**JACOBSON:** All right. I think we'll go ahead and call the-- start the hearing. Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Mike Jacobson. I'm the Vice Chair of the committee. I'm from District 42, Lincoln, McPherson. Logan, Hooker, Perkins, and McPherson County. The committee will take up bills in the order posted. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. Committee members will come and go during the hearing. We have to introduce bills in other committees and are called away. And every now and then, we have to take care of a baby. It is not an indication that we are not interested in the bills that are being heard in this committee, just part of the process. To better facilitate today's proceedings, I ask that you abide by the following procedures. Please silence or turn off your cell phones. Move to the front row when you're ready to testify. Order of testimony will be introducer, proponents, opponents, neutral, and then the closing. Hand your green sign-in sheet to the clerk-- committee clerk, when you, when you come up to testify. Spell your name for the record before you testify. Be concise. Is my request that you limit your testimony to 3 minutes. If you have not test-- if you're not-- if you're not-- will not be testifying at the microphone but want to go on record as having a position on the bill being heard today, there are gold sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets shall become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testifying-- testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We need 10 copies. If you have written testimony but you not-- do not have 10 copies, please raise your hand now so that the page can make copies for you. To, to my-- well, our committee Chair is not-- or our committee counsel is not here. But I will note that, to the end of the table over here, is Natalie Schunk, who's the committee clerk. The committee members with us today will introduce themselves, beginning at my far-- actually, I'm going to make-- mix it up. At my far right, start over here.

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

**AGUILAR:** And I'm Ray Aguilar, District 35, Grand Island.

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

**BOSTAR:** Eliot Bostar, District 29.

**JACOBSON:** Our pages today are Maddie [PHONETIC] and, and Mia. Mia will come in later. The committee will take up bills today in the following order. And we'll start with LB1307, Senator von Gillern.

**von GILLERN:** Thank you. Good afternoon, Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Brad von Gillern, B-r-a-d v-o-n G-i-l-l-e-r-n. I'm here to present today on LB1307. LB1307 establishes a process with the Nebraska Department of Insurance to manage health insurer claims and payments resulting from benefit mandates passed by us, the Legislature. If we, the Legislature, pass a health insurance benefit mandate that exceeds the essential health benefits benchmark, the state must pay for the cost of that mandated benefit for all health insurance plans sold through the Federal Insurance Exchange. This has been the case since the Affordable Care Act, or Obamacare, was passed in 2010, and does not apply to any small or large group insurance plans, nor self-funded group health plans. Other testifiers who follow me can explain the actual process for a claim from insurance companies that would flow through under LB1307. But, again, the point I want to make is that we already have an obligation as a state to pay for health insurance mandates today, and LB1307 does not change that obligation or add any new obligation. It's my understanding that the current list of potential state mandates that exceed federal requirements is very limited. If we, as a Legislature, add new mandates, the potential for claims from health insurance companies to defray the cost of those mandates increases. While LB1307 does not create a fiscal impact to the state budget, any new state insurance mandates passed by the Legislature will have a fiscal impact to the General Fund. You can see that reflected in the fiscal notes for some of the other bills we'll be hearing today in committee. It makes sense to establish this process for the state to manage these claims utilizing the expertise at the Department of Insurance. There will be testifiers behind me who will give you more details about the federal requirements and the process established by this bill. I'd be happy to answer any questions that-- as I am able. Thank you.

**JACOBSON:** Questions from the committee? All right. Seeing none, thank you, Senator.

**von GILLERN:** Thank you.

**JACOBSON:** I trust you'll stay for the close? I now ask for any proponents.

**ROBERT M. BELL:** Vice Chairman Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell, last name is spelled B-e-l-l. I am executive director and registered lobbyist for the Nebraska Insurance Federation, and I am appearing today in support of LB1307. I'd like to take a moment to publicly thank Senator von Gillern for introducing LB1307 on the Federation's behalf. Thank you. As you know, the Nebraska Insurance Federation is the state trade association of insurance-- Nebraska insurance companies, including many of the health plans operating in the state of Nebraska, such as Blue Cross Blue Shield of Nebraska, Medica, CVS Health, Aetna, Centene, Nebraska Total Care, Cigna, and the UnitedHealth Group. The federal Patient Protection and Affordable Care Act, also known as the ACA, was the landmark federal legislation in the health insurance space this century. Aman-- among the extremely numerous changes the ACA made to the law was the elimination of underwriting in the establishment of a minimum essential health benefits by the states. As a trade-off, the ACA also contained a provision that if a state added a mandate after an establishment of the essential health benefit benchmark, the state, not the premium payers, would be responsible for any additional costs to certain ACA exchange plans. The actual statutory language is defray the cost of any additional benefits. Unfortunately, the state of Nebraska does not have-- currently have a process for the insurers to recuperate the costs of the mandates that go beyond this essential health benchmark. Instead, should an insurer seek reimbursement from the state of Nebraska, it would need to file a claim, which would go through the state claim process, possibly lead to litigation, and other additional expenses for all those involved. LB1307 would instead institute a more orderly process that places some requirements on the Department of Insurance to identify and appropriately and actuarially quantify the mandate, and then seek the appropriation from the Legislature to reimburse the health plans who have incurred the costs. Since the state of Nebraska selected the ACA essential health benefit benchmark over a decade ago, the Legislature has been careful in adopting additional benefits, and only a couple of such mandates that go beyond the benchmark exist. And it is the belief of the insurers that the cost of these current mandated benefits have been very limited. However, future actions of the Legislature, of course, remain unknown, and the provisions of LB1307 provide a pathway for the state of Nebraska to fulfill its potential obligations to the premium payers of the state. The Nebraska Insurance Federation

supports the passage of LB1307, and I appreciate the opportunity to testify.

**JACOBSON:** Thank you, Mr. Bell. Questions? Senator Bostar.

**BOSTAR:** Thank you, Vice Chair. Mr. Bell, how are you?

**ROBERT M. BELL:** I'm good. Senator, how are you?

**BOSTAR:** I'm fantastic. So the appropriation the state would make would go to who?

**ROBERT M. BELL:** In-- under the bill?

**BOSTAR:** Yes.

**ROBERT M. BELL:** Under the bill, it establishes a process. So the department would make a, a budget request in its, in its budget submittal to the Governor and eventually the Legislature. And the bill sets up a fund that the appropriation would go to, and then that fund would be used to pay. So you would fund the fund with general funds, theoretically. And then that, that fund would be used to pay the health plans.

**BOSTAR:** And the fund would be housed in the Department of Insurance?

**ROBERT M. BELL:** It would.

**BOSTAR:** So if we passed LB1307, a insurance mandate would then come with an A bill that would direct the general funds to the fund within the Department of Insurance? Is that how that would work?

**ROBERT M. BELL:** I think that's-- I think that's possible. I'm sorry. I'm trying to think through the mechanics of both the state budgetary process and in the bill. There would be a, a bit of a lapse-- of, of-- a time lapse. And so, because the benefit would need to go into effect, there would need to be a cost. The department would seek that information from health insurers as to what that cost actually was, and then they would put that request in their budget. So whether or not an A bill would accompany the mandate, I don't know, or if that would come a little bit later in the state budgetary process, if that makes sense.

**BOSTAR:** It sounds like it would be a very interesting process.

**ROBERT M. BELL:** Oh, yes.

**BOSTAR:** Since we would have to wait for the mandate to take effect to realize the costs and therefore, reimburse them from general funds. So that, that-- I mean, that could be real time here. So, OK. Thank you.

**ROBERT M. BELL:** Now, if I'm, if I'm incorrect on, on the [INAUDIBLE], I'm sure my-- the people behind me will correct me, by the way. So.

**BOSTAR:** What-- do you have the historical information of what the insurance plans have put in through the state claims process that you referenced already? So the ACA was passed in 2010?

**ROBERT M. BELL:** Correct.

**BOSTAR:** So, 14 years ago. So for the last 14 years, what have the insurance providers submitted to the state for state claims, in order to recapture revenues that they've lost or in relation to mandates that have been passed by the Legislature?

**ROBERT M. BELL:** Yeah. I know it's-- they have not put in any claims.

**BOSTAR:** They haven't put in any claims?

**ROBERT M. BELL:** Correct.

**BOSTAR:** Well that's interesting.

**ROBERT M. BELL:** Right.

**BOSTAR:** Why is this necessary?

**ROBERT M. BELL:** Well, I don't know what the Legislature might pass in the future. And a couple of things. One, the one mandate that has been in effect for an extended amount of time is a requirement related to hearing aids for children. That went beyond the essential health benefits. But the way that mandate was crafted, the actual effect of it on the premium payers themselves was, was pro-- it's probably quite small. And so, whether or not an insurer would go through the lengthy process of filing a claim with the state of Nebraska to recoup small amounts of money, I, I don't know. The other mandate, of course, is your bill from last year, related to breast cancer screening. And we don't know the impact of that 100% just yet, but we expect it to be very small.

**BOSTAR:** So let's, let's take the hearing aid bill, for example--

**ROBERT M. BELL:** Sure.

**BOSTAR:** --because that's been in existence for longer. So that legislation-- I wasn't here when that legislation passed. But my understanding is that legislation required the coverage of hearing aids for children who are deaf or hard of hearing. Is that--

**ROBERT M. BELL:** Yeah. It's, it's more nuanced than that. It's the replacement of, I believe, the hearing aids, and the certain frequency of the ask for the replacement, and with certain cost-sharing aspects of, of the law are in play, as well.

**BOSTAR:** Understood. Thank you. The-- so that legislation, a mandate--

**ROBERT M. BELL:** Um-hum.

**BOSTAR:** --did not result in enough cost for the insurance companies to deem it worth it to put in a claim?

**ROBERT M. BELL:** Yeah, that's my understanding.

**BOSTAR:** Did you or your organization support or oppose that legislation?

**ROBERT M. BELL:** I believe I opposed that.

**BOSTAR:** Why did the Insurance Federation oppose the legislation when it would create such a minor cost that the insurance industry itself wouldn't seek to recoup their costs through a claim?

**ROBERT M. BELL:** In general, we oppose health insurance mandates. So.

**BOSTAR:** Just for fun.

**ROBERT M. BELL:** It's a principle. The market-- you know, we believe that the market would take care of, of the situation in-- for a lot of these mandates, that, that we see-- that we're going to see later today, that we have seen throughout the years. You know, sometimes the Legislature disagrees. So-- and in that case, it did.

**BOSTAR:** Thank you very much.

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

**JACOBSON:** Other questions from the committee? I just have one, and I--

**ROBERT M. BELL:** Sure.

**JACOBSON:** I see Director Dunning's going to speak. I'm assuming he's going to testify, so I-- that may be a, a question he can answer better. But, I guess, just to follow up a little bit on whether there's an A bill or not. As I understand this, this is a reimbursement of, of actual costs that would be determined from the department doing some actuarial review to see if that cost is justified.

**ROBERT M. BELL:** Correct.

**JACOBSON:** So it would be a bill coming afterwards, and it would not necessarily be the Fiscal Office doing an estimate, other than the question of in any future mandates, would we put some money into the fund expecting that there will be ultimately a claim that would be determined by the Department of Insurance as to whether or not it should be paid or not, is my guess, I don't know. Is that [INAUDIBLE]--

**ROBERT M. BELL:** That's my understanding. So if, if I'm, I'm--

**JACOBSON:** [INAUDIBLE].

**ROBERT M. BELL:** --I feel like you're previewing a question for the Director of Insurance.

**JACOBSON:** I kind of am, yes. Thank you. Any other questions? Yes, Senator Bostar.

**BOSTAR:** Thank you, Mr. Vice Chair. One last thing. So, Mr. Bell, if, if we were to pass LB1307--

**ROBERT M. BELL:** Yeah.

**BOSTAR:** --and ultimately, then, have the reimbursements for mandates, would the Federation stop opposing mandates in the Legislature?

**ROBERT M. BELL:** Oh, I, I doubt it. So.

**BOSTAR:** Why?

**ROBERT M. BELL:** Again, we have a general opposition to health insurance mandates that go beyond the central health benchmarks.

**BOSTAR:** The case being made for this bill is about dollars and cents for premium payers.

**ROBERT M. BELL:** It actually makes it easier to not, you know, oppose the mandate. It was a double negative. So, I don't know. I guess if the bill passes we would have to see, so.

**BOSTAR:** Thank you very much.

**JACOBSON:** All right. Thank you Mr. Bell.

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

**JACOBSON:** Further proponents? Director Dunning.

**ERIC DUNNING:** Vice Chair Jacobson, members of the Banking, Commerce and Insurance Committee, my name is Eric Dunning. For the record, that's spelled E-r-i-c D-u-n-n-i-n-g. I'm the Director of Insurance, and I'm here today to testify in support of LB1307. As Mr. Bell indicated, under the ACA and subsequent regulations, anytime the state passes a mandate that mandates a new health insurance benefit that wasn't in existence prior to December 31, 2011, the state must make payments to an impacted individual or to the insurer to defray the cost of additional benefits, limited though, again, to the coverage provided through the federal exchange. Right. So not all of the place-- not all of the areas in which the state of Nebraska has jurisdiction to impose mandates get reimbursed, just that, that one narrow part. Again, Nebraska's passed a very limited handful of new mandates. And that-- but I can confirm that we have not been asked, to date, for reimbursement under federal law. Now, as is their right, under federal law, we believe that the insurers will be, in future, asking for reimbursement of their costs to provide for new benefits that arise, that, that have a cost greater than what we saw, for example, under the, the hearing aid mandate. However, since there's not a clear-- there's not a clear mechanism under state law that allows for the collection of both the actual costs of each mandate and for the distribution of the money owed back to the insurers. This bill would allow for the department to obtain that information and then review it with the existence-- the assistance of our actuaries, to determine how much money is owed back to the insurers on a statewide average. Bill also creates a mechanism that allows us to evaluate that amount. So further, under Section 1(c), those amounts cannot be paid without appropriation by the Legislature, so you would get a second review of those amounts. The bill does not create the right to

payment. That's created under federal law. Without the bill, the insurers still have the-- are still entitled to the money. Not passing the bill doesn't mean they won't get paid, it just makes that process messier. It merely sets out-- this bill merely sets out an orderly process for meeting those requirements under federal law. We believe that the method proposed in LB1307 is a reasonable and federally compliant way to do all of that. Thank you for your consideration of LB1307. I'd be happy to take any questions.

**JACOBSON:** Thank you, Director Dunning. Questions from the committee? All right. Seeing none, thank you for your testimony.

**ERIC DUNNING:** Wow. After that set up, I really expected something.

**JACOBSON:** Wow. We're going soft, Director.

**JEREMIAH BLAKE:** Good afternoon, Vice Chairman, members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B as in boy, l-a-k-e. I'm a government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in support of LB1307. And I also want to thank Senator von Gillern for introducing this bill. So Blue Cross offers health insurance policies through the government's ACA exchange to all Nebraskans in all 93 counties. We reentered the market in 2023. So without repeating kind of what's already been discussed, the issue is how do we file these claims in the future? One of the option-- options suggested in the fiscal note from LFO is to file a claim through the State Claims Board, but the statutes governing the State Claims Board did not contemplate this issue. Health insurers would likely file a miscellaneous claim based on their independent claims costs, but it's not clear how the board would process such a claim or if the Department of Administrative Services has the expertise, such as an actuary, to adequately, adequately review the claims. LB1307, which is modeled after the law that was adopted in Utah, will establish a process to identify state mandates, accept claims from health insurers, and provide legislative oversight of those claims for defrayal. As the director and others of the-- discussed, the Department has the knowledge to identify these state-mandated benefits and the expertise to review and aggregate claims data. And the final step in this process, of course, is that it would allow the Legislature to provide oversight, as well. Again, this bill is targeted to the individual health insurance policies sold through the federal exchange. To give you some frame of reference, approximately 117,000 Nebraskans purchased coverage through the exchange in 2024.

This bill does not require the state to defray the costs of benefit mandates for employer groups, whether insured or self-funded. This, this bill will not only establish a process in response to a federal require-- federal requirement, but also help lower claims costs for the 117,000 Nebraskans who purchased health insurance on the exchange. Again, I want to appreciate-- extend my appreciation to Senator von Gillern for introducing this bill. And I'm happy to answer any questions you have.

**JACOBSON:** Thank you, Mr. Blake. Questions? Senator Bostar.

**BOSTAR:** Thank you, Vice Chair Jacobson. Mr. Blake, how are you today?

**JEREMIAH BLAKE:** I'm well. Thank you, Senator.

**BOSTAR:** OK. You mentioned that the State Claims Board doesn't have an actuary, so that could lead to a complication with going that route. What I'm trying to understand is why would an actuary be necessary if the claims that are being sought are actual costs incurred by the insurer?

**JEREMIAH BLAKE:** So the way I envision this process, and maybe I'm not the expert that should be answering this question, but the, the way I envision this process is that, at the end of a plan year, say, at the end of 2023, after claims run out into 2024, at some point, we as the insurer are going to have enough data to say, OK, this is for the exchange market. This is what we spent on claims for this mandate.

**BOSTAR:** OK.

**JEREMIAH BLAKE:** We're going to submit that information to the Department of Insurance. And the Department of Insurance is going to say, OK, this code, which is adjacent to this specific service, say colorectal cancer screening, right? There's multiple things that happen in colorectal cancer screening.

**BOSTAR:** As we've been learning.

**JEREMIAH BLAKE:** Yeah. Yeah. Absolutely. So you start getting into the nuances of OK, what codes are actually included in this mandate; what are not included. Different insurers can take different perspectives on what that policy is, so the department would be able to sort through that. The other thing you have to consider is that what Blue Cross may reimburse for those codes is different than what a different insurer may reimburse.

**BOSTAR:** Where does an actuary come into this?

**JEREMIAH BLAKE:** And so you have to take-- what's that?

**BOSTAR:** Where does an actuary come into this?

**JEREMIAH BLAKE:** So an actuary is going to be able to sort through all of that data in order to make, you know, a recommendation as to what the, the actual impact is to the state or what its obligation is.

**BOSTAR:** I guess I was-- I guess I'm misunderstanding then, what an actuary does. My understanding is that it's almost in a way, forecast-looking, right. It's there to take historical data and make projections on anticipated costs for certain things, rather than looking at and trying to audit actual costs previously incurred. OK. But we can, we can leave that aside.

**JEREMIAH BLAKE:** OK.

**BOSTAR:** The Insurance Federation, it seemed from Mr. Bell's testimony and the insistence that mandates even under this, where full reimbursement would be provided by the state, they would still oppose any mandates, it seemed to imply that the resistance in mandates is purely ideological and not necessarily rooted in any sort of economic or cost basis to premium payers. Is that also the position of Blue Cross Blue Shield?

**JEREMIAH BLAKE:** So insurance mandates have-- well, it depends upon how the insurance mandate is structured. Right. So there are different flavors of insurance mandate. The Legislature, in theory, could write an insurance mandate to say, on the individual exchange, this benefit shall be required. Under that situation, the state would pick up the cost, and I'm not sure we would have a position on that. There are other mandates in many of the bills we'll consider today that apply to the individual exchange market, as well as the, the insured group market. Right. So those are your Nebraska employers, and those are many of our customers. Right. And so, again, in the interests of keeping claims down and rates down for them, I think we would continue to oppose many mandates.

**BOSTAR:** But a mandate that was reimbursed by the state and didn't hit your members, would you then going forward, not oppose those?

**JEREMIAH BLAKE:** If a state mandate applied to the exchange market only and again, there was a structure in place for the state to reimburse protocols

**BOSTAR:** Let's say LB1307.

**JEREMIAH BLAKE:** OK. I'm not sure why we would take a position on that issue.

**BOSTAR:** Thank you very much.

**JACOBSON:** Other questions? Senator Ballard.

**BALLARD:** Thank you, Vice Chair. Thank you for being here, Mr. Blake.

**JEREMIAH BLAKE:** Yes.

**BALLARD:** Good seeing you. I know this question might require you to have a crystal ball, I realize that, but most of your opposition comes in on mandates that will increase premiums--

**JEREMIAH BLAKE:** Um-hum.

**BOSTAR:** --which I appreciate, as well. If we pass LB1307, do you believe that Nebraskans will rest assured that premiums will, will not go up beyond the normal cost of doing business?

**JEREMIAH BLAKE:** No. I can't give you that insure-- assurance at all. Again, there's a lot that goes into rates, right? What we negotiate for reimbursement rates with hospitals, the cost of prescription drugs, there are many, many factors that go into what an insurer pays for coverage. So if, if, if, if this process is put in place and the state begins to reimburse for the cost of the actual mandate, that's just one small piece of the larger formula that goes into determining what a premium rate is.

**BALLARD:** OK. I, I just asked the question because you-- we talked about premiums and mandates. I, I look at it like a, like a teeter totter.

**JEREMIAH BLAKE:** Yep.

**BALLARD:** Like, the more mandates, the more premiums--.

**JEREMIAH BLAKE:** Yep.

**BALLARD:** --and vice versa. So I'm just trying to figure out what is that formula or equation that goes into increased premiums. So I appreciate you being here.

**JEREMIAH BLAKE:** Yeah.

**JACOBSON:** Further questions? Senator Bostar.

**BOSTAR:** Thank you, Vice Chair Jacobson. Thank you, Mr. Blake. Just to sort of follow up on Senator Ballard's line of questioning. Over the last 10 years--

**JEREMIAH BLAKE:** Um-hum.

**BOSTAR:** --how, as a percentage in general, if you can estimate without an actuary--

**JEREMIAH BLAKE:** Um-hum.

**BOSTAR:** --how much you think premiums have increased.

**JEREMIAH BLAKE:** Actually, on the next bill, I think, in my testimony, since 2018, the average employer-sponsored plan has increased 22%, I believe, was the number.

**BOSTAR:** And the mandates that we've passed, have resulted in such minor costs that the insurance carriers haven't even seemed to ask for that money from the state. Is that correct?

**JEREMIAH BLAKE:** I can't speak for other health insurers. I can tell you that Blue Cross reentered the market in 2023, so we're still closing that plan year out and analyzing that data.

