WILLIAMS: Good afternoon, everyone. We are at the appointed hour. Welcome to the Banking, Commerce and Insurance Committee hearing. My name is Matt Williams. I'm from Gothenburg and represent Legislative District 36. I serve as Chair of the committee. The committee will take up the bills in the order posted. Our hearing today is your part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. The committee, committee members may come and go during the hearing. We have to introduce bills in other committees and may be called away. It is not an indication that we are not interested in the bills being heard. It's just part of the process. To better facilitate the proceeding, I ask that you abide by the following procedures: please silence or turn off your cell phones, move to the front row when you are ready to testify. The order of testimony on each bill will be the introducer, followed by proponents, followed by opponents, neutral testimony, and then the senator will be asked to come back and, and make closing remarks. Hand your pink sign-in sheets to the committee clerk when you come up to testify. Spell your name for the record before you testify and please be concise. It is my request that you limit your testimony to five minutes. We do use a light system. The green light will be on for the first four minutes, followed by the yellow light coming on for one minute. And then it will be red, and we would ask that you conclude your testimony at that time. If you will not be wanting to testify at the microphone but want to go on the record as having a position on a bill today, there are white tablets at the entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent records at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and we will need ten copies. And if you do not have enough copies, please raise your hand and the pages will make those for you. To my immediate right is our committee counsel, Bill Marienau; to my left, at the end of the table, is committee clerk, Natalie Schunk. Committee members that are with us today will introduce themselves, starting with Senator Pahls.

PAHLS: Thank you, Chair. Rich Pahls, District 31, southwest Omaha.

McCOLLISTER: John McCollister, District 20, central Omaha.

SLAMA: Julie Slama, District 1: Otoe, Nemaha, Johnson, Pawnee, and Richardson Counties.

LINDSTROM: Brett Lindstrom, District 18, northwest Omaha.

AGUILAR: Ray Aguilar, District 35, Grand Island.

FLOOD: Mike Flood, District 19, Madison and the southern half of Pierce County.

WILLIAMS: And our pages today are Logan and Natalie. Thank you for being with us and taking your time. And with that, we will ask Senator Kolterman to come and this will open the public hearing on LB767. Senator Kolterman.

KOLTERMAN: Thank you, Senator Williams. Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n, and I'm here today to introduce LB767, which would adopt the Pharmacy Benefit Manager Licensure and Regulation Act. As all of you probably remember, last year I introduced LB375, which was to highlight the issues that I have witnessed personally that affect the business relationship between our local pharmacies, insurance companies, pharmacy benefit managers, and pharmaceutical industry. Following that hearing, I made a commitment to continue to work with all the different stakeholders that this legislation would affect in order to come up with legislation that would be agreeable to all. While LB767 doesn't address every single concern out there, the stakeholders that I'm aware of agreed that LB767 represents a solid middle ground that everyone can live with. Before I get too far into it, I would like to make some-- acknowledge some people that have been working on this legislation with me starting with the Department of Insurance, the Nebraska Pharmacy Association, the National Association of PBMs, the Insurance Federation, the insurance companies-- I won't name them all-- the Hospital Association-- Nebraska Hospital Association, Nebraska Medicine, PhRMA, and the Nebraska Medical Association. In addition to that, Senator Williams, Senator Morfeld, Senator Bostar, and myself have had countless meetings with all of these stakeholders and it's been a pleasure to work with all of them. I'd be remiss if I didn't thank my, my associate Tyler Mahood, my legislative assistant, and Bill Marienau, legal counsel for the Department of Insurance [SIC]. They've all played a key role in getting this to where it is today. I'll now walk you through the bill. Section 1 through Section 6 of LB767 contains the NAIC model legislation, which establishes the standards and criteria for the licensure and regulation of PBMs. Section 7 establishes uniform auditing standards. PBMs must have our local pharm-- give our local pharmacies a 14-day notice before the initial on-site audit and further establishes uniform standards for similarity situated pharmacies. We have heard that the first five business days of any month are the busiest times of our, of our

pharmacies, though-- so they have asked for limits on when audits can take place on site. Therefore, everyone is in agreement to prohibit on-site audits during these five days. Another concern we heard is that some PBMs hire third-party auditors who are incentivized to find mistakes by receiving a percentage of the recoupments that a pharmacy remits to the PBM for any mistake the pharmacy makes. With agreement of all involved, LB767 puts an end to this business practice. We're also limiting what is allowed to be recouped in this audit. If a clerical mistake is made on a prescription that does not cause financial harm to the covered person or the health plan, these mistakes when found during an audit the PBM would not be allowed to claw back the payment the pharmacy receives for this prescription. Section 8 governs a maximum allowable cost list. These lists, commonly referred to as MAC lists, refer to a list of products which includes the maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available. Each PBM may have more than one MAC list, and no MAC lists are alike and change constantly. Therefore, we are requiring that these lists be updated at least every seven business days noting any price change and must also be available to each contracted pharmacy in a format that's readily accessible. If there's any issue with pricing on these MAC lists, a pharmacy has a 15-day limit to appeal and must be investigated and resolved by the PBM within seven days. If an appeal is valid, the PBM must adjust the drug price within a day after the appeal is resolved and allow the pharmacy to reverse and rebill the claim. Section 9 of LB767 is, is of utmost importance to our local hospitals, as you will hear from testifiers who follow me. Section 9 prohibits discrimination against 340B entities and 340B contract pharmacies. The 340B drug pricing program requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to healthcare organizations that care for many uninsured and low-income patients. The health entity then must invest these savings they receive from buying drugs at discounted rates into providing care for uninsured and underinsured patients. Those following me will be able to further explain the benefits of this program that our citizens receive. In front of you, I've handed out AM1643, which I hope the committee will adopt, which further clarifies this antidiscrimination language. It's just a clarity that was asked of PhRMA and worked out with the, the providing pharmacies. Section 10 of LB767 governs a regulation of what qualifies as a specialty pharmacy. Following numerous discussions, I believe we have come to some solid middle ground. We have all agreed that if a pharmacy holds a specialty pharmacy accreditation from a nationally recognized body and is willing to accept the terms of a condition, the PBM shall not exclude a pharmacy from its specialty

network. The remaining sections provide for enforcement by the Department of Insurance to, to ensure compliance in other technical matters, such as an operative date of January 1, 2023, and a severance clause. As I stated before, LB767 is a culmination of many years of hearings, meetings, and negotiations. On that, everyone is going to be happy with everything in LB767. We believe we've reached a middle ground that is amenable to all. With that, I'm happy to try and answer any questions you may have, and I've asked several people to come and testify today as well. Thank you.

WILLIAMS: Thank you, Senator Kolterman. Are there questions for the senator? Senator Flood.

FLOOD: Thank you, Chairman Williams. Thank you, Senator Kolterman, for all the work you've done on this. What enforcement ability do we have to regulate the conduct of a bad-actor PBM?

KOLTERMAN: That will all go through the Department of Insurance. We have not had-- the Department of Insurance has not had any model legislation in the past, and so they will actually be the ones that are responsible for that.

FLOOD: Does the Department of Insurance have the ability to restrict them from doing business in the state of Nebraska under this regulation?

KOLTERMAN: I can't answer that. I don't-- I think somebody from the Department of [INAUDIBLE] will be testifying or I'll get that answer for you.

FLOOD: On this practice of auditing, which I think constituted harassment under the testimony received last year of these pharmacies, you stated in your testimony-- in your remarks here today that that practice was, was going to be ended, that it would be prohibited. You're not saying that they're prohibiting the use of audits, only that they can't do it for the purpose of nickeling-and-diming these independent pharmacies?

KOLTERMAN: That's correct. In our, in our conversations, we, we had probably three or four meetings with all the players in the room sitting across the table from each other. And in those meetings, it was loud and clear that the, the pharmacies were tired of getting beat up. And quite honestly, the insurance companies in good faith brought forth, forth the auditing information and agreed to work with them on that issue. And so the idea of the 14 days and the 7 days and things

of that nature all came about as a compromise. And it was brought to us really by the insurance companies saying we can agree to these. And, and the pharmacy said, yeah, we'll, we'll accept that.

FLOOD: Did the pharmacy-- did the PBMs that you spoke with admit to using these tactics to intentionally harass pharmacies for the purpose of improving their bottom line and their efficiency?

KOLTERMAN: No, they did not. In fact, they were somewhat surprised that-- the ones that were at the table were somewhat surprised that it was going on. And I don't, I don't think it was a common practice. I think it was one or two bad actors.

FLOOD: Do you know who they were?

KOLTERMAN: No, I don't.

FLOOD: Thank you.

KOLTERMAN: I've got an idea, but I can't-- I'm not going to say.

FLOOD: I, I would welcome your speculation.

KOLTERMAN: No, I'm not going to say.

WILLIAMS: Additional questions of the senator? Seeing none, I'm assuming you'll be staying to close?

KOLTERMAN: Absolutely.

WILLIAMS: All righty. I would invite the first proponent to come and testify. Welcome, and as a reminder, again, if you'd please state and spell your name for the record.

