HOWARD: [RECORDER MALFUNCTION] Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as chair of this committee. I'd like to invite the members of the Committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: I'm Senator Dave Murman, District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo Counties.

ARCH: John Arch, District 14 in Sarpy County.

B. HANSEN: Senator Ben Hansen, District 16: Washington, Burt, and Cuming Counties. I'm a Cancer; I like long walks on the beach [LAUGHTER].

ARCH: Nice.

HOWARD: Unfortunately, Senator Williams and Senator Walz will not be joining us today. We are joined by our committee clerk, Sherry Shaffer, and our committee counsel, Jennifer Carter. And we have two pages, Maddy and Erika, with us today. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon we will be hearing two bills. We'll be starting with a gubernatorial appointment and then hearing two bills, and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing your room you'll find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the 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're not testifying, but would like to have written testimony submitted for the record, the Legislature's policy is that it be submitted by 5:00 p.m., the night before the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. I would ask, if you do have handouts, please provide ten copies and hand them to the pages when you come to testify. We do use a light system for testifying. Each testifier will have five minutes to testify. That means you get four minutes with a green light, one minute with a yellow, and when it turns red, we'll ask you to 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'll hear from supporters, then opponents, then anyone wishing to testify in a neutral capacity, and then the introducer of the bill will be given an opportunity to make closing statements, if they wish to do so. We do have a strict no-prop policy in this committee. And with that, we'll actually begin today's hearing with a gubernator, gubernatorial appointment, Dr. Michael Allen Sitorius, to the Nebraska Rural Health Advisory Commission. Welcome, Dr. Sitorius. So do we have him state and spell, and spell his name?

SHERRY SHAFFER: Yes.

HOWARD: OK. Would you mind stating and spelling your name for the record?

MICHAEL SITORIUS: Michael, M-i-c-h-a-e-l Sitorius, S-i-t-o-r-i-u-s.

HOWARD: Thank you. And could you tell us a little bit about yourself and how long you've been serving on the Rural Health Advisory Commission?

MICHAEL SITORIUS: So I'm a-- grew up in Cozad, Nebraska. My dad was a GP, and so I've been in the medical field since I was very young. I actually got my start in medicine by cleaning my dad's office and helping in that, that way. I went to Hastings-- graduated from Cozad High School, went to Hastings College and the University of Nebraska Medical Center. I am trained as a family physician, board certified, and I've been practicing family medicine for almost 40 years. I am currently the chair of the Department of Family Medicine at the University of Nebraska Medical Center, and have been since 1990. And I have had a passion about rural health, having grown up there and having seen the needs, and have committed most of my academic career to building programs to train young physicians in the broad depth of family medicine so that they could have the opportunity to practice in rural Nebraska.

HOWARD: Thank you. Are there questions from the committee? Senator Arch.

ARCH: Dr. Sitorius, thank you for your service-- 15 years. You've, you've seen, obviously, healthcare change in the rural, in the rural

communities. Are, what, what do you see now as, as the challenges that we face in those rural areas?

MICHAEL SITORIUS: Well, I think that one of the biggest challenges is-- the demographics have changed considerably-- is to, for us to provide the training for people to be able to take care of many, many more senior citizens than we might have been thinking about training them for in the past, but also how to utilize technology and IT to help with providing that care and communication to the, the centers. I think that there is a tremendous need, not only for medical care, but also for social services and behavioral health.

ARCH: OK. Another question: Have, have you, have you seen communities rise to this challenge? Have you seen-- I mean I, it's, it's a big state and there's obviously different areas of need for, for rural healthcare. How, how have communities responded to this?

MICHAEL SITORIUS: Well, I don't know how they, they have, but those that have been able to, to get themselves together, know what they would like to have when it comes to healthcare, have been far more successful about achieving those goals.

ARCH: Um-hum.

MICHAEL SITORIUS: And I think it just, it takes some committed leadership in the community.

ARCH: OK, thank you.

HOWARD: Other questions? You've done a lot of work internationally. Would you care to tell the committee about that?

MICHAEL SITORIUS: For the last 11 years we've been working with an exchange program with China. China has the barefoot doctor concept. Primary care or family medicine is really novel to them in the last 15 to 20 years. And we've been working with three different health institutions, healthcare academic institutions, mostly in Shanghai the last five years, but in Xi'an and also in Beijing, to try to build a primary care infrastructure that's similar to the family medicine-internal medicine concept here in the States.

ARCH: Hmm.

HOWARD: Senator Murman.

MURMAN: Thanks a lot for being here. I'd just like to say I think I remember you, from playing basketball at Hastings College back in-- a long time ago.

MICHAEL SITORIUS: I hope those were good memories.

MURMAN: They are. They are.

MICHAEL SITORIUS: That is--

MURMAN: That's the first memory I have of you.

MICHAEL SITORIUS: But that is true.

MURMAN: But I just want to say I'm proud that you're from Nebraska and the service you've given, and thank you very much.

MICHAEL SITORIUS: Thank you.

HOWARD: Seeing no further questions, thank you, Dr. Sitorius, for your service on the Rural Health Advisory Commission. After this the committee will meet. We'll have an Executive Session, and we'll most likely send your confirmation to the floor for a full debate, but I don't anticipate any challenges. Thank you for visiting with us today.

MICHAEL SITORIUS: Thank you.

ARCH: Thank you.

HOWARD: Thank you. With that we'll close the hearing for the gubernatorial appointment of Dr. Sitorius to the Nebraska Rural Health Advisory Commission, and we'll open the hearing for LB554, Senator Wishart's bill to change provisions relating to prescription drugs not on the preferred drug list under the Medical Assistance Act. Welcome Senator Wishart.

WISHART: Thank you, Chairwoman Howard. I believe my office already passed out the amendment that I plan to work off of today. So good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th District in west Lincoln, and I'm here today to introduce LB554. If you don't have that amendment, I have extra copies here. So let me start off by acknowledging that the original bill I introduced does need some work. I have provided you with an amendment that was worked on by NABHO, the psychiatrists' association,

and others to address their concerns, and I provided you with that amendment, and this is what I would like to move forward with you on working off of. I have also met with the Department of Health and Human Services yesterday, and one of the managed-care entities this morning, and understand they have some concerns that this amendment may not address. So again, I'm willing to work with the committee and to work with them and others to see if we can find a solution, as long as we find a solution that doesn't undercut the underlying reason why I'm bringing this bill. So two years ago I was contacted by a constituent of mine about a situation concerning her brother. She is his guardian and his sister. His name is Curtis, and he has schizophrenia. He has the paranoid type and suffers from significant obsessive thoughts, causing suicidal and homicidal ideation at times, which has led to several hospitalizations in the past. And I want to read you a portion of the letter she provided to me. And she's also here today to testify in more depth about the situation. But I think it's really good to start off with this letter to better understand what I'm trying to get at. So Curtis, he's been hospitalized before at the Norfolk Regional Center in the 1980s. But then he was able, from 2006-2017, to get on a cocktail of medication that allowed him to live independently for 11 years and, in fact, he had a part-time job. So he remained free from hospitalizations for these 11 years, but it was reported at the end of February that his insurance-- he qualifies for Medicaid-- his insurance stated they would no longer pay for one of the prescription drugs he was on that had been working for eleven years. And that is when his doctor worked to put him on a different kind of medication. And at that point, he rapidly went downhill, ended up being hospitalized, I believe, six times within a year. He no longer is living completely independently. He is now back in Lincoln, living in a group home situation. And so when I when I got this information and sat down with my constituent and, and talked about this, and with the Ombudsman's Office, I agreed to look into it more in-depth. And it just happened that, at that same time this summer, I was on the 296 mental health task force, where we were going around to mental health facilities, assisted living facilities that, in particular, housed a high portion, proportion, portion of people who have severe mental health issues. What I find, and I'd encourage this committee to look at that report, it was pretty horrific, some of the situations that people are living in right now. And it was very clear that this is an incredibly vulnerable population of people. Not a lot of people have the same supports that Curtis does. In fact, a lot of the people that we met with had burned through their family, had zero family support. They were very transient. A lot were dealing with

criminal, you know, issues because of some of the mental health issues they were facing. And then many of them, the guardians that they had was a lawyer that was hundreds of miles away that they never met. So that's, that's what we're talking about. Every single one of these facilities I went to and asked them, do you deal with the same situation, similar to Curtis, where somebody is on a program of medications that has gotten them to a point where they're doing quite well-- they're stable? The goal is that we're trying to transition these people to independent living. Do you deal with a situation with their, where their insurance provider decides not to cover that and they end up having to go on to something else? Every single one said yes. And the fallout was similar in the sense that people would become, within a week, violent. Staff would get accosted, issues-- police would be called. The issues would, would be problematic. So that's why I brought this bill. I think this is a serious issue that we need to address. Our goal in our state should be to work towards people with mental health issues living as independently as possible, as long as possible, and as healthy as possible. And in my opinion, and from what I witnessed on the mental health task force, is that people are not being provided the level of care that will help them towards that independence. Actually I found that too often people are being overmedicated and sedated because we've pushed them aside to the, kind of the fringes of society, with little supports to actually transition them to independence. So it really frustrates me when I hear about a situation where an individual has been able to achieve eleven years of independent living but, because their medication is switched, they're ending up back in a situation where they're in assisted living. So you may hear from opposition today-- and this is something we did discuss with the department-- that there are savings that are made from drug switching, and I understand that. But I'll tell you that, from this one case alone, that's hundreds of thousands of dollars in hospital bills, let alone sort of just the moral issue of somebody going from independent living to hospitalization and then, you know, to a situation where they're no longer living independently. So again, I agree that the language does need some work. I think the amendment I provided to you today has come a long way. And again, I'd be able to, be willing to work with everybody on this bill, as long as we're able to, can focus on addressing this issue. So thank you. I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions for Senator Wishart? Do you want to tell us how the amendment is significant, is different from the green copy?

WISHART: Yeah, so originally with the green copy, I want to, my, I think one of the main issues was there was an interpretation that I was eliminating the ability for providers to put people on generics; and in fact, sometimes a generic medication actually works better for a patient. So I really wanted to clear that up. And so again, I worked on, we worked on this with NABHO and the psychiatrists to address, kind of, that concern. So the main thing here is just that if a, if a, if a doctor is, is saying that somebody should be on this medication, they should stay on that medication until the doctor says otherwise.

HOWARD: OK, thank you. Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you, Senator. So if a doctor, if a pharmacy contacts a doctor and says we've got this generic, this new copy would allow them to, the doctor to decide one way or the other.

WISHART: It would be up to the physician, yes.

CAVANAUGH: OK, thank you.

HOWARD: Other questions? Seeing none-- oh, Senator Hansen.

WISHART: Yes.

B. HANSEN: Can't they, can't medical doctors already do that now, so they find out something doesn't work and they can just switch them back to it? So we, with your amendment, I'm trying to figure out, like can't they already do all this kind of stuff?

WISHART: Yeah. So there actually are a few ways that doctors can address this issue. So you can, as a doctor, check, make a kind of a check at the beginning, saying that you should not switch somebody off of this medication. One of my concerns is we're leaving this population vulnerable to whether somebody makes that, checks that box or not. So I would prefer that the onus be on us to, to, to, to reach out to the physician and see if this makes sense. And then the other, the other issue you bring up is, can a doctor switch them back? Yes they can. And in the case of, in a lot of these cases you end up with a physician kind of advocating for that patient to get back on. But the problem is that once somebody from-- and there'll be medical

professionals who can speak more to this, I'm just kind of a layperson here-- but what I've heard is that once you switch somebody, once you switch somebody off, there's a lot of fallout before you bring them back on.

B. HANSEN: OK, thanks.

WISHART: Yeah.

HOWARD: Any other questions? All right. Seeing none, you'll be staying to close?

WISHART: Yes, I will.

HOWARD: Fantastic. It's Wishart day!

WISHART: It's Wishart day!

HOWARD: All right. We'll now invite our first proponent testifier for LB554. Is there anyone wishing to testify in support? Good afternoon.

MARLENE WAGNER: Good afternoon. I'm not [INAUDIBLE], so this is a first.

HOWARD: Oh, you're doing great so far.

MARLENE WAGNER: I know my name. I'm Marlene Wagner. And that's M-a-r-l-e-n-e Wagner, W-a-g-n-e-r. Thank you, Senator Wishart. And good afternoon, Senators. My name's Marlene Wagner. Lincoln has been my home for 46 years. I live in Senator Wishart's 27th District, and I am here to voice my support for LB554 and to tell you why.

HOWARD: Take your time.

MARLENE WAGNER: My six siblings and I grew up on a farm in northeast Nebraska. My brother Curtis had what I would describe as a relatively normal childhood. He was smart, funny, kind. He performed well-- thank you-- performed well in school. In his late teens he began to have, he began isolating himself with what he would say, now say, were feelings of severe panic and fear. As the years progressed, he began having auditory hallucinations and delusions. Unfortunately, Curtis's illness was, went untreated, leading to an attempted suicide and a formal, at that time, and a formal diagnosis of schizophrenia, schizophrenia of the paranoid type at age 29. For the next 20 years, Curtis and his doctors struggled to find an effective combination of drugs to manage

his illness, finally coming to a place where his symptoms were under control in 2006. From 2006 to 2017, with proper treatment and medication, Curtis enjoyed relative stability and independence. He had his own apartment for four years and even held a part-time job for a while. Sadly, his independence was short-lived. In February of 2017, Curtis was denied coverage for one of his medications, Anafranil, which was critical to his care and to his ten years of relative stability. One month later, for the first time in ten years, he was hospitalized. He would go on to have five subsequent hospitalizations over the course of 2017 into 2018, the last of which followed an, another, another suicide attempt. Curtis was experiencing severe delusional thoughts with auditory hallucinations. He heard voices telling him to do dangerous and threatening things, like jumping off a bridge. And for the first time in his life, he expressed having harmful thoughts toward other people. The psychiatrist who treated Curtis at Faith Regional Hospital in Norfolk said, and I quote: In less than a year he has gone from independent living to possibly needing secure psychiatric facility for long term. It is felt that the demise of his mental health is reflective of the discontinuation of Anafranil he had been stable on since 2008-- or it's 2006; I'm sorry. The psychiatrist contacted the insurance company on Curtis's behalf and requested authorization to put him back on the drug. Thankfully the request was approved and his condition began to improve. But, as Senator Wishart said, his cocktail of drugs got messed up, and it's taken two years, basically, to get him back to where he's stable. But he's still, he, he can't live on his own. Curtis is now 60 and has had to live with the relic, with the reality of this horrible disease for nearly 40 years. As angry as I am on my brother's situation, and as sad as it makes me that he suffered needlessly, this isn't just Curtis' story. Think of the many Nebraskans suffering from mental illness who had similar experiences without anyone to speak for them. What happened to them? Where are they now? Imagine if Curtis didn't have an advocate. He may have harmed himself or someone else. He may have ended his life, you know, or ended up dead or in the penal system, all because an insurance company made a shortsighted decision that negatively, negatively affected his care and had real consequences for his life. This-- think of the others out there, in similar situations, who don't have an advocate. Who will speak for them? I am here today because LB554 is a step toward helping others to not have to go through what happened to my brother. Insurance companies are not healthcare practitioners and should not be legally allowed to make decisions, effectively changing prescriptions, which could jeopardize the health and safety of their insureds and the

general public. This is our opportunity to stand together and to say this is not OK. We need to do better for each other, better for Nebraskans, better for some of our most vulnerable citizens. Thank you.

