**HANSEN:** Good afternoon, everybody, and welcome to the Health and Human Services Committee. As Senator Ballard was just telling me, the best committee in the State Legislature. So I feel honored to be here. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming and parts of Stanton Counties, and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

**BALLARD:** Senator Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

**WALZ:** Good afternoon. My name is Lynne Walz and I represent Legislative District 15, which is Dodge County and Valley.

**HARDIN:** Brian Hardin, District 48: Scottsbluff, Gering, and Kimball way out west.

**RIEPE:** Merv Riepe, Legislative District 12, which is most-- much of Omaha-- or not much of Omaha, but a big chunk of Omaha and Ralston.

**HANSEN:** Also assisting the committee is our legal counsel, Benson Wallace and our committee clerk, Christina Campbell, and our committee pages, Delanie and Payton. So thank you for being here. A few notes about our policy and procedures: please turn off or silence your cell phones. We will be hearing two bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill out and hand it to Christina when you come up to testify. This will help us keep an accurate record of their hearing. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying, which is right in front of the microphone. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns

yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask that you wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from the supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make a closing statement if they wish to do so. And as always, as somebody in the audience has always said every time she's been here to Chair this committee, we have a strict no-prop policy in this committee. So with that, we will begin today's hearing with LB200 and welcome, Senator Briese. Thank you.

**BRIESE:** Thank you and good afternoon, Chairman Hansen and members of the HHS Committee. I'm Tom Briese, T-o-m B-r-i-e-s-e, and I represent the 41st Legislative District and I'm here today to open on LB200, which is a bill to adopt a Canadian prescription drug importation program. For some background, in September 2020, the Trump administration finalized a rule in FDA guidance which would allow states to create programs to safely and responsibly import medications from Canada. And that program has continued under the Biden administration. So far, at least five states have passed legislation to take advantage of this program and notably, Florida and our neighbor Colorado are in their final stages of federal approval. Having reviewed the legislation from those two states, this legislation is modeled strongly on the Colorado legislation and it shares many similarities with Florida's. And I passed out or passing out some handouts: one describes the Canadian drug importation in general; one describes the Colorado program; and another, the New Mexico program. Under this bill, the State Department of Health and Human Services would create a program and contract through at least one vendor to coordinate the wholesale importation of Canadian prescription drugs. The vendors would be directed to identify potential drugs for importation based on shortages, prices and drug which-- drugs which are in widespread use. The key goal of this program would be to reduce costs for prescriptions for everyday Nebraskans. Drugs could only be imported from Canadian suppliers who are in full compliance with Canadian laws and initial batches of drugs would be statistically sampled for purity and degradation, as well as statistically valid samples of all subsequent shipments. Drugs imported would have to be approved for sale in the U.S., would have to

be FDA approved, not violate U.S. patent laws, and be expected to create cost savings for the people of Nebraska. Controlled substances, biological products, infused or intravenous drugs and drugs inhaled during surgery would not be included in the program. So why this legislation? Why this year? According to a CBS News report, Americans spent $535 billion on prescription drugs in 2018, an increase of 50 percent since 2010, and that far out place-- outpaces inflation during that time period. According to the federal Department of Health and Human Services report tracking drug price changes from 2016 to 2022, there were over 1,200 products whose average price increase from July '21 to July '22 was 31.6 percent. Some drugs in '22 increased in price by 500 percent. One article indicated the average list price in the U.S. for prescription drugs was 2.56 times higher than the prices in 32 other developed countries, while brand name drug prices average 3.44 times higher. According to Statista, in 2020, patented drug prices in the U.S. averaged 3.57 times higher than Canadian drugs. One article notes that the, quote, High cost of prescription drugs is a significant driver of medical debt because Americans are increasingly reliant on medication to manage long-term conditions, unquote. A 2019 CDC study found that 11.4 percent of adults aged 18 to 64 did not take their prescription drugs as prescribed in order to reduce how much they spent on their medication. I would submit to you that those are sobering statistics and numbers and the importation of Canadian drugs is one of the free-market steps we can help to ease this crisis. Taking steps to save our citizens money, I think, could be an important function of government. And when we're seeing record-high inflation now and who can say when it's going to slow down, household budgets are seeing a squeeze like never before. And for many folks in Nebraska, being able to afford their medications really is a matter of life and death. And even though this bill doesn't have anything to do with drug company profits, it doesn't look to me like this bill is going to have a negative impact on anybody that's struggling. In the last two decades, the largest drug manufacturers have well outpaced their peers on the S&P 500, bringing in net profits at a rate of 13.8 percent versus the 7.7 percent average of the 500. The Government Accounting Office found that the average profit margins of the 25 largest drug companies from 26-- 2006 to 2015 range from 15 to 20 percent, while the average profit of the 500 largest non drug companies fluctuated between 4 and 9 percent. And I do note that the fiscal note has some significant numbers and I'm not going to question the accuracy because there are many unknowns on something like this. But I do somewhere here have a copy of the Colorado fiscal note in which they were predicting about a $1 million cost to submit for the

federal waiver. After that, it would grow from there. But note that we provide in this bill-- I believe it's on page 8-- for a fee on the products to cover administrative costs. It seems to me perhaps we can use life some-- utilize some sort of a fee system as well to cover the majority of other state-incurred costs. So what we're talking about is opening up the market, expanding capitalism by allowing Canadian alternatives to what the market here is providing. And if somehow the Canadian companies are able to make these drugs and sell them for lower prices, I don't see why companies here at home couldn't seek to match or beat those prices and stay competitive. And yes, this hopefully can put some downward pressure on U.S. manufacturers and suppliers to modify their existing practice. And this truly as a free-market solution to a lingering problem for many Nebraska consumers. And I assume we're going to hear some folks talk about potential safety issues and things of that sort. But we have to recognize that the bill provides very-- or considerable provisions in there or numerous provisions in there to ensure that these items are safe, that they are going to be as safe as any product here. And I do note that on page 5, line 18 through 20, they're going to have to abide by the-- or we're going to have to ensure that the Canadian suppliers essentially meet the requirements of the Drug Quality and Security Act. And within that Drug Quality and Security Act, there is a multi-page provision entitled drug supply chain security. And so that-- we're going to have to match that security that's found in there. So I think any safety concerns that folks might want to present will be arguably over-- overblown. But with that, I'd be happy to answer any questions.

**HANSEN:** Thank you, Senator Briese. Are there any questions from the committee? Yes, Senator Riepe.

**RIEPE:** First of all, I, I admire you and for your spirit of trying to cut through some healthcare costs. That's, that's a real challenge and experienced by everyone. I have a couple of questions. First of all, I assume-- and you can respond yes or no-- that this is enabling legislation is fundamentally what it is.

**BRIESE:** Well, it would put in place a process for the state to apply for the federal waiver, yes.

**RIEPE:** OK. The other question I would have or a comment, I guess-- you can respond to this-- is it seems to me like mail-order pharmacy, as they say in Nebraska, it's not for everyone. And so-- and I have a concern with that. Local pharmacies, you take away some of their

profit margin. They still have to keep their doors open. So that's a concern for local pharmacies. The other concern that I have-- and I only have two more questions if I may, Mr. Chairman.

**HANSEN:** Yes.

**RIEPE:** One is the fiscal note, which talked about a cost. I know you cited what Colorado was, but the fiscal note talked about between $8.7 to $12 million for first-year startup. I'll give you time to respond if you have some thoughts on that or I'll move on to my last one.

**BRIESE:** Well, the Colorado fiscal note doesn't suggest those high of numbers, but again, I'm not going to argue with our fiscal people on this. But it seems to me, again, that we could utilize a fee system on these drugs, as we've indicated in the bill, for administrative costs, but perhaps to cover more of those costs. We want to ensure that that fee system doesn't take the price of these drugs out of, you know, out of what we're trying to target here, but I think there's ways hopefully to handle that. But there would be some upfront costs associated with that. What that amount would be, we're kind of left to speculation. And going back to your comment on the local pharmacy, we certainly want to ensure the viability and success and profitability of our local pharmacies and they would be part of this if they, if they choose to-- if they want to do that and be part of the importation program.

**RIEPE:** I know a lot of times, the local pharmacist is the one that families or individuals would contact, maybe even before their physician--

**BRIESE:** Sure.

**RIEPE:** --just because of a trusting relationship.

**BRIESE:** You bet.

**RIEPE:** The other question or concern I guess I have-- I'll give you a chance to respond to that-- was other states have tried to implement since 2019 without success. Now-- so I was a little bit surprised that here-- is Colorado implemented or, or in the process?

**BRIESE:** My understanding is they're getting very close to attaining the federal waiver. And so I think both Colorado and Florida and the others are waiting on a waiver from the Feds to allow them to do this.

**RIEPE:** One last concern that I have is particularly with sometimes people's prescriptions will run out and they need it right away or it requires refrigeration. I'm not sure-- there's, there's a number of complexities in here that, that give me pause.

**BRIESE:** Yeah and I-- as far as, you know, lack of supply or running out, I would assume that the typical pharmacy is going to have a supply of that medication in place anyway, regardless of the source. Whether it's coming from north of the border or locally, I would, I would hope they would have access to American manufacturers, American suppliers. But yeah, the, the fact that it hasn't been implemented and folks have been working on it, again, I think they're still waiting on federal approval. And then as far as implementation, I think some states, you know, have spent a considerable amount of money trying to get things in place and maybe they've gotten the cart before the horse. I would suggest that in Nebraska, we don't do a whole lot until we have federal approval. And again, of course, that's going to take a little money to do that. Again, Colorado, I think, looks like about $1 million or so they spent on that. But we're going to have to get, get things in place, make sure it's going to work, I think, before we really undertake the financial obligations associated with this. So--

**RIEPE:** So the fiscal--

**BRIESE:** --it seems to me that would be a prudent route.

**RIEPE:** And so the fiscal note even referenced that the Canadian government's not very helpful either or very supportive of the concept. So it seems like we have some pressure coming from a variety of ways that are not--

**BRIESE:** Sure.

**RIEPE:** --enthusiastic about the concept. I always get concerned in healthcare about continuity of care and, you know, it's complicated enough without--

**BRIESE:** Yes.

**RIEPE:** --making life more difficult.

**BRIESE:** And going back to your initial comment, you know, the cost of healthcare in this country, in this state, you know, the ever-increasing cost is-- really, really drives down or curtails economic growth in our country, I think.

**RIEPE:** Absolutely.

**BRIESE:** It's just outrageous. And as far as Canadian participation and their ability to do that, that goes back to my comment earlier. Get federal authorization, get it in place, and then make sure we're going to have the sources available north of the border. Make sure that the drugs that we are after are going to be available probably before we start contracting with vendors and vendors start setting up the chain and things of that sort. Again, some of those states, I think, maybe got the cart before the horse, but I think the prudent route would be to get federal approval, make sure we're going to have supplies available. And there's no guarantee we're going to have supplies available going down the road. But I would think Canadian manufacturers, they'd have a vested interest in ramping up production and ensuring that they can provide things for us. Their bottom line would hinge on that as well. And again, Canadian government's not going to let them run short of certain items, but we would have to wade into that portion, I think, once we had federal approval.

**RIEPE:** Thank you very much.

**BRIESE:** Sure.

**HANSEN:** Are there any other questions? I have maybe just one question.

**BRIESE:** Sure.

**HANSEN:** And I don't know if you touched on it earlier or somebody can answer it afterwards, but what's involved-- kind of more the bullet points-- with federal approval? So we send it off to the federal government for approval. It goes where? And then--

**BRIESE:** Yeah, so--

**HANSEN:** --why, why does it take so long? Like, what's the process? I'm just kind of curious more than anything else.

**BRIESE:** I'll look at my notes on that, see if I can answer that in the closing, but I'm not well equipped to answer step by step what is entailed in the process.

**HANSEN:** And that's fine. Somebody else might be able to answer it too, so.

**BRIESE:** Sure.

**HANSEN:** OK. All right. Thank you, Senator Briese.

**BRIESE:** You bet. Thank you.

**HANSEN:** All right. So with that, we will take our first testifier as a proponent of this bill, whoever wants to come up first. You can come up and sit up here if you want. You can come up here. Yeah. Yeah, you can hand your green sheet to--

**KELLEY CLARK:** Thank you. Where do I hand it?

**HANSEN:** To the pages right there.

**KELLEY CLARK:** Thanks.

**HANSEN:** And then again, the green light will turn on. And then when you have one minute left, the yellow light will turn on. And then when the red light is up, we'll ask you to wrap up your thoughts.

**KELLEY CLARK:** Well, I'm already going to ask for two more minutes, I am, because I, I limited as best I could. And I think when I get into my material, you'll understand.

**HANSEN:** OK. We shall see.

**KELLEY CLARK:** Thank you. First, I'd like to thank you for hearing me today, all of you. I have one little discrepancy with Senator Briese. I believe there are 16 states that have--

**HANSEN:** Can I, can I interrupt you for one quick second?

**KELLEY CLARK:** Yes.

**HANSEN:** Can you spell-- say your name and then spell it out for us--

**KELLEY CLARK:** Oh, I'm sorry.

**HANSEN:** --quickly? Thank you.

**KELLEY CLARK:** Margaret and I go by Kelley, K-e-l-l-e-y, Clark, C-l-a-r-k. I'm from Omaha--

**HANSEN:** Thank you.

**KELLEY CLARK:** --District 4--

**HANSEN:** Thank you.

**KELLEY CLARK:** --Senator von Gillern. Yes. Well, anyway, I've been given only five minutes-- and I know this-- to address this body, this august body regarding LB200, the bill that can radically change lives in this state. So will you do something that's a little bit different, maybe, from what you're used to and be so kind as to participate in a little exercise? All of you. I would ask you to close your eyes and do some imagining. Now, imagine if you, if you will, that you have a son or a daughter. Some of you actually do have that so imagine it is that child. This beautiful baby came into your life and was a bit different than other children. They were different to quiet down, to have sit still in church or synagogue, had an odd way of pronating their hands when they walked. They excelled in life. They had many friends and were a great basketball player because there, they could be expected to run free. But when they became 15, they began exhibiting some bizarre behavior like climbing out of the classroom window or taking your car out for a drive in the middle of the night to the next state, or one day going to your backyard and setting themselves on fire. This is the story of my son. He's tried five times to commit suicide by hanging, by drugs, by fire. You may open your eyes, please. I guess you already do. This is the story of my son. It took a long, arduous time to get a proper diagnosis, proper medications for him through trial and error. He is now 44, lives in his own world with schizophrenia and resides with my husband and me. He must have four medicines to keep him from exhibiting those bizarre behaviors. Just one of those drugs costs $1,556 a month. With-- we are able to afford insurance so we are lucky. We aren't indigent. We aren't the dirt-poor category, but our insurance only covers part of it and it's $586 just for that one drug along with some other fairly expensive drugs that he needs. Looking at what Senator Briese was speaking of, if we purchased this-- and I've checked with Canada. I checked with the NorthWestPharmacy, for instance. The cost in Canada would be $173 for a month. Also in our family, my husband has brittle diabetes and thank God the federal government has recently brought the cost of his insulin from $200 a month to $39. But there are other medications that he needs. And I have had cancer this past year, a mastectomy and a nephrectomy-- a partial nephrectomy, removed my kidney and my anticancer drugs are often very expensive too. Our out-of-the-pocket expense per month for medic-- medical costs exceeds $1,700 a month. And here are some frightening statistics. I went to the CDC, I went to the Nebraska government and I went to the Kaiser Family Foundation, which is responsible for much polling and evaluation of politics--

policies, I beg your pardon. This is-- these are some statistics: 46 percent of the U.S. population used one or more prescription drugs within the last 30 days. Those who are older than 65, almost 90 percent take at least one Rx a day, 36 percent take at least five a day. And that doesn't include the OTC drugs, over the counter, that they need for other remedies. And my friends, herein lies the fault of our consciousness. Twenty-two percent, that's almost one in four people, of those-- of any age characterized as in need of medication are either going without or dividing doses to get by. Many people are going without food, heat, air conditioning, trips to medical care in order to afford those medications.