**BOSTAR:** Thank you very much.

**JEREMIAH BLAKE:** You bet.

**JACOBSON:** I, I do have one question if no one else does, from the committee. Just to kind of clarify a couple of points, and, and I think you did a good job of really laying it out. And you made Senator Bostar's-- or Senator von Gillern's close earlier, but-- easier for him. But, as I understand it, when you're-- and, and I think the people need to understand that if you're not in the ACA, if you're not, not offering policies in ACA, you're really unaffected by, by this, by this reimbursement issue, because this is really those ACA

policies. And you said what, 117,000 Nebraskans are on it, but Blue Cross primarily, they got back in the ACA business. But you do a lot of Veba plans, employer sponsored plans, and those plans really aren't affected by this. In other words, if we-- if, if the state passes a mandate, that that's going to be passed on to those employer groups, regardless.

**JEREMIAH BLAKE:** That's correct.

**JACOBSON:** And you don't get any reimbursement. They suck it up. They pay those costs.

**JEREMIAH BLAKE:** That's correct.

**JACOBSON:** So that's where you're likely going to continue to oppose mandates because it's going to impact those employer groups, even though you get reimbursed under the ACA policies. Is that pretty much the case?

**JEREMIAH BLAKE:** That's fair.

**JACOBSON:** Did I miss anything there?

**JEREMIAH BLAKE:** No. That was very accurate.

**JACOBSON:** All right. OK. I don't have anything else unless somebody else does. Thank you, Mr. Blake, for your testimony. Further proponents? OK. Seeing none, I'll open it up to opponents. Anyone wishing to testify in opposition to the bill? Any opponents? All right. If not, anyone wishing to speak in a neutral capacity? If not, Senator von Gillern, it's all yours. Hopefully, I didn't do your close for you.

**von GILLERN:** You kind of did, kind of really, kind of stole my thunder there. Thank you. That's OK. As long as we're all on the same page, that's what matters. So the, the goal of the bill here, what enticed me to, to carry this forward is, to me, it's a, it's a red flare that gets fired up when we're talking about passing additional mandates. Because-- it's, it's easy to pass mandates when we, when we know somebody else is going to pay for it. When we, when we see that the state might be on the hook, we might think about it a little bit harder. And that's just human nature. We're, we're-- it's, it's always easier to think about something when, when another person is paying for it. And that is the beauty of, of group health plans and that's what makes them work, is the costs are shared amongst large numbers of

people. So that, that is also what makes it work. So, so that-- that's what really enticed me to, to carry the bill. The, the fiscal note is interesting. In fact, the, the term-- and Senator Bostar, you made my job easier, too, because you find-- you said the word auditor, and I had made a note. Where it says actuarial staff, I actually think it probably should say auditing staff. But in the fiscal note, it says the department's actuarial staff will review these claims and the director shall request the necessary appropriations to pay the cost to the insurer, and that's absolutely more of an auditing task than it is a actuarial role. An actuarial would certainly be doing forecasting, not, not auditing of actual records. And then, again, Senator Jacobson, you really made, made my close easy because, again, pointing out that these are only ACA claims, that's a small portion of all the insureds in Nebraska. And therefore, led to-- I believe, has led to the fact that most of these claims have not been-- re-- reimbursement has not been requested for that yet. So, with that, I'd be happy to take any other questions.

**JACOBSON:** Any questions for Senator von Gillern? I would note that there were no letters submitted on LB1307. So if there's nothing else, we'll close the hearing on LB1307. And we'll move--

**von GILLERN:** Thank you.

**JACOBSON:** --LB1274, Senator Cavanaugh. Welcome.

**J. CAVANAUGH:** Good afternoon, Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Senator John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h, and I represent the 9th Legislative District in midtown Omaha. I'm here to introduce LB1274, which would provide for insurance coverage of prosthetics and orthotic devices equivalent to what is covered under Medicare. I brought this bill after meeting with a provider in my district who advocates for those with the loss or absence of a limb. Prosthetics and orthotics are important everyday tool to allow for movement and independence, but are expensive and they're not always covered by insurance. LB1274 seeks to address this by requiring that coverage of prosthetics and orthotics shall, at a minimum, require coverage equal to the coverage provided under Medicare as of January 1, 2024. Those behind me will be able to speak more specifically about the need and importance of covering prosthetics and orthotics. I thank the committee for your time and consideration of this bill. And I'd be happy to take any questions that I might be able to answer.

**JACOBSON:** Any questions for Senator Cavanaugh from the committee? All right. Seeing none, thank you. And I'll turn this back to our Chair.

**SLAMA:** Thank you. You're too kind. Thank you, Senator Cavanaugh and Senator Jacobson. With that, we'll open proponent testimony on LB1274. Welcome.

**VINCENT LAU:** Good afternoon-- is it Chair Slama?

**SLAMA:** Slama.

**VINCENT LAU:** Slama? Thank you.

**SLAMA:** No worries.

**VINCENT LAU:** --and Banking, Commerce and Insurance Committee members. My name is Vincent Lao, V-i-n-c-e-n-t, and last name is L-a-u. I'm a certified prosthetist-orthotist who practices in Omaha, Nebraska. I've been a clinician for 8 years with 5 of those years here in my home state of Nebraska. I also serve as Nebraska lead advocate for the American Orthotic and Prosthetic Association, or AOPA. AOPA was founded in 1917 as the largest nonprofit organization, consisting of more than 2,000 patient care facilities and suppliers that design, manufacture, distribute, fabricate, fit, and care for patients using orthoses and prostheses. I'm here before you today on behalf of my profession and those we treat, in support of LB1274, a bill that will ensure state regulated commercial health plans cover orthotic and prosthetic care at an equivalent or better level than Medicare's current policy. The policy is commonly referred to as the Insurance Fairness Act, and has already been enacted in 21 states in the U.S., including some of our neighboring states such as Iowa, Missouri, Arkansas, Illinois, Indiana, Colorado, and Utah. Around 30,000 Nebraskans live with limb loss, limb difference, or a condition where they benefit from use of a prosthetic or orthotic device. This population is dependent on quality, timely O&P care to maintain independence, stay active in the workforce, and be involved in their communities. Unfortunately, the quality of life for these people is often determined by the insurance coverage available to them. I have many clients who are successfully employed in active roles such as farming, welding, manufacturing, sales, and education. They serve in their community by volunteering, fundraising, and caring for others. These people go dancing with friends, attend church, and even enjoy sports while using their devices. Many are involved in care for children or grandchildren, and plenty of our clients are children

themselves. However, I also have clients who are denied medically necessary mobility devices by their insurance, therefore limiting their activities or preventing them altogether. These are fellow human beings that I treat every day. I want to help them, but I'm often limited by short-sighted insurance policies. LB1274 would create parity for coverage for orthotic and prosthetic devices, raising the floor on quality of life for this population. Furthermore, LB1274 will ensure long-term viability of the O&P profession in Nebraska. As a field, O&P care is reimbursed in a lump sum upon fitting and delivery of a client's device. This payment covers all appointments, administrative and technical time, and materials used in the device. If an insurance company needs coverage of a patient's medically necessary device as prescribed by their physician, the clinic's time involved in the evaluation, casting, and administrative tasks go unrecouped. If a device is delivered without insurance coverage, the cost of care is either passed to the patient or the clinic takes a financial loss, an undesirable situation in either case. The combination of unbilled time or waived fees threatens the financial stability of O&P providers, many of which are privately owned small businesses. Even the closing of a single O&P clinic, as recently seen in Omaha, significantly impacts a large client population, leaving many searching for a provider they feel they can trust with their prosthetic and orthotic care. The effect is more drastic in the rural Nebraska communities, where a lack of nearby O&P care requires longer travel times for routine care. By aligning state-regulated, commercial health plans with Medicare, we can keep providers and their clients healthy in the long-term. For the sake of those using orthotic and prosthetic devices, their family members, communities, and the providers that serve them, I strongly urge the committee to vote in support of LB1274 and make Nebraska the 22nd state to adopt insurance fairness to create equitable care for those living with limb loss, limb difference, and mobility impairment. I believe that every Nebraskan should have equal access to the good life that we enjoy here, don't you? Thank you for your consideration.

**JACOBSON:** Thank you for your testimony. Questions from the committee? OK. Seeing none, thank you.

**VINCENT LAU:** Thank you very much.

**JACOBSON:** Further proponents.

**JAMIE CARNEY:** Hello.

**JACOBSON:** Welcome to the committee.

**JAMIE CARNEY:** Thank you. My name is Jamie Carney. Our Jamie cat car, anyway. Jamie from my first name. It's my first time doing this. I'm a little bit nervous. But I suppose I'm--

**JACOBSON:** Take a deep breath. You'll do fine.

**JAMIE CARNEY:** Thank you. I suppose I'm representing people with, with limb difference. And I'd like to-- first, to say thanks for having me. I've been using a prosthetic leg since I was a year old. Growing up in Ireland, I never had to worry about my prosthesis being covered by insurance. In the last couple of years, I've moved to Nebraska, and I married that beautiful Nebraska lady, and we're expecting our first child in a couple of weeks. Last year, we started the process of getting a new prosthetic leg. However, I was denied a prosthesis, as my limb difference that was [INAUDIBLE] was not covered as a preexisting condition. As a result, I'm still fighting insurance to get a new leg. Do you think I should be able to live a normal life like most people in this room? Do you think I should be able to play sports with my, with my son? Do you think I should be able to maintain employment, simply by being able to walk? If so, please support this bill. Yeah. Thanks.

**JACOBSON:** Thank you. Questions for the testifier? OK. Seeing none, thank you, Mr. Carney, for your testimony.

**JAMIE CARNEY:** Thank you very much.

**JACOBSON:** Further proponents? Anyone, anyone else wishing to speak in support? OK. Seeing none, we'll move to opponents. Mr. Bell.

**ROBERT M. BELL:** Good afternoon, again, Vice Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm an executive director and registered lobbyist for the Nebraska Insurance Federation, and I am appearing today in opposition to LB1274. As you know, the Nebraska Insurance Federation and the state trade association of Nebraska insurance companies, including many of the health plans operating in the state of Nebraska. LB1274 has 2 provisions. First, it would require health plans to provide coverage for prosthetics and orthotics and the repair or replacement of equipment, equipment at the level that it is at least as equal to the coverage provided by Medicare. This provision would also require

insurance-- the insurance contract to allow for an insurer to use an out-of-network supplier if the plan allows for out-of-network services or other covered benefits. Second, the bill places requirements-- certain requirements on the amount of out-of-pocket sharing a plan can place on a consumer related to these devices, and it restricts the ability of the supplier in the insurer to contract for less than the Medicare fee schedule. The insurers have a number of issues with this proposal, not the least of which is the general apprehension of state mandates. Please note, the prosthetics and orthotics are considered durable medical equipment in the health finance world, and all plans already cover durable medical equipment, though not necessarily at the same levels of coverage required by Medicare. So LB1274 would be an expansion of the essential health benefit benchmark of the ACA and require deferral for additional costs by the state of Nebraska. Additionally, insurers do object to any restriction on their ability to negotiate with health providers or suppliers on reimbursement. The negotiated rates of insurers are one of the major drivers of cost savings for Nebraskans who purchase insurance, and one of the major areas of competition between health insurers, as drafted rates could go higher than Medicare rates, but not lower. This infringes in our ability to negotiate. It could severely impact the savings insurance companies bring to consumers. In summary, the Nebraska Insurance health plans already provide coverage for this equipment, and the provisions of the legislation could increase costs for Nebraskans who pay for health insurance. For these reasons, the Nebraska Insurance Feder-- Insurance Federation respectfully opposes the passage of LB1274. I appreciate the opportunity to testify.

**JACOBSON:** Thank you, Mr. Bell. Questions? Senator Kauth.

**KAUTH:** Thank you, Vice Chair Jacobson. Mr. Bell, so you said the insurance companies already provide coverage.

**ROBERT M. BELL:** Correct.

**KAUTH:** Correct. OK. So-- but sometimes it's less than what the Medicare rates are?

**ROBERT M. BELL:** So there's, there's a couple of provisions going on within-- in this bill. One, it requires coverage at the same level. And then, it talks about the, the, the fee schedule related to that. And right now in state law, we don't have a requirement on that fee schedule, so an insurance company or the people that, that run the networks for the insurance company would, would negotiate that with

the supplier of that durable medical-- piece of durable medical equipment, to come up with an appropriate fee schedule, not necessarily based on Medicare. Maybe based on Medicare, kind of depends on how that negotiation goes, but also, it would require coverage. And that's the first part of the bill, that's equal to Medicare coverage. And if you note in the fiscal note, I think it was the state of Nebraska, pointed out that, you know, while they do provide-- and I can't remember if it's the state of Nebraska or the University of Nebraska, but they provide coverage for this equipment. However, it's at, it's at a different level than-- of Medicare, so there would be impact on that particular plan, presuming that Medicare has a higher level of coverage for these-- this type of equipment.

**KAUTH:** And if it's [INAUDIBLE] to Medicare, if Medicare goes up, then you guys are automatically forced to go up with it.

**ROBERT M. BELL:** Under this? Yeah, yeah,yeah, under this provision. So-- which does get into the whole question of contingent legislation and whatnot. But it, it may, it may go to a date specific in the law. I, I, I don't remember specifically, in the LB, right now.

**KAUTH:** OK. Thank you.

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

**JACOBSON:** Senator von Gillern.

**von GILLERN:** Well, thank you, Vice Chair Jacobson. And thank you, Mr. Bell.

**ROBERT M. BELL:** Yep.

**von GILLERN:** This may be an inappropriate question. I'll let the Vice Chair rule on that. If LB1307 passed would this fiscal note look differently or would this conversation be any different today?

**ROBERT M. BELL:** I don't, I don't actually think so. I, I think the, the defrayal, if I remember right-- yeah. So the last paragraph of the actual fiscal note, the LFO--

**von GILLERN:** Yeah, it talks about defrayal.

**ROBERT M. BELL:** -- talks about the defrayal.

**von GILLERN:** OK.

**ROBERT M. BELL:** And so, I would assume that they would identify that the defrayal is going to be there, and that if the bill would pass as is--

**von GILLERN:** OK.

**ROBERT M. BELL:** --then the Department of Insurance would go into that process, then, that is in LB1307, but it wouldn't specifically change. It would notif-- it would notify the Legislature that this cost would exist.

**von GILLERN:** OK. Thank you. All right. And it wasn't a softball. I honestly was asking. Didn't know the answer.

**ROBERT M. BELL:** Yeah.

**von GILLERN:** Thank you.

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

**JACOBSON:** Further questions? Senator Bostar.

**BOSTAR:** Thank you, Vice Chair. Thank you, Mr. Bell.

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

**BOSTAR:** OK, a, a couple things you talked about. One, I understand that there's coverage, but it seems to me that what we're talking about is having adequate coverage. And while a mandate like this could potentially increase premiums, although I'm certainly not convinced to the extent that the insurance companies will care, since they have yet to care. Isn't there as, as policymakers-- imagine you're doing our job.

**ROBERT M. BELL:** Sure.

**BOSTAR:** We are-- we need to look at the big picture. Right. And so, if we're looking at a society level view, isn't having individuals, having them have the ability to be covered to an extent that they can get the prosthesis that they need in order to be productive in society, isn't there a benefit to, to us? I mean, yes, may-- maybe there is a tiny amount, probably not, but maybe there's a tiny amount of increase in premiums. But if we are improving our workforce, adding productivity, how, how should we be looking at this?

**ROBERT M. BELL:** Well, I think you're getting into an interesting question, particularly on this bill, is what is the current coverage provided by insurance companies versus what is provided by Medicare? And there would need to be some comparing and contrasting of those level of benefits. Presumably, they're trying to bring those benefits up, from what I heard from the proponents. And yeah, I mean, I would-- if, if I had a family member that needed a prosthetic and the insurance company said, no, I mean, I'm getting that phone call, right? And I'm, I'm unleashing all of my inner knowledge of the insurance world onto how to appeal that process, within the insurance company and externally, outside of the insurance company, to make sure. Because that's a determination by the insurance company that's adverse to the, to the consumer. Right. And there's processes that already exist in law to address that. You know, presuming again, that we're talking about a state regulated plan. But yeah. I mean, that's, that's a great question. I mean, yeah. I mean, if, if presumably, the more benefits that are provided by insurance, there could be additional benefits to society as a whole but that comes at a cost. And that cost is going to be paid by the premium payers or in this case, maybe the state of Nebraska if LB1307 passes. if affords some plans, but not all.

**BOSTAR:** So the cost will be borne upon--

**ROBERT M. BELL:** Right.

**BOSTAR:** --Nebraskans. But the benefits can similarly be borne upon Nebraskans. And if the benefits outweigh the costs, then it's an appropriate cost, right? We would be, we would be prudent to take that action in that scenario. And this is where we actually need an actuary. Second question I had, you talked-- and we've talked about this before.

**ROBERT M. BELL:** Sure.

**BOSTAR:** Planned competition.

**ROBERT M. BELL:** Yeah.

**BOSTAR:** Right. And that one plan being able to provide a specific benefit, they can do so in order to appeal to a population that may want to purchase their insurance over a competitor's.

**ROBERT M. BELL:** Absolutely.

**BOSTAR:** I think the problem I have with that, fundamentally, is that a lot of people don't have choice. Right? Their employers dictate-- for, for most Nebraskans, your employer is the one that chooses your insurance for you. So your ability to go and say, well, this carrier or this plan would be able to give me the benefits I need isn't necessarily a choice an individual has.

**ROBERT M. BELL:** So 2 points-- counterpoints, or maybe we're agreeing on, on this.

**BOSTAR:** I think it was agreement.

**ROBERT M. BELL:** One-- what's that?

**BOSTAR:** I think you always agree with me.

**ROBERT M. BELL:** I [INAUDIBLE]. You do have that personality flaw. One, if you're on the ind-- if you have to go buy insurance on the individual exchange, so the, the, the ACA exchanges, you can look at those individual plans and say, is my-- you know, is-- does this have what I want, you know, versus, you know, Ambetter versus Medica versus Blue Cross. But really-- where it really comes into play with competition, with health insurers, is-- you're, you're right. It's not the individual consumer. It's actually the employers. Right. It's sitting down with the employers who have these-- who have this option that they're going to provide to their plans. Or maybe it's an association, you know, you know, an association of banks or something like that. And they sit down. OK. We want this sort of coverage for our employees. That's really where that competition comes into play. And it's very competitive. One note-- I would note that an autism mandate passed a number of years ago, on the treatment of autism. I think they carved out the ACA plans to avoid the defrayal. But at that time that bill was being debated, there was a plan on the exchange, I think it was offered by UnitedHealth Group, that actually offered the coverage that they were seeking. Now, not all plans on the exchange offered it-- but so even in the individual market, there, there are-- there is competition that goes on there. So.

**BOSTAR:** And I understand that it's the employers who are making the decision and--.

**ROBERT M. BELL:** Right.

**BOSTAR:** --choosing which plan to then have effectively imposed upon all of their employees.

**ROBERT M. BELL:** Right.

**BOSTAR:** And the interests of the employer and the employee may not be aligned. Right. I mean, so when we talk about having market competition and market forces, the more we have elements within that free market where individuals don't get to be free actors within the marketplace, the more we're not talking about a free market at all. And that's where I think we come in, in order to set standards and make sure that services are provided that are adequate. Because it's not a real market, because individuals can't do that.

**ROBERT M. BELL:** Oh, man. Now I, I would, I would completely agree. This is not-- we are far, far, far removed from a free market in healthcare finance. You know, we have governmental intervention right and left. There are tax consequences for employers to provide health insurance plans, you know, important ones that, that people like. There's all kinds of things. The, the free market does not apply in, in health insurance. But there are still aspects of that, where they do like to compete, or we move into a situation where we have so many government directions that it's, it's Medicaid or Medicare, essentially, for, for everybody, even for those that are under 65, where the government completely dictates everything, including the rates. And-- yeah.

**BOSTAR:** It sounds like for this population, Medicare would be better.

**ROBERT M. BELL:** Perhaps.

**BOSTAR:** Thank you.

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

**JACOBSON:** Other questions from the committee? All right. If not, thank you, Mr. Bell--

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

**JACOBSON:** For your testimony. Further opponents? Mr. Blake, welcome back.

**JEREMIAH BLAKE:** Thank you. It's good to be here. Vice Chair Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B as in boy, l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross Blue Shield of Nebraska, testifying in opposition to LB1274. I'm also

testifying on behalf of the State Chamber of Commerce in, in opposition to this bill. Blue Cross and Blue Shield of Nebraska currently covers prosthetic devices under both our employer group and individual health products. Our opposition to LB1274 is not about covering prosthetics, but about the negative impact health insurance mandates have on consumers overall. As part of my role at Blue Cross, I get the opportunity to attend meetings with our employer clients to give them updates on issues in the Legislature and in Congress. I attend these meetings because our account management teams receive questions on a regular basis from our employer groups about the impact of new mandates on their health plans. While this bill and others we will be discussing today are well-intentioned, they all increase the cost of healthcare. According to a recent study, the average cost of an employer-sponsored health insurance plan was nearly $24,000 in 2023. This is a 22% increase since 2018. Employers are looking us-- looking to us for answers to slow the growth of health insurance premiums and out-of-pocket costs for their employees. On its own, this bill, this bill may not be the, the straw that breaks the camel's back, but it all adds up. The sum of state mandates have the potential to impact the bottom line for Nebraska businesses and families. We believe a better option is to give us the flexibility to work with our employer groups and our partners in the provider community to answer these questions and come up with effective solutions. If we don't provide the right benefits package to our members, employer groups will choose from one of the many other health insurers in the market. As a Nebraska-based insurance company, our competitive advantage is our ability to adjust to the unique needs of our customers, but insurance mandates like LB1274 and similar bills limit our ability to compete. The final point I want to make is that, as we discussed on Senator, Senator von Gillern's bill, state insurance mandates apply only to the fully insured health insurance policies that are regulated by the state Department of Insurance. The large, multi-state employers that provide self-funded coverage to approximately 700,000 Nebraskans under the federal liss-- ERISA law, are not subject to state insurance mandates. Again, I, I certainly understand that Senator Cavanaugh has the, the best of intentions, and I appreciate the gentleman who testified in support of this bill. Again, my opposition to this bill is-- and the other mandates we will discuss today is not a reflection on the importance of these issues, but to the financial impact these bills have on ratepayers. With that, thank you for your time, and I'm happy to answer any questions you have.

**JACOBSON:** Questions from the committee for Mr. Blake? Senator Bostar.

**BOSTAR:** Thank you, Vice Chairman. Mr. Blake, hello. The chamber-- are you representing the Chamber of Commerce, as well?