HOWARD: Thank you. Are there questions? Thank you for coming and telling that personal story.

MARLENE WAGNER: Yeah.

HOWARD: I know how hard it is.

MARLENE WAGNER: I'm sorry. I practiced and I didn't want to blubber.

HOWARD: Well, you did a wonderful job; thank you.

MARLENE WAGNER: Thanks.

HOWARD: Our next proponent testifier? Good afternoon.

JAMIE SNYDER: Hi. I'm Dr. Jamie Snyder, J-a-m-i-e S-n-y-d-e-r. I'm here representing NMA, Nebraska Medical Association, as a member, and our regional organization of Child and Adolescent Psychiatry, as the recent past president, I am a Nebraska-licensed psychiatrist. I've been working here in Nebraska for 16 years at various locations, both Lincoln and Omaha. I completed my training a long time ago, and I've worked in three different states and at the military base in Ohio. I'm board-certified both in adult and child and adolescent psychiatry, but my practice is primarily child and adolescent. And so, as a subspecialist, I tend to see some of the sickest kids in the state, kids that have failed all kinds of other treatment. And by the time they get to me, they've often been prescribed the sort of typical first-line treatments for whatever might ail them. So partly because I'm stubborn, and partly because of those circumstances of my work, I spend a lot of time on the phone with MCOs and Medicaid, and working through the process to try to get the patients what I think is best for them. And while I'm fine with that-- I understand that cost savings are important-- part of the challenge right now is how onerous the process is. And anything that we can do, such as Senator Wishart's bill to make it easier for physicians to get the medications that they feel they need for their patients, is going to be beneficial. I have pretty good relationships with my colleagues at the MCOs and I, most of the time, can get what I feel I need for my patients. But it takes an awful lot of time and energy and, and, like our previous testifiers

have mentioned, patients often sort of fall off the map a little bit. I have actually given my cell phone number to patients so that they can reach me in a crisis because the folks that we see are often not doing so well themselves. Their parents often have mental illness. Maybe they don't have good transportation. They don't have a lot of financial resources or emotional resources. And so if they go to the pharmacy, and they find that they can't get their medication filled, they sometimes don't have great ways to fix that. And sometimes the system doesn't work, and maybe I didn't get the prior authorization request at my office or I work in three different offices. So there's lots of different processes that are broken in trying to keep our patients on medications that work for them. The other thing that I've seen is if a patient doesn't fill a prescription on time. Or there are certain other circumstances where, even though they've been grandfathered in and can receive the medications that are requiring prior "auth," there are certain circumstances where that can be cancelled. And we have to go back to old medicines that we know didn't work because they didn't get it filled in a timely manner or they've changed doctors or other things that can happen. So when a child is, or anyone comes off a medication that they've been stable on, that can really destabilize them pretty significantly. And we've got pretty good research, especially around the antipsychotics, that the more they're off their medicine the worse they get, and the more difficult it is to get them back healthy again. And so any of these sort of glitches in the system-- lack of communication with the doctor or other things-- can really have a significant negative impact on the patients and their long-term mental health. The other thing is the big picture about cost which was mentioned briefly. You know, yes, some of these medications are expensive and I will always try and use the less expensive one if I can, but also, hospitalization is expensive. And so I think we have to work to find a place where cost savings is great but not at the expense of a patient and their mental health. So I would be willing to continue working on this with Senator Wishart or others to try to make this work for all of us.

HOWARD: Thank you, Doctor. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier? Good afternoon.

LINDA JENSEN: Hi. I'm Linda Jensen, L-i-n-d-a J-e-n-s-e-n. I'm here today, representing the Nebraska Nurses Association. Also, in my spare time, I'm a volunteer for NAMI Nebraska, the National Alliance on Mental Illness, and I cochair the OTOC Mental Health Action Team. The

Nebraska Nurse Association is the largest group of healthcare professionals in Nebraska and, I guess, the United States. And in, in Nebraska, we number over 20,000-- I don't know how many nurses. And we wish to thank Senator Wishart and several other senators cosponsoring LB554 for their foresight and caring about the unique problems of people requiring specific anticonvulsant, antidepressant and/or antipsychotic medications for their illness. And I believe the bill also addresses medications for HIV, multiple sclerosis, epilepsy, cancer, and immunosuppressant therapy. People afflicted with these diseases frequently vary widely in their responses to various medications. So there isn't one, just one medication that works. Thus it's important that healthcare providers be allowed to use their expert knowledge and judgment to prescribe those drugs that are likely to be more effective for that individual person. While it may seem to save money to only use those medications on a preferred list, research clearly has indicated that, when people with these specific illnesses are unable to access the most appropriate clinically-indicated medications, they experience higher rates of emergency room visits, hospitalization, and other health services. Policies such as prior authorization, that restrict choice and access to medications-- so we might say, well, you can't have it this week but, you know, if you wait a week or two, maybe you can have that medication-- can result in multiple, has been shown to cause increases in hospitalization, lengthy hospital stays, emergency room visits, and outpatient hospital visits and more physician visits. And rates of suicide, behavior, and homelessness also rise among people who report difficulties accessing their needed medications. These outcomes are harmful to people with the illnesses, and they're also very expensive to Medicaid and other state agencies than the cost of actually just covering the medications that work. Our organization supports public policies that ensure that all people with serious health problems have access to the right treatments at the right time. So we strongly suggest that you make all FDA-approved anticonvulsants, antipsychotics, and antidepressants available without prior authorization or step therapy requirements, and allow all people with these specific diseases mentioned in this bill to access medications and outsourced patient services they need when they need them. And I did attach an article that substantiates that information. Just last week a friend told me that her son fell at his work, as he had a grand mal seizure-- convulsion. This young man was diagnosed with childhood schizophrenia at age four, and now he's almost 30 years old. He lives in his own house and he works in a sheltered workshop. She inquired more and found out that the Heritage Health managed-care company had switched his medication to generic

versions without notifying anyone knowing of his health history. So that's why this LB554, that prohibits substitutions, is so important. So you know, I mean if that's what works, OK. But if they've tried it before and it doesn't work, then don't substitute because they only have to be 85 percent of the original brand medication, and sometimes the balance is so fragile with people with these serious diseases that this 15 percent can make a big difference. So I wish to thank each of you for your service to the state of Nebraska and encourage you to vote LB554 out of committee and advance it to the General File.

HOWARD: Thank you. Are there questions from the committee? Seeing none, thank you for your testimony today.

LINDA JENSEN: Thank you.

HOWARD: Our next proponent testifier.

BETH ANN BROOKS: Good afternoon, Senator Howard and HHS Committee members. I am Beth Ann Brooks, B-e-t-h A-n-n B-r-o-o-k-s, a Nebraska-licensed physician from Lincoln, today representing the Nebraska Psychiatric Society and the Regional Council of the American Academy of Child and Adolescent Psychiatry, testifying in support of LB554, as amended. I'm a board-certified psychiatrist and child and adolescent psychiatrist who has practiced for more than 40 years. I currently treat adolescents. I also am a member of the Nebraska Medical Association and NABHO, the Nebraska Association of Behavioral Health Organizations. My testimony replaces the neutral letter, dated February 20th, from the two psychiatric organizations regarding the original LB554. In our opinion, the original bill did not sufficiently address references to medical necessity and generic-equivalent medications. We appreciate Senator Wishart working with us on amendments to clarify the language and strengthen the control that prescribing healthcare providers can exercise over their clinical decision-making. Nothing is more important to healthcare providers than the best treatment outcomes for their patients, which includes prescribing the best therapeutic option. Urine culture insensitivities demonstrate which antibiotic will best treat a specific urinary tract infection, but psychiatry does not have similar tests to guide us in prescribing a specific antidepressant, antipsychotic, or anticonvulsant medication which will be an exact match to treat a psychiatric disorder. We have to use our best clinical judgment to align psychiatric symptoms with appropriate classes of medications and then, within those classes, to anticipate the benefits and side effects of specific medications. If a first-degree family member has

responded to a specific agent, then that same medication may be best indicated for a patient with similar symptoms. Healthcare providers who prescribe-- and in Nebraska, that's physicians, nurse practitioners, and physician assistants under the supervision of physicians-- healthcare providers who prescribe are committed to saving patients and the system prescription costs. But cost consideration should not be the primary factor when selecting the most appropriate therapeutic agent. For example, in my practice I write for the generic medication, and that's not in capital letters; it's not a brand name, it's a scientific name. And that connotes to the pharmacy that they can prescribe that medication through whichever brand or method of prescription that they have on the preferred drug list. But there are times when it's necessary to write for a specific brand name because it has greater efficacy in the past or with a family member or in terms of its side-effect profile. Previous testimony has indicated greater costs from higher levels of care, including repeat hospitalization, can be minimized by advancing amended LB554 out of committee, because this would allow judicious clinical decision-making and, when indicated, writing prescriptions that do not allow substitutions. Thank you for allowing me to testify about this bill which will help safeguard the health and well-being of some of Nebraska's most vulnerable citizens. I'd be I would be happy to answer any questions you might have.

HOWARD: Thank you. Are there questions? Senator Hansen.

B. HANSEN: Thank you for coming today; appreciate it. Just a quick question. What percentage of patients would you say that you end up putting on a brand name medication, like an antipsychotic or an anticonvulsant, that then does have a negative reaction once you switch to generic, and then you have to switch them back? What percentage, would you say, just off the top of your head? Do you know?

BETH ANN BROOKS: I'm not sure that it actually goes in that order. I think oftentimes a generic medication is written for and there may, at that point, because of patents or whatever, there may only be the brand name and then, over time, as they are on that medication, a generic becomes available. And so then sometimes the substitution would be written for and in the beginning the convention might be to have written for the brand name because it was the only medication available. But notwithstanding that, I would say probably in the neighborhood of about 10 percent of patients, but you have to take each individual's prescribing history and what was dispensed to them.

And sometimes, frankly, with preferred drug lists and proscripted formularies, it's actually hard for the prescriber to know what was actually dispensed to the patient. I'll give you an example. This last week an adolescent had been discharged from a group home. In the group home we used an electronic medical record and the whole menu comes up and the teen had been on generic medication, whatever. I wrote for a generic medication but I wrote for tablet instead of capsule, and when the family went outside, using their Medicaid resources, the mother was told, I'm sorry but your doctor wrote for tablets, not capsules, and tablets aren't on our preferred drug list, so you'll have to pay $500 for this month's prescription-- tablet versus capsule in generic form. And so, from my opinion-- and I am not a pharmacist, I'm not a pharmacy benefit manager, and I'm not a representative of a managed-care organization-- I do support managed Medicaid. I support judicious prescribing and, where at all possible, generics. But the problem is that sometimes you don't hear back from those patients, and it's reported that about half of the patients who are turned away from pharmacies because what was written doesn't match what is available, and they're told to go back to the prescriber, they don't. And we don't have a means to know about it. But I wouldn't suggest that it's that common that the brand name is started with, but it just may be that that's the only medication originally available.

B. HANSEN: OK, thank you; appreciate it.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

BETH ANN BROOKS: Thank you.

HOWARD: Our next proponent testifier? Good afternoon.

SUZANNE DAY: Thank you. Thank you for the opportunity to tell you why I support LB554. My name is Suzanne Day, S-u-z-a-n-n-e D-a-y. Before I go on, and in the interest of HIPAA-- does anybody know what that is? OK, very good. My son Derek has given me permission to talk about his medical history to you today. In 2014, at the age of 17 and a senior in high school, Derek experienced a psychotic break. What started out as conversations that didn't make sense progressed to him talking in word-salad fashion. For those of you not familiar with the term "word salad," it is unintelligible speech that indicates advanced schizophrenia. Derek would refuse to go places because "they" were watching him. By the time of his actual diagnosis of paranoid schizophrenia, Derek was failing all of his classes. Derek was

nonfunctional. I thought I'd lost my son for good. If you remember the movie "Beautiful Mind" with Russell Crowe, that was my son. After two and a half years of trying different medication combinations, Derek and his provider were finally able to get control of his symptoms. Today, almost five years later, Derek is engaged in his healthcare. He is excited about his life. He is currently a junior in college, majoring in computer science, with a 3.5 GPA. He is independent and even driving, which I never thought would happen. There is no word salad anymore. Derek has a bright future; Derek has a future. Serious mental illness costs America $193.2 billion just in lost earnings alone, a year. Today I ask you, when you have symptom control in a person with serious mental illness, why would you risk losing that control? Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

SUZANNE DAY: Thank you.

HOWARD: Our next proponent testifier for LB554? Seeing none, we do have some letters for the record: Don Zebolsky, representing himself; Debbie Plotnick from Mental Health America; Linda Jensen, representing herself; Dr. Richard Azizkhan, Children's Hospital and Medical Center; and Annette Dubas, Nebraska Association of Behavioral Health Organizations; and Loren Knauss, the National Alliance on Mental Illness-Nebraska. Is there anyone wishing to testify in opposition to LB554? Good afternoon.