**HANSEN:** Ms. Clark, I'll ask you to wrap up your thoughts, please. I gave you an extra minute.

**KELLEY CLARK:** OK. Oftentimes, insurance will not pay for the tier five, which are the newer and better medications, so substitution drugs are made-- given with less effective or sometimes deleterious effects. In Nebraska, let's consider for a moment there are an estimated 16,000 people with schizophrenia, 16,000.

**HANSEN:** Ms. Clark, I-- we got a lot of testifiers behind you. I hate to cut you off, but we have to kind of move through if we can. So if you can really wrap up your thoughts.

**KELLEY CLARK:** OK, bipolar is 34,000. And that drug I mentioned, Latuda, that is manufactured by a company called Sunovion is the same company that supplies Canadian pharmacies as our pharmacies. It's the same company and they're selling it to us for $173, Sunovion. In Nebraska, 5,596 prisoners-- I, I, I have about one and a half more minutes, OK?

**HANSEN:** Actually, we're going to stop you because we have a lot of testifiers behind you. We have to give the same courtesy to everybody so I'm sorry.

**KELLEY CLARK:** Well, let me just say one thing.

**HANSEN:** OK, very, very quickly.

**KELLEY CLARK:** I can tell you if you, you turn your back on these, the least of us, then way-- then why are you occupying that chair? And if you turn your back, have you-- have, have-- you have another, maybe bigger worry because you just lost my hope. Thanks.

**HANSEN:** Thank you, though. Appreciate your thoughts. All right, we'll take the next testifier.

**M. CAVANAUGH:** Questions?

**KELLEY CLARK:** Oh, yes. Sorry. Ms. Clark, there might be a couple of questions for you from the, from the--

**KELLEY CLARK:** Sure.

**HANSEN:** --from the committee if you would like to-- can you have a seat right back up here again?

**KELLEY CLARK:** Sure.

**HANSEN:** Sorry about that.

**KELLEY CLARK:** That's fine.

**HANSEN:** Are there any questions from the committee? Yes, Senator, Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you so much for your testimony. If-- not that I have any doubt in Senator Briese's ability to bring this legislation to fruition, but if this were to not be enacted, it sounds like your, your needs won't change and that you're getting a lower-quality drug that-- we could be giving you a higher-quality drug.

**KELLEY CLARK:** That's absolutely true.

**M. CAVANAUGH:** And I was just trying to get to figure that out in your testimony.

**KELLEY CLARK:** We're already doing that in our lives.

**M. CAVANAUGH:** So-- and I apologize. You do not have to answer this question because it's a personal question.

**KELLEY CLARK:** I will.

**M. CAVANAUGH:** But is your health insurance-- how are-- how is your medical bills? Are you through Medicaid, Medicare? Are you self-insured or--

**KELLEY CLARK:** My son who is disabled is--

**M. CAVANAUGH:** Yes.

**KELLEY CLARK:** --Medicaid.

**M. CAVANAUGH:** And, and, and so for him specifically, he's getting a lower-quality drug through his Medicaid.

**KELLEY CLARK:** The insurance will not pay for the tier five-- it's called tier five.

**M. CAVANAUGH:** OK.

**KELLEY CLARK:** And they're the better, newer modes of medication, often.

**M. CAVANAUGH:** OK.

**KELLEY CLARK:** And so it's-- the insurance makes you substitute with a lesser-quality drug sometimes.

**M. CAVANAUGH:** I believe we've had a few bills on that in the past in here and that just kind of flagged that for me. So sorry I--

**KELLEY CLARK:** No, that's fine.

**M. CAVANAUGH:** --took us down a different road than LB200, but thank you for that information.

**KELLEY CLARK:** Thank you, Senator.

**M. CAVANAUGH:** Thank you, Senator Cavanaugh. Any other questions from the committee? All right. Seeing none, thank you again. Appreciate it.

**KELLEY CLARK:** Thank you, sir.

**HANSEN:** All right. We'll take our next testifier in support. Welcome.

**JINA RAGLAND:** Good afternoon, Chair Hansen, and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I'm here today testifying in support of LB200 on behalf of AARP Nebraska and our members and all those 50-plus across the state. It is no secret that the U.S. pays the highest prices for prescription drugs in the world. By importing equally safe, less-expensive drugs, Nebraska can anticipate reducing our overall expenditures on drugs and depending on how the state program is structured, can pass those savings on to Nebraskans who are impacted

by the program. Establishing an importation program may take time, but fiscal analysis performed in other states estimates significant savings for those states and their consumers. Similar savings could also be realized in Nebraska. The size of the savings in which consumers would benefit depends, of course, on how the state structures the programs and what medications would be selected. Policymakers have long looked to Canada as a potential source of savings where prescription drugs-- drug costs on average 30 percent less than, than in the U.S. For drugs imported under this program, Nebraska can make sure savings are passed on to payers and consumers to help them afford their medications. Safety, development and approved standards for prescription drugs in Canada are similar to the standards to the U.S. Though not a complete solution to the problem of high drug prices, safe and legal importation will help put a downward pressure on prices. As an example in the difference in prices for some more commonly prescribed medications, Lyrica is-- costs $6.04 in the U.S. and $0.63 in Canada. Xarelto costs $12.44 here, compared to Canada's $2.11 price. And Eliquis costs $6.21 in the U.S. compared to $1.60 in Canada. Legislation authorizing a state to seek federal approval for an importation program was enacted in Vermont in 2017, Colorado, Florida and Maine in 2019, and New Hampshire and New Mexico in 2020. As of September 2022, Colorado, Florida, Maine, New Mexico and Vermont have submitted proposals to HHS for approval to begin importing drugs from Canada. All, of course, are waiting for approval, which we've talked about. Florida, based on a concept paper the state submitted to the federal government in August 2019, projected that its program would save over $150 million annually when fully operational. So what are the impacts of high prescription costs to Nebraska consumers? According to an AARP 2022 survey, 84 percent of Nebraska residents age 45-plus think being able to pay for prescriptions in either extremely-- is either extremely or very important. This increased from 78 percent compared to in 2019. We know that roughly 154,000 Nebraska residents are diagnosed with cancer, 121,000 have diabetes and 115,000 have asthma and COPD. The average older American takes 4.7 prescription drugs on a chronic basis, and the average annual cost for one brand name drug used on a chronic basis was $6,426 in 2019, almost $1,338 more than 2015. In Nebraska, the average cost of prescription drug treatment increased 26.3 percent between 2015 and 2019, while the average income for Nebraska residents only increased 10.4 percent. No one should have to choose between buying medications or buying food for themselves or their families. The high cost of prescription drug impacts all Nebraskans. Tax dollars are spent on drugs and implementing this program can save taxpayer, taxpayers a lot

of money as a result. In conclusion, AARP believes that we should reduce barriers to global price competition by allowing for the safe importation of lower-priced drugs from licensed wholesalers and pharmacies operating in Canada. As previously noted, this is not a complete solution-- and we know that-- to the problem of higher drug prices. But safe and legal importation would be a step forward in putting downward pressure on the prices. Thank you for the opportunity to comment, thank you to Senator Briese for introducing it and I'd be happy to answer any questions.

**HANSEN:** All right. Thank you. Are there any questions from the committee? Yes, Senator Riepe.

**RIEPE:** Thank you, Chairman. In your research or background on this, have you looked at the implications of-- because America is credited with taking-- doing the research and spending a lot of the money. So we're-- but-- and, and I know there's some criticism that we haven't passed those costs on to when we sell them to Canada or Europe or anyplace else. Do you have a response to that? How do we protect-- I'm not talking about excessive profits. I'm just-- how do we protect the creativity and the ingenuity and the incentive for creation of new research drugs?

**JINA RAGLAND:** Great question, Senator Riepe, and I'm not sure I actually have any answer to that. I think that's, that's fair and legit. I mean, as far as passing on costs down to the consumers-- and that's where I'm coming from today.

**RIEPE:** Sure.

**JINA RAGLAND:** We hear stories every day from consumers who are trying to put food on the table, can't afford a medication. And you've heard the story from behind about, you know, not being able to do that. You know, I think there's enough profit that's gone around that I-- and I think Senator Briese made that point too. There is administrative costs that could be built into this, but not enough that it doesn't trickle down the savings to the consumer. So I guess that's my answer. And I'm not sure that that's completely what-- where you were going and if not, I'd be happy to clarify.

**RIEPE:** No, I just-- and I don't know whether you have a response. I think in the legislation some place, it talked about price fixing. That's always a red flag for me because it rarely works. I don't know whether you want to respond to that. Do you see this as price fixing--

**JINA RAGLAND:** No.

**RIEPE:** --setting prices?

**JINA RAGLAND:** No, we're-- we--

**RIEPE:** Well, as--

**JINA RAGLAND:** Yeah, I mean--

**RIEPE:** --the good senator--

**JINA RAGLAND:** --from our perspective, again, we're just here on behalf of consumers. We want to find whatever gives them the best option. And right now, they can shop around in various ways, but oftentimes they're very limited based on formulary restrictions of what they can and can't take. So I think that that just provides another opportunity.

**RIEPE:** OK. Thank you. You've been very kind.

**JINA RAGLAND:** Thank you, Senator Riepe.

**HANSEN:** Any other questions? All right, seeing none, thank you.

**JINA RAGLAND:** Thank you, Senator.

**HANSEN:** We'll take our nest-- next testifier in support. Are there-- welcome.

**JOHN HANSEN:** Chairman Hansen, members of the committee, for the record, my name is John Hansen, J-o-h-n, Hansen, H-a-n-s-e-n. I am here before you today as the president of Nebraska Farmers Union, our state's second-oldest and second-largest general farm organization. We have been working on health reform issues for all 33 years that I've been president of our operation. And we have done lots of different kinds of things in order to try to bring about reforms so that we get a, a better, more affordable healthcare system that, that is accept-- is accessible and affordable for rural folks and rural communities. So my sister organizations in, in Farmers Union along the Canadian border have long sponsored bus tours to go up into Canada for a day's worth of, of mostly prescription buying with a little entertainment, a few other things involved. And so they've been doing bus tours for years. They have been doing all different kinds of things in order to try to explore the-- kind of the obvious rift between the U.S. prescription

medication price structure and the Canadian one, saying apples to apples, oranges to oranges. We're talking about, in some cases, the same manufacturers, but at significantly different price points. And so we are in support of LB200 because we think it's a structural fix in a way that would help provide more competition and it is market based. We spend a lot of time working on reform of agricultural markets. We believe in the marketing system. We want the marketing system to work, but you have to have certain things in the system and have them be present in order for the system to function as it should. We-- you know, we need markets that are accessible, that are competitive, that are transparent, that are fair. And when you do that, you have price discovery. And right now, our, our U.S. system unfortunately doesn't have enough competition in it-- in the prescription area to get to price discovery. But when you walk across the border and you see the same product manufactured in some cases by the same company, and you can see what they sell it for there at a profit, then you get some idea of what the lack of competition in the U.S. is costing us on a regular basis. So we view this as a, as a bit out of the box. We like it. We think it's a, is a structural fix. And at the end of the day, there's very few things-- and when you get into the world of, of economics and markets that are not made better by more competition. I guarantee you that our drug companies are not going to go broke if we do this and that they will be competitive and that they will respond to the competition as they should. And so at the end of the day, these kinds of things that bring additional competition have huge benefits industry wide. And we encourage you to support LB200 and thank you for your time and attention. I would be glad to answer your questions if we could do so.

**HANSEN:** All right. Thank you, John. Are there any questions? Yes, Senator Riepe.

**RIEPE:** Thank you, Mr. Chairman. Are you aware that the Canadian government's health system does or does not provide subsidy to the prescriptions to drive that price down to, say, $173?

**JOHN HANSEN:** I'm not exactly an expert--

**RIEPE:** I don't know either.

**JOHN HANSEN:** --by any means on the Canadian system. But I do know that for years, they've also, because of the structure of their healthcare system, have been able to negotiate prices with manufacturers and suppliers. And, you know, we, we in the U.S. have-- we come in after

the fact and try to raise insurance prices and other things to compensate for higher costs rather than sort of at the upfront end. And, and so we're starting to do more of that now and I think that to the extent that the U.S. does more of that negotiation, I think that that will benefit us.

**RIEPE:** I think it's only recently that the Medicare is now eligible or able to negotiate and so I'm curious how that'll play out. I don't know whether you want to respond to that or not.

**JOHN HANSEN:** Well, I, I think that would be a positive thing. And I-- you know, I just-- apples to apples, oranges to oranges. It's-- when you look at the drug prices in Canada versus the drug prices in the U.S. for the same products, same manufacturers, something somewhere is wrong. It reminds me of what my grandfather used to say relative to bulls, which was, was what's the difference between a $1,000 bull and a $5,000 bull? Unfortunately, most of the time, it's only $4,000. It's the same bull, just more money.

**HANSEN:** All right. Thank you. Any other questions from the committee? All right, seeing none, thank you.

**JOHN HANSEN:** Thank you.

**HANSEN:** Are there any other testifiers in support? All right, seeing none, are there testifiers in opposition that would like to testify? Welcome.

