JACOBSON: Welcome to the Banking Committee-- can-- Banking, Commerce and Insurance Committee. I'm Senator Mike Jacobson from North Platte, representing the 42nd District, and I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing is your opportunity to be part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. When it's your turn to come forward to testify, give the testifier sheet to the page or to the committee clerk. If you do not wish to testify but would like to indicate your position on the bill, there is-- there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit to the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, and spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents of the bill, and finally anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer, if they wish to give one. We will be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you will, you will have one minute remaining, and the red light indicates you need to wrap up your final thought and stop. Questions from the committee will follow. Let me emphasize when the red light comes on and I say "wrap up your comments," don't read the last paragraph, or I'll interrupt you through the paragraph. Do your-- wrap up your comments. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard; it's just part of the process, as senators may have bills to introduce in other committees. A few final items to facil-- facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room; such behavior may be, be cause for you to, to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8:00 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only

those testifying in person before the committee will be included on the committee statement. I will now have the committee members with us today introduce themselves, starting on my left.

RIEPE: Thank you, Chairman. I'm Merv Riepe. I represent Omaha and the little town of Ralston.

von GILLERN: Brad von Gillern, Legislative District 4, west Omaha and Elkhorn.

BOSTAR: Eliot Bostar, District 29.

HALLSTROM: Bob Hallstrom, Legislative District 1, covering Otoe, Johnson, Nemaha, Pawnee and Richardson Counties in southeast Nebraska.

HARDIN: Brian Hardin, District 48: Banner, Kimball, Scotts Bluff Counties.

WORDEKEMPER: Dave Wordekemper, District 15; Dodge County, western Douglas County.

JACOBSON: Normally, our, our committee counsel, Joshua Christolear would be here, but he is ill today. At my far left is our committee clerk, Natalie Schunk. I'm going to have our two pages please stand and introduce yourselves, and tell us a little bit about, about yourselves.

AYDEN TOPPING: My name is Ayden. I am a second-year psychology student at the University of Nebraska.

KATHRYN SINGH: My name is Kathryn, and I'm a third-year environmental studies student at the University of Nebraska.

JACOBSON: With that, we will begin today's hearing with LB253. Senator Bostar, you're welcome to open.

BOSTAR: Thank you, and good afternoon, Chairman Jacobson, fellow members of the Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, representing Legislative District 29. Here today to introduce LB253, a bill to require coverage for biomarker testing by state-regulated insurers. Biomarker testing is an essential tool in modern medicine, allowing for the precise diagnosis, treatment, and management of diseases such as cancer, Alzheimer's, Parkinson's, preeclampsia, arthritis, and rare genetic conditions. Analyzing biological markers

provides valuable insights into a, a patient's condition, enabling targeted therapies that improve outcomes and reduce unnecessary treatments. This makes biomarker testing a fundamental component of personalized medicine, especially for complex diseases like cancer, where it helps guide treatment decisions and identify patients who will benefit most from specific therapies. In oncology, biomarker testing is the standard of care for many cancers, ensuring that patients receive timely, comprehensive, and guideline-based testing. Access to these diagnostics is critical for matching patients with the most effective treatments while minimizing exposure to ineffective options and their potential side effects. A biomarker is a measurable characteristic that in-- that indicates normal biological processes, disease progression, or a patient's response to a specific treatment. Biomarkers include, but are not limited to, gene mutations, genetic characteristics, or protein expression. Despite its medical benefits, access to biomarker testing is often restricted due to inconsistent insurance coverage, leaving patients vulnerable to delayed or ineffective treatments. This problem disproportionately affects rural communities, low-income individuals, and Medicaid recipients who may not have the resources to pay for testing out-of-pocket. LB253 addresses this issue by requiring state-regulated health insurers, including Medicaid, to cover biomarker testing when supported by scientific and medical evidence. Specifically, approval by the Food and Drug Administration, determinations by the federal Centers for Medicare and Medicaid Services, or local coverage determinations by the Medicare administrative contractor or national clinical practice guidelines and consensus statements, ensuring that decisions about testing are based on clinical necessity rather than personal financial constraints. In addition to improving patient care, LB253 helps lower health care costs, as multiple studies demonstrate that comprehensive biomarker testing leads to significant savings. A study sponsored by CVS Health found that while broad panel biomarker testing increased upfront costs by approximately $1,200 per patient, it resulted in $8,500 in savings per patient per month due to more precise and preventive treatment selection. Additional research indicates that insurers benefit significantly from broader biomarker testing, with potential savings reaching as high as $250,842 per patient compared to sequential or exclusionary testing methods. Without coverage for biomarker testing, patients often face hundreds or even thousands of dollars in out-of-pocket expenses, making life-- life-saving diagnostics inaccessible for many Nebraskans. LB253 requires that biomarker testing shall be covered for the purposes of diagnostic treatment, appropriate management, or ongoing monitoring of a disease

or condition when the test is supported by medical and scientific evidence and does not require coverage for biomarker testing used solely for screening purposes. Additionally, if prior authorization is required, the health plan or its third-party administrator must notify the covered individual of the approval or denial within five business days for standard requests, or within 48 hours for urgent requests. Biomarker testing supports critical advancements in medicine and helps patients receive the most effective treatments, leading to better health outcomes, fewer complications, and long-term cost savings. Thank you for your time this afternoon. I'd urge the committee to advance LB253. I'd be happy to answer any initial questions.

JACOBSON: Questions from the committee? Senator Hardin.

HARDIN: So, this is treatments and testing, not screening.

BOSTAR: Correct. This is, this is not screening; this is about identifying the best treatment course for a particular disease, condition, ailment so that time and, and resources aren't wasted on ineffective treatments.

HARDIN: OK. So, this would be Medicare, Medicaid, major medical.

BOSTAR: I mean, to the extent that we have reach into state-regulated health insurance plans and Medicaid, that's what's covered in the bill.

HARDIN: OK. CMS.

BOSTAR: Sure.

HARDIN: OK. Thank you.

JACOBSON: Other questions? Senator Riepe?

RIEPE: Thank you, Chairman. I think you're fully aware of, too, is that we get a lot of complaints about unfunded mandates.

BOSTAR: I've heard them.

RIEPE: I'm sure you have. Anyone around this table has. My concern gets to be-- and you can respond to this, this-- while I believe in biomarkers, I do have a concern of any mandate that we put on carriers, the insurance carriers. And I also ha-- quite frankly, have a, a real concern about the expanded Medicaid, because, quite frankly,

the Medicaid program is better than many commercial programs. Particularly, I know, in my own district, it's a better health plan than many of my constituents have. And I don't know how we square that.

BOSTAR: Well, I, I--

RIEPE: I don't know that I had a question in there. I apologize for not being very specific, but--

BOSTAR: Well-- you know, I, I always appreciate the conversation. I think that we should strive to advance the efficacy and access and affordability of all health insurance coverage. And so-- health insurance as well as Medicaid, so that we are doing what's best for patients and the state as a whole. I agree there are concerns around unfunded mandates, and while some, I think, would try to argue that this is an unfunded mandate, or-- let me say this. I think this is a funded mandate. The research demonstrates that the coverage of these things saves more money than their initial cost. So, what we're doing here is we're putting downward pressure on all health care costs in the system; that includes for insurance. Look, I, I believe the insurance companies are going to come up here and tell you it's an unfunded mandate-- they don't like mandates-- and that it's going to increase premiums. Well, study after study says that's wrong. And I think that there tends to be a knee-jerk reaction to legislation that would ultimately benefit taxpayers, payers, insurers, as well as the health of Nebraskans when it, when it looks like a mandate. And, and, and there's this reaction to saying, well, if it's a mandate, it's bad; not all of them are bad, and not all of them are unfunded. And if we can improve health outcomes and lower system costs, I think that's the mandate we should pursue.

RIEPE: I know we talk about the long run, but, you know, Keynesian economics theory says in the long run, we're all dead.

BOSTAR: Well--

RIEPE: So, you know, the, the payoff-- we have to kind of look at a two-year budget, we have to look at something fairly close, and--

BOSTAR: I think I think this is close. I don't-- I think that, you know, we do have some of these discussions where the payoff is further down the line, but this is specific and close. So, if you are diagnosed with cancer and there-- let's, let's say two tracks. On one,

you're-- you don't go through biomarker testing, and so you're given very expensive treatments that also come with significant side effects, and they don't work. So, you try something else, and it doesn't work. And eventually, you get to the one that'll work for you or has the best outcome or prognosis. Versus-- and by the way, each of those treatments is, I mean, an enormous amount of money-- versus what we're talking about of, let's say, roughly $1,200 to find the right one first. It's, it's savings right now. I don't think you got to wait for those savings, and on top of it, your prognosis will be better, you'll be treated effectively sooner, and there is value in the lives of Nebraskans and improving them. But even ignoring that, there are dollars and cents benefits immediately with this. The research backs that up, and someone who comes up here and sits in this chair very soon and says there isn't, I want to see their data.

RIEPE: I-- as I said earlier-- when I started off, I said I believe in biomarkers.

BOSTAR: Yes. No, no. I--

RIEPE: So, to me, it gets down to who's writing the check. It's going to be--

BOSTAR: We're saving money.

RIEPE: OK. We'll let that rest for a while. Thank you. Thank you.

JACOBSON: Other questions? I, I just have one. I, I get back to insurance 101 when we look at these kind of discussions. Insurers are the middleman. They're, they're paying out the claims; they are also collecting the premiums, and in the middle, they hope to make something, and they're regulated by the Department of Insurance as to how much they could make. So, with that said, they're working in many cases for V-- VEBA plans and other groups' health programs who basically tell them how they want to run their program. So, it, it seems to me that we can talk about how this saves money, and this is a no-brainer, but that's-- it's being talked about by the people that aren't writing a check. But the people that are writing the check, if they have reservations, I'd be curious to know why. Because if this is a no-brainer, then it would seem that they would want to do it, or the VEBA plans they represent would want to do it, and yet we're pushing them to force them to do it. And, and so, I'm a little bit with Senator Riepe that I have some fundamental concerns about using studies to dictate how this works as opposed to the insurers coming to

that conclusion, and more importantly, the people they're managing plans for come to the conclusion that they've read the studies and they agree with those studies. I-- and I, and I-- it kind of gets back, again, to-- biomarkers, I think, are a good thing, particularly in cancer. I think we've seen really good results there. I, I don't know that it's that same elsewhere, but would you agree that at some point here, the insurers are reading the same information? And why would they not want to save money if indeed it's a no-brainer to do that?

BOSTAR: Well [INAUDIBLE] I think those are good questions. I think, I think a few things on this, right? The most cynical response is, as you said, "it's not their money." Maybe they just don't like mandates because people don't like getting told what to do. I don't actually think that's it. But in, in the most cynical version of myself, that's my answer. I think, I think change is hard, and I think progress is difficult, and I think turning advancement and research and data into tangible benefits is-- isn't easy. And I think that there is-- I think the insurance industry in general-- I think they have a hard time; I think they've got a very difficult job; I think the way they're perceived is not ideal; and I, you know, to some extent, I understand the, the, the sort of instinctive reaction to being told to do something differently. And if there's, you know, if there's counterfactual data that says no, if we cover biomarker screenings, our costs will go up and there are no savings, then all I'm saying is that I want to see that, too. Let's let's look at it all. But right now what I'm seeing is, is the opposite, and, and I, and I think we should make evidence-based decisions in this room, even if instinctual reactions would lead us to the contrary.

JACOBSON: Well, thank you for that. I would just argue that the insurers are the ones that are writing a check. OK?

BOSTAR: They're writing the check, but it-- but it's, it's your money, my money, everyone's money. Right? I mean, that's what I mean by that. It's-- as you said right there, the middleman.

JACOBSON: I got that, but-- and people are concerned about high cost of health insurance, and--

BOSTAR: Yes.

JACOBSON: --this doesn't help when they're making an educated decision on-- as the check writer. So, I thank you, I think you've answered my

question. Any other questions from the committee? If not, thank you. I assume you'll stay for your close. Because we got a lot of hearing left. First proponent, please. Out of curiosity, how many plan to testify on this bill? Can I see a show of hands? And if you're going to testify, if you can find your way to the front row, that'd be perfect. Welcome.

MEGAN WORD: Hi. Thank you. Thank you, Mr. Chairman and members of the committee. My name is Megan Word, M-e-g-a-n W-o-r-d. I am the government relations director for the American Cancer Society Cancer Action Network. Thank you, thank you to Senator Bostar for introducing this legislation and being its champion. On behalf of the thousands of cancer patients and survivors across Nebraska, we urge you to support Senator Bostar's legislation, LB253, to expand access to biomarker testing. LB253 is critical legislation that will improve access to care for more Nebraskans. Comprehensive biomarker testing will enable more patients to access the most effective treatments for their disease and avoid unnecessary or ineffective treatments, helping achieve the triple aim of-- triple aim of health care: better health outcomes, improved quality of life, and reduced costs. Biomarker testing in cancer care is used to better understand the patient and identify the most effective treatment. Biomarker testing enables doctors to identify characteristics of the disease and prescribe precision treatments to some patients, removing the trial and error that can be costly to both the patient and the health care system. In a recent survey of cancer patients, 50% of those patients said they were able to avoid unnecessary treatments or procedures because of the information provided by their biomarker testing. Data on biomarker testing and cost savings also highlights the promise of precision care. For one example, on a study that Senator Bostar mentioned sponsored by CVS Health found that lung cancer patients who underwent broad panel biomarker testing experienced a savings of approximately $8,500 per member per month in total cost of care. Today, there's inconsistent access to biomarker testing, and one significant factor to that barrier is insurance coverage. It's not always covering, covering the testing patient's need, even when it is standard of care and supported by the latest evidence. Not all communities are benefiting from the la-- the latest advancements. A recent study showing patients covered by Medicaid who are diagnosed with a particular type of lung cancer are not only at a 19% higher risk of not receiving biomarker testing and a 30% higher risk of not benefiting from precision medicine, these patients also have a 23% higher risk of mortality when compared to commercially insured

patients. LB253 limits the circumstances when testing should be covered and the evidence that must be demonstrated in order for testing to con-- qualify for coverage. It does not require all biomarker tests to be covered, and does not require coverage of biomarker testing for screening purposes. Insurers can still require utilization management, including prior authorization. And while there may be increased costs for testing, these estimates do not account for cost savings and cost avoidance. To date, 20 other states have passed similar legislation.

JACOBSON: Thank you.

MEGAN WORD: Thank you.

JACOBSON: Questions from the committee? All right. Seeing none. Thank you for your testimony.

MEGAN WORD: Thank you.

JACOBSON: Next proponent. Welcome.

APARKISHOR GANTI: Good afternoon, members of the Banking, Commerce and Insurance Committee. My name's Dr. Aparkishor Ganti, and I'm the director of thoracic oncology at Nebraska Medicine. I'm a medical oncologist--

JACOBSON: Can you spell your name, first and last, please?

APARKISHOR GANTI: It's Ganti, G-a-n-t-i. I'm here to--

JACOBSON: Is that first and last name?

APARKISHOR GANTI: The first name's Aparkishor, A-p-a-r-k-i-s-h-o-r, last name's Ganti, G-a-n-t-i.

JACOBSON: Thank you.

APARKISHOR GANTI: I specialize in the care of lung cancer and head and neck and thyroid cancer, and I'm here today to speak in favor of LB55-- LB253, which will require coverage for biomarker testing for the purposes of diagnosis, treatment and management, and ongoing monitoring of a disease or condition when the test is supported by medical evidence. Biomarker testing is an important step in precision medicine. This allows doctors to choose treatments that are specifically targeted to the individual's specific condition. This

often leads to improved survivorship and improved quality of life. Most of the current applications are in the field of cancer, but there are other applications in Alzheimer's disease and other neurological conditions, rare infectious diseases, and respiratory illness, with ongoing research which will potentially uncover other uses for these biomarkers. Personally, I can speak to the importance of this testing and how it helps us to take care of patients in an appropriate manner, decreasing costs for both payers, patients and insurance providers in the long run. For example, I specialize in lung cancer, and the most common treatments in lung cancer are related to the presence or absence of these biomarkers. For example, all guidelines today recommend biomarker testing for lung cancer patients at all stages because not only do these tests help us decide what treatments are good, sometimes, the presence or absence of these mutations help us decide against specific treatments. For example, immunotherapy, as you all know, is routinely used for most lung cancer patients; however, there is excellent evidence to suggest that if a patient has a mutation in the EGFR gene, also known as epidermal growth factor receptor, the chances of that patient responding to immunotherapy are less than 5%. So, by having this test, you will not only real-- recognize a patient who is a suitable candidate for EGFR-targeted treatment, but also who is not a candidate for immunotherapy. So, from a cost perspective, I understand the importance of decreasing costs, but identifying the correct drug will avoid the complications of ineffective treatments and the unnecessary costs of treatments and the management of their side effects and complications, thereby impacting patients positively. And not only lung cancer, but there is evidence in other cancers that this biomarker testing is useful. So in closing, as a practicing oncologist, I appreciate Senator Bostar for introducing this bill, and for each of you on the committee for consideration of making these critical resources available to all Nebraskans. Nebraskans deserve the best, most innovative medical care, and LB253 will ensure that they are afforded such access by using precision medicine to provide the best and most targeted, cost-effective care. Thank you.

JACOBSON: Thank you. Questions from the committee? Senator Hardin.

HARDIN: The cost of the testing is generally around $1,200, something like that?

APARKISHOR GANTI: Around that range, yes.

HARDIN: Does it ever cost more than that, or radically more than that?

APARKISHOR GANTI: Not typically.

HARDIN: Not typically? OK.

APARKISHOR GANTI: The costs of these tests have come down quite dramatically over the past 5 to 10 years. So typically, the cost these days is around-- somewhere around $1,200 per test.

HARDIN: About how long does it take to get the results?

APARKISHOR GANTI: So typically, the turnaround time once the lab gets the specimen is somewhere between 5 to 10 business days.

