requiring Medicare supplement insurance to provide Medicare beneficiaries with disabilities under age 65 that same guaranteed issue of access to supplemental coverage given to those that are age 65 and older. In Nebraska, concerns remain that we are not providing that access to those individuals. People who aren't yet 65 can enroll in Medicare if they're disabled and they've been receiving disability, disability benefits for at least two years. As with end-stage renal disease, or ESRD, or if your disability happens to be ALS or Lou Gehrig's disease, you do not have to wait 24 months for Medicare coverage. You can require Medicare as soon as you become entitled to Social Security disability insurance. Federal legislation was enacted in late 2020 that ended the waiting period, allowing ALS patients to get Social Security disability insurance and Medicare immediately after diagnosis. More than 367,000 residents are enrolled in Medicare in Nebraska and as of January 2023, 48 insurers offered Medigap plans in Nebraska and about 182,000 people are on Medicare with a Medigap plan. And Senator Kauth, to answer your question, roughly 11 percent of those beneficiaries are under 65. I don't have the exact number, but it's a percentage of about 11 percent. Thirty-four states now have the same guaranteed issue requirements for Medigap. And again in Indiana, Tammy's Law became law in July 2020 and most recently was enacted in Virginia in 2021 to ensure that Medigap plans for disabled enrollees under age 65 were put into play. Individuals who are under age 65 who qualify for traditional Medicare due to their disability that have ESRD or ALS are among those with the greatest healthcare needs. They're greatly in need of affordable Medigap policies to supplement Medicare cost sharing. The other note I want to make in closing is though-- those who obtain Medicare often have-- or those under 65-- have high medical bills and medical costs and those are reported to be the most common reasons for bankruptcies; 66.5 percent of bankruptcies are caused directly by medical expenses, making it the

leading cause for bankruptcy. AARP supports LB32, thanks Senator Jacobson, and thanks the committee for your consideration.

SLAMA: Thank you very much, Ms. Ragland. Are there any questions from the committee? Seeing none, thank you for being here.

JINA RAGLAND: Thanks.

SLAMA: And just so everyone knows, this is not my legal counsel's phone just going off. We've got the light system. We've found it's also helpful to supplement with a bit of an alarm once you get to three minutes and 15 seconds just to wrap things up so that we can make sure everybody who came here to be here today can, so. All right, good morning.

LESLIE SPRY: Good morning, Chair Slama and members of the committee. My, my name is Dr. Leslie Spry, L-e-s-l-i-e, Spry, S-p-r-y. I am testifying in support of LB32 on behalf of the Nebraska Medical Association. I'm a kidney guy in, in here on behalf of the Nebraska Medical Association and I previously served as the member of the Nebraska State Board of Health and as well as a past president of the Nebraska Medical Association. The Nebraska Medical Association supports LB32, which would make Medicare supplemental policies accessible and affordable to individuals under 65 who are eligible for Medicare because of disability or end-stage renal disease. Without sup-- a supplemental policy, Medicare beneficiaries with end-stage renal disease must figure out a way to pay 20 percent of medical costs not covered by Medicare. For patients needing dialysis multiple times per week, this amount-- can amount to as much as $20,000 or more per year. Additionally, Medicare alone is not considered full coverage by transplant centers, meaning that without supplemental insurance, these individuals cannot be added to the transplant waiting list. The most difficult problem is watching these young dialysis patients not be able to get on the transplant list. Getting a kidney transplant will double their life expectancy as compared to staying on dialysis. I have seen patients start GoFundMe pages in order to obtain comprehensive coverage in order to get on that transplant list. I have reviewed patients in our not-for-profit dialysis unit and 6 percent of our patients out of a total population of 307 are under the age of 65 and having difficulty obtaining supplemental coverage. Half of those individuals are unable to get any supplemental coverage and ultimately must rely on charity care, the Nebraska Chronic Renal Disease Program, which only pays a small portion of that and also has income limits, or exhaust their resources until they qualify for Medicare or Medicaid.

Over the years, I have seen multiple patients who fall in this gap and end up in bankruptcy. While medical costs for these folks are substantial, the numbers of them are small compared to the overall 65-and-over Medicare population in Nebraska. While my experience is primarily with renal disease, the Nebraska Medical Association also supports extending coverage to those who qualify for Medicare because of disability, which can be equally devastating to their-- to patients' finances. The majority of states, including our neighbors in Kansas, South Dakota, Colorado and Missouri have already taken action to make affordable supplemental coverage available for Medicare patients under the age of 65. Nebraska should do the same for these critically ill and disabled patients. Giving these individuals the ability to purchase supplemental policies will allow them to focus on their health rather than the enormous stress of figuring out how to deal with the financial burden of their condition and ultimately keep additional patients off the Medicaid rolls. Thank you for your time and I'll be happy to answer any questions.

SLAMA: Thank you very much, Dr. Spry. We appreciate your testimony. Is there any questions from the committee? So I have one. In your experience, what is the cost of replacing that kidney versus a lifetime on dialysis?

LESLIE SPRY: So the first-year costs for kidney transplant are usually around $100,000 to $120,000. And then after that, even Medicare has shown that the cost benefits accrue over time. So the first-year average cost for dialysis patients per year is about $80,000. So yeah, you end up spending some more money the first year, but after that, costs go down substantially. And so about-- if, if that kidney lasts two years, you're in the plus.

SLAMA: There we go. Well, thank you very much. I appreciate it. Good morning.

DEAN LARGE: Good morning. My name is Dean Large, D-e-a-n L-a-r-g-e. I live in southwest Nebraska and I am one of those people that's affected by the Medicare gap for people under 65. I have-- when a person needs the access to Medicare prior to 65, their life has already been turned upside down. The last thing they need is problems with insurance. I went on Medicare on--- in December, on December 1, 2022, but I will turn 65 on September the 10th in 2023. So I'm 64 years old. I have failed kidneys. I'm on home peritoneal dialysis and have been since October of 2021. In December of 2022, I took out a Blue Cross and Blue Shield Medicare Advantage to try to fill that gap.

However, my kidney dialysis provider is not contracted and I still have a gap. Here in southwest Nebraska, there was only one insurance company that even provided anything. I got Blue Cross and Blue Shield as a Band-Aid to get me through till September. I have been on the policy for two months and still have no idea if I'm exposed to any large bills or not because of my dialysis contract-- or my dialysis provider not being contacted. The state of Nebraska and the Unicameral needs to take a very serious look at the gap in the Medicare coverage for people that's under 65. I want to encourage the support of LB32. And also for your information, I am trying to get on a kidney transplant list and I've been trying for the last two years and insurance is one of the big hurdles that I-- you've got to deal with.

SLAMA: Thank you very much, Mr. Large. We appreciate it.

DEAN LARGE: Any questions?

SLAMA: Any questions from the committee? Senator Dungan.

DUNGAN: Thank you, Chair Slama. Thank you for being here today. I appreciate you sharing your personal story. I think that's incredibly important. One of the things we've heard a lot about here today is the transplant list and the hurdles that go into that. For those of us who have not had to deal with that incredibly difficult process, can you explain a little bit more as to what hoops you do have to jump through to get on that list? I know it's a lot.

DEAN LARGE: Are you sure you want to really go and hear my story?

DUNGAN: Yeah and I know we're trying to get a lot of folks in today, but--

DEAN LARGE: Well, one of the--

DUNGAN: --I think it's really important to hear about that.

DEAN LARGE: I started down the transplant list-- and I'll be flat-out blunt and honest-- in July, two years ago. And my wife was fighting cancer and I was coming-- being healed from bypass and I-- my health wasn't good and whatever else so it just took a little longer. And I tried-- the University of Nebraska at Omaha is where I was at. The first thing I ran into is a COVID mandate vaccination program. So that has been a hurdle that I have not wanted to deal with. So therefore, I have to look out, out of state. And at that time, it was Tulsa, Oklahoma, and found out later on that it was Sioux Falls, South

Dakota, was an option. And here in the last two months, you know, after 15 months of fighting and whatever else, I found a place in Denver. And of course, the legal side or the insurance side is a big thing. But I have polycystic kidney is what basically caused-- it's a genetic trait and it runs in the family. And I am trying to find a donor to help me move up because the only viable hospital right now that I have-- that I can drive to is got-- without a donor has got a five-year waiting list. I'm not going to make it without a-- without having a donor to go with me or somebody to help me out or policy changes at the university in Omaha policy changes. And/or because when you turn around and start trying to go to, like, Sioux Falls, South Dakota, whatever else, are you willing to move there for two years to get on their list?

DUNGAN: Thank you. I appreciate going into a little more detail about that. I think it's important for people to hear. Thank you.

SLAMA: Absolutely. Thank you, Senator Dungan. Additional committee questions? Seeing none, thank you very much, Mr. Large.

DEAN LARGE: Thank you.

ANNA ZELINSKE: Hello.

SLAMA: Good morning.

ANNA ZELINSKE: Good morning. My name is Anna Zelinske, A-n-n-a Z-e-l-i-n-s-k-e, and I submitted my testimony online so I'm just going to share some highlights. I'm here representing the Amyotrophic Lateral Sclerosis Association, or ALS Association, and the people of Nebraska who are living with ALS or Lou Gehrig's disease. So for those of you who don't know about ALS, ALS is an always fatal neurodegenerative disease that affects the way the brain communicates with the muscles and slow-- so slowly over time, usually within two to five years, the message is going to the hands to where we're able to use our hands or our feet where we're able to walk eventually to our ability to swallow and eat and also to breathe. Once the messages die that go to the diaphragm, then the lungs no longer work and the person passes away. Typically, this is within two to five years, as I mentioned, and scanned-- there's no diagnostic test for ALS. So if a person is dealing with weak hands or weak feet, there's a lot of ruling out. And so a person who has a very laborious job may end up being out of work for quite a while before they have an answer of what, what the disease-- what is causing the disease. And this is a

reason why people with ALS are eligible for SSDI benefits and therefore Medicare before other diseases. And so while relief comes after the end of this search for what's causing the person's diagnosis, that obviously is short lived because the answer is the person will continue to lose function and will pass away from this disease. I understand this probably evokes some sadness or potentially even pity for people going through this, but I've worked in disability world for more than 20 years and I've learned people with disabilities don't want our pity. They don't want to be made to feel-- felt sorry for. People living with disabilities in Nebraska don't need people feeling sorry for them. What they need is access to services and insurance and ability to be able to live well with their disease. And with ALS, to actually die well. And well-- and not leave their young families often in peril or bankruptcy. So another just reality is that any one of us here in this room are really one diagnosis, one accident, one wrong place, wrong time place away from dealing with this, very real-- these very real issues. So I respectfully ask for your support for this bill. Thank you.

SLAMA: Thank you very much. Ms. Zelinkse. Are there any questions from the committee? Seeing none, thank you.

ANNA ZELINSKE: Thank you.

SLAMA: Additional proponent testimony for LB32? Do we have any op-- Mr. Bell, are you opponent?

ROBERT M. BELL: I am an opponent.

SLAMA: OK. Last call for proponent testimony. Seeing none, we'll move to opposition testimony for LB32. Good morning, Mr. Bell.

ROBERT M. BELL: Good morning, Chairwoman Slama 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 LB32. As you know, the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies. Many of the federation members' companies are active in the Medicare supplement insurance marketplace and have policyholders who would be impacted by the passage of LB32, which would mandate that insurers of Medicare supplement insurance offer such policies individuals who under 65 years of age and who are eligible for Medicare by reason of disability. Medicare supplement policies,

commonly referred, referred to as Medigap policies, are plans sold by private insurers to provide coverage for some of the costs original Medicare does not cover. According to information from America's Health Insurance Plans, or AHIP, over 182,000 Nebraskans had Medigap policies in 2020. 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 LB32 will lead to increased premiums for Nebraskan seniors, leading to disruption and dislocation of 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, according to MedPAC-- a MedPAC report, beneficiaries younger than 65 account for a disproportionate share of Medicare spending, as do individuals with end-stage renal disease, or ESRD. And that's the handout I gave to you from that report from this summer. I would highlight that the ESRD population has, on average, six times higher cost than the average senior population. According to the Kaiser Family Foundation, over 1,000 Nebraskans under 65 are eligible for Medicare because of ESRD, which would add, with some back-of-the-envelope math based off of what Dr. Spry said, approximately $80 million of cost to the Medigap population, or over $400 a year for a senior enrollee in premium. We are sympathetic, of course-- I'm going to shorten my testimony, I guess, so sorry about that. We are sympathetic to the difficulties for individuals under 65. In the ESRD population, as you've already heard, Medicare Advantage is an option and has recently become an option for these individuals. Medicare Advantage is very similar to insurance that's provided by employers. It's, it's managed care. So the insurance that I have through my wife's employment is, is a managed care type of, of policy where I can only see certain doctors or I have to get prior authorization and all of those other, other matters that go along with it. I would-- just two additional points, if I may, Madam Chairwoman.

SLAMA: Very briefly.

ROBERT M. BELL: Yes. There are a small number of Medigap policies that are offered to individuals under 65 already, but of course, they would be subject to underwriting and-- yeah, and you've already heard about other states so I'll leave that be, so. And Senator Jacobson and I have spoken about these differences between Nebraska and other states. With that, the federation is opposed to the passage of LB32. Thank you.

SLAMA: Thank you, Mr. Bell. Are there any questions from the committee? Yes, Senator von Gillern.

von GILLERN: Mr. Bell, I was jotting down a few numbers as you went.

ROBERT M. BELL: Yeah, sorry.

von GILLERN: I want to make sure I got this correctly. You said there's 182,000 existing policies in Nebraska.

ROBERT M. BELL: Medigap policies, yeah.

von GILLERN: Medigap policies.

ROBERT M. BELL: So Nebraska is a very heavy Medigap state. So compared to, say, Missouri, which was mentioned, if you took the same rate of Medigap policies in Nebraska, that-- we would expect to see about double the number of Medigap policies that were-- would be in Missouri. So Missouri has about half of what we would have by, by rate. So we have a very healthy Medigap market for seniors in our state.

von GILLERN: And back to your back-of-the-envelope math--

ROBERT M. BELL: Yep.

von GILLERN: --is it that-- those 182,000 policies would potentially increase by approximately $400?

ROBERT M. BELL: Yeah, yeah. And again, this is just-- I mean, there's a lot of caveats on that.

von GILLERN: I know. I'm not nailing you on, on--

ROBERT M. BELL: Yeah, yeah. So you take-- if you take $80 million divided by 182,000, that's $430 a year.

von GILLERN: OK. And what is-- what are those premiums annually? What does that $400 represent as a percentage increase? What were those premiums?

ROBERT M. BELL: That I don't know. I mean, it's going to depend greatly. I mean-- and again, this is pretty bad math.

von GILLERN: Five percent, 50 percent increase?

ROBERT M. BELL: That I don't know--

von GILLERN: OK.

ROBERT M. BELL: --so.

von GILLERN: Great. OK. Thank you.

ROBERT M. BELL: Yep. You're welcome.

SLAMA: Thank you, Senator von Gillern. Additional questions from the committee? Seeing none, thank you, Mr. Bell.

ROBERT M. BELL: You're welcome.

SLAMA: All right, additional opponents? Good morning.

JEREMIAH BLAKE: Good morning. Good morning, Chairwoman Slama and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs associate and registered lobbyists for Blue Cross and Blue Shield of Nebraska and I am testifying in opposition to LB32. In order to not be repetitive with Mr. Bell, I'm going to skip over this a little bit, but as you know, Blue Cross and Blue Shield of Nebraska offers Medicare supplement policies to cover the costs that Medicare does not, including deductibles, copays and coinsurance. We offer seven standardized plans in Nebraska and premiums are based on the individual's age and other health indicators. LB32 would require insurers like Blue Cross to make Medicare supplement, supplement plans available to individuals who are under the age of 65 and who are eligible for Medicare. The bill also limits our ability to rate and price plans for this new population, resulting in higher premiums for other members. And as Mr. Bell referenced, there's the report from MedPAC that found that this population is more expensive to cover. Although we don't offer plans in other states or have experience in Missouri or Kansas or other states, we can't quantify what that impact would be. But reasonably, we can assume that because of the additional costs, it would increase rates for our members. Again, with that said, we're more than happy to sit down with Senator Jacobson and the committee and try to work something out that's workable for, you know, the needs we've heard here today and something that's unique to Nebraska. So with that, I'll close and answer any questions you have.