**MARCIA MUETING:** Hi. Good afternoon, everyone. Chairman Hansen, members of the Health and Human Services Committee, my name is Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g, and I am the CEO and a pharmacist. I'm the CEO of the Nebraska Pharmacists Association and I'm a pharmacist as well. I'm here today to express opposition to LB200, which would implement a Canadian drug importation program in the state of Nebraska, as we've heard. I'm concerned that any intent-- any attempt to implement the plan outlined in LB200 would create significant risk of exposing Nebraska patients to substandard and counterfeit medications. It would be unlikely to save any money and it would become costly and implementable. With my experience as a pharmacist, I experienced patients making that decision at the counter. Can I afford this medication? We know that patients need less costly drugs. They do. How will this impact insurance, insurance like Medicaid and Medicare? One thing I do know for sure is that we will still be at the mercy of pharmacy benefit managers because they are

the ones who are setting the prices that our patients pay. Wyoming spent months studying Canadian drug importation and eventually concluded that it would be a waste of money to implement it. Among other things, Wyoming said there was no way for the state to prevent pharmacy benefit managers, or PBMs, from making money on the spread for cheap Canadian medicines by simply marking them up to U.S. prices. I got a call from an independent pharmacy owner this week in response to this bill, and he said, I don't want-- I-- don't send me the stuff from Canada. I don't want the liability. I don't know where it's come from. This is going to be a costly and impossible to implement program. Florida is attempting to implement importation, but they have not been able to secure either FDA approval or a blessing from the Canadian government. They have, they have, however, spent $25 million of Florida taxpayer money hiring staff, building a warehouse and designing IT systems. In fact, as a response to the federal government's final rule on importation of prescription drugs, Canada implemented a regulation blocking any bulk export of medication that would have the potential to create a shortage of drugs in Canada. We're-- I'm very worried that attempting to implement Canadian drug importation over the objections of the Canadian government and the drug regulators, Health Canada, would expose Nebraska's patients to unsafe medications from Canadian vendors willing to antagonize their own regulators. Thank you for the opportunity to comment and I would be happy to answer any questions.

**HANSEN:** Thank you. Are there any questions from the committee? I might have a couple.

**MARCIA MUETING:** OK.

**HANSEN:** When you say it's unlikely to save money, how do you mean?

**MARCIA MUETING:** We don't know what this is going to cost, right? We don't know what the impact to the patient will be. There are two really big unknowns in this plan. We don't know what it's going to cost the state to set up and design a program to operate a warehouse, to ship these medications to wherever in Nebraska. And we have no idea what that cost will be passed on to the patient, is that correct? I mean, that's what I understand.

**HANSEN:** I think to some extent, I think Senator-- we have typically fiscal notes that will give us an estimate about how much it would cost the state of Nebraska. But yeah, you're right. Sometimes it's going to be more, sometimes it's going to be less, just kind of

depends. But-- and one other thing when you talk about PBMs, I think Senator Riepe mentioned something about price fixing.

**MARCIA MUETING:** Right.

**HANSEN:** So PBMs, then, if they get a cheaper medication from somewhere else, they're able to charge the same as when they get from the United States?

**MARCIA MUETING:** Sure. I'm-- absolutely. I want to give you another example that I thought was striking and this is in a Medicare patient here in Nebraska. A pharmacist called me and told me that they filled a prescription for the medication. It cost the pharmacy $2. Pretty good. The PBM asked-- it's telling the pharmacy to collect $42 from the patient and then the PBM on the backside is clawing back $35 from the pharmacy. There would be no way to prevent that unless people don't use their insurance. I mean, I think it's important to know where the prices are being fixed, where the prices are being generated. What we pay for prescription drugs in Nebraska, in the United States is up to our insurance. I have a high-deductible plan. I pay 100 percent of the cost out of pocket, but it's dictated by my insurer what that cost is. Prescription drug pricing is tricky. It's not just simple-- a simple matter of buying something cheaper. There's no way to prevent that spread pricing between the insurance company, the PBM, and the patient.

**HANSEN:** OK.

**MARCIA MUETING:** That is not regulated.

**HANSEN:** Thank you for your explanation, actually. Thank you.

**MARCIA MUETING:** Of course.

**HANSEN:** And just to make sure, any questions? Yes, Senator Hardin.

**HARDIN:** In your third point, you said that we'll still be at the PBMs' mercy.

**MARCIA MUETING:** Um-hum.

**HARDIN:** Are you aware of any limitations on what PBMs can do with rebates?

**MARCIA MUETING:** Limitations. I think it depends on which plan it is. For example, Nebraska Medicaid plans, the pharmacy benefit managers for those drugs that are covered under our preferred drug list, they are expected to pass those rebates back to the state.

**HARDIN:** But do they have any requirement to do so?

**MARCIA MUETING:** Yeah. Remember, I'm just a pharmacist, so I haven't read those contracts.

**HARDIN:** I'll continue to ask the question--

**MARCIA MUETING:** Yeah.

**HARDIN:** --because I know the answer to that question.

**MARCIA MUETING:** Oh, OK.

**HARDIN:** No.

**MARCIA MUETING:** OK, so there you go. Rebates are a big part of pricing.

**HARDIN:** They are all of the pricing.

**MARCIA MUETING:** Agreed.

**HANSEN:** Any other questions? [INAUDIBLE] OK. All right, thank you very much for testifying. Appreciate it.

**MARCIA MUETING:** My pleasure.

**HANSEN:** All right, we'll take the next testifier in opposition. Welcome.

**SHABBIR IMBER SAFDAR:** Chairman, members, thank you for your time. My name is Shabbir Imber Safdar. That's spelled S-h-a-b-b-i-r I-m-b-e-r S-a-f-d-a-r. I am the executive director of the Partnership for Safe Medicines. We are, as of this year, 20 years old. We're a not-for-profit that studies counterfeit medicine in America. And I do a lot of track and trace and drug supply chain training for pharmacists around the country. I also, unfortunately know quite a bit about Canadian drug importation plans because they've been around for 20 years. So I'm going to touch on a couple of high points. There's a lot of information in your packet. I expect you to ask me questions. It's perfectly fine. My wife's tired of hearing me talk about these

things. I have a number of colleagues in Canada who could not travel here to testify. They wrote letters which I have put in my packet; one-- the two of these. Basically, if you are any kind of healthcare stakeholder in Canada, and that includes doctors, nurses, patients, pharmacists, hospital pharmacists or wholesalers, you've been on one of these letters. And what they've said is that they are absolutely not OK with participating in this plan. This is not up to the FDA. It's not up to Nebraska. It's up to the Canadians if they want to ship pallets of their medications. And the reason the Canadian advocates have said no is because they have drug shortages. They have drug shortages that make us look like we are living in a land of plenty. They don't make medication in Canada. They're a tiny country of 38 million people compared to our 335 million. They don't have a market big enough to demand that. So everything they get typically is made in one production run and arrives once a year in the country and they get an amount that has been sized for their country. And they-- even today, because their country is growing, they run out of things like Tamoxifen, which is a breast cancer drug. And their pharmacists spend the better part of a week trying to find it for their patients. They absolutely don't want to have American-induced shortages. That is, that is why they actually objected. And that is why, as you can see from this handout, back in 2020, as a response to the regulation from the federal government, they put in place a regulation to block exports if they might cause a shortage. They want-- they're very kind. They would be happy to offer advice about what's different between our systems of healthcare and how to address issues of cost because these bills come from a good place of trying to make medication more affordable. It's just the Canadians are not willing to do without to try and help us. I want to talk a little bit about the fiscal note really quickly. So Florida, optimistically-- and you can see the contract on their website-- built a warehouse, I think, as my colleague Marcia mentioned, and retained staff and set up an IT system. They've spent at this point about $28 million and the warehouse that they've secured has-- spends about another $1 million a month just staying open. They've got no permission. There's-- if you look at the regulations the federal government passed, there's no regulation that says they have to approve the plan on any deadline. And even if they do, you've still got the Canadian government to get past and they're not on board with it. So this is, this is a real issue. Any money spent on these plans is really not going to be recoverable because the Canadians have no reason to worry about how much money a state government has spent to set this up. They're just

going to refuse it. I don't want to go over my time, so I will, I will let it slide and I'll answer your questions.

**HANSEN:** Thank you. Are there any questions from the committee? Yes, Senator Hardin.

**HARDIN:** The Canadian government-- thanks for being here.

**SHABBIR IMBER SAFDAR:** Sure.

**HARDIN:** The Canadian government is not required to fulfill everything from tier one through tier five. They will do what they can, is that correct?

**SHABBIR IMBER SAFDAR:** That's correct. And not only are they not required to, but they're not required to sell you medicine for the same price that they've negotiated. So if I was-- no wholesaler will do business because the wholesalers as a unit have agreed and signed these letters. But the wholesalers, if they wanted to, could just price gouge Nebraska because they're not obligated to sell to you for the price that the province of Ontario negotiated for themselves.

**HARDIN:** While not required to, is there any history that we have here in the U.S. that in fact those drugs are still cheaper than what we can buy them for down at the local drugstore?

**SHABBIR IMBER SAFDAR:** So that's interesting. There's a lot of medicine that cannot be brought in or is not price affordable to bring in under these plans. Federal law prohibits you from importing insulin so you can't bring insulin in under this plan. Federal law prohibits these plans from importing biologic drugs. So people who have really interesting blockbuster arthritis drugs that are biologics, that can't be brought in for cheaper under this plan. Medicaid pricing, which was a surprise to me and I think to the Canadians, is actually better than Canadian pricing. So if you look at, like, Maine, you know, they did an analysis and they figured out that they would not be doing Medicaid because it costs $1 million more to buy it from Canada than it does just to buy with their Medicaid and their rebates. And I think 340B is the other one, 340B is also cheaper, so yeah.

**HARDIN:** Are bio-injectables not allowed because they're typically refrigerated?

**SHABBIR IMBER SAFDAR:** Yeah, cold chain drugs, I think, are, are problematic. But the fact that they're biologic is an absolute prohibition and the law has been there since 2003.

**HARDIN:** As well as many mental nervous drugs.

**SHABBIR IMBER SAFDAR:** As what?

**HARDIN:** Many mental nervous drugs.

**SHABBIR IMBER SAFDAR:** Some of them, yeah. Yeah, if they're small molecule, they're usually allowed.

**HARDIN:** Thank you.

**HANSEN:** Yep. Any other questions? Yes, Senator Ballard.

**BALLARD:** Thank you, Mr. Chairman. So what factors contribute to this discrepancy in drug prices? Is it mainly R&D or is it other factors?

**SHABBIR IMBER SAFDAR:** So there's a couple of things. You know, generic drugs are cheaper, cheaper here than in Canada in many cases because our market is larger and we have more competition amongst the generic product. But the biggest thing-- and I'm not an expert on the Canadian drug supply and their economics, but the Canadians tell me when I ask them what is the difference, they say a number of things, chiefly among which is they don't have PBMs, right? There's no one back there playing games with the price between the manufacturer and the pharmacist. They have-- if they have a PBM, it operates as what's called a transparent PBM where they have to show their pricing and all the rebates are required to be given back to the plan sponsors or to the patient. They, they're mystified as to why we have PBMs, honestly. So that's the biggest difference I can think of.

**BALLARD:** Thank you.

**HANSEN:** Yes, Senator Hardin.

**HARDIN:** Are you also mystified why we have PBMs? Because I am.

**SHABBIR IMBER SAFDAR:** So I grew up in St. Louis and there is one of the largest PBMs with an enormous complex of buildings along the--

**HARDIN:** I have many friends who work in-- that are legal drug dealers. I understand, so--

**SHABBIR IMBER SAFDAR:** Yeah.

**HARDIN:** But I still ask them. It's like asking a band, why do you have a drummer? Why is-- is that a musician? I ask them the same thing.

**SHABBIR IMBER SAFDAR:** I don't understand how you can take so much money out of the healthcare system that you create three Fortune 15 [SIC] companies in under ten years, but that money had to come from somewhere. And I think it probably came out of the pharmacists and out of my pocket and out of your pocket and out of the state's pocket.

**HARDIN:** Thank you.

**HANSEN:** Any other questions? Can I ask a really simple one?

**SHABBIR IMBER SAFDAR:** Sure.

**HANSEN:** Pardon my ignorance. Are people from Canada able to buy prescription medications from the United States to get shipped to them?

**SHABBIR IMBER SAFDAR:** They don't generally do that. They just--

**HANSEN:** Is it because of price or, or just they just can't legally?

**SHABBIR IMBER SAFDAR:** Well, I mean, legally, you actually aren't supposed to get-- so no patient in either country is supposed to be buying medicine from the other country because you have to have a doctor's prescription from that country. So Canadians don't come here typically for medication. They probably should because if you look in your packet-- this is one of the things I train pharmacists on because we have the Drug Supply Chain Security Act, which has a serial number. This is a fake label. It's not a real drug. But I make it for training because I train pharmacists. And, and our drugs-- our drug supply is safer than Canada's. They don't have a Drug Supply Chain Security Act. They don't have a serial number on a bottle when it comes off the factory, but we do. And when they passed the importation regulations, they blew a hole in this system, which is terribly sad and not particularly safe. But if I was a Canadian, I would want to come here just for the safer medicine.

**HANSEN:** OK. Thank you. Any other questions? Senator, Senator Hardin.

**HARDIN:** Are you aware of any exceptions to our drug chain security in the United States?

**SHABBIR IMBER SAFDAR:** There are certain kinds of injectables and blood products and radiology-- radiological products that are not required to be serialized. And then these drugs that come in under this, under a proposed Canadian system, would not be-- they would be-- basically, a label would be stuck on them as they cross the border. But that would not be as good as what I can do today, which is I can actually call every person in the supply chain back to the manufacturer and trace that number. The Canadians can't do that. They actually have wanted to do that, but it's a very expensive system to set up and we've been doing it for nine years. It's just about done now.

**HARDIN:** Are you aware of any large retailers in the United States who do that, not with bio-injectables, but with generics?

**SHABBIR IMBER SAFDAR:** Almost all generics will have to also be serialized when the final-- I mean, if you look at it now, at the bottle that comes off the factory line, which is sometimes a 500-count bottle, that bottle today will have-- unless it's one of those special categories, it'll have a serial number that-- and a barcode that looks just like that.

**HARDIN:** Can anyone change that serial number as far as you know?

**SHABBIR IMBER SAFDAR:** I mean, you, you could-- you can't-- I mean, you can relabel it. You could stick a whole new label on it with a new serial number. But the beauty of the system is that if anyone took a little bit of time to look into it, they would see that the person you bought it from has a different number. And so we've actually seen HIV medicine that had fake pedigrees, they call it, fake histories caught by pharmacists in Texas who just made a couple phone calls and discovered that, you know, you said you bought this bottle from this wholesaler, but this wholesaler is a different number. And so one of you is lying. But I know the medicine is not safe for patients.

**HARDIN:** Thank you.

**HANSEN:** Yes, Senator Day.

**DAY:** Thank you, Chairman Hansen, and I'm going to ask an overly simplified question because no one has mentioned it. Is, is one of the potential reasons that there is such a discrepancy in pharmaceutical prices and the reason that we have PBMs and Canada does not because we operate in a for-profit system versus a universal publicly funded

system that they operate in, in Canada, where people are not as highly incentivized to make profit off of healthcare?