HARDIN: OK. Thank you.

JACOBSON: Senator Wordekemper.

WORDEKEMPER: Thank you for being here. Is there a time when you submit for the biomarker testing and the insurance company will deny that test or deny paying for that test, and then you'd have to seek other treatments?

APARKISHOR GANTI: It has happened.

WORDEKEMPER: OK.

JACOBSON: Other questions? Do you routinely do biomarker tests, or ask for it?

APARKISHOR GANTI: Yes.

JACOBSON: On virtually every case?

APARKISHOR GANTI: Yes.

JACOBSON: And, and, and you're saying that the biggest, best results have been-- that you've seen is with cancer, but, but it's safe to say we're more experimental in other areas?

APARKISHOR GANTI: I specialize in cancer, so that's what my-- most of my knowledge is from. And there, there is ample evidence to suggest that these are not experimental, and all of the national guidelines, some of which I sit on, I recommend using-- obtaining these tests prior to starting treatment. As for the other areas, I am not an expert on that, so I would rather [INAUDIBLE].

JACOBSON: Thank you. All right, and-- yes, Senator Hardin.

HARDIN: In your experience, do the insurance carriers generally just not pay for this biomarker testing, or are there some that through individual consideration or case management, do they occasionally pay for it?

APARKISHOR GANTI: So, most of the times, I have not had any problems getting the testing done.

HARDIN: OK.

APARKISHOR GANTI: And some of the labs can often offer the-- these tests to patients at a very nominal cost in case their insurance companies don't pay for it.

HARDIN: OK.

APARKISHOR GANTI: But I have not had too many problems in getting the tests for my patients. As far as who pays for them, it-- often, the insurance companies will pay for them, but if the insurance companies do not, labs have been known to pick up the tab.

HARDIN: Are these labs in the U.S.? Are they local? Are they international? Are-- where are these labs located? Just curious.

APARKISHOR GANTI: Most of the labs are here in the U.S.

HARDIN: OK.

APARKISHOR GANTI: We have a lab in our own institution that does some of these testing as well. A lot of academic institutions have their own individual labs that do it, but the commercial labs are mainly present in the U.S.

HARDIN: Thanks for being here.

JACOBSON: Senator Riepe.

RIEPE: Thank you, Chairman. I guess my question is going to be the big R-word, and that is, given the cost of this, and particularly the aggregate cost that we as the state would be paying on the Medicaid-- so, we're like the insurance company on that. We're, we're-- we have a great big bill on this. Do you have any rationing process where, at a certain age, you would say your probability of living-- like a lot of

times they do with colonoscopies; when you get to a certain age, you don't get another colonoscopy. Or I think they say that with men, you know, any kind of a prostate surgery at a certain age, you will outlive it rather than having the surgery. Do you have that on this bio to try to man-- manage the cost here? That said, maybe if you're beyond 80 years old, that you don't-- you're not going to get a biomarker?

APARKISHOR GANTI: I, I would argue that most of the-- there, there is no rationing in that sense, but I would argue that-- especially in lung cancer, we have a lot of elderly individuals who get lung cancer. The median age of a developing lung cancer is 70. So, half of the individuals who get lung cancer are over that age. And most of these older individuals actually are not good candidates for chemotherapy, which would be the other treatment option. And many of these targeted therapies, which are used in the presence of these specific biomarkers, actually have a significant positive impact on the quality of life and the qualit-- for their-- whatever time they have left. So, in fact, I would be more insistent on treat-- getting those biomarkers on those individuals to see if I can treat them with these targeted agents to improve their quality of life.

RIEPE: Mm-hmm. Well, does that go to the-- to a 90-year-old if it goes to a 70?

APARKISHOR GANTI: Sorry, I didn't catch that.

RIEPE: You said a 70-year-old smoker. Would it be a 90-year-old smoker? Would you give biomarkers to a 90-year-old?

APARKISHOR GANTI: If they are a-- if, if I feel that they would be able to tolerate the treatments that would ensure from that biomarker testing, I would.

RIEPE: OK.

APARKISHOR GANTI: Because like I said, it's not so much about the quantity of life, it's about the quality of life as well. And I've had patients, for example, one of the-- who was a 75-year-old schoolteacher who came to me basically on the exam table because he couldn't stand up. We got these biomarker testing on-- done on him, and luckily for him, he had a mutation called ALK, which at that time was just newly diagnose-- found out, and there was a treatment for that. We started him on a treatment targeting that ALK mutation. Three

weeks later, he sends me a postcard from Arizona where he was playing golf. So, that's the kind of dramatic effect that these medicines can have. So, that person, I would never have treated with chemotherapy because he would not have tolerated it. I would have more likely killed him sooner if I had given him chemotherapy. But this gentleman lived for another 2 to 3 years with good quality of life, and his favorite pastime was to send me pictures of him golfing in Arizona in February.

RIEPE: I hope you understand our position, that we have such a financial-- huge financial exposure through Medicaid that our technical ability exceeds our affordability.

APARKISHOR GANTI: I, I, I completely understand.

RIEPE: That's where-- I mean, I'm being real frank about it. That's one of the challenges as an organization, as the Legislature, that we have.

APARKISHOR GANTI: I, I completely understand that.

RIEPE: And that's not limited to yours. That's limited to a lot of projects--

APARKISHOR GANTI: Sure.

RIEPE: --that we're going to see and talk about more today.

APARKISHOR GANTI: But, but the other-- on the contrary, let's say we did not get biomarker testing and we had to address them-- treat them with what we would consider standard in the absence of biomarkers, which would be chemotherapy and immunotherapy. Those are not cheap, either. I mean, biomarker testing is about $1,200. Immunotherapy, the cost of a drug that the federal government gets-- I work at the VA as well, so I'm familiar with that-- the drug Keytruda, a single dose is about $8,000, and if we did not get the biomarker testing and we didn't know if the patient had a mutation that may or may not predict for responsiveness to that immunotherapy, we are basically spending those $8,000 plus whatever side-- management of side effects is with that treatment. And we might have to do 2 or 3 treatments before we find out that it's not working. So, there itself, we've spent around $30,000, whereas we could have known that upfront by doing a $1,200 test. That's, that's where my, my thoughts are, and that's how I think about this in-- from a financial perspective. I completely understand where you're going for with all the costs that are involved, and I

understand that there's a limited-- the resources are limited. But look at it from the other perspective: if we did not get a test, we would have-- we would be spending all this money on "treaking"-- taking care of these patients, and we'd probably spent-- would be spending more money that way.

JACOBSON: Any other questions?

RIEPE: Thank you.

JACOBSON: Senator Hardin.

HARDIN: Is biomarker testing accurate every time? If not every time, how much of the time is it accurate?

APARKISHOR GANTI: It's not every test is 100% accurate, but biomarker testing-- if a-- if we detect the presence of a biomarker that is, that is very, very accurate; over 99%. The absence of a biomarker is less so, because it depends on which part of the tumor you take the biopsy from. And even within one tumor, if you take a biopsy from this part, it may or may not be the exact same as taking a biopsy from this site. So, if you find something that's very accurate. If you don't find something, then the level of accuracy drops down to about 80-85% somewhere in that range.

HARDIN: About 85%?

APARKISHOR GANTI: Mm-hmm.

HARDIN: OK.

APARKISHOR GANTI: So, it is very specific. If it is there, it's very good.

HARDIN: Any idea what our percentages look like if we don't use biomarker testing? Are we 50/50 two-thirds of the time, 25% of the time?

APARKISHOR GANTI: So, I'll give you an example of lung cancer. About 40% of patients with lung cancer have a mutation that can be targeted. So, if we did not do the testing at all, we would be treating all of our patients with chemotherapy and immunotherapy. The response rates, the proportion of patients who respond to chemotherapy by itself is about 30% at best; add immunotherapy to it, it becomes about 55% or so. So, half of those patients would not respond. If you do the

biomarker testing and you-- the patient has a biomarker, the-- most targeted treatments have response rates of around 75% to 80%. So, we are-- if by not doing biomarker testing we are giving the patient at best a 30% chance of responding to whatever best treatment we would give in the absence of biomarkers, whereas if we got a test and the test was positive, we are looking at a much, much higher rate of response and survival. Improved survival.

HARDIN: Thank you.

JACOBSON: Seeing no other questions. Thank you for your testimony.

APARKISHOR GANTI: Thank you.

JACOBSON: Next proponent. How are you?

SHERRY MINOR: I'm good. My first time.

JACOBSON: Take a deep breath. It's just we're-- we don't bite.

SHERRY MINOR: OK. My name is Sherry Minor, S-h-e-r-r-y M-i-n-o-r, and I am an ovarian cancer survivor and an Omaha resident. When I woke up on November 17, 2023, I had no idea my life would-- or my life would change and end up in an emergency department undergoing an MRI that would identify four large masses in my uterus. I received my diagnosis in the most unusual way. I was coming home from work, and I experienced a diabetic incident where I blacked out behind the wheel and crashed my car into others. I got to the emergency room and the doctors ordered an MRI to see if I had any back injuries. I was shocked when they found four large masses that required more testing, but they were likely cancerous. After seeing two different gynecologists and an oncology gynecologist, I got the devastating news that at 41 years old, I needed to go undergo a full hysterectomy, with a follow-up of at least six rounds of two distinct types of chemotherapy. They also ordered biomarker testing to identify the best targeted treatment to me for during, after, and the rest of my life. It felt like I was on the right path, and I was hopeful for a positive outcome even though I know the road would be bumpy. I was shocked when my insurance company denied my coverage for the biomarker testing. I received a denial letter in the mail stating that they considered the test that my doctor ordered and used to guide my treatment to be investigational. My doctors and I appealed the denial by phone and by mail, but time was not on my side. My oncologist identified a scholarship that paid for the test, saving me almost $5,000 out of

pocket, not to mention the toll on my emotional health. But not all patients are this lucky. I literally owe my life to the dedicated oncologist who knew the best course of treatment for me and would settle for nothing less than the best treatment possible today. Science continues to create targeted treatment for various illnesses, and Nebraskans who can benefit deserve access. So, Senators, I urge you to vote LB253 from committee to the floor so that Nebraskans with cancer diagnosis can receive the right treatment at the right time. Thank you.

JACOBSON: Let me be clear. You, you testified that, that the biomarker testing that you received, that you paid for through a scholarship was over $5,000?

SHERRY MINOR: It was almost $5,000.

JACOBSON: OK. So, more than the $1,200 that we've been told earlier.

SHERRY MINOR: Yes. Yeah.

JACOBSON: OK. Thank you. Other questions from the committee? All right. Seeing none. Thank you for your testimony.

SHERRY MINOR: Thank you.

JACOBSON: How are you?

ALEX DeGARMO: I'm well, Senator. How are you?

JACOBSON: Good.

ALEX DeGARMO: Good afternoon, Chairman Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Alex DeGarmo, A-l-e-x D-e-G-a-r-m-o, and I'm the public policy director for the Alzheimer's Association Nebraska chapter. The Alzheimer's Association is dedicated to leading the fight against Alzheimer's and all other dementias by advancing global research, promoting risk reduction and early detection, and enhancing quality care and support for those affected. On behalf of the Alzheimer's Association, we appreciate the opportunity to stand with the Nebraska Biomarker Testing Coalition in support of LB253. This legislation would ensure appropriate coverage of approved biomarker testing used to treat and diagnose a variety of diseases, including Alzheimer's and dementia. There are currently 35,100 Nebraskans living with Alzheimer's disease, but as many as half of them were not formally diagnosed. An early and accurate diagnosis

of Alzheimer's can improve access to care and support services, enhance quality of life, and reduce the financial impact of the disease. With historic approval of treatments that slow the progression of the disease, early detection and diagnosis of Alzheimer's are even more critical to ensure individuals receive the most benefit at the earliest point possible in disease progression. Current diagnosis, diagnosis of Alzheimer's disease relies largely on documenting cognitive decline, at which point Alzheimer's has already caused severe brain damage. Experts believe that biomarkers offer one of the most promising paths to improve dementia detection, diagnosis, and treatment. There are currently FDA-approved biomarker tools that, when applicable, can be used to aid in the diagnosis of people with symptoms of Alzheimer's or another dementia. These tools have a wealth of research and clinical data to support their use in the clinical setting, while other emerging biomarkers are still promising but under investigation. Continued progress around blood place-- bud-- blood-based amyloid biomarkers is likely to lead to new diagnostic tools coming to market within the next couple of years. Without taking action on this legislation, dementia diagnosis may take up to two years, increasing the long-term cost to the individual, family, and state. A 2018 analysis, diagnosis led to projected cost savings of approximately $63,000 per individual: $30,000 in Medicare savings, $20,000 in Medicaid savings, and $13,000 in other savings. LB253 ensures that Nebraskans can obtain biomarker testing, which will reduce the time it takes to receive a dementia diagnosis, and enable access to new treatments and care planning. Thank you for your time and consideration. I'd be happy to answer any questions.

JACOBSON: Thank you for your testimony. Questions from the committee? I'm seeing none. Thank you.

ALEX DeGARMO: Thank you, Senator.

JACOBSON: Next proponent. How are you?

CAITIE NINEGAR: Good. How are you?

JACOBSON: Great.

CAITIE NINEGAR: Good afternoon. My name is Caitie Ninegar, C-a-i-t-i-e N-i-n-e-g-a-r. I work for a local clinic, Be Well Memory and Infusion here in Lincoln. We specialize in treatment for Alzheimer's patients and dementia patients. We provide the new FDA-approved disease modifying infusions that slow the progress of the disease. In order to

provide that treatment, we need an early diagnosis, and we get that via this biomarker testing. If these biomarker tests are inaccessible, we cannot do our jobs, we cannot provide the treatment to our patients. They are used as diagnostic tools that ensure eligibility for the treatments we provide. Expanding coverage through LB253 would ensure that individuals have access to care that could significantly impact their future, reducing long-term health care costs, unnecessary hospitalizations, and reducing the burden on long-term care facilities like memory care facilities. In addition to my testimony today, I provided you a copy of a letter from Dr. Puente, who is our neurologist and medical director. I appreciate your time and your consideration, and I'm happy to take any questions.

JACOBSON: Questions from the committee? All right. Seeing none. Thank you for your testimony.

CAITIE NINEGAR: Thank you.

JACOBSON: Next proponent. Welcome.

LISA FUCHS: Hello. My name is Doctor Lisa Fuchs, L-i-s-a F-u-c-h-s, and I want to thank you for the opportunity to provide proponent testimony for LB253, a bill to cover biomarker testing. The American Lung Association in Nebraska is, is who I'm representing today, as well as myself. I urge lawmakers to support LB253 to increase coverage of biomarker testing. The legislation will improve access to critical cancer care for patients in Nebraska, including those with lung cancer. The American Lung Association is one of the oldest voluntary public health associations in the United States, currently representing the more than 34 million Americans living with lung diseases, including more than 1,300 Nebraskans diagnosed with lung cancer annually. The Lung Association is the leading organization to save lives by improving lung health and preventing disease through research, education, and advocacy. Comprehensive biomarker testing allows doctors to identify abnormalities, as you heard earlier, in the cells' DNA, which in turn helps health care providers determine the best course of treatment for lung cancer patients. This is particularly important when treating lung cancer, as there are currently FDA-approved lung cancer treatments for tumor abnormalities and at least nine distinct genes. Studies show that individuals with lung cancer who have access to this biomarker testing are thus able to receive that targeted therapy and have a better and overall chance of survival. Biomarker testing is a crucial part of cancer care, treating other chronic conditions that you heard about today. Despite the

evidence for the value of biomarker testing, most health care coverage plans are more restrictive than the National Comprehensive Cancer Network's guidelines for the biomarker testing. Many patients who should receive biomarker testing may be unable to do so because of insurance coverage, including the Nebraska Medicaid program, and high out-of-pocket costs. Nebraska can increase equitable access to health care by passing this bill. Current biomarker testing rates show significant racial disparities. For example, research shows that black patients with non-small cell cancer are less likely to receive the treatment versus white patients. So, increasing the coverage of biomarker testing will improve health equity in Nebraska and make cancer and chronic disease care more affordable and accessible for all patients. Sadly, I lost my father to lung cancer. I wish that the biomarker treatment for his lung cancer would have been available. The American lung cancer [SIC] in Nebraska urges you to support this bill, LB3-- LB253.

JACOBSON: Thank you for your testimony.

LISA FUCHS: Mm-hmm.

JACOBSON: Questions? Senator Hardin.

HARDIN: How trusted is biomarker testing by doctors in general, or for those in particular, in your particular--

LISA FUCHS: I'm a professor.

HARDIN: You're-- OK.

LISA FUCHS: Yeah. So, I'm not a medical doctor, but--

HARDIN: OK. What's your sense of how much it's tested at this point?

LISA FUCHS: I think, you know, when you hear the word evidence-based, it's pretty true. True to what is the best of the best to treat patients. For my father, he found out accidentally that he had lung cancer. He was healthy, retired, and at 55, lived on a beach. And one day, you know, he called, he said, I have stage three. Never smoked. So, you know, if, if maybe he would have had that testing, I don't know. But, you know, he could have maybe lived a little bit longer because we could have targeted the treatment better. He received treatment through MD Anderson, the MD Anderson cocktail. So, the best treatment available. And I think the LB253 is the best treatment available at this time.

HARDIN: Thank you.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony.

LISA FUCHS: Thank you.

JACOBSON: Next proponent. No other proponents? OK, if not, we'll go to opponents. First opponent. Welcome to the committee.