SLAMA: I appreciate that. Thank you. Mr. Blake. Are there any questions from committee members? Seeing none, thank you very much.

JEREMIAH BLAKE: Thank you.

SLAMA: All right, additional opponent testimony to LB32. Good morning.

TOM GILSDORF: Thank you, committee members. My name is Tom Gilsdorf, G-i-l-s-d-o-r-f, and I'm with Medica Insurance Company, a nonprofit insurance company based in Minnetonka, Minnesota. We're 12 states and in Nebraska, we offer individual health, group health insurance, Medicare Advantage, Medicare supplement and. Medicare cost plans. And I won't repeat some of the information from the previous testifiers, but I am testifying in opposition to LB32; 180,000 individuals on Medicare supplement plans in the state of Nebraska. That's half the state's Medic-- Medicare population. And it's, it is a popular option in part because it is still an affordable option for seniors, a lot of whom are on fixed incomes, don't have the ability to, you know, increase what they can pay. "MedSup" premiums do go up based on the risk pool that's insured by that insurance company. It is a vibrant market. There's dozens of carriers in this market and it's, again, a very popular option. So there was a 2018 study by the University of California, I think the-- that the doctor that previously testified. It's consistent. There's about 1 percent of the Medicare population across the, the country is-- has ESRD. That represents 7 percent of Medicare's costs. And the average cost of a dialysis patient to the Medicare program is $90,000. So again, affordability is a concern for, you know, half of this state's population. And this conversation would be different if we were having it three, six years ago. So I want to talk a little bit about Medicare Advantage. Is it a perfect option? No, I don't, I don't know that it's a perfect option for everyone. But in this state, Medicare Advantage is available in 86 of the 93 counties and 95 percent, percent of the state's Medicare population has access to a Medicare Advantage plan. There might be one in the county or in the more metro areas, there's, there's several. It's guaranteed issue. Medicare has provided a, a support structure with risk adjustment payments to help with the financial viability of those programs. A lot of those programs have, have travel benefits to the doctor, to the pharmacy, meal programs, all things that are not available with the Medigap market. And as Medigap premiums increase, you know, you look at the premium of an average Medicare Advantage PPO plan. It might be zero, $50, $75. There was a question on "MedSup" premiums. Out-of-pocket-- average out-of-pocket for a Medicare Advantage PPO may be $4,000 to $6,000. If that's out-of-network, it's going to be higher. But when you start to look at Medigap premiums that get to $250, $350, $450 a month, you start to get to $3,000 to $4,000 to $5,000 to $6000 in out-of-pocket costs in premiums. So,

again, I just want to make this, this committee-- maybe just a minute here?

SLAMA: Less than a minute.

TOM GILSDORF: --OK-- aware of the options. I think we have options here with education through our SCHIP program on what is available, as well as with this bill, the opportunity to look at appropriately putting the rates where they need to and plan availability. I think some things that maybe have worked in other states. But again, I think education to the population is key.

SLAMA: Thank you--

TOM GILSDORF: Thank you.

SLAMA: --Mr. Gilsdorf. Are there any questions from the committee? Seeing none, thank you very much.

TOM GILSDORF: Thank you.

SLAMA: All right. Additional opponent testimony to LB32. Seeing none, is there anybody wishing to testify in the neutral position on LB32? Seeing none, Senator Jacobson, you're welcome to close. And as you approach, we have letters for the record: 12 proponents and one opponent.

JACOBSON: Thank you, Chairperson Slama and members of the committee. I want to close by really speaking to you more about the reality of the need for this bill. What we've heard today in testimony is that other states are doing it. I don't know why Nebraska cannot. I refuse to believe that Nebraska cannot. I would also tell you that we've heard about premiums, but all we've heard as wild estimates. We've not heard any hard numbers. And this is-- this bill has been hanging out there to be studied. We have a good idea of what's happening in other states in terms of premium costs. It's easy to go ahead and scare people with premiums to be able to keep from doing the right thing. I live in western Nebraska. I live in west-central Nebraska. I'm in District 42. I can tell you I'm painfully aware of the problems we're having with providers. If you look across western Nebraska and across the Third Congressional District, many community hospitals lost money last year. It's becoming more and more challenging to keep those hospitals open. Providers under various plans are becoming more and more limited. What we've learned in McCook, we saw what the problems are with no providers on Medicare Advantage. Don't get me started on Medicare

Advantage. I've got a long list of problems with Medicare Advantage. It's a replacement to Medicare, not, not a supplement. This is a bill that I believe is-- it needs to be done. It's probably two or three years late. Put yourself in the position that you've worked your entire life, you and your spouse. You're about to retire, a few years away from retirement. You're going to travel. You're going to enjoy retirement. And suddenly you're dealing first with the impact of the disability by your spouse. And then you're faced with the idea that you're going to spend down all the money that you've saved for retirement to cover the needs that this plan would cover. I don't think that's right for Nebraska. I think we have a choice today to ask ourselves, is it Nebraska, the good life, or is Nebraska not for everyone? I think it's the prior. I think we can do better. And I hope you will forward-- vote favorably on LB32. Thank you.

SLAMA: Thank you very much, Senator Jacobson. Are there any questions from the committee? Seeing none, this brings to a close our hearing on LB32. We'll now move into LB145, Senator Bostar. All right. Senator Bostar, welcome to your committee.

BOSTAR: Good morning.

SLAMA: Good morning.

BOSTAR: Good morning, Chair Slama and fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29. I'm here to introduce LB145, legislation to provide affordable access to coverage of mammography, as well as other forms of diagnostic imaging during breast health examinations to better protect Nebraska women from breast cancer. And for the record, I will be speaking about the white copy amendment that was just, just distributed and not the green copy bill. Forty-five percent of American women report struggling to access preventative care, costs being cited as a leading barrier to care access, according to an Ipsos poll released on January 31, 2023, on behalf of the Alliance for Women's Health and Prevention. Twenty-five percent of women surveyed said they could not afford to access healthcare, underscoring the role that high healthcare costs are playing in patient engagement and well-being. Preventative care like well visits and screenings reduce the risk for disease and help support healthy lives. LB145 will remove barriers to care and bring breast cancer screenings within reach of many more Nebraska women. According to the Centers for Disease Control and Prevention, approximately 40 percent of women have breast tissue

that is considered dense. Women with dense tissue have a higher chance of developing breast cancer. The more dense the tissue, the higher the cancer risk. Generally, glandular and fibrous tissue is more dense than fatty tissue and is more likely to develop cancer. Dense tissue can also hide cancer because tumors and dense tissue appear similar on a mammogram. Mammograms provide a lower level of sensitivity than other types of diagnostic imaging and this reduced sensitivity can lead physicians and experts to miss small tumors in the screening process, putting women with dense tissue at a greater risk of complications and death. Other forms of diagnostic imaging, such as ultrasound or magnetic resonance imaging, can provide healthcare practitioners with better information earlier, as these forms of imaging are better at detecting the presence of tumors in dense tissue. This legislation allows women with dense tissue to access screening methods that can more easily detect small tumors and cancers still in early stages, thereby giving them a better chance to defeat the disease and live healthy lives. The CDC also notes that a woman's risk for breast cancer is higher if she has a mother, sister or daughter, a first-degree relative or multiple family members on either her mother's or father's side of the family who have had breast or ovarian cancer. Family history, as well as certain specific genetic mutations, can place some women at a significantly increased risk for breast cancer. LB145 stipulates that health insurance plans that cover mammography must also provide coverage for other forms of diagnostic imaging when medically appropriate. This legislation states that any woman who is under 40 years of age is entitled to at least one mammogram each year and additional mammograms if determined necessary by their healthcare provider if they are determined to be at an increased risk of breast cancer, due to a family or personal history of breast cancer or prior atypical breast biopsy, positive testing for a concerning genetic mutation or dense tissue based on breast imaging. LB145 goes on to specify that any woman who, based on the National Comprehensive Cancer Network guidelines for breast cancer screening and diagnosis and the recommendation of the patient's healthcare provider, has an increased risk for breast cancer due to a family or personal history of breast cancer or prior atypical breast biopsy, positive testing for a concerning genetic mutation or dense breast tissue based on breast imaging is entitled to one digital breast tomosynthesis or 3D mammogram and one bilateral breast ultrasound each year. And finally, any woman who, based on the National Comprehensive Cancer Network guidelines for breast cancer screening and diagnosis and the recommendation of the patient's healthcare provider, has an increased risk for breast cancer due to a family or personal history

of breast cancer or prior atypical breast biopsy, positive testing for a concerning genetic mutation or a history of chest radiation which can increase cancer risk is entitled to one diagnostic magnetic resonance imaging each year. According to the American Cancer Society, breast cancer is the second most deadly cancer affecting women. Furthermore, a 2021 clinical review from the American Society of Clinical Oncology Journal finds that the incidence of invasive breast cancer is increased among adolescent and young adult women since 2004 and breast cancer among this population is frequently hereditary. This population of younger women are also more likely than older women to present with aggressive subtypes, advanced disease and increased mortality risk. The earlier the detection, the better chance healthcare professionals have of both treating and curing breast cancer for women of all ages. LB145 better equips our physicians and healthcare providers with the tools and resources they need to keep women in Nebraska healthy. Thank you for your time. I would encourage your support of LB145 and I'd be happy to answer any questions you may have at this time.

SLAMA: Thank you, Senator Bostar. Are there any questions from the committee? Yes, Senator Kauth.

KAUTH: Senator Bostar, what's the current mandate for care? What do people get now and at what ages?

BOSTAR: So under the ACA-- I have this. It's actually in the white copy as well, just because it's carried over text. I believe it's over 40 years of age.

KAUTH: OK.

BOSTAR: You're entitled to--

KAUTH: Every year?

BOSTAR: --a mammogram.

KAUTH: Every year or every other year?

BOSTAR: Every year. Possibly. There are definitely people behind me that will know [LAUGHTER] the specifics of that. And then there are-- I think there are circumstances where that can-- that's-- that changes depending on your, your personal medical factors.

KAUTH: So this is just looking to reset it, if it's at 40 to reset it to 35 and still allow the--

BOSTAR: So this-- so this bill would, if you're under 40, if you have a, a-- one of--

KAUTH: [INAUDIBLE].

BOSTAR: --multiple risk factors, you would be entitled to at least one mammogram a year.

KAUTH: So, if you're like 20 or 25--

BOSTAR: Correct.

KAUTH: --it's just no age limit, it's just those risk factors make it--

BOSTAR: Yes.

KAUTH: --OK.

BOSTAR: And then, depending on other risk factors, you could be entitled to, at any age, for example, an ultrasound.

KAUTH: Um-hum. A further diagnostic tool--

BOSTAR: Right.

KAUTH: --based on your personal medical.

BOSTAR: And then a whole separate set of risk factors, could it-- could, under this legislation, entitle you to an MRI.

KAUTH: OK. Thank you.

BOSTAR: Thank you.

SLAMA: Thank you, Senator Kauth. Additional questions from the committee? Just a quick follow-up, judging from the white copy, page 1, line 26, we're taking that from 50 to 40, that age limit? OK. I see nodding heads in the audience.

BOSTAR: Yes.

SLAMA: That is good enough for the record. Thank you. All right. Thank you very much, Senator Bostar.

BOSTAR: Thank you.

SLAMA: We'll now open it up for proponent testimony for LB145. Good morning.

MARY JANE GLADE: Good morning. Thank you, Chair Slama. I'm Mary Jane Glade, M-a-r-y J-a-n-e G-l-a-d-e. I am a doctor of nursing practice, certified a family nurse practitioner. I actually went back and got my doctorate in 2019 from Creighton and did my dissertation and my scholarly project on this very matter, so I have my lovely 60-page, you know, presentation, if anybody ever wants to read it. But about eight years ago, I was working at a gynecology and fertility clinic here in Lincoln, Nebraska, a very large women's health practice and I started a screening program there for women based on their risk factors and identification of if they needed more screening based on their personal risk factors. So I called it a cancer risk assessment and I looked at their family history, their personal history and I would individualize a screening plan that was appropriate for them based on their risk. I identified many women that needed additional screening at different ages, whether it be mammography before age 40, MRI of the breast, whole breast ultrasound. And when we added these additional screenings, we found very early stage cancers, precancerous lesions. And I have it all that the data shows and supports that if we identify these women and provide additional supplemental screenings, we're going to reduce cancer in Nebraska. I, I would be amiss to say that-- I bet everybody in this room has been affected by somebody or knows somebody or been affected by cancer and maybe not just breast cancer. What would you have done if you could have prevented that patient from getting that cancer or that family member or preventing them from getting chemotherapy or radiation or finding their cancer at a very early stage? I'm sitting here today as a, as a high-risk individual, but also as a provider who truly cares about my patients and identifying the risk factors to provide supplemental screenings that could change their lives, you know, in Nebraska. And, you know, not a lot of states have legislative like-- Legislature like this, but there are many states who provide supplemental breast ultrasound for those women with dense breast tissue. I think a lot of us have heard about Katie Couric. Her, her cancer was not identified on her mammogram. She was getting an automatic breast ultrasound every year, which identified her cancer. I'm sitting here as-- for a patient who wasn't able to come today. Diagnosed at 35, she was identified as high

risk at 30. She was getting an MRI and a mammogram at age 30. And because of the cost of her insurance not covering it as a covered preventative service, she did not get her MRI two years ago. She now was diagnosed with a five centimeter breast mass in her lymph node. She has a four and a two year old. She's going through chemotherapy. She is kicking herself because if she would have had the ability to have that MRI done two years ago, her story would be much different. And, you know, we hope she survives it. But breast cancer is a leading cause of cancer deaths in Nebraska and 15 percent of those diagnosed this year have an elevated risk that should be identified. So thank you very much and I'm open to questions.

SLAMA: Thank you very much, Dr. Glade. Are there any questions from the committee? Senator Dungan.

DUNGAN: Thank you, Chair Slama. Thank you for being here. I appreciate your expertise in the area. And I know we have a lot of testifiers, but one of the things I wanted, maybe, to have you expand upon just a little bit-- this may sound dumb, but obviously catching the cancer earlier or catching the possibility earlier can make it easier to provide that care or prevention.

MARY JANE GLADE: Right.

DUNGAN: How does that exactly work? Catching it earlier. What are the things that you can do that can then lead to prevention and/or preliminary care that can reduce the need for the more extensive care down the road?

MARY JANE GLADE: Absolutely. So I sit down with every patient, I go through their risk factors, their family history, might incorporate genetic testing so if they're identified to have a genetic predisposition to cancer, such as a BRCA1 mutation which is probably the most well known and we have speakers to speak on this, we identify screening methods for them, which might include a breast MRI start at age 25, because their risk of developing breast cancer is 87 percent in their life. So if we add an MRI in addition to a mammogram, we're able to catch cancers that are less than a centimeter, more likely to be node negative so less need for chemotherapy/ radiation, which are extremely high costs in cancer care and for preventative surgery some of the time to reduce their breast cancer risk to less than 5 percent.

DUNGAN: And I think you kind of answered my follow-up question with that. But just to clarify for the record, if we catch these things

earlier, do you believe, in your professional experience, that's going to lead to reduced costs moving forward?

MARY JANE GLADE: Absolutely. One hundred percent. And we can show-- I mean, the data shows that. I have it here. We have publications that the cost of a cancer treatment if you're doing chemotherapy/radiation, is probably about $200,000 a year now. If we catch a atypical lesion on an MRI, we do an excisional biopsy, we take it out, we put them on a medication and they go on their, their, their day and their life.

DUNGAN: Thank you.

MARY JANE GLADE: Yes.

SLAMA: Thank you, Senator Dungan. Additional questions from the committee? Seeing none, thank you, Dr. Glade.

MARY JANE GLADE: All right. Thank you very much.

SLAMA: And I would ask those wishing to be proponents on this bill, just start moving forward to some of these front couple of rows, just to lower turnaround time and to make sure that you can get heard. All right. Good morning.