**SHABBIR IMBER SAFDAR:** I'm-- so this is where I'm going, I'm going to tell you what I know and then--

**DAY:** OK.

**SHABBIR IMBER SAFDAR:** --I'll tell you I know a lot less than I should about the Canadian healthcare system. When I look at utilization, one of the reasons that the Canadians are a little upset about this program is that they only use 2 percent of the world's supply of pharmaceuticals and we use, like, 44 percent, right? We use an enormous amount more. And it's partially because there's medicines that we have access to that come to our market first, but then I'm sure they are for profit-- I mean, I have a cousin actually, who's a physician in Canada, and I know he makes good money. So there must be people making profit in the Canadian healthcare system. So I don't know that I would pin that as a difference between the two.

**DAY:** OK, thank you.

**HANSEN:** Any other questions? Thank you for testifying. Appreciate it.

**SHABBIR IMBER SAFDAR:** Thank you for your time.

**HANSEN:** Thank you. We'll take our next testifier in opposition, please. Welcome.

**LINDA CARROLL SHERN:** Thank you. Mr. Chairman, members of the committee, my name is Linda Carroll Shern, L-i-n-d-a C-a-r-r-o-l-l S-h-e-r-n, and I'm representing PhRMA, Pharmaceutical Research and Manufacturers of America. We are the trade association representing the research-based biopharmaceutical industry. Ensuring patients have access to the prescription drugs they need is critical and no patient should ever have to walk away from a prescription they need due to cost. However, the importation of medicines from Canada is not a solution to patients' access and affordability problems for a number of reasons. First, there are major barriers to implementing these programs. States need federal approval of their importation plans before they import drugs from Canada. A handful of states have submitted plans, but none have been approved. There has been no indication from the FDA or when or if their programs will move forward. Second, this legislation fails to recognize the challenges of the Canadian prescription drug market. Canada prohibits distribution

of drugs if it would cause or exacerbate a shortage of medicines in Canada. The states that have already passed these laws have combined populations larger than the entire country of Canada and drugs in Canada are already going in and out of shortages. As of yesterday, there were over 1,800 drugs in shortage in Canada. Third, these programs raise significant safety concerns, as we've, as we've already heard. Finally, importation is unlikely to produce sweeping savings. The difference in cost of prescriptions between the U.S. and other countries are often inflated and very complex. The Congressional Budget Office estimates, estimates that a national importation program, if it was implemented in the United States, would only reduce prescription drug expenditures by 1 percent. Several states, including some of those that have passed importation laws, have expressed concern with the ability to recoup state costs and prove significant savings. For example, Vermont estimated 0.3 to 1.3 percent savings in the private market. Wyoming found either no savings or savings not to be significant enough to outweigh the barriers to implementation. In closing, PhRMA would like to be a productive partner in finding solutions that help patients pay less at the pharmacy counter. Importing price controls from other countries like Canada are not a solution. PhRMA respectfully asks for a no vote on LB200 and I'm happy to answer any questions.

**HANSEN:** Thank you for your testimony. Are there any questions from the-- yes, Senator Riepe.

**RIEPE:** Thank you, Chairman. I-- you-- I believe I heard this right that you stated the states that have introduced and you said Vermont.

**LINDA CARROLL SHERN:** Vermont is one of them. Wyoming is one. There have been--

**RIEPE:** OK.

**LINDA CARROLL SHERN:** --six states.

**RIEPE:** Because our fiscal note by the Fiscal Office said that there were no states that had implemented it.

**LINDA CARROLL SHERN:** None have implemented. These are just states that have passed the law. They haven't implemented their program. They only passed--

**RIEPE:** Oh, they're in the process of implementing?

**LINDA CARROLL SHERN:** Right.

**RIEPE:** OK. And my second question, if I may, Mr. Chairman, what's your-- do you have an organizational relationship with Bio Nebraska or is that--

**LINDA CARROLL SHERN:** We do.

**RIEPE:** Oh, OK.

**LINDA CARROLL SHERN:** We do.

**RIEPE:** Are they-- do you do things together or do you--

**LINDA CARROLL SHERN:** Many of our member companies are members of Bio Nebraska, but Bio Nebraska represents the innovation that's going on in Nebraska.

**RIEPE:** OK. Because I know we had an opposition from Mr. Owen, and I don't know whether he's going to testify in opposition or--

**LINDA CARROLL SHERN:** Nebraska has a very robust innovation community of startup companies and clinical research companies going on right now in your state.

**RIEPE:** OK. Thank you for being here.

**HANSEN:** Are there any other questions from the committee? All right, seeing none, thank you.

**LINDA CARROLL SHERN:** Thank you.

**HANSEN:** We'll take the next testifier in opposition. There is one.

**ROB OWEN:** I wasn't planning to do this, but my name came up, so. Good afternoon, Chairman--

**HANSEN:** Welcome.

**ROB OWEN:** --members of committee. My name is Rob Owen, executive director of Bio Nebraska.

**HANSEN:** Spell your name, please.

**ROB OWEN:** R-o-b O-w-e-n. We are a nonprofit trade association with a little over 100-member organization throughout the state dedicated to

supporting, promoting and growing the bio sciences in Nebraska. One of our member organizations is PhRMA, and then we have several PhRMA individual companies who are also members of our organization. But our goal is really to promote, support and grow the bio sciences in Nebraska. And I did put in a written statement yesterday in opposition to LB200 outlining many of the things that were talked about today. And I think it was interesting that PBMs were brought up. That's been-- it seemed like an ongoing discussion in this Legislature and many others for years and years. So I'm not sure I have any answers to anything, but since my name was up, I thought I'd come up here and answer any questions you may have. But we do work with our PhRMA members. They are here and active, but really to support and promote what we're doing here with our partnerships with the Nebraska Medical Center and such. There's a lot of great innovative works going on here. And our PhRMA membership companies and PhRMA are part of those partnerships. So I'm happy to answer any questions anyone may have.

**HANSEN:** All right, thank you. Are there questions from the committee? Yes, Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you for being here, Mr. Owen.

**ROB OWEN:** Yes.

**M. CAVANAUGH:** Nice to see you.

**ROB OWEN:** Good to see you.

**M. CAVANAUGH:** I actually do have a question and it's OK if you don't feel comfortable answering it or can't, but you brought up PBMs. Hypothetically, Senator Briese walks away from today and decides he wants to do a white-copy amendment to this bill and take away the Canadian part of it and reintroduce an amendment that takes away PBMs. Is that something that Bio Nebraska would support?

**ROB OWEN:** I am not qualified to answer that question.

**M. CAVANAUGH:** I'm going to ask that of Senator Briese--

**ROB OWEN:** I think my answer--

**M. CAVANAUGH:** --if he's interested in that.

**ROB OWEN:** --my answer maybe is that I think someone already said that healthcare costs and our whole system is very complicated.

**M. CAVANAUGH:** Yes.

**ROB OWEN:** And I think if you pull one piece out, doesn't necessarily mean you're going to get the result that you're looking for. There are so many pieces of this I don't know.

**M. CAVANAUGH:** Sure. I appreciate that. I just-- it seems that the intention of this legislation is to help lower the costs. And that seems to be some-- a universal thread that we're hearing today is that these PBMs are a problem. So thank you so much for being here. Appreciate it.

**ROB OWEN:** Yep, absolutely.

**HANSEN:** Are there any other questions from the committee? That's brave of you to come up here. Thank you.

**ROB OWEN:** Thank you very much.

**HANSEN:** All right, thank you for your testimony. Is there anybody else wishing to testify in opposition? All right, seeing none, is there anybody that wishes to testify in a neutral capacity? And seeing none, Senator Briese, you are open to close.

**BRIESE:** Thank you again, Chairman Hansen and members of the committee. And I certainly appreciate the testimony here today. Thanks to everyone that came and offered their opinion on what's going on here. Just occurred to me here as I was sitting at the end here that Nebraska drug consumers are subsidizing drug purchasers north of the border, outside of the border, across the globe, aren't they? That's not right. That's not right. And this is a step that we can take that can possibly make a dent in that. Long-term viability of a plan like this? Yeah, it's a-- questionable. Is it a permanent solution to anything? Questionable. But it could make a dent in things and it can make a point. It can get the attention of-- earlier, I said I'm not worried about-- it's not about Big Pharma's profits and things like that, even though I quoted some numbers. But I guess they're here to defend themselves and maybe it is about Big Pharma profit. Again, you know, our consumers, our constituents are subsidizing Big Pharma and subsidizing the drug prices for consumers across the country. Somebody mentioned PB-- PBMs earlier and, you know, this, this requires a targeting of drugs that will save Nebraskans money. And if PBMs stand in the way of this, I would expect corrective legislation next year, Senator Cavanaugh. And page 7, line 23, the department shall set a

maximum profit margin for all participants. That would seem to include PBMs in that situation, that they're not going to be able to reap the benefits of reduced costs of these items coming from Canada. And we'll get back to your price-fixing question in a little bit, Senator. And somebody said it was costly and impossible to implement. You know, again, the Colorado fiscal note suggested a cost of $1 million to attain federal approval and it seems to me like some states such as Florida, they probably did get the cart before the horse if they spent that much money on that prior to federal approval. I would think that if we go down this road, we better get approval before anybody spends a whole lot of money on it. And to answer your question, Senator Hansen, I didn't really get a good answer of what is entailed in that application process. And it's with the FDA, but I don't know the specifics. And as far as lack of participation from Canada, that, that would be another area where we would want to hold back on our investment in this until we have some assurances that we're going to have access to some of these drugs from north of Canada-- or north of the border. And somebody expressed concern about, you know, liability for the retails, for the pharmacists. And, you know, there's no reason a Canadian supplier couldn't be brought into a suit down here. And, and currently, I believe-- I've read that 40 percent of U.S. drugs are already imported and 80 percent of the ingredients are already imported. And somebody suggested a member calling in and worried about liability, things of that sort. You know, are they suggesting immunity in all situations here? I don't think so. But as far as drug safety, it'll be up to each vendor to ensure drug safety. Each batch will have to be statistically sampled at the very least, and they'll have to certify these batches as to labeling and documentation. And again, the vendors are going to have to ensure, ensure compliance with the Drug Quality and Security Act. And within that act, there is a multi-page portion of it that is going to-- Canadians are going to have to abide by what's considered the drug supply chain security provision of that act. I'm not sure how we're going to force them to do that, but that's part of the statute that we're going to have to ensure that the supply chain is safe and Nebraskans are protected. And Senator Riepe, you asked about the price fixing. You're probably referring to page 7, lines 23 through 26, where we try to ensure that-- essentially, we're trying to ensure that margins are maintained for our local pharmacies, but also that they're not going to be gouging us or the PBMs aren't going to be gouging us, as was suggested earlier. If they have access to a cheaper supply, we don't want others profiting from that at the expense of Nebraska consumers. So anyway, I appreciate the discussion. And again, somebody talked about continuity here, continuity of the

drug supply and things like that. This isn't going to disrupt continuity. There's still going to be an American supply chain. Pharmacies are going to have the ability to opt into this program if they choose to. So it's not going to disrupt anything. But what it arguably could disrupt is the profit model of Big Pharma and some of our suppliers south of the border. At the very least, this can get their attention and force some change and hopefully put in place a mechanism that can save your constituents, my constituents, the money in the long haul. If it's not going to save us money, we have to approach it cautiously. We have to wade into it slowly, it seems to me, ensure that it's going to work before a significant investment is put out. So thank you for your consideration.

**HANSEN:** Thank you, Senator Briese. Are there any questions from the committee? Yes, Senator Riepe.

**RIEPE:** I had one for clarification.

**BRIESE:** Sure.

**RIEPE:** In the document that we received and I, and I quote, it says the, the secretary requires that the drug is imported from a licensed pharmacist for personal use by an individual, not for resale.

**BRIESE:** OK.

**RIEPE:** So I'm trying to figure out--

**BRIESE:** And what document was that?

**RIEPE:** It's on the memorandum dated 1/25/23. It's about-- what was it about? I know it was nicely put in my notebook.

**M. CAVANAUGH:** The committee statement [SIC].

**RIEPE:** Oh, it's, it's the committee statement [SIC]. Thank you.

**BRIESE:** OK, OK. But, but, but explain that again, if you would?

**RIEPE:** Well, it just said that the-- it's required that the drug is imported from a licensed pharmacist for personal use by an individual, not for resale. And it goes on in quantities that do not exceed 90-day supply.

**BRIESE:** OK.

**RIEPE:** I'm just trying to, I'm trying to--

**BRIESE:** Well, I, I--

**RIEPE:** I'm trying to get my head, like--

**BRIESE:** Sure.

**RIEPE:** Because we've been talking about pharmacists could participate, which sounded to me like they could receive it in great volume. And this implies that it's-- it has to be John Doe specific.

**BRIESE:** Yeah, well, that does imply that. I don't think that's the intent here, but I'd have to look at the bill again--

**RIEPE:** Oh, OK.

**BRIESE:** --on that.

**RIEPE:** I got a note from somebody smarter than me down the line here that says it's a federal law. I didn't see that in here.

**BRIESE:** OK. But, but these, these drugs aren't to be then exported out of state. It's to be utilized by Nebraskans eventually.

**RIEPE:** OK. OK, thank you. Thank you whoever sent it down.

**HANSEN:** Any other questions? I got one question.

**BRIESE:** Yes.

**HANSEN:** Like-- and more of an opinion question. So if we ended up-- because essentially, we're opening up the markets to Canada for--

**BRIESE:** Pardon?

**HANSEN:** We're opening-- I'm-- we're opening up the markets to Canada for us to buy prescriptions from them. Would you foresee new manufacturers or new suppliers or people who make ingredients opening up in Canada now that the market has been opened to them?

**BRIESE:** Well, that would, that would be the hope. It would seem to me that any potential shortages in Canada would be addressed through the market. One would hope that if they-- if their, if their market increases as much as we're talking about potentially doing, one would think that-- because I think-- it's my understanding the Canadian

government-- somebody mentioned price controls, don't import price controls. I think that's part of the, part of the solution. In Canada, I think prices are controlled by the government, it seems to me, from what I've read anyway. And I think we could be the beneficiaries of that down here eventually because one would think that the market would generate additional production, additional supplies up there.

**HANSEN:** Yeah, I know there's probably different rules and regulations I know in Canada versus here. But I think one of the previous testifiers said that they do not manufacture any medic-- or prescriptions in Canada, which is why they have to rely on the United States.

**BRIESE:** Yes, and so that--

**HANSEN:** But just as a thought, that's why I got your opinion about if we did open that market up, then maybe there might be some people who will start manufacturing in Canada, not just for Canada itself, but then also for the United States.

**BRIESE:** Right.

**HANSEN:** Just didn't know for sure, so.

**BRIESE:** And like was pointed out, if, if the whole country did this, yeah, that's probably not a sustainable situation. But a handful of states getting into it and being one of those states, I think, could be beneficial. And again, I think it has a potential to force change in how things are done here. I think our discussion of PBMs was possibly part of that conversation, but.