THOMAS "ROCKY" THOMPSON: Good afternoon. Good afternoon, Madam Chair and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as Medicaid deputy director for policy and communications in the Nebraska Department of Health and Human Services. I'm here to testify today in opposition to LB554. LB554 is a bill which inserts unneeded medical provider practice authority into statute and prohibits the Heritage Health and managed-care organizations from covering generic versions of the three classes of drugs not included on the state's preferred drug list. And Senator Wishart did share a copy of the amendment, an amendment with my staff yesterday, and I'll address that later on; that's not on your testimony. The department is concerned with both provisions of the bill, as written. The practice authority outlined in subsection (2)-- prescribing medically necessary prescriptions of patients-- this language is concerning as not all healthcare providers can prescribe under the state's licensure

statutes. Also, licensure statutes authorize the practice rights of prescribing medical professionals and is not needed in Medicaid statute. Section 4 [SIC], which precludes the generic drugs in the class as previously mentioned, is unadvisable for a number of reasons. Not only does this fall, fail to meet industry practice standards, it will result in excessive financial impact to the Medicaid program. As I shared with Senator Wishart, the three classes outlined in this bill-- antidepressants, antipsychotics and anticonvulsants-- make up a third of the Medicaid's drug spend in Nebraska. Replacing all generic drugs in these classes with brand name drugs would increase each MCO's overall drug spend, leading to an annual cost to the state of $151 million. There is no clinical evidence to support increasing our drug spend this significantly. Many individuals use generic prescription drug medication; generic drugs are meeting their needs. This bill could drastically change an individual's drug regime with no consideration as to what is working for them or what their treating physician deems to be in their best interest. The department opposes LB554 and would, instead, suggest advancing LB245, which would more effectively deal with issues surrounding these specific drug categories by allowing us to add them to the Medicaid preferred drug list, allowing the state to more properly manage utilization, determine effectiveness, and collect additional drug be, rebates from manufacturers. Now Senator Wishart shared with the department yesterday a proposed amendment, clarifying the bill would not require that the MCOs fill all prescriptions in these three classes of the brand names. I still have concerns with this revised approach. After speaking with MLTC's pharmacy staff, I understand that, due to marketing and outreach by drug manufacturers, provide, providers routinely prescribe drugs by their brand name, although a generic is available. To provide, if a provider does not want a substitution, already under state law, he or she may designate other prescription, dispose, dispense as written, or brand medically necessary. Even if this bill only leads to a shift to brand name products by 33 percent, this would still be an increased cost to the state of $45 billion. Data on the average drug acquisition costs across these three classes is that generics are between $20 and $30, and brand names are between $700 and $775 per fill. Lastly, I do want to point out a study from the American College of Physicians in 2016. This report states that most of the peer-reviewed evidence has found that generic drugs are as effective as their brand-name counterparts. It concludes that best practice advice for clinicians is to prescribe generic medications, if possible, rather than more expensive brand name medications. It is in the interest of the state and our contractors to ensure that our

Medicaid members are receiving their proper regime of drugs so that they can continue living the life they choose, whether it's in their home or elsewhere. And I appreciate Senator Wishart's willingness to work with the department on this legislation so she can achieve our shared goals. Thank you for this opportunity to testify, and I'm happy to answer any questions you might have.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you for being here, Mr. Thompson. So the cost of the drugs between the two, generic and name brand, is obviously of concern. And the testimony that we've heard here previously from practitioners is that they are cognizant of that and they're, what they're really looking for is for drugs not to be changed without proper notification or consultation. So if that's the intent here, is that something that the DHHS can get behind?

THOMAS "ROCKY" THOMPSON: I think that's something we can work with and work with our MCOs on. And I did point out in the testimony there are state statutes that go to prescribers and say they do not replace with generics and those kind of orders. And that's already in state statute. If we need to clarify that, I think that's something we can work on.

CAVANAUGH: OK, because it sounds like it's-- even if it's in statute-- that it's not the common practice. And I mean, I think we all know when we go to the pharmacy, you know, I certainly like to get the generic drug because it's less expensive. But when we're dealing with very serious illnesses such as schizophrenia, that balance is so delicate. And so I think the intent here is to ensure that we're taking that into consideration.

THOMAS "ROCKY" THOMPSON: Yes, Senator, and I understand that. And I would also like to figure out what the issue we're trying to address is, because I know in some of the testimony some folks talked about discontinuing medication, not necessarily replacing medication with generics. So if that's the issue, then I would like to address that issue, too.

CAVANAUGH: Thank you.

HOWARD: Other questions? I wanted to ask about-- so what it sounds like to me is that a physician has recommended a certain type of drug

and then, when they go to the pharmacy, they're being given a generic. Is that your understanding of what's happening?

THOMAS "ROCKY" THOMPSON: Senator, I believe that, under the pharmacy statutes, there are actually-- it's actually one of the purposes is to try to utilize a generic when available. But I'm not an expert in that.

HOWARD: So, so you don't think that they're just automatically giving you a generic; they're, they're, rather they're working in consultation with the patient to say, do you want the generic?

THOMAS "ROCKY" THOMPSON: I'm not sure how that process will work at the counter with a pharmacy, so I can't answer that.

HOWARD: In this instance it sounds like the brand name was no longer covered. Is that your understanding of what happened with Curtis?

THOMAS "ROCKY" THOMPSON: I don't know if that was the case or if the, if there was a new generic to the market, and so it was pushed to the generic. I'm not sure.

HOWARD: And then tell me a little bit about how our drug rebate program works.

THOMAS "ROCKY" THOMPSON: Sure. So the Medicaid program is required by federal law to cover any, up any drug that is approved by the FDA. And as part of that, the drug manufacturers offer to the state a drug rebate. And there are instances where a state can achieve a greater rebate, for example, if a drug is on the preferred drug list, which is a stat, a list of drugs that will be available to a Medicaid member without prior authorization, so there is an additional rebate with that. In many cases the brand name drugs get a greater rebate than generic drugs if they're on our PDL.

HOWARD: Perfect; thank you. Other questions? Senator Cavanaugh.

CAVANAUGH: Sorry, you spurred a question. If they get a greater rebate than the discussion that you were having during your testimony about the cost difference, is that based on the rebate?

THOMAS "ROCKY" THOMPSON: Senator, the fiscal note we prepared does factor in the rebate we currently receive on these drugs.

CAVANAUGH: OK.

THOMAS "ROCKY" THOMPSON: There is additional rebates available if those drugs are on our preferred drug list. And right now we're prohibited from stat, by statute, from having these three classes of drugs on our preferred drug list.

CAVANAUGH: And forgive me, but would this bill allow them to be on the preferred drug list?

THOMAS "ROCKY" THOMPSON: This bill does not touch that perception.

CAVANAUGH: So that's a separate issue that we need to address, is putting nongeneric or name brand drugs on the drug list.

THOMAS "ROCKY" THOMPSON: Senator, there's a different bill that I think Senator Erdman has that addresses that.

CAVANAUGH: OK.

THOMAS "ROCKY" THOMPSON: Now just allowing us to put it on the preferred drug list is not immediate; it's automatically put on the preferred drug list. There is a committee made up of clinicians that just, that goes through different drugs and determines them for their effectiveness or usefulness and also their price.

CAVANAUGH: But before they can even be in front of that committee-- they have to be allowed to be in front of that committee.

THOMAS "ROCKY" THOMPSON: Correct.

CAVANAUGH: OK. Sorry, I have one more question.

HOWARD: Sure.

CAVANAUGH: You referenced LB245. And I just, I'm not sure what that bill does.

THOMAS "ROCKY" THOMPSON: Senator, that's the drug, that's the bill I was talking about--

CAVANAUGH: OK.

THOMAS "ROCKY" THOMPSON: --with the preferred drug list.

CAVANAUGH: Thank you.

HOWARD: All right. Any other questions? Seeing none, thank you for your testimony today.

THOMAS "ROCKY" THOMPSON: OK, thank you, Madam Chair.

HOWARD: Our next opponent testifier.

JAMES WATSON: Good afternoon, Senator Howard. My name is James Watson, J-a-m-e-s W-a-t-s-o-n, and I'm the executive director of the Nebraska Association of Medicaid Health Plans, testifying in opposition to LB554. The Nebraska Association of Medicaid Health Plans consists of all three managed-care organizations contracted by the state of Nebraska to provide services under the Heritage Health program, and those three are: Nebraska Total Care, UnitedHealthcare, and WellCare. I'm going to keep my testimony brief because my intent, really, is to just give you some background, back to LB830, which happened in 2008. It was introduced by Senator Lathrop, and the idea behind LB830, which became state law that this LB554 attempts to change, was to bring cost effectiveness to the Medicaid prescription drug program, which at that time was run by the Department of Health and Human Services. It required the department to establish a comprehensive pharmacy and therapeutics committee and a comprehensive preferred drug list. And then the preferred drug list made it possible for the department to access rebates offered by the drug manufacturers, as well as controlling costs. However, the original bill introduced by Senator Lathrop, which became state law, did allow a provider to prescribe medication that was not on the state's PDL if the Medicaid recipient had been achieving therapeutic success with that medication or if there was a prior therapeutic failure. Then January 1, 2017, the state of Nebraska launched its Heritage Health program. Prior to Heritage Health, most Medicaid and CHIP enrollees in Nebraska received their physical health benefits through one of two regional health plans and their pharmacy benefits through a state-managed pharmacy program. Nebraska Medicaid developed Heritage Health to create a healthcare delivery system in which all Medicaid recipients' behavioral health, physical health, pharmacy services are provided by a single statewide plan. When that happened, it became apparent that each of the Medicaid MCOs has a process where a Medicaid resident physician can request an authorization for a brand name if the physician feels like a generic medication is not working as well. That would also include all the appeal rights that are given to Medicaid beneficiaries under the contract between the state and the MCOs. And my major point is that

our association believes today that the system is vastly different than it was in 2008, and legislating away the current flexibility to address the issues between the physician and health plan is not really the best choice under the current Heritage Health system. I'm happy to answer any questions. I'm not clinical. I'm actually a recovering attorney, so I can't talk to you about that aspect of it, but I did do some research on the background.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

JAMES WATSON: Thank you.

HOWARD: Our next opponent testifier. Good afternoon.

MICHAEL SKOCH: Good afternoon. Madam Chairman, Senator Howard, and members of the Health and Human Services Committee, my name is Michael Skoch, M-i-c-h-a-e-l S-k-o-c-h. I am a physician, board-certified in family medicine, with 25 years' experience in primary care in Hastings, Nebraska. I come today as the chief medical director for Nebraska Total Care, a managed, a Medicare, Medicaid managed-care organization. I speak in opposition to LB554. The language of LB554 unnecessarily restricts the time-honored physician-patient relationship to the extent that it dictates for Nebraska Medicaid members which medications can and cannot be prescribed in the care of patients with behavioral health needs. Restricting the use of generic antidepressant, antipsychotic, and anticonvulsant medications, as described in LB554, disrupts the physician's ability to care for his or her patient and alters a long-tenured relationship between physician and pharmacist in collaboratively managing a patient's care needs. As a family physician, more than 50 percent of the clinical work that I did occurred in the realm of behavioral health. My clinical work now, as a hospitalist in Omaha, continues to regularly provide opportunity to care for patients with behavioral health needs. I know firsthand the implications of choosing brand name and generic medications. There are many factors that contribute to a physician's choice. It has been my experience that, not infrequently, generic medications work for patients as well or better than brand name counterparts. Cost effectiveness, often the bane of many and an, an essential human need, is an important consideration, particularly in the space where taxpayer funds are used to support the care rendered to patients. I am aware, to be sure, of clinical cases where a generic medication may fail when a brand name has worked. This is an unusual but real circumstance. It happened in my practice. In such cases there

are mechanisms in place for prescribing physicians to specify that the written prescription be filled only with a brand name drug. Without the prohibitive language of LB554, that is to say in the current healthcare system, the course of care for a patient negatively impacted by a generic substitution can be quickly corrected by the prescribing physician in writing a brand-name-only specified prescription. There is no need to legislate this process. Based on data accumulated from Nebraska Total Care's two years' experience at managing pharmacy spend, Nebraska Total Care estimates that, should LB554 be signed into law, aggregate spending for these classes of medications may quadruple from our current $9 million annual spend to a whopping $38.9 million spent annually, and that's in the event of a reduction in generic fills by 50 percent. Our analysis concluded further that, if the generic fill rate for these classes of drugs drops to 10 percent, the estimated cost to taxpayers will be $62.4 million annually for those Medicaid members managed only by Nebraska Total Care. Total expense across the three MCOs could triple that figure. Physicians and nonphysician medical providers are best suited, through their training, to determine appropriate treatment for their patients. Clinical decision-making should not be relegated to, or usurped by, legislation. Every prescriber is, is privileged to determine a patient's care plan, including the use of generic or brand prescription medication. This occurs at the point of generating every prescription for every patient. Systems are in place in the clinical process that already effectively govern generic substitution. LB554 is unnecessarily prohibitive and will negatively impact care for patients while guaranteeing increased expense to the system in the Medicaid space. LB554 will exclusively prohibit the use of reliable, cost-effective psychotropic medications in the Medicaid population. As the committee debates the future of LB554, I respectfully request consideration of concerns heard today in opposition of the bill. For the sake of quality healthcare for Nebraska's Medicaid population, LB554 should not be advanced. Thank you for your time and attention.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you for coming, and could you, could you please walk us through a hypothetical patient visit where, where a prescription is required? So the physician sees the patient and decides that, whatever it may be, a psychotropic med is, is necessary. How did that, what happens at that point? Do they enter, do they enter a, do they enter a brand name into the system? Do they, do they pull down and select a

particular medication? Does it automatically default to generic? Those are the kinds of things, I guess, I'm trying to understand.

MICHAEL SKOCH: So you heard my, one of my psychiatrist colleagues speak earlier about writing to the generic name. My personal experience as a prescriber, generally I learned brand names and, and in those days we were confronted by drug reps, you know, frequently. And it doesn't happen so much anymore, but-- so we heard brand names, so I would, I would write to the brand name. At the pharmacy, and of course, the decision is made in collaboration with the patient, and--

ARCH: What does, what does that mean? What, what, what's that phrase?

MICHAEL SKOCH: That phrase means that when I'm, when I would meet, when I meet with a patient that requires a specific treatment, I discuss the options and then invite the patient into, you know, the considering, the consideration of the treatment plan. Obviously I'm the expert, so, so, you know, we ultimately go with my recommendation, but there are options and patients, to the extent that they're able to do so, deserve the opportunity to, you know, consider those.

ARCH: OK.

MICHAEL SKOCH: So the prescription is written. If a brand name is written at, at my ex, my action at that moment-- you heard this spoken to earlier as well-- there is a checkbox. Or the physician prescriber-- physician/nonphysician prescriber-- can write the letters "NDPS," no drug product selection, meaning fill it with what I tell you, not with a generic. Or the physician can write "brand only;" that suffices. But in answer to your question earlier, Senator Howard, when you asked about what happens at the pharmacy, in general, whether it's Medicaid or commercial pay, if a patient takes a prescription that's written with a brand name to the pharmacy and a generic exists, the pharmacy actually has, the pharmacist actually has the liberty to substitute a generic at that point, without question.

HOWARD: Without any-- I'm so sorry-- without any discussion with, with the patient?

MICHAEL SKOCH: Yes, it, it can happen at the pharmacy that a generic substitute can be given to the patient, even though a brand name is written, if the physician did not specify: fill with brand only. It's a practice that's been going on for as long as I've been in medicine.

HOWARD: So is your understanding that that is maybe what happened in Curtis's situation in that it wasn't covered anymore?

MICHAEL SKOCH: You know, when I listened to Ms. Wagner's testimony, I heard the word discontinued. Anafranil is a, is not a-- the generic for Anafranil has been around for a long time; it's an old medication. And I may have misheard, but I did hear Ms. Wagner state that the drug had been discontinued. That is not possible. It may have been substituted. The generic for Anafranil is clomipramine, but a, neither a pharmacist-- a pharmacist certainly cannot discontinue a drug, and an MCO or any, any insurer cannot discontinue a drug at the point at which a prescription is being requested.

HOWARD: Senator Arch.

ARCH: Could I-- I want to get back to the hypothetical patient. So the physician has written the script or electronically prescribed--

MICHAEL SKOCH: Yes.