JEREMIAH BLAKE: Good afternoon, Chairman Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm a government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB253. Advance in-- advances in precision medicine have revolutionized disease treatment, and it's likely we've only scratched the surface of what is possible in this field. Blue Cross and Blue Shield of Nebraska supports the use of precision medicine, including coverage of biomarker testing, because these strategies can save lives and reduce the incidence of unnecessary care. After the introduction of this bill, our team conducted a review of our current medical policies regarding biomarker testing. We have more than 20 medical policies that include requirements for biomarker testing, and we approved more than $110 million in benefits in biomarker testing in 2024 alone. I believe this demonstrates our commitment to biomarker testing when there is clinical evidence to show its efficacy. Most of the proponent testimony has focused on the benefits of biomarker testing in cancer treatment, as well as Alzheimer's. We agree that testing can guide treatment decisions, improving patient outcomes, and imp-- and reducing unnecessary care. However, we are concerned that this bill will require biomarker coverage for tests beyond cancer treatment as well as ans-- Alzheimer's, and it includes situations where the tests may not provide clinical utility in the treatment decision. As noted in the fiscal note on this bill from DHHS, there are more than 600 CPT codes for biomarker tests. Our own data shows that providers are requesting biomarker tests without evidence to support its clinical utility in treatment decisions. As LB253 currently stands, we would have no choice but to pay benefits for testing that would be considered experimental or lacking clinical utility under guiding treatment plans. This drives up the costs for health care and health insurance for all Nebraskans. Our second concern with LB253 is that-- is the same with any other insurance mandate: it would ultimately increase costs for our members. When the Legislature enacts a mandate to cover

a new service, such as biomarker testing, it removes any incentive for providers to negotiate a fair price for those tests. There's been quite a bit of discussion about the cost of these tests today, but ultimately what a, a, a mandate does is create inflationary pressure on health care services, which is a concern for many Nebraskans. And then finally, I would just note briefly that there's some language in here regarding prior authorization requirements and turnaround times. And as we're discussing this bill and LB77, I would just ask that the committee consider it, that there be some uniform policies concerning, concerning prior authorization requirements and timelines. So, with that, I would respectfully answer any questions you have, and thank you for your attention.

JACOBSON: Questions for Mr. Blake? Senator Hardin.

HARDIN: Senator Bostar indicated that savings of biomarker testing is roughly $250,000 when it's not-- when it is used versus not used; you're saying that numbers are not quite that way, that there are 660 or so differentiators involved? Tell me about that. Is that a function of the ICD-10 system being so complicated that doctors are simply checking the wrong box on the kind of thing that's needed? And so, is it just a miscommunication process? Or do the doctors not know, and they're just shooting in the dark as to which biomarker tests need to be performed? Can you just kind of comment on what that confusion is about?

JEREMIAH BLAKE: Yeah-- yeah, I'd just make a couple of comments. So again, I would refer back to my testimony, where-- again, we pay for a lot of biomarker testing today because we agree, right? If you can identify the best treatment plan for an individual cancer treatment, there's-- it's better outcomes for the patient, and there's savings associated with that. And when that-- when those circumstances present themselves, we absolutely should be paying for biomarker tests. We also get requests for biomarker testing where there's no clinical utility to it, right? We don't believe that the test would actually guide treatment decisions and improve patient outcomes. I will tell you again, when we went back and looked at the data in 2024, we approved about $110 million worth of tests; we denied about $5 million worth of tests where there was no clinical utility. Under, under this bill, it becomes a question, a legal question, a compliance question of if we get a request from a provider for an FDA-approved test, but there's no evidence to show that it will, will provide some clinical utility and gride-- guide treatment decisions, do we have an obligation to cover that or not? And that's how you see the creep and,

and the increase in costs, which ultimately is what we would have to pass along to our members. And if I could just one last-- one last comment. Again, if, if, if you just do the simple math, $110 million worth of biomarker testing last year at $1,200 apiece-- I don't know what a biomarker test is, how much it costs, but at $1,200 apiece, we would have done 91,000 biomarker tests last year. That seems awfully high to me, which leads me to believe that biomarker testing is probably-- the, the cost of that is pretty variable.

HARDIN: So, you're saying you're not anti-biomarker, you simply are saying this bill's not necessary.

JEREMIAH BLAKE: We do a lot of biomarker testing today because it's the right thing. When you put something into law, it means something that we have to comply with. So, that becomes the complication. Then, in theory, we're paying for things that we may not otherwise pay for because there is no clinical utility to that to us.

HARDIN: Are other carriers as conscientious as Blue Cross Blue Shield on these things, or are you guys an outlier?

JEREMIAH BLAKE: I can't wait to hear them sit down and testify on this issue.

HARDIN: Very well. Thank you.

JACOBSON: Other questions? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here.

JEREMIAH BLAKE: Yeah.

RIEPE: I had a question. Who does the testing sources? Are those by the providers themselves? I mean, do they have a vested interest in the margin, if you will, of testing?

JEREMIAH BLAKE: As you know, Senator, we receive claims, we pay claims. We don't do any cider-- type of testing, so I don't know if I'd be the best person to answer that question, so.

RIEPE: OK. I know in the hospital business, you know, we--

JEREMIAH BLAKE: Yeah.

RIEPE: --we make money in a couple different ways. OK. Thank you.

JEREMIAH BLAKE: Yep.

RIEPE: Thank you, Chairman.

JACOBSON: Senator Hallstrom.

HALLSTROM: Yeah. Would it be your testimony that you don't have any opposition to cancer and Alzheimer's, because that's fairly well-established with regard to the benefits and the clinical utility from biomarker testing?

JEREMIAH BLAKE: The bill as currently drafted includes any kind of biomarker testing. Again, we do a lot of biomarker testing, and if the scope were narrowed, that would make a lot of sense to me.

HALLSTROM: And would, would the increased cost be part of that subset of the $5 million that you'd be worried about that this bill would, would impact, since you're doing biomarker testing on $110 million?

JEREMIAH BLAKE: That's a good question. I don't know if I'm prepared to answer that right now. Again, I, I just think that if, if the bill were specific to areas where, where there's current evidence to show that there's clinical utility in the biomarker testing and that's what the bill reflected, we'd be much more comfortable with it.

HALLSTROM: OK. And my reading of the bill is we've already got medical and scientific evidence to back the biomarker, biomarker testing. Is there anything with regard to a standard of clinical utility that needs to be in the bill, or would be helpful?

JEREMIAH BLAKE: I think that would be helpful, and if that's something the committee wants to consider, we'd certainly be open to having that conversation.

HALLSTROM: And has any, any other state done something like that?

JEREMIAH BLAKE: Yes, other states have gone that direction as well.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony.

JEREMIAH BLAKE: Thank you.

JACOBSON: Other opponents? Mr. Bell.

ROBERT M. BELL: Good afternoon. Chairman Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist of the Nebraska Insurance Federation. I'm here today in respectful opposition to LB253. As a reminder, the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies, including most of the health plans operating in the state, including, as you've already heard from, Blue Cross Blue Shield Nebraska, Medica, Nebraska Total Care/Ambetter, Aetna, which is also called CVS Health, UnitedHealth Group, and Cigna. As always, I would like to express my appreciation to Senator Bostar's attention to this issue on biomarkers and many conversations we've had in the last couple of years. I know the Senator has a real passion for health care policy and its impacts on everyday Nebraskans. The invention and use of biomarkers for treatment-- to guide treatment of certain types of cancer in Alzheimer's is a scientific miracle, and it's truly a blessing for those who are in need. This is why, in part, the state-regulated health plans already provide coverage for the use of biomarkers. I think with a bill like LB253, the devil is in the details. The first, the scope of this-- and you've heard some of this already from Mr. Blake, but first, the scope of this particular model is-- it's just too broad. While biomarker coverage is already provided, the biomarker test needs to be warranted by the underlying condition. While LB253 does have some limitation related to medical and scientifical-- scientific evidence, which could be met by using-- by meeting any one of a list of five broad categories, including mere FDA approval, FDA approval is for safety and efficacy, not for clinical utility. These categories are so broad, broad that essentially they are no limitation at all. And then also, just to point out normally Band Aid bills like LB253 also are a little bit more surgical in the application to the-- of the types of politic-- policies that mandate would apply to, and typically include exclusions for specified disease or other types of limited benefit coverage, which could also be considered health insurance, which policies would not be particularly relevant to this type of mandate, but could be adversely "apacted"-- impacted by such a mandate both on the availability and the cost, should the mandate apply. And then, yeah, similar to what Jeremiah said, if, if, if the committee does move forward with this, you know, do note that there's prior authorization discussions going on right now, and that perhaps those would not be needed in a piece of legislation like this. For these reasons, the Nebraska Insurance Federation respectfully opposes LB253 as currently drafted. I would point out to you on scope, with all health insurance

mandates-- I don't know if I've talked about this just yet this session-- as a function of both federal and state law, this-- these mandates do not apply to ERISA plans, Medicare, or the new agricultural organization plans that was passed last year. We think this roughly accounts for about half of Nebraskans. So, I know there was a bill last week or two weeks ago where an individual came in and said, hey, insurance companies aren't keeping their promise. And we do know, like, in the ERISA-- I think it was on breast cancer screening-- I do know that in, in ERISA plan world, when, when people are designing those plan benefits, they don't always include the state mandates that are passed by the state legislature. We know that to be a fact. So, with that, thank you.

JACOBSON: Thank you. Questions? Senator Hardin.

HARDIN: How would you define the difference between screening and testing?

ROBERT M. BELL: Oh, was I not being clean on my language? Probably going back and forth. So-- well, yeah. So, a screen would be-- in, in-- I think in a medical sense-- not doctor, obviously-- but you're, you're just checking for something on, on somebody that's completely heal-- healthy. A test might be something that's a little bit more specific to somebody not feeling well. In, in biomarker testing, I think you're going in-- maybe I have that backwards-- but in this, my understanding is that you have been diagnosed with a particular disease, like a tumor or something along those lines, and they can go in and, and test that and, you know, come up with a treatment plan based off of the biomarker of that particular disease.

HARDIN: So, a mandate would essentially-- would it elevate screening to testing, if we add the mandate piece to it? Because it essentially forces everyone on the march to get the testing done before they may be ready for that. Is it premature?

ROBERT M. BELL: I don't know. I, I, I think for the most part, like, doctors and other medical providers are going to do a pretty good job of accurately prescribing or however this would-- this test would happen. And I think that really the words "test" and "screening" are probably interchangeable, right? Our worried is about how it's drafted right now, and could the language be tightened? I think so. Just a broad application of this-- so, let's say there's an FDA-approved biomarker test. I was reading some in the Journal of the American Medical Association a vu-- a viewpoint, so not a scientific article

necessarily, that said, you know, there, there is a downside for, for having the wrong biomarker test, right? Because you go down this treatment path, and-- which can affect both the health of the individual and the pocketbook of the individual before you realize it doesn't work. And it, it, it wasn't-- there wasn't a clinical utility to that particular biomarker test, so.

HARDIN: OK. From your seat, is the Blue Cross Blue Shield ratio of $110 million true and $5 million false kind of [INAUDIBLE]

ROBERT M. BELL: Man, my colleague set me up for that one, didn't he? I don't know. I mean, I think you heard-- and some-- I did not hear all of Senator Bostar's opening. I'm sure it was fantastic. But--

HARDIN: Jeremiah was just--

ROBERT M. BELL: Yeah, yeah. I know he mentioned CVS, talking about-- so, CVS Health, a member, definitely feels that way. Blue Cross feels that way. I would assume most of our, our plans in the federation do cover this, because they recognize the savings too, right? So-- and they want people to get good, good health care. There's probably quite a bit of back and forth before that is approved would be my-- there's a little bit of a ying and yang [SIC] that goes on sometimes on, on these types of things, so.

HARDIN: OK. Thanks.

ROBERT M. BELL: Yep.

JACOBSON: Senator Riepe.

RIEPE: Thank you, Chairman. Twice, you used the frame, saying "as written." Does that imply that you have some alternate language that you--

ROBERT M. BELL: I don't, I don't have any language with me today, but if the committee was interested in talking language or Senator Bostar was-- and I'm sure he probably is-- that we, we theoretically could sit down and, and limit the scope and, and make sure we're actually addressing an issue in the marketplace. And again, with that said, we believe that most plans are already covering biomarker coverage. And, and I missed some of the proponents, too, and I apologize about that. But I'm, I'm sure you heard stories where the-- they are not-- that that their insurer said no initially. Perhaps they went through internal review or external review process and, and those decisions

were overturned, or perhaps a doctor called the insurance company and there was a discussion and, and then it eventually happened, or then perhaps they pay for it out of their own pocket, or a charity stepped in and paid for the-- however much the cost-- the test may cost. I'm sure many of those situations existed. But yeah [INAUDIBLE] your additional questions. Sorry I kind of rambled there. We can, we can sit down and discuss.

RIEPE: OK. Thank you. Thank you, Chair.

JACOBSON: Senator Hallstrom.

HALLSTROM: Have you had any conversations with Senator Bostar?

ROBERT M. BELL: On biomarkers?

HALLSTROM: Yes.

ROBERT M. BELL: Oh, yes. Over-- but not, not on specific language, per se, so.

HALLSTROM: You're just take-- thinking "Along Came Jones," there's slow walkin', slow talkin' Jones--

ROBERT M. BELL: Oh my gosh.

HALLSTROM: I think that we could get in and, and work on some language, hopefully.

ROBERT M. BELL: Yeah.

HALLSTROM: If, if Senator Bostar is welcoming.

ROBERT M. BELL: If he, he'd-- you know, and it's just not-- I mean, it's Senator Bostar's decision, of course. And, and I'm sure he's working with advocates that may also have opinions. So.

HALLSTROM: Thank you.

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

ROBERT M. BELL: You're welcome.

JACOBSON: Any other opponents? Any other opponents for LB253? If not, anyone wishing to speak in a neutral capacity on LB253? Seeing none. Senator Bostar, are you-- welcome to close.

BOSTAR: Thank you, Chairman Jacobson.

JACOBSON: By the way, there were 24 proponent letters, 1 opponent letter, and 1 neutral letter, letter. And there were no ADA letters submitted.

BOSTAR: Thank you, Chairman Jacobson, fellow members of the committee, for your time and attention to this matter. I-- you know-- want to talk about a couple things. You know, this, this phrase about utility keeps getting brought up. Also, you know, I think Mr. Blake talked about how the test is-- can be certified for safety and efficacy, but not necessarily utility, which is interesting. I mean, efficacy in and of itself, I, I think to me, anyway, would imply that it is serving a function. And they talked about how-- what if a doctor submits a request for the-- one of these tests and, and the insurance doesn't feel like it has utility. And, and then, under this bill-- it doesn't have clinical utility. Under this bill, then they wouldn't have a choice but to cover, cover that test. You know, if you recall back to the pre-authorization hearing, you know, in one category there was something like over 80% of these denials are overturned. So, some of the instincts-- we talked a lot about instincts in the opening as well, but a lot of the instincts here tend to be wrong. And so, maybe the podiatrist who's doing the pre-authorization review on-- for a request being submitted by an oncologist doesn't understand the clinical utility of a particular treatment or test. Perhaps he doesn't have the education or background to understand it, and denies it. That doesn't mean that it didn't have utility; it just means that someone in an insurance company denied it. And often, as we've seen, a lot of these things get overturned. I think what's important is that we're getting the right treatments to the people who need them in a timely manner, because that's what makes a difference. And not spending time in this paper chase that we've all heard so much about, hearing after hearing. I want to talk briefly about the fiscal note because I think it's interesting. So, there are two fiscal notes: there's one that came out previously, and another one that came out today at, at 11:59 a.m. So, an hour and a half before the hearing started. Which is super, super swell that that's how that works. Really appreciate it. And there's a couple things I want to address. One is-- again, we-- there is-- there are numerous studies, including, you heard, by CVS, which is a member of the Insurance Federation, demonstrating cost savings in the pursuit of these tests. So, I just want to-- if we had any dynamic fiscal scoring whatsoever, this wouldn't look this way. But, but that's not how we do things. We're very simple here. And so, we like to go with straight, direct end cost for paying for something,

and we don't look at any cost avoidance down the road, even if down the road-- to our conversation earlier, Senator Riepe-- is, is right now. So, Department of Insurance gave its-- you're looking at-- so, '26-'27, so full, full fiscal year, almost $2 million in coverage for increased sort of above ACA coverage provisions. Right? So, anytime we do something that goes above and beyond the ACA, there is-- there's an associated cost to us. But I think that's a wild number, and, and I, I appreciate, actually, the Fiscal Office on this one, because they do point out that there was no-- in the bottom paragraph, it says it is unclear what method the QHP providers used to arrive at these estimates. I got to tell you, yeah, it-- who knows? Because if we do our own math, and you look at what Medicaid says-- so, you're talking about Medicaid gives it a five-cent to nine-cent premium increase; per member per month premium increase impact for direct costs for these tests, which-- I've seen estimates that are somewhat lower, I've seen estimates that are somewhat higher, looking just in research for this bill. I, I generally think Medicaid's numbers are, are right on this. They went through and done this, and they're also the ones that are seeing the tests that are currently being paid for. So, I think that's a good number. So, if you imagine that we've got 400,000 people on Medicare-- which we do in Nebraska-- got about 400,000 people on Medicaid in Nebraska, which-- thankfully, Medicaid provides us the number; it's 4,000-- 400-- sorry. 400,568, but we'll just call it 400,000. And then you got another 65,000 CHIPs, and then you-- there's some of that-- there's some other kinds of-- there's an underinsured, uninsured population that exists. All in, let's imagine that there's a million people in Nebraska who are on private-pay insurance, which-- I actually think it's, it's probably not quite that much, but that-- I think it's close enough for our estimates-- and we have power to impact about 60% of them, right? The other 40% are sort of ERISA, some military, things like that. So, 600,000 people insured, and then if you look at $0.05 to $0.09 per member per month, you're looking at $360,000 to $648,000. That's just-- there's no extra people in Nebraska. That's all the people. So, I don't know what Department of Insurance is doing. I don't know why I got this an hour before the hearing, but the numbers don't make any sense. And I'm happy to go through that math with anybody who's interested. With that-- oh, I'll just add one note. Very eager and excited to receive language from the insurance industry on this bill. I'm, I'm, I'm really particularly pleased that they committed to providing that. And so, with that, I'd be happy to answer any final questions.

JACOBSON: Thank you. Any questions?