**HANSEN:** OK. Well, thank you. Appreciate it. And that will close the hearing for LB200.

**BRIESE:** Thank you.

**KELLEY CLARK:** Sir, may I ask a question?

**HANSEN:** Actually, you--

**KELLEY CLARK:** Some questions from the constituents.

**HANSEN:** Well, actually the hear-- the hearing, the hearing is closed, but you can ask that of us after we're all done for today. We have one more hearing after this, but then you can ask us or Senator Briese

afterwards. And that opens it up for LB75. And with that, we will welcome Senator Vargas. Welcome to the Health and Human Services Committee, Senator Vargas.

**VARGAS:** So many people left--

**HANSEN:** I know.

**VARGAS:** --Chairman Hansen.

**HANSEN:** Boy, yeah. It says nothing against your good character.

**VARGAS:** They don't want to talk about maternal, maternal and child morbidity? Well, I appreciate everybody for sticking with us. Good afternoon, Chairman Hansen and members of the Health Human Services Committee. My name is Senator Tony Vargas. That's T-o-n-y V-a-r-g-a-s and today I'm presenting LB75, a bill to allow maternal and child death review teams the ability to conduct reviews on instances of severe maternal morbidity. This issue is close to home for me, as my wife, Lauren, delivered our daughter Ava about five weeks premature. Lauren's labor was difficult. She had preeclampsia and required multiple blood transfusions. We're incredibly grateful for the resources that not only kept her safe and Ava safe throughout the pregnancy and delivery and postpartum period, but I'd also like you all to imagine the number of mothers and babies whose lives would be impacted and potentially saved by better care. We all want to see better, healthier outcomes for all of our families. First, what is severe maternal morbidity? Severe maternal morbidity, SMM, is divided by-- defined by the CDC and LB75 as unexpected outcomes of labor and delivery that result in significant short- and long-term consequences to a woman's health. Often these are called near-miss events where a mother almost died during labor. The CDC has 21 indicators of severe maternal morbidity, both diagnoses and procedures. Diagnosis then can include heart attack or heart failure, aneurysm, sepsis, shock or eclampsia, like I mentioned regarding my, my wife. Procedures that indicate an incident of severe maternal morbidity may also include a blood transfusion, placing a mother on a ventilator or a hysterectomy. LB75 allows the state's maternal and child death review teams to conduct reviews of instances of severe maternal morbidity. Last year, my bill, LB626, structurally modified the Maternal and Child Death Review team and split the work into two teams, a team that focuses on infant, child and adolescent deaths, and a team that focuses on maternal mortality. I want to thank you all for supporting that legislation unanimously and it passing into law. Now, Nebraska has a

very low annual maternal mortality rate, but it is my hope that by granting this team the authority to review instances of severe maternal morbidity, that they will be able to offer more recommendations over the next few years to prevent these heartbreaking cases and crises for families. Now, often instances of severe maternal morbidity are preventable, especially with additional education to providers. However, individual institutions often don't want to share this data because of privacy and reputation concerns. By housing the reviews at the state level under statute, it guarantees liability protection for the entity sharing the records, and that recommendations from the team will be shared in an anonymous manner. Reviews of severe maternal morbidity will also most likely reveal health disparities across our state, both for mothers of color, but also for mothers who give birth in our more rural communities. There are two small cleanups from LB71 that are made in LB75 that I want to make sure to highlight for the committee. First on page 7, line 4, we're removing the word "nursing" from the experience requirements for the data abstractor to allow the agency to hire someone other than a nurse, such as a social worker or an epidemiologist. This is in response to Nebraska's severe nursing shortage. The second, on page 8, lines 4 to 5, we're moving date language inadvertently included in LB74 [SIC LB75]. It allows teams to review stillbirth deaths prior to January 1, 2023. I'd also like to note that this bill would have no fiscal impact because these reviews are completely optional. That being said, LB75 is giving the state the authority to conduct these reviews that they do not currently have in statute. And again, we're not requiring it of them. In 2021, the Maternal Mortality Review Committee released their report. They did conduct reviews of morbidity using de-identified hospital discharge data without proper statutory, statutory authority and without additional funding from the state to do this work. This is problematic from a protected health information standpoint and an overstep by the state and the committee. It makes LB75 even more necessary to pass this year. DHHS has also received funding this year from CDC grants called ERASE MM, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality. That provides funding for these maternal, maternal mortality review committees and their staffing and will fund a data abstractor position focused on maternal mortality in Nebraska. Now, LB75 is granting authority for SMM reviews in anticipation as well of other future funding opportunities from the CDC and others that can support these reviews, thus making the state prepared to accept those funds immediately without statutory delay. Behind me you will hear from physicians, advocates, data experts on why LB75 is an important bill to protect

mothers in our state. I want to thank you for your time and attention to this important issue and this important bill. I'm happy to answer any questions you may have. The only other data point I wanted to touch upon is these numbers across the state, when we talk about maternal morbidity, we have nearly 60,000 U.S. women that are affected by severe maternal morbidity across the country. And we want to make sure that we are not only covering our statutory authority so that we are not viable. It is also critical, important for us to continue to have the resources we need to make recommendations to influence policy. Thank you.

**HANSEN:** Thank you, Senator Vargas. Are there any questions from the committee? Yes, Senator Riepe.

**RIEPE:** Thank you, Chairman. Thank you, Senator Vargas, for being here. I know you said in Nebraska, the impact and then you quoted 60,000 across the country. The thing that I read is I think in Nebraska, there was 145. I read that someplace in there. I have three points. I'd, I'd like to expand on one of them. And I quote from the neutral position of the Department of Health and Human Services, which I trust a lot of their judgment. I quote, "DHHS currently coordinates the review of all maternal deaths within the scope of the Maternal Mortality Review Committee utilizing" yadda, yadda, yadda. My second piece is on being a recovering hospital administrator is dependency of volunteers on any program is one heck of a challenge for sustainability. And the third one that I have and then I'll finish is there is a quote in there. It says-- the fiscal note says significant fiscal impact. Now, they don't define it specifically and I was digging. Unfortunately, in our life, 200,000 or 300,000 doesn't seem significant. But-- so I was taken aback a bit by that quote or that notation of it being significant, but I will give you a chance. Thank you very much for being here and I will-- I appreciate your effort.

**VARGAS:** Thank you, Senator Riepe, and-- well, it sounds like for our volunteer review teams, you might want to add some more funding to make sure we have the support for our teams, which I'm more than happy to talk with you with. There's a couple of things I want to address in terms of the fiscal note. One, when we made some of these changes in the past years, there was no fiscal impact, even when we were allowing or making some changes to the different review teams. In this-- and, and I'll point you to our Fiscal Analyst's fiscal note. And this is the-- probably the most succinct I can be. In the Fiscal Analyst's note, they say "due to the specification within LB75 that nothing in this subsection is to be interpreted to require the review of any

incident of severe maternal morbidity, the bill has minimal fiscal impact." They're anticipating little to no largely because nobody is being required to do this. However-- and to your point earlier, I think they have reviewed some cases-- I think close to 140-- which they had done where we didn't have the statutory authority to be able to do it. That doesn't mean that there are more. And there are likely many more. That's just some of the information that they had received that, that they had done. So there's two things: we want to make sure they would have the statutory authority to do something that they're already doing to cover our liability as a state. We want to make sure that we are doing this in a way that is allowing them to do it, not mandating it and that's why we've given them this authority. And we anticipate minimal fiscal impact. And maybe DHHS assumed that there was going to be a mandatory aspect to this or there was a different interpretation of it, either/or. It was helpful to get the fiscal note from the, from the Fiscal Analyst saying that they anticipate minimal impact because we're not requiring this.

**RIEPE:** OK. Thank you.

**HANSEN:** Yes, Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you, Senator Vargas, for bringing this important legislation, expansion of a really important program that we have. You might not know the answer to this and I might be asking it for future testifiers to answer-- or maybe you do. The fiscal note does say that this would require 15 additional volunteer reviewers to attend four meetings per year. And I'm just not sure if that's something that is laid out in statute to the number of reviewers on the committee or if the committee just decides itself. I'm seeing some head shakes, but I'll let people behind you maybe answer that question when they come and testify. You're also welcome to answer it if you'd like.

**VARGAS:** I'll, I'll, I'll absolutely let the people testify behind me. And the only thing I'll say is, again, this is based off of their interpretation on load. There already are reviewers on both of these teams. There is a little crossover with those four people or five people that are-- exist on both these teams as volunteers. But as we mentioned, some of this is already being done. We want to make sure we have the statutory authority to be able to do this and, and make sure that we-- the liability is clear and we are not having any holes in, in law for us to do what we already currently are doing.

**M. CAVANAUGH:** An additional question about this is-- shoot, I lost my train of thought on it. I'm sorry. I'll come back to it in your closing.

**VARGAS:** I'll be here for the closing.

**HANSEN:** Thank you, Senator Cavanaugh. Any other questions from committee? I just have, I think just one question. Since you struck off nursing experience and you said that might open it up to other qualified individuals such as social workers, is there any other qualified individuals that you could see maybe applying for this and being part of it? I just didn't know if you had any examples. Because I think nursing-- the purpose of having nur-- what's the purpose of having the nursing experience? Is that-- like, why was it in in the first place? Do you know?

**VARGAS:** My understanding was this is making sure that we have more expertise in the field, but we also want to make sure that we have qualified staff and that we're not potentially taking a nurse or-- that is having a workload to be in this capacity that potentially can be in another capacity. So this is just providing more flexibility to DHHS.

**HANSEN:** OK. I think I know-- OK. So it's probably to make sure that somebody has some familiarity with the healthcare industry and what all the terms mean maybe, so.

**VARGAS:** Well, you'll hear from some of the testifiers. We have a lot of expertise and people that are on the teams and are reviewers and so I think we have much of that experience.

**HANSEN:** Awesome. And I think I read in here there's still the confidentiality and, you know, HIPAA regulations, all kinds of stuff, and informed consent, I'm assuming, from the individual, the data?

**VARGAS:** That I need to make sure, but they-- the people behind me will speak to that, yeah.

**HANSEN:** OK, cool. Thank you.

**VARGAS:** Thank you.

**HANSEN:** All right. Good. So with that, we will take our first testifier in support.

**VARGAS:** Thank you.

**HANSEN:** Thank you, Senator Vargas. Welcome.

**ANN ANDERSON BERRY:** Good afternoon, Senator Hansen and the members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a UNMC faculty member and the medical director for the Nebraska Perinatal Quality Improvement Collaborative, otherwise known as NPQIC. However, today I am not speaking as a representative of the university. I am here today to testify on behalf of NPQIC and in my role as a private citizen in favor of LB75, which will allow Nebraska DHHS to collect information on and review cases of severe maternal morbidities, or SMMs. As a medical director of NPQIC, I coordinate collaboration with all of Nebraska's delivery hospitals, support perinatal clinicians and serve Nebraska communities. With other public health leaders and key stakeholders, we are committed to improving healthcare and outcomes for all Nebraska mothers and babies. Implementation of quality improvement initiatives to address perinatal health issues and reduce maternal and infant mortality is a key part of this work. Severe maternal morbidity is defined by the U.S. Centers for Disease Control and Prevention as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. Nebraska families, both mothers and infants, are often impacted by severe maternal pregnancy complications. It is concerning that we don't fully understand the rates or causes of severe maternal morbidities in our state. These are near-miss events that put mothers in life-threatening medical situations, require expensive intensive care admission and transfusions, and can cause neonatal injury at the time of delivery. Assessing potential causes, frequencies and outcomes of pregnancy complications such as severe hemorrhage, hypertensive seizure, seizures, stroke, infection and many others is how LB75 would allow us to improve perinatal care in Nebraska, with the data driving opportunities for prevention. These events profoundly impact families and can lead to lifelong medical needs for both the mother and the infant. A trial collecting information on SMMs has been initiated by NPQIC with four major health systems in Nebraska. This trial has been successful, with systems finding the reviews feasible and informative. As a trial, these reviews are internal. And while they have been helpful for these systems, without legislation allowing DHHS to collect and evaluate SSMs and their frequency and trends at the state level, organizations like NPQIC can't work across health systems at a state level to enact initiatives to ensure provision of safer care for Nebraska families. This is the work our collaborative is well poised

to conduct. For Nebraska, where we have a very small population, monitoring SMMs and implementing preventative measures in real time is an important step that provides valuable information we just don't get from our reviews of maternal mortality. Thank you for your consideration of LB75, which will allow dedicated healthcare professionals like myself and NPQIC to work with DHHS to better understand the needs of pregnant women in Nebraska, allowing us to implement quality improvement initiatives designed to improve maternal health and delivery of care, leading to healthier moms and babies here in Nebraska. I'd be happy to take your questions regarding implementation, cost and cost savings, or anything else you'd like to discuss. Thanks for this opportunity.

**HANSEN:** Thank you. Are there any questions from the committee? Yes, Senator Riepe.

**RIEPE:** Did you want to go first?

**M. CAVANAUGH:** You go first.

**RIEPE:** OK. I'm Curious George, if you haven't noticed. My question is this, is this legislation to identify the need, which then subsequently moves on to initiatives and programs because--

**ANN ANDERSON BERRY:** The--

**RIEPE:** Okay. My piece is if your spending cohorts, Michigan and Iowa probably have similar people fitting into the same cohorts: income levels, ethnicity, all of those issues. It's probably free and available through research, literature research.

**ANN ANDERSON BERRY:** So NPQIC actively monitors what's going on in national trends, but Nebraska has some unique healthcare situations. Being a very rural state with most of our population on the eastern edge of the state, understanding how maternal morbidities arise from transfer complications from western Nebraska to central Nebraska into the major medical centers in Lincoln and Omaha. That's one area that I could just off the cuff anticipate could be informed by these reviews. We really don't understand how moms can be urgently transferred without a maternal transfer service that's statewide in times of weather, which we have a lot of, in times where our hospital beds are full, which many of our majorical medical-- major medical centers have. And so there are things that we could understand just about our systems with this that would be very different than other states and

the data that they would collect. So quality improvement looks at more than just understanding why a mom medically could have a hemorrhage, but how Nebraska can respond to that. And that's really critical for serving our specific population and that's part of my job as the medical director of NPQIC.

**RIEPE:** I remain unconvinced that there aren't like states: rural, bad weather, ambulance systems. Whether that's Arkansas or Iowa or Michigan or Ohio, you name it. To me, this is a path that's been worn and then, you know, statistics are statistics and there isn't that much variation. And I don't think that this programs have any-- will have any control over availability of hospital beds. You can react to that if you would like.

**ANN ANDERSON BERRY:** I can say that we can look at where we would triage moms to, provide better triage systems, provide better communication between different systems as part of this, one very small example of how this can be impactful. And again, this doesn't mandate these reviews. This just allows these reviews to be conducted by statute, which is also really important because DHHS has done these reviews. We've also had examples of the four major-- the four biggest health systems in the state being able to conduct these reviews without onboarding new employees. And this would allow us to conglomerate that information and allows for statewide programs to impact better maternal health.