SARAH KUHL: All right. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. I am Sarah Kuhl, S-a-r-a-h K-u-h-l, director of Community-Based Pharmacy Services for Nebraska Medicine. Nebraska Medicine is a nonprofit integrated healthcare system affiliated with the University of Nebraska Medical Center. We have over 9,000 employees and 1,000 affiliated physicians. Our providers perform over 1 million outpatient visits and about 100,000 emergency room visits every year. A vital part of our health delivery to patients is our pharmacy department and 340B program. I'm here to testify in support of LB767 on behalf of Nebraska Medicine, and my testimony will speak specifically to the provisions of the bill that prohibit discrimination against 340B-covered entities and the

requirements for inclusion of a specialty pharmacy into a PBM network. As director of Community-Based Pharmacy Services, my job is to ensure patients have access to their medications by removing barriers to care, whether that be clinical, financial, or logistical reasons. Providing support to our patients through the 340B program and through our specialty pharmacy program are two important ways we at Nebraska Medicine remove barriers to care for our patients. Nebraska Medicine, along with other 340B hospitals and clinics, including critical access hospitals in Nebraska, are able to purchase drugs at a discounted price for our in-house pharmacy or partner with pharmacies serving our patients because of a federal program called 340B. The 340B program is intended to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services to the community. Because of the 340B program, Nebraska Medicine has been able to provide reduced-cost medications to more than 10,000 patients every year, along with other investments to serve our patients, especially those in underserved communities. The 340B drug pricing program allows Nebraska Medicine to invest in initiatives that benefit our community, such as our Psychiatric Emergency Services unit for those with urgent mental health and substance abuse conditions. In addition, the program helps us fund important community outreach, including much of the work done in the state by Nebraska Medicine during the COVID-19 pandemic. In recent years, many of the largest PBMs have started reimbursing 340B pharmacies for prescriptions at significantly lower rates than other pharmacies, while still charging patients the same high copays. Instead of the 340B savings going back to help our patients and community as intended under federal law, the 340B savings are being, being absorbed by PBMs. PBMs will say that they do not like the 340B program because some drug manufacturers will not give them rebates on drugs dispensed at 340B pharmacies, and this may increase premiums. There is no evidence that rebates to PBMs from drug manufacturers actually impact individual premiums as premiums for individuals have continued to rise along with PBM profits. Put simply, LB767 says that a PBM cannot treat a patient's prescription differently because of the patient's pharmacy of choice is a 340B-covered entity. Additionally, LB767 prioritizes patient choice and care by setting reasonable parameters for including a specialty pharmacy within a PBM's network. Specialty pharmacies focus on high-cost, high-touch medication therapies for patients with complex diseases such as cancer. At Nebraska Medicine, our dually accredited specialty pharmacy is integrated into the patient care model. Our Nebraska Medicine specialty pharmacists and Nebraska Medicine physicians work together to provide care for our patients. Everyone on the care team can see what is happening with the patient's

care in their medical chart, including their prescription fills, their office visits, and labs. Oftentimes, even though our patients would benefit from utilizing our pharmacy, PBMs require patients to have their specialty prescriptions filled and mailed from the PB own-- PBM-owned or affiliated specialty pharmacy, ultimately creating more barriers to care for our patients. PBMs run a complex and nontransparent business. I have a unique vantage point because I also help Nebraska Medicine's benefit team manage the pharmacy insurance for our Nebraska Medicine employees. It's been my experience that policies implemented by PBMs can lead to a lack of patient provider choice and treatments based upon coverage restrictions, as well as restrictions placed on where a patient can obtain medications. LB767 will provide basic guidelines for PBMs to operate while balancing the importance of patient care choice and access to the medications they need. On behalf of Nebraska Medicine, I respectfully ask you to support LB767 and ask for the committee to advance this important bill to General File. Happy to take any questions.

WILLIAMS: Thank you. Are there questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. Is it a common practice of PBMs to try to capture the precedence of the, the customer of, of certain pharmacies?

SARAH KUHL: I would say yes. So it's important to remember that these specialty-- or these PBMs own their own pharmacies, so they actually benefit from driving those prescriptions into their pharmacies. So even when a patient wants to use, say, our specialty pharmacy, there's a good amount of time that even when we fight and ask to have that patient fill with our pharmacy because we know they'll benefit from being able to get their drugs the same day as their appointment, they don't have to wait for something to be mailed out. Everything can happen on the same day and that pharmacist is aware of everything happening with that patient. They still have to use that mail-order pharmacy to get their medication.

McCOLLISTER: Do they have the information on the customer? Are they-- are the pharmacies obligated to publish that information for PBMs?

SARAH KUHL: No.

McCOLLISTER: So how would the PBMs have access to that information?

SARAH KUHL: So when we, when we process those prescriptions, it rejects and says this patient can't fill here, and then they say it

needs to go to our own-- our pharmacy that we own. And then we have to send that prescription to them.

McCOLLISTER: And that's a common occurrence?

SARAH KUHL: Very common.

McCOLLISTER: Thank you.

SARAH KUHL: Yeah.

WILLIAMS: Additional questions? I just have one. First of all, thank you for participating in, I think, all of the group meetings that we had. At the end of the day, from your experience, do you believe that the 340B issue and the specialty pharmacy issue as presented in LB6-- or LB767 provides a workable solution?

SARAH KUHL: It really does. It's going to be a tremendous benefit for Nebraska Medicine and patients.

WILLIAMS: Thank you. Any additional questions? Thank you for your testimony.

SARAH KUHL: Thank you.

WILLIAMS: I would invite the next proponent. Good afternoon.

OLIVIA LITTLE: Good afternoon. I appreciate the opportunity to testify before you today. My name is Olivia Little, O-l-i-v-i-a L-i-t-t-l-e. I am here today on behalf of Johnson County Hospital and the Nebraska Hospital Association. I am here in support of LB767, which would prohibit discriminatory practices by PBMs on 340B entities and 340B contract pharmacies. Johnson County Hospital is an 18-bed critical access hospital located in Tecumseh in Johnson County, Nebraska. Besides the hospital, we also have a rural health clinic. Our service area expands into Gage County, as we have a rural clinic in Adams, Nebraska. Johnson County Hospital participates in the 340B program. In Nebraska, 62 hospitals participate in the 340B program, including 90 percent of critical access hospitals. This is a program that is not utilized by a few in the state of Nebraska, but by many. The intent of the 340B program, as my colleague, Sarah, has said, is to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. In the fiscal year of 2021, Johnson County Hospital had a 340B benefit of $731,000. The 340B benefit is a combination of our 340B savings and our 340B contract pharmacy utilization. The following are only some of the ways

in which we use our 340B benefit to allow great things for our patients in our communities. Our 340B benefit was used to help fund services offered through the hospital that do not generate enough revenue to offset expenses like our home health program and Lifeline. These particular programs allow people to stay in their homes longer and lessens the burden on taxpayers by keeping them out of nursing homes, assisted-living facilities, which Medicaid, a program supported by taxpayers, may have to cover if the patient does not have finances to pay. While our hospital is taking a financial loss on these programs, our 340B benefit continues to allow our hospital to provide these services while staying off of our county tax rolls. Our 340B benefit was also used to fund almost half a million dollars in community benefits, which included subsidized emergency and trauma care, charity care, free monthly blood pressure checks, toenail care, and trauma education in conjunction with our emergency medical services, just to name a few. Again, all while staying off of our county tax rolls. Part of our 340B benefit comes from our 340B contract pharmacy relationship with our local retail pharmacies. The 340B program is vital to these retail pharmacies as well to keep their doors open and to serve our communities. I have here a quote from just one of our contract pharmacies from Colby Haynes, a pharmacist and owner of Chief Drug Pharmacy in Tecumseh, Nebraska. As a small-town pharmacy, the 340B program has allowed us to keep our doors open. With continued decrease reimbursement from PBMs, our future is not certain. We often lose money on prescriptions we fill, but continue to fill these medications for the sake of the patient and their health. The 340B program has allowed us to continue serving our community and providing needed access to medications. We have been able to decrease costs for cash-paying customers with the help of the 340B program. That allows those patients access to medications they may not have been able to afford otherwise. So many PBMs are requiring patients to use mail order or give them major copay breaks to entice them to use a mail-order pharmacy. If this trend continues, small-town pharmacies will not survive and we will not be here when we're needed to administer vaccines, dispense medications, and offer advice to people in need. Some PBMs are trying to undermine the 340B benefit by reducing reimbursement and adding on additional mandates such as claim resubmissions with modifiers for 340B claims, which are classified as such retrospectively. Requirements such as these add on additional costs for added staff hour-- hours and software costs, just to name a few. With the passage of LB767, PBMs would no longer be allowed to reduce reimbursement and discriminate against 340B claims with additional resubmission and data mandates that are not required for non 340B claims. West Virginia passed similar 340B nondiscrimination

state legislation, and recently their state insurance commissioner found that the PBM was in violation of state legislation due to the PBM requiring post-adjudication claim modifiers that applied only to 340B entities and not to other similar entities. With the passage of LB767, we would afford Nebraska's 340B entities and 340B contract pharmacies the same nondiscrimination protections. I ask that you please protect the 340B program through the passage of LB767 so that we may continue to serve our patients and our communities. Thank you.

WILLIAMS: Are there questions? Senator Slama.

SLAMA: Thank you, Mr. Chairman. Not a question, but a comment. It's wonderful to have representation from Johnson County Hospital here and, as your representative, thanks for being here.

OLIVIA LITTLE: Thank you.

WILLIAMS: Ms. Little, we have a number of us here that have critical access hospitals, and you were very straightforward in talking about the things that you have used the proceeds of the 340B. Would the other critical access hospitals have a similar list of things that they would use to benefit their community and their--

OLIVIA LITTLE: Yes.

WILLIAMS: --consumers?

OLIVIA LITTLE: It's up to the hospital really on what they choose to do. A lot of them, if you ask any hospital currently, a critical access hospital is to keep our doors open. We are very fortunate that in our financial state that we're able to stay off our county tax rolls. I think a lot of people in our county don't realize that specific to Johnson County Hospital, that we are not on our county's tax rolls. Our taxpayers are not supporting our hospital and we are self-sufficient and 340B has allowed us to do this. Many of the hospitals around, I've seen that one critical access hospital in Nebraska closed last year. And I'm seeing that that's going to be more of the fate if we can't protect a program like 340B. Because critical access hospitals, we just don't have a lot of revenue or avenues to generate revenue into our system or savings into our system that we can pass along to our patients.

WILLIAMS: Thank you. Any additional questions? None? Thank you for your testimony.

OLIVIA LITTLE: Thank you.

WILLIAMS: Invite the next proponent. Good afternoon and welcome back.