HARDIN: You heard the, the $110 million versus $5 million.

BOSTAR: Yeah.

HARDIN: Is that typical, based on your research? And if so, I mean, that's 96% of it that was covered. So, is this a bill about 4%?

BOSTAR: Well, I, I, I think one, one piece in that that I would be really interested to know is-- so, that's how much they pay out, and versus what they-- what gets denied. I want to know what's initially denied. Right? So, in that 110 they told you includes every denial that they ultimately reversed, which represents a delay in specific treatment care for generally and often very aggressive diseases. So, that's what I would want to know. I understand that they ultimately cover a lot of these, which I think demonstrates the point of this bill. But I want to know how much did they decide to cover initially, and that number does not tell you that information.

HARDIN: If you ask Jeremiah very politely, maybe he'll give that information to you.

BOSTAR: I look forward to doing so.

JACOBSON: Other committee questions? Seeing none. Thank you for your close, and this concludes L-- the hearing on LB253. We'll move on to LB6-- LB68. Senator Raybould. OK. We'll begin our hearing on LB68. Senator Raybould, please proceed.

RAYBOULD: Thank you. Good afternoon, Chairman Jacobson, and members of the committee. My name is Jane Raybould, J-a-n-e R-a-y-b-o-u-l-d, and I represent Legislative District 28. I appreciate the opportunity to introduce LB68, which focuses on improving the health of women in our state. LB68 would allow Nebraskans to get a full year's supply of self-administered hormonal contraception at a time covered by private and public health insurance. The intent of LB68 is to eliminate gaps in contraceptive use, and decrease unplanned pregnancies by making it easier for Nebraskans to consistently access the birth control they need to take care of their health and well-being. Women in Nebraska use birth control for a variety of reasons, whether for pregnancy prevention or to address other chronic health concerns. Contraception can rel-- help regulate irregular menstrual cycles and hormonal imbalances, making periods less painful; prevent hormonal acne; reduce risk of developing uterine cancer and ovarian cysts; and help manage endometriosis. In fact, 15% of women in the U.S. who use contraception

do so for reasons other than pregnancy prevention. No matter the reason that a woman needs access to contraception, it should be readily available when she needs it. Unfortunately, many women face barriers to consistently accessing birth control. Women who travel frequently for work, who live in rural areas, who have difficulty taking time off of work or accessing childcare, those who work long or unusual hours, or those experiencing domestic violence may find it particularly difficult to pick up additional pill packs once every month, or once every three months. In fact, a 2022 survey conducted by the Kaiser Family Foundation found that 33% of hormonal contraception users have missed their-- taking their birth control because they were not able to get their next supply in time. Currently, the vast majority of women in Nebraska receive insurance coverage for a three-month supply of birth control at a time, including those covered by Medicaid. However, major medical associations, including the American College of Obstetricians and Gynecologists, ACOG, recommend payment policies that cover a year's supply of combined hormonal contraceptives to improve access and continuation. It is standard medical practice for health care providers to prescribe a year's supply of birth control at a time, with a woman returning to her provider for a yearly exam. To be clear, LB68 does not require a health care provider to prescribe a full year's supply of contraceptives; it is still up to the professional judgment of a provider to write a prescription that best meets the needs of their patient. However, when providers do write a year's prescription for contraception, that prescription should be as easy as possible for the patient to access. When we pass LB68, Nebraska will be treading a well-worn path. 23 states and the District of Columbia have passed legislation requiring coverage of a year's supply of birth control at a time, and three other states have required coverage for a six-month supply. I can tell you that right now, the University of Nebraska in Lincoln, through their insurance plan, provides that 12-month supply. Research from the states that I have-- that have already passed this legislation shows the benefits to women and a reduction in unintended pregnancies. A recent study of women under California Health Plan found that those who received a 12-month supply were about half as likely to receive emergency contraception, and about 35% less likely to become pregnant than those receiving less than a 12-month supply. An earlier study from the University of California at San Francisco showed that dispensing a one-year supply led to a similar 30% reduction in the likelihood of unplanned pregnancy, and resulted in a 46% reduced likelihood of an abortion. LB68 would also bring cost savings to both private and public insurers, due to a decrease in

unintended pregnancies. A 2019 study from the researchers at the University of Pittsburgh and the U.S. Department of Veterans Affairs showed that dispensing a year's supply of contraception would result in cost savings of over $2 million annually, and a study of the California Medicaid Family Planning Waiver Program showed that even taking into account pill wastage, dispensing a 12-month supply reduced costs to the Medicaid program. I want to address a few concerns you may hear from opponents of LB68. First, similar legislation in the past was opposed by organizations that have a moral objection to birth control access generally. I want to be clear that LB68 does not require insurers that do not currently cover hormonal contraceptives, for whatever reason, to start covering birth control. This bill only applies to those insurers who policies already provide coverage for birth control. It's also important to remember that family planning services are already covered by Medicaid. Second, you may hear from insurances-- insurers that policies like LB68 put them at a competitive disadvantage compared to federally-regulated insurers that are not required to provide a similar benefit. However, as I explained earlier, research has shown that insurers actually realize a cost savings from providing a year's supply of birth control because of a reduction in unintended pregnancies, even taking into account any pill wastage. Third, opponents might say that Nebraskans are unlikely to take advantage of a year's supply of birth control, even if the benefit is made available to them. It may take time and education for consumers to become aware that accessing a year's supply is an option. Providers can also play a part in educating patients about this option. The goal of the bill is simply to make more options available to women. LB68 is a simple bill that increases access to medication that improves women's lives, reduces unintended pregnancies, and provides cost savings to the state. These are goals that we can all agree on. Thank you for your time, and I'm happy to answer any of your questions if I'm able.

JACOBSON: Questions for Senator Raybould? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here, Senator Raybould. So, if I could just make sure I understand from your opening, this bill, then, doesn't, as you put it, require anybody who doesn't already cover contraceptives to do so, it just addresses the way in which they provide that access. Correct?

RAYBOULD: That is correct. So, if you already provide contraceptives as part of your insurance package for your employees, then this just is asking you that when you get that, that it be allowed to be

dispensed for that full year. But also, again, it depends on your medical provider. It is really up to the medical provider. They typically do that one-year plan, but depending on each patient that they have, it can be different. They would say, I'd like to see you in three months or, you know, six months. Let's come back and see if this took care of your situation with menstrual cramps, or something like that.

DUNGAN: So, you still need the prescription from the doctor in the first place, obviously.

RAYBOULD: Absolutely.

DUNGAN: And then from there, it's just talking about the way it's distributed, not mandating anybody do or do not provide something?

RAYBOULD: Yes, that is correct. This is not a mandate. It wants to make sure that insurers provide that option for women to have access to-- a continuation of access to the contraception.

DUNGAN: And did you have a chance to look at the fiscal note that came out about this?

RAYBOULD: I did. I've looked at-- well, certainly, I saw the response from University of Nebraska-Lincoln that they already offer this as part of their insurer. But I did see the note from Medicaid, and I think, you know, all they, they-- it's like you look at a balance sheet; you only look at the expense, but you don't see the benefits on that. And so, certainly, a tremendous benefit would to prevent an unintended pregnancy. But they didn't take into the cost once, once that baby is born there, you know, is an additional person now on Medicaid that wasn't on Medicaid, and, and it may in some instances-- and may not-- require additional public services that is an additional cost to the Department of Health and Human Services. So, I didn't think their cost and categorization was complete because they only list expenses. If you're in business, you just can't list expenses without looking at some of the savings and potential savings that have been well-documented by some of the studies.

DUNGAN: Well, and I think that's always the problem we see with the static versus dynamic forecasting in there. But it's fair to say, though, as they put in here, that the, the, the costs to Medicaid, they say are negligible, right? Because this is a 90/10 matching, some 90% of the funds that we're talking about are coming from the feds,

10% coming from general funds, which is under $10,000 per year. You saw the part in there where they say that that's a negligible cost to the general funds?

RAYBOULD: Yes.

DUNGAN: So, fair, fair to say characterization of this fiscal note is it really has a very, very de minimis impact on the funds for Nebraska?

RAYBOULD: I would, I would say so. They had additional $61,183 for fiscal year 2025 to 2026 and $81,577 for the fiscal year 2026 to 2027. But again, as a business person, you know, you should look at the-- at also the cost benefits and cost savings that have been well documented by a lot of the studies that we provided in my testimony.

DUNGAN: Got it. Thank you.

RAYBOULD: Thank you.

JACOBSON: Other questions from the committee? All right. Seeing none-- oh. Oh, go ahead, Senator von Gillern.

von GILLERN: Sorry. Need to flag higher. Thank you, Senator Raybould. I'm just reading through this, and forgive me if I'm being thick. I'm trying to do the math. Is, is it 3 plus-- 3 months plus 12 months for a total of 15 months?

RAYBOULD: No, sir. It's, it's 12 months.

von GILLERN: OK.

RAYBOULD: So, typical dispensing is at three months, in some cases six months. That's usually the typical amount. Right now, I, I believe it's at six months. And that depends on your medical provider.

von GILLERN: OK. Section 1 paragraph (a) says for the first prescription up to three months, and then paragraph-- Section 1 paragraph (b) says for subsequent refills up to a 12-month supply.

RAYBOULD: Up to the 12-month supply.

von GILLERN: So, those are two prescriptions, one for three months, one for 12 months?

RAYBOULD: No. It's up to 12 months. Up to 12.

von GILLERN: OK. So, the three would be part of the 12.

RAYBOULD: Yep.

von GILLERN: Thank you very much. Appreciate it. That's it.

JACOBSON: All right. Thank you.

RAYBOULD: OK.

JACOBSON: Thank you for testif-- or, for your open.

RAYBOULD: Yeah.

JACOBSON: [INAUDIBLE] move to proponent testimony. Welcome.

ADELLE BURK: Hi. Chair Jacobson and members of the committee, my name is Adele Burke-- that's A-d-e-l-l-e B-u-r-k-- and I'm a senior manager of public affairs with Planned Parenthood North Central States in Nebraska. PPNCS provides, promotes, and protects sexual and reproductive health care through high-quality services, education, and advocacy. We proudly serve Nebraska at our health centers in Lincoln and Omaha, and by telehealth, providing essential care to more than 8,000 patients annually. In fiscal year 2024, PPNCS in Nebraska provided oral contraceptives to over 1,300 patients. I'm testifying in strong support of LB68 and thank Senator Raybould for introducing this important bill to improve the availability of birth control in our state. Access to contraception is essential for many Nebraskans' physical, social, and economic well-being. Nearly 9 in 10 sexually-active women have used birth control in their lifetime for pregnancy prevention, and many women use birth control to manage other types of medical concerns. Hormonal birth control is up to 99% effective in preventing pregnancy, if used correctly. It is essential that individuals taking hormonal birth control take the pill every day at the same time, and that those using the ring and patch replace them at the correct intervals of time. If an individual using combined hormonal birth control pills, for example, misses more than two pills in a row, they are at increased risk of becoming pregnant. Unfortunately, Nebraskans still experience obstacles to consistent birth control access, including logistical barriers that prevent them from picking up additional pill packs in a timely way. Studies show that when patients do not receive a one-year supply of the birth control method of their choice, 1 in 3 patients will fail to refill their prescription, which increases the likelihood of an unintended pregnancy. This, in turn, leads to increased costs to insurers,

including Medicaid, for unplanned births. LB68 would reduce barriers to consistent use of birth control by requiring insurance companies and Medicaid to provide coverage of a year's supply of contraception, if provided by a medical provider. Currently, PPNCS providers prescribe a year supply of birth control, and it's standard practice to prescribe an annual supply at the time of the visit once a patient is counseled on available methods and a complete medical history is taken. Despite receiving a year's prescription, our patients and patients across Nebraska are limited in their access to that supply by insurance. You may hear concerns about providing a year's supply of medication will result in undue expense. It's important to remember that 12 months of birth control pills, rings, and patches are not used-- that are not used is very little in cost compared to unintended pregnancy that may result from not having access to these medications. Prescription birth control is safe and improves the lives of patients; it is already being prescribed for 12 months at a time with regularity, and we know when people have access to a full year's supply, they're more successful with consistent usage and preventing pregnancy. For these reasons, we thank Senator Raybould for introducing the bill, and urge the committee to advance LB68 to General File.

JACOBSON: I'm just curious. So, what's the magic to 12 months? I mean, so we get to 12 months, we stop, and then everything's fine?

ADELLE BURK: Yeah, so I think that it is, first of all, consistent with what most providers are prescribing--

JACOBSON: Yeah, but I'm just trying to figure out what's the magic to 12 months?

ADELLE BURK: Yeah. I mean, I think it's, like, striking a balance between a longer period of time versus a shorter period of time, right? It--

JACOBSON: So, 12 months as opposed to 10 years.

ADELLE BURK: Yeah. Yeah. I mean, it's, it's pretty typical to go to a doctor annually for a checkup, and so that's why providers typically prescribe for a year to align with, like, a pap smear or something like that.

JACOBSON: But what happens at the end of that year?

ADELLE BURK: So, they would go back to their, their provider for an updated prescription, or request an updated prescription.

JACOBSON: And they-- and it would not be covered by insurance.

ADELLE BURK: It would be.

JACOBSON: So, this is a-- do it a year at a time into perpetuity?

ADELLE BURK: Yeah. I-- so-- I mean, right now they-- they're getting the prescription yearly, but it's only being dispensed to them on shorter intervals of time. So, this would be--

JACOBSON: But-- I mean, you're-- this would be a requirement for insurance companies to pay it, as long as it's prescribed.

ADELLE BURK: Yes.

JACOBSON: All right. Thank you. Senator von Gillern.

von GILLERN: Thank you for your testimony. You said in your first paragraph that PPNCS has provided oral contraceptives to over 1,300 patients, and I honestly don't know the answers-- are those-- are you acting as a pharmacy? Are those, are those people that are-- are those women that are covered by an insurance program?

ADELLE BURK: Yeah. So there's-- you know, we, we take patients that have insurance or no insurance. So, we see patients that have Medicaid coverage, we see patients that have private insurance, we see patients that are self-pay. And we do have a, a pharmacist.

von GILLERN: And what about someone who is indigent and can't pay?

ADELLE BURK: Yeah, absolutely. So, we have access to some funding to help provide a sliding scale fee to, to certain patients. And, you know, there are definitely patients that, that do self-pay as well if they don't have insurance.

von GILLERN: So, that's part of the-- that's part of potentially a federal grant or federal funding, or--

ADELLE BURK: Yeah.

von GILLERN: It's not part of-- it's not a, for lack of a better term, a charitable contribution on the part of Planned Parenthood or the mission or the outreach? It's, it's--

ADELLE BURK: Yeah.

von GILLERN: --it's for, it's for sale.

ADELLE BURK: Well, I would say that Planned Parenthood, like any, like, health care provider that uses-- that, that takes patients under Medicaid, for example, or to self-pay patients. Like, we're not turning a profit. We're a nonprofit organization. So, like, you know, it's-- you don't make a, a bank using-- taking Medicaid patients.

von GILLERN: Yeah. Yeah. No, I, I get it, I get it, but-- OK. That answers my question. Thank you.

ADELLE BURK: Yeah.

JACOBSON: Other questions? Seeing none. Oh, Senator Riepe.

RIEPE: I have a quick one. Do you have a preference over the, the pills versus the shots?

ADELLE BURK: It is entirely up to patient preference.

RIEPE: OK.

ADELLE BURK: You see different rates of effectiveness, and then, you know, you know, the extent to which it's convenient to the patient. It-- you know, those are all pretty variable. It's, it's, it's up to the patient.

RIEPE: My understanding is the shot can be self-administered, so you wouldn't have to have an office visit.

ADELLE BURK: Yeah. And there's someone behind me who can talk to more specifics about, like, how that works. Yeah.

RIEPE: OK. Thank you. Thank you. Chairman.

JACOBSON: OK. Other questions? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. And thank you for being here. I appreciate it. Just to clarify, because I think this bill is a little bit complicated when you first look at it-- this isn't changing what is or isn't covered by insurance, correct?

ADELLE BURK: Exactly. It just has to do with the time period or the, the number of packs that are dispensed to a person at the time.

DUNGAN: So, as of right now, insurance, for example, would cover contraceptives into perpetuity as well, but this just changes the timing with which it's administered.

ADELLE BURK: Absolutely.

DUNGAN: And going back to Senator Jacobson's question-- because I think it's an interesting line of questioning-- the, the thought behind the 12 months, is it correct to say that that's essentially to make it easier, so you're not running into other barriers of having to go pick this up every month, or every three months, or every six months; just having it in your bathroom or wherever you keep it makes it easier, and then you only have to pick it up once a year.

ADELLE BURK: Yeah. Yeah. So, I would say, you know, 12 months seems like a logical timeframe based on the interval at which you're going to see a provider for care related to, you know, your birth control. But six months makes sense, nine months makes sense; I mean, you know, any interval makes sense. It's more about increasing the availability.

DUNGAN: OK. And the last thing I was going to ask about, you mentioned this briefly in your, your testimony regarding some of the opposition. I'm sure this isn't your first rodeo having this discussion in your position.

ADELLE BURK: Sure.

DUNGAN: Can you speak at all to any of the other opposition that Senator Raybould mentioned in her opening? I'm sure we'll hear it here today, but is there any response you would have to some of the opposition that's come up in the past regarding these kind of issues?

ADELLE BURK: Yeah. And I would say, particularly with regard to the cost argument-- I touched on it a little bit in my testimony, but research has shown that for every $1 spent by, you know, public entities like Medicaid on contraception, there's a $6 in cost savings through prevented unintended pregnancies, which makes logical sense, right? So, the research supports that this is a cost savings to insurers and, and to taxpayers.

DUNGAN: OK. Thank you.

JACOBSON: Other questions? Seeing none. Thank you for your testimony.

ADELLE BURK: Thank you.

JACOBSON: Other proponents. How are you?

MARIEL HARDING: Good afternoon. Good. How are you?