**JEREMIAH BLAKE:** Correct.

**BOSTAR:** That's unusual. Is there-- is it, is it this bill? Is it a new thing where they're getting more involved in insurance policy? Can you talk to me about what's happening there?

**JEREMIAH BLAKE:** Sure. So the State Chamber has policy on state-mandated benefits, but they oppose state manded-- mandated benefits. So, that's why they are opposed to this bill.

**BOSTAR:** OK. You talked about how mandates would increase the cost of healthcare. And I think I'm with you to an extent, that mandates can increase the-- can increase health premiums, but not necessarily healthcare. Right. The, the right required coverage from an insure-- a health insurance provider, can ultimately serve to improve public health and lower healthcare costs systemwide.

**JEREMIAH BLAKE:** Absolutely.

**BOSTAR:** So it's not just a given that if we do something from the regulatory perspective that we're going to increase healthcare costs. We could be lowering healthcare costs, theoretically.

**JEREMIAH BLAKE:** Is that a question?

**BOSTAR:** It is.

**JEREMIAH BLAKE:** OK. Yeah. Absolutely. Certainly. I mean, we want to, we want to invest in preventative services up front, so that we can, you know, get cancer screening, right. We want to identify issues early, be-- before it comes a real issue. That's not always the case. Right. Sometimes, services are ordered by a treating physician that may not be medically necessary. Then it becomes, you know, an additional cost to the healthcare system.

**BOSTAR:** OK. Thank you very much.

**JEREMIAH BLAKE:** Yeah.

**JACOBSON:** Further questions from the committee? If not, Mr. Blake, thank you for your testimony.

**JEREMIAH BLAKE:** Thank you.

**JACOBSON:** Further opponents? Anyone else wishing to speak in opposition? All right. Seeing none, anyone wishing to speak in the neutral capacity? Any neutral testifiers? If not, as you come up for your close, Senator Cavanaugh, there were 13 letter-- proponent letters and 1 opponent letter received. With that, otherwise, go ahead with your close. Thank you.

**J. CAVANAUGH:** Thank you, Vice Chair Jacobson. And thank you, Chair Slama. So I'll try and be quick. I just want to thank Mr. Lao and Mr. Carney for being here. And I, I do appreciate the comments of Mr. Blake and Mr. Bell. And I did have a chance to speak with them before they testified. And I appreciate the constructive criticisms that were pointed out in their testimony. I think we've got some stuff to work with here, that we can figure out how to move forward. We might not get to exactly where this bill is, but we can certainly find a path to improve the situation for the folks that Mr. Carney and Mr. Lao we're talking about. I just would point out for, I think it was Senator Kauth's question, or at least conversation with Mr. Bell, there is a date in here that says only Medicare as of January 1, 2024. So it would just be what it is currently. And then if it changes and we wanted to change it in the future, we'd have to do that statutorily. So it wouldn't--

**KAUTH:** Thank you.

**J. CAVANAUGH:** --wouldn't open it up to just a-- I'm, I'm-- obviously, I, I think a lot of people around here know, I'm very opposed to us giving up our authority to make these types of decisions and generally oppose bills that do that, so this bill definitely constrains it to just what we're doing right now. And to Senator Bostar's conversation with Mr. Bell and Mr. Blake, I, I think you're exactly right. I think we're talking about an opportunity here to-- we create a mandate that does increase costs. And this bill was proposed in 2009, and the estimated increased costs in 2009 was between 0.036% and point zero-- I'm sorry-- 0.03% and 0.06%, which was a few dollars a month per plan. Obviously, since that time, the ACA has gone into effect. And so those numbers may be a little bit different, in terms of how the cost per insurance plan would be affected by this. But you're right about the fact that we're talking about saving costs in the long run. Appropriate prosthetics have an effect on someone's productivity, their ability to live a full life, but it also has an effect on things like slips and falls, and other injuries that then, insurance is

ending up paying for. It has an effect on ability to exercise appropriately and avoid other healthcare costs that we're talking about, which are things like diabetes and heart disease and things like that. But it also has effect on mental health. Somebody's ability to exercise and somebody's ability to, to play sports with their children and to fully engage in the life that everybody engages with-- everybody else is able to engage in, that has a positive effect on people's mental health. So it has all of these other ancillary positive effects that are harder to quantify on a dollar amount than, than the actual cost of the prosthesis or orthotic itself. So those are the things that this bill is getting at. I-- like I said, I think-- I've had, had an opportunity to talk with the opp-- opposition here today, prior, about some of their concerns. Certainly sit down with them and talk through those and see if there's a way that we can resolve more concerns before we move forward with this bill. So I'm happy to take any questions.

**SLAMA:** Thank you, Senator Cavanaugh and to Senator Jacobson. Are there any questions from the committee? Seeing none, before we close, we did receive 13 proponent letters for the record and 1 opponent letter for the record on LB1274. This brings to a close our hearing on LB1274. We'll now open our hearing on LB1364, Senator McDonnell.

**McDONNELL:** Thank you, Senator Slama, members of the Banking Committee. I see we have a, a new member.

**SLAMA:** We're doing our best today.

**McDONNELL:** My name is Mike McDonnell, M-i-k-e M-c-D-o-n-n-e-l-l. I represent Legislative District 5, south Omaha. LB1364, a vital piece of legislation that seeks to fortify-- fortify our state's position in the national security and cyber defense through strategic public-private partnerships. LB1364 proposes the allocation of funds from the Cash Reserve Fund to the Site and Building Development Fund, specifically earmarked for the NC3 Project known as "The Farm," located at the strategic nexus of Highway 34 and Highway 75 in Bellevue, Nebraska. The Governor has already earmarked $20 million in the budget for this important investment in our collective technological security-- technology security that $20 million from previously allocated by LB1232 in 2022. As a result of that bill, planning and studies have shown that this project has a much larger potential impact than we did-- than when we passed it into-- when we passed LB1232. The bill, LB1364, serves as a pivotal mechanism to ensure the full scope of this endeavor receives the proper support

needed. The essence of LB1364 lies in the commitment to allow us to develop national competitive rents for government entities in charge of our national defense. The presence of these government entities is the requirement to attract national contractors such as Lockheed Martin, Oracle, and others who have voiced support, thereby, thereby attracting top-tier talent and enterprises to Nebraska. This initiative is not just about building infrastructure, it's about creating an ecosystem where the confluence of the government, academia, and private industry can thrive, innovate, and safeguard our nation's security, security interests. The urgency of this bill is underscored by the evolving threats of our national security which demand a robust and collaborative response. Recent incidences in Nebraska, including a thwarted malware attack on the Butler County Health Care Center and attempts on our agriculture co-ops highlighted the critical need for strengthened cyber defense. The farm aims to be a, a bastion of innovation and collaboration addressing 21st century threats while fostering economic growth and technology advancements in Nebraska. The proposed site and expansive 43.3-acre tract owned by the city of Bellevue is ideally situated for this mission offering immediate accessibility to Offutt Air Force Base, major transportation routes. This location is not just a plot of land, it is the future site of the ecosystem designated to cultivate national security solutions and workforce development through the REACH Facility and the broader Prairie Hill Farm neighborhood. The economic implications of this project are profound, with the potential to generate significant industry growth, create high-paying jobs, and catalyze further economic activity in the region. The initial $20 million investment in the REACH Facility alone is projected to yield a return of over $12 for every state dollar invested, signaling an extraordinary opportunity for economic and security advancements in Nebraska. In conclusion, LB1364 represents a strategic investment in our state's and our nation's future. It is a commitment to public-private collaboration, economic development and, most importantly, the security and the well-being of our citizens. Also here to testify is George Achola, Mayor Rusty Hike of Bellevue, Jim Ristow, the city administrator, Jerry "Indy" Gandy and the Nebraska-- of the Nebraska Defense Research Corp-- Corporation. You also will be presented with letters from Omaha Chamber of Commerce, Congressman Bacon, Mary Hawkins, president of Bellevue University, Jeffrey Raikes, and Lockheed Martin. Thank you so much for, for the past support. When we talked about NC3 in the past and, and looked at a, a $50 million investment in Offutt based on the facilities, the infrastructure, but also knowing that it would command, control, and communicate the next

generation of nuclear defense software was so important to our state and our country. During that process, as I mentioned in my opening, the people behind me that are going to testify found out just how, how much we need going forward to secure our country and how much potential there is for us to help and develop a site which would be next to none in, in our country and around the world. And so I'm here to please ask you to think about this. I know you've been supportive in the past, and looking at the dollar amount when you look at the bill, we did not ask for, for a number yet based on we're working with the Governor's team. They have been supportive. And the people behind me are still trying to talk and, and strategize about what that next step should be financially.

**SLAMA:** Fantastic. Thank you, Senator McDonnell. Are there any questions from the committee? Senator Kauth.

**KAUTH:** Thank you, Chair Slama. Senator McDonnell, so what did-- what exactly did you discover that would indicate a need for more money for this? And are, are the chamber and the private partners also going to be kicking in more?

**McDONNELL:** Yes, we'll always be the last dollar into the state and a minimum will be 1 on 1, 1 for $1. And most likely there will be more from the private sector. And the people behind me will elaborate more on that.

**KAUTH:** Thank you.

**SLAMA:** Thank you, Senator Kauth. Any additional questions for-- from the committee? Seeing none, thank you, Senator McDonnell. Will you stick around to close?

**McDONNELL:** Yes, I'll be here.

**SLAMA:** Outstanding.

**McDONNELL:** Thank you.

**SLAMA:** We'll now open up-- it up for proponent testimony on LB1364. Welcome.

**GEORGE ACHOLA:** Welcome. How is-- how is everybody doing? How's-- how's-- is it a boy or girl?

**SLAMA:** A boy. We're, we're doing our best today.

**GEORGE ACHOLA:** Congratulations.

**SLAMA:** Thank you.

**GEORGE ACHOLA:** I'm going to let the clerk hand out some of the documents. I warned her. I'm not going to go through all these documents, so. But I think it's information that you should have. Good afternoon, Chair Slama and members of the committee. My name is George Achola. George is G-e-o-r-g-e, Achola is A-c-h-o-l-a. Besides being the vice president and general counsel of Burlington Capital Real Estate, Senator von Gillern, in my private capacity I am one of your constituents so I'm glad to be here--

**von GILLERN:** Thank you.

**GEORGE ACHOLA:** --before you. One of the things that I, I do believe that a well-informed Legislature is essential for effective governance and representation of the state's interest. Informed legislators are better equipped to understand intricacies of those issues, assess the potential impacts of proposed policies, and make informed decisions that benefit the state and its residents. In that regard, I'm offering the following to also consider as part of your work for this important bill and this important project. The first thing that you have in your packet that I've given you is testimony that was previously provided to the Appropriations Committee in support of the original $20 million that was passed back in 2022. And in particular, I wanted to turn you to page 7 of that and page 7 you will see that summarizes the importance of this project, but also indicated that there would be an economic impact study that will be conducted to kind of assess what the economic impact of this project would be. The mayor of Bellevue testified there. The president of the university testified there. The chamber of commerce testified there-- the state chamber of commerce also testified there in support of this project, as well as other folks. And I also handed you a brochure-- a brochure that also provides you a thorough summary of this project. I know that in your busy 60-day session, it's difficult to get a lot of information, to read a lot of information so we thought it would be beneficial to give you a brochure that kind of summarizes what this project is and what it can do. And one of the things that Senator McDonnell indicated, if you look-- if you look at page 13 of that brochure that summarizes the economic impact study that was provided, it's a roughly estimated $333 million could be attributable to the state's investment of $20 million for each facility alone, and also a, a, a return of about $12 for every dollar that's invested. I've also provided you an, an, an

article from the Examiner dated January 9, 2024 that provides a good summary of the project so you can understand this has been out there, this has been public. This has generated a lot of public interest. Also in there is, you know, on page 3 of the brochure, when you go back to take a look at it, it talks about this is just not a national issue. The reason we're here is because this is also a Nebraska problem. And the things that occur here are going to help Nebraska solve problems. And, and there's an article that was from yesterday's Nebraska Examiner in reference to another piece of legislation that talked about some of the cyber issues that the state of Nebraska faces. And this can be a companion project to help the state of Nebraska, along with the federal assets that are being brought to bear to help protect Nebraska. So I think that's also important. And then the last thing that I provided you was a statement from STRATCOM Commander Anthony J. Cotton that he provided to the Senate Armed Forces Committee, and on page 10 of that, he talks about the NC3 and how it it is a priority to the country and the fact that STRATCOM has been designated as the, the, the federal government agency, [INAUDIBLE] part of the military that is going to provide jurisdiction oversight for that very important project in which we are-- which we are a partner with them on. And also, as you indicated earlier, there was a letter from Congressman Bacon. He's been taking the lead on the congressional side, on the military side to make sure that the assets are there, the finances are there to make sure that this project moves forward. So basically what I'm trying to, to, to, to provide you the information. I'm not here to sell you. I mean, I think if you look at the documentation that I've given you, this is an important project for not only for the nation but the state of Nebraska. And I think when you look at it, you think you could make a well-informed decision that this is something that is worthy of an investment of the state of Nebraska to move forward. And the last thing that I will add is I have a letter that came in late from Manny Quevedo, who is with the, the MOVE Venture Fund. It kind of illustrates the importance of this project. Also, we have the chamber that predominantly represents big business, but we also have Manny who also represents entrepreneurs, small businesses, and those individuals. And they indicated that this is also a project that would be very beneficial to this project. So I'll hand those in and I'll conclude my remarks.

**SLAMA:** Thank you very much, Mr. Achola. Are there any questions from the committee? Senator von Gillern.

**von GILLERN:** Yeah, thank you, Mr. Achola, for being here today, for your testimony.

**GEORGE ACHOLA:** Thank you.

**von GILLERN:** If the project were to move forward, what would Burlington's role be in that?

**GEORGE ACHOLA:** Yeah, Burlington's role, we're the quarterback. You know, on a real estate project of this size and complexity, you need somebody who knows what they're doing, who understands the complexity of the real estate. And so what we bring to bear is our knowledge of real estate, our knowledge of the federal and state, you know, political actors. The pieces that we need to make sure that this thing is done on time on a budget is a phrase that we always hear. So that's the role that we play in this process, is making sure that once a concept is agreed to, a concept is put into place and funding is in place, that it's finished on time, on budget, and carries out the vision of the mission that it's ultimately required.

**von GILLERN:** So who would Burlington be, be contracted with in that effort?

**GEORGE ACHOLA:** Yeah, as you'll see in the information that I provided, there is a 501(c)(3) that's been set up by the city of Bellevue, primarily has 2 representatives on there. As you know, we don't want-- we want folks that can do real estate to do real estate. So the 501(c)(3) has been established, and under the old statute it required a 501(c)(3) or political subdivision, so a political subdivision. So the 501(c)(3) has been established that has folks on there with some real estate and business background to help us shepherd through this process.

**von GILLERN:** OK. Thank you.

**JACOBSON:** Further questions for Mr. Achola?

**GEORGE ACHOLA:** And I think the one thing I did want to address, I know Senator Kauth asked the question about additional investments. Yes, there would be additional private dollar investments, not only from the private sector, philanthropy, government, other government actors. So I think there would be additional dollars to leverage what the state would put in so hopefully that answers and addresses your question.

**JACOBSON:** Other questions by the committee? If not, thank you, Mr. Achola, for your testimony.

**GEORGE ACHOLA:** Thank you.

**JACOBSON:** Further proponents?

**JERRY GANDY:** Good afternoon, Vice Chair and members of the committee. I thank you for letting me be here today. We did submit 3 letters that I secured, 1 was from Jeff Raikes. I'm talking about the importance--

**JACOBSON:** Can I get you to, to say and spell your name.

**JERRY GANDY:** I'm sorry. I should have introduced myself. I apologize. Jerry Gandy, that's J-e-r-r-y G-a-n-d-y.

**JACOBSON:** Thank you.

**JERRY GANDY:** And I did submit 3 letters, 1 from Jeff Raikes, you'll see that, 1 from Lockheed Martin, and 1 from Aviture small business here and it discusses the importance of the project. I'm the executive director of the Nebraska Defense Research Corporation, or NDRC, and prior to joining NDRC, I served 32-plus years on active duty and as a senior executive service civilian in the U.S. Air Force, with my final position being the director of Mission Assessment and Analysis for U.S. Strategic Command at Offutt Air Force Base. After retiring from civil service, I managed a diverse and highly technical portfolio of Air Force and Space Force work for a major defense company, providing me a sound foundation in leading-edge technology and an excellent understanding of how to create partnerships with industry. Throughout my years of government service and my 7-plus years of industry, I've been a champion of positive change, building effective teams to solve complex problems, finding ways to turn challenges into opportunities, and creating a solid reputation for doing the can't be done. I've been blessed to provide support to my nation for all those years, and for the last 14 years to call Nebraska my home. My children have all been enriched by receiving a Nebraska education, finding careers, building homes and families, and raising their own next generation of Nebraskans. Today, I'm honored to lead the team at NDRC as we provide a bridge of trust between government, industry, and academia to support and promote technology discovery, facilitate knowledge transfer, and accelerate the development and delivery of emerging capabilities for the Nuclear Command, Control and Communications Enterprise Center, or the NEC, and the U.S. Strategic Command missions. NDRC supports those government stakeholders through accelerated market research, stakeholder coordination and collaboration and technology concept exploration and capability

refinement to enable rapid development and delivery of cutting-edge, secure, and mission-enhancing capabilities to today's warfighters. Look, when I embarked on this journey with the NDRC nearly two years ago when I left industry, University of Nebraska President Carter promised me that I would be leading an outstanding team of professionals continuously delivering emergent, cutting-edge technology to warfighter. The fighter pilot in me loves to attack complex problems with wonderful wingmen, and I am blessed and fortunate to be able to lead an equally dedicated NDRC staff who are committed to the vision of providing exceptional success-oriented outcomes for extremely complex issues, such as providing cybersecurity solutions to address an increasing threat posture on many fronts. The proposed REACH Facility in LB1364 represents the fulfillment of that vision as an exemplar for redefining capability deliveries and support of our nation's defense. I'm here today to garner your support for LB1364. As currently envisioned, the Prairie Farm Innovation and Collaboration Hub Campus Initiative, with the REACH Facility as the anchor building for the complex, will be a game changer for our mission area, our government stakeholders, academia, and industry in Nebraska. The REACH Facility will be unique in Nebraska, a purpose-built infrastructure with spaces for collaboration to allow rapid innovation and transition of technology that benefit our nation's defense while simultaneously providing support for commercial expansion. Moreover, the REACH Facility will develop and support an ecosystem that ensures all business owners can collaborate with the combined talent of government, academia, and private industry to deliver solutions supporting national security, cybersecurity, and other related disciplines. Finally, the REACH Facility is designed to provide a defense software plant that will eliminate the facility-related barriers to entry for all businesses and will level the playing field for competition. Now's the time to press forward with LB1364 and enable the creation of the permanent REACH Facility. Nebraska can be at the forefront of providing public-private partnerships that facilitate collaboration to accelerate prototyping, technology development, and technology transfer in support of emerging capabilities. My team has already begun working and had success with U.S. Strategic Command to identify and assess issues and mission capability gaps the Command would like addressed, establishing the preliminary collaborative business partnerships that will provide combined, combined solutions to close those gaps. And so in, in closing, I wholeheartedly encourage you to support funding the REACH Facility and the opportunities that it will provide. By investing fully in this vision, we will create viable solutions that generate

previously unimagined results and provide Nebraska's workforce with the chance to learn and grow in a collaborative environment. Thank you for your time.

**JACOBSON:** Thank you, Mr. Gandy. Questions from the committee? Senator Kauth.

**KAUTH:** Thank you, Vice Chair. Thank you. Do you happen to know what percentage of funding is coming from the federal government? I'm hearing a lot of defense and national security, and so I'm thinking they should be bearing a big brunt of this.

**JERRY GANDY:** Are, are you-- specifically you're talking about the, the funding that we've been working on the last couple of years?

**KAUTH:** Right. So, so for this big, massive project, how much of it will the federal government be paying? How much is the state paying? How much are-- I'm just looking for the breakdown.

**JERRY GANDY:** Yeah. I don't have those exact percentages. I'd have to work with the 501(c) on that.

**KAUTH:** OK. And do you happen to know what is the timeline for-- we're just getting started, you know, figuring this out to-- it's going to be up and running and producing results, national security results. What does that look like, 5 years, 10 years?

**JERRY GANDY:** Oh, I think we're already producing some national security results with some of the work we've been doing the last couple of years here in our interim facility. But in terms of getting the facility up and running, I think we're probably in the 2- to 3-year range.

**KAUTH:** OK. Thank you.

**JERRY GANDY:** And getting the permit to [INAUDIBLE], about two years. The design is, is, is done.

**JACOBSON:** Senator Ballard.

**BALLARD:** Thank you, Vice Chair. Thank you for being here, Mr. Gandy. Is there anything like this anywhere else in the country?

**JERRY GANDY:** There are a couple of places where states have made this investment in this kind of capability. The Georgia Cyber Center was

completely built on state dollars, in my understanding. We visited that and that was to collaborate with the federal government and the state government on cyber security. San Antonio has made a similar investment in the Port of San Antonio. We have the opportunity to do that kind of investment here in Nebraska on this critical emerging technology issues we have for the mission partner we have here at STRATCOM. And, and I will tell you, you ask that, you know, you ask when are we going to have results? The other thing that's happened is we garnered attention from not just STRATCOM, but other Department of Defense combatant commands and agencies on the work we're already doing in our interim facility.

**BALLARD:** Thank you.

**JACOBSON:** Further questions from the committee? All right. Seeing none, thank you, Mr. Gandy, for your testimony. And thank you for the service to our country. Further proponents?