DAVID RANDOLPH: Yeah. Good afternoon. Chairman Williams and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in favor of LB767. My name is David Randolph, D-a-v-i-d R-a-n-d-o-l-p-h. I am the owner of Dave's Pharmacies in both Hemingford and Alliance, Nebraska. Last year, I sat before you and shared stories of how the unfair practices of pharmacy benefit managers have hurt both my pharmacies and my patients. Thank you to Senator Kolterman and members of the committee for hearing me and working during the interim on LB767. I would like to address two sections of the bill: audit protections and transparency of pricing on generic medications. In the past three years, I've had ten major audits-- major audit would mean that there are more than 20 claims that they were looking at in the audit-- and countless desk audits. Desk audits are basically a fax that we receive saying, we're looking at claims A, B, C, D, less than five claims that we have to address and turn back in. I've said three years because, for the most part, audits were not allowed in 2020, so we don't have much information there. In that time of three years, I've lost over $6,000. I do not have large, big-box pharmacies. Six thousand dollars is a lot of prescriptions. That was even after a letter was sent by my state pharmacy inspector employed by the state of Nebraska to the auditing company stating that what I did was correct. They "overrid" his legal opinion as a state inspector of Nebraska. LB767 will provide my pharmacies protection from this kind of unfair audit practices. I will be given adequate notice of an on-site audit. Each pharmacy will be audited the same, under the same standards and parameters as any other pharmacy. When LB767 passes, PBMs will not be able to audit my pharmacy for more than 24 months after a claim has been submitted. I've had two audits in that same amount of time that have included prescriptions over three years old. The issue with that is, number one, sadly, patients pass away. How am I to get information from a patient that is no longer with us? Patients move. In this one case here, I had to track down a hospital provider through four different states, four different hospitals that she had changed jobs in that time. Took my staff and myself countless hours to find this information, but it was worth thousands of dollars, so we did it. I will be able to see a complete list of the prescriptions being sought for the audit. LB767 protects me from audits in the first five businesses-- business days of the month. As you've heard, some of the busiest times of the month for any pharmacy. The companies that audit me will no longer be paid based on a percentage of the recoupment, which incentivizes them in audits for expensive medications. The audit

in which that I lost the $5,000 on was from one of these companies, and the inspector wrote that letter to the company, and they would not even return a phone call to me or him, wasn't in their best interest. We get a percentage of this $5,000. My last audit had 35 claims, 31 of which were for over $500 for each medication. If this was truly about fraud, waste, and abuse, we'd be looking across the board at a random sample of all medications, not just the expensive ones. LB767 will require that actual overpayments and underpayments will be calculated and paid upon a mathematical projection, not just a pie-in-the-sky figure. Under LB767, PBMs will not be able to consider a clerical error as fraud and a reason to take back payment from my pharmacy for not only the cost of the drug, but the dispensing fee as well. Pharmacies are losing out a ton in this area when just a day supply is entered in wrong. The right medication is dispensed, the patient is counseled, no harm is done, but for some reason they put in a wrong day supply. Right now, the PBM will take that back, plus a dispensing fee. Nothing was done wrong, but just a wrong day supply entered in, and sometimes it's to their benefit. I'm grateful that L-- or that LB67 [SIC, LB767] has an auditing entity that will provide a copy of the audit to the plan sponsor and the funds will be returned to the health benefit plan or sponsor. And it looks like my time is up, so--

WILLIAMS: Mr. Randolph, your time's up.

DAVID RANDOLPH: Yep.

WILLIAMS: Anybody that comes from Hemingford, Nebraska, to testify can give us a few more closing comments.

DAVID RANDOLPH: OK, thank you. When LB767 passes, a pharmacy like mine will be able to access the price list for generic medications, and this list will be updated every seven business days. Not going to lie to you, that's a start. My prices are updated daily. There's no reason theirs can't be. The reimbursement for generic drugs will no longer be calculated on project-- products, which I can't even purchase in this country. And that has happened. We get a drug code from Canada. You can't get it here. Under this bill, it will make it easier for me to appeal a generic price, which is below my cost. In the past year, I have appealed over 1,500 claims for my two stores-- remember, I said, I'm not that busy of store here-- for underpayment of generic medications. In all of that time-- it takes me 20 minutes to an hour every day to do this-- adjustments were only made in 21 cases out of 1,500. That's just over 1 percent of the total. Considering how COVID has caused the cost of everything-- which you guys know, I'm building a house again-- to go up, why have they not adjusted the prices of

drugs accordingly as well? For all these reasons, I encourage this committee to advance LB767 to the General File for consideration by the full Legislature. Thank you.

WILLIAMS: Thank you, Mr. Randolph. Are there questions for Mr. Randolph? Senator McCollister.

McCOLLISTER: Yes. Thank you, Mr. Chairman. Thank you for appearing from so far away. Do you have a choice to do business with various PBMs?

DAVID RANDOLPH: I, I do have a choice. I can reject any of their contracts. However, it's in my best interest to do business with as many as I can because my patient base is so wide and diverse, especially in rural Nebraska, where there's not very many pharmacies out there. So for me to be able to take care of those people, I need to sign these contracts.

McCOLLISTER: Tell me about this underpayment for generic drugs. What, what is that phenomenon?

DAVID RANDOLPH: OK. Well, for one thing, the, the claims that I'm talking about turning in, I don't turn in unless I lose $5 because my time is worth something and if I lose a quarter, I'm not going to turn that in, and I lose a lot of quarters. But what that is, is I buy from my wholesaler a drug. Let's say I buy Tylenol, because everybody knows what that is, at $5. What the PBM is paying me on that Tylenol that I paid $5, they're going to say, no, we're going to pay you $1. It cost me $5 to buy it, but they're paying me $1. So I can appeal to the PBM and, and send my invoice, so I'm not lying, I'm sending my invoice into that PBM saying this cost me $5, you're paying me $1, please reconsider. And like I said, 21 out of 1,500, they came back and said, we don't care.

McCOLLISTER: But in the case you just offered, are they obligated to give you $4 to, to at least equal what you paid?

DAVID RANDOLPH: In a perfect world, yes, and, and that would be just to break even. That doesn't keep my lights on and pay my staff and put it in a bottle. In a perfect world, yes, but they're not.

McCOLLISTER: Does LB767 resolve that issue?

DAVID RANDOLPH: It will help in the aspect that, number one, they will have to update their price list within seven day-- you know, they'll have seven days to update the price listing. So that will help, along

with the fact that the appeal process hopefully will hold them more accountable because like right now, what's going on right now, there is a drug called Losartan, which is blood pressure medication. It went from about $3 for a month's supply to $29. Because of a shortage, they're blaming it on COVID. Who knows, honestly, if that's what it is or not. But until they update their price list, I am going to lose $26 on every Losartan prescription I fill and I fill a lot of Losartan.

McCOLLISTER: On the example you gave with the Tylenol and the PBM publishes their price for this product, can you buy it from them at the published price, and therefore at least not lose money?

DAVID RANDOLPH: I can't buy it from the PBM because they're, they're not a wholesaler. But if they would give me a drug like Tylenol, OK, they give me that, then I could go out and look for-- through my accredited wholesalers-- and I have about ten that are accredited-- and say, OK, where can I get this Tylenol for this price because PBM X says it's available? So then I have an opportunity, it's not always going to happen, believe me, because I spend a lot of time looking for that. But at least they have to present that because in the past, they haven't. They've just said, we'll pay you this much and find it. Well, good luck.

McCOLLISTER: One last question.

DAVID RANDOLPH: OK.

McCOLLISTER: Does LB767 have any shortcomings that we should be aware of?

DAVID RANDOLPH: Again, it's a start. I'm, I'm not going to lie to you. It is a start. We're behind the game compared to most states. Most states have got a lot stricter bills regarding PBMs, but it is a start for us. I would have loved to have seen two days instead of seven. But we'll take one step at a time and hopefully we will get there. This will help stop a little of the bleeding. It will not stop a lot of the bleeding, and there are a lot of stores, and not just independents, everybody has heard of Shopko. I worked for Shopko. They're no longer around in the state of Nebraska. And part of that reason may have been mismanagement, but part of that reason is things like this.

McCOLLISTER: Thank you for your testimony.

DAVID RANDOLPH: Um-hum.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony. Invite our next proponent. Another familiar face. Welcome back.

TIM REDLINE: Thank you. All right. Good after-- good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Tim Redline, spelled T-i-m R-e-d-l-i-n-e. My wife and I own Redline Specialty Pharmacy in Hastings, Nebraska. And I'm also a board member of Nebraska Pharmacists Association. I appreciate your time today in allowing me to speak on these important issues affecting Nebraska pharmacies and your friends and neighbors who are not able to choose which pharmacy they use. I am in support of LB767 and want to speak to you about how pharmacy benefit managers, or PBMs, limit patient choice with regard to specialty medications. I submitted written testimony and gone into greater detail on these issues, but I want to discuss a situation that happens in Nebraska every single day. But what are specialty medications? As Sarah mentioned, they are typically high-cost medications usually injected or infused, require special handling, special storage, special patient training. One of the most frustrating situations that happens is as an independent specialty pharmacy in a lot of cases if we get a prescription, for one, we can fill that for the patient. We can go through the whole process, get-- help the physician work through the prior authorization, gather medical records, do the patient teaching, patient training. Sometimes we'll even send a nurse to the patient's home to do the teaching. But then after the first or second dose, the PBM requires us to transfer the prescription to an out-of-state mail-order specialty pharmacy. So why is this a problem? Well, when a patient first starts, especially medication, that's the most crucial part in their care. Oftentimes, they've just been diagnosed with a very serious medical condition. And we've spent a lot of time working with the patient, getting them on board, getting them trained to use their medication correctly so they have positive outcomes. And then when the PBM requires it to be transferred to a different pharmacy, that creates countless hours of additional work, not only for us as the pharmacy, but also for the physician and their staff to transfer the information to the other pharmacy. And then the patient suffers because they have to transfer their care and try to deal with an out-of-state mail-order pharmacy. This practice also sends tax dollars and jobs to other states. So why can't we just keep providing these to our patients? Well, many of these PBMs require what's called dual accreditation and I'm a big proponent of accreditation. We hold several accreditations for the pharmacy services that we provide. But many of the specialty pharmacy network contracts require a pharmacy to

hold two specialty pharmacy accreditations. Now this practice is very cost prohibitive, very time consuming. It's redundant. It provides really no additional benefit to the patient and truly only serves to create barriers to entry for other Nebraska pharmacies wishing to continue to serve these types of patients. We've come a long way on this issue, and I thank Senator Kolterman and this committee for their work. I believe LB767 provides a positive solution to this issue allowing any pharmacy who holds one specialty pharmacy accreditation to participate in these specialty networks. Thank you. I'm happy to answer any questions.

WILLIAMS: Thank you, Mr. Redline. Are there questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, sir. And I know it came up in some of the meetings. Can you talk about the price, the cost for accreditations?

TIM REDLINE: So the cost for accreditation can range from depending on-- there's probably four or five different national organizations that provide accreditations, and they range from $15 to $50,000 to become accredited. That's usually a two- or three-year accreditation cycle.