ARCH: --and indicates: I want the brand.

MICHAEL SKOCH: Yes.

ARCH: Now with your MCO, is that just, is that an unchallenged, automatic fill at that point?

MICHAEL SKOCH: So the MCOs-- you also heard Deputy Director Thompson speak to the preferred drug list. So the MCOs in Nebraska are held accountable. We actually have a performance measure to adhere to the preferred drug list, which we do not manage; it is managed by the state pharmacy. But we have an expectation, contractually, to adhere to that particular list across all categories at a, at a fairly significant percentage rate. So in the event that a brand name is written, if that brand name is on the PDL, which in a lot of cases they are, it gets filled without question. If it is not, it defaults to the drug on the PDL which, if it's a generic, if it is a generic, it becomes a generic prescription at the point of fill. These are, these are generally not even reviewed at our level. It's an automatic at the pharmacy.

ARCH: Thank you.

HOWARD: Thank you. Other questions? Seeing none, thank you for your testimony today.

MICHAEL SKOCH: You're welcome. Thank you for your time.

HOWARD: Our next opponent testifier.

MARTIN WETZEL: Hi my name is Martin Wetzel, M-a-r-t-i-n W-e-t-z-e-l, and I'm the behavioral medical director for WellCare of Nebraska, a Heritage Health Medicaid managed-care organization. I'm a physician and a psychiatrist, and I've been practicing in Nebraska since 1992. I'm here today on behalf of WellCare of Nebraska, testifying in opposition of LB554. I want to thank the committee for the opportunity to testify. I also want to thank the Legislature and the committee for bringing attention to mental healthcare and for helping us in our efforts to get patients to get access to mental healthcare. I also want to apologize if it seems rather confusing to have a psychiatrist attesting for the bill and, and opposing the bill. And part of the reason that I'm opposing this is I have not had the opportunity to review the amended bill. However, I do believe that my psychiatric colleagues and I are all on the same page, which is to advocate for the best quality medical mental health for our patients. So I'm going to try and amend my testimony a little bit around that background information for you. I fully acknowledge that it's important that licensed, qualified medical professionals be able to prescribe medications that are medically necessary to treat mental illness. And note that most of these prescriptions come from primary care providers. It's difficult to legislate prescribing practices because prescribing practices are very different in the clinical setting than FDA approval. For example, many medications that are prescribed for psychiatric conditions are also used for medical conditions, for example: for pain, for migraine, for insomnia, for instance. The opposite is also true. Medications that are FDA-approved for nonpsychiatric prescription use for medical, other medical issues are also prescribed for psychiatric disorders, such as beta blockers, which are used for anxiety and depression. So trying to legislate prescribing of medications would be extremely difficult law to interpret for the healthcare system for pharmacists, patients, and providers. As has already been mentioned, I think this would put a tremendous amount of pressure on pharmacists to try and figure out, first of all, if the medication being prescribed-- brand name listed on the prescription is being prescribed-- for a psychiatric purpose or for a nonpsychiatric purpose. And if so, did the provider actually

mean to write that brand name prescription? It was mentioned earlier about the EMR. I know firsthand that in the electronic medical record, when you bring up selections for medications, oftentimes it comes up as the brand name, even though the provider is meaning for that medication to be generic. So it could come through to the pharmacy as brand name, leading the pharmacist, particularly for the patient who's already been on a generic, to now have to find the provider, find out what their intent was, what did they mean-- did they mean to change from a generic to a brand name product. Remember also that people go on and off of Medicaid actually fairly frequently. So someone who has a Medicaid benefit for a prescription that is generic, which is not very costly, could potentially go off of Medicaid and then, hopefully, be able to afford that medication. If it was a brand name product, that patient may not be able to afford that if they go to commercial insurance or to no insurance whatsoever. The vast majority of mental healthcare prescriptions are by primary care providers. They're written by pediatricians, family medicine doctors, OB-GYNs, and internal medicine providers. And the professional organizations of these groups encourage the use of generic medications because they improve access to affordable medications and their caregivers. In fact, over 90 percent of WellCare's members now, currently taking these medications, are taking generics. We also know that when a patient is appropriately diagnosed and treated with a mental health disorder, their chances of taking the medication for, as prescribed, is less than 50 percent. There's many reasons for this but, in the clinical setting, the difference between a generic and a brand name drug has very little influence on the outcome for patients except in extremely rare circumstances. I would recommend that the guidance for these, prescribing of medications for Medicaid members, come from the state's Pharmacy [SIC] and Therapeutics Committee, where they can have input from medical experts, policies can be made, and those policies can be adapted quickly to changing prescribing guidelines and for emerging new medications. In my opinion, the greatest barriers to good mental healthcare are due to lack of knowledge about mental health and the incredible stigma associated with these disorders. In my 27 years of practice, I've seen some progress in reducing these and other barriers to good mental healthcare. And while I oppose LB554, as written, I do want to sincerely thank the Legislature for its efforts to bring down those barriers to care. Thank you.

HOWARD: Thank you. Are there questions? Does it often happen that a drug, especially a drug that they use for mental healthcare, is just

sort of removed from the list without-- or removed from a coverage option? Does that often happen in your shop?

MARTIN WETZEL: Could you give me a little more of an example?

HOWARD: Well, I'm trying to think about Curtis's situation.

MARTIN WETZEL: Sure.

HOWARD: Because I think that's really sort of the problem that we're trying to solve. And it sounds like, when you use that language of discontinuation, does it mean that it's just not covered anymore? Is that the same-- are we using the right word?

MARTIN WETZEL: Yeah, and that's, I think, an extremely important point, is we have to be very, very careful about our definitions, because discontinuation may mean something different than substitution, which is different than therapeutic substitution. So if, for example, Anafranil-- the brand name is Anafranil, the generic name is clomipramine-- in Anafranil's case, I don't, I can't imagine that there is a therapeutic substitution for Anafranil; it's an incredibly unique drug. So again, it would be, it would have to be an issue in, in that particular drink, drug's case, of a, a generic versus a therapeutic brand name. So it would be the difference between the generic and the name brand. And of course, I can't speak to an individual case, but that would be one example.

HOWARD: Thank you. Senator Arch.

ARCH: The PDL is the approved list.

MARTIN WETZEL: Correct.

ARCH: How often, how often does that list change?

MARTIN WETZEL: The pharmacy committee meets regularly. I believe it's monthly or quarterly. I'm sorry if I don't know that frequency, but I know they're meeting quite regularly. We have representatives from the MCOs there. The state has representatives. There are also providers who serve on that committee from the community.

ARCH: And do you see, after each one of those meetings, there's always changes going to that list?

MARTIN WETZEL: There are always changes. Drugs are moving. Maybe a generic becomes available on the market for the first time. So that might be something that becomes approved. There may be a brand name drug that is offering a rebate program now that may be changing the influence of that. There may be clinical issues that are coming up or utilization issues. So again, I'm not intimately familiar with that particular committee, but my understanding is that's their role is to look at this from a very big picture, point of view from not only cost but also what is the most effective and quality way to manage what is an incredibly large number of medications.

ARCH: I have another question. So have you, are you aware of a situation where a physician has said, no, no, I want that name, name brand. It's, it's not on the PDL Is there a, is there a process for appeal of that?

MARTIN WETZEL: Yes.

ARCH: And can exceptions be made when-- I mean, I'm sure that as you mentioned, there are some very unique pharmaceutical products, I mean that are--

MARTIN WETZEL: Exactly.

ARCH: --very specific to a very specific disease.

MARTIN WETZEL: That's correct. And again, I just want to emphasize that, as far as I'm concerned, all of us here are in alignment. We don't want people to get sick. When people get sick, it's, it's very expensive. So, you know, coming from the perspective of a managed-care organization, our job is to keep people well; that's our goal. And if, if it's been made very clear that there's a risk to that wellness and it has something to do with whether someone's on a brand name or generic, that should be considered-- absolutely.

ARCH: So, so there is an appeal process for that?

MARTIN WETZEL: Yes.

HOWARD: Thank you.

ARCH: Thank you.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

MARTIN WETZEL: Thank you.

HOWARD: Our next opponent testifier. We have one letter for the record, in opposition: Brett Michelin from AAM. Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Wishart, you are welcome to close.

WISHART: Since I am next up, I'll take, take advantage of that and close, just to clarify a few points. So first, we, we got caught up talking a lot about generic, switching from generic and name brand. And while we did hear that there are, you know, some cases where a generic doesn't work, or potentially the name brand doesn't work and the generic works, I think my amendment addresses some of the concerns that we've heard about eliminating the ability for people to be on generics. But I wanted to step back and say that's not the only issue. The issue, in terms of Curtis's situation, and the issue that I heard the most when I went to assisted-living facilities who work with people with mental health, is that the insurance company no longer was paying. They were going to no longer pay for Curtis's medication, and so his medical provider worked with him to find another medication and it didn't work, and then he spiraled downhill. So I guess what I want to be clear about is there is some point where this is not working, where there is a breakdown in the system. And I really want to assure you that it's not just one person. I, it, it really is, is more people than I think we should feel comfortable with as a state. So if the breakdown in the system is that-- I think we need to work more to figure out what that is. What I think my amendment does is it puts another level of assurance that it truly is up to the physician to say whether that person should be switched off of that or not. You know, if, if the situation is that a box isn't getting checked by physicians for that person to, to stay on that medication or, or whether Curtis's physician didn't check that box that-- and I don't know the situation in terms of if an insurance company no longer is going to pay for a drug, whether that even applies. So I think we really need to get-- dig deeper into, into what is happening. My concern is that right now it seems like the system is leaving a very vulnerable population of people even more vulnerable. And so I think there should be a way that we can work on finding a commonsense solution to this.

HOWARD: Thank you, Senator Wishart. Are there questions? Senator Hansen.

B. HANSEN: I think you have to address-- your biggest hurdle, probably in all of this, is the fiscal note. Do you see your amendment affecting the fiscal note for the better of it all?

WISHART: Yes, I do. I see it affecting it in that I, I-- there was an interpretation, at least in my conversations with the Department of Health and Human Services, that my previous bill said you could not utilize generics. And in fact, in talking with some of the healthcare providers, there are cases where actually a generic works better than the name brand. And so that is not my intention whatsoever. So I think the fiscal note will address that. You know, I think the, the other area we just need to be aware of is that, you know, there is a huge human and fiscal impact when somebody who was otherwise living independently spirals downward, And, and so we really need to take that in consideration when, when we're looking at cost savings and discontinuing somebody's ability to have a certain kind of medication that's worked for them.

B. HANSEN: Thanks.

HOWARD: Any other questions? Seeing none, thank you, Senator Wishart.

WISHART: Thank you.

HOWARD: We'll close the hearing for LB554 and the committee will take a brief break. We will reconvene at 3:00 p.m.

WISHART: OK.

[BREAK]

HOWARD: Winter is coming. All right. This will open the hearing for LB498, Senator Wishart's bill to provide for medical assistance coverage of family planning services, as prescribed. Senator Wishart, you are welcome to open.

WISHART: Well, good afternoon again, Chairman Howard and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th District in west Lincoln. I'm here today to introduce LB498. I'm actually-- this is deja vu, multiple times over. I'm bringing back a bill that was introduced-- it's been introduced for, I believe, the past-- at

least-- four years. I remember the first time it was introduced was when I was still a staff member at the Capitol, and then the second time when I was a senator, one by Senator Jeremy Nordquist from Omaha, and the other time it was introduced by Senator Paul Schumacher from Columbus. So LB498 creates a state plan amendment to the Medical Assistant [SIC] Act to be submitted by September 1, 2019, to CMS, to expand family planning services to Nebraskans whose family earned income is at or below 194 percent of the federal poverty level, which is currently the eligibility level for pregnant women. Under this bill, eligibility will be based on individual income, not family income. And family planning services and services related to family planning are covered under this proposal at different federal matches and are defined to include: cancer screenings, pap smears, colonoscopies, mammograms, contraceptives, HPB [SIC] vaccinations, STD testing, interpersonal violence screening and prevention, prenatal care; and the list continues-- all our key preventative care services for Nebraskans. For every $1.00 Nebraska invests, the federal government invests $9.00. These are Nebraska community member dollars that we should be bringing back to our state to invest in this important preventative care. Additionally, this program saves the state money by helping people prevent unintended health outcomes. The current estimate is that states with comprehensive family planning services save at least $4.00 for every public dollar invested, according to a study, study published in The Journal of Health Care in 2008 and other supporting studies; and that's included in the fiscal note. Twenty-eight other states have successfully leveraged these funds to expand access for family planning services, including our neighbors: Colorado, Montana, and Wyoming. Based on the U.S. Census statistics, approximately 8,000 women and 1,500 men, between 138 and 194 percent of the federal poverty, poverty level, who are uninsured, would enroll. Due to this change, for family planning services only the approximate cost per recipient is $360 for services provided without utilization controls. The state match for family planning services, again, is at 10 percent with 90 percent paid by the federal government. So assuming that we would start this in January 1st of 2020, as an implementation date, we can anticipate savings in 2021. And unlike prior iterations of this bill, I did not include additional appropriation for Every Woman Matters program, as much as it pains me not to do that. Because we're in a tight fiscal budget climate, I think it's important to focus on this bill and the savings that we could see. I did want to briefly discuss the fiscal note on this bill. I was a little confused as to why the Department of Health and Human Services is not recognizing these savings when they have in the past

years. If you pull up-- and I pulled up-- the history of the bills in previous years, the department showed savings, and pretty significant savings, again, citing the Journal of Medicine study from 2008 that shows the potential of savings. So I'm sure-- I'm guessing they'll be here today to talk to that. But from the work that I've done on this and from consultation with the Fiscal Office, we do anticipate that we will see savings. And what is included in this fiscal note is a very conservative interpretation of the savings we would see. With that, I'd be happy to take any questions.

HOWARD: Thank you, Senator Wishart. Are there questions? When we talk about savings, what is the savings a product of?

WISHART: Preventative healthcare. So for example, with, with cancer screenings, but also allowing somebody-- a woman to have access to contraceptives, or a man to have access to contraceptives, and allowing them to better plan their life and for when they're going to have their family. It is important and it has resulted in savings in other states that have utilized and expanded these services.

HOWARD: Thank you. Other questions? Will you be staying to close?

WISHART: Yes.

HOWARD: Thank you, Senator Wishart. We'll now invite our first proponent testifier for LB498 to speak. Good afternoon.