JACOBSON: Good.

MARIEL HARDING: Good afternoon, Senat-- Chairman Jacobson, and members of the committee. My name is Mariel Harding, M-a-r-i-e-l H-a-r-d-i-n-g. I am the senior director of programs and initiatives for the Reproductive Health Collaborative of Nebraska, and I'm here on behalf of our organization and our board to express our support for LB68, which we believe would have positive impacts on contraceptive access, especially among the patients our network serves. A little bit about who we are: Reproductive Health Collaborative is a nonprofit organization that ensures all Nebraskans have access to high-quality sexual reproductive health care. We do this through funding low-cost health centers across the state, educating our communities about sexual and reproductive health with unbiased, medically-accurate information, and advocating to expand and enhance sexual reproductive well-being and equity in Nebraska. The network of health centers that we fund includes ten nonprofit health care agencies from Omaha to Scottsbluff, Norfolk to Chadron. Nearly 20,000 Nebraskans access health care at these clinics annually to receive cancer screenings, HIV testing and treatment, basic infertility services, and, of course, contraception and pregnancy counseling. Access to contraception can be challenging in Nebraska. As of 202020-- 2023, over 100,000 women in Nebraska live in contraceptive deserts, which are counties that lack rec-- reasonable access to full range of contraceptive methods. These counties are, unsurprisingly, overwhelmingly located in rural parts of the state. Contraception is a normal part of life for most people. A National Health Statistics report published in 2023 found that 99.2% of sexually-experienced women ages 15 to 49 had ever used a method of contraception, with 87.8% having used methods such as the pill, patch, ring, implant, or IUD. Rural patients seeking sexual reproductive health services often face low appointment availability and longer travel times, making obtaining contraceptives, refills, and follow-up appointments arduous and time-consuming. Notably, other-- a higher proportion of rural women refer to-- rely on highly effective methods, including sterilization, which I think is pretty marked. We believe that LB68 is a step towards filling gaps in contraceptive access, especially in rural areas, among patients in poverty and those who rely on Medicaid. Initial-- coverage of initial prescriptions for a three-month supply, as well as refills for a 12-month supply could provide a much needed relief to patients and clinicians alike by

easing these barriers, and better coverage would allow patients to access a wider range of contraceptive methods to choose what's right for them and reducing the amount of factors that they must weigh, like costs and logistics. Additionally, studies have shown that dispersing a year's supply of oral contraceptives at once is associated with higher method continuation and lower costs than dispensing fewer cycles per visit, and we've known for years that increasing contraceptive access, especially at free and low costs, reduces unintended pregnancies overall. Granting more Nebraskans coverage and the ability to choose their preferred method of contraception is a key pillar of advancing shucks-- sexual and reproductive health equity in our state, and we ask you to advance LB68. Thank you for your time, and I'm happy to answer any questions.

JACOBSON: Thank you. Questions? All right. Seeing none. Thank you for your testimony. Other proponents? How are you?

ERIN FEICHTINGER: Happy to be in the best-lit hearing room in the building. You all know it's true.

JACOBSON: Perfect. I thought you were going to say the best committee, but--

ERIN FEICHTINGER: I've never been in front of this committee. This is new for me. I'm looking forward to it. Should we get into it?

JACOBSON: Just remember the light.

ERIN FEICHTINGER: Chairman Jacobson, members of the Banking, Commerce and Insurance Committee, my name is Ering Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r, and I'm the policy director for the Women's Fund of Omaha. The Women's Fund will always support increased access to contraception, because all Nebraskans deserve to be in control over the choice about if, how, and when to start a family. That said, I'd like to talk today specifically about how LB68 will also greatly impact survivors of intimate partner violence. Increasing access to continuous contraception allows survivors in situations of intimate partner violence to address reproductive coercion, and in turn, increase their safety. Reproductive coercion includes explicit attempts to impregnate a partner against her will, control the outcomes of a pregnancy, coerce a partner to have unprotected sex, and to interfere with contraceptive methods. The most common forms of reproductive coercion include sabotage of contraceptive methods, pregnancy coercion, and pregnancy pressure. Birth control sabotage is

one of the most common forms of this coercion, and is the active interference with the partner's contraception-- contraceptive methods in an attempt to promote pregnancy. This includes hiding, withholding, destroying a patient's-- or, a partner's contraceptives, breaking, poke-- poking holes in condoms, removing vaginal rings, contraceptive patches, or IUDs. Just some stats to give you a sense of the scope. One-quarter of adolescent females reported that their abusive male partners were trying to get them pregnant through interference with their planned contraception. In one study of family planning clinic patients, 15% of women experiencing physical violence also reported birth control sabotage, and among adolescent mothers on public assistance who experienced recent intimate partner violence, 66% experienced birth control sabotage by a dating partner. The intention of birth control sabotage is to promote pregnancy, which is of course, another form of reproductive coercion. We also know that homicide is a leading cause of pregnancy-associated mortality in the United States, and the majority of pregnancy-associated homicides were committed by an intimate partner. For Nebraskans experiencing intimate partner violence, as Senator Raybould noted, increased access to continuous birth control can help them protect themselves against birth control sabotage and reproductive coercion, and in some cases, save their lives. And we would urge this committee to support LB68, and I'm happy to answer any questions to the best of my ability.

HALLSTROM: Any questions from the committee? Thank you.

ERIN FEICHTINGER: All right.

HALLSTROM: Next proponent.

TAYLOR GIVENS-DUNN: Thank you so much. Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is Taylor Givens-Dunn, T-a-y-l-o-r G-i-v-e-n-s-D-u-n-n, and I'm the policy and power-building manager at I Be Black Girl. I Be Black Girl serves as a collective for black women, femmes and girls to actualize their full potential to authentically be through autonomy, abundance, and liberation. We are the first and only reproductive justice organization in Nebraska that centers black women, femmes and girls, and we would like to express our support of LB68. LB68 is a critical step toward eliminating "unnecessarier"-- unnecessary barriers to "contraceptin"-- contraception, and advancing reproductive health care for all Nebraskans. As you've heard, conventionally, most insurance plans only cover 1 to 3 months of contraception supplies at a time, forcing people to make frequent trips to the pharmacy and navigate a

complex health care system to maintain consistent use. This creates potentially dangerous gaps in coverage, particularly for Nebraskans living in maternal care deserts. We know that these gaps disproportionately impact black women and people living in rural and low-income communities-- excuse me-- where systemic barriers to health care are most acute. So sorry. Excuse me. So sorry.

HALLSTROM: Take a moment.

TAYLOR GIVENS-DUNN: It's that time of year. OK, I think I'm OK. Thank you so much. Thank you. OK. Hormonal contraception allows women and people who can get pregnant to plan and space their pregnant series, directly reducing maternal mortality. This is especially crucial for black women who face maternal mortality rates more than twice that of white women due to systemic inequities in health care. As you've heard, these contraception-- contraceptives are also used in a variety of ways. Many people use birth control to manage menstrual pain, treat acne, and address conditions like endometriosis. The American College of Obstetricians and Gynecologists affirms that these medications play a crucial role in overall maternal health, helping to lower rates of postpartum depression and reducing the risk of ovarian and endometrial cancers. These issues disproportionately impact black women. For many, contraceptive access is not just about pregnancy prevention. It's about maintaining overall health and well-being. When contraception is difficult to access or is interrupted, the risk of unplanned pregnancies increases along with the associated health risks. LB68 is a really simple solution that addresses these challenges head-on by ensuring that people can obtain a full year, year supply of birth control at once, minimizing unnecessary disruptions. I think what we'd like to highlight at IBBG is that the impact of contraception access extends beyond just the health of the birthing person, it's also better for babies. Studies have shown that unplanned pregnancies are associated with higher rates of pre-term birth and low birth weight, which can cause long-term health issues for babies. So, LB-- or, access to contraception is overall better for both the birthing person and children in our state, and we should do the right thing by making sure that this simple, common-sense solution will take place in Nebraska, increasing access to contraception for all. Thank you so much for your time, and thank you for putting up with my coughing fit. I appreciate you.

HALLSTROM: Any questions from the committee? Seeing none. Thank you.

TAYLOR GIVENS-DUNN: Thank you. That was painful.

HALLSTROM: Next proponent.

SCOUT RICHTERS: Good afternoon. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in support of LB68. We'd like to thank Senator Raybould for bringing this legislation, as access to contraception is consistent with ACLU's longstanding advocacy for reproductive freedom, bodily autonomy, and personal liberty. Access to contraception is critical to the ability of women to participate in the social, economic, and political life of Nebraska, and the country as a whole. We know that there are significant barriers to contraceptive access, and LB68 removes one barrier to that access. By enabling Nebraskans to access a full 12-month supply of contraceptives in one visit to the pharmacy, this bill reduces the chances that there is a gap in contraceptive use, and thereby reduces the risk of unintended pregnancies. LB68 honors the principle of bodily autonomy, and the ACLU of Nebraska offers its full support for this legislation.

HALLSTROM: Any questions? Seeing none. Thank you.

SCOUT RICHTERS: Thank you.

HALLSTROM: Any other proponents? Are there any opponents? Mr. Bell.

ROBERT M. BELL: Good afternoon, Vice Chairman Hallstrom, and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies, which includes most of the major health plans in our state. I appear today in opposition to LB68. First, the members of the federation certainly appreciate Senator Raybould's attempt to remove a possible impediment to women's health. As you have heard, LB68 would require health insurers in the state-regulated market to pay for the dispensing of a-- first, a three-month prescription for birth control for a first restriction-- prescription, then a 12-month prescription afterwards. Typically, most prescriptions are dispensed on a three-month supply or less; this helps avoid all the costs that can sometimes happen when prescriptions are purchased in bulk, including lost pills, spoilage, change in prescriptions, et cetera. My understanding is that some plans also offer a six-month option. It is important to consider how a health policy works. Typically, a health insurance policy lasts for one year. Though certainly some medications on a three-year supply would go over the end of the year date, LB68 could lead to situations where a health

insurer or its consumer is paying for the vast majority of the prescription year-- of the prescription outside of the plan year, which is obviously a, an accountant kind of concern. While the members of the federation appreciate the fact that some women may have difficulty getting to a pharmacy four times a year or may have minor complications when changing plans, we do not believe this burden is significant, and that, that the legislation is necessary. If insurers and their business partners find that policyholders are clamoring for such a benefit, the market will provide. In 2021, former Senator Carol Blood introduced LB20 with similar provisions as introduced in LB68. The Banking Committee at that time amended LB20 to reduce the 12-month supply to a 6-month supply, and made some other changes. This amendment at the time shifted the federation to neutral. LB20, in the end, did not pass. One final note, any state legislative bill that imposes a mandate will not apply to most federally-regulated, self-insured, large group plans governed by the Employee Retirement Income Security Act of 1974, otherwise known as ERISA, or the new agricultural organization plans. According to the research I have read, ERISA plans cover around 35% of privately-insured Nebraskans. LB68 would have no effect on these policies. For these reasons, the Nebraska Insurance Federation respectfully opposes the passage of LB68. I appreciate the opportunity to testify. Thank you. And I would say we do not mind paying for maternity and, and births and things [INAUDIBLE] or our policyholders. That's why they have insurance. So.

HALLSTROM: Thank you. Mr. Bell. Any questions of the committee?

DUNGAN: I got some

HALLSTROM: Yes.

DUNGAN: Thank you, Chair Hallsen-- Hallstrom. Thank you for being here, Mr. Bell.

ROBERT M. BELL: Yep. No problem.

DUNGAN: So, it sounds like from your testimony and what other people have said, there's not really any additional cost to you, if this passes.

ROBERT M. BELL: Well, that depends. Right? That depends if something happens in the interim of that 12 months. So, let's say I get a-- let's, let's get outside the birth control aspect because, you know, I'm a man. Let's say I get a 12-month supply of something, of whatever

it may be, and let's say I misplace it or I lose it, or something happens to it, or I keep it not in the proper temperature; I leave it in my car last week, or something along those lines. Or, my prescription changes. Essentially, we have waste in the system, and then I have to get a new prescription, and then, you know, there's new costs, and that-- those costs could be borne by me. It may not even be the health insurance plan, right? Because we're talking about-- in terms of birth control-- something that's not usually outside of the cost-sharing provisions of an insurance policy.

DUNGAN: But it sounds like the concerns that you have about any kind of additional cost are borne by just mishandling by the patient once they have that.

ROBERT M. BELL: Yeah. Exactly, yeah.

DUNGAN: So, to the insurance company, if this bill passes, you, the insurance company, procedurally don't see any additional cost.

ROBERT M. BELL: Right. Unless, unless the mishandling or other things.

DUNGAN: Right. Which could happen with a three-month supply.

ROBERT M. BELL: Certainly.

DUNGAN: Right. So, it's really if the patient does what they're supposed to do, you don't see any change or additional cost incurred by passing this bill.

ROBERT M. BELL: Right, right. I know, I know the argument was made by the proponents that we would come up and say that-- or, or they're trying to say that, that we would have to pay for less births, right? Or the, the premium payers would have to pay for that. And, you know, I, I have nothing to dispute that, or, or say that the--

DUNGAN: The dynamic forecasting aspect of saving money in the long run, if there's less unintended pregnancies.

ROBERT M. BELL: Yes. Yes, yes, yes.

DUNGAN: Right. No, and I, and I get where-- I get where you're coming with that. I just want to be very clear, because looking at the fiscal note, it seems very evident to me that any of the costs incurred by this bill are negligible at best to the state, and I just want to make sure that we're clear on the record that the insurance companies

aren't saying if this bill passes it's going to be some massive increase in premiums or anything like that.

ROBERT M. BELL: Nope, nope. And I didn't say-- I hope I didn't say that [INAUDIBLE]

DUNGAN: You didn't. I just want to be clear. I know we often hear that premiums will go up, so this is not one of those bills.

ROBERT M. BELL: Correct.

DUNGAN: OK. I also do appreciate you pointing out the irony of us being an all-men committee, hearing this bill.

ROBERT M. BELL: Yes.

DUNGAN: I think it's a-- so thank you for saying that, instead of me having to make the point. I appreciate it.

ROBERT M. BELL: It-- I was, I was trying to be more subtle than you, Senator Dungan.

DUNGAN: Well, you know, I'm nothing if not subtle.

ROBERT M. BELL: OK.

DUNGAN: Thank you, Mr. Bell. Appreciate it.

HALLSTROM: Senator Bostar. [INAUDIBLE]

BOSTAR: Thank you, Vice Chair, and Mr. Chairman, both. And thank you, Mr. Bell.

ROBERT M. BELL: Sure.

BOSTAR: Just to follow up on-- I, I-- just out of curiosity, follow up on, on Senator Dungan's question. If I were to get a prescription and then lose it, that, that obviously, at least to some extent, has some insurance coverage. Does that-- am I on the hook for the replacement drugs? How does that work?

ROBERT M. BELL: I would assume so. Depends on the situation. For instance, if you're over your deductible and your other cost-sharing requirements, it would likely be the responsibility of the plan. If, if I lose whatever prescription that I have, I spill it or something along those lines, I assume that when I go back to the pharmacy, if I

have a certain number of refills, I'm going to be responsible for the cost sharing related to that particular prescription.

BOSTAR: But refills are also timed. Like, I can't, I can't go to the pharmacy one day, pick up my prescription,--

ROBERT M. BELL: Yeah, that's a good point.

BOSTAR: --and then show up the next day and say I'd like the refill. Like, I-- they won't-- they will not give it to me. Which is actually kind of the point of the bill, because they, they won't just give it to you.

ROBERT M. BELL: True, true. You would probably have to have a conversation with your medical provider related to that.

BOSTAR: Medical provider being my, my prescribing doctor?

ROBERT M. BELL: I believe so, yeah. Or perhaps a pharmacist as well. So, I-- I'm, I'm not-- honestly, I'm, I'm kind of out over my skis on that one. So, I, I don't know.

BOSTAR: I mean, I think-- and, and if I remember right, I mean, I-- assuming that it's outside of what's covered, since it had already been covered, and duplicative medication is outside of the plan, isn't it just the respon-- like, isn't it-- the individual who has been prescribed, isn't it their financial burden to bear?

ROBERT M. BELL: I'm going to have to get back to you on that one. I, I don't know. And, and, and again, we're talking about pharmaceuticals that are relatively affordable, right? So, we're not, we're not talking about the show-stopping $15,000 per injection kind of drug that they advertise all the time on, on the TV, so.

BOSTAR: That's where I find all my medication.

ROBERT M. BELL: Yeah.

BOSTAR: Television. Thank you.

ROBERT M. BELL: You're welcome. No comment.

JACOBSON: Further questions? I'm seeing none. Thank you for your testimony, again.

ROBERT M. BELL: You're welcome.

JACOBSON: Further opponents? Mr. Blake, welcome.

JEREMIAH BLAKE: Good afternoon, Chairman Bakie-- Chairman Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, and I'm testifying in opposition to LB68. We absolutely respect the, the, the intent of Senator Raybould, and thank her for introducing this bill. We want to make sure that contraceptives are available and accessible to women. Birth control coverage is heavily regulated under federal rulemaking, and with required-- and is required at little or no cost-sharing as a federal minimum standard for birth control. Many Blue Cross Blue Shield of Nebraska policies cover prescriptions on a 90-day basis. In addition, we have a significant number of members who are covered under policies that allow for six months of birth control coverage for prescriptions, and I know the committee loves Blue Cross data, so I'll show a little bit-- share a little bit of data with you. In the last six months, our data shows that seven women elected for a six-month fill of hormonal contraceptives; the same data shows that the vast majority of women-- I believe it's about 12,000 women-- elected for a three-month refill or fill of, of prescrip-- of hormonal contraceptives. Because there isn't much demand for a six-month option, we believe it is not necessary to mandate a 12-month option as proposed under LB68. And if access is the concern, Blue Cross does offer mail-order as an option to our members, so this is a convenient option for women who live in rural areas who would otherwise have to travel to a pharmacy for a refill, and it's also a convenient option for women who live in urban areas but do not want to wait in line at the pharmacy counter. So, for these reasons, we would ask you not to advance this bill, and I would be happy to answer any questions that you may have.