BOSTAR: And so would you need that cost every two or three years?

TIM REDLINE: Yes.

BOSTAR: Thank you.

WILLIAMS: Any additional questions? So Mr. Redline, with LB767, that has gone a significant step forward on this accreditation issue, though, correct?

TIM REDLINE: Yes.

WILLIAMS: So it's limited at now to one and, and the pharmacy can choose which accreditation method they want to use?

TIM REDLINE: Right, right. Yeah.

WILLIAMS: OK.

TIM REDLINE: Prior-- yeah, there's, like I said, four or five national accrediting organizations. And without this bill, even if we did-- even if we held five specialty pharmacy accreditations, they still

wouldn't have to let us into the specialty pharmacy network. They could still exclude us.

WILLIAMS: Thank you.

TIM REDLINE: Thank you.

McCOLLISTER: One more.

WILLIAMS: Senator McCollister.

McCOLLISTER: Yeah, thank you, Chairman Williams. What's involved in, in obtaining an accreditation? What kind of process is it?

TIM REDLINE: The process involves meeting the, the standards that the accreditation body produces. And that really revolves around all of the services that go into servicing these patients, whether it's how you order the drugs, where you get them from, how you manage the patients clinically, do you have policies and procedures in place to make sure that it is stored appropriately and, and delivered appropriately maintaining temperature.

McCOLLISTER: Thank you.

TIM REDLINE: Um-hum.

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

TIM REDLINE: Thank you.

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

KAITLYN BRITTAN: Good afternoon. Thank you, Chairman Williams and members of the committee. My name is Dr. Kaitlyn Brittan, K-a-i-t-l-y-n B-r-i-t-t-a-n, and I'm a rheumatologist from Omaha, Nebraska, and I'm speaking on behalf of myself, the Nebraska Medical Association, the Nebraska Rheumatology Society, and the American College of Rheumatology in support of LB767. I'm speaking with you today because many PBM practices have detrimental effects on patient care. As the cost of medicines continue to rise and patient access to them becomes more challenging, physicians are increasingly called on to argue for treatments supported by medical evidence but difficult to access due to decisions outside their control and often made without their input. PBMs often have impact on which prescription drug a physician may provide a patient, even if the physician believes a

different drug will be more beneficial. This can lead to additional administrative work, follow-ups for the patient, and unnecessary delays in getting the proper medication into the hands of the patient. PBMs also take away from the local economy by circumventing local pharmacies. They have the ability to restrict the quantity of a drug a patient can get through their local pharmacy, often requiring patients to receive their medicines through the mail. By making patients wait for their medicines, this negatively impacts the timeliness of the delivery of care. They also claim to lower costs by negotiating discounts of high-priced drugs. There's no transparency available to the patient, to the provider, or to anyone involved in the care of the patient. It's not clear where the benefit of this cost goes, but it's clear it's not being passed along to the patient. The lack of transparency in the supply chain supports a market that does not allow consumer choice to impact the artificially rising costs. I'm going to give you a brief example of how PBMs can impact care from my point of view. As a rheumatologist, I take care of many patients with rheumatoid arthritis and prescribe specialty medicines. Rheumatoid arthritis is a condition that, without adequate and timely care, can cause permanent, disabling deformities. After I prescribe a medicine with a great deal of thought and hope that I can prevent these long-term damage to my patient, I submit the prescription to the pharmacy. The PBM ultimately decides and lets me know what their formulary would allow and where I can fill the script. They'll give me a handful of options, and if I think the medications are adequate, I'll change my prescription at their request. Ultimately, when we agree upon a medicine, I will prescribe it, often having to send it through a mail-order pharmacy. There may be delays in this getting to the hands of the patient, but ultimately they'll start the medicine. If the patient responds favorably to this medicine, we still will get letters asking us if this medicine is needed. Sometimes the following year, the PBMs change their formulary, and I'm notified that the medicine that they had me choose for my patient is no longer an option. They want me to take a stable patient and put their health at risk switching medications. This isn't appropriate. I'd like to remind you all that, unlike physicians whose professional oath and duty are to make decisions in their patients best interest, PBMs have fiduciary duties to corporations and shareholders. Who do you want having the final say in what medicines you, your loved ones, and your constituents ultimately receive? Again, I, the Nebraska Medical Association, the Nebraska Rheumatology Society, and the American College of Rheumatology urge you to support LB767, which is a great start in improving access to timely care for patients. I'm happy to answer any questions you may have.

WILLIAMS: Thank you, Dr. Brittan. Questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, ma'am. You know when we get legislation in committee that-- this tells a common story, and you sort of brought it up where there's a practice on the insurer side of our healthcare equation, and the open question is we don't know where the money goes, right? There's some cost-saving measure. And what we hear, I believe most of us on the committee and we've heard in committee on various bills, is that those measures ultimately lower premiums to assist with access to healthcare. And I think that's always the balance. But I just wanted to, since you sort of opened the door on it, do you have a perspective on that sort of response to the points that you brought up?

KAITLYN BRITTAN: I think at the end of the day, this opens the door to the importance of transparency. If they really are saving cost somewhere in this whole stream of manufacturers to patients, insurers, then that should be something that they would be very proud to show. The cost of medicines right now are outpacing inflation on average 9 percent annually, and we aren't seeing the cost savings coming back into the patient's pocket. And my patients can't get on medicines that allow them to remain functional and contributing members of society. And so I would say that there's a lot of other areas that need to be explored in this. But with the opaque system and not seeing where those costs are being saved, I think it's a little hard to take their word for it.

BOSTAR: OK, thank you very much.

KAITLYN BRITTAN: Um-hum.

WILLIAMS: Additional questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Mr. Chairman. Are PBMs' financial statements available for inspection?

KAITLYN BRITTAN: I know that there is some degree of financial information, but not the nitty-gritty of where everything is coming from. I, I can get more information on that for you, but I don't know the degree that we can see.

McCOLLISTER: So you have no way of looking into their finances, do you?

KAITLYN BRITTAN: Not that I'm aware of, but again, I can get that information. We, we do know that the market, 77 percent of the market

is taken care of by three PBMs who are associated with insurance companies. And so we know that a large portion of the money that these corporations are making come from the PBM side in billions of dollars.

McCOLLISTER: Do their, their financial statements go to the Insurance Department for the state of Nebraska?

KAITLYN BRITTAN: I do not know that.

McCOLLISTER: Thank you.

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

KAITLYN BRITTAN: Thank you.

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

CARMEN CHINCHILLA: Good afternoon, Chairperson Williams and members of the Banking, Commerce and Insurance Committee. My name is Carmen Chinchilla, that's C-a-r-m-e-n C-h-i-n-c-h-i-l-l-a. Thank you for the opportunity to speak to you today. On behalf of the Nebraska Oncology Society, I would like to express our strong support for Senator Kolterman's LB767 to adopt the Pharmacy Benefit Manager Licensure and Regulation Act. Pharmacy benefit managers act as intermediaries between an insurance, manufacturers, and pharmacies and play a uniquely central role in the prescription drug market, handling everything from negotiating prices with drug manufacturers and setting patient copay amounts to determining which drugs are covered by which insurers. This system in Nebraska is currently unregulated, and Nebraska Oncology Society feels that LB767 is a good first step in ensuring that regulations work towards helping Nebraskans access medications based on what their physicians indicate, based on what their medical expertise indicate, and not on what the industry dictates based solely on financial considerations. As an organization, we value transparency and oversight and this bill will help start create that. We respectfully ask for the committee's support and advancement of LB767. Thank you for your time and I welcome any questions.

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

RICH OTTO: Good afternoon, Chairman Williams, members of the committee. My name is Rich Otto, R-i-c-h O-t-t-o. Thanks for the opportunity to speak in front of you today and thank you to Senator

Kolterman for introducing LB767. I'm testifying in support of this legislation and for the Nebraska Retail Federation and the Nebraska Grocery Industry Association. Our retail pharmacy members continually relay concerns that they want their pharmacist spending as much time as possible with patients. Unfortunately, they're spending more and more time dealing with PBMs and the concerns and the complex system they've created. We think this unfortunately hurts and negatively impacts patient health. We support this bill for a few quick reasons. Most of them have been discussed, but I just want to mention those real quickly. This does put Nebraska on par with 30 other-- 39 other states that have some kind of licensure for PBMs, thus creating greater transparency for the PBMs. Implementing changes to the pharmacy audits that the PBMs conduct. Instituting parameters for the MAC lists, the seven days that they've mentioned. I believe 42 out of 50 states have that, including Wyoming, Colorado, Montana, North Dakota, Iowa, Minnesota, and Kansas. And then language which preserves a pharmacy's ability to work with the 340B entities. On behalf of our more than 200-member locations that have retail pharmacies, we encourage you to advance LB767. Be happy to answer any questions you may have.

WILLIAMS: Any questions for Mr. Otto? Senator Pahls.

PAHLS: Thank you, Chair. By listening to your conversation, you're saying this is not cutting edge. This is practical because so many states are already doing it. This is not-- we have not reinvented the wheel.

RICH OTTO: No, we're behind the curve if you ask me, Senator.

PAHLS: OK, thank you.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony. Invite the next proponent. Any additional proponents? Seeing none, is there anyone here to testify in opposition? Again, anyone testifying in opposition? None. Is there anyone here testifying in a neutral capacity? Welcome, Mr. Head.