TIFFANY SEIBERT JOEKEL: Good afternoon. Chairperson Howard, members of the committee, my name is Tiffany Seibert Joekel, T-i-f-f-a-n-y S-e-i-b-e-r-t J-o-e-k-e-l, and I'm here, on behalf of the Women's Fund of Omaha, to testify in full, enthusiastic support of LB498. Family planning has benefits for women and children, along with decades of research about the impact on women's educational and work force achievements, family income and stability, and babies' health, and children's lives. Decades of research have shown us that better access to family planning helps women to decide when to start a family and if they'd like to start a family. Affordable-- access to affordable coverage for family planning saves money, as Senator Wishart indicated. If we look at the fiscal note, it shows a cost in the first year of approximately $284,000 in General Funds. The second year, when the savings kicks in, as Senator Wishart indicated, it's $500,000 in General Fund savings. So on net, over the biennium, you're saving the General Fund over $200,000. The reason for that is because, at this income level, women in particular are eligible for Medicaid coverage

if they become pregnant. But we aren't covering anything prior to that if they would like to try to prevent an unintended pregnancy. So the, the moment the woman at this income level becomes pregnant, they'd be, have access to Medicaid coverage for their prenatal care. They would have access to Medicaid coverage to cover the birth costs of that baby. And then any baby born with Medicaid is eligible for Medicaid at least for the first year of that child's life, as well as the mother is eligible for 60 days of postpartum care. So this is a population at an income that we cover when they're pregnant and we cover when that child is born. And this is allowing an opportunity to provide coverage for family planning to better allow families in this income range to make that decision when they're ready, and if they're ready, to have children. I wanted to talk-- a couple of things, especially in relation to our conversation yesterday. This bill is not about kids; this is about adults. This is adult coverage. This would allow coverage be above the Medicaid expansion income level at 138 percent of federal poverty level to 194 percent of the federal poverty level. There's a chart on the back of my testimony that sort of gives you the income range for a single person. So what I would note, just in, as, as an example, is a single person, working full-time at a minimum-wage job of $9.00 an hour, would not be covered by Medicaid expansion. They'd make a little over $18,000 a year and so they would not have access to that coverage. So that person would potentially be able to access family planning services under this bill. And another thing I want to make clear, given our conversation yesterday, is Medicaid does not provide coverage for elective abortions. That is very clear in federal law. It is also very clear in Section 7 of the bill, on page 5. And so I wanted to make sure we talked about that. I was reflecting on your comments yesterday, Senator, Senator Hansen, about when we consider investments that the state should be making in healthcare, I believe you said we should think about prevention, cost effectiveness, and patient experience or patient--

B. HANSEN: Patient satisfaction.

TIFFANY SEIBERT JOEKEL: --satisfaction. And I was reflecting on that and thinking about how I think LB498 really checks all of those boxes. It checks prevention, not only in unintended pregnancies, but also STIs, screening for breast cancer, and other cervical cancer, etcetera. So I think it meets that. That check checks that box. It's clearly cost-effective. I think, you know, the fiscal note will show that a cost of $360 per person, at the very least, prevents a capitation rate, under Medicaid, for pregnancy of, I believe, $4,700

is what the fiscal note states. So I think that meets that. And then your patient, patient satisfaction piece is another thing that I think we didn't properly cover yesterday, as advocates, which is that this-- we're not forcing these services on anyone. This is about someone seeking out this care and being able to have a conversation with a medical professional about their health and about what they're choosing for their family. And it is about, you know, I believe the quote was "shoving birth control down someone's throat" yesterday, from some opponents, and that is absolutely not what this is about. This is about making sure that all Nebraskans have access to some level of healthcare where they can have conversations with their providers about how and when and how best to start a family, if that's appropriate for them. I would also note, yesterday there were some concerns about the impact on health of hormonal birth control. Senator Wishart's bill is limited to FDA-approved methods. So to the extent that the FDA is, has any authority in, in, you know, giving any sort of standard about what is good or allowable for folks' health, I think Senator Wishart's bill limits it for that.

HOWARD: Are there questions from the committee? Senator Arch.

ARCH: You may not know the answer to this question. It's OK. Just say: I don't know.

TIFFANY SEIBERT JOEKEL: OK.

ARCH: In-- with Medicaid expansion at 138 percent, will family planning services, is that a required service under Medicaid expansion? And will that then be covered, everyone that qualifies up to 138 percent, so the difference here is 185 percent?

TIFFANY SEIBERT JOEKEL: I-- first, the answer to your question is yes, I believe family planning is, is part of the core Medicaid--

ARCH: Required service.

TIFFANY SEIBERT JOEKEL: --service. Um-hum. And then this would expand it up to 194 percent just for family planning services. So any other service-- I break my arm-- that's not covered by this bill. It's strictly family planning related.

ARCH: Thank you.

TIFFANY SEIBERT JOEKEL: You're welcome.

HOWARD: Other questions? Senator Hansen.

B. HANSEN: Do you know of any other states that do this?

TIFFANY SEIBERT JOEKEL: I think there's 20, 28 states, I think. It's highly encouraged by the feds, 90-percent match, so lots of people have taken--

B. HANSEN: And--

TIFFANY SEIBERT JOEKEL: [INAUDIBLE] and lots of other [INAUDIBLE].

B. HANSEN: --they're using that-- kind of the same percentages that, that this--

TIFFANY SEIBERT JOEKEL: Oh yeah, uh-huh. Um-hum, because it's limited to-- we can only cover family planning up to the level, income level at which we cover pregnant women. So in Nebraska, we cover pregnant women at 194 percent. Many states have gone into the 200-250 percents for pregnant women and so, similarly, extend this because of the philosophy that if they'd become pregnant, they would become eligible, so to the extent we can help people prevent unintended pregnancies, it makes sense to align those two.

B. HANSEN: OK, thank you.

TIFFANY SEIBERT JOEKEL: Sure.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

TIFFANY SEIBERT JOEKEL: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

HEATHER YOUNGER: Hello. Hello, Chairperson Howard, members of the Health and Human Services Committee. I am Heather Younger, H-e-a-t-h-e-r Y-o-u-n-g-e-r, not too hard, not too bad to spell. I'm kind of excited to be here because this is my old committee when I was a page [LAUGHTER]. Kind of exciting-- I'm like ooh, I know exactly where that room is. I am representing Family Health Services, Inc. We are a Title X family planning agency, pretty much in the southeast corner of Nebraska. We were founded 46 years ago in Tecumseh, Nebraska, for the purpose of providing low-cost reproductive healthcare to low-income women in southeast Nebraska. We had 8

counties then; we have 13 counties now: Lancaster, York, Seward, Fillmore, Saline, Jefferson, Gage, Johnson, Pawnee, Thayer, Richardson, Nemaha, and 0toe Counties. So we are spread out. Our agency also provides WIC services down in Tecumseh and those agencies down there, so we provide the family planning side. So I'm on the family planning side of our agency. Our agency-- as a whole, we provide all these services for, for Lancaster County here. Our agency is located on North Cotner. We are small but mighty. And let me tell you a little about what we do. When people, somebody comes into our clinic, we of course ask for any-- we, we ask for what they're making. So we're on a sliding-fee scale. And that sliding-fee scale, we execute that for everybody who comes in. Kind of a picture of what we're dealing with at Family Health Services-- in 2018, at 200 percent or below the poverty level, we have 67 percent of our clients; that's in our agency, so over half. As far as uninsured, in 2016, we were at-- uninsured was 56 percent. We are now seeing people who are uninsured at 68 percent in 2018, so in two years. And that-- just wanted to call attention to that. Our public insurance that we were seeing at our clinic in 2016 was 18 percent; we are now at 7 percent. So those people who were on public insurance are now no longer on public insurance and that-- we kind of are seeing them as uninsured, either-- and you know, when we talked to them some of it is cost, some of them is they didn't know, so you know, with some of the access issues there. So we look at this as a great opportunity because we see a lot of women who come in and they are working, and they are working to support for their children. And the large problem they have is that their kids are, of course, covered under Medicaid, but they're working to try and support, support, support. But they will fall under the sliding-fee scale and still have to pay. But with this bill they would be covered under Medicaid, as well, for these services. I don't know if you have questions about Title X services and how we provide them but, when we talk to people, we, of course, provide them all the methods, including natural family planning. You know, we kind of find out what their goals are, what are, what they would like to do, what their plans are for the future. We are very hands-on with our clients. We don't push; we just kind of go. We kind of let them lead the conversation. That's what we've all been trained to do is let them lead. So what are your goals? How do you-- so you don't want to have a baby. How do you, how do you want to do that? Here's some of the options here and some of the things. What do you, what would you like to do? And we pride ourselves on being very laid back about that, because that's not our job is to judge, not on anybody. In my past, I worked for the Everyone Matters program as a community health

educator. I also was in charge of the Infertility Prevention project for the state of Nebraska-- I worked for the state of Nebraska for 14 years-- which is chlamydia and gonorrhea screenings. So I know what Title X agencies do do for chlamydia and gonorrhea screening. And what we found just with irregular patients, it can be life changing and we can find it before it progresses, because many of those diseases do not have symptoms. So it's very important that these services-- which SDIs are included-- that we, we're able to provide those to people, all people. We provide all-options counseling, and everybody should leave our agency, particularly women usually-- men, we talk to them as well, of course-- but women, we want them to leave with a reproductive health plan. So that's kind of what you'll see when you come into our clinic. A case that I want to just kind of tell you about is we had a patient who came. She was fleeing an abusive relationship in another state on the coast, came, landed herself in our clinic. She and her daughter both ended up receiving services, and she was just so grateful, even though she had to pay. And under this new bill, she wouldn't have to pay anything. And she's just trying to get, get her feet back on the ground. But she was making money, but just a little too much. So for those people who are just trying to make it day to day, I think this-- that little bit of stretch on this would be extremely beneficial. And the cost savings is amazing. So thank you. Any questions?

HOWARD: Are there questions? Thank you for your testimony.

HEATHER YOUNGER: Absolutely, thank you.

HOWARD: Our next proponent testifier. Good afternoon.

KATHERINE LESSMAN: Hello. Senator Howard and members of the Health and Human Services Committee, thank you for having me. My name is Dr. Katherine Lessman, K-a-t-h-e-r-i-n-e, Lessman is L-e-s-s-m-a-n. I am a board-certified OB-GYN and here in representation of the American College of Obstetricians and Gynecologists. Of note, I am on faculty at Nebraska Medicine, but I am not here representing them. I am here today because access to all forms of contraception is a vital, life-defining public health measure. I also testified for increased contraceptive access here two years ago, and I'm grateful for another chance to try to explain why this is so important. Two years ago, I learned that I had a vastly different understanding of how different birth control methods work than others who were considering the bill. After that experience, I'd like to lead by saying that I'm a Christian whose job is to understand and teach female reproductive physiology

and its complications. I have been immersed in this for more than a decade and have never personally performed an abortion. When used, as they typically are in the office or hospital setting, our contraceptive medic, medicines and devices do not damage or destroy embryos. The family planning expansion that we're discussing today does not cause abortion, but rather it prevents-- or prevents it more effectively than almost anything else we can do. And it all, has also very recently come to my attention that we may hear about cancer risks to some of these medicines. There are some small risks in breast cancer and there are populations for whom each method is not recommended, just as that is true in every other medication, including psychology and psychiatry, as we just heard from. But I will also say that in women with breast cancer genes, who are not ready for their ovaries to be removed for ovarian cancer risk reduction, we do use birth control pills because that risk is more than the risk of the breast cancer. And these medicines do reduce ovarian cancer risk, and they are used to treat early uterine cancers in women who intend to preserve their fertility. As many as one in seven sexual encounters that our young women have are not fully volitional or consensual. Because of this and other individual physiologic variability, natural family planning is not acceptable, or even truly available, to many, many young and old Nebraska women. Women and teens are pressured into, or forced into, sex every single day, including by the people they should be able to trust the most. I am a firm believer that any woman who is mature enough to understand her need for contraception should have access to all of our best methods. Last year I delivered a baby to a woman who couldn't get her birth control anymore because she and her two children had become homeless, and it was too much of a burden to get to the clinic to get her shot every three months. When she first came to me with her new pregnancy, she wasn't sure if she was going to keep the pregnancy. Ultimately she did and she delivered a preterm baby at 30 weeks, a beautiful little girl who had anomalies in her spine, neck, and major blood vessels. The baby stayed in the NICU for months. The father wasn't involved, and her family isn't supportive. The guilt that she had from being unable to be with her baby in the hospital, at the same time as she was with her other kids in the shelter, continues to tear her apart. She loves this little girl but she wasn't ready for her, and she certainly isn't ready to do it all over again. Her life is in chaos and, on top of that, her periods are irregular. For her, to expect that she understand in utero, and utilize natural family planning is unrealistic, to say the least. And to expect her to abstain from sex is paternalistic and arguably prejudicial. At Nebraska Medicine, we are able, we have been

able to access long-acting, reversible contraceptives for people, like my patient, through a grant program, as long as the woman has sufficient financial or social need. This has been able to help the population that we're discussing today, but only at our location. It doesn't help women with the same financial or social needs in the rest of the state because a resident or student must be involved in the placement of the contraceptive device when using this grant. It is for training purposes. Through this program, we have been able to help many women achieve their goals and care for their families, and it's time to offer the same basic services to more Nebraska women. To understand the effectiveness of different birth control methods, let's take a look at the real-life, long-term user data. When 100 women use natural family planning for 10 years, 94 of them experience at least one unplanned pregnancy. For condoms it's 91 out of 100. For birth control pills, 61 out of 100 have at least one unplanned pregnancy. Depo-Provera, the shot, is 46. The copper intrauterine device, which doesn't have any hormones in it, is 8. For comparison, getting tubes tied-- female sterilization-- is 5. The hormonal intrauterine device is 2, and the rod in the arm is 1. It's also important to know that women like some forms of birth control better than others, even though each woman should be afforded the opportunity to decide for herself. Ninety percent of women who try intrauterine devices are still using them at one year. For the rod, it's 80 percent. For pills and the shot, it's closer to 60-70 percent. We know full well that it's cost-effective many times over to provide effective, acceptable birth control to everyone who wants it-- and this is especially true among our most vulnerable Nebraska women-- and that doing so not only saves money, but it prevents abortion, as well.

HOWARD: Thank you. Are there questions? Senator Hansen.

KATHERINE LESSMAN: Yes.

B. HANSEN: I think, maybe, we might have just needed some more clarification about the bill. And maybe this might be a better question for Senator Wishart. But when they talk about the coverage of natural family services per the FDA, and it says: approval of family methods, including the drug or device, what would be the drug?

KATHERINE LESSMAN: So admittedly, I jumped at the opportunity to advocate for contraception and to serve as a medical reference, but the fine details of this particular bill are-- I'm not, I'm afraid to misspeak.

B. HANSEN: And that's fine.

KATHERINE LESSMAN: But the medicines--

B. HANSEN: Not worried about it yet.

KATHERINE LESSMAN: The medicines are progestin and estrogen, as well as the copper IUD.

B. HANSEN: OK. And may, can I ask you just a couple more then?

KATHERINE LESSMAN: Absolutely.

B. HANSEN: OK. And the screening and treatment for preinvasive cervical and breast cancers-- so the screening I understand, but the treatment-- what would that include, like for instance, of breast cancers? It says preinvasive, so say a woman finds out she has breast cancer, would that include the treatment of it?