**HARRISON JOHNSON:** Good afternoon. Despite outward appearance, I am not Mayor Rusty Hike or city admin-- city administrator Jim Ristow. My name is Harrison Johnson. That's H-a-r-r-i-s-o-n J-o-h-n-s-o-n, and I am the director of economic community development for the city of Bellevue. And I'm here to voice my support and our support for the appropriation for the development of the NC3 Project. One of our state's most pressing issues is the flight of many of our young people and their families and our ability and our lack of ability, rather, to attract new residents. Their loss isn't just an issue for our friends-- or their friends and family and our friends and family, but also for the state in losing the economic and social productivity that would otherwise bring-- that they would otherwise bring if they stayed in the state of Nebraska. Our young people are moving out of the state for the reasons that young people are always moving: for friends and familial connections, job opportunities and, of course, quality of life which, of course, now includes affordable housing. Our state needs the innovative leadership and commitment in developing industries and providing opportunities that will bring good-paying jobs and increasing the quality of life. Local and state leaders must join efforts to achieve this goal. Bellevue, along with many other cities, is working to develop districts that will center in commercial, industrial, and recreation growth. In 2023, the city of Bellevue established the Inland Port Authority, which is actively working to bring manufacturing commercial development with an estimated over $1 billion in development. We're also establishing an entertainment district centered around Bellevue city's new water park

investment, with a $140 million of development. And finally, of course, the NC3 Project, a cutting-edge and vitally important defense initiative that will modernize the communication and command for the existing missions at Offutt Air Force Base. And we estimate that to bring over $100 million, of course, in development as well. The combined projects we estimate, according to study with the mega site analysis conducted by the Greater Omaha Chamber, totals the annual economic activity of these 3 efforts is $810 million annually, with $158 million of annual earnings that will be boosted due to this. Over a third of jobs created by the NC3 project are-- we project we will be paying over $125,000 annually. To make this project a reality, the city of Bellevue is investing $20 million in water and sewer infrastructure, and we've also purchased $3 million of land for these facilities. We're working with the Nebraska-- University of Nebraska to create a pipeline of students to the job opportunities at the NC3 building itself. And, of course, we have invested-- we're planning to invest $60 million in the Bellevue city water park adjacent to this. The NC3 Facility itself will be owned and operated by the nonprofit, which was testified earlier, and with representation from the city and educational leaders, as, as again testified earlier. It will primarily host federal employees within the Air Force and also provide space for defense contractors with emphasis on small to medium defense companies. These efforts, we believe, are at the heart of the issues that, that are affecting Nebraska's brain drain. By providing low-paying jobs and attracting individuals with re-- with recreation opportunities for young families, we believe this will be a successful initiative. So we're asking for, again, the funding for the LB1364 for the NC3 Project. And I'm happy to answer any questions.

**JACOBSON:** Thank you for your testimony. Questions from the committee? All right. Seeing none, thank you, Mr. Johnson, for your testimony. Further proponents? Just a reminder, everyone, we do have a light system here. So when you get yellow, please kind of move towards wrapping up your comments. Further proponents? Seeing none, are there opponents? Anyone wishing to speak in opposition? Anyone wishing to speak in a neutral capacity? All right. Seeing none, Senator McDonnell, you're welcome to close.

**McDONNELL:** Thank you. Just a follow-up. Yes, your, your question about a couple of other places that, that Indy answered in the country. But not like we're doing it. Not that public-private partnership. Not a city like Bellevue stepping up at $20 million. Not like the private sector stepping up in millions and millions of dollars. Not like we've-- you've already done as a state of Nebraska with $20 million.

Also, Senator Kauth, your question about the numbers and the breakdown through the 501(c)(3), we'll get that for you.

**KAUTH:** Thank you.

**McDONNELL:** But what we're doing here, I believe is special because of that partnership. And as always, I would always ask the, the state to be the last dollar in. Not because I don't believe in the people behind me. I do. The work they've done is amazing, and they are making a difference as we speak today on our national security. But how much more can we make a difference going forward? Again, back to that partnership, back to the talent behind me, and the work they've done. This is exciting for the state, but it's also necessary for the country that we continue to take these steps forward, put our dollars-- invest our dollars in a way that it protects our citizens, and we look to the future.

**JACOBSON:** Thank you, Senator McDonnell. Questions? Senator von Gillern.

**von GILLERN:** Yeah. Thank you, Senator McDonnell. Want to-- a couple of-- got kind of a list of questions here. Start with the easy ones. Other than Bellevue, can you tell us where this site is? I don't-- did you tell us earlier? Maybe I missed it.

**McDONNELL:** Yes, it's-- actually, I can give you the exact address off of Highway 36.

**von GILLERN:** Oh, that's fine, just 36 and--

**McDONNELL:** Yeah, and 75.

**von GILLERN:** OK. All right, that's fine.

**GEORGE ACHOLA:** [INAUDIBLE]

**von GILLERN:** I haven't had time to go through the, the packet that we received. Thank you. I figured it was in there. The-- did you say-- did I hear you say Bellevue is putting in $20 million?

**McDONNELL:** In infrastructure, Bellevue is putting in $20 million in infrastructure and acquiring more land,--

**von GILLERN:** OK.

**McDONNELL:** --because we're currently talking about the 43.3 acres.

**von GILLERN:** And Bellevue is acquiring that land?

**McDONNELL:** Yes.

**von GILLERN:** OK. All right. And then Senator Kauth asked a question earlier about federal dollars. Do you know the answer to that? What, what-- how much?

**McDONNELL:** That's what I'll get back to her through the 501(c)(3).

**von GILLERN:** OK. That's all right. OK. I love the state, the last dollar in. It always concerns me when I see a bill that has X's where the dollar signs are.

**McDONNELL:** Well, as an appropriator, it bothers me, too, a little.

**von GILLERN:** I'm being quite, quite frank with you on that. I think my last question is, knowing that there is a mix of public-private money in here, would you agree in your bill to, to not requirement-- or not require the use of project labor agreements restricting the work to union contractors and make this merit shop work and, and open to all contractors?

**McDONNELL:** Well, I'll, I'll answer the X first. The idea-- the reason we had X in there was based on the idea of not knowing what that next step should be. And, and working with the Governor's team, with the people behind me, should it be an additional $10 million, $30 million, $40 million? We just haven't gotten there yet, but, but we will shortly based on, on that next investment. We know the history on the $20 million. PLAs, I believe in PLAs. And PLAs aren't just for, basically, a, a union labor organization. It sets the bar at a level that's the best of the best. So I believe in PLAs for everyone based on the training and the, the quality of, of the work. So I, I believe in PLAs.

**von GILLERN:** Thank you for your response. I'm just as passionately a believer in letting the market determine who does the work and, as is well known, you and I are on varying different positions on that. I would ask you to--

**McDONNELL:** And even both believe in the quality of the work.

**von GILLERN:** --I would ask you-- I would ask you to consider amending my LB205 into your bill, but that's probably quite a-- quite a reach.

**McDONNELL:** Well, I, I always appreciate the conversation, so.

**von GILLERN:** Thank you.

**McDONNELL:** Thank you.

**von GILLERN:** Thank you for consideration.

**JACOBSON:** All right, well, any other questions from the committee? All right. Seeing none, thank you.

**McDONNELL:** Thank you.

**JACOBSON:** Thank you, Senator McDonnell. And there were-- for the record, there were 2 proponent letters received as well. And with that, that will close out the hearing on LB1364. And we'll move on to opening the hearing on LB1094. Senator Bostar. Welcome back. It's almost like--

**BOSTAR:** It's good to be here.

**JACOBSON:** --you never left.

**BOSTAR:** It certainly feels like I never left. Good afternoon, Vice Chair Jacobson and fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar. That's E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29. Today, I am here to present LB1094. LB1094 proposes to make epinephrine auto injectors or EpiPens, vital for saving lives during allergic reactions, more accessible and affordable for the nearly 200,000 families in Nebraska grappling with food allergies by capping the out-of-pocket expense to no more than $60. LB1094 also helps thousands of Nebraskans with asthma by ensuring coverage for certain generic inhalers. As of 2022, an estimated 197,282 Nebraskans have food allergies. And alarmingly, more than 36,000 of them are children. The absence of a cure for life-threatening food allergies underscores the critical importance of epinephrine auto injectors in preventing fatal para-- anaphylaxis, which is a life-threatening allergic reaction that would prompt administration of epinephrine. Without prompt administration of epinephrine, the consequences can be dire. In 2022, a Papillion Lavista eighth grader died after eating a granola bar that contained peanuts. The student was delayed from receiving epinephrine

and did not have access to his own. Unfortunately, one of the greatest burdens food allergy patients and families face is the rising cost of epinephrine auto injectors. Currently, the cost of a brand name EpiPen ranges from $650 to $730, depending on the pharmacy, and the generic version costs between $320 and $750, making it too expensive for many Nebraskans who cannot simply afford the only medicine that can save their lives. This trend is nothing new, as 6 years ago, CNN reported that these lifesaving devices increased by more than 400% since 2007. While the price of epinephrine auto injectors continue to rise, so too has the use of high-deductible health insurance plans, as they have increased nationally by 83.7% over the last 10 years. The combination-- this combination is problematic for food allergy families. As a recent NBC news story summarized the problem, even as the cost of EpiPens and other epinephrine auto injectors have stabilized, many are paying thousands of dollars out-of-pocket each year due to high-deductible insurance. This is especially acute in Nebraska, as in 2022, 65.3% of our state's private sector employees were in a high-deductible health insurance plan. For a typical family living in Nebraska with a child with a peanut allergy, they must purchase, each and every year, at least 2 packs of epinephrine auto injectors, one for at home and the other for at school, which means that their total cost of $1,400 is 88.2% of the median monthly mortgage payment in Nebraska of $1,586. LB1094 also aids the state's estimated 122,491 citizens with asthma. In a CNN report from December of 2023, doctors are cautioning asthma patients about significant changes in inhaler coverage. Flo Vent, for example, will be replaced by an authorized generic version due to Medicaid rebate changes. Although the generic is deemed effective, it may not be as widely covered by insurers. Patients are being advised to secure new prescriptions and address coverage concerns promptly, particularly during respiratory virus season. LB1094 ensures the generic corti-- corticosteroid inhalers, critical at controlling asthma and allowing people to breathe, are covered by insurers in state-regulated plans to make sure that no asthma patient is denied coverage for a prescription inhaler needed to save their life. I urge the committee to advance LB1094 to thank you for your time and attention this afternoon. Be happy to answer any questions.

**JACOBSON:** Thank you, Senator Bostar. Questions from the committee? OK. Seeing none, I trust you'll stay for the close.

**BOSTAR:** I will not miss it.

**JACOBSON:** We'll now ask for any proponents. And again, just a reminder, we do like to use the light system. So if you would please, begin to wrap up your comments when it turns yellow and try to stop when it turns red, we'd appreciate it. Thank you. Welcome.

**HEATHER NICHOLS:** Hi, Senator Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Heather Nichols. It's H-e-a-t-h-e-r N-i-c-h-o-l-s. I'm a respiratory therapist testifying today on behalf of the Nebraska Society of Respiratory Care in support of LB1094. As a member of the Respiratory-- Society of Respiratory Care, we see many of these things that-- on a daily basis. Anaphylaxis is a life-threatening allergic reaction that recurs within minutes of exposure to the allergen. Epinephrine is the only effective treatment for anaphylaxis. The high cost of epinephrine causes patients to not get their epinephrine in time for the lifesaving drug for them. This bill can help, help get the epinephrine injections at a fixed maximum cost. The other part of this bill is inhaled corticosteroids that acts directly on the lungs, that inhibits the inflammatory process that's caused by asthma. Inhaled corticosteroids help prevent asthma attacks and improve lung function. They may also be used in treatments of other lung conditions like chronic obstructive pulmonary disease. Inhaled corticosteroids prevent chronic symptoms such as wheezing, chest tightness, shortness of breath, and cough. Patients that have found-- that have found to have corticosteroids in their system have an improvement in quality of life. They decrease their asthma attacks, their asthma systems, their hyper-responsiveness, and they decrease their needs for oral steroids and medications. They also decrease their frequency to emergency room visits and hospitalizations. Our goal with the Nebraska Society of Respiratory Care is to maintain patient safety for our residents for Nebraska. We thank Senator Bostar for introducing this bill, and I'm available for questions.

**JACOBSON:** Thank you. Questions from the committee?

**KAUTH:** Actually, I have one.

**JACOBSON:** Yes, Senator Kauth.

**KAUTH:** Do you know much about the, the actual epinephrine? As far as-- I know it's a 6-month expiration, so you most likely won't use it, so then it gets thrown away.

**HEATHER NICHOLS:** It does.

**KAUTH:** But I've been told that, that-- and I, I need epinephrine. So I have allergies. So-- but I've been told that you can make it last longer or to go ahead and use it if, if that's all you've got around. Is there any way to stretch it out?

**HEATHER NICHOLS:** Technically, no. But if it's the only thing that's available and it's expired, you should try to use it--

**KAUTH:** OK.

**HEATHER NICHOLS:** --if it's going to save your life, because at least it should be there. But all those expiration dates are there from the FDA and all those things. So technically, it's not to be used, but if it's the only thing available, as a healthcare provider, I would say we should use it. But we should not stretch it out. But yes, that increases the cost to the families.

**JACOBSON:** Other questions from the committee? I guess they just have one. The-- I'm trying to understand in terms of the costs and, we're talking about limiting this cost-- out-of-pocket costs to $60. And I thought I heard you or someone maybe, I guess, Senator Bostar, that this could be anywhere from $300-$600 for the pen. So are we-- what-- are we talking about that kind of gap, that needs to be picked up by insurance or--

**HEATHER NICHOLS:** There is a huge gap, yeah. But it's-- I think you would have to come up with a cost that it would be efficient for families to be able to. And I think $600 is a lot. And that's right where it's at, between $600-$700 for an EpiPen. Along with the inhaler costs, if they have asthma on top of that, with their anaphylaxis reactions, then they're increasing their cost for their steroid inhalers that are like $150 a month to $200.

**JACOBSON:** And the other thing I'm kind of curious about, I'm not a big fan of big pharma, needless to say. But I'm still trying to figure out how many years epinephrine has been around. And surely, we run the patent, and is there-- why are there not, given the demand it's there, and I got to believe they can make it for a lot less than that, why isn't anybody else in this competitive space?

**HEATHER NICHOLS:** That's a very good question. I don't have the answer for that.

**JACOBSON:** OK. Thank you.

**HEATHER NICHOLS:** I'm sorry, I wish I could answer that. But I agree with you.

**JACOBSON:** Well, thank you very much.

**HEATHER NICHOLS:** Yeah.

**JACOBSON:** All right. Further proponents. Welcome.

**KATHERINE WHITE:** Thank you. Good afternoon, Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Katherine White, K-a-t-h-e-r-i-n-e W-h-i-t-e, and I'm here today in support of LB1094. My 16-month-old son, Tucker, was diagnosed with potentially life-threatening peanut and egg allergies when he was only 6 months old. Because of this, we have to carry 2 EpiPens with us everywhere we go. They're the only tool available to help reverse or slow the effects of anaphylaxis, a life-threatening allergic reaction, before seeking emergency treatment. Food allergies do not run in my family, so you can imagine my surprise when I learned that if I didn't have insurance, a 2-pack of EpiPens would cost somewhere between $650 and $750 out-of-pocket. Even with insurance, the cost was still going to be around $300. On top of the outrageous cost for this necessary life-saving medication, each pack of EpiPens has a shelf life of just one year, so even if we make it through the year without having a reaction that warrants using an EpiPen, they still have to be replaced annually to guarantee efficacy. Furthermore, many medical providers recommend having at least 2 packs of EpiPens once a child is school aged, 1 for home and 1 for school and/or daycare. You can imagine the financial burden this can place on a family, just to have peace of mind that your child has access to the lifesaving medication they may need in case of exposure to their allergens. Food allergy diagnoses already take a taxing mental health toll on parents. We have to constantly read food labels and trust that daycare providers, educators, friends, and family members understand the risks and take necessary precautions to avoid a reaction. It breaks my heart to think that the cost barrier for auto injectors may force some families to choose between having access to this lifesaving medication or maintaining better financial stability. Passing LB1094 and providing affordable access to EpiPens would help alleviate some of the stress and burdens that food allergy families face. After Tucker received this diagnosis, I began to seek out resources to further educate myself about food allergies. Some of the materials provided to me by his allergist referenced FARE, Food Allergy Research and Education, the nation's leading nonprofit advocate for food allergy families.

Last August, it was through FARE that I learned that Illinois successfully passed and signed into law, HB 3639, which cast the cop of a 2-pack of auto injectors at just $60. This law inspired me to turn my worries about Tucker's food allergies into action, and I reached out to Senator Bo star's office to propose introducing similar legislation here in Nebraska. I was ecstatic when he introduced LB1094, and I immediately reached out to FARE about helping ad-- helping advocate for this EpiPen price cap here. I am happy that they are here today in support of this legislation, as they understand the crucial, crucial precedent that passing this bill in Nebraska will set for other states. I appreciate the committee's willingness to consider this cap on out-of-pocket costs for both EpiPens and inhalers. I hope that in the future, we can take this legislation a step further and require that schools, childcare facilities and restaurants provide training to staff on how to use an EpiPen, and also require them to keep a set of EpiPens on hand, possibly alongside AEDs, in case they are ever needed to respond to an allergic reaction. This would ensure that lifesaving medication would be readily available and in the hands of capable individuals in the case of an unexpected reaction And depending on the severity of the reaction, could literally be the difference between life and death. Thank you for your time today and I encourage you all to vote LB1094 out of committee. At this time, I'm happy to answer any questions.

**JACOBSON:** Thank you. Questions from the committee? All right. Seeing none, thank, thank you, Ms. White, for your testimony.

**KATHERINE WHITE:** Thank you.

**JACOBSON:** Further proponents. Welcome.

**JASON LINDE:** It's good to be back in Nebraska. And just off-script real quick, I'll be happy to answer your-- the questions that you raised earlier.

**JACOBSON:** Sure. Go ahead.

**JASON LINDE:** So-- all right. Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee, it is great to be back in Nebraska. My name is Jason Linde, that's J-a-s-o-n L-i-n-d-e. I'm the senior vice president of advocacy at FARE, which stands for Food Allergy Research and Education. We're the nation's leading nonprofit engaged in food allergy advocacy. We represent the more than 33 million Americans with potentially life-threatening food allergies,

including the nearly 200,000 families who are lucky enough to call this great state home. To put that figure into perspective. I'd like you to think of a full Memorial Stadium on any fall Saturday, double it, and then add in the population of North Platte. It is why I'm happy to be here and testify in support of LB1094, and thank Senator Bostar for his leadership on a bill that would reduce the costs of epinephrine auto injectors to $60 and make asthma inhalers more affordable. I know this issue well. I am the German Russian grandson of a dairy farmer from rural eastern South Dakota who was born allergic to milk. You can imagine how popular I was, and my son has a life-threatening food allergy. Life-threatening food allergies are on the rise, as the CDC found that over the past 20 years, the rates of children with food allergies have grown by more than 50%. And with children who have a peanut or tree nut allergy has tripled. Life-threatening food allergies and the risk of fetal anaphylaxis are growing at an even faster rate among Latino and Asian American children, and adult onset of food allergies is a real and shocking development. So there are now more adults and children with a peanut allergy. Unfortunately, while the rate of food allergies has surged, so too of the prices of auto-- epinephrine auto injectors. According to the San Jose Mercury News, this epinephrine auto injector cost $8 to manufacture. $8. CNBC found it has $1 of medicine in it, yet Nebraska parents are paying anywhere between $500-$750 for this 2-pack every single year while Viatris, formerly known as Mylan, has earned more than $750 million from food allergy families from the last 2 years. And while some may argue that bills like this would harm innovation, this EpiPen has not changed in design for the last 37 years since the FDA first approved it. Now, earlier, I couldn't help but sit in the audience and hear some of the debates of those opponents. So I'm actually going to go off-script and address what I'm sure is coming. Look, the real, the real point here is this. Who's going to pay for this lifesaving medicine? Most of Nebraska's people who are in private health insurance are already paying way out-of-pocket costs because they're in high-deductible health insurance plans. That means the moment they walk in every time at Walgreens, Walmart or somewhere else, they're $1,400 out-of-pocket. Meanwhile, I know there's been a quote shared the last few years about how health insurance costs have gone up 24% over the last 6 years, actually, 24% over the last-- 22% over the last 6 years. Folks, that's 3.6%. I'd ask you, what has been our inflation rate over these last few years? It sounds like, frankly, that the business-- the increase on rates is minimal, but who's really paying? The fact is that so many of Nebraskan families are paying ridiculously out-of-pocket expenses

right now, while the health insurance costs, frankly, are not going up that much, certainly less than what we're experiencing as consumers. So I would just ask this committee to move this bill forward. And hopefully, we can find a solution that works for all parties, especially the 200,000 food allergy families. This is a life or death matter, and they shouldn't be able to-- they shouldn't leave behind their medicine when other states have passed similar bills. So I'll be happy to answer any questions you may have, and thank you so much for hearing me out.

**JACOBSON:** Thank you, Mr. Linde. Questions from the committee? All right. If not, I just have one for you.

**JASON LINDE:** Sure.

**JACOBSON:** I, I guess, again, I'm kind of curious.

**JASON LINDE:** Yeah.

**JACOBSON:** So how is it that no one else has been able to go in there and start manufacturing this since it's off patent?

**JASON LINDE:** Yeah. I really appreciate the question. There's 5 manufacturers. And you know, the-- you know, I'm a free market guy, just Canada, you know. My father was born in West River, South Dakota. My mother, East River. Right. There's 5 manufacturers. They're all doing great. Every single one of them. The generic is charging between $300 and $500. So the fact is that the market hasn't worked the way it's supposed to. But, you know, in Nebraska, this is a public power state I used to do some business on-- for the rural co-ops. Sometimes the market misses, right? Rural broadband, EpiPens, sometimes the market misses. And the fact is, is, like I said earlier, if what we're talking about is a 3.6% increase in healthcare costs over the last 6 years, that's de minimis. And what happens is the, the-- look, that school district where the young man died here just 2 years ago, paid out $1 million. And I am a parent of a, of a young man myself. I-- there is no cost. So many people are leaving these medicines behind.

**JACOBSON:** Well, thank you for that. I think you--

**JASON LINDE:** Thank you, Senator Jacobson.

**JACOBSON:** --answered my question. So, thank you.

**JASON LINDE:** Yeah.

**JACOBSON:** And-- yes. For what it's worth, I would just say that on our VEBA plan, bank VEBA plan, I don't know that we've seen an in-- annual increase less than 5, and many of them are running closer to 10. So--

**JASON LINDE:** Yeah.

**JACOBSON:** --I'm not quite sure where those percentages are at, but I can tell you, if we get a number--a, a, a-- an increase that's single digit, I'm, I'm celebrating.

**JASON LINDE:** Yeah. My only concern is the people at the back end. The, the-- your residents are-- these high-deductible health insurance plans are really financially difficult. So, yes.