BILL HEAD: Thank you, Chairman Williams. Thank you and thank you members of the committee for the opportunity to testify today. My name is Bill Head, B-i-l-l H-e-a-d. I'm here on behalf of the Pharmaceutical Care Management Association, which is a very long-winded way of saying the PBM trade association. I want to start by thanking Senator Kolterman and you as well, Chairman Williams, for all your work during the interim period and, and during last session

on, I think we had at least four stakeholder meetings, if not more, and I wish more states would emulate that model. I think bringing everybody together, as Senator Kolterman described, sort of brought us to a place where not everybody is happy, but not everybody is upset. We didn't get everything we wanted and want to continue to work with the Legislature if other legislation like this or additional legislation is considered. But I do want to spend a couple minutes talking about PBMs and let me begin by saying they've been around since the 1970s. They are a B2B organization. They are hired by health plans, by employers, by trades, by unions and trust. More than 260 million Americans get their prescription drugs administered through their plan sponsor by a PBM. The PBMs' interest and their competition with each other is based on their ability to lower the costs for the plan sponsor and ultimately for the patient. And what happens is that often rubs up against other entities within the supply chain. The pharmacists that you've heard from today are important people in-- for the PBMs. The PBMs don't exist without pharmacies and pharmacists. So when they are facing a critical time financially, it is in our vested interest that, that that be addressed. Much like on the medical side, PBMs develop pharmacy networks for plan sponsors, so the more pharmacies in that network, the more attractive that PBM is to the plan sponsor. The state of Nebraska, both for Medicaid and for the state employee program, hires a PBM. And among those contractual terms, they require the PBM to conduct, conduct audits. I think, as you're probably well aware, there's a billion dollars of fraud, waste, and abuse that is, is, is lost in the system. So PBMs are contracted to conduct those audits on behalf of the plan sponsor. When I hear statements about the PBM doing this and the PBM doing that, everything the PBM does, including reimbursement, MAC list, and what have you, is all done under the auspices of its contract with the plan sponsor. The PBM isn't acting independently and willy-nilly about this or that, and certainly has no interest in trying to put the pharmacy or the pharmacists in a bad situation. And particularly in a rural state like Nebraska, rural pharmacies are vital to pharmacy networks. I think the concern we have with respect to specialty pharmacy is that because these are high, high-touch, high-cost drugs that are infusion injectables, that there is a patient quality, a patient safety aspect to it. So we require that independent, nationally recognized accreditation for that-- for those pharmacies in much the way we do-- we would not go to a hospital that wasn't nationally accredited and hospitals often have multiple accrediting entities accrediting them. So it's, it's not in a way to discourage especially pharmacies, it's really a way of to protect the patient. And frankly, you know, the specialty pharmacy that the PBM uses has the same requirements. So it

really is a patient safety factor. When we talk about, you know, utilizing that preferred pharmacy or that preferred specialty pharmacy, it really is in a patient interest. When they use a PBM specialty pharmacy or a PBM mail-order pharmacy, they have access to a pharmacy 24/7. So at 3:00 on a Sunday morning, they have an adverse reaction, they can get on Zoom or they can get on a phone call and have a conversation with a pharmacist. So it really is a, a consumer quality and consumer protection aspect. But I really want to close by just, again, acknowledging all the work that Senator Kolterman has put into this and you, Chairman Williams as well, and bringing everybody together because I do think we got to a place where we're not happy with, with being regulated and being forced to accept, especially pharmacies, but we got some of what we asked for. And so for those reasons, we are in a, a neutral position. But just really commend the process for how we got here. And so with that, would be happy to answer questions.

WILLIAMS: Thank you, Mr. Head. Are there questions? Senator Bostar.

BOSTAR: Thank you, Chair Williams. Thank you, sir. You mentioned that the activities of the PBMs, including those that I think have been brought up in this hearing and last session's hearing as some of the challenges that have been expressed, are all being done at the direction of insurers and that that effectively is the relationship PBMs have. They're there to execute a vision on behalf of the insurers. Do you think that the insurers should be doing this differently or on behalf of the PBMs or is this-- while it is on behalf of the insurers, in the end, this is the best way to operate?

BILL HEAD: Senator Bostar, I would, I would defer to my colleagues who represent that industry. But you know, we're-- most of us, I think, have insurance through our employer and they really are obligated to sort of provide the best for the most, right? So whatever helps keep the premium down for, I think, the vast majority of beneficiaries is, is, is a good thing.

BOSTAR: So-- OK, you mentioned the best of the most. So PBMs, it's my understanding pursue dual accreditation for their specialty pharmacies. Is that correct?

BILL HEAD: Yes.

BOSTAR: And for an industry that likes to limit costs in order to provide the best for the most with often as little as possible, why? I mean, and you brought up patient safety, but what are the functional

differences in the accreditations? Is it just that there's two sets of eyes? Or help me under-- because this is actually going back to some of our meetings before, I've never really understood what-- why we have so many accrediting sources for specialty pharmacies and what differences they provide and what value, what value do they add to a pharmacy from the perspective of a consumer or a, a patient or an insurance company?

BILL HEAD: No, and I, I think that's a fair question, Senator, but much in the way that hospitals have multiple accreditations, there are some nuances, right? I think you're right. I think your general point is, is well taken, which is they generally do the same things. The accreditation is roughly the same. But some do have the reputation for focusing more on the paper, you know, the paper trail, if you will, the administration of it, where some may focus more on the transportation, the handling, the distribution of it. And so it's really just an added, as you, as you said, another set of eyes, if, if you will. Because when it comes to these drugs, because they are injectables, because they are very, you know, patient sensitive and because they are very costly, we want to make sure that any entity, including our own, are in fact, you know, keeping the patient, you know, quality and safety first and foremost.

BOSTAR: How are the "accreditors" regulated?

BILL HEAD: I don't know. I don't know the answer to that. That's a great question. I think because they've been around, around the Joint Commission, URAC, AUC, they've been around forever and I think because they have accredited, done so much accrediting in other healthcare organizations, that they've come to be accepted. I don't know their origins or sort of what their sort of internal self-accrediting or outside accrediting.

BOSTAR: So if we, if we had an "accreditor" that was maybe, maybe bad actor is taking it too far, but insufficient, right, to the point where we would say, yes, you have to have two accreditations because there's at least one out there where we don't really feel comfortable. Who would be responsible for ensuring that that, that doesn't happen and if it did, there would be a check to correct it?

BILL HEAD: I, I, I think there are probably at least six or seven that any-- everybody in this room would agree that are nationally recognized independent accrediting organization. I think to be nationally recognized independent accrediting organization, you-- it would be hard pressed to, to fly under the radar as being legitimate.

I think the ones that exist have been around for some time, and I think everybody recognizes them as such. I think nobody doubts URAC's, you know, standards, AHHC [SIC] standards, the Joint Commission standards, and health organizations across, you know, thousands of health organizations across the country utilize them. I don't think I've heard of somebody trying to fly under the radar and, and, and so that's why we use that language, nationally recognized independent accrediting, because it is, it is a high standard, I think, in terms of just recognition.

BOSTAR: And I, I think-- and I'm sorry this is a long way around, I think, to saying that, you know, if the standards are so high, this is why I think I struggle with the idea that more than one may be necessary. But thank you very much for answering the questions.

BILL HEAD: Thank you for the questions.

WILLIAMS: Additional questions? Senator McCollister.

McCOLLISTER: Yeah, thank you, Mr. Chairman. From the testimony I've heard, and thank you for being here, there's three large PBMs in Nebraska and the country?

BILL HEAD: In, in, in the country, and I think the doctor said they were 85 percent of the market. I, I would point out that the wholesalers, there are three large wholesalers that have 98 percent of the wholesale drug market so, you know, 98 percent of the drugs being sold. The pharmacies are being sold by three wholesalers, who, by the way, then in turn represent the pharmacies when they negotiate with PBMs. So just sort of a side note, if I may, that pharmacies, particularly rural pharmacies, often will-- can independently contract with the PBM. But across the country, 80 percent of rural pharmacies rely on what's called a PSAO, Pharmacy Services Administrative Organization, which will represent a large number of independent pharmacies to give them more bargaining clout, and those are also owned by the wholesalers. So in terms of market share or market share for those three doesn't compare with the market share with the wholesalers.

McCOLLISTER: Just to make sure I understand, what's the intersection between the wholesalers and a PBM?

BILL HEAD: Well, the mail-order pharmacy would purchase from a wholesaler, but there's no economic connection between a wholesaler and a, a PBM. We-- the PBM will negotiate with a PSAO, which is often

the other side of the business of the wholesaler. But that would be the, that would be the intersection of them contracting with the-- between the PBM and the PSAO.

McCOLLISTER: The PBM would also be governed under the auspices of the state of Nebraska. Do you have to register with the Insurance Department?

BILL HEAD: Well, we do now under the, under the bill, so we would be required to register and be licensed by the state. And frankly, I think we always agree to that if you can to do business in a state, it makes sense to at least at a minimum register, if, if not be licensed. And so we've never had an issue with that.

McCOLLISTER: And you were previously?

BILL HEAD: I'm sorry?

McCOLLISTER: And you were previously?

BILL HEAD: No, we're not-- we were not previously required to be licensed in, in the state. Mr. Marienau may know differently. But I-- so this, this is new and we have no, no qualm whatsoever with, with that requirement.

McCOLLISTER: Thank you, sir.

WILLIAMS: Additional questions? Senator Pahls.

PAHLS: Thank you, Chair. You're telling me there are three major wholesalers?

BILL HEAD: Correct.

PAHLS: OK. And I use this, and it just made me think this morning we were talking about Social Security and I was just showing the difference of when I was on Social Security or before, because this time last year, I was not on-- so February 1, I get on Social Security, so I'm just-- or on Medicare. So, yes, Medicare. So I bought a Medicare and a plan. And the difference, and I'll just use one because-- and I'm lucky because I don't have to use that much, my insulin went from $40 to $200, and if it wasn't for GoodRx, got it down to $100, but everything and even from the needle from 10 cents to 50 cents and same way with, you know, when you test your blood and all that. Everything has gone up unbelievable. Now I can afford it, but I, I just don't see how some, some of these people who are on Medicare--

do we have the wrong plan? Is that it? Because I've tried-- I've had the same company that I had when I was in the business world. Now I have their supplement, the same company.

BILL HEAD: Yeah.

PAHLS: And I've had two of their, you know, plans. What, what-- what's, what's the issue?

BILL HEAD: And you're, you're caught-- I assume you-- if you have the supplement on Medicare Part D that you probably pay lower out-of-pocket though, right, with the supplement?

PAHLS: No, it's gone up.

BILL HEAD: Oh.

PAHLS: It went from $40 to $200 for the-- for-- that's just one insulin.

BILL HEAD: Right.

PAHLS: And you take an "I pen." But then all the other-- I mean, truly, my costs have gone up dramatically. So not only am I getting less money here, guys, I'm paying a whole heck of a lot more in insurance, so I want-- you got a little empathy out here.

BILL HEAD: Well, you know, and I think people forget this, too. PBMs are the only entity in the supply chain, and the supply chain is much larger and complex than we're discussing today, but we're the only that exerts any downward pressure on, on pharmaceutical prices.