KATHERINE LESSMAN: So that is a great question. Usually the next step is an excisional removal, lymph node dissection, if needed, or sentinel lymph node dissection, if needed, and radiation and/or chemotherapy, accordingly. I am not sure about the nuance [INAUDIBLE]--

B. HANSEN: Yeah, and that's fine, too.

KATHERINE LESSMAN: In this bill.

B. HANSEN: Just trying to weigh like the cost journey, I, you know--

KATHERINE LESSMAN: Um-hum.

B. HANSEN: What we are all covering, because sometimes it's a little bit broad. And one more-- the last one, it says: And follow up family planning appointments and counseling. Do you know what that would entail?

KATHERINE LESSMAN: So that is primarily helping women choose the method that's best for them--

B. HANSEN: OK.

KATHERINE LESSMAN: --and then following up to make sure that it is, indeed, working, acceptable, and. troubleshooting it, if need be.

B. HANSEN: All right, good. Thank you.

KATHERINE LESSMAN: Um-hum.

HOWARD: Other questions? Seeing none, thank you for your testimony today. Our next proponent testifier. Good afternoon.

MEG MIKOLAJCZYK: Good afternoon. Good afternoon, Chairperson Howard and members of the committee. My name is Meg Mikolajczyk, M-e-g M-i-k-o-l-a-j-c-z-y-k. You can sing it to the Mickey Mouse song [LAUGHTER]; I'm not going to. I'm the deputy director of Planned Parenthood Nebraska. Planned Parenthood of the Heartland is a sexual and reproductive healthcare provider, serving about 8,500 patients annually in our two Nebraska health centers. We strongly believe that every person should have the opportunity to lead a healthy and meaningful life, regardless of their income level or socioeconomic status. And that's why we proudly support LB498. I'm going to skip ahead a little because I think some of this has been plowed ground already, but these preventive services we're talking about are vital and they're lifesaving. For example, this bill provides greater access to HPV vaccination, which guards against several strains of HPV, including the two most commonly associated with causing cervical cancer and other cancers. The bill also creates greater access to well woman exams, pap smears, and other cancer screenings. And at Planned Parenthood, we provide about 1,000 cervical cancer screenings every year. And we know that, with early detection, the five-year survival rate for cervical cancer is 93 percent. This fact alone highlights the absolutely necessary reason for creating even easier and affordable access to these services. And I'm going to deviate a little. I want to share my, part of my personal passion for this bill, specific to HPV vaccination and well woman exams. When I was in law school, I couldn't afford the HPV vaccination and, at that time, insurance didn't cover it. It was $300 a shot. I was closer to the end of the range when, at the time, it was suggested. So I thought, well, I'll just try my luck. Then I was off of insurance because I couldn't afford it anymore. I was part-time and I thought I was super healthy. And I received a certified letter from my gynecologist saying, you have a very abnormal pap smear and we're going to have to do some immediate work. Now I had no insurance at the time, there are preexisting conditions. So now I'm trying to also fight to have any sort of help with this. I had to have a LEEP procedure, which is the cauterization of your cervix after I had biopsies and a colposcopy. All of this was very expensive; I didn't know how I was going to afford it. It's also terrifying, being

told that you have stage-- or precancer is what they called it, being told that your fertility is on the line as someone who always wanted to have a kid. And I do; she's great. But at the time I didn't know, and I didn't know if I could afford it, and I didn't know how I was going make it through law school. I didn't know what my prognosis was. I don't want that for anybody, and that's part of the reason I work at Planned Parenthood to do this work, and it's why I'm so committed to making sure. If we can get someone a vaccination, we prevent them from having their cervix cauterized. That sounds really awful, and I'll tell you it wasn't, it wasn't very fun. So OK, out-of-pocket costs. I've included with my testimony just a few of the most basic costs, under the family planning program that we offer, because I think there's also a misconception about how much birth control costs or how much a pap smear costs. You know, if someone were to come in and have an office visit and get an HPV screen, a pap smear, an STI check, and an IUD inserted, it could be $1,700 or more. And for the folks that we're talking about in this population, that's over a month's income. And if you or me or any of us were forced to come up with a month's income, we might be having to make some very difficult decisions. Or we would forego the care. So importantly, this bill also expands eligibility for family planning-related services. So for example if a person is diagnosed during their visit with something like an STI or a UTI, this bill would allow them to get coverage for treatment. Even more critical, related services would include treatment for invasive cancers-- I think that goes to your question, Senator Hansen-- so a person does not receive a diagnosis and then is left stuck, not knowing how to get treatment. All Nebraskans deserve access to these preventive healthcare services at an affordable rate. I also just want to highlight-- and I've got a citation here in my testimony, as well-- but we are very conservative when we estimate what the preventive costs and the savings are. When we look at HPV vaccinations versus cervical cancer treatment, when we look at catching breast cancer early or making sure people don't get public inflammatory disease because an STI has gone untreated, the savings are much higher. It's at least $7.00 for every dollar invested. And it's also really great for the people in our state to be able to access that care earlier, and be healthier and happier, and have the families and the lives that they want. So we just thank you, Senator Wishart, for bringing this bill and we urge the committee to advance LB498.

HOWARD: Thank you. Are there questions? Senator Hansen.

B. HANSEN: You kind of brought up the HPV vaccine, and--

MEG MIKOLAJCZYK: Kind of, yeah.

B. HANSEN: Yeah. And so I, I kind of looked at that a little bit, too, especially when it came to initial trial studies, the HP [SIC] vaccine, research afterwards, post studies, effectiveness of the HP [SIC] vaccine. It's not always-- it's not 100 percent effective in producing cervical cancer.

MEG MIKOLAJCZYK: Um-hum.

B. HANSEN: But you know, like maybe this might be another question for Senator Wishart, is, if somebody does get a side effect from this vaccination, who's going to pay for it?

MEG MIKOLAJCZYK: So actually, I believe that with the family-related, family planning-related services and that, I'll, you know, Senator Wishart, I'll defer to you. But part of that coverage is that, if something happens during your family planning visit that needs a follow-up, one of the things that are cited in journals are, on the rare occasion that an IUD insertion causes some sort of problem, this imagines that you'll be able to get treatment as a result.

B. HANSEN: OK.

MEG MIKOLAJCZYK: So I think that would fall under it, too, but I'm not-- I'm a JD, not an MD, so--

B. HANSEN: OK, just curious.

MEG MIKOLAJCZYK: --not the right kind of doctor.

B. HANSEN: No, thank you.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

MEG MIKOLAJCZYK: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

DONNA ROLLER: Good afternoon, and I appreciate the privilege of being here, Senator Howard and the rest of the committee. I'm just a

grandma. This is going to be-- this is not supposed to be emotional; I'm sorry.

HOWARD: Would you mind spelling and stating your name for the record?

DONNA ROLLER: I'm sorry. I'm Donna Roller, D-o-n-n-a R-o-l-l-e-r.

HOWARD: And I'm so sorry. Could a page grab your green sheet, too?

DONNA ROLLER: Oh, sure. I don't know why I'm so spaced out today.

HOWARD: Oh, no. You're doing great, Donna.

DONNA ROLLER: I'm not speaking here in any professional capacity. I'm speaking here as a mother and a grandmother. And my daughter had a very high-risk pregnancy and, luckily he was born and he was full-term, but he ended up being in NICU for quite some, ten days. And I was realizing I just want this committee to know that women are different, and we should hold the highest regard in our culture because, being older and observing the professionalism of the hospital, and what mothers, even on a normal pregnancy, go through, I realized that women need to be respected more for their job. And we need to be served, give every woman, no matter what income status, the right to the healthcare that is listed in this bill. All of those services are-- most of them I used myself-- and I have the economic means-- but everyone should have that access to preventable and normal kinds of things. And everybody should have that right; and I am advocating for that. And there's-- I also feel that men often don't understand what women go through. And I'm glad that there are more women doctors today. And because I was misdiagnosed with-- or not paid attention to issues that I had-- and it was a difficult birth and it had lifelong changes and resulted in, you know, wrecking my body in various ways. So a woman fixed me. So I, I just, this is not a religious issue. This is not a man's issue, unless you are a man that truly cares about women and their health. And so I was quite shocked to hear that this bill has been reintroduced for several times over a period of years. What's the delay? Am I not, are women not equal to have these kinds of health, health benefits? So I just want you to move this past committee and please pass this bill, and let's serve all women because they deserve it.

HOWARD: Thank you. Let me see if there are any questions. Are there any questions? Seeing none, thank you for your testimony today.

DONNA ROLLER: I'm sorry. I--

HOWARD: No, you're perfect. You're already gone.

DONNA ROLLER: I don't even know why it's emotional, but it is.

HOWARD: No, you're wonderful. OK. Is there anyone else wishing to testify as a proponent for LB498? Seeing none, we do have several letters: Abbi Swatsworth from OutNebraska; Tom Gray, representing himself; Sarah Hanify and Becca Brune, from the National Association of Social Workers-Nebraska chapter; Phyllis Salyards and Sherry Miller, of The League of Women Voters of Nebraska; Danielle Conrad, from the ACLU of Nebraska; Kathleen Uhrmacher, from the Women's Foundation of Lincoln and Lancaster County; Karen Bell-Dancy, from the YWCA of Lincoln; Karen Dunning, representing herself; Chris Funk, from the Center for People in Need; Jennifer Rokeby-Mayeux, representing herself; Reverend Craig Loya, from Trinity Episcopal Cathedral in Omaha; Reverend Chris Jorgensen, Hanscom Park United Methodist Church-Omaha; Reverend Dr. Jane Florence, St. Paul United Methodist Church-Lincoln; Rabbi Teri Appleby, South Street Temple-Lincoln; Reverend Lynn Seiser, Martell and Roca United Methodist Churches; Reverend Bonnie McCord, United Methodist Church-Chadron; Reverend Stephanie Alschwede, South Gate United Methodist Church-Lincoln; Reverend Scott Jones, First Central Congregational Church-Omaha; Reverend Steve King, Trinity Episcopal Cathedral-Omaha; Rabbi Steven Abraham, Beth El Synagogue-Omaha; Reverend J. Scott Barker, Bishop, Episcopal Diocese of Nebraska; Reverend Patrick Messer, First Plymouth Congregational Church-Lincoln; Reverend Stephen Griffith, United Methodist Church-Lincoln; Reverend Jamie Norwich McLennan, Gothenburg First United Methodist Church-Gothenburg. With that, I would invite our first opponent testifier for LB498. Good afternoon.

MARION MINER: Good afternoon. Excuse me. Madam Chair Howard and members of the Health and Human Services Committee, My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here as the associate director for prolife and family at the Nebraska Catholic Conference. The conference advocates for the public policy interests of the Catholic Church and advances the Gospel of Life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here today to express the conference's opposition to LB498, as it stands now. I do want to say it's, it's important to note that the conference is certainly not opposed-- excuse me-- to all that, to all of the services that are covered in the family planning program. Those things that have to do with-- excuse me-- cancer screenings, and STD

and STI treatments, and those types of things are certainly laudable endeavors, and we have no objection to those. And I won't go into the specific numbers because those have been covered by others, as far as who this would expand coverage to. But I'll go ahead and jump right into the reasons that the conference opposes this policy, as it's, as it's written now. First, numerous studies from sources across the ideological spectrum, and across many years, have illustrated pretty convincingly that greater access to contraception does not reduce unintended pregnancy and abortion, but, in fact, tends to increase both. Second, studies purporting to show that increased contraception availability decreases abortion are largely estimates and projections that are not based on any hard data. And third, some studies have concluded that a rise in contraceptive usage has been a significant factor in the breakdown of marriage, which comes with a high social cost that falls disproportionately on the poor. Now just to go through some of those studies, and I have footnoted-- excuse me-- most of those at the bottom of the handout, two studies by the Guttmacher Institute, for example, which is the research arm of Planned Parenthood, found that 48 percent of women with unintended pregnancies and more than half of women seeking abortions were using contraception in the month they became pregnant. Those studies are from '06 and '08. In addition, numerous studies examining sexual behavior and STD transmission have demonstrated a greater willingness to engage in sexually risky behavior when a person believes the risk has been reduced through the use of contraception. And that's pretty commonsensical, but we have hard numbers, as illustrated by the study, to back that up. In addition, researchers in Spain, to take another example, examined patterns of contraceptive use and abortion from 1997 to '07 in Spain and found that a 63 percent increase in the use of contraceptives during that time coincided with a 108 percent increase in the rate of elective abortions. In July 2009, results were published from a three-year program in the United Kingdom, conducted at 54 different sites and funded by the UK government, which sought to reduce teenage pregnancy through sex education and advice on access to family planning, beginning at ages 13 to 15. "No evidence was found the intervention was effective in delaying heterosexual experience or reducing pregnancies." In fact, young women who took part in this family planning program were more likely than those in the control group to report that they had been pregnant and had early heterosexual experience. And the specific statistics are there on your handout. Finally, a study completed in 2018, which analyzed whether oral contraceptives played a causal role in the rise of nonmarital births in the United States during the 20th century, concluded that access to

the pill significantly increased both nonmarital births and demand for abortion, and that the effects are especially concentrated among less-educated families and minority women. It's also worth pointing out that LB4098 [SIC] includes coverage, without qualification, of all United States FDA-approved family planning methods, including "the drug or device, insertion or provision, and removal" of various forms of birth control. I note that provision because many forms of family planning that are approved by the FDA function not only to prevent pregnancy but also to terminate a pregnancy which has already begun, even though they're classified by the FDA as contraceptives. Hormonal birth control-- let's take an example-- works in one of three ways: by preventing ovulation, by preventing fertilization if ovulation has occurred, and by preventing implantation after an already fertile, fertilized zygote or embryo has come into existence. That third form is an early abortion. At fertilization a new organism, with its own unique and complete set of human DNA, forms and begins to grow rapidly, even before implantation. This new life, although extremely small in size, is human, has a unique and complete set of DNA, and is alive and growing. Hormonal birth control, when effective, will not only prevent pregnancy, it will end the life of the new human person. Since LB498 allows for Medicaid coverage of all contraceptives approved by the FDA, it also allows for coverage of those contraceptives which also function as abortifacients and terminate already existing human life. It's a wrap up. In conclusion, we oppose LB498 because social science has demonstrated that, if the goal is to prevent unintended pregnancy and lower the rate of abortion, this is not the thing that you do to make that happen. It increases sexually risky behavior, it increases the rate of unintended, out-of-wedlock pregnancy, and it increases the rate of abortions, which has devastating effects for those directly affected and for society. So for those reasons, we ask that you not advance the bill to committee, as written.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: I was going to wait and see if anybody else wanted to go first. So I'm going to go ahead. Thank you, Chairwoman. Thank you, Mr. Miner, for being here today.

MARION MINER: Good afternoon.