**JACOBSON:** Yeah. They are. I agree. Thank you.

**JASON LINDE:** Thank you.

**JACOBSON:** Further proponents? Welcome.

**DANIEL ROSENQUIST:** Thank you. Good afternoon, Vice Chair Jacobson and members of the committee. My name is Dr. Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a family physician in Columbus and the immediate past president of Nebraska Medical Association. The NMA supports LB1094. Both steroid inhalers and epinephrine injectors are critical, disease modifying, and sometimes lifesaving therapy for Nebraskans with asthma and severe allergies. LB1094 takes 2 steps to ensure patients can access these medication therapies. First, the bill limits the cost sharing of-- for epinephrine injectors to no more than $60 for a 2-pack. While epinephrine is available, as you've heard, by syringe injection, auto in-- injector devices such as the EpiPen are the safest and the quickest method of administering this medication, keeping in mind that delays and errors may be fatal. As you heard, the price of the, of the, of the branded name-- brand products between $500 and $750, you might be able to find a generic EpiPen pack for between $100 and $200 if you use a good-- Good Rx coupon or something similar. Patients with severe food allergies should generally have 2 auto injectors at home-- on hand. A 2006 report in the Journal of Allergy and Clinical Immunology found that a second dose is necessary 18% of the time. I was just reading a-- from the back of the room, a JAMA article today, that says 10% of the time, do you need a second injection about 15 to 20 minutes after the first one. Only 1 out of 50 of those people do not respond to that second dose, so that second dose could be very critical. Additionally, you need a-- you need a set

at home, you need a set at school, you need-- at work, wherever else you might be. They need to be replaced as they expire. Many times, the shelf life is between 12 and 18 months. That's always debatable, but it's-- that's where that's kind of at. This leaves the family on the hook for a significant cost to manage a life-threatening allergy. By capping cost-sharing requirements of $60 for a 2-pack, this will help Nebraska families keep this lifesaving medication readily available. Second, the bill will require health plans that cover prescription inhaled corticosteroid medications, commonly referred to as ICS, to also provide coverage for the generic and authorized generic versions of those medications. Steroid inhalers are first-line treatment for patients with persistent asthma and COPD, either alone or in combination with another medication called the long-acting beta agonist or also, a long-acting muscarinic agonist which is called LABA or LAMA. At times, these pat-- providers feel that LABA is an unnecessary or it has unwanted side effects such as tremors and tachycardia and other symptoms. And patients don't want to tolerate those and we, as providers, don't want to use those. Last year, the maker of a common allergy medic-- asthma medication, Flovent, announced it was discontinuing the branded inhaler and making an authorized generic version instead. While the authorized generic version is the same medication and the same device, some insurers have opted not to cover this. While insurers may have other insure-- other inhalers on their formulary, not every treatment is equivalent, especially when it comes to children. For example, if other inhalers on the formula are breath-actuated, you have to be able to, to inhale and inspire deeply enough to make this work. There's another rare condition called eosinophilic esophagitis, for which fluticasone propionate, which is the active ingredient in Flovent, is the treatment of choice. Other ICS inhalers have been-- have not been shown to have the same effectiveness. These delays in access and risk to the patients should-- could be avoided if insurance would cover the equivalent generic inhaler. As a physician, it is common sense that when a patient is doing well with 1 type of inhaler and a generic version is available, their insurance should cover that. By capping the cost-sharing for epinephrine injectors and expanding coverage, LB1094 will help ensure patients avoid disruptions in accessing these necessary and lifesaving therapies. I thank you, and I'm happy to answer any questions.

**JACOBSON:** Questions from the committee? All right. Seeing none, thank you, Dr. Rosenquist, for your testimony. Further proponents? Welcome.

**MICHAEL DWYER:** Good afternoon, Vice Chairman Mos-- excuse me. I almost said Vice Chairman Moser. Excuse me.

**JACOBSON:** We're close.

**MICHAEL DWYER:** --and members of the Banking, Commerce and Insurance Committee. My name is Michael Dwyer, M-i-c-h-a-e-l D-w-y--e-r, and I'm here to testify in support of LB1094. And I paused for a moment because my original form and my testimony intended for me to speak in the neutral. And after hearing most of the testimony today, I'm going to-- I am changed to be a proponent. The original intent of my testimony was to remind the committee about the importance of not only epinephrine, but the broader issues, in particularly, rural EMS. So I'll try to tail that down a little bit and speak more specifically to LB1094. EpiPen is an urgent med. In, in an EMS world, that means that if I don't have that in a patient very quickly, the likelihood that they're going to survive a complete airway obstruction isn't good. That-- EpiPens are extremely important, as was mentioned before. As a volunteer service, we have 4, 2 in each of our squads, and have to replace those, I think, officially we replace them every 6 months. So for a volunteer squad, at $600, that's $2,400 times 2. If my math is right, that $4,800 a year, which is a significant expense, if you will, for a volunteer squad. It's got a lot of pancakes to be able to do that. The report that you should have had, and I believe all of your offices have, I have been working on it in advance of the Governor's Volunteer Fire and EMS summit in August. And I believe all 49 senators had it. But if not, this speaks to a-- an, an evolving model, if you will, in EMS, that uses systems like Epi injectors to be able to respond in front of EMS more quickly. I was pio-- pioneering a-- in 4 of the western counties, a, a model that's modeled after a-- an Israeli program. And the idea is to be able to get hands on a patient much, much quicker. Frankly, our response time is really good. But best case scenario, it's 6 minutes out the door, plus whatever time it takes to get to the patient, evaluate, and actually use the EpiPen. In an emergent situation like this is, that's-- that-- I, I don't like the math at all. So this is really, really important. In closing, rural pre-hospital EMS, as the report identifies, is in trouble. The short version is that calls are up and the number of responders is down, and that is not sustainable. There are a couple of bills in the Legislature, and we'll continue to do good work to convince the Legislature of that, but my really overriding purpose today is to just remind the committee that, that pre-hospital, particularly rural EMS, need some help. With that, I'll close. Thank you for listening, and I will be--

**JACOBSON:** Thank you. Thank you for your testimony.

**MICHAEL DWYER:** happy to take any questions.

**JACOBSON:** Any questions for the testifier? If not, thank you, Mr. Dwyer, for your testimony. Any others wishing to speak in support of LB1094? If not, anyone wishing to speak in opposition of LB1094? Mr. Blake.

**JEREMIAH BLAKE:** Senators, for the record, my name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h, B as in boy, l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB10-- LB1094. At Blue Cross, we work closely with our partners at Prime Therapeutics to respond to market conditions and the pharmaceutical industry to meet the needs of our members. Concerning EpiPens, I have distributed for your reference, a recent news article that describes a $50 million settlement from one drug manufacturer for anti-competitive tactics. As noted in the article, the drug manufacturer increased the price of EpiPens from $100 to $600. And I think I heard a reference to $800 today. The settlement referenced in this article is in addition to other settlements in 2022, in the amount of $264 million, and another in 2021, in the amount of $345 million. Concerning inhalers, I have distributed a second article that explains how one drag-- drug manufacturer abruptly discontinued production of a maintenance inhaler in January. According to the article, the drug manufacturer determined that they could increase profit by ending production of a brand name inhaler and producing an authorized generic version instead. In response to that decision, we updated our formularies to ensure appropriate access to clinically appropriate options for our members. However, the decision by this drug manufacturer will likely increase costs for our health plans. There's nothing I would love more than to work with the proponents and Senator Bostar on a bill that would pro-- protect patients from the high cost of drugs, but this bill would not do that. Instead, this bill would protect drug manufacturers who've shown their priority is profits, not patients. I sympathize with everybody who testified in support of this, about the challenges they face finding alternative inhalers or replacing expired EpiPens. We make every adj-- every effort to adjust to market conditions and provide coverage at-- for the care of our members, regardless of how unseemly the prescription drug market is at times. But this bill rewards drug manufacturers by limiting our ability to negotiate for safe and effective alternatives for EpiPens and inhalers. For this reason, we oppose LB1094. I'm happy to answer any questions you have.

**JACOBSON:** --Mr. Blake. Questions from the committee? Seeing none, thank you for your testimony.

**JEREMIAH BLAKE:** Thank you.

**JACOBSON:** Further opponents? Welcome.

**MICHELLE CRIMMINS:** Thank you. My name is Michelle Crimmins. For the record, that is spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s. I'm a registered lobbyist representing Prime Therapeutics, a pharmacy benefit manager owned by 19 not for-- not-for-profit Blue Cross and Blue Shield insurers, subsidiaries or affiliates of those insurers, including Blue Cross and Blue Shield of Nebraska. My testimony today is in opposition of LB1094. Section 2 of LB1094 requires coverage of a generic or authorized generic version of an inhaled prescription corticosteroid used for the treatment of asthma. Authorized generics are generic drugs created by the manufacturer of the branded drug. The manufacturer creates an authorized generic to capture additional market share, increasing their profits. These drugs are often more expensive than net, than net cost of the brand name drug. That's an important point. It's not cheaper always for the authorized generic. Generic drugs are manufactured by a different manufacturer from the branded drug. When there's only one generic available on the market, which happens during the exclusivity phase, the generic drug is oftentimes priced at the same rate or higher than the brand name drug. The price of the generic drugs falls only when there's additional competition in the market. Drug formularies are designed to include drugs available at the lowest net cost, saving consumers and the insured population money. This may mean that the branded drug is included in the formulary as the lowest net cost option. Mandating coverage of the generic or authorized generic would remove the negotiating power of-- power of PBMs and increase the cost of drugs. Several times today, we've heard the example, Flovent. Unfortunately, a manufacturer that has decided to remove the brand name drug of an inhaler from the market in favor of their authorized generic drug, which is, at times, up to 3 times more expensive than the net cost of the brand name drug, this shows the games that manufacturers often play to game the market and increase their profits. Because of this, we are in opposition of this bill. I'm open to any questions. Thank you.

**JACOBSON:** Questions for Ms. Crimmins? All right. Seeing none, thank you for your testimony.

**MICHELLE CRIMMINS:** Thank you.

**JACOBSON:** Further opponents? Mr. Bell, looks like you're up next.

**ROBERT M. BELL:** Good afternoon, Vice Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, and I am appearing today in opposition to LB1094. As you know, the Nebraska Insurance Federation is a state trade association of insurance companies, including many of the health plans writing business in the state of Nebraska. You've already heard what LB1094 would do. We certainly sympathize with the senator and the proponents and all Nebraskans, about access and cost of these vital, lifesaving pharmaceuticals. And in general, share the outrage of the cost of, of this. If you go in and read about EpiPens in your spare time and the congressional hearings related to EpiPens and the antitrust lawsuits by the Department of Justice related to EpiPens, and then what other states have done on EpiPens, which, you've already heard, Illinois has passed this cap. Colorado passed a cap that required the pharmaceutical companies to reimburse pharmacists for the difference, which, I would encourage this committee not to do, if you read about what's going on in Colorado right now. So-- and it's led to a bunch of litigation and whatnot, and pharmacists are not getting reimbursed, of course. With this, I mean, and as you've already heard, this helps-- does-- would help a Nebraska family that needs EpiPens, right, if, if their plan already doesn't have a lower cost sharing than $60, which many wouldn't. If you're in a high-deductible health plan and if you have the option not to be in a high-deductible health plan, if you're buying these and you're having to pay $1,000 every year, you might look at your insurance choices if you have that option. Many employers who offer high-deductible health plans also offer low-deductible health plans. But what is a low-deductible health plan right now versus a high-deductible health plan? It can be a little bit confusing, as well. Everything seems to have higher cost sharing right now. Our concern is you're, you're not punishing the true bad actor here, which is the pharmaceutical companies. And I wish I had a solution to that to present to you and slide across the table. I do not, but we're definitely willing to converse further about that. On the issue related to the inhalers, it's true, related to what Flovent has done, and the manufacturer, who escapes me right now-- I can't remember which manufacturer did, did Flovent. You can find it on your phones. The, the authorized generic is significantly more expensive than the name brand competitor on there. And why they withdrew their

product is a story-- is an interesting story, too, related to increases that went above what they were supposed to, according to the federal government. And so, to avoid being punished by the federal government, they removed it from the market. And so, even when you try to pass laws or the Congress tries to pass laws, unfortunately, pharmaceutical companies find ways to circumvent that. So--

**JACOBSON:** All right. Well, thank you for your testimony.

**ROBERT M. BELL:** Yeah. I-- sorry. It went red. You're welcome.

**JACOBSON:** I figured you wouldn't mind me cutting you off. Questions by the-- from the committee? All right. Seeing none, thank you, Mr. Bell.

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

**JACOBSON:** Further opponents? Any further opponent testimony? Anyone wishing to speak in a neutral capacity on LB1094? All right. Seeing none, Senator Bostar, you're wel-- welcome to come up and do your short close.

**BOSTAR:** Well, that's wishful thinking.

**JACOBSON:** There were, there were 12 proponents.

**BOSTAR:** Thank you. Thank you, Vice Chair Jacobson and fellow members of the committee. You know, I think I'll, I'll start by just saying that if you want to start an epinephrine manufacturing business that we can sell it for cheaper, I'm interested.

**JACOBSON:** Let's talk.

**BOSTAR:** I'm going to talk about the generic first. That really applies to the, the inhalers, the corticosteroids. And you heard a lot about the brand name inhalers were pulled off the market. The generic costs more, so the insurers are coming in and explaining why they're not covering them. And I understand that. We can debate whether that's a good reason or a bad reason. It's certainly an understandable reason, but in the end, it doesn't matter to the family who needs inhalers. That's the reality. And then I want-- that brings me to my-- I think my second point I want to make is it was-- this legislation was-- it was stated this legislation was designed to protect Pharma. I don't represent Pharma. I don't represent insurance. I represent the families and the individuals that live in my district. That's who I'm trying to protect. That's all I'm trying to protect. We have children

dying in Nebraska. We talk about costs. We talk about mandates. We talk about premiums. There's a cost to, to not doing things. We got into that a little bit in some of the previous bills. There's a human capital cost. If we want to be crude, right, there's actuaries. We seem to be talking about them a lot. Right. They can put a value on an individual's life for the purposes of-- especially within the healthcare space. They can and they do. It's part of the process. It's part of the system. And it's millions of dollars, to be clear. The cost to getting some of these things wrong is more than the cost to get them right. Is only insurance at fault in this? No. When they say there's a dollar of medicine in an $8 package that's being sold for 700 bucks, I believe those numbers. I think those numbers are right. Is that only on insurance for why it's costing so much? No. Of course not. But when pharmaceutical companies and insurance companies spend their time arguing with each other and pointing their finger back and forth, our children are dying. That's what I care about. I don't care how we solve this. And it's very nice for insurance to come in and say, we want to keep talking about it. We want to find a solution. Where's their amendment? Where's their bill? I don't care how we solve this. $700 for EpiPens is absurd. Not covering inhalers, the only inhalers available on the market, is insane. These systems are broken. I'm not here to point fingers. I'm not here to say it's anyone's fault. Because at the end of the day, that doesn't matter to the people who need this. We just need to find a solution. Happy to answer any questions.

**JACOBSON:** Questions, Senator Bostar? If not, thank you for your testimony. And again, there were 12 proponent letters that were received on LB1094. This will conclude our hearing on LB1094. We will move to LB917, Senator Wayne, who's sporting a suit and tie today.

**WAYNE:** It's been a--

**von GILLERN:** You do look very nice.

**WAYNE:** It's been a long day. Good afternoon, Vice Chair Jacobson and fellow members of the Banking and Insurance Committee. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, which is north Omaha and northeast Douglas County. Senator Bostar, you just said something that resonates 100% with me when I'm thinking about this bill. The cost of getting this wrong outweighs, for sure, the cost of trying to do something perfectly right. LB917 will require the Department of Insurance to establish prior authorization process to include the following: Allow for

electronic prior authorizations; a maximum timeframe for insurance providers to review and respond; a uniform process for providers to appeal the prior-- a prior authorization; a standardized form for prior authorization; and a time frame in which prior authorizations must be honored. You might wonder why I would bring a bill like this. Well, it's very simple. A year and a half ago, my wife was diagnosed with cancer. It took a month and a half for us to figure out a treatment plan while my doctors-- or her doctors dealt with insurance to figure it out. That happened over the 4th of July, so that wasn't a very happy time. And then in my own situation years ago, I didn't think about it until it really affected my wife and her deal. But for me, I had a simple torn rotator cuff. But I had to go through hoops of X-rays, MRIs, and more things, although my doctor was 100% sure, based off of what I was doing and how it worked and where the pain was, what it was. But we took weeks arguing about whether I could get an MRI next, or do I have to go get a X-ray? I'm not a doctor, but X-ray wouldn't show anything, is why my doctor kept saying, you don't need to go get a X-ray. Just go get a MRI, and we can have surgery. Finally, he just did it anyway. And we got the X-ray and then, backed into the insurance approving it. But throughout the process of watching my family go through this, it was every step. We don't know. We have to call insurance. And that is just fundamentally insane to me. What we found out in this process is, this is intentionally complicated. You have doctors spending hours and hours a week on the phone with insurance companies trying to provide services to their patients. No doubt this bill will help people if it's just simply to simplify the process, that you don't have to sit and wonder. And this isn't a liberal or a conservative idea, is because this is in every state. And Texas just recently passed a gold card standard, that we can talk about. Insurance companies will get up and say this is a huge burden and it's going to cost money and their job with prior authorization is to save money and make sure they're taking care of the patients. They profited over $69 billion last-- in 2022. The American Medical Association is very supportive of legislation like this. And they have model legislation, and mine doesn't even go as far as theirs. But what they found out and why it's important to doctors, is 33% of physicians report having witnessed prior authorization process harming a patient. 94%, % of physicians have reported delays in care due to the process of prior authorization. As I said before, Texas recently passed a bill giving physicians a 90% prior authorization request approval, a gold card, which would exempt doctors from dealing with insurance companies like this. We talk about a doctor-patient relationship all the time on the floor, all the time

in committees, but we are literally allowing companies to step in between them to delay care. And when you're dealing with some of the most dramatic times of your life, your doctor should be able to give you an answer without having to call and be on the phone for hours to get prior authorization. To tell you how crazy this is, I couldn't get Ozempic for my diabetes for about four months. So my doctor said, let's switch over to Mounjaro. My insurance company actually said, no, he needs to get worse before he can switch. He's actually doing a pretty good job of keeping his A1C good, so he doesn't need to switch. He's doing fine. I wasn't switching because I didn't like the medication. It was because I couldn't access it. So I had to go in, after 4 months of not getting it, to have my A1C go up before they would switch me. So when the insurance companies and the people come up and say X, Y and Z, or to Senator Bostar, we're working on it, I'm a living example of somebody who was harmed by this. Luckily, I didn't drink. I watched my food. I wasn't stressed out in the Legislature when this happened, so my sugars didn't go up that much. But imagine you sitting there saying you have to get worse in order for you to get better, to get prior authorization for this medicine. I want to see what they have to say. Because there's no excuse, that on Jan-- on June 28, my wife was diagnosed and we couldn't get an answer until August 2, of her treatment plan. So please, come defend that. I'll answer any questions.

**JACOBSON:** Questions for Senator Wayne? Senator Kauth.

**KAUTH:** Thank you, Vice Chair Jacobson. First, thank you for coming and testifying. I'm glad your wife is doing better. Can you kind of walk me through what you think this will look like?

**WAYNE:** So--

**KAUTH:** I mean, is there, is there a structure that you're envisioning or--

**WAYNE:** --so my first draft was to put everything in statute, and my LA talked me out of that and said, let's have the insurance-- the Department of Insurance work with the industry to come up with guidelines, but let's set some parameters. So on the last page, the per-- the real parameters are: urgent, has to be within 24 hours; non-urgent within, I believe, 5 days. The model legislation says urgent within 24 hours, non-urgent within 48 hours. So I'm trying to leave flexibility to allow our department to work with the industry to come up with some solutions. So it would be rules and regs that were

adopted by the Department of Insurance, that people can go to on the Secretarial website to find out how to do this, to make sure patients can-- or be informed. So it would be steps, like-- whatever those steps are, I, I just think it needs to be laid out. Because right now, each insurance company is doing something different. And so, you hope your doctor knows which insurance you are and then they figure it out. But if you change a job, then you might have something new. And I just-- it's too complicated, and people are, are literally being hurt by it.

**KAUTH:** Thank you.

**JACOBSON:** Other questions? I, I just have one quick one. I-- and I'm curious, too, to hear the, the rest of the testimony. But, I, I guess I'm wondering to what extent does this really just prompt more appeals? In other words, I-- when I first started out as a lender, you know, I was told early on that you need to study the financial statements and the information you were given. And if you get pressed to giving them an answer, tell them, if I need-- if you need an answer today, the answer is no, but if you give me a few days, I might be able to get the yes. And is that going to be the problem we're going to have here with what you're drafting, that, well, the answer is we're going to deny it and need to go through an appeals process. In the meantime. It all gets worked out through the appeals process. Is that a risk?

**WAYNE:** That's probably a risk. But the issue is if your doctor is recommending something, you, you shouldn't be put on the back burner having to wait, on what your process is or, or what, what therapy you need. So I, I don't know if it increases the claims. And,and maybe that's a good thing, because then the industry will balance itself out one way or another. But, but the problem is the process. And even the prior authorization changes all the time. One time this is prior authorized, then you got to do something different the year later. And we need to have something for, for the patients. Nothing against insurance companies, but for me, it was unconscionable that I had to get worse to get better, and that I had to wait almost 5 1/2 weeks to figure out a plan.

**JACOBSON:** Well, and for what it's worth, I think anytime anybody gets the word that they've been diagnosed with cancer, you can't get an answer fast enough in terms of when-- when's the treatment going to kick in. So I certainly empathize with what you and your wife went through, and, again, appreciate your testimony, too, and bringing the

bill. All right. No other questions for Senator Wayne, we'll move to proponents, so [INAUDIBLE] proponents for LB917. Again, remind you of the light system. Welcome to the committee.