JACOBSON: Question for Mr. Blake? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you for being here, Mister Blake.

JEREMIAH BLAKE: Yes.

DUNGAN: So, it sounds like right now, a medical provider can prescribe contraception for up to 12 months, for--

JEREMIAH BLAKE: Yeah, I'm taking the proponents at their word. I don't know that, but yes.

DUNGAN: Are there any other circumstances or instances that you can think of where your insurance company-- I'll ask about yours specifically-- would not cover the medication for the entire prescribed term, or?

JEREMIAH BLAKE: No.

DUNGAN: OK.

JEREMIAH BLAKE: No. Again, unless there's a change in prescription or something like that. If, if they have a valid prescription for that term and it's extended beyond 12 months, yes, we have federal requirements that we have to cover those contraceptives, and we have to cover them with no cost-sharing to the member.

DUNGAN: So you're saying you currently have to do what this bill already requires?

JEREMIAH BLAKE: No, we,--

DUNGAN: OK.

JEREMIAH BLAKE: --we would have--

DUNGAN: I just want to make sure I'm understanding. Sorry.

JEREMIAH BLAKE: Yes. Yep, yep. So, there's the issue of what is required to be covered, right? What in terms of birth control,--

DUNGAN: Right.

JEREMIAH BLAKE: --contraceptives is required to be cov-- is required to be covered, and then what the member's out-of-pocket cost-sharing is. All of that is prescribed in federal rules.

DUNGAN: OK.

JEREMIAH BLAKE: So, we have significant federal requirements to cover different types of contraceptives at no cost share to the member. The question this bill is seeking to address is that when the member walks up to the pharmacy counter, what is the length? What-- how much of a prescription, what length of time is that prescription good for, right? Or-- what am I trying to say? Like, what, what--

DUNGAN: The amount that is distributed? 12 months versus three months.

JEREMIAH BLAKE: The amount. Thank-- thank you. The amount. Yeah. 12 months versus three months. Right. So, if, if a member has a valid prescription, they're on birth control for five, five years, for example, and they refill it at a three-month increment or a six-month increment or a 12-month increment, we're required to cover that contraceptive at no cost share to the member.

DUNGAN: OK. I guess I'm trying to understand the, the heart of your opposition. Is it simply-- if I'm going to be blunt, as Mr. Bell indicated, I often am--

JEREMIAH BLAKE: Yeah.

DUNGAN: --is it because it's a-- you just don't like being told what to do kind of thing? Is that really what this comes down to? Because it sounds like you're saying we already do the majority of the [INAUDIBLE]-- and that's perfectly fine. That's legitimate if that's your position, but I just want to make sure I understand the nature of your opposition.

JEREMIAH BLAKE: It, it may not be popular what Mr. Bell raised, but again, the, the-- if, if a woman, six month in-- six months into her prescription decides she no longer wants to take that, again, that's six months of a prescription that was paid for by our members that is just going to be wasted, right? And, and if there were a dramatic need, if we were seeing members coming to us and clamoring for this, if they were exercising the six-month option currently, maybe it would make sense to extend that to 12 months. But we just don't see that interest from our members. Most everybody's asking for a three-month script.

DUNGAN: OK, but fair to say again, the same concerns that were raised by Mr. Bell and yourself, now, about potential waste and the-- that, that could be the same for any medication that currently exists.

JEREMIAH BLAKE: Absolutely, yes.

DUNGAN: OK. Thank you. I appreciate it.

JEREMIAH BLAKE: Yep.

JACOBSON: To, to that point, though, how many other medications do you subscribe for more than 90 days?

JEREMIAH BLAKE: I don't know. I'm sure there's--

JACOBSON: Is that-- is it pretty much the norm that you're [INAUDIBLE]

JEREMIAH BLAKE: --I'm sure there's-- I'm, I'm thinking of, like, you know, something like-- what am I trying to say? I-- the, the term escapes me. But I'm, I'm sure there's other chronic conditions in which, again, an individual is on the drug for a long period of time, and how-- the question is, "how long do we dispense that drug?" I'm assuming, and I can go back-- I will go back and double-check this-- I'm assuming our policies are fairly, fairly consistent. I don't know that we would be treating these any differently than we would, you know, blood pressure medication.

JACOBSON: Yeah. And I-- I'm just looking at blood pressure, for example. I look at my wife's medication, my medications. I don't know of any of them that are prescribed for more than 90 days.

JEREMIAH BLAKE: Mm-hmm.

JACOBSON: I mean, I-- that's why I was just curious if you knew what--

JEREMIAH BLAKE: Right.

JACOBSON: [INAUDIBLE] how much the-- and I think, for that same reason, if there's a change in prescription level or some change, there's-- I think about-- as prescriptions change, I'm looking at the wastage that's there. So.

JEREMIAH BLAKE: Right. And it-- the, the prescription is one thing, right? It's what the doctor prescribed you. It's another thing to dispense the medication. What happens to it then?

JACOBSON: Right. Senator Bostar, you still want to ask a question?

BOSTAR: I do. Thank you, Chairman.

JACOBSON: All right. Go for it.

BOSTAR: Thank you, Mr. Blake. I appreciate you bringing up mail--

JEREMIAH BLAKE: Yes.

BOSTAR: --delivery as an option for--

JEREMIAH BLAKE: Yes.

BOSTAR: --to ensure accessibility of pharmaceuticals to Nebraskans, particularly rural folks. It could, it could be difficult.

JEREMIAH BLAKE: Yep.

BOSTAR: Do you think that-- you know, let's say someone has a prescription,--

JEREMIAH BLAKE: Mm-hmm.

BOSTAR: --and they've, they've had various prescriptions with a particular pharmacy that they've been working with for years, the pharmacists know them, they understand their, their needs and particular requirements, and what have you. The, the relationship is there.

JEREMIAH BLAKE: Yep.

BOSTAR: And then they-- let's say they move to-- they have an opportunity, they move out to rural Nebraska--

JEREMIAH BLAKE: Mm-hmm.

BOSTAR: --and they would like their pharmacy to now deliver, you know, mail those, those drugs to them.

JEREMIAH BLAKE: Mm-hmm.

BOSTAR: And as long as the, the particular drug can be mailed, right? Because there are some, right? There's some prescriptions--

JEREMIAH BLAKE: Yeah, of course.

BOSTAR: --that, that can't be. But let's say these are all drugs that can be. Do you think it makes sense that the pharmacy that they've been going to their whole lives, that they should be able to get those medications mailed to them from that pharmacy versus, let's say, being forced to have to change pharmacies?

JEREMIAH BLAKE: Yeah.

BOSTAR: Specifically also, change pharmacies to receive it by mail.

JEREMIAH BLAKE: Yeah. That's a, that's a really good question. You know, again, I would love to have a conversation, a larger conversation about mail order. I wish I would have looked at the

statute before I sat down, but I know there's a statute that limits the ability of health plans to use mail-order pharmacies. So if, if there's an interest in having a bigger discussion about how mail order can, can resolve some of those access issues, we'd love to sit down and have that conversation.

BOSTAR: And again, I'm talking about specifically drugs that are permitted across the board to be mailed.

JEREMIAH BLAKE: Yes. 100%. Yep.

BOSTAR: And just relating to whether or not it seems right for, let's say, a PBM to bar your local pharmacy from mailing a drug only so that that institution can then go to the individual Nebraskan and inform them that the only way they can get the drug mailed to them is by changing pharmacies to a PBM-owned, controlled specialty pharmacy.

JEREMIAH BLAKE: Good question. So, I agree with you. We're not talking about specialty medications, right? We're talking about--

BOSTAR: Sure.

JEREMIAH BLAKE: --drugs that can be safely put in the mail and, and sent to the member, and there's very little risk of the drug spoiling or becoming harmed in some way. My response to that would be, is if everybody is on a level playing field, and the pharmacists are playing on the same playing field as a mail-order pharmacy, then I think that's perfectly legitimate. I will tell you, for the record, Blue Cross and our preferred PBM, Prime Therapeutics, does not own pharmacies. We don't refer to our own pharmacies.

BOSTAR: I appreciate that. Thank you.

JEREMIAH BLAKE: Yeah.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony.

JEREMIAH BLAKE: Thank you.

JACOBSON: Other opponent testimony? All right. Seeing none. Any neutral testifiers? All right. Seeing none. Senator Raybould, you're welcome to close.

RAYBOULD: Thank you very much. I want to thank all--

JACOBSON: Oh, let me just say before you start. Excuse me. We did receive 80 proponent letters, 9 opponent letters, no neutral testifiers [SIC], and there were no ADA comments submitted. Thank you. Sorry about that. Go ahead.

RAYBOULD: Yes. Thank you all very much for your attention to this matter. And I want to thank all the testifiers who spoke in favor of this. I wanted to just address some of the concerns that were mentioned, particularly around wastage. It says-- I'll repeat something that was in my opening. In a study of the California Medicaid Family Planning Waiver Programs showed that even taking into account pill wastage, dispensing 12-month supply reduced costs to the Medicaid program. Also, further research has shown that insurers actually realize a cost saving from providing a year's supply of birth control because of reduction in unintended pregnancies, even taking into account pill wastage. One other thing I wanted to point out that there is nothing in this bill that it requires a health care provider to prescribe a 12-month supply of self-administered hormonal contraceptive. There's no-- there's nothing in it that requires that. It's really up to your physician to make that determination. If-- and oftentimes, when people get prescribed medication for whatever reason, if their system can't tolerate it, you reach out to your medical provider and they will change your prescription to a different type of-- and if we're-- since we're talking about contraception, they'll say we suggest this other type of contraceptive for you. And also, if you probably misplace your, like, packet or something like that, it's up to you. I'm-- it's my understanding that you will be responsible for, you know, going out and purchasing that, that month's supply that somehow you left in a bathroom somewhere and that was miles away, that you would be responsible for, for taking care of that payment. I just wanted to say, on a, a, a real life situation, I was a full-time working mom of two children under the age of two. So, you can imagine how tired a mom can possibly be. And so, contraceptives are important for every family, every need; from our rural community-- communities that do not have the great access that we have here in Lincoln or Omaha or Grand Island or Kearney. So for them, it becomes a more practicable, reasonable way of, of dealing with their family's planning needs. And for a lot of those reasons that have been said before, I ask for your support and encouragement on LB68 so that we can get it out of committee. So, thank you. And of course, I'll take questions.

JACOBSON: Questions? I just have one quick question.

RAYBOULD: Sure.

JACOBSON: So, I, I just want to make sure I understand this, that-- so, the medical provider says you can have 12 months.

RAYBOULD: Sure.

JACOBSON: There's certainly insurance company [INAUDIBLE] what-- why not be able to allow them to do four three-month automatic? You know, just-- instead of going out, as you indicated, somebody loses a 12-month supply,--

RAYBOULD: Sure.

JACOBSON: --yeah, now they're out of pocket, but they didn't want to be out of pocket to begin with, but would that caused them to not take it and not refill it because they're now out of pocket, so--

RAYBOULD: Well, I think, you know, most people kind of know how they handle their own finances and what makes sense for their own family needs. I would say that an automatic three-month renewal is the same thing. You know, it's the same thing, to, to be able to, to have access to that. For some military personnel that are stationed in another country, I think the 12-month packets all at once makes the most sense, and I would say it--

JACOBSON: So, they would have the option to go 12 months.

RAYBOULD: Yeah, I think each--

JACOBSON: They could do three, they could do six, they could do twelve, whatever they want.

RAYBOULD: Yes. I think that option is--

JACOBSON: All right. Thank you, that answers my question.

RAYBOULD: --what women need.

JACOBSON: All right. Thank you very much.

RAYBOULD: OK. Thank you.

JACOBSON: That concludes our hearing on LB68, and we will move on to LB64. Senator Fredrickson, I don't believe you've been to our committee yet. And no glasses today.

FREDRICKSON: Well, I feel so badly for anyone else who has to present here today, because I know I'm your favorite bill.

JACOBSON: Well, I'm a little dis-- well, I'm disappointed that you didn't wear your glasses, but that's, that's another story.

FREDRICKSON: That's fine. That's fine.

JACOBSON: Can I see a show of hands, how many plan to testify on this bill?

FREDRICKSON: Oh, wow.

JACOBSON: OK. Looks like we have one.

FREDRICKSON: All right.

JACOBSON: OK, then.

FREDRICKSON: All right. Good afternoon, Chair Jacobson and members--

JACOBSON: Let's get off to the races.

FREDRICKSON: Let's get off to the races. Good afternoon, Chair Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is John Fredrickson, that's J-o-h-n F-r-e-d-r-i-c-k-s-o-n, and I represent the 20th Legislative District, which is in central west Omaha. I'm here today to introduce LB64. LB64 would allow Medicare recipients under the age of 65 who have end-stage renal disease, or ESRD, to enroll in supplemental Medicare insurance plans, otherwise known as Medigap. The bill also provides a guaranteed issue annual open enrollment period of 30 days beginning on the applicant's birthday for all eligible enrollees. Furthermore, LB64 provides that the premium for an individual who is under 65 shall not exceed 150% of the premium for a similarly-situated individual who is 65 years old. Currently, 33 states require Medigap insurers to sell at least one Medigap plan to eligible people under the age of 65. Unfortunately, Nebraska is one of only four states that specifically excludes end-stage renal disease patients under the age of 65 from accessing affordable Medigap coverage. Nearby states of Colorado, Kansas, Minnesota, Missouri, and South Dakota all require Medigap insurers to make Medigap plans available for purchase by eligible individuals, individuals under age 65 with end-stage renal disease. The Kansas statute and South Dakota regulations became effective in 1999, more than 20 years ago. Dialysis patients compromise-- comprise

an extremely vulnerable population in our state. These individuals need either multiple weekly dialysis treatments or a kidney transplant to stay alive. There are no other treatment options available. This bill is critical for dialys-- dialysis patients in Nebraska for two primary reasons. First, access to fair and equitable Medigap plans for dialysis patients under the age of 65 provides them with financial security and stability. People become eligible for Medicare coverage upon reaching age 65, or under age 65 when diagnosed as disabled or with end-stage renal disease. Medicare only pays 80% of medical expenses, leaving patients responsible for the remaining 20%, which has no out-of-pocket cap. These costs for dialysis patients can be as high as $16,000 per year. We know that patients with adequate medical insurance are more likely to keep up with their medical care and necessary treatments, reducing preventable hospitalizations and emergency room visits, which ultimately contribute to increased health care costs for all Nebraskans. Second, while some patients do well on dialysis, the optimal choice is still a kidney transplant when possible, as it often provides a higher quality of life and adds to a patient's life expectancy. Part of the transplant-- part, part of a transplant patient evaluation process is extensive financial clearances to determine if the patients can afford the 20% deductible for the cost of follow-up medical care. If a patient does not have supplemental insurance or the financial resources to cover the out-of-pocket costs of the surgery and follow-up care, most transplant centers will not list patients on their active transplant waitlist. I have been provided with an independent actuarial study to specifically address the question of cost for Medigap coverage for the under-65 end-stage renal disease patient population. This 2025 Health Management Associates-- HMA-- report evaluated Medicare fee-for-service claims data and determined that if Medigat-- if Medigap carriers were required to offer policies to those under 65 with end-stage renal disease, the estimated average Medigap premium would increase by only 0.2%, or the equivalent of $0.40, if the carrier chose to pass the cost on to the insured. It is important to point out that the pool of Nebraskans who would be purchasing Medigap plans as a result of LB64 would be extremely small. Specifically, this pool would only include applicants who are under the age of 65 and who have worked and have assets which would be subject to spending down. These individuals are called "non-duals," as they are covered by Medicare, but not our state's Medicaid program. There are only roughly 400 non-dual end-stage renal disease patients in Nebraska under the age of 65. However, not all of these individuals will choose to purchase a Medigap plan. Some may have coverage from another source,

such as health insurance from a spouse's employer. In addition, having the option to purchase a medigap plan would keep people from having to spend down their assets to go on Medicaid, resulting in savings to the taxpayers of Nebraska. The HMA report estimates that one out of four Nebraskans could avoid spending down their assets to avoid accessing Medicaid. While these individuals are eligible to purchase Medicare Advantage plans, these plans simply do not work in the rural areas of Nebraska, where not all providers are in-network for the plans, resulting in higher out-of-pocket costs. I encourage you to support LB64 so that Nebraskans with end-stage renal disease who are under age 65 have the opportunity to purchase a Medigap plan, just like all other eligible patients in our state. Thank you for your time and attention to this bill, and I'd be happy to take any questions.

JACOBSON: Questions from the committee? I, I just have one question, and the reason this was not included last year when Medigap was, was passed-- or two years ago, I don't remember. Time flies. But, is-- if you're under age 65 and you're not otherwise insured,--

FREDRICKSON: Mm-hmm.

JACOBSON: --you're probably not going to be paying any premium for a Medigap policy unless and until you're diagnosed with end-stage renal disease. And then you'd be crazy not to, because no longer is it an insurance policy; you're basically signing up to pay a premium of under $200 a month to get arguably $4,000 a month benefit. And so, the concern I had with it was it doesn't seem to be like insurance, it seems like insurance providers who, who support themselves through premiums paid by the other participants in the plan need to basically subsidize those that are there. I'm not saying they don't need coverage somehow. I'm not sure that putting that on the backs of other Medigap policyholders is the [INAUDIBLE] place to go, that perhaps there's another source of funding to try to help those individuals. So I, I, I, I think we'll probably hear some information that will dispute the cost averages, because I've heard that before, but-- this kind of gets out of the realm of insurance. It seems like it's really a, a funding source to support the companies that own the dialysis centers to have an insured deep pocket behind them to cover the cost for, for treatment. And that's where I probably have the rub, but-- am I missing something here?