**RIEPE:** I just don't see it unique to Nebraska or-- you know, I just don't, but--

**ANN ANDERSON BERRY:** Thank you.

**RIEPE:** I have no more. Thank you.

**HANSEN:** Thank you, Senator Riepe. Any other questions?

**M. CAVANAUGH:** Yes.

**HANSEN:** Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you for being here, Dr. Anderson Berry. Appreciate it so much. There-- I realize now that you probably haven't had access to, but the Department of Health and Human Services put in a letter in neutral. And I wanted to ask you to address something that they put in their letter because for me, it requires your, your level of expertise and clarification. So they said that the leading causes

of-- there's 100-- there's 10 to 15 maternal mortalities annually approximately. This would-- this legislation would include an additional 115 severe maternal mortality events statewide. But then they go on to say that the leading causes of maternal mortality are directly related to the leading causes of severe maternal morbidity as an argument as to why we wouldn't need to look into severe maternal morbidity.

**ANN ANDERSON BERRY:** And I would argue the alternative. To have a small state like Nebraska with about 25-- 20,000 to 25,000 deliveries a year and somewhere between 10 and 12, maybe 15 maternal deaths is statistically not enough information to gather actionable data. If we can expand that to 115 or so severe maternal morbidities, that gives us a lot more information about near-misses: where these near-misses are occurring, what types of patients, what types of providers, what types of facilities, what the timing of these are within the labor and delivery process, whether they're happening in preterm or term deliveries. And then we can start to define what actions need to be taken to decrease these near-misses. You decrease near-misses, you decrease mortality. So I would argue that it's almost more fruitful to review the SMMs than the maternal mortalities, although I'm certainly not advocating for dropping that. That needs to be done in a timely fashion as well.

**M. CAVANAUGH:** Thank you.

**ANN ANDERSON BERRY:** Yes.

**M. CAVANAUGH:** That's very helpful.

**HANSEN:** Are there any other questions from the committee? Yes, Senator Hardin.

**HARDIN:** Thanks for being here. Senator Vargas suggested this earlier, I believe, that this is not something that would be mandatory. Pragmatically speaking, how does it work? Does-- is this one more page that someone signs up for when they do an admission saying, if such a tragedy takes place in my life, you can use it? Or is it something that's automatically wrapped in like other kinds of things tend to with HIPAA and so on and so forth?

**ANN ANDERSON BERRY:** Yes, this would be part of the consent to treat, I think, from most hospitals' standards. And again, this is a may not a shall as far as the bill is concerned. And so I would imagine, having

worked in maternal child health now for the last two decades, that a staged implementation of this, just as we staged trial implementation in the major, major health systems, would be most appropriate. We wouldn't go from zero detailed reviews to 115 detailed reviews and have that expectation on DHHS. NPQIC and our very involved group of perinatal providers would work together to devise a system that was meaningful and approachable, something that we, we could support. I think one of the questions to Senator Vargas was, you know, how are we going to have this many volunteers? We have dedicated perinatal providers who want to understand this better, who are in support of this bill and show up. They show up for the maternal mortality reviews. They show up to do their internal maternal morbidity reviews. They're going to show up for this because it's that important. So I'm confident that we'll have the workforce to support the volunteer needs for this.

**HARDIN:** OK. And what have we learned from other states that seem to be doing it the way that perhaps you envision it? If we're not wearing the pioneer or the coonskin cap, I guess, to do this, if others have already gone that way, what have you learned--

**ANN ANDERSON BERRY:** Yeah.

**HARDIN:** --or what's available?

**ANN ANDERSON BERRY:** We've learned that hemorrhage drives many of the severe maternal morbidities. And so NPQIC is already working to have massive transfusion protocols, as-- at as many hospitals across Nebraska as possible. But then you have to train your staff to implement massive transfusion protocols. A woman who hemorrhages after delivery can require 30, 40 units of blood. These are-- like, this is three times, four times her blood volume. You know, it's NPQIC's job to work with our delivery hospitals, some of whom deliver 100 or 50 babies a year. Every single delivery hospital has to be on top of every single protocol because you don't know if it is your wife, your daughter, your next-door neighbor who has had a completely uncomplicated pregnancy that is going to walk in and have that hemorrhage. One of my own nurses in my own hospital required 32 units of blood. It was her second pregnancy. Completely uncomplicated, healthy woman. She almost died in front of our eyes. This is-- these are real people that have horrendous and emergent problems. And if we don't do our job at NPQIC, these women end up dead.

**HARDIN:** So forgive my ignorance because I have to say that our, our nurses, our hospital staffs don't have the ability to deal with hemorrhages as it now stands.

**ANN ANDERSON BERRY:** You know, many hospitals don't carry that much blood in house, right? So they need to have alternatives. They need to have communication lines in place to get women where they need to be fast or get blood where they are fast. And that's what NPQIC works on. We work on systems, we work on quality. So it's not to say that our nurses across rural Nebraska are not great, but our nurses across rural Nebraska have to be great at trauma. They have to be great at delivery. They have to be great at med surg. They have to be great at post-op. They have to be great at sepsis. And so that's where NPQIC steps in and helps them be great at perinatal health. And we need this data to help them be excellent at perinatal health so that we don't have moms with near-misses losing their uterus, dying worst-case scenario, right? It's important work.

**HARDIN:** Thank you.

**ANN ANDERSON BERRY:** Yes.

**HANSEN:** Are there any other questions from the committee? Yes, Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you. This just brings up something that I, I have shared before publicly, but I suffered from postpartum hemorrhaging very severely, postpartum hemorrhaging. And the medical team that I had in the room at that time had told me in advance of me even giving birth that they were going to prep for hemorrhaging because I bled when I had my epidural and they had just gone through training. And I still had severe hemorrhaging and this young woman-- nurse had gone through that training. And I just bring that up because it sounds like this is exactly the kind of thing-- preventative medicine that these kind of studies are helping us. That, that training, I assume, would have been initiated for some reason that they would have gone through that kind of training.

**ANN ANDERSON BERRY:** Absolutely. Yes and NPQIC has applied and gained funds and admission to Project AIM [SIC] which is a national-funded project, a consortium of states that helps to train on severe hemorrhage, hypertension management. And so we're constantly rolling out new initiatives to our delivery hospitals across the state to make sure that they have a plug-and-play plan in place. They don't have to

design it. They don't have to do the research. They don't have to look at their own data. That's my job, that's my team's job. And then we take it to them and they say-- and say, we'll teach you how to do this. You do this this way, you're state of the art. If it changes, we'll be back and teach you updates and different initiatives. And, you know, that's why we have NPQIC. That's why you all pushed forward to fund NPQIC in 2015. And I take that responsibility incredibly seriously.

**M. CAVANAUGH:** Well, I appreciate it. I've benefited from it so thank you.

**HANSEN:** Any other questions from the committee? I might have a couple.

**ANN ANDERSON BERRY:** OK.

**HANSEN:** And so just to clarify what this bill does and what your involvement would be, so we pass this bill. Then the, then the state would collect information from you?

**ANN ANDERSON BERRY:** The state would collect information from--

**HANSEN:** That you, that you--

**ANN ANDERSON BERRY:** --the hospitals.

**HANSEN:** The hospitals, OK. So would you be providing any information or would the state--

**ANN ANDERSON BERRY:** No, I would be the recipient of the analysis and I would help to find interested providers to help with the detailed technical analysis. And then I would take the de-identified information from that process and use quality improvement initiatives to help get that out to all of our delivery hospitals so that they have the benefit of that information to modify their practice.

**HANSEN:** OK. So do you already, do you already collect, like, information and trends? I think you do or--

**ANN ANDERSON BERRY:** We get our information from the state and from the CDC.

**HANSEN:** OK.

**ANN ANDERSON BERRY:** And so we look at the maternal mortality reports that DHHS puts out and then we look at CDC WONDER to get a lot of information about what's happening in our state as well.

**HANSEN:** OK. And again, maybe because I don't know, this is all voluntary? Does-- do you pay the state for information or does the state pay you for services at all?

**ANN ANDERSON BERRY:** This committee passed a bill to give NPQIC money to function--

**HANSEN:** Yes.

**ANN ANDERSON BERRY:** --and interact with the state. So the money for NPQIC funnels through DHHS to pay for the work that we do. At NPQIC, we don't pay for data. We work with them. We work very collaboratively with them. We've done, you know, many initiatives, hearings, screening, opioid screening, CARA and CARTA [PHONETIC] implementation. So we work with DHHS on, you know, a weekly, bi-weekly basis on different initiatives. And so this would fall right into place with that.

**HANSEN:** OK. There's just so many things in HHS, the department, that there's money going everywhere and different agencies. And so sometimes I kind of need to wrap my head around who pays for what--

**ANN ANDERSON BERRY:** Yeah.

**HANSEN:** --and where, and where, like, responsibility comes from. And so that helps.

**ANN ANDERSON BERRY:** OK. Yeah, I don't anticipate this would have any change in how any funds flow. This is-- again, it's a shall, not a must-- or it's a, it's a may, not a shall.

**HANSEN:** May not a shall.

**ANN ANDERSON BERRY:** And, and, you know, again, we're providing volunteers from the perinatal community, maternal fetal medicine specialists, anesthesiologists, neonatologists, pediatricians, public health officials from across the spectrum. And those individuals work willingly because they know that these types of initiatives have impact in how our patient outcomes progress.

**HANSEN:** Awesome. Good. Thank you.

**ANN ANDERSON BERRY:** OK. Thanks--

**HANSEN:** Just to make sure--

**ANN ANDERSON BERRY:** --for all your questions and your time.

**HANSEN:** I think we're good. OK. Thank you. Appreciate it.

**ANN ANDERSON BERRY:** Thank you.

**HANSEN:** All right, we will take, take the next testifier in support. Welcome.

**CHAD ABRESCH:** Thank you. So, good afternoon, Chairman Hansen and members of the committee. My name is Chad Abresch. That's C-h-a-d A-b-r-e-s-c-h. I'm a faculty member at UNMC, but I am testifying as an individual. My position does not represent the University of Nebraska System. For more than a decade, I have led a national public health organization called CityMatCH and in this role, I have enjoyed a firsthand look at what some states and communities around the country are doing right to improve health outcomes. And without question, there is one thing that all high-performing jurisdictions share in common and that's a commitment to collecting and using high-quality data. The reason for this shared commitment could be obvious. After all, data is a powerful tool. It can illuminate otherwise murky issues, providing clarity instead of guesswork. Data can be used to evaluate performance, improve efforts, make progress or profits, justify hard decisions, and even settle seemingly impossible disputes. In short, data can provide a factual foundation for action. I'm here today to voice my support for LB75 because LB75 is about data. Specifically, it will provide us with clear insights into the causes of rare but devastating outcomes in childbirth. Now, we have all heard that there is a maternal mortality crisis in our nation. Our nation ranks among the bottom of wealthy countries. But I would ask, how are we doing right here in Nebraska? Well, that is somewhat difficult to say. I have included a data table at the end of my remarks and from that data, you can see that Nebraska is 11th from worst on the list. We have a maternal mortality rate of 28.2 deaths per 100,000 births. However, responsible data use should point out that when numbers are small, our confidence in what they mean is reduced. Just imagine the Huskers winning their first game next fall. Please imagine the Huskers winning their first game next fall. After just one win, would we assume that our team is back to its winning ways? No, of course not. We would need more wins. We would need more data to be sure. This is

why this table includes those final two columns. If you look to those, they show the low- and high-confidence intervals. In other words, because the number of deaths is small, for statistical considerations to have confidence in the rate, we should acknowledge that that rate could be as low as 17.4 or it could be as high as 43.1. Now, this is a very large range. It could mean that we are actually absolutely worst in the country or conversely, we could be in about the middle. Now, if you look just two rows down to Texas, you will see that Texas is number 15 and they do not face this same challenge. Their population is much larger. Consequently, their numbers for births and deaths are higher and their confidence interval is very small. In Nebraska, we need to supplement our data in order to clarify the picture. LB75 will do exactly that by carefully investigating not just maternal deaths, but also severe maternal morbidities. These maternal morbidities represent instances in which maternal death was narrowly avoided. Maternal morbidity is about 100 times more common. And so that data can give us a lot more information and unearth key strategies that we could use to lower both. To be sure, we need this data. As I close, let me be clear about one more point. When I said that our numbers are small, I mean that they are small for statistical considerations, not for human impact. Twenty-one families is far too many Nebraska families to know the unthinkable pain of losing a new mother. When my wife gave birth to our last child, she experienced a massive postpartum hemorrhage. I stood by helplessly as the room filled with nurses. A barrage of orders and a rush of activity ensued until she was whisked away for emergency surgery. I was left alone with our newborn daughter in a room that had been suddenly silenced. Praise God that my wife returned. For some, that silence is enduring. We owe it to these families to expand the ability of our state's maternal mortality review team to gather data and use it to sharpen our health promotion and protection for all Nebraskans. Thank you, Senator Vargas, for introducing this important legislation. I'm happy to take any questions.

**HANSEN:** Thank you for testifying. Are there any questions from the committee? All right, seeing none, thank you.

**CHAD ABRESCH:** Oh, there were so many hard ones before.

**HANSEN:** I was gonna talk about the Huskers, but I'm not going to touch that, so. Thank you. We'll take the next testifier in support, please. Welcome.

**NYOMI THOMPSON:** Good afternoon, Senator Hansen and members of the Health and Human Services Committee. My name is Nyomi Thompson. That's N-y-o-m-i T-h-o-m-p-s-o-n and I'm representing I Be Black Girl. I Be Black Girl serves as a collective for black women, femmes and girls to actualize their full potential to authentically be through autonomy, abundance and liberation. I'm testifying in support of LB75 because adequate data collection will reveal health disparities yielding proper solutions to the maternal health crisis imposed upon the black community. In addition to being two to four times more likely to die from childbirth than white birthing folks, black birthing folks are also two times more likely to experience severe maternal morbidity. This is due to the already existing health disparities, such as increased likelihood of chronic illness, access to healthcare and inadequate care that are exacerbated during pregnancy. Data collection is the sole reason I'm able to relay those figures, providing an understanding of the gravity of severe maternal morbidity. Severe maternal morbidity goes further than birth outcomes. It carries into systemic oppression, racism and other social determinants of health. Such a complex issue with several factors will require an adequate amount of resources to address. To efficiently distribute our resources and funds, which we must acknowledge are limited, we need to know root causes of disparities and areas of improvement. Equitable, evidence-based intervention can only began when there is a holistic understanding of the problem. Unless measured and documented, disparities in severe maternal morbidity outcomes can go unnoticed, even when the intent is to improve these outcomes. Reproductive healthcare organizations and administration need to know what disparities exist, who is experiencing these disparities and why these disparities are happening to effectively improve patient care. There is a benefit to all Nebraskans when people are able to contribute to society after giving birth and benefits family well-being when the parent is physically and emotionally able to raise their child. This cannot happen without being aware of all possible consequences of birth and the proper allocation of resources. We can and must improve the depth of our data collection to make Nebraska a safe place for birth and families to thrive. Please consider moving LB75 forward and thank you for your time.