**TAMI BURKE:** Thank you. So good afternoon, members of the committee. I appreciate your time. My name is Tami Burke, T-a-m-i B-u-r-k-e, and I'm here on behalf of the Nebraska Rheumatology Society, but mainly for myself. And I'm-- to express my support of LB917. I'm going to share my personal health journey. And it's, it's long and exhausting, so just yawn with wild abandon. I do not care. You won't offend me, but I hope that you listen. And if you ask the why in why am I qualified-- and you have a poorly written document in front of you that took me hours, because it's hard to realize the impact of what it takes for decades to get a diagnosis. So I have an autoimmune disease. In fact, I have a, I have a plethora of them, and I have a brain tumor. And you would not believe how tricky it is to get a treatment plan figured out. And after years of trying and failing on certain meds, then we can add one that, that maybe offers hope. One of my qualifications, I think, as well, is that I am a mental health therapist. By the way, I've psychoanalyzed all of you and it's going to be great on Instagram, so I encourage you to look later. But I was a teacher, so I'm, I'm very much about I want to know. I want to know my product. And I went into insurance sales, and I was successful because I educated my clients on what they were purchasing and why. So I have a skill set that I think makes me a qualified purchaser of insurance plans. I've had group coverage. I've had, you know, enrollment in the open market. And the variety of complications and effort and issues is unbelievable. And so I'm, you know, can't express enough, I guess I, I feel the-- Senator Wayne's pain. But what I'm going to do today is-- rather than read that awful letter, is tell you, as a teacher, I'm giving you a history lesson on my, on my health. So I have Sjogren's, rheumatoid arthritis, lupus, and the medicine that I take is a biologic. And the gentleman from the health insurance industry can tell you that it's not a cheap date. My doctor tells me it takes 3 to 5 years of continual coverage before you're going to see the full benefit of this medicine. It starts right away. We don't cure anything that I have, but we manage symptoms, we try to slow progression of the disease, and we're really trying to prevent permanent damage. Twice in the last 7 years, I have lost the ability to get my medicine, in my-- it's an IV infusion. I get it every 4 months. I have two 2 weeks apart. 4 months later, I do it again. Pre-authorization every single time to get this medicine. Twice, there has been a, a hiccup in forms, in a box didn't get checked. This was

not explained. I literally, on the last one was told, well, you slipped through the cracks. So I have a $47,000 bill that I'm expected to pay because I didn't read a document that was not made available to me until after I got the bill and had a heart attack, and, and they provided it. So, what I'm going to do now is sell you LB917. This, this would not have happened. I would have had access to the documents. I would have been able to electronically access them. My doctor could have had continuous-- like a continuity of how to do these pre-auths. I've worked with the same provider and her staff for over a decade, and it's always different every time. And these are, you know, they're bright people that I trust. So, please buy into this bill. The therapy piece is the basic human needs. We need to have food and shelter. When we're financially taxing people-- I mean, like, I sold the one kidney nobody really wants and-- when you have autoimmune disease. So I can't make money doing that. But what I-- you know, I look at this-- and I work with people with chronic illnesses. Mine could be much worse. I'm not complaining. I just feel for those that feel like they're human-- their basic needs are taken away and they're threatened. I don't feel safe. I, I don't-- because there's this-- an uncertainty. My symptoms, I've regressed. I have symptoms now that I didn't-- I'd forgotten that I had a decade ago. My husband said to emphasize how irritable I am. He said that's one of the worst symptoms that I have. You know, fatigue, I had-- I now have vision, hearing loss, you know, permanent joint damage. It's really cool stuff. It-- it's not a big deal, but we really could make this easier. And so I really implore you, if not for me, for Senator Wayne, for, for my therapy clients that I work with. It's a traumatizing thing, and I, I just appreciate your consideration, so thank you.

**JACOBSON:** Thank you for your testimony. Senators for Ms. Burke? All right. Seeing none, thank you for your testimony.

**TAMI BURKE:** Thank you.

**JACOBSON:** Further proponents? Welcome.

**JOHN FINDLEY:** Thank you. Good afternoon, Vice Chairman Jacobson and the members of the Banking, Banking, Commerce and Insurance Committee. My name is Dr. John Findley. It's J-o-h-n F-i-n-d-l-e-y. I've been a family physician for 25 years, and am currently the president of Brain Health Connect. It's a physician hospital organization and accountable care organization that represents nearly 2,000 providers across the state. I'm a part of Brain Health, a Nebraska owned and governed health system. At Brain Health Connect, we strive to connect payers,

employers, providers, and patients to drive cost effective population health improvements. As you know, dozens of states have been working to pass prior authorization reform, with 20 bills enacted in 2023 and 70 measures pending, according to the AMA. Hospitals and patients are seeking relief, and it's the reason I come to you today in support of LB917 on behalf of Bryan Health, the Nebraska Hospital Association, and for the patients for whom it's our mission to serve. LB917 would create a standardized process for prior authorization, as well as shorten the response time that insurance companies have to do prior authorization requests to 3 days for urgent and 5 days for non-urgent claims. In 2022 alone, Bryan Health has 45 full-time equivalent positions at a cost of over $3 million, dedicated to completing over 60,000 prior authorizations for outpatient lab testing, imaging, surgeries and procedures alone. Though Bryan has a very high pre-authorization acceptance rate, none of this guarantees that we will be paid for the care that we give. It only guarantees that we will not receive a denial because we didn't complete a process. There are not currently standard turnaround times to receive an answer on authorization from insurance companies. Today, a patient may wait up to 14 days to receive an answer on an authorization. That's 14 days that we have delays in care or treatment, and not to say the emotional toll that it takes when you're waiting for that answer. Unnecessary delays are-- in care are exceedingly and far too common. There are no uniform or transparent criteria used across payers to determine whether something will be authorized. Insurance companies can also change their prior auth requirements without any notice to health systems or providers or patients. A drug or procedure that may not require a prior auth today may need further work in the future. As a family physician, I'd like to share a perspective on how patients are impacted by prior auth delays. The truth is, is there's multiple everyday examples. I, like most providers, figure out workarounds. And the bottom line is that we often have to send patients to emergency rooms in circumstances where they have ongoing suffering because of the inability to get the care they need. I want to thank Senator Wayne for bringing this to our attention. This is a very important issue. The way it impacts patient outcomes, provider burnout, and the financial integrity of local health systems is undeniable. We are aligned in our goal to reduce healthcare cost and increase patient outcomes. Prior auths achieve neither of those aims. As you hear from myself and others today, again, I asked that you be moved to take action in support of LB917. The patients, providers, and healthcare systems in Nebraska are looking to you for relief. So with that, I thank you and would entertain any questions you may have.

**JACOBSON:** Senator von Gillern.

**von GILLERN:** And Dr. Findley, thank you for being here today.

**JOHN FINDLEY:** You bet.

**von GILLERN:** I-- in my own personal and family experiences, some doctors seem to be able to navigate the system better than others. Can you comment to that? Because it doesn't seem like the same, and, and we've had the same insurance coverage for a period of time. But again, some physicians or offices seem to be able to navigate better.

**JOHN FINDLEY:** I'm not sure that I can answer that directly. I think there's workarounds per se, as I alluded to there, that doctors might, at times, circumvent the process. But the process itself, I'm not aware of any expedited way that you can overcome their authorization rules.

**von GILLERN:** So, so it's your experience or from what you know that, that if, if there's a-- an insurance plan that every doctor experiences the same time delays for approvals?

**JOHN FINDLEY:** Yes. I'd say generally for that particular carrier, you're going to have the same experience of how easy it is to have for that to go through.

**von GILLERN:** All right. Thank you.

**JOHN FINDLEY:** It may vary among payers, but.

**von GILLERN:** OK. Thank you.

**JACOBSON:** Other questions from the committee? All right. Seeing none, thank you, Mr. Findley, for your testimony.

**JOHN FINDLEY:** Thank you.

**JACOBSON:** Further proponents. Welcome back.

**DANIEL ROSENQUIST:** Thank you. Good afternoon, Vice Chair Jacobson and members of the committee. My name is Dan-- Dr. Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a family physician in Columbus and immediate past president of the Nebraska Medical Association. I'm here to testify in support of LB917 on behalf of the NMA. I was here before you last year when Senator Bostar brought forth LB210. At that

time, I expressed to you the NMA's concern and my personal frustrations as a physician about how payers are handling prior authorization. The burden of prior authorization has not improved. Providers in all specialties can provide countless examples where delays in, in response have disrupted or delayed treatment, compromised patient health, and increased costs. Patients with cancer, heart disease, mental health disease, they need immediate attention. They don't need a delay. I knew I was coming down here to testify, so last week, I put out a request to my physic-- my partners, and actually, their staff, because their staff do-- our staff does most of our prioritization. Over 50 denials that they gave-- they forwarded to me. I'll go through-- one of them was for a generic drug that's $7 for 9-- 30-- for a 30-day supply. Denied. I-- there-- over 20 of them were for-- or 32 of them are for diabetes medications other than insulin. Semaglutide-- I don't like to give the manufacturers a lot of credit. It takes, it takes-- you have to titrate. It's 0.25 milligrams for-- weekly for a month, 0.5 milligrams weekly for a month, 1 milligram weekly for a month, 2 milligrams weekly for a month, 4 milligrams is the final dose. We were getting denials for 1 and 2 milligram doses. These people had already been approved for those other doses. We could not titrate them. If we lose them for 2 weeks, we've got to start the process all over again. What a waste. And so, many times, we have to authorize each step in the process. You can imagine our frustration. And again, it's my frustration, but think of my staff. They're the people that actually do this. And this was February. If I had to query them last month, it would have been double that, because the-- at the first of the year, you see all this. We find LB917 to be a very reasonable proposal. The bill sets forth minimum standards. These are things that a patient should be able to count on their health provider or insurer to do, such as responding to prior authorization requests in a timely manner. The bill includes very basic, commonsense standards to reduce the burden on physicians and other practitioners, including transparency about prior authorization requirements and streamlining, streamlining prior authorization requests. Seeking authorization for a treatment can often provide like-- feel like a moving target. The, the rules change. Completing the process electronically would be welcome to most of us. We understand that payers have an interest in keeping healthcare costs down. The overwhelming majority of providers also recognize their role in delivering affordable, evidence-based treatments for their patients. But the current prior authorization landscape adds unreimbursed administrative burdens, increasing the frustration and burnout across the healthcare, healthcare workforce. The NMA appreciates Senator

Wayne for bringing LB917, and we hope this committee will agree that something needs to be done to address this. Thank you. I'm happy to answer any questions.

**JACOBSON:** Thank you. Committees-- questions from the committee? All right. Seeing none, thank you, Dr. Rosenquist, for your testimony. Further proponent testimony? OK. Opponent testimony on LB917. Mr. Blake.

**JEREMIAH BLAKE:** Hello, Senators. Again, my name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B as in boy, l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in LB917. I just want to take a second and thank Senator Wayne for sharing his story and for bringing this important conversation to the committee. I think it's an important conversation that we need to have. At Blue Cross, we are committed to improving interoperability and the seamless flow of healthcare information. The ability to communicate and share information among patients, doctors, hospitals, and insurance companies is essential to improving health outcomes and lowering costs. This is why we have made significant investments in new technology to streamline the prior authorization process. In 2021, we launched an online system called NaviNet that allows providers to electronically submit prior authorization requests. This is a web-based system that walks the provider through the clinical criteria for services and allows them to submit supporting documentation, review the status of requests, and file an appeal. NaviNet can be used to submit prior authorization requests for medical services, prescription drugs, and imaging services. And I would just note that all of our medical policies are also posted on our website and available in that NaviNet. We invest in technology like NaviNet to streamline and expedite the prior authorization process for providers, patients, and our medical team. Unfortunately, not all providers use the online system. Even today, in 2024, we continue to see-- receive a signif-- significant number of prior authorization requests by fax. As you can imagine, it takes longer to process a request that is faxed to our medical review team compared to one that is submitted via a web-based portal. I would suggest that instead of requiring health, health insurers to adopt a new system for receiving prior authorization requests, we should suggest that providers utilize the online systems that are currently available to them. Another step we have taken at Blue Cross to reduce the administrative responsibilities around prior authorization process is to offer gold carding for physicians and mid-level providers. Specifically, providers with low denial rates can be exempt from

medical review requirements in exchange for access to provider records for auditing. We are also in conversations to expand the use of alternative payment models that pay for high-quality, cost-effective care, rather than the volume of services that a patient receives. If we can shift the payment methodology to focus on the quality and effectiveness of care, issues like prior authorization may become moot. The final point I want to make is that the Biden administration recently issued regulations that require changes to the prior authorization process. The regulation was released in late January and exceeds 700 pages, so I'm not prepared to discuss the regulation in any detail, but I have concerns that this bill would conflict with some of the requirements of that federal regulation. We recognize the opportunity to improve prior authorization processes for both providers and insurers. That's why we create gold carding programs and invest in tech-- technology to streamline the process. However, we oppose state mandates, it's become very clear today, that interfere with our ability to protect our members from rising healthcare costs. For this reason, we oppose LB917. Thank you.

**JACOBSON:** Thank you. Questions from the committee? Seeing none, thank you, Mr. Blake--

**JEREMIAH BLAKE:** Thank you.

**JACOBSON:** --for your testimony. Further pro-- opponent testimony on LB917? Welcome back.

**MICHELLE CRIMMINS:** Thank you. Senators, thank you. My name is Michelle Crimmins, spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s. As stated previously, I am a registered lobbyist representing Prime Therapeutics. Prior authorization requirements are set on prescription drugs that should be only used for certain health conditions, have dangerous side effects, are harmful when combined with other drugs, may be misused or abused, or if there's equally effective drugs available at a more affordable cost. The prior authorization requirements for these drugs are specific to the drug prescribed. For example, many drugs to treat breast cancer require genetic testing to confirm that the prescribed therapy will benefit the patient. It's important that the prior authorization form reflects the need for the test results. That lets the doctor know what to submit to the insurer. Gener-- generic prior authorization form would not ask for the test results, and it could lead to confusion and increasing provider frustration. Prior authorization may also be used for opioids, an often misused and abused drug, and the prior authorization request for

an opiate would be different from the prior authorization request for the breast cancer drug example. As you can see from the examples, a singular prior authorization form cannot possibly ask questions valid to each specific prescribed drug. To determine that the requirements have been met, the prior authorization form should reflect the prior authorization requirements. We appreciate the work performed by providers in service of their patients, and have invested in electronic prior authorization capabilities to make prior authorization submission as easy and seamless as possible. An increase in adoption of electronic prior authorization would have a greater effect on improving the prior authorization process than a singular prior authorization form, which will have the unintended consequence of adding complexity to the process. For these reasons, we oppose this bill. Thank you.

**JACOBSON:** Thank you. Questions from the committee? Seeing none, thank you for your testimony. Mr. Bell.

**ROBERT M. BELL:** Good afternoon, again, Vice Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I am executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today appearing in opposition to LB917. As you know, the Nebraska Insurance Federation is a state trade association of Nebraska insurance companies, including many health plans operating in the state of Nebraska. Some of our companies-- our stock companies, they do operate for profit. Some of those companies are mutual insurance companies, and they operate for the benefit of their policyholder. Prior authorization is a tool used by health plans intended to improve quality, safety and affordability of healthcare services financed by health insurance. Each plan does use a prior authorization slightly differently, applying prior authorization to a whole variety of different services. If a health plan denies prior authorization for state-regulated health plans, this would be an adverse determination under Nebraska law and trigger the existing laws related to reviews and appeals within the health plan and the external review of the health plan, should the adverse determination continue. External review is a subject that came up before this committee on LB1024 earlier this year. LB917, would direct the Department of Insurance to promulgate rules and regulations related to standardization of prior authorization forms throughout the state regulated health plan industry. In general, because prior authorization is an area of intense market competition for insurers, they are opposed to any kind of standardization, even in forms. Health insurers compete not only

for market share of employers and consumers, but also for the networks of healthcare providers. In fact, healthcare carriers are actively working with health providers on programs related to prior authorization that share risk with the providers. Other health carriers are actively rolling back prior authorization in some areas and in areas of suspected, suspected fraud and abuse, insurers are redoubling their efforts on prior authorization. You already heard the federal government is implement-- implementing a prior authorization reform currently. And this would include electronic interop-- interoperability reform in Medicare Advantage plans, Medicaid managed care, and also these state exchange plans. This federal reform is likely to change prior authorization, and plans are concerned about complying with both a new federal requirement, at the same time, implementing the standardization as required within LB917. I will say-- and we take a look at prior authorization bills across the nation. Certainly, there's technical issues within here that I, I didn't get, but Senator Wayne, this is one of the better prior auth bills that the health insurance industry has seen, but we still are opposed. I appreciate the opportunity to provide these concerns. The Nebraska Insurance Federation respectfully opposes the passage. Thank you.

**JACOBSON:** Thank you. Questions from the committee? Senator Kauth.

**KAUTH:** Thank you, Vice Chair Jacobson. Mr. Bell, when will we know more about this 700-page authorization from the Biden administration? When will that go into effect?

**ROBERT M. BELL:** I don't, I don't know the details. So it, it, it was finalized in June or excuse me, in January. So-- and I think Mr. Blake said it's 700 pages long? So it's, it's going to take a while. It does a lot related to electronic, which, of course, Senator Wayne's bill, while it authorizes the standardization of forms, it does, it does talk about electronic prior auth, as well. And of course, the more we can utilize technology to make prior authorization a, a better experience both for the healthcare provider and the healthcare plan, that-- I mean, that would be that would be great-- and the consumer, of course, as well. But I don't know the details yet, but we can work on getting that information to you and the committee.

**KAUTH:** Yeah. Great. That will help.

**JACOBSON:** Further questions? Senator Bostar-- Ballard.

**BALLARD:** Thank you, Vice Chairman. Thank you for being here, Mr. Bell.

**ROBERT M. BELL:** Yeah.

**BALLARD:** Mr. Blake mentioned gold carding, from his--

**ROBERT M. BELL:** Sure.

**BALLARD:** --is that a common practice among your members?

**ROBERT M. BELL:** Depends on the member. Right. For Blue Cross Blue Shield, I think that, yeah, that's something they, they lean into pretty hard. And they work with their healthcare providers to do gold carding to share the risk with the provider to, to say that, hey, if you've, you've reached a certain level of-- the-- if you understand what gold carding is, I mean, gold carding is you receive that gold card after you reach a certain level of prior authorization, OK, which is, I believe, in the 90s. I mean, probably somewhere in there. I don't know that I-- I want my doctor to be 100%, but-- on, on that. But sometimes, you know, prior authorization leads to further discussions with the healthcare provider, right, on the best course of, of action. And there's, there's some pushback there. I mean, we all share together, right? And we all enter into these contracts with insurance companies. We pool our resources. And, and there's-- this is a cost, this is a cost containment in affordability and safety and quality. We want to make sure that everybody's getting the best care for the money that everybody is spending. I think some, to your original question, some do it, some do not. So I don't think that they all do it.

**BALLARD:** OK. Thank you.

**ROBERT M. BELL:** Yeah.

**JACOBSON:** Further questions. Now, Senator Bostar. You were on my mind. I knew you'd have a question.

**BOSTAR:** Thank you, Vice Chair. Thank you, Mr. Bell. Do you think we should adopt some legislation around gold carding?

**ROBERT M. BELL:** No. I'm-- we are on record opposed to legislation. I believe the market is taking care of gold carding.

**BOSTAR:** I think after the series of legislation we've heard today, I think we can almost unanimously agree the market is not taking care of the problems that are within our system.

**ROBERT M. BELL:** Well, [INAUDIBLE]. Can't disagree with that. Sure.

**BOSTAR:** I mean, we, we heard from testifiers on this bill about working on gold carding, so I just wanted to-- I mean, I think, bring up. The committee is probably aware of it, since we have a bill currently sitting in committee related to gold carding--

**ROBERT M. BELL:** You do?

**BOSTAR:** --that we could do more on this. And--

**ROBERT M. BELL:** Absolutely. You could. We would, we would oppose that, to be clear.

**BOSTAR:** And-- I noticed when you did.

**ROBERT M. BELL:** Yes.

**BOSTAR:** So thank you for that. I just wanted to see if anything had changed.

**ROBERT M. BELL:** On that right now, no. I do know that insurers are actively working with some healthcare providers, some health plans, not all health plans you know, on coming up with their own approach to gold carding.

**BOSTAR:** Because they feel like there's some value in having some process on that.

**ROBERT M. BELL:** Some do and some do not. Right.

**BOSTAR:** And I think if we find value, right, I mean, this is where-- this is the kind of benefit that I think us in the Legislature can provide to Nebraska is when folks are out there innovating and finding that value and finding what works really well, like on gold carding, that we can take those best practices, those lessons learned, and apply them broadly so that everyone has the opportunity to benefit from that.

**ROBERT M. BELL:** Sure. We would oppose-- again, that general mandate to a health plan to do that. Some health plans may find that great. Other health plans do not. So.

**BOSTAR:** Thank you very much.

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

**JACOBSON:** Further questions? If not, thank you, Mr. Bell, for your testimony.

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

**JACOBSON:** Further opponent testimony on LB917? Further opponents. Seeing none, anyone wishing to testify in a neutral capacity on LB917? All right. Seeing none, Senator Wayne, you're welcome to close. And by the way, there were, get the number here, 11 proponent letters, 2 opponent letters, and 1 neutral.

**WAYNE:** So to add a little levity here, I thought of, I thought of dumber and dumber when he said it was the best-- one of the, one of the better prior authorizations. So I thought to myself of that scene, so you're saying I have a chance? And then, Bostar had to ruin it for me by saying everything's messed up. But in all seriousness, what you heard was one hospital system say that it costs around $3 million just to do prior authorization. Do you want to know what's driving healthcare costs up? Those people who have to continue to do prior authorization for unnecessary reasons. Little things, like if you're authorizing somebody to go because of, let's say, diabetes to a, a 2 milligram, but you have to fight about whether they can get a point-- a 1 milligram, and go through that process of a denial, and, and-- like, it's just a waste of everybody's time. And it's definitely a waste of the patient's time. And it causes harm. What I heard was the insurance industry is opposed to everything, including standard forms. Not even forms. We, we can't get basic forms. And what we're doing here is we're continuing to focus on the business and not the patients. The patients would like a standard form and so would the doctors, so they could figure out how to navigate the system. And what you heard here today was even the same insurance company can decide, now this is going to require a prior authorization. You're not going to get your meds. You better hope you have your 30-day supply, because it may take that long. And you may have to go do something else. We don't know yet because they just changed their requirement, without even notices to their providers. We have to do something. And so,

instead of going as far as other states have done, I left it to our Department of Insurance to work with them to put together a standard. I don't know how more flexible we can be. This is a very important bill. I don't know if this committee will have an Exec on it before, but I don't dabble in this area. But when I do, it's because it's personal and it's something that I continue to hear. Besides the economic stuff I talk about, in north Omaha, when I go on the radio or I go on a show and I-- or I'm being interviewed or in a public meeting, and I talk about prior authorization, everybody nods their head. Everybody has had an experience where they said, you can't get that med yet. We got to go back and check with the insurance company one more time. We're tired of waiting for the industry to come up with a solution. People are being denied medical care. And to me, a delay is denial. When people get diagnosed, when people need the opportunity for medication, and their doctor says this is what their need, they should at least be able to get a quick turnaround on whether or not that's approved or not for their insurance, that their paying, I want to add, that they're paying for. And with that, I'll answer any questions.