FREDRICKSON: Well, I, I certainly thank you, Chair Jacobson, for your question. I think I, I certainly appreciate what you're saying with that. What, what my argument to that would say, it-- so, I have heard

from the opposition that they have concerns that this would increase premiums. Like I said, there are only around 400 Nebraskans who are under 65 with ESRD. And so, even if you have 100% uptake of Medigap, which-- it's unlikely to believe 100% would do that-- you know, that's, that's not a huge number. So, if you look at the study I passed out, this was actually done specifically on Nebraska. And the-- and our rates here, the estimate would be if they did decide to pass on the expense to the other policyholders or the other Medigap members, it'd be around $0.40 a month. So, we're talking about around $6.00 a year of increased fees, potentially, if that was a decision to be passed down to the other folks who did that. So, I would argue that, you know, I think that that would be not overly burdensome, especially when you consider that dialysis is not necessarily an optional treatment for folks.

JACOBSON: Right. No, I, I, I agree with that. I think probably what we're going to find is disagreement on what those costs may be.

FREDRICKSON: Sure, sure.

JACOBSON: And-- but I do think it's kind of a foregone conclusion that everyone with ESRD under the age of 65 would be on a Medigap policy if they're not otherwise covered on another insurance company policy, wouldn't they?

FREDRICKSON: Well, I, I, I mean, I would imagine that if you don't have coverage through a spouse's employer or something, that if you have the option to purchase coverage, you, you, you certainly would,--

JACOBSON: [INAUDIBLE].

FREDRICKSON: --you'd jump on it. I certainly would.

JACOBSON: I agree. Thank you. Other questions from the committee? If not, thanks for your opening. Hanging around for close?

FREDRICKSON: I will hang around for close.

JACOBSON: Oh, good. Proponents. How are you?

WENDY FUNK SCHRAG: Good. How are you?

JACOBSON: Go ahead.

WENDY FUNK SCHRAG: Should I start? Good afternoon, Chair Jacobson, committee members. My name is Wendy Funk Schrag, W-e-n-d-y F-u-n-k S-c-h-r-a-g, and I work for Fresenius Medical Care, and we support LB64. We serve over 640 Nebraskans with end-stage renal disease, or ESRD, in eight outpatient dialysis clinics located in Grand Island, Kearney, North Platte, and Omaha. Two things changed since last year, which is why we're here again with this bill, and the first is a study that was done by Kaiser, and I draw your attention to the handout that's coming your way. So, last October, a Kaiser Family Foundation study released average Medigap rates per state, and they got their information from the NAIC, and these are through the end of 2023. This is the average across all 2023 current Medicare-- Medigap policyholders, so it includes people under age 65 for those states, which you can see a lot of them. The second column is all the states that offer plans under age 65, people who smoke tobacco and people who are in a high deductible or select plan. And so I also-- I added the columns that indicate which states offered the under-65 plan and which states also offer open enrollment, and you can see that down a ways is Nebraska, with one of the higher rates already. And as you can see, there are a lot of states that offer Medigap for under age 65, including ESRD, at a very reasonable cost. And so we, throughout the years-- I've worked in dialysis for 35 years-- we have really not seen rates go up when states passed these bills. I think when I started working in dialysis, there were maybe 18, 20 states that offered Medigap for under age 65. We've seen a lot of states pass these bills since, and they've helped our patients a lot. And so, we just haven't seen those rates go up really high, and you can see states know how to do this. And the state that has the highest rate actually excludes ESRD, in Vermont. So, excluding ESRD evidently hasn't saved them what they thought it would. So, that was the first thing that really got our attention, and we thought we really needed to bring that to your attention. The Health Management Associat-- Associates study found the same average Medigap plan cost per month, and also concluded that Nebraska could save between $300,000 and $500,000 over a five-year period if they put-- allowed ESRD people under age 65 to buy a Medigap plan, and that's because of Medicaid avoidance. So, 65% of people with Medicare under age 65 are also on Medicaid. That's not just dialysis, that's anyone over-- under age 65. So, we thought that Medicare Advantage was going to be a great thing when it came out, and actually, half of our patients who are Medicare beneficiaries, whether over or under age 65, have Medicare Advantage. That takes care of half your population right there, because MA doesn't need a secondary. Now, this summer, when Great Plains Health Center in north, North Platte

decided they were not going to accept any MA plans, we had 23 out of our 70 patients that got the letter and had to decide, "do I stay with my MA plan but not be able to go to my local health clinic, or do I get a supplement with Medicare?" Well, they couldn't, because they were either under age 65 or they were past their guarantee issue period. So, we ask--

JACOBSON: Your light is on, so I'm going to need you to wrap up.

WENDY FUNK SCHRAG: So we ask you to support the bill because those patients who did change to original Medicare-- only five-- they cannot buy a supplement, so they're Medicare-only.

JACOBSON: Correct.

WENDY FUNK SCHRAG: Thank you.

JACOBSON: All right. Thank you. Questions from the committee? I don't think I have any que-- oh, yes, Senator Hardin.

HARDIN: Just a comment. What is it that puts us in the rare company of California on this? We don't have a lot in common with California. Unfortunately, we, we do with this.

WENDY FUNK SCHRAG: I know. Yeah.

HARDIN: And so, comment for me on how did we end up in such rare company.

WENDY FUNK SCHRAG: Well, it's interesting, because there had not been a state in over 20 years that had exempted ESRD. And I don't know the-- I don't know what made California exempt ESRD, but it was over 20 years ago. But interestingly, there's actually a bill going through the legislature in California right now to go ahead and accept ESRD into their plans.

HARDIN: Thank you.

JACOBSON: Other questions. All right. Seeing none. Thank you.

WENDY FUNK SCHRAG: Thank you.

JACOBSON: Next proponent. How are you?

CASSANDRA BERTWELL: Good. How are you doing?

JACOBSON: [INAUDIBLE].

CASSANDRA BERTWELL: Good afternoon, Chair Jacobson, and members of the committee. My name is Cassandra Bertwell-- cassandra, C-a-s-s-a-n-d-r-a; Bertwell, B-e-r-t-w-e-l-l-- and I am a kidney transplant recipient and former dialysis patient from Lincoln, Nebraska. I'm here today to ask you to support LB64. This important bill will provide access for under-age-65 end-stage renal disease patients' affordable Medigap coverage. When I was 25 years old, I was diagnosed with lupus. Shortly after my diagnosis, I was also diagnosed with end-stage renal disease and crashed into dialysis. At that time, I was working full-time and had Blue Cross Blue Shield coverage through my employer. As an end-stage renal disease patient, I was also eligible and paid for Medicare. Working full-time while undergoing dialysis and chemotherapy for my lupus was very challenging, however, I pushed myself through extreme exhaustion and nausea to continue working full-time because I was so fearful of losing my private health insurance coverage. I missed many days of work due to being so ill. People with chronic illnesses like end-stage renal disease shouldn't have to do this, but we do. That's because most Nebraskans who are under age 65 and living with end-stage renal disease don't have access to supplemental medical coverage. In 2017, I was fortunate enough to receive a kidney transplant through a living donation from my brother. My transplant saved my life and ultimately allowed me to become a mother. My daughter was born on the third anniversary of my kidney transplant. My lupus is currently in remission, and thankfully, I'm doing well post-transplant. I'm currently employed at a major insurance carrier as a senior life underwriting consultant. I also have medical insurance through my husband's employer. This insurance helps cover my immunosuppressant therapy that is required to keep my lupus in remission and my transplanted kidney healthy. None of this would have been possible if I did not have a living donor and access to private insurance coverage when I was undergoing dialysis. This issue is so important to me because Medigap provides coverage for life-saving kidney transplants. As part of the kidney transplant evaluation process, transplant centers conduct extensive financial clearances to ensure there's no financial liability for both the patient and the transplant center. Without supplemental insurance or financial resources to cover the 20% coinsurance for the surgery and follow-up medical care, most transplant centers will not place kidney failure patients on the active transplant waitlist. I remember going through this financial evaluation process prior to my kidney transplant, and I am forever grateful that I had access to insurance

through my employer and Medicare coverage. Without it, I would not be thriving like I am today. Patients like me shouldn't be penalized simply because we got sick at a younger age. If passed, LB64 would strike this prohibition and expand access to Medigap for end-stage renal disease patients who are under age 65. One of the positive outcomes of my difficult life journey is that I am here today advocating for the people who will walk the path after me. Thank you for giving me the opportunity to comment on LB64, and I urge you to support this important bill.

JACOBSON: Thank you for your testimony, and thanks for sharing your story.

CASSANDRA BERTWELL: Thank you.

JACOBSON: Questions? All right. Seeing none, thank you again. Further proponents? How are you doing?

LESLIE SPRY: Good. Good afternoon. Chair Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Leslie-- Dr. Leslie Spry, L-e-s-l-i-e, Spry, S-p-r-y. I am testifying on behalf of the Nebraska Medical Association. I'm a kidney guy from here in Lincoln, and I have previously served as a member of the state board of-- Nebraska State Board of Health, as well as past president of the Nebraska Medical Association. I'm currently serve as the medical director and chief medical officer for a nonprofit, Dialysis Center of Lincoln, here in Lincoln. The NMA supports LB64, which would make Medicare supplement policies accessible and affordable to individuals under 65 who are eligible for Medicare because of end-stage kidney disease. The average cost of one year of dialysis for our not-for-profit dialysis unit is about $40,000 per year, but if you consider costs of other medical care, primary care physician, medications, et cetera, that cost is actually about $60,000 to $80,000 per year. Without supplemental insurance policy, Medicare beneficiaries with end-stage renal disease must figure out a way to pay for that extra 20% of medical costs that are not covered by traditional Medicare. Additionally, Medicare alone is not considered full coverage by transplant centers, meaning that without supplemental insurance, these individuals are not added to transplant waiting lists. It is diff-- very difficult watching young patients not be able to get on the transplant list as a result of this. I've even had patients go have a GoFundMe page in order to be able to pay their 20%. Receiving a kidney transplant will double their life expectancy compared to staying on dialysis. I've reviewed our patients at our

nonprofit kidney care center dialysis unit, and we have 21 patients out of our total population of 320 that are under the age of 65 and are having difficulty obtaining supplement coverage. About half of those individuals are unable to get any supplemental coverage, and ultimately must rely on charity care, the Nebraska Chronic Renal Disease Program-- which has income limits-- or exhaust their resources until they qualify for Medicaid. Over the years, I've seen multiple patients who fall into this gap and end up in bankruptcy. Due to these challenges, some of these patients have opted for Medicare Advantage plans, which has its own problems, including our problems that we have with Medicare plans-- Advantage plans, who do not necessarily understand all of the complicated problems associated with end-stage renal disease and Medicare. Giving individuals under 65 years of age with end-stage renal disease the ability to purchase supplemental policies will allow them to focus on their health rather than the enormous stress of figuring out how to deal with their financial burdens of their condition. Thank you for your time, and I'm happy to answer any questions.

JACOBSON: Questions? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. Thank you, Dr. Spry, for being here. I think you've testified in this committee before last year, is that correct?

LESLIE SPRY: That would be correct, yes.

DUNGAN: I think I told you this previously, but you cared for my grandfather in the last couple of years of his life, and I want to say thank you for that.

LESLIE SPRY: Yeah, [INAUDIBLE].

DUNGAN: I know you probably have worked with a lot of folks, but it, it really meant a lot. So, I wanted to start by saying thank you for your service. It's incredible. Am I hearing you right then, that saying if we were to open up access to this coverage for some of these younger folks, it would allow them to get on the transplant list?

LESLIE SPRY: Yeah. I mean, that-- that's, that's a major problem, is that the-- all the transplant services look at your financial wherewithal, and that's a big deal. And if-- so, I mentioned that $60,000 to $80,000 per year that it takes to-- for all the medical care associated with end-stage renal disease and in-center dialysis,

so your first-year costs for a transplant are between, oh, about $100,000 to $120,000 for one year. But after that, then, costs go down, and if that patient lives 18 months, CMS, Medicare is money ahead at that point, because the cost of the drugs for-- annual cost of drugs are much less than that. But the transplant program is all-in for the first part of that, and unless you have the 20% to pay $20,000, $25,000, $30,000 upfront, they're not going to put you on the list.

DUNGAN: And so, you've seen people resort to things like GoFundMes and stuff like that to make up that difference.

LESLIE SPRY: I've, I've had a patient go on Facebook and advertise that he needed a kidney. I've had people who do GoFundMe pages and things like that. I had bake sales, I've a, a patient in York that had a big bake sale, so there's lots of different ways you try to get around that right now.

DUNGAN: Yeah. Well, thank you for your testimony. Appreciate it.

JACOBSON: Other questions from the committee? I'm just curious. You mentioned Medicare Advantage plans and had problems with that. I, I mean, according to all the ads, it's the, it's the panacea, so, so what-- what's wrong with Medicare Advantage?

LESLIE SPRY: Well, in the last two-- well, in the last two years since Medicare Advantage has been able to cover end-stage renal disease, our percent has gone from 6% to 28% within my dialysis unit. Medicare Advantage plans do not understand end-stage renal disease. The billing processes--

JACOBSON: Is that because sometimes, like you say, that they don't reimburse well?

LESLIE SPRY: No, they reimburse the same. They just make you work for it. With prior authorizations, with "we don't cover that," with-- I'm going to get into the weeds here, but we have a lot of new drugs that are coming on market right now, and Medicare already knows that, already provides for its payment under something-- a program called TDAPA. None of these Medicare Advantage plans even know what that is. And they, they, they slow up this whole process, so that, that it's just very difficult.

JACOBSON: Thank you. I-- you made the case for why Great Plains Health got out of Medicare Advantage.

LESLIE SPRY: Well, I'm-- and I, and I'm familiar with that. So, I--

JACOBSON: Thank you.

LESLIE SPRY: You bet.

JACOBSON: All right. Any other questions of the committee? Seeing none. Thank you for your testimony. Other proponents. OK, seeing none. How about opponents?

TOM GILSDORF: Good afternoon.

JACOBSON: How are you?

TOM GILSDORF: Good. How are you?

JACOBSON: Good.

TOM GILSDORF: Thank you, Chairman, members of the committee, for the opportunity to speak. My name is Tom Gilsdorf: Tom, T-o-m; Gilsdorf, G-i-l-s-d-o-r-f. I'm the regional manager for Medica Insurance Company, and Medica is a nonprofit health insurer. In Nebraska, we are focused on providing affordable, comprehensive health insurance for Nebraskans. We offer an array of Medicare plans across the state, which include Medicare supplement, Medicare cost plans, and Medicare Advantage plans. We also offer ACA or marketplace plans and employer group commercial plans. And I'm gonna focus most of my discussion regarding the birthday rule or the annual open enrollment component of LB64. This bill will raise premium costs for seniors, Medicare supplement plans that are currently on Medicare, as well as those who will be on Medicare in the coming years by removing the current enrollment guidelines for Medicare supplement in exchange for an annual open enrollment for these plans. And again, Medicare supplement does not have a cost or utilization management; it does not have a risk-adjustment component like their counterparts Medicare Advantage do. It will drive overall premiums paid by seniors higher in a market that we're already seeing double-digit premiums on for "med supps" across the state. If we do look at other states that have implemented similar birthday rule, or open enrollment or community rating rules, you will see higher average premiums for Medicare supplement, with a shrinking number of seniors choosing these options and, in a lot of cases, forced to other alternatives that may have networks, cost sharing when services are needed, or, or may elect to go without coverage altogether. In Missouri, for example, which-- there has been a birthday rule in place for several years-- premiums for similar

Medicare supplement plans are consistently 30% to 50% higher for the same coverage, and the state of Missouri has about two times the number of individuals on Medicare Advantage, or the majority of individuals in Missouri are on Medicare Advantage at about two times the percentage of Nebraska. If this bill is implemented, Medicare Advantage will likely be the dominant Medicare coverage in Nebraska within less than five years. In conclusion, this bill will increase insurance premiums paid by seniors choosing Medicare supplement now and in the future, limiting "med supps" from being an affordable option to individuals on Medicare, retired, and with limited incomes. And I thank you for your time, and will take any questions you have.

JACOBSON: Thank you. Questions? All right. If not, just to be clear, again-- and, as somebody I-- I know that we talked about in any of the other testimony is the birthday rule and, and the fact that that really leads to adverse selection. Is that really primarily the concern?

TOM GILSDORF: Yeah, absolutely. Anytime you can just choose once a year to go to the lowest rate, what happens is the lowest rate just rises. And you know, this is not-- this market is not a vacuum. You do have Medicare Advantage options, and, you know, if you see 10% increases on your insurance premium, Social Security checks don't go up 10%. So, it just makes Medigap plans-- which are very popular in the state of Nebraska because they have been affordable-- less affordable for seniors turning 65, and we have, you know, 160-plus thousand seniors on, on Medicare supplements, and are happy with them. And we'd like to keep it that way.

JACOBSON: Thank you.

TOM GILSDORF: Yeah.

JACOBSON: Thank you for your testimony. Further opponents? How are you?