CAVANAUGH: Here we are again. I have several questions that I'm going to put on hold for those for a moment, because I'm looking at your testimony and you have in here, the rise of nonmarital births in the

United States. And so my first question to you is, do you view it as the role of the Legislature to legislate births?

MARION MINER: No. But I do--

CAVANAUGH: And the type of birth, the type of parental relationship?

MARION MINER: I think that the state has-- and this has, this has been the traditional view, not only in the United States. Even now, but, but across time, the traditional view has been that the state certainly has an interest in protecting the public welfare, which includes supporting family life and supporting policies that are going to be best for the children, especially for the most vulnerable. So that's what the state has an interest in protecting.

CAVANAUGH: So I know people-- I'm assuming you probably know people who have children and are not married.

MARION MINER: Um-hum, sure.

CAVANAUGH: So I don't-- I guess that, as an objection of the causal relationship-- I know people who consciously make that decision.

MARION MINER: Um-hum.

CAVANAUGH: So I-- whether they have access to Medicaid expansion or not, it's, it's not the role of the Legislature to, to dictate that. So I guess that's just something that I find concerning in your testimony. But I'll move on since you answered that question. So you're not opposed to the already-existing free contraception to those.

MARION MINER: That's just something that's not that's not contemplated by the bill, so that's-- I'm not addressing that today.

CAVANAUGH: OK. Well, I'm asking.

MARION MINER: We don't think-- I mean, consistent with what I'm, with what I'm testifying with today, there are, there's a lot of evidence out there that providing contraceptives to people and encouraging their usage is, just doesn't have beneficial effects, either for the for the people that are using contraceptives or for society at large. So that would be my position on that.

CAVANAUGH: So you heard some of the previous testimonies; I, you've been in here this whole time. And you heard one of our testifiers from the health center and-- I'm going to forget the region; she listed off a lot, a lot of counties.

MARION MINER: In south-- yeah, southeast Nebraska.

CAVANAUGH: Yes, thank you. And she talked about the experience, the patient experience--

MARION MINER: Um-hum.

CAVANAUGH: --and how they let the patient guide the conversation.

MARION MINER: Um-hum.

CAVANAUGH: So the supposition that people are being directed towards contraception, that it's, that it's being promoted to them, is not what we've heard today in testimony.

MARION MINER: Oh, and that, and that's not really what I'm-- that's not really what my point is. I'm not making that assertion. But I, I would--

CAVANAUGH: Well, you are making--

MARION MINER: But I--

CAVANAUGH: You did make that assertion.

MARION MINER: --would contend, I would contend that, when you make something available to someone for free, it incentivizes usage of that and--

CAVANAUGH: Well--

MARION MINER: --it encourages further participation in that practice.

CAVANAUGH: They're not making it available for free. They're making the conversation available under Medicaid expansion. And you still have to get a prescription, and then it's determined whether or not, you know, you have to pay for that prescription, a portion of that prescription. This isn't just like, willy-nilly, everything is free. It's the conversation that you have with your medical provider. And I've been in the room with a doctor talking about contraception.

MARION MINER: Um-hum.

CAVANAUGH: I've never had a doctor tell me that that's what I should do. And I've never been on Medicaid, just regular old healthcare in the U.S.A. And that's not the experience I have, as a woman. If I want contraception, that is a request that I make, that I tell the doctor.

MARION MINER: Um-hum.

CAVANAUGH: That's not how the conversation goes. And I feel that's important to express to you because, again making an assumption here that your gender is not female and that you haven't had those conversations with your own doctor. But that's how it goes in the doctor's room. So the supposition that this is being pushed, that contraception is being pushed, I just want to dissuade you of that, that that's not the case.

MARION MINER: I'm, I'm not making any claims about what goes on in, you know, in the, in the, between the physician and--

CAVANAUGH: It feels like you are,--

MARION MINER: Well no, what I'm--

CAVANAUGH: --based on--

MARION MINER: What--

CAVANAUGH: --your--

MARION MINER: What I'm--

CAVANAUGH: --testimony.

MARION MINER: What I'm, what I'm trying to convey through the, through my testimony is that we-- with the way that we spend the money that we have,--

CAVANAUGH: Um-hum.

MARION MINER: --it, it shows, it illustrates what's important to us, what's worth supporting and what isn't. And so you make that, you make more money available for free or low-cost contraception to people. That sends a signal about what is important to the state and it, and implicitly--

CAVANAUGH: Yes, it does; you're right.

MARION MINER: --and implicitly encourages practices that, again, studies have shown have, have disproportionately heavy negative impacts, especially on the poor. And that's something that we don't want to see happen.

CAVANAUGH: It shows the state that the people of the state, that the state cares about women's health and women's lives. So let's take a woman; her name can be Mary. And Mary has a heart condition that she was born with.

MARION MINER: Um-hum.

CAVANAUGH: And she's Catholic.

MARION MINER: Um-hum.

CAVANAUGH: And her husband works for the Coast Guard. And she travels all over the country, following her husband in the Coast Guard.

MARION MINER: Um-hum.

CAVANAUGH: If she were to get pregnant while stationed somewhere remote with her husband, she would have to make two different choices: one, to terminate the pregnancy because she could die; or two, to leave her husband's post and go somewhere else where she can get severely specialized care. Now that could be her choice to get pregnant but, if it's an unplanned pregnancy and she doesn't take any birth control because she, A, doesn't have access, the government doesn't allow it, you have convinced us to legislate against it-- she could die because you think that hormonal birth control is-- I don't even know what you think it is. It's medically sound; it is FDA-approved. But Mary could die because she's not taking it.

MARION MINER: I'm not sure what your question is, but I would--

CAVANAUGH: So my--

MARION MINER: But--

CAVANAUGH: --question is, why do you think that it's OK for you to come here and tell us that medicine, that federally-approved medicine is not OK, that we should not be allowing patients access to federally-approved medicine? But not just federally approved medicine,

specific medicine that you keep claiming causes all these problems. But I know women, I know lots of women who have heart conditions who are on birth control, even though the Catholic Church-- and they are Catholic-- tells them not to be because, if they get pregnant-- and they're married-- and they get pregnant, they will die. I know women who will die from pre, preeclampsia, I know women who will die from diabetes, and I know women who will die from endometriosis. And they all have to make that choice about taking birth control. And the women that I know have money-- means-- so they can pay for it. And you're saying that women who are poor don't deserve that.

MARION MINER: That's not--

CAVANAUGH: And so--

MARION MINER: That's not what I'm saying.

CAVANAUGH: My question to you is, why? Why don't women who are poor deserve that?

MARION MINER: That's not what I'm saying.

CAVANAUGH: Well, that's what I'm asking you to answer. Why don't those women deserve the same care that women of means deserve and get?

MARION MINER: I'm going to refrain from answering, from defending a position that I never took in the first place.

CAVANAUGH: OK.

MARION MINER: But I will say that I think, if you want the answers to the questions you're asking about whether this is effective and whether it has good effects,--

CAVANAUGH: It's lifesaving; it's effective. It's lifesaving.

MARION MINER: I would--

CAVANAUGH: The science proves it.

MARION MINER: I would refer you to the studies that I've cited, and--

CAVANAUGH: I would refer you to science. I would refer you to the FDA. I would refer you to the federal government. I would refer you to HHS. I would refer you to a doctor's office. I would refer you to the doctors that are sitting behind you. It is science. Studies about

well-being of people, that's an ideological argument. We're talking about healthcare.

MARION MINER: This--

CAVANAUGH: Healthcare is science.

MARION MINER: This is, this is empirical--

CAVANAUGH: Why--

MARION MINER: This is empirical data.

CAVANAUGH: Why is it-- but it's-- it has nothing to do with the healthcare of people.

MARION MINER: Yes, it does.

CAVANAUGH: We are talking about creating equity in access to healthcare; that is what the issue is at hand. That is what Senator Wishart's bill is about, is equity and access to healthcare. And you are asking us, as a, as a committee, to consider not allowing a small population of people equal access to healthcare, that a lower income population has and a higher income population has, because of some social science. And I'm a sociologist. I love social science as much as the next person. But these are social science studies about a scientific problem. Healthcare is a scientific problem. And I don't believe that any women, woman deserves to not be told all of her options. Whether she chooses to not take birth control, when she is married and Catholic and could die, is her choice but she should have that choice.

HOWARD: Senator--

CAVANAUGH: Yes, I'm sorry.

HOWARD: You were [INAUDIBLE].

CAVANAUGH: I feel like you're not-- you're not and-- sorry.

MARION MINER: I'm happy to answer a question if--

HOWARD: [INAUDIBLE].

MARION MINER: And, and it--

CAVANAUGH: I didn't ask a question; I just went on a, a long-- sorry.

HOWARD: That's OK. Let's see if there are--

CAVANAUGH: Yes, lets.

HOWARD: --other questions from the committee. Let's give other committee members an opportunity. Are there other questions from the committee? No? Do you have any follow-ups?

CAVANAUGH: I appreciate that. No, thank you. Thank you for being here.

MARION MINER: Thank you.

HOWARD: Thank you for your testimony today.

MARION MINER: You're welcome. Thank you.

HOWARD: Our next opponent testifier. Good afternoon.

TERESA KENNEY: Good afternoon. Thank you for listening to my testimony today. My name is Teresa Kenney; that's T-e-r-e-s-a K-e-n-n-e-y. And I am a women's health nurse practitioner, and I'm here in opposition to LB498 because I believe that women, especially those who are socioeconomically disadvantaged, deserve better. I believe women hold an inherent dignity and worth, and I believe their bodies, including their fertility, were made good. And I believe it is wrong for us to treat any woman contrary to the dignity and respect that she deserves. And unfortunately, women have often been treated poorly in order to control their bodies, and it has overridden the harms done to them by hormonal birth control. In healthcare we do take a vow to do no harm, and I take this vow very seriously and I try my best, and to my ability, to avoid medicines, procedures, and interventions that do more harm than good. I also took a vow to protect human life from its very beginning, from the moment it has unique DNA, at its conception until the person's natural death. I take those vows very seriously and it's the, for these two reasons that I have concerns about the bill being proposed in committee today. The intrauterine device, the IUD, one of the several forms of birth control being offered, but to more low-income women by this bill, is being pushed in an increasing level in the United States because it's 20 times more effective than the pill for reducing unplanned pregnancy. Introduced first, though, in the 1970s as the Dalkon Shield, the first IUD ended up hurting thousands of women. Eighteen women died because of this IUD, because of-- the filament that was attached at the end allowed a deadly

bacteria to enter into the uterus. You might think that this kind of thing could never happen again, but the mainstream birth control device, the Essure, was just taken off the market in the fall of 2018, after 16 years, due to over 16,000 FDA complaints and 9,000 needed removals, mostly by hysterectomy. Women who had Essure coils implanted reported everything from severe pain to autoimmune reactions, sensitivity to metals, hair loss, weight gain, brain fog, abnormal bleeding, and cramping. To date, Essure has been linked to at least four adult deaths, 15 fetal deaths and 631 pregnancies, according to the Regulatory Affairs Professionals Society. The Dalkon Shield and Essure devices are just two examples of the horrific side effects of some kinds of birth control, especially IUDs, and the irreversible damage that they can cause. Oral contraceptive pills, for their part, fail at a rate of 9-30 percent, 30 percent for the U.S. and for women in the U.S. The failure of contraceptives often leads to a deemed necessary next step, which is abortion. In 2014, about half, or 51 percent, of abortion patients in the United States reported that they'd actually use a contraceptive method in the month that they became pregnant. This was reported by the Guttmacher Institute, the Planned Parenthood's research arm. In 2014, 471,000 abortions were provided to patients who reported that they were using contraception in the month that they became pregnant. No method and no user is perfect, and abortions will continue to be a necessary backup to failed contraceptions. Each of these abortions is a loss of life, and each of those lives deserve the same opportunities as you and I. Contraceptives have serious and unavoidable risks. Research has linked hormonal contraceptive use with an increased risk of depression, especially in our young women. A 2000 study show, showed that, in a group of 1.5 million Danish women, that there was a 70 percent increase in the risk of depression. It also tripled the risk of suicide in this group of women. This study included women using oral contraceptive pills, the patch, and hormonal IUDs; and that was reported in the American Journal of Psychiatry. In addition, the birth control pill has other hormonal contraceptive effects. Often the hormonal pill actually decreases sex drive in women, and this effect doesn't magically reverse after women come off the pill. It often can take months to years for this effect to recuperate from. We should often we should consider how the mind/body altering of hormonal contraception affects the way women-- and how it impacts their lives. Would men be as welcoming to the massive hormonal assault and change that a woman goes through when taking suppressive and manipulative hormones that affect every aspect of her body? As Mother Jones stated in a recent article discussing male birth control, women have long

complained of weight gain, moodiness, and other birth control side effects. But despite that, 62 percent of U.S. women use contraceptives. A recent clinical trial for a male contraceptive delivered via injection was ended early despite promising early results, due to participants complaining about side effects such as: depression, decreased libido, and mood changes. I'll leave you with this question. If it were your daughter or granddaughter, how would you expect her body to be treated? With it-- would it be worth the risks? If not, why would we treat women of low income, economic means with less dignity and respect? Thank you, and I'd take any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next opponent testifier. Good afternoon.

DAMIAN OLSEN: Good afternoon. Senator Howard and the rest of the committee, I appreciate this opportunity. My name is Dr. Damian Olsen, and I'm an OB-GYN physician practicing in Omaha, Nebraska.

HOWARD: Could you spell your name for the record?