PAHLS: OK. I was just curious, so [INAUDIBLE].

BILL HEAD: Right, so, so, so I'm, I'm, I'm empathetic for that. But at the end of the day, we don't set prices. We don't get to say what the pharmaceutical industry is going to charge and God bless them for being around. But at the end of the day, those are prices we have no control over, and all we try to do is exert downward pressure for the, for the patient, for the payer, ultimately.

PAHLS: Well, then who sets that price for the difference in the insulin? I'm just-- who do you, who do say, the insurance companies?

BILL HEAD: Well, well, it, it starts with the pharmaceutical manufacturer. What, what they're, what they're, you know, AWP price

is, average wholesale price is and then, you know, how that's distributed through the wholesaler to the pharmacy and then what-- what's negotiated through that plan.

PAHLS: Yeah.

BILL HEAD: But, but on a personal note, I would, I would encourage you to, to shop around for other, particularly on insulin, for other supplemental plans that would cover that cost because there, there are many options under Part D supplemental plans.

PAHLS: OK. Thank you. I just speak my interest. I was just amazed.

BILL HEAD: No, I completely understand.

PAHLS: Thank you.

WILLIAMS: Senator Bostar.

BOSTAR: Thank you, Chair Williams. I'm sorry, I-- and I was probably looking at something. Did you say that the PBMs are the only ones who are trying to put downward pressure on pharmaceutical prices?

BILL HEAD: Correct.

BOSTAR: Thank you.

BILL HEAD: Well-- and if I could just sort of make, make the point, if, if you look at the, the data, the, the average person-- the person-- a person who has their drug benefit administered by a PBM saves $10 on a generic, saves about $260 on a brand drug, and saves about $1,300 on a specialty drug if their drug is administered by a PBM versus somebody who gets their drug-- has a drug benefit, but it's not administered by a PBM. They don't get the savings.

BOSTAR: Thank you.

WILLIAMS: Any additional questions? Seeing none, thank you, Mr. Head.

BILL HEAD: Thank you.

WILLIAMS: Anyone else here to testify in a neutral capacity? Welcome again.

DAVID ROOT: Thank you, members of the committee. My name is David Root. I represent Prime Therapeutics. We're a PBM that does business here in the state of Nebraska. And to be honest--

WILLIAMS: Would you please--

DAVID ROOT: I'm sorry?

WILLIAMS: --spell your name.

DAVID ROOT: Oh, Root, R-o-o-t, first name David, D-a-v-i-d.

WILLIAMS: Thank you.

DAVID ROOT: Sorry. Don't want to take up a tremendous amount of the committee's time, but did want to echo the sentiments of many of the other people that have spoken previously in the fact that we appreciate all of the effort of the various senators involved in this, in putting together the meetings, actually listening and bringing constructive ideas to the table. So we appreciate that. And, and again, as my colleague, Mr. Head, indicated, we would welcome that approach in a variety of other places across the country. So thank you for being a trendsetter there. You know, as far as the, the legislation is concerned, I think it's really something that we've heard before. While not perfect, it accomplishes the goal of good legislation. Every party had to do a little give and take. And I think that it-- this, this gets us in a good-- in, in good footing. It allows-- it provides a level of certainty, you know, among the playing field for all of the participants. Everyone understands what is expected of each of them and the rules that will govern that, that play. Again, just for the benefit of the rest of the committee, we are a PBM that operate in this state. So with that, I'll conclude my comments. And if anyone has any questions or any follow-up questions, I'd be glad to take them.

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

DAVID ROOT: Thank you.

WILLIAMS: Additional neutral testimony? Welcome, Mr. Blake.

JEREMIAH BLAKE: Thank you, Mr. Chairman. Good afternoon, Chairman Williams and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake. That's spelled J-e-r-e-m-i-a-h B as in Boy -l-a-k-e. I'm the government affairs associate for Blue Cross Blue Shield of Nebraska, and I am testifying in a neutral capacity on LB767. So I'm going to sound a little bit like a broken record here, but as you know, I'm a relative newcomer to Blue Cross and the discussions on PBMs. While I wasn't involved in the past discussions,

what I've learned is that Senator Kolterman has done a masterful job of bringing the parties together for discussion. Despite our sometimes competing interests, the parties at the table have a better understanding of the challenges that we all face. That doesn't mean we all agree on every provision in this bill, but I believe the parties would agree that Senator Kolterman has given everyone an opportunity to offer their input. And for that, I want to thank Senator Kolterman. Last year, Blue Cross and Blue Shield of Nebraska testified in opposition to the PBM bills due to concerns that they would increase the cost of healthcare for Nebraskans. To be clear, this bill will increase costs for our members. Specifically, the provisions in Section 9, which were discussed previously regarding the reimbursement for 340B drugs, will increase healthcare spending for our members. The 340B drug pricing program, which was established by Congress in 1992, allows eligible hospitals to purchase prescription drugs from manufacturers at a significant discount. Section 9 of this bill requires payers to reimburse 340B hospitals and pharmacies as the-- at the same rate as non 340B hospitals and pharmacies. As a result, the reimbursement rate that we pay to certain hospitals and pharmacies will increase, resulting in additional costs for our members. However, we recognize that our ability to serve our members depends in part on the viability of our partners in the provider community. This bill strikes a delicate balance between the competing interests of our members and our partners in the pharmacy and hospital communities. For this reason, and in the spirit of compromise, we have taken a neutral position on LB767. Again, I want to thank Senator Kolterman for his leadership on this bill, and I'll be happy to answer any questions you have.

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

JEREMIAH BLAKE: Thank you.

WILLIAMS: Additional neutral? Welcome, Mr. Bell.

ROBERT BELL: Thank you, Chairman Williams. Chairman Williams and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell. Last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today to testify in a neutral capacity on LB767. The Nebraska Insurance Federation is a state trade organization representing the domestic insurers of Nebraska and insures license to do business in Nebraska with an economic presence in our state. The federation membership includes several members who provide major

medical insurance. And again, I'm going to sound like a broken record, too. I'm stealing Jeremiah's line there. But I want to appreciate-- my members very much appreciate the ability to sit down in a large group with the stakeholders in this room with Senator Kolterman, with Senator Williams, with Senator Bostar. Senator Morfeld was at a, I believe, a couple of those meetings as well. I, I was thinking back to my first interaction with Senator Kolterman when I was at the Department of Insurance eight years ago, and he called me over to the lobby because he introduced a bill that I wrote the fiscal note on that asked for several employees for the Department of Insurance related to, I think it was pharmaceutical transparency prices, some tool. And he wasn't happy with the fiscal note. And we, we had, we had a talk, but he's such a fair-minded individual, we were able to talk it through, and he understood that if there's additional duties, there's going to be, you know, there's a need for additional resources at, at, at a state agency level. And that bill didn't end up passing. We moved on to, to other things. But I think that showed his spirit of, of-- and willingness to listen and collaborate and, and that was a good thing. I'm not going to bore you with the details of the bill. You've already heard about them. Is everybody happy in this room? I don't think anybody's really happy in this room with the provisions of LB767 from what I heard, including from my friends in the, in the retail pharmacy business or the PBM business. But just a couple of things I wanted to point out. I just, I just want to leave with you with a couple of thoughts as, as we talk about other bills that are going to come before this committee in the future. We, as an insurance industry, are trying to get our arms around the escalating cost of healthcare. I believe, according to CMS, nearly 20 percent of our GDP in this, in this country is spent on healthcare. Of that, I think 8 percent of that 20 percent. So it's in the $350 billion range in the United States that's spent on pharmaceuticals. And so as, as Mr. Head was talking, PBMs are the one entity out there that are utilized by insurance companies to push back on pharmaceutical companies to negotiate those and give us the market power to, to do those things to help lower the cost of healthcare, which is what we're trying to do because it's very, very expensive right now. It's very expensive to provide healthcare in the United States. I think according to the information from CMS, I think the average American spends something like $12,000 a year on healthcare costs, you know, and so my family of five, that is-- going to do math in my head, which is probably a mistake, but $60,000. And it depends on the year, right? Sometimes that's accurate between the insurance premiums that we pay and the out-of-pocket that we might pay. If, if there's a, if there's a surgery or if somebody has an illness, certainly that cost is going to

be above $60,000 for, for our family. If, if nothing happens, it's, it's not that high. But on, on average, it's very expensive. So when we, when we read bills that come into this Legislature that, you know, seek for good reasons, probably, you know, they see there's an adverse effect because of pushback by the insurance industry to get our arms around this risk related to, to healthcare. And just know when, when we pass or when-- I don't pass, but when the Legislature passes a law that further restricts our ability to make market-based decisions, there is a consequence. And that consequence is the escalating cost of healthcare and of health insurance premiums in the state. And that's premiums paid by your constituents. And so I, I, I promise not to-- I promised people earlier I wouldn't rant too long on that, but I want you to know that, that is part of it. I heard a lot of, of talk today about narrow networks. Narrow networks are, are, are something that insurers utilize to come up with a cheaper insurance product so that somebody can afford it. That's not necessarily available in some of the rural parts of the state because we don't have the availability of medical providers out there, but in Lincoln and Omaha, certainly, you can go buy a product that's a CHI product or a Nebraska Medicine product. That is a deal between the insurer and that particular health entity. That is a little bit cheaper. It's a little bit more affordable. And yes, you have to change your pharmacy. You might have to do these things, but you get a little bit of savings out of that. And that's not necessarily a bad thing. And just finally, of course, insurance companies are financially regulated by the Department of Insurance. So financial, all of our information is out there for the public to inspect. So with that, thank you for the opportunity to testify.

WILLIAMS: Questions? Senator Pahls.

PAHLS: Thank you, Chair. I don't sleep about insulin because I don't use that much of it, but I'm very curious what is your organization's position? Because I think the president currently is saying insulin should sell at $35 a person. Would, would-- because you would not lose any money on that, your insurance company, would they?

ROBERT BELL: I mean, it's going to depend on the insurance company and depends on the insulin, right?

PAHLS: Yeah.