BRANDI PRESTON: Hi. My name is Brandi Preston, B-r-a-n-d-i, Preston, P-r-e-s-t-o-n, and thank you all for your time. If you had an 87 percent chance of getting in a car accident today but you had no choice but to get behind the wheel, I'm sure you would all do something a little differently. You probably wouldn't have your children in the car, you would likely wear your seatbelt, you would drive the speed limit. You might even slow down for that yellow light instead of racing through it. These precautions are similar to the screening protocols recommended for our high-risk women. The difference? Car insurance companies give discounts for good grades, a clean driving record, completing driver's education. Medical insurance does not. Another difference? Driving behaviors are a choice. Women do not choose their genetics nor do they choose the density of their breasts. I certainly did not choose mine. When I was nine years old, my mom was diagnosed with breast cancer. Sorry. Every time. She was an Omaha police officer. She was a marathon runner. She never smoked and she rarely enjoyed a cocktail. Her lifestyle choices were about as healthy as one can get, yet she was diagnosed with breast cancer at the age of 35 and unfortunately, lost her battle at the age of 40. Forty is when most women begin breast imaging. My mom had already had

five breast surgeries, chemotherapy, radiation and was dead at that milestone age. At the age of 19, I learned I, too, carried the BRCA1 gene mutation, giving me an 87 percent lifetime risk of developing breast cancer. In 2010, my insurance did not cover my genetic testing, even though I had a 50/50 chance of carrying the same mutation my mother had. I was subject to my deductible for my appointments and for my screenings, costing me thousands of dollars out of pocket each year. At the age of 22, I was proud to say I worked my way through college and graduated with no student loan debt. However, I graduated with $20,000 in medical debt. Weighing my cancer risk and my financial future, I chose to undergo a preventative bilateral mastectomy and reconstruction. My breast tissue was removed entirely. My pectoral was taken from my chest wall, attached to my skin, so my skin and my nipples would not fall off and die. I then had implants. My breasts now are purely aesthetic. I have no feeling or sensation and I will never be able to breastfeed children. That is my story, but data also tells a story. Serious data shows five-year survival rate for early-stage breast cancer is 99 percent. On the contrary, 12 percent or one in eight women with metastatic triple-negative breast cancer, the same kind my mom had, will survive to five years. That number to me seems criminal. One in eight. Especially when we have the screening modalities to find this cancer early and to beat it. Women should not be dying from this disease. I testified here today in hopes that when another young woman contemplates the decision between annual breast screening or breast amputation, that cost is not a driving factor. And LB145 has the ability to ensure that the cost will not be the determining factor in whether or not a woman lives or she dies. Thank you for your time.

SLAMA: Thank you very much, Ms. Preston. Are there any questions from the committee? Seeing none, thank you, again.

BRANDI PRESTON: Thank you.

SLAMA: Good morning.

KIM DANIELSON: Good morning. Hello. My name is Kim Danielson, K-i-m D-a-n-i-e-l-s-o-n, and I am 46 years old. I'm married, I have two beautiful girls, ages ten and seven. I work full time outside the home and I am a breast cancer survivor. I was diagnosed at Stage 1 invasive breast cancer in December of 2021 after having a screening breast MRI. This shocked most people because I'm kind of known by my friends as the poster child of breast screening. I never miss an appointment. What was even more shocking to me, is that I had a completely mammo--

completely clean mammogram six months prior to my cancer diagnosis. Even at the time of my diagnosis, they could not see my cancer on a diagnostic mammogram. I was getting high-risk screening for a multitude of reasons. I do not have a genetic mutation like Brandi, but I do have a family history of breast cancer and dense breast tissue. Even though I was diagnosed with cancer, I truly consider myself lucky. I'll probably be one of the good stories that you get to hear today. My cancer was caught at a very early, treatable stage, which allowed me to have options like a less invasive surgery-- lumpectomy versus a mastectomy. My radiation wasn't as aggressive. And because I had not-- the cancer had not advanced to my lymph nodes, I did not have to endure chemotherapy, which all those treatments, we know, can lead to life-long side effects. I was fortunate, though, because I had the means and financial ability to get my supplemental screening, which caught my cancer. Most women I know do not qualify-- or that qualify, do not go on to get this because it is a financial burden to them or they will go get their first breast MRI and decide it was expensive and can't continue on. My breast cancer was actually caught on my fourth breast MRI, so four years of screening. I can't-- I find it hard to imagine what my journey and outcome would have been if I had not been getting these breast MRIs. The reality is what we've learned, learned is that breast cancer diagnosed at an earlier stage are less expensive to treat than those diagnosed at late. Effective screening allows us to decrease the number of women diagnosed at late stage, detect cancer sooner when it's easier to treat, reduce healthcare spending and overall, save lives. The problem is mammograms are not enough and if you have additional risk factors like family history and dense breast tissue, we know that supplemental screening, like an ultrasound and breast MRI, is recommended by guidelines, however not affordable to most women. So I just want to thank you for your consideration and support for the bill to, to provide this screening for women that desperately need it.

SLAMA: Thank you very much, Ms. Danielson. Are there any questions from the committee? Senator Kauth.

KAUTH: And I don't know if you'll be able to answer this or not, but how much does it cost to do that, do the ultrasound or the MRI?

KIM DANIELSON: So I know from an MRI-- Brandi has some of these statistics, but I know, like, from an MRI standpoint, it's, you know, it's somewhere--it can be like $1,300 to $2,000 and it's subject to your deductible, so.

KAUTH: And then, so is there-- if you have the dense breasts, is there any thought that you just say no mammograms and save that and go straight to these or is a mammogram always going to be part of the screening process?

KIM DANIELSON: Mammograms are always still-- like still the start of that process. So usually you alternate, so you'll get a mammogram and then six months later, you'll get their supplemental screening. So you get two different modalities once a year, but they're staggered to help offset.

KAUTH: OK. Thank you very much.

KIM DANIELSON: Yeah.

SLAMA: Thank you, Senator Kauth. Additional committee questions? Seeing none, thank you, Ms. Danielson.

KIM DANIELSON: Thank you.

SLAMA: Good morning.

MARGARET WOEPPEL: Good morning, Chairwoman. Thank you for allowing me to be here. My name is Margaret Woeppel, M-a-r-g-a-r-e-t W-o-e-p-p-e-l. I am the vice president of Workforce Quality and Data with the Nebraska Hospital Association and I am testifying in support of LB145. About one in eight U.S. women will develop invasive breast cancer over their lifetime. Nebraska ranks the second highest category for breast cancer incidence and the third highest category for breast cancer, breast cancer deaths. This year, in 2023, it is estimated that 1,670 Nebraska women will be diagnosed with breast cancer and 270 Nebraska women will die of breast cancer. We are seeing an increase in breast cancer diagnosis in younger women. In 2021, the CDC reported 9 percent of breast cancer cases were in women less than 45 years old. In Nebraska, 12 percent of breast cancer hospitalizations are in the age range from 18 to 45. On a personal note, as a female with family-- a direct family history of breast cancer, I have been having annual breast examinations and mammograms since my thirties. I have always asked to use the most evidence-based mammography technology, even when it costs me out of pocket. Not everyone has the ability to pay additional out-of-pocket costs as I have. The late stage breast cancer treatment is significantly more than early or preventative treatment. Investing in early, preventative, high-quality annual examinations will save money. Thank you.

SLAMA: Thank you very much, Ms. Woeppel. Are there any questions from the committee? Seeing none, thank-- oh. Sorry. I thought your hand was a-- thank you very much. Additional proponents? Good morning.

DANIELLE HENRICKSEN: Good morning. Good morning, Chairwoman Slama and members of the Banking, Commerce and Insurance Committee. My name is Danielle Henricksen, D-a-n-i-e-l-l-e H-e-n-r-i-c-k-s-e-n. I'm the cancer center director for Bryan Health and a radiologic technologist by background, spending a majority of my clinical time working in interventional radiology. I've worked at Bryan for 20 years and I come to you today on behalf of the Nebraska Hospital Association and my hospital colleagues in support of LB145. LB145 expands health coverage-- health insurance coverage to include additional forms of diagnostic imaging, lowers the age at which screening is covered and allows physicians the ability to personalize screening frequency to meet the needs of patients with complex medical histories that are under the age of 40. This bill allows physicians to order the imaging that is best for each individual patient. A traditional mammogram may not be the best imaging methodology for a patient with a dense breast tissue. Allowing the autonomy and expertise of the provider to prescribe the best screening methodology will result in more cancers being detected earlier and hopefully reduce the number of imaging studies required for patients, as they get the most appropriate test first. The earlier we can detect a possible malignancy, the better. Removing barriers to screening is integral to early detection. To demonstrate this, I share the story of Becky. She received her annual mammogram, where a small tumor was detected. Becky was feeling fine and the tumor could not be felt on self-exam. It was detected early because of Becky's diligence in screening and her insurance provider allowing for this life-saving exam on an annual basis. She has completed treatment and is able to continue her vital role of wife, mom and educator. Not all patients have the access and outcome that Becky had. LB145 increases the number of Beckys we have living and thriving among us, being the wives, moms, friends and neighbors we cherish as Nebraskans. I'm grateful for the opportunity to share the importance of cancer screening and how increased access to screening saves lives. As you hear from myself and others today, I ask that you be moved to take action in support of LB145. Thank you for your time. I welcome any questions.

SLAMA: Thank you, Director Henricksen. Are there any questions from the committee? Seeing none, thank you for being here today.

DANIELLE HENRICKSEN: Thank you.

SLAMA: Good morning.

ANN AMES: Good morning, senators. I'm Ann Ames, A-n-n A-m-e-s, and I am the CEO for the Independent Insurance Agents of Nebraska. Our trade association represents 500 member agencies and 2,000 agents across the state of Nebraska and we're here in support of LB145. We firmly believe that this is an important piece of legislation that would enable women to get earlier screenings and better diagnostic imaging and give their physicians more control over their care. We definitely understand that this is a change in coverage and it has a cost. However, we recognize that prevention is the key to good health and ultimately protecting our clients is the primary goal of all independent insurance agents. Their safety, health and well-being are at the center of the services that we provide. As we know, early detection is a key factor in improving the outcomes for women and breast cancer and we believe that this bill is fundamentally the right thing to do. We believe it's good public policy and we're asking that you support this and the health of Nebraska women moving forward. If this even saves one woman, can you put a price on, on saving the-- women in Nebraska-- mothers, wives, leaders? So we ask that you support this. And I did also provide previous written testimony, but I thought if I could be here, I might as well,so.

SLAMA: Thank you very much, Ms. Ames. We appreciate it. Are there any questions from the committee members? Senator Kauth.

KAUTH: From an insurance perspective, is the cost of doing-- the additional costs for doing these additional treatments, does that outweigh the additional costs of, if even one person gets the cancers? How, how is that-- how does that affect all of your policy holders?

ANN AMES: It's--

KAUTH: So-- when, when you write these policies.

ANN AMES: --it's going, it's going to cost more, but I don't think that you can put a, a value on someone's life. So we believe that even if there is an additional cost, it's worth that.

KAUTH: Right, but what I'm saying is it, it would apply to all of your policyholders, correct?

ANN AMES: I'm sure it would, yes.

KAUTH: But if someone gets sick, it also applies to all of your policyholders--

ANN AMES: Yep.

KAUTH: --because that would raise their insurance rates.

ANN AMES: It has the potential to do so.

KAUTH: OK.

SLAMA: Thank you, Senator Kauth. Senator Dungan.

DUNGAN: Thank you, Chair Slama. And I think my questions were along the same, the same lines as Senator Kauth. But generally speaking, is it, is it in your professional opinion that this-- the cost saving that we're going to get from prevention is maybe going to outweigh any increase in premiums moving forward?

ANN AMES: Absolutely.

DUNGAN: Do you have any, like, estimates in terms of quantities or just--

ANN AMES: I don't--

DUNGAN: OK.

ANN AMES: --off the top of my head, but it's-- I mean, cancer treatment is definitely going to be more expensive for Nebraska than prevention.

DUNGAN: And so if we drive down the amount of people who need to be treated for cancer in the long term, that's going to save money overall and probably have a positive impact on premiums or at least try not to drive them up that much?

ANN AMES: We certainly think so. And additionally, there's societal costs that we're not factoring into this, because when people are sick, it affects our entire economy. It affects their ability to work, it affects their ability to care for their children and so then there's additional costs that, you know, come as a result of being sick.

DUNGAN: Thank you.

SLAMA: Thank you, Senator Dungan. Senator Jacobson. Oh, you're good?

JACOBSON: He asked my question.

SLAMA: Wow. We're getting good at this. Any additional committee questions? Seeing none, thank you very much. Good morning.

KELLI EIHUSEN: Good morning. My name is Kelli Eihusen, K-e-l-l-i E-i-h-u-s-e-n. I received my doctorate in physical therapy from the University of Nebraska Medical Center in 2015. And as of last year, I am the only one in Nebraska with a board certification specialty in oncology physical therapy. We are here today to talk about the importance of accessibility and early detection for women and healthcare, but especially those with breast cancer. From a physical therapy standpoint, we understand that the earlier detection and the least invasive surgeries lead to decreased chemotherapies, decreased radiation treatments and from a physical standpoint, decreased impairments. From my standpoint and expertise, when you have people who are diagnosed at later stages, they have impact to their posture, upper extremity function, neuropathies. They're at higher risk for cardiac toxicities, pulmonary toxicities and have decreased bone density, changes to their muscle mass and are in and out of the hospital and in and out of rehab more frequently than those who are diagnosed earlier. For me, I would say a limiting factor for access to care is cost. So when I see my patients, I have to always consider cost of what they're going through with cancer treatments and their ability to attend appointments. If they cannot afford it, they tend to come less and that care gets exaggerated out over a longer length of time. And they ultimately spend more money within-- and place more burden on healthcare systems. For the last-- for another comment, I did do some research and the American Cancer Society recently put out a study that-- in 2019, that was based on statistics from 2015 alone. It was found in that study that an expected 8.7 million years of life were-- are going to be lost within the United States out of cancer deaths and $9.4 billion of future spending would be eliminated from the economy because of those deaths and inaccessibility for return to life roles and job roles. Of that $9.4 billion, $6.2 billion were going to be directly from breast cancer diagnoses alone. My role in people's survivorship and plans of care is to provide quality over-- along with their quantity of care. If they're surviving, why are they surviving and how can I promote them to go back into those life and work roles? So I definitely see the late impacts, the chronic impairments and the importance of finding detection early so that these women can stay in their roles in all aspects of their life.

SLAMA: Thank you very much, Dr. Eihusen. Are there any questions from the committee? Senator Ballard.

BALLARD: Thank you, Chair Slama. Thank you for being here. So what's-- I know it's going to differ, but what is the average duration for someone with a breast cancer diagnosis to spend in physical therapy?

KELLI EIHUSEN: So I would say in the state of Nebraska, we're actually doing a pretty great job of leading the country in breast cancer rehabilitation. We requested and we have found, the American Physical Therapy Association has found that it's actually cheaper on the healthcare system and insurance if we do a preoperative appointment. So we see people at time of diagnosis but prior to the-- their surgery or impact of care, then follow as necessary, whether that's with chemotherapies prior to care or whatever that need may be to keep them healthy and in their life roles. We see them, definitely, about a week and a half after surgery and then as needed at that time and then throughout radiation. From there on, it is recommended, best practice, that we see patients every 4 to 5 months as a surveillance screen for 5 years after diagnosis. And again, all of that has demonstrated pretty well in the literature to overall cost insurance and the economy, less. It depends. And I will say that with those that are detected early and have less invasive surgeries and therefore they might not need chemo beforehand and/or less radiation treatments, their plans of care are very small. For those with, you know, triple negative breast cancers, those with bilateral mastectomies, long bouts of radiation and increased chemotherapies, you're looking at a significant amount of co-morbidities and increased cost to the system. We keep people alive longer with breast cancers, but they're at a higher risk actually, of dying of cardiac diseases because of their radiation and chemotherapy exposures.

BALLARD: Thank you.

SLAMA: Thank you, Senator Ballard. Additional questions from the committee? Seeing none, thank you very much.

KELLI EIHUSEN: Thanks.

SLAMA: Good morning.