**JACOBSON:** Senator von Gillern.

**von GILLERN:** Senator Wayne, the-- notably, the Department of Insurance didn't testify regarding your bill. Have you had conversations with them? Have you-- are they up to speed on what you're trying to do here?

**WAYNE:** I have not talked to the department. Typically, I don't engage in agencies ahead of time.

**von GILLERN:** OK.

**WAYNE:** Just-- no, I never work that way. They, they write a fiscal note, tell me what it's going to cost to implement. And this is a very low fiscal note, so I believe that they think it's doable.

**von GILLERN:** And you said how many other states have done this?

**WAYNE:** Well, total, some form of prior authorizations regulation, is around 40 states. Again, that-- when I say some form, it goes from in statute, step by step, to here goes some basic guidelines you have to follow. And so we took the more-- least restrictive version.

**von GILLERN:** OK. Thank you.

**JACOBSON:** Any other questions? If not, thank you. One thing I can assure you of is that we will not Exec on it today.

**WAYNE:** OK. Tomorrow at 8 sounds good. Thank you.

**JACOBSON:** OK, that concludes our testimony on-- our hearing on LB917. And we'll move on to opening a hearing on LB1146, Senator Hansen. Senator Hansen, have you ever been to this committee?

**HANSEN:** I've never been here before. I'm so excited--

**JACOBSON:** Welcome.

**HANSEN:** --to be in the Banking and something else Commerce Committee thing. I just came from Ag Committee, and the Department of Insurance was in the Ag Committee, testifying for the first time ever, they said. And here I am, coming to the insurance company, my first or Insurance-- my first hearing.

**JACOBSON:** Wasn't Groundhog Day a week ago or something like that [INAUDIBLE]?

**HANSEN:** Yes. And I was hoping the baby would be here so I could hold the baby while I was doing this. I was gonna see if I could do 2 things at once, so. All right. Good afternoon, Chair-- Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Ben Hansen. That's B-e-n H-a-n-s-e-n, and I represent Legislative District 16. Several states, including Nebraska, have inadvertently limited access to the life-changing medication patients can utilize through step-therapy and midyear formulary laws. LB1148 remedies this situation through a simple amendment that would expand the list of products available for healthcare providers. With this bill, healthcare providers would be able to prescribe biosimilars along with biosimilars that have the interchangeability designation. For reference, there are nearly 50 biosimilars approved by the FDA, and only 7 of those products have sought and been granted interchangeability. By including biosimilars alongside interchangeable biosimilars in state statute, Nebraska could save as much as $112 million annually, according to an October 2021 study by the Pacific Research Institute, Institute. Let me be clear. This legislation would have no impact on the substitution requirement at the pharmacy level because, under federal law, pharmacists can only substitute interchangeable products for the referenced product. This legislation addresses what products are made available at the formulary level.

Recently, the FDA changed the labeling requirements for biosimilars, and the agency no longer requires companies to list whether a product is designated as interchangeable, since, quote, there are-- there may be inaccurate perceptions that interchangeable biosimilars are safer or more effective than biosimilars that are not approved as interchangeable. The interchangeability designation does not indicate higher levels of biosimilarity. Healthcare professionals can prescribe both biosimilar and interchangeable biosimilar products in place of the referenced product, with equal confidence that they are as safe and effective as their referenced products, unquote. By making this change in our state's law, healthcare professionals will be permitted to prescribe either a biosimilar or interchangeable biologic with confidence. This change expands access to biosim-- biosimilars, which, in turn, creates new choices for healthcare plans and competition in the biologic marketplace. Use of biosimilars has demonstrated lower costs for patients and the healthcare system, bringing patients more options when battling challenging diseases. Biologics, like Humera and Enbrel, account for 2% of prescriptions filled, but equal close to 40% of all drug spending. They are the single biggest driver of drug spending. On average, biosimilars can cost up to 30% less than referenced biologics and have the potential to save the United States over $100 billion over the next 5 years, provided biosimilar uptake increases. Recent Zehnder research has found that competition from biosimilars lowers the price of all biologics. The report found that every brand name referenced biologic was on track to have a higher average sales price in the absence of biosimilars, with an ASP estimated to be 50%-- 6 higher-- 56% higher without biosimilar competition. Without this simple change in law, access to biosimilars for Humira and Enbrel will be limited, as will competition among the various biosimilar options for these products. In summary, by adding biosimilars, we are helping our constituents and creating avenues for additional savings and increased price competition in the healthcare system. This has been demonstrated in the fact that cost savings from biosimilar medicines can be used to treat 1.2 million more patients and have the potential to save the U.S. healthcare system up to more than $130 billion by 2025. I do appreciate your-- appreciate your time and consideration this afternoon. If you have any questions, there will be testimony following, following that will have more insight in the area of biosimilars. With that, I ask for your support for LB1148.

**JACOBSON:** Thank you. Questions for Senator Hansen? All right. Seeing none, thank you. Going to remain for a close?

**HANSEN:** Yes.

**JACOBSON:** All right. Thank you. I'll now ask for proponent testimony.

**KATE KULESHER JARECKE:** Good afternoon, Vice Chair Jacobson and members of the committee. I am Kate, K-a-t-e, Kulesher, K-u-l-e-s-h-e-r Jarecke, J-a-r-e-c-k-e. I want to thank Senator Hansen for bringing this important piece of legislation that has the possibility of lowering drug prices for all Nebraskans. I serve as the director of state government affairs for Sandoz. Sandoz is a global leader in generics and biosimilars. We are not in the EpiPen Or the inhaler market, but we are in the biosimilars launch-- we have launched the first biosimilar in, in Europe in 2006, and in the U.S. in 2015. Our mission is simple, pioneering access for patients by bringing high-quality, more affordable, life-changing treatments to the world. This legislation will ensure improved access to biosimilars so that patients who currently cannot afford biologic medicines could have the same access to those treatments for cancer, arthritis, Crohn's, diabetes, MS, and other chronic diseases. Nebraska is only 1 of 7 states that have a current provision prohibiting the use of biosimilars in step-therapy laws. Georgia, Kentucky, New York, Tennessee, Virginia, and Washington are the other states. Arkansas, California, and Louisiana changed their laws last year, and now allow the biosimilar use. There was no opposition in any of those states, and the legislation passed unanimously in those 3 states. Why did these laws come into effect in the first place? It really is a misguided reading of the substitution provision from Congress, which developed the interchangeable designation. The rest of the world does not have the interchangeable designation and thus, have much more competition and lower drug prices. This interchangeable designation is for the substitution at the pharmacy level only. So if you bring your prescription into your pharmacy, your neighborhood pharmacy, they can substitute an interchangeable biosimilar for the name brand biologic. This provision was never intended to be at the formulary level. LB1148 would remove the hurdles now in place and allow for greater access and affordability, and would not interfere with the patient-provider relationship or change the pharmacy level practice requirements for interchangeable biosimilars. Thank you for your consideration, and I can try and answer any questions.

**JACOBSON:** Thank you. Questions from the committee? I, I just still have one. I'm curious, so why doesn't a company like Sandoz get into the EpiPen? I mean, given the margins that are in that, I mean, it just seems incredible.

**KATE KULESHER JARECKE:** I was-- knew this was going to come up. I-- well, part of it is the patent. All-- both of those products are devices, and I think they-- it's-- was brought up at the, the last hearing, the patent issue is why you don't get into it. We did get into a prefilled syringe for epinephrine. We were in a partnership with that. But it is very hard to get through the, the prefilled syringe in schools and that kind of thing, because you really do need an auto injector.

**JACOBSON:** So. So you're saying it's the auto injector that's patented--

**KATE KULESHER JARECKE:** It's-- yes.

**JACOBSON:** --not the actual product?

**KATE KULESHER JARECKE:** Correct. Correct.

**JACOBSON:** Yeah. It seems like people would probably be willing to mess with a prefilled pen to--

**KATE KULESHER JARECKE:** Right.

**JACOBSON:** --given it for, for 700 bucks.

**KATE KULESHER JARECKE:** Yeah. Yeah.

**JACOBSON:** Yeah. All right. Thank you. I-- probably an inappropriate question.

**KATE KULESHER JARECKE:** And I can get you more. Information on that, too.

**JACOBSON:** Thank you.

**KATE KULESHER JARECKE:** I'm sure we have something on that.

**JACOBSON:** I appreciate it.

**KATE KULESHER JARECKE:** Yep.

**JACOBSON:** Any other questions? If not, thank you for your testimony.

**KATE KULESHER JARECKE:** Thank you.

**JACOBSON:** Further proponents? Anyone else would like to speak in favor of LB1148? If not, opponents? Anyone wishing to speak in opposition? OK. Wow. We sure? All right. No opposition. All right. Wow. Anyone like to speak in a neutral capacity on LB1148? All right. Seeing none, thank you, Senator Hansen, for bringing such an easy bill. Do you want to close?

**HANSEN:** Yes.

**JACOBSON:** All right.

**HANSEN:** It may be the last time I'm ever up here again.

**JACOBSON:** All right. Well, I would be disappointed if you didn't.

**HANSEN:** I really don't have anything to say. But you can tell how simple this bill is, the language of the bill. And it may be not as sexy as it is, but this has the potential to save Nebraska taxpayers $100 million. I think that is, in and of itself, you know, paramount, and hopefully, getting this bill on the floor and giving this benefit to patients in the state of Nebraska. So.

**JACOBSON:** Questions? I would say this, I would-- if it were up to me, I'd Exec on it today, but I, I swore in blood to the Chair that I would not hold an Exec Session.

**HANSEN:** I think we should, and just not tell Senator Wayne.

**JACOBSON:** Senator Bostar.

**BOSTAR:** Thank you, Vice Chair. Thank you, Mr. Hansen, Senator Hansen. I would just encourage you to, you know, introduce something again next year, to come to the committee. Because I, I-- my concern is that you're not getting the real experience that we have to offer here--

**HANSEN:** OK.

**BOSTAR:** --with something like this. So--

**HANSEN:** I've gotten that pretty much in every committee, you know me, in the bills I introduce. So this is one of the simpler ones, though.

**BOSTAR:** Thank you.

**HANSEN:** Yes.

**JACOBSON:** Thank you, again.

**HANSEN:** Thank you very much.

**JACOBSON:** OK. There were 5 proponent letters received on LB1148. With that, that concludes our public hearing on LB1148. We'll move on the last bill of the day, the one we've been looking for, LB1353.

**_____:** Senator Vargas is on his way over from [INAUDIBLE].

**JACOBSON:** Oh, good.

**von GILLERN:** I just passed him [INAUDIBLE].

**JACOBSON:** We'll go into a brief pause until Senator Vargas gets here.

[PAUSE].

**JACOBSON:** Senator Vargas, welcome to the committee hearing, LB1353. It's all yours.

**VARGAS:** Thank you very much, Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Tony Vargas, T-o-n-y V-a-r-g-a-s. I represent District 7, which includes the communities of downtown and south Omaha. I'm here to introduce LB1353, which will require contrast enhanced mammography to be included in insurance and contract coverage, and require coverage for screenings and examinations for women with a variety of risk factors. I'm eager to continue to work, and thank Senator Bostar for what was passed this last year with LB145. LB1353 will not undo any of his hard work, but will continue his efforts to, to include this type of, this type of contrast enhanced and coverage for women who have increased risk or who may need additional testing, due to risk or a seen or suspected abnormality. LB1353 also prohibits the use of deductible, co-insurance, copayment, and other cost sharing requirements contained in the patient's policy or health benefit plans for services. If this prohibition results in the ineligibility of health services or health savings, HSA, the prohibition will only apply once the minimal deductible has been satisfied. However, this excludes the preventative care which remains free, regardless of whether or not that minimal deductible has been satisfied. Increasing access to and affordability of healthcare screenings or health screenings and preventative care for women is personal to me, as my mother, Lydia [PHONETIC], was diagnosed with breast cancer last year. It was detected in its early stages thanks to the diagnostic tests that this legislation seeks to

expand coverage of. Her life was saved because of that, and I believe that every woman should be able to receive that same level of care. It's been a privilege to partner with physicians and the Susan G. Komen Foundation on this legislation. And I'm happy to have so many incredible advocates behind me who could speak to the importance of screenings and preventative care, and the details of this bill. I'm happy to take any questions, but there will be individuals that will be able to answer some more of the questions following me.

**JACOBSON:** Thank you, Senator Vargas. Questions? Senator Bostar.

**BOSTAR:** Thank you, Vice Chair. Thank you, Senator Vargas. I mean, obviously, you and I have talked about this already. My only concern in the bill is the HSA language. One, because it would, it would allow HSA plans to exempt out of the coverage parameters in the bill. And I think-- and I understand why that misconception exists, but it is not necessary. Because the breast cancer screenings, of which this is, are effectively exempt from that-- from those provisions as exists already in federal law. Would you be opposed to removing the HSA section?

**VARGAS:** I'm open to working on this legislation, but I would like to wait until we hear from the proponents/opponents on this issue. But with every single bill, I'm happy to work on it--

**BOSTAR:** Thank you.

**VARGAS:** --including this language.

**JACOBSON:** Further committee questions? All right. Seeing none, thank you. I presume you'll remain for close?

**VARGAS:** Yes. I'm here

**JACOBSON:** All right. Thank you. Proponent testimony on LB1353.

**LINA BOSTWICK:** Hello.

**JACOBSON:** Welcome.

**LINA BOSTWICK:** Senator Jacobson and committee, my name is Dr. Lina Bostwick, L-i-n-a B-o-s-t-w-i-c-k. I've been a practicing nurse for 40 years this year. I represent the Nebraska Nurses Association and 30,000 nurses in this state supporting LB1353. Every single person has been affected somehow by breast cancer diagnoses. My first cousin, mother-in-law, and grandmother are among survival rates. In 17

counties, the annual incidence of female invasive breast cancer per 100,000 cases is anywhere from 14-- 147.3 to 204.6. This is from the National Cancer Institute. The places Nebraska-- has one of the top 17 states in the union for the highest incidence in these rates. We are mid-range state for mortality, at 19 to 20.5 cases per 100,000. Annually, new breast cancer cases for women 65 and older in Nebraska is 46%, 35% for those that are 50-64 in age, 14% for women that are 40-49, and 15% for those under the age of 40. Caucasian women have the highest incidence rates for breast cancer, but African American women bear the highest burden, with mortality rate at 33.7. Nationally, 1 in 8 women will be diagnosed with breast cancer, and 1 in 3-- and 1 in 3 of those cases will become metastatic. 5% of persons initially diagnosed with breast cancer are at an advanced stage, a stage 4, upon initial diagnosis. The national 5-year survival rate stands at only 22%. According to the Nebraska Cancer Incidence and Mortality, for women only, in Nebraska, breast cancer is the most common type of cancer among women and the second most frequent cause of female cancer deaths. Although breast cancer screening cannot prevent breast cancer, the passing of this bill will certainly help find breast cancers earlier, when it is more manageable to treat. Breast cancer screening means checking before there are signs or symptoms of the disease. Screening continues to lead to early breast cancer diagnoses, which is absolutely key to long-time survival. Insurance coverage for additional diagnostic magnetic resonance imaging, additional digital breast tomo-- tomography, and bilateral whole breast ultrasounds, when necessary, will save our mothers, mother-in-laws, cousins, daughters, sisters, and aunts. The Nebraska Nurses Association asks that LB1353 be moved out of the committee to the General File. I do appreciate, Senator Bostar, your question also, about the HSA. Nebraska Nurses Association would appreciate that, as well, if we could get that language and make it-- make that not-- make it so it's not an issue for women that potentially, you know, would have breast cancer, for the screening.

**JACOBSON:** Thank you for your testimony. Questions for the testifier? Senator Bostar.

**BOSTAR:** Only because I didn't have an opportunity to respond without being called. Thank you very much.

**LINA BOSTWICK:** Yes. You're welcome.

**JACOBSON:** All right.

**LINA BOSTWICK:** OK.

**JACOBSON:** Thank you for your--

**LINA BOSTWICK:** Thank you.

**JACOBSON:** --testimony, Ms. Bostwick. Further proponents? Just out of curiosity, how many intend to testify on this bill? OK, if you could move to the front row, that'd be great. And that way, we can keep this moving. Welcome. Go ahead.

**MAGGIE NELSON:** Hello. My name is Maggie Nelson, M-a-g-g-i-e N-e-l-s-o-n. In November of 2022, my mother was diagnosed with breast cancer. She received the genetic testing, and she was positive for the BRCA2 gene. This allowed my siblings and I to get the testing, as well. We all came back pos-- positive for the gene. This is very rare for all 3 offspring to be positive for this gene. It's usually a 50% chance that they do. My sister is here today, and she'll be speaking about her experience. Upon testing positive for this gene, I went to a genetic specialist, who told me the risk and recommendat-- and recommendations for my future health. She advised a MRI with contrast to get the, the best baseline. And after 6 months, she recommended to get a mammogram. She recommended doing both MRI and mammogram 6 months apart every year to ensure that I am clear or catching something very early. The provider said that the screenings would be covered under the preventive care for insurance, and there should be no patient responsibility, so I went ahead and schedule the MRI. Before going to the, the hospital, I made sure, with the billing department and the MRI tech, to make sure this would be billed preventively and not diagnostically. I do not have breast cancer. Fast forward a couple months later, I received a $3,800 bill from the hospital and an EOB from Blue Cross Blue Shield. I called both the hospital and Blue Cross to get this sorted out. The Blue Cross representative I spoke with was very good. She did confirm that since the BRCA2 gene, that this MRI could be considered preventative. She gave me the correct billing codes and then offered to call the hospital to get this sorted out. I also stayed on the line while she called the hospital. I followed up a couple more days after with the hospital, and they said that these codes that were given were bloodwork codes and cannot be used for MRI. This is as exhausting as it feels, trying to explain it to you guys. It was a mess. The claim came back under my deductible, so I appealed the decision with Blue Cross Blue Shield 2 different times, both times being denied. The second time, I went as far as writing a letter, while getting a letter from Kendee Koster, the PA who recommended the

MRI, and showing medical literature showing that MRI is the best new gold standard for catching early stages of breast cancer. I also attached the reference number and name of the Blue Cross representative that I spoke with, that concern-- that confirmed that the MRI would be considered a preventive screening. However, they still denied after the second appeal. So the $3,800 is applied to my deductible. I pay over $4,000 a year for my insurance that I never use besides that yearly visit, but yet, I still receive a $3,000 bill for the one scan that's going to keep me from spending thousands of dollars to do cancer treatment. This system is so reversed. We treat disease rather than supporting prevent-- preventative care. Most people, especially young people, cannot afford a $4,000 bill, myself included. So I was recently engaged, and we decided to actually get married before our wedding date so I could use his insurance. He's a retired veteran, and so I get all of his full benefits. I will be getting preventive surgery so that I do not have to worry as much about this gene affecting my life. I'm fortunate enough that I can use his insurance. However, my friends and my family, this will be something that will affect them in the future. I do not want to see them or my future children have issues trying to get this-- or take these steps to stay alive. For insurance companies, $4,000 is a small price to pay to cover what a cancer treatment would be. If women would qualify for a yearly MRI, just like other recommendations their doctors give, with our yearly exams, we could save a lot of lives.

**JACOBSON:** Thank you. Questions from the committee? Senator Bostar.

**BOSTAR:** Thank you, Vice Chair. Did you have anything else you wanted to add or were you finished?

**MAGGIE NELSON:** No, I don't-- sorry. I'm nervous. I think it's-- no. That's-- my sister will speak a lot more and in depth. So.

**BOSTAR:** Thank you.

**MAGGIE NELSON:** Yep.

**BOSTAR:** Thank you for telling your story.

**MAGGIE NELSON:** Yep.

**JACOBSON:** Thank you for your testimony. Further proponents? Welcome.

**SARA KLINGELHOEFER:** Thank you. Thank you for letting us come talk to you guys today. Hello. My name is Sara Klinghoffer. I'll spell that

for the record. It's a long one. S-a-r-a K-l-i-n-g-e-l-h-o-e-f-e-r. I testify today as a private citizen in support of LB1353. Although I've gotten a lot of compliments about my hair, it was not my choice. I'll explain that in a little bit. I am 34 years old. I am young, active, healthy, a nonsmoker. I have less than one drink per month. I breastfed my babies and my BMI is within the recommended range. All of these are protective factors that are supposed to protect me from breast cancer. Despite all of these, I was diagnosed with a very aggressive breast cancer at the young age of 33 years old, 5 months after having my third baby. Stage 2, grade 3, my cancer was very, very aggressive. It grew an entire centimeter just between diagnosis and surgery, which luckily was only a month apart. The only reason I was diagnosed when I was, was because my mother was diagnosed 2 months before me. And she was-- also tested for the BRCA gene, in which she was positive. It should be known that immediately after hearing my mom had cancer, even before knowing her BRCA results, I innocently called my OB-GYN clinic about getting a mammogram or some type of screening because I was terrified. I'm a worrier. I was told I was too young, because of insurance regulations and all that, that my mom was in her late 50s, I was only 33, so I did not qualify for a screening based on their standards. This was before I knew my BRCA status, before I found my lump, 2 months before my own diagnosis. I will never know this for sure, but I cannot help but wonder if these 2 months could have kept me at a stage 1 or even stage 0, had I been tested earlier like I wanted to be. Even after receiving my BRCA positive results and finding a lump, I was still told that I was very young, that I should maybe wait a month, see if the lump grew or changed, and that I should even wait 6 months after breastfeeding. I think another insurance recommendation. I refused to follow this plan and demanded imaging. My oncologist told me, had I waited 6 months, the conversation we were having that day in his office would have been palliative and preparing me for my death. He also told me the person-- he also told me the reason postpartum breast cancers, which I had, are more fatal are because they are not caught early enough. The only reason I am alive today is because my mom had access to screenings, because, due to my age, I would have never been screened in time. I was literally fighting for my life, and insurance and medical communities were placing barriers in my way. My cancer diagnosis has placed me into a club I never wanted to be part of, the breast cancer under 40 club, and there are so many of us. We are all so frustrated with the insurance and medical system. Breast cancer in your 30s or younger tends to be aggressive and fast growing. There are many of us who are not diagnosed until we are stage 4, which is currently not curable.