**HANSEN:** Thank you. Are there any questions from the committee? All right, seeing none, thank you. We'll take the next testifier in support. Welcome.

**DOMINIQUE BROWN:** Hello. Good afternoon. Hello. My name is Dominique Brown. That's D-o-m-i-n-i-q-u-e B-r-o-w-n and I join you today as a

wife, mother, lifelong Nebraska resident residing in Douglas County and a supporter of LB75. My first pregnancy came as a surprise, discovered as part of an annual exam. Neither I nor my doctors had any reason to believe that the pregnancy would be anything other than normal, but at 20 weeks gestation, I went into preterm labor. Upon delivering my son several hours later, I learned that I had an incompetent cervix and I was heartbroken. Two years later, I became pregnant again and this is when I became aware of how dangerous childbirth can be. Early in the pregnancy, I asked my general practitioner for a referral to an OB. He resisted, assuring me that he was fully capable of providing me care and saying that my previous loss was an anomaly. My instinct told me to protest, but at a young 23 years old, I trusted my doctor. I began leaking amniotic fluid. I called my doctor repeatedly and told it was discharge that was common during an early stage of pregnancy. I again requested to be referred to a specialist and was denied. I even tried locating my own high-risk OB/G just to be told I needed a referral from my general practitioner to be seen. Then one morning while I was showering, I experienced the most excruciating pain that I had ever felt. It literally brought me to my knees. Thankfully for me, my mother was there and quickly called the ambulance. But what happened from that point on can only be described as humiliating and chaotic. Once in the ER, I was told by the male doctor that I had to keep my voice down, that I was screaming-- because I was screaming and crying from pain and that the pain could not possibly be that bad. And if I would just concentrate on my breathing, the pain would go away. What I eventually came to learn was the pain was a direct result of having a dry womb. The amniotic fluid that serves as a shock absorber for the contractions that I was feeling was gone. I was transferred to labor and delivery and by that point, the agony had me delirious. By that point, my mother had left my side and it was just my partner and I and our amazing nurse. I asked if I could use the restroom and she obliged. And within moments of sitting down, I felt the instinctive urge to push. And that is where my son, Nicholas, was delivered at 18 weeks over a commode. I wish I could say that that was the end of an already horrific day, but it was not. My partner and nurse quickly went into action. The details of what happened next are somehow blurry and yet crystal clear at the same time. I recall the bleeding. There was so much blood that it began to drip off the bed and onto the floor. And at one point my partner grabbed sheets from the closet and tried to wipe it up just so he could get close to me. I remember her asking me if I was willing to accept blood product. I remember telling my partner I felt like I was going to pass out and then I remember waking

up cold and restrained in post-op recovery. I had undergone, undergone emergency surgery to remove a retained placenta. I required multiple blood transfusions and found myself the closest to death that I had ever been. I lost my second son to an incompetent cervix and could have lost my life. Over the course of eight years, I have become pregnant two more times. Unfortunately for me, my cervix continued to serve as my arch nemesis. Nonetheless, my last two pregnancies resulted in two live births. On paper, they could be deemed successful, but over those two pregnancies, I was hospitalized for a total of ten weeks and had three cerclages placed. My children were born extremely premature at 27 and 29 weeks. With each pregnancy, it felt like the stakes were getting higher and I was gambling for my own life. Today, I'm grateful to have a happy, healthy seven-year-old son whom I'm absolutely adore. But unfortunately, I lost my daughter, Alicia Jean, at 19 months old due to medical negligence. Too often women, especially black women, have their pain discounted. We are told we are overreacting and made to feel like we are exaggerating when we express the trauma we've endured. I am a married, college-educated, middle-class woman, and yet my socioeconomic status cannot afford me consistent, compassionate and adequate care. I will never know what my family will look like today if credence was given to my concerns. But I promised my children, Anthony, Nicholas and Alicia, that I would ensure their deaths weren't in vain. I didn't know how or when I would fulfill that promise, but today is that day. Thank you for granting me this opportunity and I sincerely hope my story encourages each one of you to pass LB75. Thank you.

**HANSEN:** Thank you for sharing your story.

**DOMINIQUE BROWN:** Thank you.

**HANSEN:** Are there any questions from the committee? All right, seeing none, thank you.

**DOMINIQUE BROWN:** Thank you.

**HANSEN:** We'll take our next testifier in support, please. Welcome.

**SYDNIE CARRAHER:** Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. I am Dr. Sydnie Carraher. For the record, S-y-d-n-i-e C-a-r-r-a-h-e-r. I am a UNMC staff member, the program administrator of the Nebraska Perinatal Quality Improvement Collaborative and a neonatal nurse practitioner at CHI Health. However, I am not speaking as a representative of the University of

Nebraska System. I am here today to testify regarding LB75 on behalf of NPQIC and in my role as a private citizen. The Nebraska Perinatal Quality Improvement Collaborative, known as NPQIC, is a network of hospital teams, perinatal clinicians, community and public health leaders and other stakeholders committed to improving healthcare and outcomes for all Nebraska mothers and babies. We work collaboratively to implement quality improvement initiatives, initiatives focused on current and emerging perinatal health issues to achieve systems-level change and reduce maternal and infant morbidity and mortality. In the United States, roughly 860 women die annually as a result of pregnancy or delivery complications and over 50,000 women experience severe maternal morbidity, or SMM. As you've heard, severe maternal morbidity is the unexpected outcome of pregnancy and delivery that results in significant or short- or long-term consequences to, consequences to a woman's health. Examples include blood product transfusions, kidney failure, sepsis, cardiac arrest and hysterectomy, just to name a few. In many cases, these conditions can be preventable with timely and appropriate care. NPQIC has been working to implement severe maternal morbidity reviews. The Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine recommend that birthing facilities routinely identify and review SMM events. The purpose of identifying and evaluating these cases is to facilitate opportunities for improvements in care. When a mother experiences a severe morbidity, relevant case information is abstracted from the medical record and entered into a standardized data collection tool. A team of professionals at the hospital where she received care is then assembled to review the case and to assess its preventability. Teams can learn what worked and did not work in the care process. As a result, they can recommend and implement specific practice changes or quality improvement efforts to prevent future cases of maternal morbidity and other adverse outcomes, including mortality. In May of 2022, NPQIC launched a severe maternal morbidity review pilot with four of Nebraska's largest health systems. The purpose of the pilot was to implement and refine the process for local morbidity reviews, with the goal of expanding reviews at all birthing facilities statewide. Site leaders from each hospitals met regularly to discuss the review process. The pilot team has developed a standardized data collection tool that any Nebraska hospital could use. The health systems involved in this pilot continue to collect data on their own SMM cases and review them internally. The review findings are not shared outside pilot hospitals and are intended only for the use within the facilities for quality improvement. Therefore, fully

understanding the impact of SMM at a statewide level is challenging. LB75 would pull back the curtain on these critical incidences in our hospitals and provide a much-needed population perspective. A better understanding of these tragic events would allow NPQIC and others to develop quality improvement initiatives tailored to the needs of our providers and families across the state. Thank you for your time and your attention to this critical matter and I'm happy to take any questions.

**HANSEN:** Thank you. Are there any questions from the committee? Yes, Senator Hardin.

**HARDIN:** Since you're here in a personal capacity, can I ask in plain language from your position, what's this look like? I mean, in a, a world where this information is shared, project it out there for me ten years. What, what would the-- what does the narrative look like at that point? Can you give us a vision?

**SYDNIE CARRAHER:** So if the SMM committee or the MMRC committee were able to review these instances of severe maternal morbidity, again, this guides our work as far as statewide for practice change, quality improvement initiatives. By having this data ten years from now, that is going to tell us, you know, what is the burden of SMM and what has the impact been of these large-scale initiatives or programs that have been developed across the state to reduce morbidity and mortality for these moms and these babies?

**HARDIN:** Lives saved?

**SYDNIE CARRAHER:** Yes, absolutely. Lives saved. Moms that go home with their babies and families that have mothers there to care for them.

**HARDIN:** Thank you.

**SYDNIE CARRAHER:** You're welcome.

**HANSEN:** I have a question.

**SYDNIE CARRAHER:** Yes.

**HANSEN:** I was reading your testimony. I'm just still trying to figure out the state's role in this, right, and so it seems like you have the data currently, but they're only shared within the hospitals.

**SYDNIE CARRAHER:** So there's two different ways of looking at morbidity reviews. So there's one at the hospital level, which is there for the hospitals to look at clinical changes within their system locally. But if you want to look at more maternal morbidity from a population standpoint, we need data from across the state. And so having the information from the SMMs at the MMRC level gives us that population standpoint. They look at different definitions for those SMM cases. So it's not that we, we don't have the data. Our hospitals are using their data for their own local review. They're not sharing that outside of their facility. It's there to guide changes in their clinical practice if they need to reeducate their providers, those kinds of things in their system, if they need to make adjustments. Whereas from a population standpoint, it gives us a-- just a much larger platform and it guides our work. As of now, the MMRC does put out recommendations based on their review and those are the recommendations that we use to guide our work. And so if there are things that we are not aware of or that we don't have that data on, we can't then guide our work if we don't have that necessary information.

**HANSEN:** OK. Is there a reason why, why they won't share the information-- so you're saying you get the information from hospitals.

**SYDNIE CARRAHER:** So it's a little bit different. So at the hospital level, what we're using as a definition for them to review cases is any mom that's had four or more units of packed blood cells or an ICU admission. So those are a much narrower definition. When you look at it from the population standpoint, with the CDC codes, there's 21 different things that they're looking at. And that's not-- it's very-- that's from hospital discharge data so that's very difficult for a hospital to be able to, you know, review those in a timely fashion. They will be able to go back and flag a case that this mom got four units of packed blood cells or she was transferred to the ICU. We need to go and review that case.

**HANSEN:** OK and this is information you're unable to get.

**SYDNIE CARRAHER:** Right.

**HANSEN:** OK. All right, thank you.

**SYDNIE CARRAHER:** Yes.

**HANSEN:** And seeing no questions, thank you for your testimony.

**SYDNIE CARRAHER:** Thank you very much.

**HANSEN:** We will take the next testifier in support, please. Welcome.

**EMILY BARR:** Chairman Hansen and members of the Health and Human Services Committee, thank you for hearing my testimony today. My name is Emily Barr, E-m-i-l-y B-a-r-r, and I am the executive director at the Nebraska Coalition for Patient Safety. I'm here to testify in support for LB75, a bill to ensure that maternal morbidity events are examined. I am testifying as individual for myself. My position does not represent that of the University of Nebraska System. The Nebraska Coalition for Patient Safety is a federally listed patient safety organization through the Agency for Healthcare Research and Quality. We are a 501(c)(3) nonprofit organization that serves a key role in helping healthcare organizations across the state overcome the challenges of optimizing patient safety culture. Our work at the Nebraska Coalition for Patient Safety is focused on collecting and analyzing data from healthcare providers to identify trends and patterns related to patient safety in a protected and confidential manner. Through event analysis, we share insight into underlying causes of patient safety events and provide members with education and resources to collaborate to prevent future patient safety events. I want to thank Senator Vargas for introducing LB75 and for his commitment to ensuring that the number of causes of severe maternal morbidity are comprehensively reviewed. LB75 gives the State Child Death Review Team and State Maternal Death Review Team an increased capacity to investigate maternal morbidity and develop protocols to collect data to provide education and recommendations to decrease occurrences of these events. Reporting and reviewing severe maternal morbidity allow for learning to improve safety and a reduction of risk to patients. Researchers estimate that over 200,000 people die nationally each year because of medical error in hospitals. By expanding the scope of the Child and Maternal Death Review Teams, aggregation of deaths and morbidity events will assist in creating systematic methods to collect, analyze and learn from these safety events in Nebraska. Findings from a 2019 report from the Office of the Inspector General demonstrated that eight out of every ten hospitals that work with patient safety organizations say feedback and learning from events has helped them prevent future patient safety events, which correlates to the significance and importance of LB75. The Child and Maternal Death Review Team seeks to identify preventable causes of severe maternal morbidity to ensure Nebraska is meeting the healthcare aims of safe, effective, patient-centered, timely, efficient and equitable care. By reviewing incidents of death and severe maternal morbidity, we can better understand contributing factors and health

systems engineering to create effective solutions to mitigate future risk of these adverse events. By adding review of severe maternal morbidity to the scope of the Child and Maternal Death Review Team, LB75 will support the efforts to provide recommendations for policy changes and education opportunities to improve outcomes for women and children in Nebraska. Reviewing reported data can help establish accountability to monitor organizational safety performance and improve the accuracy of reputed-- reporting future events. Thank you for your time, attention and consideration of LB25 [SIC LB75]. I'm happy to answer any questions you may have.

**HANSEN:** Thank you. Are there any questions from the committee? Yes, Senator Riepe.

**RIEPE:** Thank you, Chairman. I have a question, asking for clarity. I know that you're with the Nebraska Coalition for Patient Safety and part of your focus-- and I'm quoting here-- is collecting, collecting and analyzing data. You know, it was my understanding, in looking over the bill briefly, was that that's the role of DHHS. It sounds to me like needless duplication. That's all I can tell you.

**EMILY BARR:** Well, with patient safety organizations, hospitals and other providers, ambulatory care clinics, long-term cares, assisted living, etcetera, they can voluntary report all patient safety events to their patient safety organizations. So we do-- we can work closely with the DHHS. We have other examples of analytic contractors that we work with to really understand events that are happening across the state.

**RIEPE:** Just a-- if I'm a hospital administrator, I'm going to find the one, the primary reporting position. I'm not going to report to two, three, four, five because it's all going to get messed up and it all takes time and all it takes staff and all it takes money. So my inclination as an administrator would be is my relationship is going to be with DHHS. I'm not messing around with anybody else. So I see this as needless duplicate. I'm just trying to figure that out.

**EMILY BARR:** Yes. And patient safety organizations, they were created in response to the high rates of mortality and morbidity that were happening within the hospitals. So we also can support knowing more about our data reporting to a national standpoint. But, you know, we, we work closely. We have over 70 partners across the state of Nebraska, large hospitals, smaller hospitals, and we work with their teams to really help understand what some of those quality improvement

opportunities are for their teams to be able to decrease the risk of some of these patient safety events.

**RIEPE:** OK, thank you.

**HANSEN:** Are there any other questions? Yes, Senator Ballard.

**BALLARD:** Thank you, Mr. Chairman. So under this act, we're, we're required to-- the department is required to collect certain data. What are we learning besides just the raw data about patient safety from these data points?

**EMILY BARR:** With this data, we can-- you know, by looking at aggregating and trending this data, we can really get down to what are some of the root causes of these events that we're seeing. So it's not just the data. It helps us tell the story of why these events are happening and be able to trend it accordingly so that we can put best practices in place, potentially talk about different policies that need to exist. But again, it really helps us understand the story behind these events.