ALAN THORSON: Good morning. My name is Alan Thorson, A-l-a-n, last name is T-h-o-r-s-o-n. I am testifying in support of LB145 on behalf of the Nebraska Medical Association, representing nearly 3,000

physicians, residents and medical students across the entire state of Nebraska. Senator Slama, thank you for the opportunity, Senator Dungan, Senator Ballard, Senator Kauth, Senator Jacobson, Senator Aguilar, Senator von Gillern. I have provided some written testimony. Being respectful of both your time and the time of those behind me who still want to testify, I'm not going to read that. I'm going to give you a very brief clinician's view of what LB145 means. Previous Nebraska legislatures have recognized the health benefits of breast cancer screening. However, current statute no longer recognizes the current recommendations of the American Cancer Society. LB145 would update statute to recognize those recommendations. Secondly, the current statute is-- deals with screening for average-risk patients. It does not take into consideration the high-risk patients, some of which you've already heard about. This includes family history, genetic alterations, dense breast tissue. The-- for current-- for those patients that have increased risk, there's a issue called supplemental breast cancer screening. LB145 does a nice job of defining supplemental breast cancer screening and, and does a nice job of distinguishing that from diagnostic breast imaging. In summary, from the clinician standpoint, Nebraska statute at the present time does not provide the same life-saving benefits for high-risk breast cancer patients, the ones who really need to be carefully observed, as it does for average-risk patients. LB145 does a great job of equalizing this playing field for our high-risk patients. I urge you, as committee members, to support LB145 here in the committee and also once the bill comes to the floor. Thank you very much.

SLAMA: Thank you very much, Dr. Thorson. Are there any questions from the committee? Seeing none, thank you very much for being here.

MICHELLE WEHRLY: Good morning.

SLAMA: Good morning.

MICHELLE WEHRLY: My name is Michelle Wehrly, M-i-c-h-e-l-l-e W-e-h-r-l-y, and I am here in support of LB145. I am a nurse practitioner that works in Lincoln and Omaha. For the past 10 years, my practice has been focused on not only breast cancer patients, but those at high risk due to what everybody else has said in terms of personal history, family history, genetic mutations. I'm going to be kind of short and sweet because I know there's a lot of people behind me that want to talk. But I will say that my biggest complaint for my high-risk women is the cost aspect. To piggyback off of what Kim said, a lot of women can't afford to go forth with these additional

screenings that have been recommended by their providers, due to that out of pocket. I had a patient call me that said Michelle, my options are either to pay my mortgage or have my breast MRI and that to me is terrible. We need to do better for these women. So I am asking for your support with this bill and I thank you for your time this morning.

SLAMA: Thank you very much, Ms. Wehrly. Are there any questions from the committee? Thank you very much for being here

MICHELLE WEHRLY: Yeah.

SLAMA: Good morning.

ANNIE HASSELBALCH: Good morning. I am Annie Hasselbalch, A-n-n-i-e H-a-s-s-e-l-b-a-l-c-h. If you get that right at the end, I'll give you a quarter. I am here-- and the thing that has struck me the most about this opportunity, even the previous LB, was we were all talking about numbers. That's been a lot of the questions. One is a number I want you to remember. It took one breast screening MRI for me to be diagnosed with breast cancer that was in my lymph nodes. My age was 38. I endured radiation, which cost $77,000 in cash. My surgery cost $37,000 for the surgery alone, anesthesia was $7,864. The years I am in physical therapy is to be determined. I'm a physically active, healthy female that enjoys all of the great things in Nebraska: horseback riding, going to the lake, running, hanging with my dogs. I still go to physical therapy once a week. My year diagnosis will be March 11 of 2023. I will be three years out. So when you look at the cost of what breast cancer screen-- what breast cancer treatment is, it is exorbitant. The average cost of an MRI in Nebraska, cash, is $1,250. And as Michelle previously so eloquently stated, not everyone in Nebraska has access to the amazing healthcare that I do. I work in reimbursement on the insurance side every day. I can navigate the healthcare system and get what I need. I feel extremely blessed with the knowledge that I have, the insurance coverage that I have and the fact that I just don't take no for an answer very well. That's the Nebraska thing. My ask is, in your support for this bill, is that every woman should have the opportunity to return to the quality of life that I have been so fortunate to be able to get access to. I would not even want to count-- I know my physical therapy bill for just this year is over $3,000. I'm having an MRI, actually, tomorrow at Lakeside in Omaha. That's about-- I think my insurance is like $2,000. So moving forward, I would just like you to keep those numbers in mind, but the most important one is one. And that was me. It took

one screening to find my cancer and it was still in my lymph nodes. Thank you very much.

SLAMA: Thank you very much, Ms.. Hasselbalch. Are there any questions from the committee? Seeing none, thank you so much for sharing your story. Good morning.

TANYA MARTIN-DICK: Good morning. My name is Tanya Martin-Dick, T-a-n-y-a M-a-r-t-i-n-D-i-c-k. Thank you for this opportunity this morning. I live here in Lincoln, Nebraska. I am a wife, a mother of two, vice president at Union Bank and Trust, was an avid runner and I'm now currently a member of the nonprofit board for the Lobular Breast Cancer Alliance. It is a national organization. On November 24 of 2020, at the age of 47, I got that dreaded phone call. You have ductal carcinoma in situ. I was assured that it had been caught very early. In fact, I was referred to a surgeon and a lumpectomy was what was probably in my future. I was fortunate, fortunate enough to have a fabulous friend, Annie Hasselbalch, who you just heard. And she encouraged me to go see a high-risk specialist, Mary Jane Glade. In her wisdom, Mary Jane ordered an MRI to make sure that we knew what we were up against. We were shocked to find out that I had, in my dense breast tissue, a tumor that was 3.2 by 4 centimeters. It had gone undetected on mammogram for the prior four years. Obviously, this completely changed the trajectory of my care. I would then undergo a double mastectomy because that tumor could not be removed without removing the entire breast. I also underwent four months of chemotherapy. I lost my hair, I lost my toenails, I went through extensive physical therapy for lymphedema. That is a constant for me now. Had LB145 been in place, my story might have been different. You see, for years, my doctors told me that I had very dense breast tissue. I did not have a genetic disposition, but I was never offered anything other than a mammogram and I was faithful and going to get my mammograms. The cost of my healthcare over the last two years has exceeded $250,000. Today, I ask you and I urge you to please support LB145. Not for me, but for the women that will come after me and specifically, for my 18-year-old daughter.

SLAMA: Thank you very much. Are there any questions from the committee? Seeing none, thank you so much for being here.

SHAWN McCARVILLE: Good morning.

SLAMA: Good morning.

SHAWN McCARVILLE: My name is Shawn McCarville, S-h-a-w-n M-c-C-a-r-v-i-l-l-e. I am here this morning to share my story and hopefully prevent the women that follow from the financial toxicity that I endured because of a gene mutation that I did not ask for. My mom was diagnosed with metastatic disease at age 29 and lost her battle at 33, leaving behind two daughters aged six and three. With my family history, it's always been a weight on my shoulders. When I was 24, in 2019, I was tested and it was discovered that I carried the same gene that Brandi had discussed, leaving me with an 87 percent chance lifetime risk of getting breast, breast cancer. That led me to start surveillance every six months, which was-- it was recommended to do MRIs. My insurance was not supportive, seeing as I was only 24 years old. I had to pay $1,800 dollars every six months out of pocket, but that didn't matter to me. I would go into debt knowing that my family wouldn't have to go through what they did with my mother. Fast forward to 2000-- or 2021, I had a beautiful daughter and it was put into perspective on how real this disease is. I was given the opportunity to change my future and be there for my daughter's graduation, wedding and hopefully, meet my grandchildren someday by having a prophylactic double mastectomy. I am here so that my sister, who gets the same genetic test this year, doesn't have to get into a mountain of debt in order to possibly save her life. Thank you.

SLAMA: Thank you very much, Ms. McCarville. Are there any questions from the committee?

SHAWN McCARVILLE: Thank you.

SLAMA: Thank you very much.

LAURA SCHABLOSKE: Good morning, Senator Slama--

SLAMA: Good morning.

LAURA SCHABLOSKE: --and members of the committee. My name is Laura Schabloske, L-a-u-r-a S-c-h-a-b-l-o-s-k-e. I'm here on behalf of the Nebraska Cancer Coalition, also known as NC2, in support of LB145. NC2 is committed to providing an environment for conversation to work on a variety of perspectives, voices with partners across the state to connect our vision of conquering cancer together. Our purpose is clear-- to be the neutral voice of oncology in our state. We are affiliated with every major health system, all accredited cancer centers, all oncology practices, advanced practice providers and primary care physicians in all 93 counties of Nebraska. We're leading

the charge to increase access to cancer screening, including breast cancer screening, to improve the quality of life of those that live in our state. You've heard many statistics and a lot of numbers today. I'll ask you to remember this: 13 percent of Nebraskans will be impacted by breast cancer. One in eight women. Those of high risk currently face an inequity in the way our statute is written. We do not reflect the recommendations for early cancer detection that the American Cancer Society recommends for women. All the statistics are in the testimony provided in a written format for you today. For women at high risk, including those with family history, gene mutation, dense breast tissue and other factors, LB145 is a game changer. As a woman myself who is at high risk, this bill would have changed my trajectory as well. We empower each of you to think not only of those that you know, but of those that you serve. LB145 will provide inequity-- will balance the inequity scale that we have today. For these reasons, NC2 strongly urges you, as members of the committee, to support LB145, not only here in the committee, but when it reaches the legislative floor. Thank you.

SLAMA: Thank you very much, Ms. Schabloske.

LAURA SCHABLOSKE: Impressive. [LAUGHTER.]

SLAMA: I do my best. Any questions from the committee? Seeing none, thank you very much. Good morning.

LINA BOSTWICK: Good morning, Senator Slama and committee. My name is Dr. Lina Bostwick, and I am-- I'm here on behalf of the Nebraska Nurses Association, which is 30,000 nurses in Nebraska. And we're supporting this bill, LB145. My practice: I am an educator, so I'm a doctor of nursing education and the Nebraska Nurses Association supports LB145 and we wish that you will do the same. I'm not going to read the statistics that you've already heard, but are-- there are some that are important to repeat. And I do believe that nationally, one in eight women will be diagnosed with breast cancer. And we know about every 5 to 6 years this changes and the risks increase and we see higher numbers. The other statistics I'm going to give you is about Nebraska. According to the Nebraska Cancer Incidence and Mortality, for women only, in Nebraska in May 2021, this was reported on page 21. Breast cancer is the most common type of cancer among women and the second most frequent cause of female cancer deaths. Between 2014 and 2018, 7,263 Nebraska women were diagnosed with invasive breast cancer. Another 1,465 were diagnosed with in site. The in site, the place where the cancer started was within the breast. And

1,188 women died from, from breast cancer itself. What I would like to let you know also, is I have a first cousin, my mother-in-law, my grandmother are survivors, thank goodness. I have to tell you a little bit about my mother-in-law. She had two strokes and this was, this was probably been about, oh, five years ago now. What she found out-- she was, she was a trooper at going and a role model for us at doing her mammography. She kept her appointment even during these true strokes and what she found out is that her strokes were caused because she did have a mutation type of breast cancer. So it has saved a lot of her further-- she got early treatment that way and also further healthcare related to having strokes. She hasn't-- not had another stroke with-- because it caused her platelets to be high. LB145 revision speaks to routine breast assessments for early detection and clarifies assessments needed for women under the age of 40 years, which is a progressive move for beating breast cancer in our state and I would hope other states could follow this, as well. The Nebraska Nurses Association asks you to move LB145 out of committee to General File and thank you for hearing us today.

SLAMA: Thank you very much, Dr. Bostwick. First question, could you please spell your name for the record?

LINA BOSTWICK: Why do I do that every time? I want to get right to it.

SLAMA: I do the same thing.

LINA BOSTWICK: L-i-n-a B-o-s-t-w-i-c-k. Thank you very much.

SLAMA: All right. Thank you, Doctor. Are there any questions from the committee? Senator von Gillern.

von GILLERN: Thank you, Dr. Bostwick, for being here today. And I just want to-- I have to leave early for another hearing. I need to testify at another hearing. So I just couldn't leave without thanking each one of you for being here today, and particularly Ms. Preston and Ms. McCarville, who were so brave to take the positive actions that you did. My mother made that decision in 1973 and lived for decades afterwards because of the bravery of making the decision to have a double bilateral mastectomy. It's very personal to me. I've seven breast cancer stories in my family. And like Ms. Martin-Dick, the one that I worry about the most is my 31-year-old daughter. And so this is very personal and you can probably hear that in my voice, but thank you all for being here today. I-- forgive me for violating protocol. I don't think there was a question in there anywhere. [LAUGHTER.] I

didn't want you-- didn't, didn't want to-- I couldn't leave without making that statement, so thank you all for being here today.

LINA BOSTWICK: Yeah. And I have the same concern, my daughter, who is 28. This is her grandmother, so early detection could protect her from having strokes. So I appreciate that.

von GILLERN: Thank you.

SLAMA: Thank you, Senator von Gillern. Any additional questions? Thank you, Doctor. Good morning.

SARAH VIRUS: Good morning. My name is Sarah Virus, V-i-r-u-s. I am here in support of bill-- LB145. This is important for me for a few reasons. I myself have the BRCA2 mutation. I have an aunt or a sister and a cousin with it. Most recently, we found out my 20-year-old daughter had it. I think the reason foremost-- for this coming and testifying is because I don't want her to put off her screenings when it's time because of the cost. She's going through nursing school, she's trying to, you know, do all the things right, pay off her school debt as she goes, so having to go through the MRIs and the mammograms, as are laid out in the recommendations, would get kind of costly for her for being so young. The second reason: I run the Hereditary Cancer Foundation and we talk about and support people who have genetic mutations. We talk about why it's important to find out your status, because what we've known and heard is when we catch it early, we can take action upon it. So I would really urge you to consider moving forward with this.

SLAMA: Thank you very much, Ms. Virus. Are there any questions from the committee? Seeing none, thank you for being here. All right. Additional proponent testimony for LB145. Last call for proponent testimony. Seeing none, we'll now open it up for any opposition testimony to LB145. Seeing none, we'll now accept neutral testimony for LB145. Welcome back, Mr. Blake.

JEREMIAH BLAKE: Good morning again. Again, 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 and registered lobbyist for Blue Cross and Blue Shield of Nebraska and I'm testifying in a neutral capacity on LB145, specifically the white copy amendment that Senator Bostar circulated. I just want to, first of all, thank all the testifiers for showing up today and sharing their story. It takes a lot of courage. There's also a breast cancer survivor in my family as well, so this is very

personal to me as well. I appreciate that Senator Bostar has taken this issue on. At Blue Cross, we share this commitment to increasing screening rates for women across Nebraska. Under our health plans, breast cancer screenings are covered as a prevent-- preventative service for women, beginning at age 40. This means that women are eligible for an annual screening without any cost share. We also cover breast cancer, genetic screening and counseling at 100 percent for women with a family history of breast cancer who-- or who meet other criteria. Preventative health measures such as breast cancer screening can help avoid developing health problems and prevent minor issues from becoming major health concerns. I also appreciate Senator Bostar's efforts to draft this bill in a way that ensures that women are screened using evidence-based practices. Specifically, the amendments circulated by Senator Bostar references the National Comprehensive Cancer Network guidelines for breast cancer screening and diagnosis. It really rolls off the tongue, doesn't it? Blue Cross also uses these guidelines to write our medical policies for breast cancer because they are the gold standard. However, there is one area in this amendment that strays from those guidelines and that is to require, require coverage for MRIs for women with dense breast tissue. I appreciate everybody testifying today and, and I want to clarify that there are always unique circumstances and, and this isn't clinical guidance. These are guidelines that are published by accredited organizations. According to the American Cancer Society. MRIs are not recommended for women who have a lifetime risk of breast cancer that is less than 15 percent. We want to make sure that women are screened and, and cancers detected early, but we also strive to find the balance between the benefits of higher levels of screening and the value they provide. In the future, if we begin to see that MRI screenings expand to circumstances that are not supported by evidence or best practice, it's my hope that we can work with the, the, the parties in this room to ensure that MRI screenings are used only in those cases where it is medically necessary. The one thing I would raise as a technical issue and the only request that I'm making on this bill is that we would appreciate an effective date of January 1 of 2024 to align this bill with the health plan contract cycles. With that, I appreciate your attention and would be happy to answer any questions you have.

SLAMA: Thank you, Mr. Blake. Are there any questions from the committee? Seeing none, thank you very much.

JEREMIAH BLAKE: Thank you.