ROBERT BELL: So I mean, there's-- I think there's a lot of different types of insulin out there. Certainly, we would oppose a mandate and we have in this committee before with some kind of cost cap on that

because it doesn't start-- stop the pharmaceutical company from charging the insurer that additional cost, right? We're just-- we use, we use copays, coinsurance as utilization tools to, to help, to help people make informed financial decisions, right? So if there is a brand name drug, and I'm getting so simplistic--

PAHLS: Yeah.

ROBERT BELL: --here, Senator, but if there's a brand name drug that costs $100 and a generic drug that costs $5, I mean, obviously, we would prefer the insured if they have this-- if they work the same to choose the $5 drug, right? And so that's part of the reason that those, you know, you get a little skin in the game as, as the policyholder, right? And so--

PAHLS: But as my researching of insulin, it's been around a long time.

ROBERT BELL: It has.

PAHLS: So it's not a lot of new research, even though they are changing, and it's not like a major-- I was just curious.

ROBERT BELL: Yeah, I mean, we would oppose that legislation. We did, I think, last year, in fact, before this committee. I think Senator Wayne maybe had a bill.

WILLIAMS: Two years ago.

ROBERT BELL: Two years ago? OK.

PAHLS: Well, obviously, this isn't the federal level.

ROBERT BELL: At the federal level-- there's a lot of stuff going on at the federal level, yes. But yeah, I mean, the-- and what's interesting is that the market in this area has kind of-- insurance companies compete against each other, right? So Medica might compete against Blue Cross Blue Shield, who competes against United and, and Aetna, etcetera, etcetera. And they might decide, you know, it's, it's a good thing. We only want to charge our members $20 for insulin on a copay and we're going to market that and they will get some business that we didn't otherwise get. So we like the flexibility to make those kinds of decisions.

PAHLS: Thank you.

WILLIAMS: Any additional questions? Seeing none, thank you, Mr. Bell.

ROBERT BELL: You're welcome.

WILLIAMS: Anyone else here to testify in a neutral capacity? Seeing none, Senator Kolterman, as you're coming up. First of all, I'm going to echo the same thank yous that have been around to many of the people in this room today that have been willing to come and sit in the stakeholders' meeting and give their input to where we are today. We have four letters in support: one from Marcia Mueting from the Nebraska Pharmacists Association; from Anne Roth from Hy-Vee Incorporated; from Ally Dering-Anderson, herself; and from Jeanie Shipman, representing herself. And we have one neutral letter from Carey Potter from Medica. Senator Kolterman.

KOLTERMAN: Well, this didn't take as long as the last time we had a hearing on this issue. First and foremost, I do appreciate everybody coming. I think Robert Bell said that at the end of the day, not everybody's happy. But I will tell you this, I'm happy because we didn't have any opposition today.

PAHLS: Yeah, that's true.

KOLTERMAN: That's great, isn't it? No opposition to a very testy bill. Try to answer some questions that were brought to me. And he's not here, but Senator Flood asked about how the department can regulate these PBMs. The first one is they can impose monetary penalties and later refuse to renew or issue a license. And then if they don't have a license, they can't operate in the state. So there are some teeth in the bill. Those, those rules and regulations will be put together, I'm sure. As far as on page 4, Senator McCollister, you asked about financials. I believe that the department will have the right to ask for financials. Now I don't know if those will become public or not, but that's on page 4 of the bill under the rules and regulations. Senator Pahls, your issue, just, just so you're aware of this, I was in the insurance business for 40 years and, and I'm on the same type of plan you're on, Part D, Medicare Part D, which is a prescription drug plan. We don't have any control over that in this room--

PAHLS: I know.

KOLTERMAN: --or at the state of Nebraska. That's all done on a federal level. But I could give you some advice on what plans are good and which ones aren't.

PAHLS: I may even ask.

KOLTERMAN: So, so if you'd like to sit down and visit we could do that.

PAHLS: OK. Thank you. I appreciate that.

KOLTERMAN: Because not all are created equal. Let me just tell you that. Senator Bostar, you asked about mail order, I think, or alluded to mail order or something of that nature. Medicaid and Medicare aren't-- we have no control over that in here either because the mail order, a lot of the mail order that's being pushed at these people are coming from not necessarily the PBMs, but the Part D Medicare providers. And that's again a federal level as well. I, I just want-- I want you all to know how this works. So as an example, we didn't get to a fiscal note. I have several fiscal notes, but I don't think I have a final fiscal note. But as an example, I've had, I've had large providers come to me when-- or contractors come to me. People that have a contract with the state of Nebraska to provide them their health insurance program. People that go to the University of Nebraska and sell the University in Nebraska their health insurance. People like the Healthcare Alliance, which, which sells health insurance to all of our educators in the state. I think that's the largest self-insured plan in the state that's got 80,000 participants in it. Those people all negotiate in many cases directly with a PBM, and the PBM could go to them now and say, well, since we're now going to use specialty pharmacy and we're not going to be able to dictate to you that you have to use our specialty pharmacy, instead of giving you a 21 percent break in your rates, we will now only give you a 15 percent break in your rates. That's going to cost, cost your plan to go up in cost. I get that. I understand that completely. My sole purpose in bringing this bill and working so hard over the last-- I would say for the last seven years since I've been here, we've been working on PBM bills. We've been working on pharmacy bills and I've covered a lot of them. My sole purpose is this, I have 10, maybe 11 independent pharmacies in my district. They're all over the state. Not every pharmacy in small-town America is a CVS or a Walgreens or a Rite Aid or anything of that nature. I don't want to see my local pharmacies closed down because they're getting beat up by an insurance company or a PBM. I get that. But at the same time, insurance companies and the PBMs are there for a reason as well, and you heard that today. So anything we can do to bring the people together, work through our common problems, and keep these associations strong, whether it's an independent business in Hemingford, Nebraska or Alliance or Hastings or Seward or Auburn or wherever it's at, we have an obligation to do that, I believe. That's why we're here as senators to make sure that our constituents are being heard and that they're getting a fair

shake. So will the rates go up? In many cases, they might. But I will tell you this, it's also-- it's already working in many states and we're just, as you also heard, we're maybe behind the curve a little bit. So ultimately, we will now have some regulation in this through the Department of Insurance. The other thing that's important to me is our critical access hospitals throughout the state. I can't imagine what life would be in a small town like Gothenburg or Seward or York or Henderson if they didn't have that hospital. In many cases, that's the largest employer in that community and they're there to take care of our constituents. And so when we think about this bill and advancing it to the floor, it's not 100 percent foolproof. It's not 100 percent the way we want it, but it's a step in the right direction. We need to work, work and get it advanced. And I'd appreciate your support in moving this to the floor as soon as possible. I've prioritized this as my priority bill for the year. I'd like to get it heard. I'd like to get it passed. And if you have any questions, I'd like to try and answer those now. Thank you.

WILLIAMS: Questions for Senator Kolterman? Seeing none, thank you.

KOLTERMAN: Thank you.

WILLIAMS: And that will close the public hearing on LB767. We'll take a short ten-minute break.

[BREAK]

WILLIAMS: All righty, we will open the public hearing on LB826 to redefine a term under the Public Funds Deposit Security Act. Senator Lindstrom.

LINDSTROM: Good afternoon, Chairman Williams and members of the committee. I bring for your consideration LB826 to redefine a term under the Public Funds Deposit Security Act. Nebraska banks are required to pledge collateral equal to 102 percent of the amount of public deposits on hand, which are in excess of $250,000 FDIC-insured amount. Among the current permissible forms of collateral are bonds or obligation-- obligations of a political subdivision of another state. These bonds may be pledged as collateral for public deposits if they are rated within the two highest classifications by at least one of the standard rating services. Political subdivision bonds can be provided with enhancements pursuant to a state guarantee, financial appropriation by the state, or through insurance coverage. LB826 would authorize the use of bonds or obligations of another state or political subdivision of another state, which are rated within the two

highest classifications by at least one of the standard credit rating services to be used as collateral for public funds, which such classifications included in the underlying credit rating or enhanced credit rating, whichever is higher with respect to bonds or obligations of a political subdivision or another-- of another state. There will be someone from banking-- from our banking community that will follow me to make-- that may be an-- be able to answer more technical questions and as pertains to the banking industry. Thank you, Chairman and the committee.

WILLIAMS: Thank you, Senator Lindstrom. Are there any questions at this point? Seeing none, we'll invite the first proponent. Welcome, Mr. Hallstrom.

ROBERT HALLSTROM: Chairman Williams, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m, appear before you today as registered lobbyist for Nebraska Bankers Association to testify in support of LB826. Senator Lindstrom has given you the background on the pledging for public funds requirements, the collateral that must be pledged for any deposits that are in excess of the $250,000 FDIC-insured amounts. And one of the things I'd like to just make sure is clear for the committee, for many, many years, banks have been able to use, for pledging purposes, bonds or obligations that are issued by another state or by political subdivisions in another state and the protection that's provided for use of that collateral for the public funds is that they must be rated in one of the two highest classifications by at least one of the rating service agencies. There are local political subdivisions that are able to get credit enhancements, however, and those credit enhancements frequently have a state guarantee or a state appropriation for the bond that enhances or increases the rating on those bonds. We have developed the single bank pooled collateral program in Nebraska, for which the Department of Banking is responsible for examining the administrator of that program. And in the course of, of examining the administrator, the department discovered that there were some banks that were holding out-of-state political subdivision bonds that had their underlying credit obligation on their own credit worthiness was not sufficient to meet the two highest classifications. They were aware, I believe, or made aware that the credit enhancement from a state guarantee or a state appropriation did, however, put those bonds into the two highest classifications. But based on the fair reading of the plain language of the statute, did not feel in their interpretation that they could accept the credit, credit enhanced rating, but had to go with the underlying rating. As a result of that interpretation of the law, the banks involved did get rid of that particular collateral that was

out-of-state bonds, but they also requested us to look into things and see if we could work with the department to determine if there was a way to authorize the use of the credit enhanced rating. And that is what LB846 does in a nutshell. The rationale behind using the credit enhanced rating is obviously those guarantees or state appropriations that give a higher rating ultimately result in a lower interest rate having to be paid for those bonds. So it's good for the issuing institution and you have the opportunity to also provide the safety and soundness and protection for the public funds by the banks that are use-- utilizing that type of collateral. We have visited with the department. I think the department is on board. In fact, hopefully is here to support the bill this afternoon in this form and I'd be happy to address any questions of the committee.