DAMIAN OLSEN: Sorry. It's D-a-m-i-a-n O-l-s-e-n. I oppose LB498 as I believe there are significant moral, social, and health implications to this bill. While most turn a blind eye to it or try to point the finger at something else, the negative social implications of birth control are massive. In a recent New York Times article by William Bennett, he stated, "The family is the nucleus of civilization and the basic social unit of society." "For a civilization to succeed, the family must succeed, and right now, it's not." A huge reason the family is being torn apart in our modern society is birth control. Women have become objects to be used for pleasure, with the promise of sex without consequences. They are then duped by the same medical profession when they find themselves pregnant. The subsequent option posed to them is abortion, which was the only foreseeable backup plan because becoming pregnant in the first place was never an option. Aside from helping to contribute to the almost 900,000 abortions per year in the U.S., contraception has led to infidelity, a sexually-transmitted disease epidemic, sharp rises in domestic violence, and a true breakdown in the family, the most precious nucleus of civilization. In my informed opinion, contra, contraception should not be considered a standard of primary care. As part of the Hippocratic, Hippocratic Oath that I took upon receiving my medical diploma, I pledged to do no harm. I have witnessed so many harmful results from contraception. To quote Dr. Peck and Norris, who have studied the risks of oral contraceptions in detail: Oral contraceptive

pills fail the most important test of preventative medicine: they increase the risk of disease. First and foremost, oral contraceptive pills are classified as Group 1 carcinogens. This means they have known carcinogenic risk to humans, most notably increased risk of breast cancer, liver and cervical cancer. Oral contraceptive pills increase the risk of HPV, which leads to cervical cancer. Breast cancer occurs in one in eight women and is particularly increased in young women who are exposed to oral contraceptive pills prior to a full-term pregnancy. It has also been suggested that oral contraceptive pills act as a cofactor with HPV to help cause cervical cancer. One of the most well-known and devastating side effects of hormonal contraceptives is cardiovascular. This includes: DVTs, which are peripheral blood clots; PEs, which are blood clots in the lungs; myocardial infarctions, which are heart attacks and strokes. I've seen far too many women fall victim to blood clots that have led to severe disability and even death. Estrogen containing contraception is estimated to increase risk of thrombosis by three to five times the general population. Some common and well-known side effects include: weight gain; depression; migraine headaches, which may seem inconsequential until they happen to you or your patient. While the American Congress of OB-GYNs, and the specialty of OB-GYNs as a whole, has embraced the IUD as the next greatest advancement in our field, I strongly disagree with this notion. Throughout my medical training, I have numerous, had numerous experiences of women being harmed by IUDs. I will never forget when, as a medical student on my OB-GYN rotation, we had a mother who had very recently given birth die of complications with the placement of her IUD. During residency in our resident-run clinic, that served primarily the underinsured and uninsured, the IUD was pushed, by many of my coresidents, onto patients. I was then left to manage many patients returning to the clinic for repeat visits, complaining of side effects, including constant bleeding or new onset pelvic pain. I managed patients who needed surgery to find an IUD that had perforated through the uterus and was left either embedded in the wall or somewhere in the patient's abdomen. For all of these reasons and through all of these experiences, I've come to believe that hormonal contraception has done more harm than good in the field of women's healthcare. I would like to also address the abortifacient effects of contraceptives, because this is rarely discussed with patients by their doctors. One of the known mechanisms of action of contraception is to thin the lining of the endometrium. This can cause an early embryo to slough off the inhospitable lining. Many women do believe that life begins at conception and not at implantation or beyond. I urge you to vote against this bill in order to foster and

preserve true preventative healthcare and uphold the dignity of women, no matter their socioeconomic status. Do not allow this bill to transmit yet another blow to our Nebraska families, the nucleus of our struggling society. Thank you for your time.

HOWARD: Thank you. Are there questions? Doctor, where do you practice?

DAMIAN OLSEN: I practice at the Pope Paul VI Institute.

HOWARD: Is that, is that in Omaha? Or--

DAMIAN OLSEN: It is in Omaha, Nebraska; yep.

HOWARD: Thank you. Thank you for your testimony today.

DAMIAN OLSEN: Thank you.

HOWARD: Our next opponent testifier. Good afternoon again.

THOMAS "ROCKY" THOMPSON: Happy Friday, Madam Chair and members of the Health and Human Services Committee.

HOWARD: We're almost there.

THOMAS "ROCKY" THOMPSON: That's right. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as the deputy director of policy and communications within the Division of Medicaid and Long-Term Care at the Nebraska Department of Health and Human Services. I'm here to testify in opposition to LB498. LB498 is a bill which would expand the Medicaid program by providing a limited family planning benefit for a new population of individuals who are not eligible for Medicaid at this time. I'm here to testify in opposition today due to concerns related to the Department's fiscal note on this bill. LB498 would require MLTC to expand family planning coverage for individuals with a family earned income at or below the income eligibility level for pregnant women, as of January 1, 2019. As I said before, that's 194 percent of the federal poverty level. The department estimates that, should 1 in 3 uninsured Nebraskans under this poverty level apply for this program, Medicaid would take on an additional 15,515 members, costing the state $1.3 million for state fiscal year 2021. Additionally, this new eligibility group would require DHHS to hire approximately nine new staff members, make a one-time change for the new eligibility category, an IT system, and factor this group, group into the managed care capitation rates. While the aid expenses are covered at 90 percent of the federal matching

rate-- these are the family planning services-- staffing and operational costs like these are only covered at a 50 percent matching rate. Additionally, those family planning-related services covered under the state plan amendment would be at our traditional match rate. I've also reviewed a fiscal note prepared by the Legislature Fiscal Office, and I have significant concerns regarding the anticipated savings due to the avoidance of unplanned pregnancies. First of all, I will note that the study cited by the Legislative Fiscal Office, where the savings figure is derived from, is from 11 years ago. The state plan option considered in this legislation was not in existence in 2008. It only became an option for states in 2010 with the passage of the Affordable Care Act. Prior to the ACA, states could apply for family planning waivers. However, there are several differences in the waiver option, most notably waivers could only apply to women. The SPA option also would include family planning services for men. There were also differences in coverage options. The SPA option allows for additional services at our traditional match rate, that is, ones related to family planning services. And there's been some guidance issued by CMS about what those services would entail, and they're conducted in the course and scope of a family planning visit. I also do not think we can act, accurately determine a savings due to the avoidance of unintended pregnancies. As said previously by other testifiers, one has to assume that contraception and, and contraceptive method, methods are always 100 percent effective and that human error does not occur; and I don't know if we're OK to say that. It's important for the Division of Medicaid and Long-Term Care to be good stewards for taxpayer dollars. For these, for this reason we oppose LB498. And thank you again for the opportunity to testify against-- you-- with your, with you fine folks. And I'm happy to answer any questions you might have.

HOWARD: Thank you. Are there questions? Senator Hansen. I thought you were pointing at me.

B. HANSEN: So I'm seeing a difference between your fiscal note and the legislative fiscal note. They have the 2008 study done by the Journal of Health Care for the Poor and Underserved, I think, which shows why they have a, why they feel like they have a cost savings because of that study. Do you know much about that study at all?

THOMAS "ROCKY" THOMPSON: I read it, Senator, about two years ago in preparation for the fiscal note for Senator Schumacher's bill; I have not looked at it again since then.

B. HANSEN: Because that seems like a determining factor between both these fiscal notes and cost savings versus not. So I just, just want to know--

THOMAS "ROCKY" THOMPSON: And, and again, Senator, it's a cost savings. I think with the fiscal note, it doesn't consider the other preventive services that Senator Wishart was discussing before. The fiscal note only talks about the pregnancy, and also that it was a different program in 2008. The SPA option also has the-- that includes men.

B. HANSEN: OK.

HOWARD: Other questions? Remind me how long you've been at Medicaid and Long-Term Care.

THOMAS "ROCKY" THOMPSON: About four years.

HOWARD: About four years. And then, what was the time where you were the interim director?

THOMAS "ROCKY" THOMPSON: I was interim director from May of 2017 to March of 2018.

HOWARD: So you remember working on the 2016 fiscal note for this bill.

THOMAS "ROCKY" THOMPSON: Senator Schumacher's bill, yes, ma-am.

HOWARD: Senator Schumacher's bill. Because-- so I was just looking at it. And the 2008 study was used by the department that year. Is there any reason why we're not using it this year?

THOMAS "ROCKY" THOMPSON: Again, Madam Chair, that study is 11 years old. That program has changed since then. Most notably, it's a different type of option. It's not a waiver option; it's a state plan option.

HOWARD: Oh. Well, no. At the time it was still submitted as a state plan [INAUDIBLE].

THOMAS "ROCKY" THOMPSON: But the study, senator, was for a waiver option.

HOWARD: It was for a waiver. Was it for similar services?

THOMAS "ROCKY" THOMPSON: It was for services, family planning services just for women. That was what Medicaid could offer under an expanded benefits package in 2008.

HOWARD: OK. I guess my confusion comes because I've got four, four fiscal notes--nope, five. I've got five fiscal notes here, and each one shows a savings but this year. And so I'm just wondering why there's, why, why previous Medicaid directors and why previous agency heads had looked at the specific state plan amendment and found a cost savings. But then this year we didn't. Has there been sort of a change in the way that we look at the program as a whole? Or, or has there been some modification to the state plan amendment?

THOMAS "ROCKY" THOMPSON: I think, Madam Chair, you can anticipate costs, but anticipating savings based upon behaviors of individuals, that's very difficult to quantify.

HOWARD: Well-- well, yes, but you've done it before.

THOMAS "ROCKY" THOMPSON: Well, Senator, this is a different bill, as was explained before. It's a different program; it's a state plan option.

HOWARD: My understanding is that it's only different because it doesn't have Every Woman Matters in it.

THOMAS "ROCKY" THOMPSON: From Senator Schumacher's bill, yes. Yes, Senator.

HOWARD: But Senator Schumacher's bill still showed a savings.

THOMAS "ROCKY" THOMPSON: I would have to review the previous fiscal note before I can answer any other differences.

HOWARD: OK. I, my-- forgive me. I thought you had worked on the previous fiscal note before. How difficult is it, just in terms of timing for your office, to submit a state plan amendment?

THOMAS "ROCKY" THOMPSON: Senator, I would have to check and see what the state plan amendment looks like. Many of the state plan amendments with the ACA, regarding eligibility, that they are in a system with-- you know, there's prefilled Adobe documents and such like that-- some of them get more extensive. You know, the one [INAUDIBLE] in Medicaid expansion, there's not just one state plan in it; there's three buckets of state plan amendments, and one of them is very extensive.

So I'd have to look at this option and what we would have to do to file that.

HOWARD: Why are there three buckets of state plan amendments? I'm so sorry; I just don't know.

THOMAS "ROCKY" THOMPSON: Well, that's the guidance that has come from CMS. There's three different buckets and three different systems. There's one bucket regarding the fiscal, the fiscal cost. There's one bucket regarding the benefits because we have to tie the benefits to essential health benefits in the ACA and have a benchmark plan. And there is one bucket for just the eligibility category, adding that eligibility category.

HOWARD: So would the state plan amendment have those same requirements? Or is that just for expansion?

THOMAS "ROCKY" THOMPSON: I'm not sure, Senator.

HOWARD: OK. And then when we think about making modifications to our eligibility-- because we've had this conversation before, probably on this bill. I, I'd like to, I'd like to really understand how, how long it takes to make modifications to our Medicaid program, whether it's something that's, that's very specific to services or whether it's something very specific to eligibility. So say, for instance, we were to pass this bill, how long would it take you to implement it?

THOMAS "ROCKY" THOMPSON: I believe, Senator, the implementation date we used for the fiscal note was July of 2020.

HOWARD: OK. So, so presumably we would pass it and it would go into effect July 1 of this year. And then you'd be able to implement it July 1 of next year.

THOMAS "ROCKY" THOMPSON: I believe so, Senator. And again, it's filing a state plan amendment. To get a state plan approved, you have the information technology changes, you have the changes with our capitation rates, all those factors.

HOWARD: Absolutely. Thank you. Are there any other questions? Seeing none, thank you for your testimony today.

THOMAS "ROCKY" THOMPSON: Thank you, Madam Chair. Thank you, members.

HOWARD: Our next opponent testifier. Seeing no one wishing to speak in opposition, we do have some letters in opposition: Donn and Judith Williamson, representing themselves; Ron and Lynette Nash, representing themselves; and Nate Grasz, from the Nebraska Family Alliance. Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Wishart, you are welcome to close.

WISHART: OK. Since I'm all that exists between you and the weekend, I'll be quick. I just wanted to talk with Senator Hansen really quickly, to answer your question. Because if there was an issue associated with family planning service, that issue would be covered, since it would still be considered family planning services. So if something happened to somebody, say they, they, like you said with the HPV vaccination that they received at the family planning clinic, and then they had a problem associated with that, it would be supported and it would be covered under this program.

B. HANSEN: OK.

WISHART: So I wanted to be clear with that. And then I just wanted to quickly say that, you know, I heard the opposition. I'm going to try to get to the studies that they referenced because I'm not familiar with those. But I will say that, I mean, the essence of this bill is to allow somebody who's lower income to have access to the best form of healthcare. So if there are concerns with certain forms of birth control, this gives somebody who's lower income, who may not be able to afford a more expensive, effective form, access to that. And then it also allows them to interface with it, which is very important with a healthcare provider. So with that, I'm happy to answer any additional questions.

HOWARD: Are there any final questions? Senator Hansen.

B. HANSEN: I'm not going to nitpick here--

WISHART: Yeah.

B. HANSEN: --a little bit. But I'm going to. Some of those same questions I asked someone earlier about a little more of the specifics about what the family planning methods are, and it's mainly, especially like the drug part.

WISHART: Yeah.

B. HANSEN: Do you know what that all entails? Because I'm thinking like, I'm assuming it entails contraceptive methods.

WISHART: Yes.

B. HANSEN: But then would that include anything else that you know of, like for instance, like a, maybe like a plan B pill or a-- something, something along that methods, because that's still technically a natural family method, planning method, but it's a drug, too, so that--

WISHART: Yeah.

B. HANSEN: Would it include anything like that?

WISHART: I don't know, specific to plan B, but, Senator, I will get you a list of, an extensive list of what--

B. HANSEN: It's probably an FDA thing and--

WISHART: --that would, what that would include, yeah.

B. HANSEN: [INAUDIBLE], right?

WISHART: But when I look at, when I read drug, I think about like the pill form of birth control.

B. HANSEN: That's what I figured.

WISHART: Yeah.

B. HANSEN: I just want to-- just so I can make a better-- determine about what I'm going to vote for.

WISHART: Yeah, absolutely.

B. HANSEN: And then also, can you also mention, maybe, that study from 2008, because that-- again, that seems like one of the biggest reasons for your cost savings? For $1.00 you save $4.00 in that 2008 study. Do you know what that, were, who did that or what it's about? Or--

WISHART: Yeah. So I believe that study was done by the Journal of Health Care for the Poor and Underserved. You know, I reviewed that study but it was a little while ago when it, when actually-- I was doing research for Senator Kolowski when this bill came up. I can look back at that. And also, I'll really be tasked to, to try to get you

more updated numbers on what we can anticipate with savings because, you know, we talked to folks a lot on birth control today and contraceptives, but this is much broader in terms of the preventative healthcare services provided to women, including prenatal care, which is near and dear to my heart because my husband and I were foster parents. And, you know, the child that we watched was-- belonged to a young, teenage mother and she was low income and really could have had access to prenatal care. And so I think of her when I think about this program. So I anticipate that, with preventative healthcare, the broad spectrum that this bill includes, not just contraceptives, but I anticipate significant savings because it just makes sense. If you prevent an illness from becoming acute and people get good holistic access to healthcare and-- you know, you'll see savings. So I will work to get you an updated idea of what those savings would be.

B. HANSEN: Thanks. This just seems like a core thing with your--

WISHART: Yes.

B. HANSEN: --with your, with the legislative fiscal note, so I'm just trying to--

WISHART: Yeah.

B. HANSEN: --figure that out. All right; thank you.

HOWARD: Any other questions? Seeing none,--

WISHART: [INAUDIBLE].

HOWARD: --thank you, Senator Wishart.

WISHART: Thank you.

HOWARD: This closes the hearing for LB498, and we are done for the day.