SLAMA: Hello again, Mr. Bell.

ROBERT M. BELL: Good morning, Chairwoman Slama. Is it still morning?

SLAMA: It is, yeah.

ROBERT M. BELL: OK.

SLAMA: You got about 50 minutes left.

ROBERT M. BELL: All right-- and members of the Banking Commerce 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 in a neutral capacity on LB145. I think Mr. Blake has stolen all of my thunder. I just-- I want to make a notation that I appreciate Senator Bostar working with the insurance committee or the insurance industry on this legislation. I think he approached us in December and had even mentioned this before, that this was an issue that was, was close to him and wanted to, to work on it. And so, we appreciate his willingness to, to listen to our concerns related to cost containment [INAUDIBLE.] And, and, and, you know, it seems, you know, why, why would we ever have cost sharing on any kind of cancer screening? Right. I mean, that's always the question, because won't the insurers and our policyholders and the premium folks-- people that pay the premium. Won't they have savings if we catch cancer early? Absolutely, they will. But right now we have a situation in our country where, according to CMS, you know, 18.3 (percent) of our entire GDP is, is going to healthcare services. That's $4.3 trillion. The average American is responsible for $12,914 of that. For my family of five, that is $64,570 a year that, that is our responsibility of, of that. And so as-- particularly after the passage of the Affordable Care Act, which had many, many good provisions, but also some other provisions that, that we struggled to pay for as a society, that, you know, there-- we, we've been struggling to get our hands around cost containment related to healthcare services. Right. And so one of the reasons we have cost sharing and utilization tools in insurance policies is to drive consumer behavior rates, so-- or also provider behavior. If there is a situation where, you know, as-- you-- let's say, pick on MRIs because it's been talked about a lot today. But if we're required to use MRIs, how do we negotiate that discount with that provider, as an example. You know, that-- those negotiations become a little bit more difficult. So oftentimes, you see what the bills charged are versus the negotiated discount of the insurer. It's all part of the equation.

And, and again, I just really appreciate Senator Bostar reaching out to us. We provided him some language. He's, he has accepted that. And you know, again, it was great hearing all this testimony today. Definitely not an expert on mammography and cancer screening, but I do appreciate the opportunity to testify. Thank you very much.

SLAMA: Thank you, Mr. Bell. Are there any questions from the committee? Seeing none, thank you very much. Oh.

ROBERT M. BELL: All right. My best to Cosmo, so.

BALLARD: I appreciate it.

ROBERT M. BELL: No problem. Thank you.

SLAMA: Thank you. All right. Additional neutral testimony for LB145? Seeing none, Senator Bostar, you're welcome to close. And as you approach, we've got letters for the record on LB145. There are-- oh, fantastic-- 19 proponent letters, zero opponent and zero neutral letters.

BOSTAR: Thank you, Chair Slama and members of the committee, for your attention and your patience. I wanted to, real quickly, talk about a few of the things that Mr. Blake brought up. And first of all, I actually, I want to, I want to thank Mr. Bell and Mr. Blake for working with me on this legislation over countless meetings. It was brought up that one of the provisions here that strays from ACA is, for example, the MRI requirements for dense tissue. That's actually not in this white copy amendment, so I'll draw your attention to line 15 on page 2. Line 15 through line 21 is the, the MRI section of the white copy. And it includes for, you know, what, what could prompt coverage for screening for a, for a MRI: family or personal history of breast cancer, prior atypical breast biopsy, (b) positive genetic testing, or (c) a history of chest radiation, which would then lead to one diagnostic magnetic resonance imaging each year. The dense tissue does appear in the ultrasound paragraph, which starts on line 8, I think. Yes. And it also appears in the, the sort of-- the 3-D mammogram, the tomosynthesis starting on line 1 on that same page. So I, I just wanted to clear that up, that actually the dense tissue is not part of the MRI specific provisions in this bill. Also, Mr. Blake asked for an operative date of July--

SLAMA: January.

BOSTAR: --January 1-- sorry-- 2024. That's, that's already included in the white copy as well. So I wanted to cover those two things real quick as feedback. And this will come up this afternoon on bills, but to speak briefly on why we have screening and what screening means versus, for example, diagnostic when we're doing different kinds of testing. Philosophically, our medical system tries to treat screening as a procedure to be done without cost sharing, because the cost savings of being able to catch different diseases, cancers are far outweighed by the cost of the, of the procedure itself. Whereas a diagnostic exam, right, that's different. That's where we-- we're subject to cost sharing, generally, within our, our healthcare system. So that's why mammograms don't have cost sharing because they're, they're screening. They're there to catch cancer, which we've all determined is worth it because we're saving lives and a lot of resources and money because, as Senator Kauth rightfully points out that, you know, healthcare is extremely expensive and premiums are extremely expensive, so we have to be really good stewards of managing them. For some women, the mammogram is not an effective screen. So what we're doing here is we're saying, OK. We believe screenings shouldn't have cost sharing because we want to incentivise women to be able to be screened for breast cancer. So if the mammogram is an inadequate screening technique, then we need to create the appropriate technique to be considered screening. And that's, that's the impetus for this bill and that's what we're doing here, is we're making sure that all women can have access to breast cancer screening, because not, not, not every woman can, can use a mammogram for that purpose, successfully. And I was really pleased to hear from so many of the survivors here today. But we should keep in mind that-- the ones that we don't have the opportunity to hear from. And so I would appreciate your support of LB145. Again, I thank you for your time and consideration and I will answer any other questions if you have any.

SLAMA: Thank you, Senator Bostar. Senator Jacobson.

JACOBSON: Thank you, Chair Slama. And Senator Bostar, thank you for bringing this bill. It sounds like we're, we're none too early on getting this bill brought to the committee and clearly we need to move this forward. I guess my question-- and I'm sympathetic to the insurance industry and I appreciate their, their, their neutral testimony today. And, and I think certainly, Mr. Bell, his clarification on really what we're trying to do. I, I guess my question is on that line 15 through 22, which is-- or through 21, which as I understand, will be stricken from, that will not be part of the changes. Are we comfortable that that's going to get-- going to

achieve what you've just laid out, in terms of effectively getting the proper screening done for all women with all situations at no cost?

BOSTAR: Are you asking if the current text of the bill, of the white copy amendment--

JACOBSON: Yes.

BOSTAR: --is adequate?

JACOBSON: Correct.

BOSTAR: As I'm not a doctor--

JACOBSON: But you look like one [LAUGHTER.].

BOSTAR: --said, said no one ever. I-- when, when the healthcare providers who are experts in this field tell me that this, this legislation that's represented in the white copy amendment will save lives, help women, I trust them. And so--

JACOBSON: So you're comfortable with this change?

BOSTAR: I'm comfortable with, with the text in the white copy amendment.

JACOBSON: Perfect. Thank you.

BOSTAR: And really, I mean, the, the number of people that have been involved in working on this is really humbling and so I want to thank everyone and everyone that just showed up today as well and to tell their stories.

JACOBSON: Well, and I do also appreciate the fact the insurance industry has been willing to sit down and work with you on this and get a reasonable solution--

BOSTAR: As am I.

JACOBSON: --on a problem that's certainly a huge problem. Thank you.

BOSTAR: Thank you.

SLAMA: All right. Any additional questions? Seeing none, that'll bring to a close our hearing on LB145. Just thank you all so much, whether you're survivors or healthcare providers, for being here today. It

really means a lot. And I'll ask anybody who's planning to be a proponent on either LB142 or LB779 to make your way to the front of the room that way we're minimizing travel time. It's not church. We're very welcoming here. All right. OK, we will now open the hearing. This will be a joint hearing for LB142 and LB779. Just a note to anybody testifying today, if you're not in support or opposition to both bills, be sure to note which bill you're testifying on that way we've got a clean committee record. But with that, Senator Briese, you're welcome to open.

BRIESE: Thank you and good morning, Chairwoman Slama--

SLAMA: Good morning.

BRIESE: --and members of the Banking, Commerce and Insurance Committee. I'm Tom Briese, T-o-m B-r-i-e-s-e. I represent District 41 and I'm here to introduce LB142. And I might add, I think this is my first trip before the BCI Committee in all the years I've been here.

SLAMA: Glad to have you.

BRIESE: It's an honor to be here. You bet. This bill, in a nutshell, would limit the copay of an insured to no more than $100 per month for a 30-day supply of insulin. Insulin is literally necessary for survival for many Nebraskans, but in the face of this, insulin prices have skyrocketed in the past two decades. One insulin product is 1200 percent higher than in 1998. And according to the Health Care Cost Institute, insulin prices doubled between 2012 and 2016 and they've only gone up since then. Some of our diabetic friends and neighbors are paying over $1,000 a month for a 30-day supply. And the issue is one that I've experienced. I have a close family member who's a type one diabetic and she tells me her first vial of insulin cost $3. You know, that's a far cry from today's price of several hundred. And as a self-employed farmer, there were times that our insurance was not particularly helpful in picking up those costs. So I have lived that, but my family is fortunate enough now to have outstanding health insurance that nearly covers the cost of her insulin. So if we are taken care of, but many or most Nebraskans have limited insurance coverage. So what can be done about this? Over 20 states have taken steps to cap the insulin copays for their residents, most of them at $100 per month or less. I would say the average is $50 to $75, probably, many of them $25, $35. There's some 75s. There's some, some hundreds in there. And I would submit that we should do the same

thing. And with that, I will close and turn it over to Senator Bostar. But I'd be happy to answer any questions that you might have.

SLAMA: Thank you, Senator Briese. Are there any questions? Seeing none, thank--

BRIESE: Yes.

SLAMA: Oh.

KAUTH: Real quick.

SLAMA: Senator Kauth.

KAUTH: You said the average cost or you've heard of people who pay up to $1,000 a month?

BRIESE: Heard of people, yes.

KAUTH: Do you know what the average is?

BRIESE: I do not know. Great question. I do not know.

SLAMA: All right. Thank you, Senator Kauth. Any additional questions from the committee? Seeing none, thank you, Senator Briese.

BRIESE: Thank you.

SLAMA: All right. Senator Bostar, you're welcome to open on LB779. Hello again.

BOSTAR: Hello again. Good morning-- hopefully still-- Chair Slama and fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar. That's E-l-i-o-t B-o-s-t-a-r and I represent Legislative District 29. Today I am presenting LB779, which proposes to cap out-of-pocket expense for prescription insulin to no more than $35 per month. According to the American Diabetes Association, about 13,500 Nebraskans are diagnosed with diabetes every year and approximately 141,500 Nebraskans, or 9.6 percent of the adult population, are diabetic. People with diabetes have medical expenses roughly 2.3 times higher than those who do not. In 2017, diabetic Nebraskans spent an estimated $993 million in direct medical expenses and an additional $384 million was spent in indirect costs from lost productivity due to the disease. Diabetes is one of the most pervasive, deadly and expensive diseases in United States. According

to a recent study by the American Diabetes Association, annual insulin prices rose 55 percent between 2014 and 2019 from an average of $3,819 to $5,917. And we know that it continues to increase year after year. The increasing cost for this life-saving medication is creating hardships on Nebraska families. LB779 seeks to address this problem and alleviate the financial burden on diabetic Nebraskans by capping the out-of-pocket costs of insulin to insure-- to insured individuals to $35 per 30-day supply. Twenty-one states, including Texas, Alabama, Colorado, Kentucky, Utah and Virginia-- I won't list them all-- have passed legislation similar to LB779. Congress also took action when it passed legislation that capped the out-of-pocket expense for Medicare beneficiaries to $35 per month supply of insulin last year. I urge the committee to advance LB779. Thank you for your time this morning. I'd be happy to answer any questions you have. Actually, real quick, the amendment. After working with the insurance providers on this legislation for a little while, we've come up with language that hopefully they will confirm is, is agreeable to, to their, their policies. And what it, what it does is it would cap the cost of insulin for the, the provider's base tier of insulin. And, and I think that they will testify and talk about what happens with what's happening within the, the healthcare world that might make that change necessary, as well as it, it outlines that if there's a-- due to a, due to a shortage, if that tier of insulin is unavailable, then insulin they provide cannot exceed $35. So the bill would still create an environment where anyone could get insulin for no more than $35 per month, just changing that language a little bit. And I'm happy to answer any questions.

SLAMA: Thank you, Senator Bostar. Are there any questions? Senator Kauth.

KAUTH: Thank you, Senator Slama. The national shortage, how is that determined? Is that, is that some-- an announcement that is made or where we're identifying a national shortage and there's times that it stops? Or how does that process--

BOSTAR: Essentially if the suppliers don't have it, don't have the insulin that's, that's in that based here, that would--

KAUTH: That would--

BOSTAR: --that would be a catastrophic national shortage. And that was put in as-- I don't believe there's ever been a shortage to that extent where that level of insulin was unavailable. But that

language-- and, and we worked on this. The language was included as a means of just-- it's a reassurance that-- to, to, to folks who need this that if for some reason this-- that insulin goes away, they won't be subject to higher prices.

KAUTH: OK. Got it. Thank you.

SLAMA: Thank you, Senator Kauth. Any additional committee questions? Seeing none, thanks, Senator Bostar.

BOSTAR: Thank you.

SLAMA: All right, we'll open it up for proponent testimony on LB142 and LB779. Good morning.

LESLIE SPRY: Good morning again. Chair Slama and members of the committee, my name is Dr. Leslie Spry, L-e-s-l-i-e S-p-r-y, and I am testifying in support of both LB142 and LB779 on behalf of the Nebraska Medical Association. I'm a kidney guy, as I mentioned earlier, here in Lincoln and I've served as a member of the Nebraska Board of Health as well as past president of the Nebraska Medical Association. The Nebraska Medical Association supports LB142 and LB779, both of which would cap the cost of insulin for Nebraska patients. Part of the NMA's mission statement is to advocate for the health of all Nebraskans. With that mission comes a belief that no person should have to choose whether they receive life-saving medication solely based on cost. Roughly 8.4 million Americans need insulin to maintain their health and this number is expected to continue to rise over the next decade. I've certainly seen it in my practice. I've said that diabetes is taking over the earth in my experience. According to the prescription drug discount provider GoodRx, the average retail price for insulin rose 54 percent from 2014 to 2019. When patients have difficulty affording these medications and these necessary medications, they often make desperate decisions, including rationing their insulin supply-- and I've certainly seen that-- which have deadly consequences. Non-adherence due to high insulin costs lead to increased healthcare costs overall and more-- including more hospitalizations, emergency room visits, increased risk of kidney disease, by the way, and increased mortality rates. Parenthetically, I saw somebody yesterday who was a Medicare beneficiary where she was rejoicing the fact that her cost of her copay on her insulin in January went down from $135 a month to $35 a month because she is a Medicare recipient. And I would hope we could extend this same joy to other Nebraskans who have commercial

insurance. For these reasons, the NMA supports the advancement of the legislation that would cap insulin costs for Nebraska patients. Thank you for your time and I'm happy to answer any questions you may have.

SLAMA: Thank you very much, Dr. Spry the Kidney Guy.

LESLIE SPRY: Yeah.

SLAMA: I couldn't help but say it. Any questions?

LESLIE SPRY: That's my Twitter handle, by the way, too.

SLAMA: There you go. That's a great Twitter handle. Any questions from the committee? Senator Kauth.

KAUTH: Thank you. Who would pay the difference? Would it be the insurance companies, the pharmaceutical companies or other policyholders? How does that work out?

LESLIE SPRY: So I'm, I'm not going to be an expert in all those tiers. But what I can tell you is what's happened over the last 20 years is, is a phenomenon of genetics. I can change insulin by changing one peptide on that insulin and all of a sudden, I can qualify for a new longer period of exclusivity so I can charge more for it. And they keep doing that over and over and over. It doesn't change any of the clinical use of that insulin. What it does is just change the molecular characteristics of the drug, but doesn't actually change its clinical characteristics or therapeutic benefits. And so the insurance-- the pharmaceutical companies have repeatedly done this. They can make insulin, they could make some of the older insulins much, much cheaper. But if they change it by one peptide, they can get a new-- a patent from the FDA on that. And so that's what's been the genesis of this. I come out with a new insulin, but it's not really new and it doesn't change anything. So going back to some of these older insulins, what happened was that they could make a lot more money on that. So when you would-- you talked about a nationwide shortage. There certainly has been. And it's because there are fewer and fewer pharmaceutical companies that are actually having lines that make some of these cheaper insulins. This will probably force some of those increased lines of cheaper insulins to be made as a result of that. And that-- at least that's my hope and prayer because I work at a clinic with a heart and we can get access to some very cheap insulin over there, but it does have some limited access. But I can still go

back and use that if somebody is going to ration the new insulin that I'm giving them, so.