WILLIAMS: Any questions? Senator McCollister.

McCOLLISTER: Thank you, Chairman Williams. Mr. Hallstrom, these enhancement, is it kind of reinsurance kind of product?

ROBERT HALLSTROM: There are insurance aspects that may or may not come into the ratings. Typically, what you'll have is a state may actually have a statute. I did some research on some of the states that have a statute that provides either for a direct guarantee of the locally issued bonds or perhaps more likely an appropriation or a state aid type of issue that will back those bonds to be able to allow them to get an enhanced rating and lower the cost of issuing those bonds.

McCOLLISTER: So the state would make an appropriation to guarantee those bonds?

ROBERT HALLSTROM: Well, there's probably a distinction between an outright guarantee and then the appropriation of funds to provide more backing for them. So there's an appropriation enhancement and there's a guarantee enhancement.

McCOLLISTER: On those guarantee enhancements, does that go through a legislative process or is that the Department of Banking creating that guarantee?

ROBERT HALLSTROM: I think it's the state most frequently. I might have to look more into that, but I think it's a state guarantee established by statute.

McCOLLISTER: And who makes that call?

ROBERT HALLSTROM: Well, I, I think the state-- if it's a guarantee, then the state stands behind them and in essence, provides their credit rating to enhance those, those bonds.

McCOLLISTER: But who determines whether the state makes that guarantee in the first place?

ROBERT HALLSTROM: Well, I think it's statutorily directed, stat-- the statute provides that the state will guarantee local political subdivision bonds that are issued.

McCOLLISTER: So it, it occurs as a matter of course and so there's not somebody that checks off and says yes, this, this is proper?

ROBERT HALLSTROM: That would be my understanding. I can look more into it, but I haven't seen anything different than that, so.

WILLIAMS: Mr. Hallstrom, we're, we're talking about bonds that are issued by other states than the state of Nebraska.

ROBERT HALLSTROM: Correct, correct. These are--

WILLIAMS: These aren't bonds that are issued by the state of Nebraska. These would be other states offering this enhancement.

ROBERT HALLSTROM: And, and what we're dealing with, the, the state bonds are not-- they don't have credit enhanced ratings, but the local political subdivisions of other states are what we are addressing in this legislation.

WILLIAMS: Thank you. Any additional questions? Seeing none, thank you.

ROBERT HALLSTROM: Thank you.

WILLIAMS: Invite any other proponents. Welcome, Director Lammers.

KELLY LAMMERS: Chairman Williams, members of Banking, Commerce and Insurance Committee, my name is Kelly Lammers, K-e-l-l-y L-a-m-m-e-r-s. I am Director of the Nebraska Department of Banking and Finance. I am appearing today in support of LB826. The Nebraska Department of Banking and Finance is a regulatory agency established by Nebraska Law and which is required to conduct examinations in Nebraska-chartered financial institutions. The Public Funds Depository-- Deposit Security Act establishes requirements for the security of public funds in excess of amounts insured or guaranteed by the Federal Deposit Insurance Corporation. Currently, the Public Funds

Depository [SIC] Security Act limits the pledging eligibility of out-of-state municipal bonds to those that are rated within the two highest classifications by at least one of the standard rating services. LB826 proposes to expand the eligibility criteria for out-of-state municipal bonds to include ratings assigned to certain credit enhancements associated with the bond. The department is aware of situations in which out-of-state municipal bonds include credit enhancements backed by the full grace-- faith and credit of a state, but remain ineligible for pledging due to the underlying bond receiving a less than acceptable rating. With the proposed amendment, the ability for the bonds to be pledged would be based upon an evaluation of the entire credit, including enhancements or underlying credit ratings, which may have been excluded by the initial bond rating services. Such provision enables securities to be pledged based upon their risk exposure and thus the department supports LB826. Thank you for the opportunity to present the depart-- present the department's position. I'd be happy to answer any questions.

WILLIAMS: Thank you, Director Lammers. Are there questions? Seeing none, thank you for your testimony. Any additional proponents? Seeing none, is there anyone here to testify in opposition? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Lindstrom waives closing. Before we close the hearing, though, we do have one letter from a proponent from Anica Olson from American National Bank. That will close the hearing on LB826. Turn it over to Senator Lindstrom.

LINDSTROM: All right. We'll now open the hearing on LB706 introduced by Chairman Williams whenever you're ready.

WILLIAMS: Thank you, Vice Chairman Lindstrom and members of the Banking, Commerce and Insurance Committee. My name is Matt Williams, M-a-t-t W-i-l-l-i-a-m-s, of Gothenburg, representing Legislative District 36. I appear today to present LB706, a bill I introduced at the request of the Nebraska Real Property Appraisers Board. LB706 is the board's cleanup bill for 2022 and was put together over the fall by staff of the board and staff of the committee pursuant to interim study resolution, LR100. The bill would update the Real Property Appraisers Act for compliance with Title 11 of the Federal Financial Institutions Reform, Recovery, and Enforcement Act of 1989, the Real Property Appraiser Qualification Criteria, as promulgated by the appraisal foundation, and enforced by the appraisal subcommittee of the Federal Financial Institutions Examination Council and the policy statements of the appraisal subcommittee. If the state of Nebraska is found to be out of compliance with Title 11 by the appraisal

subcommittee, the appraisal subcommittee may remove all Nebraska-credentialed appraisers from the national registry of appraisers, resulting in there being no appraisers qualified to appraise real property in connection with federally related transactions. It's estimated that approximately 80 percent of the appraisals in Nebraska deal with these types of situations due to all of the mortgage loan activity in our state. This bill should be familiar to many of us that have been on the committee. It has come back and needs this update annually. Director Kohtz is following me and he will be able to answer and go through more thoroughly all of the explanations. Thank you.

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

TYLER KOHTZ: Good afternoon. My name is Tyler Kohtz, as Senator Williams mentioned. I am the director for the Nebraska Real Property Appraiser Board. My name is spelled T-y-l-e-r K-o-h-t-z. I'd like to begin by thanking Senator Williams for the introduction and all members of the committee for the opportunity to speak on behalf of the Real Property Appraiser Board concerning LB706. The board was established in 1991 to carry out the requirements of Title 11 and the Federal Financial Institutions Examination Council Appraisal Subcommittee requirements. The board's appraisal program is primarily funded by appraiser credentialing fees and no taxpayer money is used to support this program. The Real Property Appraiser Act consists of qualifications for credentialing, as well as standards for real property appraisal practice and appraiser conduct. The purpose of LB706 is to update the act to implement the Real Property Appraiser Qualifications Criteria adopted by the Appraisal Foundation's Appraiser Qualifications Board, effective on January 1, 2021, and also to maintain compliance with Title 11. Specifically, the following changes are included in be LB706: 2021 is updated to 2022 and the definition of Financial Institutions Reform, Recovery and Enforcement Act of 1989. The word "awarded" is replaced with "issues" in the definition of completed application for consistency purposes throughout the act. A new definition of PAREA program is added for practical applications of real estate appraisal program administered by the Appraiser Qualifications Board. New language is also added, allowing that a successful-- the successful completion of a PAREA program be accepted in place of traditional experience hours for the licensed residential, certified residential, and certified general classifications. The PAREA program provides an alternative to the traditional supervisory real property appraiser trainee model for obtaining appraisal experience. To meet all or a portion of the

experience, a candidate for credentialing as a licensed certified residential or certified general real property appraiser would submit a certificate of completion to the board. The definition of two-year education period is also amended to allow those who obtain their Nebraska credential through reciprocity to utilize continuing education credits earned prior-- obtain their credential in a class the same in a different jurisdiction to use their continuing education credits prior to their credentialing in Nebraska. Language and conflict with the definition of two-year education period is also stricken from the real property appraiser continuing education requirements in 76-2236. Currently, a real property appraiser or a license-- a person licensed under the Real Estate License Act who is also an owner of real estate, employee of the owner, or an attorney licensed to practice law in the state representing the owner is not allowed to render an opinion of value of real estate or any interest in real estate for the purpose of real estate taxation or offered as testimony in a condemnation proceeding. Language is stricken in 76-2221(4) and 76-2221(5) to remove this exception from the exemptions in the act. Incorrect language found in 76-2231.01(1)(b)(iv) is corrected, as the criteria requires that college-level examination program examinations includes six semester hours of college composition and college mathematics instead of three. Also, the criteria does not require that college-level examination programs, also known as CLEP, are offered by accredited degree award winning, committed-- granting community colleges, colleges, universities. Other education providers also administer CLEP programs. The language requiring that an applicant provide a completion date for issuance of a temporary credential is stricken from 76-2223.01(2)(b). The completion date is also-- is often unknown at the time of application and a temporary credential expires at the completion of a specific assignment for which it was issued or six months after the date of issuance, whichever occurs first. The appraisal subcommittee is authorized by Title 11 to act against noncompliant state programs if the policies, practices, and procedures in place are inconsistent with the requirements of Title 11. If the, if the state of Nebraska is found to be not compliant with Title 11, all Nebraska credential appraisers would be removed from the national registry of appraisers, resulting in no real property appraisers qualified to appraise real property in connection with federally related transactions. Such action would have a substantial negative impact on the mortgage loan industry in Nebraska and the Nebraska Real Property Appraiser Board supports LB706. Your handouts also include a summary that contains a more technical explanation of each change in LB706 for your

information. Thank you for the opportunity and if you have any questions, feel free to ask.

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

TYLER KOHTZ: Thank you.

LINDSTROM: Next proponent.

ROBERT HALLSTROM: Vice Chairman Lindstrom, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m, appear before you today as registered lobbyist for the Nebraska Bankers Association in support of LB706. Senator Williams started out by highlighting the importance of the appraisal function to the lending activities of our Nebraska financial institutions. Mr. Kohtz highlighted and noted the significance of being in compliance and updating our requirements to be in compliance with the Appraisal Qualifications Board criteria and requirements and the, the consequences of not being in compliance are significant and for those reasons, we appear to support the bill. Be happy to address any questions.

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

ROBERT HALLSTROM: Thank you.

McCOLLISTER: Robert. New glasses?

LINDSTROM: Any other proponents? Any opponents? Neutral testifiers? Senator Williams waives closing. We did have one letter of support from Scott DiBiasio representing himself from Appraisal Institute. And with that, we'll close the hearing on LB706.