**BALLARD:** Thank you.

**HANSEN:** Any other questions? All right, thank you for testifying.

**EMILY BARR:** Thank you.

**HANSEN:** We'll take the next testifier in support, please.

**SARA HOWARD:** I'm the last one, I promise.

**HANSEN:** Welcome, Senator Howard.

**SARA HOWARD:** OK. Thank you for allowing me to testify today. My name is Sara Howard, S-a-r-a H-o-w-a-r-d, and I'm a policy adviser at First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children. And my work at First Five Nebraska is focused on maternal and infant health policy and recognizes what we know all-- what we all know already, that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify in support of LB75, a bill that creates the opportunity for instances of severe maternal morbidity in the state to be reviewed so recommendations may be made to prevent these critical incidents for mothers and families. I want

to thank Senator Vargas, Senator Jacobson and Senator DeBoer for introducing LB75 and for their commitment to ensuring quality data is used to inform public policy and save lives. OK, so I've read what I need to read at the beginning. Now, I'm going to give you sort of the statutory framework of why this is going into this area of law and I'll give you kind of the history of it. This is mostly for Senator Hardin and Senator Ballard, just because this is kind of-- this is new for you guys. Senator Walz, Senator Hansen, Senator Cavanaugh, Senator Day, and even Senator Riepe have actually voted on bills that have sort of lived inside of the statute before. So in 1992, there were over 300 unexplained child deaths in the state of Nebraska. And so the Governor at the time put together a task force and said, figure it out, right? And what they found was the best way to figure it out was to create inside of the state statute, inside of our state statutes, inside of DHHS, a team that would review critical incidents of child mortality. So in 1993, the Child Death Review Team was created in statute. They put in sort of robust privacy provisions. They put in the ability to gather these records, which otherwise you can't unless you have a statute that says you can. And then that statute actually remained closed for 20 years. And then in 2013, when-- that was my first year in the Legislature-- I actually added maternal mortality to the work of the review committee. So the Child Death Review Team had been reviewing child deaths and then we added maternal mortality to really look at why are moms dying in the state of Nebraska and what are the things that we can do to prevent those untimely deaths? So the statute stays closed for several years. And then last year, we come to find out that the way that the team started to function internally was that instead of just one maternal and child death review team, they were actually functioning as two discrete teams. And so last year, the committee moved forward LB626 inside of LB741. LB626 was Senator Vargas' bill that essentially split the teams into two entities and gave them the same core group. So they both have the Chief Medical Officer of the state of Nebraska, for instance. They both have a forensic pathologist, for instance. But then the Office of the Inspector General for Child Welfare is only on the child death review side. And then we also have sort of more maternal-focused individuals who can be on the maternal mortality side. So what that meant with LB626 is that by splitting the teams, the workload for the Maternal Mortality Team went down significantly, right, with only 10 to 15 deaths. And that opened up the opportunity for them to do more work. Right now, they're looking at severe maternal morbidity already, using de-identified hospital discharge data that they currently don't have authority to report to us on. The whole purpose of the Maternal and

Child Death Review Teams is to tell policymakers why kids, mothers are passing away in the state of Nebraska and offer policymakers, the Governor and state policymakers, the opportunity to say, are there any interventions that we could introduce that could prevent those untimely demises? And so this is an opportunity for you as a committee to consider is there, is there-- is this data that we need to prevent untimely near-death experiences for mothers at labor and delivery? So that's really the question that you're being asked to consider. There's no cost because there's no requirement, especially if you look at the bottom of page 8 of the bill. It says nothing requires them to do this. But I want to make sure that they have proper statutory authority if they're already starting to put this into their report. Otherwise, there-- they shouldn't be and they shouldn't be gathering or reviewing data of living patients in any way without the statute allowing them to do so. You did have some questions. I apologize, I'm on the yellow. But I do want to thank the returning members of the HHS Committee because you've set-- you've spent time in this statute before. You sort of understand what we've done, especially in regards to stillbirth death outcomes, which was what we worked on last year to allow the teams to gather stillbirth death outcomes. And so if you do have questions for me, I'm sort of your technical closer. And so I did keep track-- you asked-- since I still have a little-- like, a moment, what is the state's purpose? Like, what is the state role? If we keep it in the Nebraska Coalition for Patient Safety, which is a fully voluntary organization for hospitals, then we as state policymakers will never know what these instances of severe maternal morbidity are for women. We as policymakers will be blind to that. So this work is really pulling back the curtain in terms of what are those critical incidents for mothers? And that's really exciting because it's something that will have sort of those-- Senator Hardin, you mentioned it, those longer-term impacts where we could produce policy interventions or supports that could prevent these needless circumstances. So I'll close with that, but if you have any questions for me, I'm happy to answer them.

**HANSEN:** I'll ask the first question. Do you have any answers to any of the questions that we had?

**SARA HOWARD:** Oh, my gosh. Thank you. I, I thought you would never ask. Also, just bear in mind when Senator Hansen first joined the HHS Committee, I was like, this is the best committee in the whole Legislature. And he was, like, right, we'll see about that and look at you now. So the only thing that I will say is there are a couple of pieces that I want to pull out. One was the question about volunteers.

So the-- this-- these death review team committees are actually really interesting because they don't have terms. There are people who've been serving in voluntary roles on these committees for decades because they're super passionate about looking at instances of mortality in the state of Nebraska. And then subsequently, they've shared their passion with looking at instances of severe maternal morbidity because they've already started doing some of those reviews. The other piece is when we think about why not just look at what Iowa is doing and why not just look at what California or Michigan are doing because they're sort of-- these are other states that are starting to do reviews of severe maternal morbidity. But I would say that, you know, Iowa mothers are not Nebraska mothers, right? These are our mothers. These are our wives and sisters and, and friends. And so I want to make sure that their critical incidents are reviewed and then are sort of-- offerings for prevention are tailored to their needs, to the needs of Nebraska mothers in particular. Because 114 sounds like such a small number, but when you think about it, you know, that is somebody you know that was terrified in a hospital room after they gave birth to a beautiful baby. And so you really want to think about our role as policymakers. Giving the, the teams the authority and opportunity to review these, not mandating it, really contemplates-- it gives the state the opportunity to jump on funding opportunities, which I'm super excited about. The CDC is really hyperfocused on SMMs right now. And so our statutes wouldn't allow them to gather that-- to pull down those funds either. They just got an ERASE grant, which is, like, really exciting because we're, we're, like, the 39th state to get it out of 50. And the ERASE grants really just hyperfocus on mortality. But because we have such a small number, there's additional funds now that will be available for severe maternal morbidity, which is really, really cool. Senator Hardin, there's one piece of nuance that I just want to pull out just for a minute. And I apologize. You said you said--

**HANSEN:** Go for it.

**SARA HOWARD:** --go bananas and I apologize that I am going bananas. There's one really neat piece of this particular statute that I think people don't notice and that is that if we give DHHS the authority to gather the records, they can convey that authority down to, like, a public health department. So last year when we were working on fetal mortality, so stillbirth deaths, we actually gave the state the authority to gather the records. But they-- the Child Death Review Team doesn't have the bandwidth to do stillbirth death outcomes. But Douglas County Public Health Department got a grant from the CDC to do

fetal and infant mortality work just in Douglas County. And so they were able to convey the state authority down to the public health department so they could start reviewing stillbirth death outcomes in Douglas County. So it's kind of a neat nuance to this statute. And it's an opportunity where if an individual county were to get funding to do SMM reviews in their particular county, they would then receive authority from the state to do so. So we're essentially giving that-- they can give that authority down to a local entity. OK. I think that's it.

**HANSEN:** All right. Are there any questions from committee? Yes, Senator Hardin.

**HARDIN:** Would comorbidities be counted county by county or municipality by municipality?

**SARA HOWARD:** Comorbidities in regards to--

**HARDIN:** The SMM and why it occurred.

**SARA HOWARD:** Why it occurred? You know, I, I can't speak to the process of an SMM review. That's a little out of my-- I can tell you all about the laws, but I can't speak to how an SMM review is conducted. And so I can circle back with you on sort of a process because they're very clear on the mortality side how they do it. And then obviously, you heard from Sydnie Carraher. They're doing a pilot project within hospitals in terms of their process. But I would guess that comorbidities are, of course, included, but I wouldn't want to speak out of turn there. So good question.

**HARDIN:** My concern is that if there are-- well, in, in my neck of the woods--

**SARA HOWARD:** Yes.

**HARDIN:** --we tend to have more drug-related challenges than perhaps an area of our population should, should have. And so will this kind of sharing be something that helps us to understand how we had a mom and a baby that had a complication? Was it related to other kinds of unfortunate things that were going on in addition to hemorrhages that might happen as an actuary might look at it and get a lot out of-- because actuaries are these strange creatures, right? They live in a cave somewhere on a mountain and they'll tell you out of 100,000 lives, this is going to happen. And most of the time, they're right. They're terrifying to hang around.

**SARA HOWARD:** Yes.

**HARDIN:** But are there other things that go on that, in fact, actually change the story? And can we learn those things from this kind of law being passed?

**SARA HOWARD:** I, I would think so. And I think that's partially why it's so important to consider that this needs to be done in Nebraska. You know, and I'll be very candid with you, I-- I'm very aware of some of the drug issues in your area. My sister passed away from an opioid overdose and so a lot of my statutory work was hyperfocused on opioids. All of you voted for it. Thank you except for Beau-- Senator Ballard. OK. So what would be really interesting is say we have several instances of SMM in the Gering-Scottsbluff area. Why? And then we look and we dig a little deeper and we see, oh, there, there's a comorbidity of a substance use disorder or something along those lines. And then we can direct interventions or consider interventions that-- for prevention in that, in that specific issue. And so I think that's why gathering this data, data at a state level is so critical because otherwise we wouldn't be able to see it.

**HARDIN:** Thank you.

**SARA HOWARD:** Thank you. Thank you for your consideration.

**HANSEN:** Any other questions from the committee? I have one question--

**SARA HOWARD:** Oh, yes.

**HANSEN:** --since this is your realm. If this does pass and we collect this information, do you foresee any potential legislation coming down the road that would use this information for some other purpose or, like, to create another committee or to-- I don't know. Like, what's-- like, I know the hopes is to disseminate this information among others--

**SARA HOWARD:** Right.

**HANSEN:** --so we can kind of help with care and treatment and understand, you know, morbidities. But, like, would you, would you see, like, potentially something like this saying, like, we want to expand services to individuals with information such as this? Is that, like, a goal or do you see that ever happening or is it more just, just dissemination of information?

**SARA HOWARD:** Well, this bill in particular is just about gathering that data. But I could see there being-- you know, NPQIC really uses this data to guide their work around training providers. And are there specific interventions that providers need to be trained on? So I wouldn't consider it in sort of, like, expanding services unless there was some, some very drastic need that we, that we uncovered. But I don't-- I can't think of it.

**HANSEN:** OK. That's what I was wondering. That's all. Yeah.

**SARA HOWARD:** It's a good question, though. I will also tell you that this is probably one of the last bills that you'll see in this area of law. So even with Senator Hardin, you're starting now, it takes usually epidemiological work ten years. So we won't open this up again for another ten years is my guess because it just takes us a long time to really know what kind of data we need in order to direct interventions, but yeah.

**HANSEN:** Thank you. Appreciate it.

**SARA HOWARD:** Thank you for your time today.

**HANSEN:** All right, seeing no other questions, thank you for testifying.

**SARA HOWARD:** OK.

**HANSEN:** Is there anybody else wishing to testify in support? Seeing that Senator Howard was your closer, is there anybody else wishing to testify in opposition? Is there anybody else wishing to testify in a neutral capacity? Seeing none, Senator Vargas, you're welcome to close. Welcome back.

**VARGAS:** Thank you very much, Chairman Hansen and members of the committee. I just have a few things. I want to thank you. I want to thank all the, the new senators, the existing senators and returning senators for their work on this. And for those that have worked on this subject area of law, I think what we've heard from a lot of the testifiers-- and thank you to all people that testified and came here-- there's, there's a personal connection, a professional connection for everyone in some way, shape or form. And I mentioned this to you regarding, regarding my wife. And I think one of the hardest things about hearing a lot of these stories is-- or even hearing from our testifiers or from Senator Cavanaugh is the stories are, are difficult to hear because we're, like, well, why is this

happening? Or, like, are we going to learn something when we pass this? Is something actually going to change? And that's the question that I really want to be answered, which is what could we do differently? You know, if the goal is to reduce maternal mortality and, and morbidities and save more lives of mothers and children, that's the ultimate goal. What are we going to do differently? And I-- when my wife was, when my wife was giving birth to Ava, we were not prepared for what then happened with her birth. We very, very quickly realized that she had preeclampsia and her blood pressure was going up. And, you know, the beauty of having our first, our first-born, Ava, into this world was amazing, but very quickly-- and you heard the statistics. My wife was one of those that had four blood transfusions. She was hospitalized for about a week while I went to the NICU with my daughter and was unable to see my daughter for days until she was able to recover herself. And I'll tell you, one of the first things that we talked about once my wife was recovering was why did this happen? And are these circumstances, are they happening to other women? And I have a privilege, as many of us do, which is we can do something about this. And in this instance, I think what we heard in terms of the recommendations, we get this data in terms of, in terms of the mortality and it is absolutely helpful. But it doesn't tell us enough in terms of the granular information that we would need. But I think we also heard is that different entities are getting the information, but not all the information. They have different definitions. But not all of it is coming to us and to the state. And we have wonderful people that are dedicating their time and resources and volunteer hours to doing this work for years, for decades. And they want to make sure, along with DHHS, that we have the statutory authority to continue doing what is best and that we're covering our liability and doing this work. And that all points in the direction of it's the reason why this was crafted in this way, which is we want to give the authority. We want to give the permissive language for them to do this. I don't want there to be more stories like this. I want there to be fewer stories that I share with you about my own personal stories or the stories you heard from some of the testifiers or from Senator Cavanaugh. And I think one of the ways that we can do that, data informs these decisions that we make. And in some instances, to answer your other question, it may not even be policy. It may not even be legislation in the future. If there's ever any recommendations, the recommendations can be purely internal and-- but we won't know until we collect the data that we need to get more granular. And also make sure we do it so we are in compliance and continue to take the opportunity of amazing, skilled, experienced staff across the state

and experts that want-- dedicating their lives to doing this. They want to continue, continue to figure out how can we reduce maternal mortality and reduce these morbidities for mothers and for children? So I appreciate you. And I'm happy to answer more questions if there are. You know, we had our closer, policy closer, and I appreciate you all very much.

**HANSEN:** Are there any questions from the committee? All right, seeing none, thank you very much.

**VARGAS:** Thank you all very much.

**HANSEN:** And for the record, there was-- there were, there were eight letters in support of LB75 and one neutral letter for LB75. And that will close the hearing for LB200 and before-- for LB75. And before we end, I'd mention that we did have one letter in opposition to LB200 that I did not read for the record. So that was a previous bill so I wanted to say that for the record. And with that, that will close the hearing for today. Thank you.