KAUTH: Thank you very much.

SLAMA: Senator Jacobson.

JACOBSON: I'd like to just follow up a little bit on that. I-- and again, although it may not sound like I'm sensitive to the insurance companies. I am and, and I recognize that, that somebody has to pay the tab and ultimately we've got to try to figure out who that is. And when we deal with pharmaceuticals, there's a lot of players and there's some bad actors out there. And I continue to look at pharmacy benefit managers that I look at it in a very "jaunted" sort of way. And there's a bill coming. It's going to be addressing that and I can't wait for that bill to get here. I would tell you that I'm concerned about-- you know, you hear about the pharmaceutical manufacturers, as you've outlined, making one slight change to be able to extend the patents. That's something I'm hoping the federal government would do, do something about, but I kind of wonder to what extent can those other-- those that went off of patent that haven't had that small peptide change, could that still be produced at a cheaper cost? And I'm, I'm curious as to whether or not that can be done because I don't expect the insurance providers to continue to pay these exorbitant costs either. And so I'm trying to figure out if it's the pharmaceutical manufacturers or it's the pharmacy benefit managers or who the bad actor is in this process with-- as it relates to insulin.

LESLIE SPRY: Well, I think Medicare changing over to this-- capping the cost is going to put some pressure and there's going to be some pharmaceutical manufacturers who will put a, put a line in to produce some of those insulins. Because although they can't-- you know, their unit price is going to be lower, you're talking about bulk quantity here. And so I think that's, that's probably would be the greatest mover out there on this and it took a while to get that done. I mean, we've known about this scam about single peptide change for 20 years. And so my hope is that Medicare is going to push this and then those production lines should then go online. Now, do I make those decisions? I don't, but I certainly advocate for my folks who have to pay for this insulin and see some of these folks that are paying exorbitant prices for some of the newer insulins that-- again, a minor change. It doesn't result in any dose change or anything else. All it does is just, just put a new name on it.

JACOBSON: Thank you.

LESLIE SPRY: That's what happens.

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Senator Dungan.

DUNGAN: Thank you, Chair Slama, and thank you for being here. Dr. Spry, As an aside, you treated my grandfather for a short period--

LESLIE SPRY: I'm old.

DUNGAN: --of time, but he-- prior to his passing away, we actually talked about you and how much he appreciated the work you had done. So thank you so much for your ongoing contributions to the community and for being here. I just wanted to make sure I said that.

LESLIE SPRY: All right. Your grandfather's name?

DUNGAN: His name was Ed Lothridge [PHONETIC].

LESLIE SPRY: OK, yeah.

DUNGAN: Yeah, it was a little while ago, a few years ago. But in addition to that, my question for you is you talked a little bit about having seen people ration their insulin supplies and that can have deadly consequences. In your professional experience-- and I know you focus more on, on kidneys, but just being a doctor and working in and around this world, if people don't have access to insulin or sufficient supplies of insulin moving forward and they decide to ration it, I assume that can have negative consequences medically and lead to higher cost procedures and higher cost needs down the road. Is that fair to say?

LESLIE SPRY: Certainly to-- again, when they start rationing it, they're, they're letting their blood sugars get higher and higher. That leads to complications: cardiovascular complications, heart complications, amputations. Early on in my business, it used to be the case that a dialysis patient lost a limb a year. And as we got better control, insulin pumps, continuous glucose monitoring, some of the other drugs that are now used, we're seeing a lot less amputations than we ever did. And we're also-- cardiovascular complications, just a lot of strokes, high blood pressure, all those things. So leaving your diabetes, your hemoglobin A1C being higher, even though you can

live, OK, and pay the mortgage, as someone I think mentioned here, that doesn't necessarily mean that you live well. And I've certainly seen that where, again, amputations and those kinds of things were-- are common accompaniments of poorly controlled diabetes.

DUNGAN: Thank you.

SLAMA: Thank you, Senator Dungan. Additional questions from the committee? Seeing none, thank you, Dr. Spry. Additional proponents for LB142 or LB779 or both. Good morning.

AANYA MISHRA: Good morning. Hi. My name is Aanya Mishra. I'm a senior at Millard North High School and I'm here for CTE advocacy from HOSA, but I decided to talk here as well. So I apologize if I'm not as polished or as well educated about this topic as others, but I wanted to give a perspective of patients that are affected by this issue. I moved to America when I was about three years old. I didn't know any English. My family was low income and uninsured and I spent most of my childhood being low insured-- and low income and uninsured. And I had this conception and this, like, idea that if I did get insured, that healthcare would be significantly more accessible to me and my family as well. And now I do have insurance. We're not low income anymore, but what I did realize once we did get insured is that being insured doesn't necessarily mean access to healthcare. And my family, my dad is diabetic, I'm pre-diabetic and my family has a history of diabetes, diabetes throughout almost every generation of our family. We're very deeply affected by it. And even though we have insurance now, we don't have the proper access to healthcare that I thought that we would have. Insurance doesn't fix everything. Having copay-- having limited copays is the solution to access to healthcare because insurance can't just be the solution to everything. Currently, my father takes multiple pills for his diabetes and he's delaying going to the doctor because insulin costs so much and he knows if he does go, he might get prescribed insulin and he doesn't want to face the reality that even though we're much more well-off now, we have good insurance, paying for insulin is just not possible. For the average American household, that's the case and I believe that's why LB142 and LB772 should be brought to the floor.

SLAMA: Thank you very much, Annie [SIC]. Are there any questions from the committee? I've got a few. So you said you're a state officer in HOSA. What, what's your office?

AANYA MISHRA: I'm vice president.

SLAMA: Oh, congratulations. That's awesome.

AANYA MISHRA: Thank you.

SLAMA: Are you interested in going into healthcare?

AANYA MISHRA: Yes, I am.

SLAMA: Yeah. What specifically?

AANYA MISHRA: Probably either becoming a doctor or healthcare policy.

SLAMA: Nice. All right. Well, I remember CTSO day fondly. I was a former FBLA state officer--

AANYA MISHRA: Oh.

SLAMA: --so don't hold that against me.

AANYA MISHRA: I just took a picture with the FBLA officers.

SLAMA: They're pretty cool. I married the DECA state president.

AANYA MISHRA: Oh.

SLAMA: I mean-- I know. It's, like-- yeah, the CTSO people will get it, but.

AANYA MISHRA: The state advisors are very much against that.

SLAMA: Yes, we were graduated and he's much older than I am, yes. Thank you, Annie [SIC]. I appreciate you being here today. You did a wonderful job.

AANYA MISHRA: Thank you.

SLAMA: All right. Additional proponents.

KELSEY ARENDS: Good morning.

SLAMA: Good morning.

KELSEY ARENDS: Chair Slama, members of the committee, my name is Kelsey Arends. That's K-e-l-s-e-y A-r-e-n-d-s and I'm the healthcare access program staff attorney at Nebraska Appleseed, testifying in support of both bills today on behalf of Nebraska Appleseed. One of

our core priorities is working to ensure that all Nebraskans have access to quality, affordable healthcare. Because these bills make insulin more affordable for Nebraskans who rely on it, Nebraska Appleseed supports both bills. We consistently hear from Nebraskans about the burden of healthcare costs and how that impacts their access, as you've heard really compelling testimony. For folks who have been prescribed insulin, more than one and six manage those costs by going to extreme measures to ration the insulin drugs that they need. And we know that these rates are higher among certain groups based on age, race and ethnicity, income and insurance coverage. And we've provided those breakdowns in the written testimony that's being passed out. I'll tell you that both versions of the testimony are identical except for the bill numbers so you don't have to necessarily read both. Nebraskans need further action like these bills to keep their healthcare costs down. Because these bills would make healthcare more affordable and accessible for Nebraskans, we urge your support on a cap for the price of insulin in Nebraska.

SLAMA: Thank you. Ms. Arends. Are there any questions from the committee? Seeing none, thank you so much for being here.

KELSEY ARENDS: Thanks.

SLAMA: Good morning.

SUZAN DeCAMP: Good morning, Chair Slama and members of the committee. My name is Suzan DeCamp, S-u-z-a-n D-e-C-a-m-p, and I'm here today as the state volunteer president for AARP Nebraska in support of both LB142 and LB779. We know the high price of prescription drugs is a burden on many Nebraska residents. Every day, our relatives, friends and neighbors are forced to choose between filling life-saving prescriptions or paying bills and buying food or other critical essentials. An AARP report showed that in 2017, 29 percent of Nebraska residents stopped taking prescribed medications due to cost. No one should have to choose between buying medications or buying food for themselves or their families. Diabetes is one of the most common chronic diseases and according to the Centers on Disease Control and Prevention, it is the seventh-leading cause of death in the United States. The roughly 141,491 Nebraskans, or 9.6 percent of the adult population, are living with diagnosed diabetes and they need to purchase insulin to survive. Diagnosed diabetes costs an estimated $1.4 billion in Nebraska each year. The monthly expense to Nebraskans averages between $450 and $500. I believe, Senator Kauth, you had asked that question earlier. According to the AARP 2022 Vital Voices

Survey, 84 percent of Nebraska residents age 45-plus think being able to pay for prescriptions is either extremely important or very important. In Nebraska, the average annual cost of a prescription drug treatment increased 26.3 percent between 2015 and 2019, while the annual income for Nebraska residents increased by only 10.4 percent. Over the last 14 years, the cost of out-- the out-of-pocket cost of many insulin brands has jumped to as much as 555 percent. In 2017, the annual cost of Lantus, a form of insulin used to treat diabetes, was more than $4,700 per year, which was an increase of 62 percent from 2012. Due to these increased prices, many insulin users have been forced to alter their medication by substituting lower-quality products, seeking other options outside of the country, or even having to ration their supply, as Dr. Spry and others before me have testified to, and some even dying by doing this. Insulin is not new. It was discovered as a treatment for diabetes almost 100 years ago. Very little about the way insulin is produced has changed, yet the prices continue to skyrocket. Approximately 90 percent of insulin sold is manufactured by only three companies, which limits competition and therefore results in higher costs to patients. Americans pay three times what people in other countries pay for the same medicine. LB142 and LB779 set out-of-pocket limits of $100 and $35 respectively for a 30-day supply of insulin. Just a little bit more.

SLAMA: Just real quick.

SUZAN DeCAMP: These bills will make the essential drug more affordable and accessible. Medications don't work if people can't afford them. As of October 2022, 24 states have enacted this legislation that limits consumers' prescription drug out-of-pocket costs. Let's make Nebraska number 25. We'd like to thank Senators Briese and Bostar for introducing the legislation and thank you for allowing me to speak. If anyone has any questions, I'd be happy to answer them.

SLAMA: Thank you, Ms. DeCamp. Are there any questions from the committee? Seeing none, thank you.

SUZAN DeCAMP: Thank you.

SLAMA: Welcome, Mr. Hale.

ANDY HALE: Thank you. Senator Slama-- Chairperson-- Chairwoman.

SLAMA: Chair, Chairperson, Chairman, I don't care.

ANDY HALE: My name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of advocacy for the hospital association. And those CTSO kids are very impressive. I would hope.

SLAMA: They're awesome.

ANDY HALE: Maybe there's a bill this session that would provide some funding to get them into our workforce, but that's, that's for another hearing, so. According to the CDC, more than 30 million people in the United States have diabetes. That is nearly one in ten Americans. Another 84 million are pre-diabetic and could require insulin in life. By 2030, 79 million adults worldwide with type two diabetes are expected to need insulin. Prices for insulin have skyrocketed, nearly tripling over the past ten years. Type one diabetes patients paid an average of $5,700 for insulin. That's type one. Because of the pricey-- prices people will pay, they usually ration their medication and some, unfortunately, even have to go without. As many as one in four people who take insulin currently skip doses because they cannot afford the medication. Simply, this bill is a good bill. We are in the business of preventative care. We've seen-- just the numbers we've heard in the statistics before show how big of a problem this is. And we are in support of both of these bills. We want to thank Senator Bostar and Senator Briese for bringing those and I will be happy to answer any questions.

SLAMA: Thank you very much, Mr. Hale. Are there any questions from the committee? Senator Dungan.

DUNGAN: Thank you. Chair Slama, and thank you for being here. Mr. Hale. Briefly-- and I'll admit I missed part of the openings so this may have been addressed and I apologize if it was. But just to not beat around the bush, we're talking about these prices increasing exponentially year after year and they're just-- they're skyrocketing. Everyone's saying that. And we heard a little bit from Dr. Spry regarding sort of the modifications in peptides that have led them to additional patents being made, which can lead to higher costs. This cost that's increasing, is it going towards profits primarily? And if so, who's benefiting from it in your experience? I'm just trying to figure out where all this extra money is going.

ANDY HALE: I won't say in my experience, but my guess that those profits are going into the pockets of the pharmaceutical companies.

DUNGAN: OK. So that's ultimately where this price excess is probably ending up. It's not necessarily distributors, it's the actual companies.

ANDY HALE: The research, research that I've seen, yes. It's, it's the actual pharmaceutical companies themselves. And I'm not sure if they're here against this bill or not, but maybe they can answer that better. But the research that we've seen, that's-- those are probably the individuals you're referring to.

DUNGAN: OK, thank you.

SLAMA: Thank you, Senator Dungan. Additional questions? Seeing none, thank you, Mr. Hale.

ANDY HALE: Thank you, Senator.

SLAMA: All right. Additional proponent testimony. Last call. Seeing none, we'll now open it up for opponent testimony to LB142 and/or LB779. Seeing none, we'll now take neutral testimony. Three for three.

JEREMIAH BLAKE: Three for three, but I'm done after this.

SLAMA: Sweet.

JEREMIAH BLAKE: Good morning again. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska and I am testifying in a neutral capacity on LB142 and LB779. Again, specifically to the amendment that Senator Polestar referred to, which I don't know if I've seen, but we-- that's what we're referring to. So in January of 2022, Blue Cross and Blue Shield of Nebraska announced that members with diabetes who are covered under a fully insured employer group health plan would have access to insulin at no cost to them. The $0 cost share insulin benefit complements our other diabetes management programs and reversal-- diabetes reversal programs we offer. I want to thank Senator Bostar for working with us on this amendment to ensure that we can continue to offer no-cost insulin to Nebraskans. I want to take a minute because there's been a lot of talk about insulin and the cost of insulin. So a report from the U.S. Senate found that three companies control 99 percent of the insulin marketplace and have worked to limit competition to increase prices. Our specific experience at Blue Cross and Blue Shield is that the wholesale price of insulin-- of our preferred insulin increased 104 percent from the period of 2013 to 2018. For reference, the Consumer

Price Index during that same period was 9 percent. Despite that, we still moved forward with the plan to offer no-cost insulin to our members. And in the future, I hope we can work with this committee to actually address the true issue here and that's the growing and unsustainable rising costs of prescription drugs by pharma. With regards to kind of the patent games that Dr. Spry referenced earlier, I got a notice last week that the Senate Judiciary Committee is actually looking at legislation on that issue. I haven't heard update as to whether or not that advanced or where that's at, but I know that's a discussion that's happening at the federal level. So with that, I'll be done and answer any questions you have.

SLAMA: Thank you, Mr. Blake. Senator Jacobson.

JACOBSON: Yes, thank you, Chair Slama. Mr. Blake, I, I appreciate your last comment here because I do share your concerns that, you know, people have this misconception that insurance companies are somehow this big pot of gold and--

JEREMIAH BLAKE: Right.

JACOBSON: --you just got to keep moving out. And the fact of the matter is, is that you've got premium payors and you've got-- you're-- you have a very difficult job to manage how this all gets done. And then you've got the providers out there that are trying to do what they can to be providers and you've got those who manufacture these products that we all need. And so it's really that balancing act. You, you indicated working with us in terms of what we might be able to do to hold down the cost of prescription, prescription drugs. Do you have anything specific that we should be looking at, at the legislative level-- at the state level that might be helpful in achieving that? Because I think we're all interested in figuring out how we can drive those costs down.