The Young Survival Coalition states that every year, more than 1,000 women under 40 die from breast cancer. Nearly 80% of young women diagnosed with breast cancer find their breast abnormality themselves. I am part of that 80%. I have 3 young children, one being a little girl who could have this gene. If she does, she will have an 80% risk of developing breast cancer in her life. And even without the gene, she is still at a significant risk. I do not want her to have to go through what I have gone through, or risk dying because rules set by our insurance companies. Cancer took a lot from me. One of the hardest things it took from me was the infancy of my last baby. I spent my last baby's first 12 months recovering from chemotherapy and multiple surgeries. In the last year, I've had 3 major surgeries, 2 1/2 months of chemotherapy, and I will suffer side effects from my current treatment plan for the rest of my life to hopefully keep a reoccurrence away. And I will never get his infancy back. There is a lot that earlier screening could have done for my family. In some ways, it could have saved me a cancer diagnosis had we had access to BRCA testing as a preventative tool. To ask for a BRCA test without a direct reason would have not only cost thousands of dollars, but I would have been told it was unnecessary by my insurance company. Aside from BRCA testing, just having access to traditional screenings could have given me an earlier diagnosis and even better prognosis, with possibly a less severe treatment path. This bill could save my own daughter's life someday, as well as my sister's. I want you to consider this if I was your friend, sister, mother, wife, or daughter, what would your decision for this bill be today? This is the end result when women don't get screenings we need and are told that we are too young. We die. This bill could save women from dying. That is why it needs passed.

**JACOBSON:** Thank you for being here. And thank you for the very compelling testimony. I'd ask for any questions from the committee. If not, truly, I appreciate you being here. Thank you. Further proponents.

**JUAN SANTAMARIA:** Good afternoon, members of the Banking, Commerce and Insurance Committee. Thank you for your time and having this session. My name is Dr. Juan Santamaria, spelled J-u-a-n, for the record, S-a-n-t-a-m-a-r-i-a, and I stand before you in full support of the proposed LB1353. I come today as an individual, citizen of Nebraska, and my views do not represent those of my employers, the University of Nebraska Medical Center and Nebraska Medicine. This bill seeks to ensure comprehensive coverage for breast cancer screenings and diagnostics for women of Nebraska. As a concerned citizen, breast

cancer surgeon, and advocate for women's health, I urge you to consider the profound impact this bill could have on the well-being of countless women of our state. Breast cancer remains one of the most prevalent and concerning health issues facing women today, especially in Nebraska, as we heard earlier. Early detection is paramount in improving outcomes and saving women's lives. Yet, access to essential screening and diagnostic services are frequently hindered by financial barriers and inadequate insurance coverages. This bill aims to address these disparities by mandating coverage for a range of critical breast cancer screening modalities, including mammography, diagnostic digital tomosynthesis, ultrasound, and MRI, magnetic, magnetic resonance imaging. The proposed amendments outlined in this bill reflect a comprehensive approach to breast cancer screening, tailored to meet the diverse needs of women across different age groups and risk profiles. It is crucial to understand and recognize that not all women face the same risk of developing breast cancer, as we have heard. Factors such as family history, race, ethnicity, and breast density contribute to different levels of risk, with some women facing significantly higher probabilities of developing breast cancer at an earlier age. We're witnessing an alarming rise in breast cancer among younger women, as we have heard, and these are increasingly pre-- presenting as more aggressive forms. Particularly concerning is the rise of postpartum breast cancer, which tends to have worse outcomes and predominantly affects women of reproductive age. By ensuring coverage for breast imaging for women younger than 40, annual mammograms for women over 40, and additional screenings for those with heightened risk factors, we are taking significant steps towards proactively and being personalized healthcare approach. This approach not only facilitate early detection, but it also will enable timely intervention, potentially saving lives and reducing the impact of breast cancer. Moreover, moreover, by prohibiting deductibles, co-insurances, copayments and other cost sharing requirements for these essential services, this legislation ensures that financial considerations do not impede access to life-saving screenings. This provision is particularly crucial in promoting equitable healthcare access, as it removes financial barriers that disproportionately affect low-income individual-- individuals and marginalized communities. Furthermore, the inclusion of diagnostics breast examinations within the scope of coverage is a critical aspect of this bill. These examinations are essential for evaluating abnormalities detected during screening or through other means, enabling timely and accurate diagnosis. In summary, I urge you to support this bill as a vital step towards advancing women's health and combating breast

cancer in our state of Nebraska. By enacting these amendments, we have the opportunity to save lives-- women's lives, alleviate financial burdens, and promote equity in healthcare access. Thank you for your time and consideration. I'll be happy to take any questions.

**JACOBSON:** Questions from the committee? Seeing none, thank you, doctor, for being here.

**JUAN SANTAMARIA:** Thank you.

**JACOBSON:** Further proponents, LB1353. Welcome.

**DOUG NIEMANN:** Hello, committee members. My name is Doug Neimann. For the record, that's D-o-u-g N-i-e-m-a-n-n, and I am a board-certified radiologist with 15 years of experience. I currently work at the Nebraska Medical Center, and I'm here on my own volition because I believe in the proposed legislation. Breast cancer, as we heard, is the number 2 cancer-related death in women, only surpassed by lung cancer. Moreover, breast cancer is the most commonly diagnosed cancer and the leading cause of cancer death in young women aged between 20 and 49, in that these cancers are more aggressive and the prognosis is worse. It is also important to note that Nebraska has the-- one of the higher incidence, the top half in the, in the United States, of newly diagnosed breast cancer. Breast cancer survival is influenced by cancer size, and if the cancer has spread to the lymph nodes at the time of diagnosis. If the cancer is small and hasn't traveled to the lymph nodes, then the chance of survival is about 90%. Thus, our goal as physicians is to find the small cancers that have not yet spread. According to the AMA, an effective cancer screening program should be re-- reproducible, valid, and able to detect the disease before its critical point. For breast cancer, that equates to small cancers that have not traveled to the lymph nodes. Screen mammography has been successful to reduce breast cancer mortality by up to 50%. Some of that is attributed to better treatment, which accounts for maybe 10 to 50% of that reduced mortality. Mammography is good at detecting breast cancer, but we can do better. What I mean is that for some women, particularly those with dense breasts, which is about half of the population, cancer detection with mammography is challenging. Our sensitivity or ability to detect the cancer in those women with dense, dense breasts is approximately 65%, versus 85% for those who do not have dense breasts. It is estimated that we miss approximately 25 to 40% of cancers in women with dense breasts, with mammography. Furthermore, it has been shown that these women with dense breasts are at higher risk for developing breast cancer. If we look at cancer

detection sensitivity rates per 1,000 women with dense breasts, mammography is 3.8, 3D mammography is 5.0, contrast enhanced mammography is 13, and breast MRI is 13. In a recently published article in 2013 [SIC], the Journal of Breast Imaging, it stated that the earlier that we find the cancer, obviously, we have a better survival rate, but we also have more effective cost treatment, which would be beneficial to the insurance companies. As of June of 2023, there are 14 states that have no cost sharing legislation in effect or soon to be in effect. And in New York, diagnostic imaging is also required to be covered. So in Nebraska, we have the opportunity to become a national leader when it comes to detecting breast cancer. We have an array of imaging modalities. Why not use them? LB1353 would allow the women of Nebraska the opportunity to receive the highest standard of care for breast cancer detection, and the benefit would be more life saves and more cost-effective treatments. Thank you

**JACOBSON:** Thank you, Mr. Neimann. Questions from the committee? Seeing none, thank you for your testimony. Further proponents? Welcome.

**MICHAEL STEINER:** Good afternoon. Vice Chair Jacobson and members of the committee. My name is Michael Steiner. First name is M-i-c-h-a-e-l, and the last name is Steiner, S-t-e-i-n-e-r, and I work for Susan G. Komen, the breast care organization. And in that capacity, I am responsible for doing their government relations, their public policy and advocacy work in part of the Midwest, and I cover Missouri, Kansas, and Nebraska. And I come from you-- from Kansas City, and I live in Overland Park, which is a suburb of Kansas City. And I appreciate what Senator Vargas has done, and he explained the bill very well. And you have my testimony, and you also should have a map of this legis-- of where this legislation has passed. And I'm happy to report that that number has increased from 13 states to 20 states. And at the end of '24, we expect that number to hopefully be around 25 states. And we first were-- began working on this legislation in 2016. And at the end of 2024, we expect that to be at about 25 states. There are a few things that I would like to touch on that I think you may hear from some of the folks that may tut-- that may speak after me. And one of the things is cost. And that's actually something that we would like to talk about, is cost. And in fact, what we would probably think-- talk about regarding this bill is actually-- is that we think that this bill is probably a cost savings, if anything. And, you know, if you think about it, you know, if you look at late stage breast cancer, some of the numbers that we know is that we hear that late stage breast cancer, you know, easily could run around, you know, $90-100,000 to, you know, a quarter of a million

dollars. But if you look at the cost of a diagnostic mammogram, you know, that's $200, and diagnostic ultrasound is $500, and MRI is $1,200. In Nebraska in 2024, you're going to look at 1,700 women diagnosed with cancer. And so if you do the basic arithmetic, you can look at that cost. Another thing that you might talk about how-- is that you are looking at this bill is going to be unfair, and that you are picking one cancer out of, you know, you're pitting one cancer against another cancer. And we don't look at it that way, in that cancer is not a disease. It's a collection of diseases. Even within breast cancer, it's a collection of diseases. And so, we don't think that that's a-- necessarily a good way to look at it. Another thing that I would like to talk to you about is that you've heard that this is a defrayal of cost, that this is a new mandate. And we would push back on that. In reviewing the fiscal note, we've noticed that this is a defrayal of cost, that this bill would require a defrayal of cost, that it is a new mandate. And we would-- we disagree. And in looking at that fiscal note, we've noticed that it's been phrased that way. And looking at your essential health benefits, we don't think that that's accurate. And we've noticed that in reviewing your essential health benefits, that mammography and imaging are already covered. And I think it probably, this warrants a discussion with your insurance department, and it probably warrants a discussion, discussion with some of your insurance folks, that we don't think that that may be accurate. And when looking at that, in looking at your essential health benefits and looking at the bill, it's important to note that this is not an expansion of anything. This is pure cost sharing. In other words, that this is just a financial relationship between the insured in the insurer, that this is not a, a new expansion of, of, of anything, that this is just a financial relationship or what you call cost sharing. And in fact, CMS has noted--

**BOSTAR:** Sir, I'm sorry.

**MICHAEL STEINER:** Yep. Yep.

**BOSTAR:** You're, you're-- been out of time for a little bit. Let me see if you have any questions.

**MICHAEL STEINER:** Yep. I'm sorry.

**BOSTAR:** Questions from the committee? Senator Ballard.

**BALLARD:** Can you finish your thought on the fiscal note?

**MICHAEL STEINER:** I'm sorry?

**BALLARD:** On the, on the cost-- can you finish your thought on the cost sharing and the fiscal note?

**MICHAEL STEINER:** Yeah. In the 20 states since this has passed, no state insurance regulator has ruled that this is a new expansion or a defrayal of cost, that no state regulator has determined that this is a new mandate that, that has violated the ACA and therefore, is a defrayal of cost.

**BALLARD:** Thank you.

**MICHAEL STEINER:** Yep.

**BOSTAR:** Additional questions from the committee? Seeing none, thank you very much. Additional proponent testimony? Seeing none, opponent testimony? Welcome.

**ANN AMES:** Thank you. Good afternoon, Senators. I'm Ann Ames. I'm the CEO of the "Big I" of Nebraska, A-n-n A-m-e-s. And I'm here to oppose this bill with the current way that it's written. We were here last year. We supported early detection. We still support that. We believe strongly that prevention is much more cost-effective than treatment. However, we-- I-- we feel very uncomfortable with the HSA language. As small businesses across the state of Nebraska, with 2,000 employees everywhere, we're concerned that this will hit lower-income women and women in rural communities harder. If, if that language were to be removed, the HSA language, we would be completely on board. But for right now, we're concerned about that.

**BOSTAR:** Thank you. Questions from the committee? Thank you, Ms. Ames. Additional opponent testimony? Mr. Bell, welcome back.

**ROBERT M. BELL:** Senator Bostar and members of the Banking, Commerce and Insurance Committee, appreciate being welcomed back. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm an executive director and registered lobbyist for the Nebraska Insurance Federation. I'm appearing today in opposition to LB1353. You already know that the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies. Last year, with the passage of LB92, the provisions of-- that, that included the provisions of many insurance-related bills, and banking bills, too. It also included the provisions of LB145, which updated Nebraska's law relevant-- related to breast cancer screening. The breast cancer

screening law was updated to eliminate cost sharing for certain new types of breast cancer screenings, including MRI's. This new law, just when it-- became operative on January 1 of-- the January 1 plan year, and I believe everyone is anxious to see the positive impacts on women's health. Under the Affordable Care Act, preventative, preventive services are generally free from cost sharing. What is cost sharing? Cost sharing is a general insurance term that encapsulates deductibles, co-pays, co-insurance, and other out-of-pocket expenses paid by premium payers. This is a way to share risk within a group, so that those who utilize the service more often pay more than those who do not. The ACA mandated that preventive services, as defined by federal law, should not be subject to cost sharing. The provisions of LB31-- LB1353 go beyond mere preventive screening for breast cancer and cross the threshold to diagnostic, as you have heard from the proponents, which the ACA absolutely allows cost sharing to apply, should a contract provide. In LB1353 are requirements that cost sharing to be waived for follow-up from the screening procedures when abnormalities are found. In all other types of cancer screenings, cost sharing would apply to these follow up diagnostic visits. To remove the cost sharing provisions from the follow-up visits will merely move these costs from the individual to the overall pool, increasing the premium cost for all. Again, on, on all other types of cancer screening, follow-up appointments for scans, biopsies, MRI's, etcetera, would be subject to cost sharing, if the insurance contract so provides. This would make the mandates in LB31-- LB1353 fall far outside the Essential Health Benefit benchmark plan of Nebraska-- and each state has their own benchmark plan-- subjecting the state of Nebraska to additional costs. The legislation would also be-- also increase costs for all the premium payers subject to the state mandate. A better solution would be to continue to monitor the performance of the new operative, LB145, which we spent a lot of time and careful negotiation in working out with Senator Bostar and this committee. For those reasons, we oppose the passage of LB1353. Appreciate the opportunity to testify.

**BOSTAR:** Thank you, Mr.-- oh.

**JACOBSON:** Questions? Thank you. I'm back. Senator, Senator von Gillern.

**von GILLERN:** Mr. Bell, can you help me understand the, the, the HSA language in here, [INAUDIBLE], what that does--

**ROBERT M. BELL:** Sure.

**von GILLERN:** --what that's intended to do and maybe some unintended results of that?

**ROBERT M. BELL:** Yeah. It, it-- if-- bear with me. It's a little bit of a journey on--

**von GILLERN:** It's 5:15, so.

**ROBERT M. BELL:** --HSA. I know. I, I realize that. It's very late. My, my office was evacuated earlier for a natural gas leak, so I'm, I'm, I'm in no rush. So.

**von GILLERN:** [INAUDIBLE].

**ROBERT M. BELL:** So the IRS allows high-deductible health plans and health savings accounts to accompany, along with those high-deductible health plans, to place tax free money into an HSA account. It has to be tied to a high-deductible health plan. And under that, all, all thing-- all treatments, things like that, you have to reach the deductible, except for certain preventive services. Right. And the IRS regulations have changed over the years, but they list out and then kind of build upon one another, starting way back in the early 2000s, up until, I think, as recently as a couple of years ago, when they last updated that rules. Breast cancer screening has always been included in that. And so, that's why the HSA language was not needed in-- under LB145. However, what you're looking at here is you're moving beyond preventive services and you're moving to diagnostic services. So there's an abnormality found in a mammogram or an MRI or something along those lines and they want to do a follow-up whatever procedure. Once you've crossed that threshold, cost sharing needs to apply under those high-deductible health plan regulations of the IRS. And so, thus, you have to have the savings clause if you pass the provisions of LB1353. You don't need it under LB145. Does that make sense?

**von GILLERN:** Um-hum. That's helpful. Thank you.

**JACOBSON:** Further questions? If not, thank you, Mr. Bell, for your testimony.

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

**JACOBSON:** I get the sense that sen-- Mr. Blake is going to follow you.

**JEREMIAH BLAKE:** It's after 5:00. Can I say good evening?

**JACOBSON:** You could, you could. It won't help, but you can.

**JEREMIAH BLAKE:** Good evening. Vice Chair Jacobson, members of the committee, my name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B as in boy, l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB1353. At Blue Cross, we share your commitment to increasing cancer screening rates for women across Nebraska. This commitment goes beyond simply paying claims. We're proud sponsors of Susan G. Komen Nebraska. We also bring the Methodist Mobile Mammogram unit to our office in Omaha for our employees twice a year. These are just a few examples of how we seek to educate Nebraskans about the importance of participating in preventative services like breast cancer screening. Under both our employer group and individual health plans, breast cancer screening is covered as a preventative service for women beginning at age 35. Women who are age 40 and above are eligible for annual screening without any cost share. We also cover cancer genetic screening and counseling at 100% for women with a family history of breast cancer. Preventative health measures, such as breast cancer screening, can help avoid developing health problems and prevent minor issues from becoming major health concerns. Last year, we were pleased to work with this committee to update our state laws to adopt the National Comprehensive Cancer Network Guidelines for breast cancer screening and diagnosis. The NCCN Guidelines are developed by 33 of the leading cancer centers in the United States, including the Buffett Cancer Center at UNMC. Blue Cross has used the NCCN Guidelines to guide our medical policies for a number of years, because they are the gold standard for cancer screening. Our opposition to LB1353 is that it mandates coverage for imaging services that are not part of the NCC [SIC] guideline-- guidelines, upending the carefully crafted agreement that we came to last year. I certainly understand the desire to ensure that women have access to cancer screening. And I would just humbly recommend that we wait and see how this new law is impacting cancer screening rates in Nebraska. So thank you for the opportunity to share what Blue Cross is doing to support breast cancer screening efforts in Nebraska. And I'm happy to answer any questions you have.

**JACOBSON:** Thank you, Mr. Blake. Questions from the committee? I would just have one. I, I-- I'm just curious, where-- Blue Cross obviously handles a lot of employer plans. Do any of your employer plans contain something that would be included in LB1353, where they're all kind of individually crafted?

**JEREMIAH BLAKE:** That's a good question. Let me look into that and get back to you.

**JACOBSON:** I'd be curious to know the answer to that. Thank you.

**JEREMIAH BLAKE:** Yeah. Um-hum.

**JACOBSON:** Any other questions? Last chance. Thank you, Mr. Blake, for your testimony. Anyone else wishing to speak in opposition of LB1353? If not, anyone wishing to speak in a neutral capacity, LB1353? All right. Seeing none, Senator Vargas, you're welcome to close. And by the way, there was 11 proponent letters, 1 opponent, and 2 neutral test--letters. Thank you.

**VARGAS:** Vice Chair, thank you very much, members of the committee. I just want to thank you for not only hearing out the proponents and the opponents of this bill, but-- I realized a couple things. One, this will be my last time in this committee, that's for sure, and I'll be done in the Legislature. And for, for those of us that have been here-- I know, for Senator Aguilar, you've been here the longest-- I, I try to step back and think about some of these bills, on what, what our intent is. The first, tremendous amount of work that's been done last year. And I've talked to Senator Bostar about this. It's great. And-- but as we all know, for every single bill that we've had, that doesn't mean that the work stops. And what we've heard, from individuals that have survived cancer, and we've heard from cancer physicians and-- is that there's a clear need to continue to move forward. Even in the statistics, looking at the last-- within the last year, there were 4, 5, 6 more states that actually passed legislation that closer mirrors this. It doesn't mean that we are not meeting the needs of all women, but it's-- means that we're not meeting the needs of more women. The question shouldn't be whether or not we should or shouldn't do this. The question should be are we able to work on this legislation? Are we able to pass something that's going to cover more women and do it in a way? And I know that there's a lot of terminology used that's sort of like pushes the narrative, that it's either, you know, preventative, or is sort of a, a, a screening. And ultimately, what I'm looking at is whether or not we're going to save more people's lives, and whether or not we're willing to do something about it that's a, a further step from what was done last year. There's times in, in the committees that I've worked on, in Appropriations, where we worked through the negotiations, and there are also times where we say, OK, where can we be a leader in this? If we were the first state to do this, it would be a whole, whole different set of

circumstances. But now we're in the middle, so-- and in the middle of taking that next step forward. That's what this bill is about. It's building on what Senator Bostar worked on. It's building off of what you worked on. And for those of you that know that we have term limits, for the, for the public, but you all know this. We're not in a period of where we can just wait and see how things go. Obviously, the bill passed last year will have a significant impact. Passing this bill and expanding it will have it-- allow it to have more of an impact. I'm happy to work on any of the language, per the question that Senator Bostar provided, and in some of the opposition testimony. And I'm not going to say no to working on any of this language, because that's not how we work with any of this. So that's my commitment to you. I appreciate your time. And the story from my mother, it was-- this is personal. It's one of the reasons why this was something that not only sparked my interest prior to the news of my mother, but I, I realized that the further the screening aspect of this-- and for those individuals that have especially more dense issues, the preventative side of this-- we're really fortunate that we caught this for my mother. But who are we not catching this early enough? So thank you very, very much for taking the time, and for all the testifiers. I appreciate you.

**JACOBSON:** Senator Vargas, thank you. And thank you for your leadership on this. I've worked with you for a couple of years now, and I can tell you we are going to miss you in this body, and the things that you brought, and for the passion you bring to the bills you bring. And today is a classic example, given the story of your mother. And you brought some very compelling testimonies here today, so you know how this is done. So thank you very much. Questions for Senator Vargas? All right. If not, thank you again very much. Thank you to all the testifiers. And I think we will consider this hearing closed.