JEREMIAH BLAKE: Yeah, we share that goal. Let me get back to you on that, OK. Senator?

JACOBSON: Great.

JEREMIAH BLAKE: Given, given where we're at in this session, I don't think it's probably the right time to have that discussion right now, but I think--

JACOBSON: I realize that.

JEREMIAH BLAKE: --this summer we would love to work with you.

JACOBSON: I think we'd be very interested in figuring out what we can do and if there's things we could do at the state level, I'd really like to hear that.

JEREMIAH BLAKE: Thank you.

SLAMA: All right. Any additional questions? Seeing none, thank you, Mr. Blake.

JEREMIAH BLAKE: Thank you.

SLAMA: Good morning because it's still morning.

ROBERT M. BELL: It is still morning certainly. Good morning, Chairwoman Slama and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell. Last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies. I appear today in a neutral capacity on LB145 [SIC, LB142] and LB779. And I would first like to appreciate my appreciation to the senators for their interest in this subject. Senator Bostar has an amendment that would make this language palatable for insurers by providing the cost-sharing limitation is limited to the insured's low-- the insurer's, excuse me, lowest tier. Such an amendment reflects current practice of most insurers and removes the opposition of our industry from the bill. Also, the amendment captures kind of the spirit of the federal rules related to Medicare patients. Cost-sharing caps, as presented by both bills, are attractive policies for those who have diabetes. I, I'm going to harp on this a little bit, but it does not address the root problem of the issue, which is the high cost of, of insulin, three manufacturers of insulin. I understand the state of California is giving it to the manufacturer of insulin to provide low-cost insulin. And not necessarily recommending that for the state of Nebraska. California does many things that I wouldn't recommend for the state of Nebraska. But I mean, everybody is looking for an answer. And to kind of address what Senator Jacobson asked, asked Mr. Blake, I did have a bill drafted up. And I'm sorry to the Bill Drafters if they're watching because it was not introduced. But that would make a pharmaceutical company notify the state of Nebraska if its price went up over a certain limit and to provide justification to the state if that happened. The problem with that, as we started to dig into it, it has

no teeth, right? There's, there's nothing you tell the state. And a few states have passed laws like that, but we haven't seen an actual reduction in the pharmaceutical cost of that. So, you know, obviously insurers see the benefit of providing low cost share to their insureds that have diabetes so they can get this insulin that they need and all of us just pay higher premiums because of it. And that's just kind of the root cause. I think I've now harped on three bills in a row that, you know, the-- at the end, if, if we're paying more for claims, premium has to go up to stay solvent, right? So that's kind of the, the main thing. One other-- I just want to point out, I just want you senators to know that this would not apply to our ERISA plans. So we're talking about large multi or employer-sponsored plans. ERISA is, of course, the Employee Retirement Income Security Act of 1974. I just point that out in case as this law passes, if there's an employee plan out there that doesn't follow that, they don't have to and you'll get a phone call. And there's honestly not a lot the state of Nebraska can do about that. It's a federal issue. Thank you very much for the opportunity to testify.

SLAMA: Thank you very much, Mr. Bell. Are there any questions from the committee? Seeing none, thank you.

ROBERT M. BELL: You're welcome.

SLAMA: All right. Additional neutral testimony on LB142 or LB779? Seeing none, Senator Briese, you're welcome close. And as you approach, we have nine proponent letters for the record on LB142 and 11 proponent letters for the record on LB779.

BRIESE: Thank you, Chair Slama and members of the committee, for your indulgence today. Appreciate it. And Senator Jacobson, like you, I am concerned about healthcare costs in general, prescription drug prices particularly. I did introduce LB200 to require the state to set up a Canadian drug importation program in an effort to hopefully make a little progress on that front. And pharmaceutical companies weren't all excited about that bill. But there are definitely profits to be protected in that industry and I think that's part of what we're talking about here. The committee has some work to do on this and considerations to keep in mind. And the amendment I have-- have to ask yourselves, does that gut the impact of this legislation? We saw quite-- or we heard quite a bit of data on the number of Nebraskans that this would impact. Some suggest 10 percent of Nebraskans. I don't recall what Senator Bostar's numbers were, but the point is there's a wide swath of Nebraskans that this can have a very beneficial impact

for. So I would ask for your consideration of LB142 and Senator Bostar's bill as well and see if we can find a landing spot somewhere in there on those. Thank you.

SLAMA: Thank you, Senator Briese. Are there any questions from the committee? Seeing none, thank you. All right, Senator Bostar, you're welcome to close on LB779.

BOSTAR: I'll be brief since we're essentially out of time. Thank you, Chair Slama and members of the committee. And thank you to Senator Briese. You know, it's-- I'll be honest, bringing, bringing a bill similar to Senator Briese feels good because then you know it's serious stuff. And thank you to all the testifiers who came and, and patiently waited through a couple other hearings in order to make it to this point. With that, I'll answer any questions the committee may have. Otherwise, thank you again.

SLAMA: Thank you, Senator Bostar. Are there any questions from the committee?

JACOBSON: A very quick one. I'm watching the clock up here.

JOSHUA CHRISTOLEAR: I know.

JACOBSON: I know that look. Very briefly, Senator Briese spoke of the amendment and I'm assuming that was a key part of getting the insurance companies into a neutral position.

BOSTAR: That's correct.

JACOBSON: OK. And that would be material likely if them-- if that-- and I should have asked them this, but I'm making the assumption that they would be in opposition if that amendment was not part of this bill.

BOSTAR: That's my understanding.

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Any additional questions? And with that, it is 11:59 and we are done with our hearings for this morning. Thank you all so much for being here.

[BREAK]

SLAMA: Good afternoon, welcome to the Banking, Commerce and Insurance Committee. My name is Julie Slama. I'm the Senator for the 1st Legislative District in southeast Nebraska and Chair of this committee. The committee will take up 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 the proposed legislation before us today. Committee members will come and go during the hearing, we've got bills introduced in other committees and are called away for that reason. It's not an indication that we are not interested in the bill being heard, it's just part of the process. To better facilitate today's proceedings. I ask you to abide by the following procedures. Please silence or turn off your cell phones. Move to the front row when you're about ready to testify. Order of testimony will be as follows: introducer, proponents, opponents, neutral, and then close, if the introducer chooses. Testifiers, please sign in. Hand your pink sign-in sheet to the committee clerk when you come up to testify. Spell your name for the record before you testify and be concise. It's my request that you limit your testimony to 3 minutes. If you will not be testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white tablets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits and the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff will-- and staff when you come up to testify. We need ten copies. And if you have written testimony but don't have ten copies, please raise your hand now, so one of our pages can help make copies for you. To my immediate right is committee counsel Joshua Christolear. To my left, at the end of the table, is committee clerk Natalie Schunk. The committee members with us today will introduce themselves, beginning on my far right.

DUNGAN: Senator George Dungan, LD26 in northeast Lincoln.

BALLARD: Bob Ballard, LD21, northwest Lincoln and northern Lancaster County.

KAUTH: Kathleen Kauth, LD31, Millard.

JACOBSON: I'm Senator Mike Jacobson, District 42. I'm in Hooker, Thomas, McPherson, Logan, Lincoln and three-fourths of Perkins County, live in North Platte.

AGUILAR: Ray Aguilar, District 35, Grand Island.

von GILLERN: Brad von Gillern, District 4, west Omaha.

BOSTAR: Eliot Bostar, District 29.

SLAMA: Also assisting the committee today are our wonderful committee pages, Caitlin and Isabelle. The committee will take up bills today in the following order: LB383 and LB308. And with that, we'll open the hearing on LB383. Welcome, Senator Bostar, it is your afternoon.

BOSTAR: Thank you. Good afternoon, Chair Slama and members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar. That's E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29, and I'm here today to present LB383, as well as a lot of other bills. Last year, I introduced and the Legislature passed LB739, which required health insurance policies to include colorectal screening coverage and laboratory tests for any nonsymptomatic person age 45 or older in line with the recommendations of the United States Preventive Services Task Force. This year, I continue the effort of improving access to colorectal cancer screening by introducing LB383, which requires insurers to cover colonoscopy screenings and annual noncolonoscopy at-home tests as approved by the United States Preventive Task Force without cost-sharing requirements. Currently, individuals who receive a positive test from a noncolonoscopy preventative screening are required to have a follow-up colonoscopy performed to complete the cancer screening. However, these colonoscopies are treated by insurers as a diagnostic exam instead of a screening and are, therefore, subject to cost sharing. A colonoscopy is a stand-alone test when used for screening. Noncolonoscopy at-home tests may be stand-alone when test results are negative. However, 5 to 7 percent of approved at-home tests will be positive when performed on an annual basis. A positive at-home test requires a follow-up colonoscopy in order to complete the screening process. Such a colonoscopy is not diagnostic, but an integral part of the screening examination and should, therefore, be covered with no cost sharing for individuals. Colorectal cancer is the third leading cause of all cancer-related deaths in men and women in the United States. Starting in 2012, national data shows that there has been a rising incidence of 2 percent a year in colorectal cancer diagnoses in people younger than age 50. Recognizing this trend and taking action by removing barriers to colorectal cancer screenings is critical to saving lives. Screening can prevent cancer through the detection and removal of precancerous growths. Screenings can also detect cancer at an early stage when

treatment is usually less extensive, less expensive, and more successful. Encouraging greater use of less expensive and minimally invasive at-home testing could result in higher screening rates and lower healthcare costs for both insurers and patients. Thank you for your time this afternoon. I encourage the committee to advance LB383 and I'd be happy to answer any questions you have.

SLAMA: Thank you, Senator Bostar. Are there any questions from the committee? Seeing none, thank you.

BOSTAR: There's the amendment, sorry, the amendment I distributed is a, a small amendment that just-- it's a cleanup amendment that shifts a line around this, not [INAUDIBLE].

SLAMA: Sounds good. Are there any questions from the committee after we heard that? OK, seeing none, thank you.

BOSTAR: Thank you.

SLAMA: All right, we'll now open it up for a proponent testimony on LB383. And if you are planning to be a proponent on this bill, it's not like church, please make your way up to the front row.

ALAN THORSON: Hi, my name is Alan Thorson. It's A-l-a-n T-h-o-r-s-o-n. I'm here to testify as a proponent of LB383 representing the Nebraska Medical Association and the Nebraska Cancer Coalition. Both organizations, I think, were explained earlier today, so you should be familiar with that representation. I have provided a written document that is full of statistics and information that may be of help and you make a decision about this bill. But I did want to take this time actually to explain a little bit more about the difference between stool-based tests and colonoscopy. Senator Bostar has already done a pretty good job of this, but stool-based tests can be blood based. OK. That's an FOBT or a FIT test. It can be a DNA type test. It can be-- as opposed to our visual exams, which are colonoscopy. OK? The visual-- visualization exams like colonoscopy are excellent because they can actually prevent colorectal cancer by removing precancerous polyps. OK? The stool-based tests are better actually at detecting a cancer early when it's still very treatable, beatable, and curable. So they're both-- they're all excellent tests, but they have a little bit different direction. The big thing, you might say, well, why would people select one over the other? And a lot of it has to do with cost. OK? And of course, when you have someone less than a Medicare age, then they're subject to insurance-- type of insurance coverage, which

was helped a lot by last year's passage of the law that Dr. [SIC] Bostar talked about. But the problem with the-- and people will select a stool-based test because it's cheap. OK? It's easy. They can do it at home. It doesn't require a bowel prep which takes several hours. They don't have to take a day off from work, which can be a significant factor for working people less than Medicare age. But as Dr. Bostar-- or Senator Bostar indicated-- sorry-- congratulations. [LAUGHTER] The-- as he indicated at the present time, it's possible if you have a, a, a symptom bleeding, a positive stool test that's considered a symptom, then the follow-up colonoscopy could be considered diagnostic and subject to cost sharing. While it's critical to understand that actually that follow-up colonoscopy is an inherent part of the screening examination when you start that examination process with a stool test. OK? My positivity rate that I would quote for a stool test is, I would say a little bit higher. I'd say about 10 to 15 percent because people with noncancerous issues, colitis, and things also can be positive and could end up needing a colonoscopy. But even at that rate, if you had-- the more people you have doing stool tests, and this affects rural Nebraskans, particularly as we study the statistics, that means that 85 to 90 people out of 100 who otherwise should have a colonoscopy actually could avoid a colonoscopy and instead do the stool-based test and have the colonoscopy only test positive. Significant potential of cost savings. I'll stop there and if there's any questions about all that, be happy to try to answer those.

SLAMA: Thank you, Dr. Thorson. Senator Kauth.

KAUTH: Thank you, Senator Slama. So you mentioned the rural districts. Does this allow people in rural communities greater access because it's mailed to them, correct?

ALAN THORSON: It's--

KAUTH: The stool-based tests.

ALAN THORSON: They could be mailed in. Is that what you asked?

KAUTH: Yes.

ALAN THORSON: Yes. Yeah, so it provides-- yeah, it, it, it does not take time away from work. It does allow them to be screened at home and they can be mailed in. Now-- and also, some of our rural residents are quite a ways from access--

KAUTH: Right.

ALAN THORSON: --to colonoscopy. If it comes back positive, they're going to have to make arrangements for that colonoscopy. But 85 to 90 percent of the time they won't have to do that. So it's a big potential benefit for residents in rural Nebraska.

SLAMA: Thank you, Senator Kauth. Any additional committee questions? Seeing none, thank you, Dr. Thorson.

ALAN THORSON: Thank you.

JINA RAGLAND: Good afternoon.

SLAMA: Good afternoon.

JINA RAGLAND: Good afternoon, Chair Slama and members of the Banking, Commerce and Insurance Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d, today-- here today testifying in support of LB383 on behalf of AARP Nebraska. You've already heard colorectal cancer is the third most common cancer diagnosed in both men and women and the third leading cause of cancer-related deaths in the United States causing more than 52,000 deaths per year according to the CDC. But about one-third of adults skip suggestive screenings that can prevent or help treat the deadly disease. Often, the reason for skipping screenings is due to lack of insurance coverage, out-of-pocket costs, the preparation, missing work, and so forth. Colorectal cancer is almost entirely preventable by taking advantage of recommended screenings and other prognostic tests, including the colonoscopy, which is, is considered the gold standard for early detection and prevention of cancers of the colon and rectum. At-home screening tests for colon cancer are an alternative that often can be more convenient and less invasive as an alternative for some patients leading to earlier diagnosis and a better prognosis. At-home colon cancer screening kits reduce the hassle of preparing for and recovering from a colonoscopy. The kits, as we said, arrive in the mail and the patient sends them back to the lab for interpretation, which eliminates the need for patients to take a day off from work or arrange for transportation or having a caregiver that might also have to take time away to transport them to and from. Half of all new diagnosis of colorectal cancer in the United States are now in people 66 or younger, according to the American Cancer Society. That statistic, according to the ACS, illuminates what it, what its researchers found in compiling their 2020 edition of colorectal cancer

statistics. The burden of colorectal cancer has shifted in recent years to younger people who are less vigilant than older adults in keeping up with colorectal cancer screenings. LB383 conforms with the U.S. Preventative Services Task Force test procedural recommendations. We know that colon cancer screenings save lives and LB383 will provide an additional avenue for accessing such preventive screenings for Nebraskans. Thank you to Senator Bostar-- Dr. Bostar [LAUGHTER] for introducing the legislation, and we would ask you to support the bill and advance from committee. And I would be more than happy to try and answer any questions.

SLAMA: Thank you, Ms. Ragland. Are there any questions from the committee? Seeing none, thank you very much.

JINA RAGLAND: Thank you, Senator.

SLAMA: Hi.

LINA BOSTWICK: Hello again. Thank you, Senator Slama and committee. My name is Dr. Lina Bostwick. That's L-i-n-a B-o-s-t-w-i-c-k, and I'm here again on behalf of the Nebraska Nurses Association, which is 30,000 registered nurses. And according to the Nebraska Department of Health and Human Services from 2023, colon cancer is the fourth most diagnosed cancer in Nebraska, yet ranks 41st in screening rates. Screening leads to early diagnosis of colorectal cancer, which is a key to long-term survival. A colonoscopy is a gold standard, as you've heard before. And in the past, cost sharing could have been a barrier when screening colonoscopy was advised related to positive stool-based screening or when screening is warranted on an annual basis. Colonoscopy is our dreaded rite of passage for many middle-aged adults. What the reality, though, that we all know at least one individual or more in our lives that have lost a battle to their-- to, to colon cancer due to lack of screening. Requiring that insurance cover the cost of screening colonoscopy without a deductible, coinsurance, or other cost-sharing measures removes that barrier. Accurate and timely diagnosis of colorectal cancer can positively impact the health of individuals and promotes safe, quality patient care. The Nebraska Nurses Association asks that you move LB383 out of committee to General File. We request that this letter be included as part of the public hearing record.

SLAMA: All right. Thank you, Dr. Bostwick.

LINA BOSTWICK: Yes.

SLAMA: Are there any questions from the committee? Seeing none, thanks for being here again.

LINA BOSTWICK: Thank you.

SLAMA: Additional proponent testimony for LB383? Seeing none, is there any opposition testimony for LB383? Seeing none, neutral testimony for LB383? Good afternoon.

ROBERT M. BELL: Good afternoon, Chairwoman Slama 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 of and a registered lobbyist for the Nebraska Insurance Federation. I am here today to testify neutrally on LB383. As you know, the Nebraska Insurance Federation is the state trade association of insurance companies, including most of the health insurance plans in the state of Nebraska. The health insurers appreciate Senator Bostar or his villainous Dr. Bostar [LAUGHTER]-- sorry-- for reaching out on LB383 and accepting our minor amendment that you saw before that. And actually we worked with a little bit before the session on the actual language of this. The insurance companies in Nebraska are not opposed to the provisions of LB383-- that's why we're here neutrally-- because it would provide further clarification on state law to match federal requirements on colorectal cancer screenings. Specifically, LB383 addresses an issue surrounding whether or not a follow-up colonoscopy from a positive stool-sample-based test would be considered preventative or diagnostic. Pursuant to the federal Affordable Care Act, most preventative services, such as colonoscopies, are preventative and free from cost sharing. However, a diversity of opinions existed in industry whether or not a follow-up colonoscopy was preventative or diagnostic. CMS, however, settled the issue with guidance a couple of years ago. So LB383 clarifies state law on the issue and brings us into compliance with the federal guidance. As a result, the Federation is neutral on LB383. Appreciate the opportunity to testify.

SLAMA: All right. Thank you, Mr. Bell. Are there any questions from the committee? Seeing none, thank you very much.

ROBERT M. BELL: You're welcome.

SLAMA: All right. Additional neutral testimony for LB383? Seeing none, as you're approaching for your close, Senator Bostar, we have four proponent letters for the record on LB383.

BOSTAR: All right. Thank you, Chair Slama and members of the committee. And this is a pretty simple bill. It eliminates cost sharing for colonoscopies for people who are already eligible for colonoscopies without cost sharing, if that makes sense. It's just a matter of whether or not they did a at-home screening test first. The way that-- the way our, our statutes currently read, it creates a disincentive for someone to do an at-home test. Because under the current statutes if they did an at-home test first and there was a, a marker of concern, they would have to get a colonoscopy and it, and it wouldn't be covered without cost sharing. Whereas, if they had just gone and skipped the at-home test and just gone and got a colonoscopy, they wouldn't have cost sharing. So we're trying to make sure that healthcare incentives are aligned with producing the best outcomes for, for our patients for costs of healthcare and we're just aligning things. So I'm happy to answer any final questions.

SLAMA: All right. Thank you, Senator Bostar. Any questions from the committee? Seeing none, thank you very much, Dr. Bostar, for your bill.

KAUTH: You are never living that down. [LAUGHTER]

SLAMA: All right. That brings to a close LB383. We'll now open up with LB308. Senator Bostar, long time no see.

BOSTAR: Indeed.

SLAMA: And if you're planning to be a proponent on this bill, please come up to the front, just so we can move everything along. All right.

BOSTAR: All of the testifiers on this bill.

SLAMA: All of them. I mean, there's crowds waiting outside.

SLAMA: Good afternoon, Chair Slama and fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar, E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29. Today I am presenting LB308, which adopts the Genetic Information Privacy Act. Direct-to-consumer genetic testing is widely popular. A Consumer Reports survey found that about one in five Americans has taken a direct-to-consumer genetic test. Genetic information consists of our most sensitive and personal information. It uniquely identifies an individual, reveals their propensity to develop certain diseases, and gives insight on family, ethnic and cultural background. Given the sensitive nature of genetic information, there are growing privacy

concerns regarding direct-to-consumer genetic testing company data practices. Traditional genetic testing administered by healthcare providers is extensively regulated, but direct-to-consumer companies market directly to consumers. And currently there are few restrictions on how companies collect, analyze, store, share or sell our personal genetic information. In response to growing concern, leading consumer privacy advocates, key policymakers, Ancestry, 23andMe, and other genetic testing companies created the Privacy Best Practices for Direct-to-Consumer Genetic Testing Services in 2018. Shortly after, the best practices were translated into model state legislation. Six states have passed this legislation so far. They include Arizona, California, Kentucky, Maryland, Utah and Wyoming. Nebraska would be the seventh if we, if we rushed. I hear that there's a lot of other states considering this at the moment. Companies like Ancestry and 23andMe have good reason to support increased consumer privacy protections. Their business models depend on consumer trust. LB308 ensures that the consumer is in control of their genetic data at all times and would require separate expressed consent for the following: Before DNA is extracted from a biological sample and analyzed; before a biological sample is stored; for genetic data to be used for research purposes; for genetic data to be shared with a third party; and for genetic data to be used for marketing purposes. Also, genetic testing companies would be required to provide consumers with a means to delete their genetic data from their databases and close their accounts without unnecessary steps, destroy a consumer's biological sample within 30 days of a request, and provide clear and complete information about their privacy practices and protocols. Additionally, genetic testing companies would be prohibited from sharing genetic data with employers or providers of insurance for any reason. Finally, LB308 provides that the Nebraska Attorney General may bring an action to enforce the provisions of the Genetic Information Privacy Act. As direct-to-consumer genetic testing grows in popularity, it is becoming increasingly important to enact regulatory guardrails to protect the privacy of Nebraska consumers. I urge the committee to advance LB308, and I'd be happy to answer any questions you might have.

SLAMA: Thank you, Senator Bostar. Are there any questions from the committee? Yes, Senator Jacobson.

JACOBSON: Thank you, Chair Slama. Senator Bostar, I'm, I'm looking really at the damages in particular, because obviously we can pass all kinds of statutes and laws and regulations. But ultimately, how does this get enforced? And so basically an action would have to be-- you'd have to contact the Attorney General, they'd have to bring the action.

And then it looks like the penalty is $2,500 per violation, I assume that means per person, or does it mean the number of people that they may have shared this information with? And I guess my big question is, how did we arrive at that $2,500? And do we think that's meaningful in terms of enforcing this, this new law?

BOSTAR: That's a great question. You're right in the-- you're right about the process of how that works. I believe it's per infraction, although I believe the testifier behind me will certainly be able to correct that, if I'm mistaken.

JACOBSON: I'll wait to hear that answer. Thank you.

BOSTAR: Essentially, this legislation was created through a large national process and negotiations. So that-- those penalty numbers came from, you know, these, these-- all of the stakeholders related to this issue coming together and agreeing on, on these provisions. And that included working with, you know, insurers, for example, as well on the national level. And this is, this is where everyone landed.

JACOBSON: And this would apply to anyone sharing this information? So, in other words, you get a direct-to-consumer company that does this and they share it with a physician or health organization, and it's-- I presume it compounds with anybody who shares that information.

BOSTAR: Yeah. And certainly that-- under this bill, any of that sharing would be prohibited without your express consent.

JACOBSON: Perfect. Thank you.

SLAMA: All right. Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, thank you.

BOSTAR: Thank you.

SLAMA: All right, proponent testimony on LB308. Good afternoon.

RITCHIE ENGELHARDT: Good afternoon, Chair Slama and members of the committee. My name is Ritchie Engelhardt, that's R-i-t-c-h-i-e E-n-g-e-l-h-a-r-d-t, and I'm the head of government affairs at Ancestry here today on behalf of the Coalition for Genetic Data Protection. Ancestry is proud of the work that we've done with our coalition partners, including 23andMe, to implement commonsense privacy protections that ensure consumers are in control of their data at all times. Senator Bostar did a great job in detailing the

provisions of the bill. I might have to hire you, we could always use another doctor on the team. So I'll be really brief, I'm not going to repeat everything that he said. In short, LB308 ensures that consumers are in control of how their genetic data is collected, processed and shared for the duration of their relationship with one of our companies. While Ancestry and 23andMe have adhered to these practices the entire time that we've offered DTC genetic testing products, LB308 will ensure that every direct-to-consumer genetic testing service is held to the same standards for privacy and data protection. Senator Bostar is right, our consumers' trust is our top priority. If people do not trust that we are employing privacy safeguards and data protection safeguards, they simply won't use our services. So we urge a favorable report on LB308, and I'm happy to answer any questions the committee may have. I can specifically circle back to Senator Jacobson's question. So the-- it's per violation. So you could have multiple violations for one consumer if you share that data more than one time with more than one entity. Those numbers were largely conforming to FTC enforcement. So FTC was part of the discussions with Future Privacy Forum back in 2018. And for privacy violations, it's typically not the case where you've got one consumer's data that you just share one time with one person, it's sharing multiples. So those violations add up very quickly. And while that number might look smaller for an individual violation, it would be into the millions, no doubt, if somebody were to, to violate the rules and broker the data.

SLAMA: Thank you, Mr. Engelhardt. Are there any additional questions from the committee? Yes, Senator Kauth.

KAUTH: Thank you, Senator Slama. One question. How would they find out that their data has been shared?

RITCHIE ENGELHARDT: It's an excellent question. So one of the-- probably the biggest risk in privacy when it comes to genetic data is that genetic data could be used for targeted advertising, right? You can learn a lot about a person from their genetics. You can learn their health risks, you can learn a lot about how they are composed physically, you can learn about their ethnic and racial background. So if you took that data and started marketing to a consumer based on that information, they would probably figure it out pretty quickly. Like, wow, it looks like this company knows more about me than they should. And there are other consumer data protection laws that are being passed across the country that really try to rein in targeted advertising, giving consumers the ability, at a minimum, to opt out of those things. But that's the thing that would probably get a

consumer's attention first, is if they started seeing advertising that looked like it was provisioned using their genetic information.

KAUTH: Thank you.

SLAMA: Thank you, Senator Kauth. Senator Dungan.

DUNGAN: Thank you, Chair Slama. And thank you for being here today. I know you and I chatted a little bit before the hearing, and you did an excellent job of explaining sort of the importance of this bill, and I think that's encapsulated here in what you handed out. Quick question I had for you that I neglected to ask yesterday, just because I think it could help me understand a little bit better. There's the subparagraph there that prohibits-- or requires valid legal process before disclosing genetic data to government agency, including law enforcement--

RITCHIE ENGELHARDT: Right.

DUNGAN: --without written consent. The language there, "a valid legal process," this is model legislation. So can you describe a little bit more of what that looks like?

RITCHIE ENGELHARDT: Yes.

DUNGAN: Does that mean obtaining a warrant or--

RITCHIE ENGELHARDT: Valid legal process would be a warrant or a subpoena, something presented to us from the courts that said you need to give this information over. So a lot of attention in this space has gone towards, you know, cold cases that were solved using genetic databases. That's really not what that provision gets at. So it would be a valid legal process. If we got a warrant for a specific person's DNA and we have that DNA, we would have to consider replying to that. For investigative genetic genealogy, where there's a cold case and they want to catch a bad guy, there is another service called GEDmatch that exists, and GEDmatch is an open-source genetic database. It was started by genealogy enthusiasts about ten years ago. And the premise was, if I did Ancestry and you did 23andMe and the Chair did MyHeritage, we could all download our raw data files, put it in a GEDmatch and then see our matches across all platforms. It was a great idea. They also had a provision that was kind of buried in the terms of service that said, for certain violent offenses, we'll let law enforcement upload profiles to try and identify unknown suspects and cold cases. So the way that works is, Golden State Killer, they

uploaded the genetic profile. They found a seventh cousin over here, maybe a fifth cousin over here. All they needed were a handful of known relatives, and then they got a really good genealogist to flesh out the rest of the family tree to identify that person. Privacy advocates were not happy when that happened because a lot of people whose data was in GEDmatch didn't even realize law enforcement could use it for that purpose. So GEDmatch ultimately did the right thing. They kicked everybody out of the database that law enforcement could access. They went back to their users and said, you're probably aware of what happened here. If you are comfortable with your data being used and processed for that purpose, you need to opt in. So all of the data that law enforcement now uses in cold case investigations is consented data for that purpose. The people to whom that data pertains have said, I am OK with you using it for this purpose, if it gets a bad guy off the streets.

DUNGAN: And under this, with the consumer's express written consent, the same information could be shared with law enforcement.

RITCHIE ENGELHARDT: Right.

DUNGAN: They're just-- they just have to consent to it.

RITCHIE ENGELHARDT: Right. So neither Ancestry nor 23andMe allow law enforcement to do those types of searches in our database. We're really not set up for it. We don't have any way to upload third-party genetic information. It's a closed-loop system. You do our tests, the results go into our system. That's the only way to get data in there. But we remind folks, GEDmatch is well set up for this. They've been doing it for a long time. The recent Idaho campus killer was caught using GEDmatch in a very similar fashion.

DUNGAN: Thank you.

SLAMA: Thank you, Senator Dungan. Additional questions? Seeing none, thank you very much.

RITCHIE ENGELHARDT: Thank you.

SLAMA: Good afternoon.

JANE SEU: Good afternoon. My name is Jane Seu, I'm testifying on behalf of the ACLU of Nebraska. I'm testifying in support of LB308. We thank Senator Bostar for introducing this legislation. There's nothing more private than your personal genetic information. Medical and

genetic information can reveal some of the most personal and private data about us, and maintaining control over that information is crucial. As medical records are increasingly digitized and genetic sequencing becomes faster and cheaper, threats to our privacy and autonomy intensify. Genetic data can reveal many kinds of sensitive information about, about you: your ethnicity, your family health, your likelihood of developing certain diseases. So this bill specifically protects Nebraskans' genetic information, have the right to protect the genetic information, to know that their genetic data is not going to be used for purposes beyond their consent. There are currently limited protections for disclosure and dissemination of personal genetic information. I think there's one major federal law besides HIPAA that provides that protection, but LB308 would require express concern to transfer or disclose the genetic data and separate express consent to retain the genetic information beyond the initial testing service. This bill would also prevent the open sharing of genetic information with law enforcement without that express consent, so thereby providing that extra layer of protection for the consumer. So we urge as part of this bill and to advance the bill out of committee. And I'm happy to take any questions.

SLAMA: Thank you very much. First question, could you please spell your name, please?

JANE SEU: Sure. Jane Seu, J-a-n-e S-e-u.

SLAMA: Thank you very much. Additional questions from the committee? Seeing none, thank you.

JANE SEU: Thank you.

SLAMA: All right. Additional proponent testimony for LB308. Any opponent testimony for LB308. Seeing none, any neutral testimony for LB308? Seeing none, Senator Bostar, you're welcome to close. And as you come up, there is one proponent letter for the record on LB308.

BOSTAR: Thank you, Chair Slama and members of the committee. The afternoon looks a little different than the morning. I would appreciate your support for this legislation, and I think it's, it's sort of a commonsense protection for Nebraskans. And with that, I'd be happy to answer any other questions the committee may have.

SLAMA: All right. Thank you, Senator Bostar.

BOSTAR: Sorry. The-- there is an amendment that I handed out and didn't mention that-- it removes a clause of language that was in the model legislation that the, that our Attorney General asked to be removed in order to conform more appropriately with Nebraska statutes. And I also forgot something else. The, the executive director of TechNet tried to submit a letter, I guess there was a complication, wasn't able to. So I said that I would distribute it to the committee if that is possible.

SLAMA: We'll let it slide.

BOSTAR: And with that, I will answer any questions, if there are any.

SLAMA: Well, thank you very much, Senator Bostar. Are there any questions? Seeing none, thank you very much. This brings to a close our hearing on LB308 and our hearings for this afternoon. If the committee could stick around for just 2 minutes, we'll have a quick [RECORDER MALFUNCTION].