CHRIS HAIRE: Great. Good afternoon, Chair Jac-- sorry. Good afternoon, Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Chris Haire, C-h-r-i-s H-a-i-r-e, and I'm a vice president and actuary responsible for the Medicare supplement products at Mutual of Omaha. I'm here today to testify in opposition to LB64. Mutual of Omaha is the second-largest Medigap carrier in the United States, with over 1.3 million policyholders nationwide and 28,000 policyholders in Nebraska. As a reminder, Medigap plans add additional

coverage on top of seniors' Medicare Part A and Part B benefits. When purchasing a Medigap plan, seniors pay a monthly premium in exchange for coverage of health care costs not paid for by Medicare, including co-payments, co-insurance, deductibles, and excess charges. Medigap plans receive no federal or state funding to operate; they're funded entirely by the premiums of our customers. The changes proposed in LB64-- and I'm-- and we'll stalk [SIC] specifically about the birthday rule-- while well-meaning will increase the cost of coverage to new enrollees, as evidenced by premiums in other states in which similar rules have, have been enacted, which are typically 25% to 30% higher than premiums in traditional enrollment states without the birthday rule. One of the primary differences-- drivers of the difference is the impact the proposed rule has on claim costs for the amount of claims paid per customer. In fact, recently, five different states have recently implemented similar birthday rules. Prior to the implementation of those rules, claim costs in those states were roughly the same as what we see nationally. Since 2021, claim costs in those states are now 27% higher than their non-birthday counterparts. The other meaningful driver are the significantly higher lapse rates, or the percentage of customers that terminate their coverage in a given year; how-- those are significantly higher in birthday-rule states. To compensate for this, insurance companies increased premiums, and compensation paid to producers is typically decreased, which puts downward pressure on the number of producers who are able to service the senior population. So, while it's natural to want to extend similar enrollment flexibility available in Medicare Advantage plans to Medigap plans, the core benefits the seniors value in a Medigap plan make that extension problematic. Firstly, Medigap plans are guarantee renewable, meaning that once a customer purchases a plan, they cannot-- that plan cannot be modified or canceled by the insurance company. That is not true of MA plans, as we saw during this last AEP, where more than 2 million seniors lost their coverage. Secondly, Medigap plans are regulated by the state and required to receive approval from the state insurance department on any requested rate increase. While MA plans also have a bid and approval process, there is less control-- particularly at the state level-- on what premium and benefit structures will be from year to year within a given MA plan. Lastly, Medigap plans are not actively-managed plans, as was mentioned before; the benefits are mandated and fixed over time. There are no networks, something especially impactful to rural seniors. MA plans, on the other hand, are able to modify benefits and cost sharing with just networks and engage in active management levers not in a Medigap plan. Thank you.

JACOBSON: I'm going to have to ask you to stop your testimony at that point, but thank you. Questions for the committee? Senator Dungan?

DUNGAN: Thank you, Chair Jacobson. Thank you for being here today. So, if we were to, I guess, bifurcate LB6-- LB64 into two separate parts, there's the birthday part, and then the ESRD component. Is the bulk of your objection, then, to the birthday rule being implemented?

CHRIS HAIRE: Yeah, I think the birthday rule has the most significant impact. I think a colleague of mine testified earlier within the ESRD piece, the-- as was mentioned before, the, the cost of covering those insurance is quite significant per the insured. I think the concern for that population varies a lot depending on the size of the insurance company, and so for Mutual of Omaha, with a big, large, you know, customer base, premium impacts probably would be more on the marginal side. I'd haven't prepared anything to, you know, give you any numbers on that. But it certainly could be detrimental if, for whatever reason, a small carrier "misprices" that piece of the market, they become the lone carrier in the market, and while only 400 customers, all 400 customers go to one carrier, there would be a significant concern there, so--

DUNGAN: But for the larger companies, if you were to-- and this is all hypothetical, but if you got rid of the birthday rule component of this and only made it the component allowing the ESRD folks to be involved, that would alleviate most of your concerns?

CHRIS HAIRE: It would alleviate most of my concerns. I still think premiums would go up, which I would probably oppose as well.

DUNGAN: OK. Thank you.

CHRIS HAIRE: Yep.

JACOBSON: To be clear, though, the rate that we have on this handout that we sent out, that is a monthly rate per person.

CHRIS HAIRE: I think somebody else gave the handout.

JACOBSON: Yeah. And it's not your handout, but--

CHRIS HAIRE: OK. Yeah.

JACOBSON: So, if we're at $221 a month, we're really talking about four hundred and roughly fifty dollars a month. And then, you

increased that because of, again, potentially concentration within any one Medigap insurer. You could see a significant premium increase, which was the primary reason why ESRD was taken out of the Medigap bill last year, and we went with the other pieces of disability. And as I recall, in the negotiations with the insurers, that was a-- the concern really came back to not pricing other seniors that are on a Medigap policy out of the market because we've raised the cost and are pushing more costs onto them.

CHRIS HAIRE: Yeah. I think cer-- yeah, correct. Certainly, as you push more costs into Medicare supplement, it becomes harder to compete against an MA plan.

JACOBSON: All right. Thank you. All right. Seeing no other questions, thank you for your testimony.

CHRIS HAIRE: Thank you.

JACOBSON: Further propon-- or, opponents. How are you doing? Go ahead.

SHAWN POLLOCK: Thank you, Chairman and, and committee. My name is Shawn Pollock, and I'm with Globe Life Insurance. We are a national company--

JACOBSON: Can you spell your name for us?

SHAWN POLLOCK: Oh, I'm sorry, Shawn Pollock, S-h-a-w-n P-o-l-l-o-c-k.

JACOBSON: Thank you.

SHAWN POLLOCK: And I am with Globe Life, I do government relations for them. Globe Life is a national company; we're domiciled in Nebraska, and we are a small to mid-size "med supp" carrier. Globe Life is conservatively-managed life and supplemental health insurance company for middle- to low-income people across the country. We sell policies worksite, and directly to individuals through agents and direct-to-consumer. I am here today-- oh, "med supp." We have-- oh, we have about 17 million life and health policies in force nationally. About 300,000 of those are "med supp," of which about 700 of them are policies here in Nebraska. So, small company. I've been working with "med supp" personally since 1993, and have been involved in the closing of pre-standardized block; been involved with the standardized block and the modernized block as the "med supp" product has, has developed over time. I'm, I'm here to talk about kind of one aspect of the "med supp" insurance policy, because "med supp" is insurance; it's

not a government subsidy or program, it is, it is not like Medicare, where you just sign up for it. You get "med supp" 1 of 3 ways: open enrollment, where folks are encouraged to sign up when they first become eligible for Medicare Part B; guarantee issue situations, which is typically when a senior loses their, their Medicare coverage by no reason of their own; or, through underwriting. So, the idea of "med supp" and the, the aspect of "med supp" that I wanted to bring to the committee is the fact that it's guaranteed renewable, and what that means to the senior and to the insurance companies. Guaranteed renewable is the long-haul look at a policy from the date it's issued to the day it ends. It's the way it's priced, it's the way seniors are looking to purchase it. It is not, like was said earlier-- the, the premiums are the only thing that can change, your policy cannot be canceled by the insurance company, and your benefits cannot change. So, in today's world, ACA, Medicare Advantage policies can cancel, benefits can change, deductibles can change, those pieces of the benefits can all change. The only thing that can change with a "med supp" policy is premium. So, when a senior buys it-- so, somebody buys it, they're looking at long term, and what does that mean? That means that they're buying it for the life policy. I think I've talked about that. So, allowing new risks to join, or risks to switch, changes kind of the dynamic of how that policy was priced. So, it, it totally changes how the product works. It also changes the-- from what-- the, the product from what the senior had originally purchased. So, with ESDRs, if you look at them, there's lots of cases out there that show that their claim costs are 6 to 10 times higher than the aged person. For a smaller company-- and Chris touched on it-- is if the same amount of risk go to a small company versus a large company, a large company can absorb it, a smaller company can't. Ultimately, I'll just-- since I'm at the end-- the, the, the paper that I passed out is a separate periodical on what happens for the annual--

JACOBSON: If we could-- hang on. Let's let somebody ask you a question--

SHAWN POLLOCK: Sure.

JACOBSON: [INAUDIBLE] Any questions? Yes, Senator Dungan.

DUNGAN: Could you explain your handout to us?

SHAWN POLLOCK: Thank you, Senator Dungan. The handout is a article that was written by Medicare Insights. There's two actual articles, one that was written in 2023 and one that was just published in

February of '25, and it's on the birthday rule. And so, it supports what's already been said about what happens with premiums going up, competition going down, and potential Medicare Advantage increases, because that's the alternative for seniors on Medicare supplement if their premiums go up.

DUNGAN: Thank you. And so, fair to say the bulk of your opposition, again-- and I understand you oppose the whole bill in its entirety, but is the bulk of your opposition around the birthday component, then?

SHAWN POLLOCK: I, I couldn't say it's the bulk.

DUNGAN: OK.

SHAWN POLLOCK: Because as a small company, if we would get hit with a lot of, of the ESRDs, the claim costs would go up considerably. That would get passed on to the entire block, and the [INAUDIBLE] selection would drive up costs for the aged.

DUNGAN: OK.

SHAWN POLLOCK: And so, you're looking at-- I, I don't have the numbers, but it's--

DUNGAN: Well, and to the-- to that point you just made, and I appreciate that it's a smaller company, it's a totally different consideration. But, you know, the numbers I think are kind of what I'm curious about, right? Because we, we have an actuary-- an objective actuary-- actuarial study that we were presented with earlier, indicating that there's a belief that in Nebraska, if the ESRD portion was passed, it would increase the premiums by $0.40 a month.

SHAWN POLLOCK: Yep. And I don't doubt that,--

DUNGAN: Mm-hmm.

SHAWN POLLOCK: --because that's an aggregate. So, when you break that up, then, amongst companies, and there's companies that have smaller pieces, that's again where I say if the same number of ESRDs, say, 25, 50, go to one company, a bigger company can, can handle those claims easier than what a smaller company can. And again, both companies are taking them and those claims, and, and dispersing them amongst the entire block of risks.

DUNGAN: OK. Thank you. I appreciate that clarification.

SHAWN POLLOCK: Sure.

JACOBSON: Thank you for your question. Other questions? All right. Seeing none. Thank you for your testimony. Other opponents? Mr. Bell.

ROBERT M. BELL: I surprised the page with a handout. I almost never have handouts. Good afternoon, Chairman Jacobson, and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, appearing today in opposition to LB64. You're getting handed a letter from an associate member of the Federation called America's Health Insurance Plans, and they're the national trade association of many health plans in the United States. As you know, we're the state trade association of Nebraska insurance companies. Many of our members are active in the-- both the Medicare supplement insurance marketplace and the Medicare Advantage marketplace, and we have policyholders who would be impacted by the passage of LB64. You've already heard from the expert, so I'm not, I'm not going to really add on. I haven't seen the actuarial report. Certainly, would be willing to take a look at that and have actuaries-- our actuaries take a look at that and, and see. I think the piece that Shawn handed out-- Mr. Pollock handed out is interesting, and I do know that was done by some Nebraska actuaries as well. Both pieces, the ESRD piece and the birthday rule, we believe would impact Nebraskans who-- senior Nebraskans who are not sharing that risk with those-- with the ESRD population in particular, would adversely affect them. Particularly, it's bad because they have options already with Medicare Advantage. If the rates increase-- and I would just highlight this-- if their rates increase on Medicare supplement due to birthday rule, ESRD, what have you, we will see more people buy Medicare Advantage, which is managed care, right? So, in the, in the-- from-- the doctor from the Nebraska Medical Association expressed, you know, hey, it's harder. It's supposed to be harder; it's managed care. I mean, by its very definition, it-- you go through more, there's limited networks, there's approvals, there's all those things that don't exist in Medicare supplement, which is probably why most-- many senior Nebraskans enjoy their Medicare supplement coverage. They probably complain about it because their rates do increase over time, so-- but-- with that, thank you for the opportunity to testify.

JACOBSON: Thank you. Questions? Senator Dungan.

DUNGAN: Thank you, Chair Jacobson. I'll try to be brief, Mr. Bell. I apologize for asking so many questions of you today.

ROBERT M. BELL: No, and I do oppose both portions of the bill, to be clear.

DUNGAN: I won't ask the same question.

ROBERT M. BELL: OK.

DUNGAN: You don't have this graph in front of you, but we were presented with an outline of the average Medigap premium costs for all 50 states plus Washington, D.C.

ROBERT M. BELL: Yeah. Don't have that one.

DUNGAN: If we assume the numbers in that are correct,--

ROBERT M. BELL: Sure.

DUNGAN: --it puts all four of the states that exclude ESRD in the top 22 most expensive average premiums. So, this graph would seem to suggest there's not a rational relationship between the exclusion of ESRD and whether or not costs for average premiums are, are reduced. Do you have any explanation of why--

ROBERT M. BELL: Well, I would call relevance. You know, do we have a report from, you know, four years before those rules were adopted on-- either on ESRD or the birthday rule, you know, and then after, and what happened to those premiums during that case? I think Mr. Gilsdorf gave you a good example of what's happened in Missouri, where we have seen an increase. We've seen an increase in premium, and we've seen a massive shift to people to Medicare Advantage. Now, we have many members that write Medicare Advantage, and they like Medicare Advantage, so I'm not going to say anything bad. But I have had heard-- I've heard rumors that some folks don't like Medicare Advantage, and bills like this shift people to Medicare Advantage because it's a cheaper product.

DUNGAN: Do, do we have-- can you get us the numbers from Missouri? Is that something we can see, too, to compare to this?

ROBERT M. BELL: Yeah, I, I think so. We'll, we'll work on that and, and see what we can get for you.

DUNGAN: Well, and, and I think your point is taken. I, I would argue that it goes to the weight of the evidence, not the relevance, certainly. But I see what you're saying. I just-- this seems to show that the ESRD is not necessarily going to reduce the cost. But your point is taken, and I think if we could look at those across a longer period of time, that would be helpful.

ROBERT M. BELL: And, and I would generally say that Nebraska's health care costs are a little bit higher for most-- than most states for a variety of reasons, and that means our insurance products are more expensive as well, so, to pay for those higher costs. You know, it could be the rural nature of our state, et cetera, et cetera.

DUNGAN: Sure.

ROBERT M. BELL: I don't know. So.

DUNGAN: Well, thank you, I appreciate that.

ROBERT M. BELL: You're welcome.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony.

ROBERT M. BELL: You're welcome.

JACOBSON: Mr. Blake, welcome.

JEREMIAH BLAKE: Good afternoon. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB64. We are the largest Medicare supplement policy provider in Nebraska. I don't have anything to add from what you've heard from the opponents on this bill, so I'd just make myself available for questions.

JACOBSON: Thank you for that testimony. Abbreviated.

JEREMIAH BLAKE: Thought-- I thought you might appreciate that.

JACOBSON: You, you don't know how much. Questions from the committee? All right. Seeing none. Thank you--

JEREMIAH BLAKE: Thank you.

JACOBSON: --for your testimony. Further opponent testimony?

von GILLERN: I bet this will be brief, too.

JACOBSON: Miss Gilbertson.

KORBY GILBERTSON: The queen of brevity. Good afternoon, Chairman Jacobson, members of the committee. For the record, my name is Korby Gilbertson. It's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as registered lobbyist on behalf of the Nebraska Association of Benefit Insurance Professionals in opposition to LB64. I too would just like to echo what the prior opponents said, and just reiterate that NABIP is concerned with the negative impact on rates and the choices for seniors. So, I think that's another issue with what you had brought up earlier. Be happy to take any questions.

JACOBSON: Wow. Thank you. Questions? All right. Seeing none. Thank you for your testimony. Other pro-- or, opponent testimony? Seeing none. Any neutral testifiers? We have one in the back.

von GILLERN: The problem child.

JACOBSON: There's always one. Welcome to the Banking, Commerce and Insurance Committee.

MARY VAGGALIS: Thank you, Chair Jacobson and members of the committee. My name is Mary Vaggalis, M-a-r-y V-a-g-g-a-l-i-s, and I'm here today on behalf of the Independent Insurance Agents of Nebraska, commonly referred to as "the Big I." The Big I's the trade association representing over 500 independent insurance agents in Nebraska and their employees. I'm here in a neutral position today, because our members are of two minds about the benefits and risks of LB64, primarily focusing on Section 2, the birthday rule section. For many consumers, their insurance agent is the conduit between the consumer and the insurance industry. Our members operate small businesses throughout the state in communities big and small. Many consumers develop lasting relationships with their agents, who serve as a trusted resource. Because of these relationships, our members see the human cost of our health care system. In outreach about this bill, many agents shared stories of elderly clients who are no longer able to afford their Medicare supplement plans due to the rising cost of health care and premiums. Many of these individuals are unable to switch plans because of health conditions; they're forced to either drop their Medicare supplement plan or switch to a Medicare Advantage plan. As providers wrestle with whether to accept Medicare Advantage patients, a switch could reduce opportunities for care, particularly

in small rural communities in our state. Removing the underwriting requirement could help them change plans and reduce costs. This is especially important for those on fixed incomes. On the other hand, agents are also concerned about the unintended consequences of this bill. Allowing a constant rollover increases the administrative burden on agents and insurers. We could see fewer agents willing to sell Medicare supplement policies if insurance companies reduced their commission for these guaranteed issue changes on top of the additional time that they would need to address each policyholder every year. Some also have concerns about carrier disruption, meaning fewer insurer/carriers in our market, or fewer carriers offering Medicare supplement plans in Nebraska. For those that continue offering these plans, the ability of consumers to shop every year is likely to make price the ultimate determining factor in their decision-making. Although affordability is important, there's also value in being insured by a good company. A company's longevity in the Medicare market or its quality customer service operations have value to consumers that go beyond their premium payment. Moreover, if customers are enrolling based on price alone, they may feel they don't need to build relationships with the local agent. This could push consumers to unreliable places for information and leave them vulnerable to scams or misrepresentations. The Big I asks members of this committee to carefully balance these considerations in its policymaking. We'd be happy to connect you with members of our organization if it would be helpful for discussions, and are certainly willing to work with Senator Fredrickson on the bill. Thank you.

JACOBSON: Thank you, Mrs. Vaggalis. Questions from the committee? All right. Seeing none. I certainly do not, so, thank you. Any other neutral testifiers? All right. Seeing none. I will note-- Senator Frederickson, you can come back up here for your close, but before you do, we received 13 proponent letters, 1 opponent letter, 2 neutral testifiers-- or, 2 neutral letters, and there were no ADA letters. You're welcome to close.

FREDRICKSON: Thank you, Chair Jacobson. Well, I just want to say thank you to the committee for your engagement with this bill. I also appreciate the testifiers coming in, both the proponents and the opponents. I listened to the concerns that were brought up; I certainly appreciate the concerns that were brought up. It seemed to me that there were a handful of concerns, but the primary sort of issue a lot of the opposition brought up was-- seemed to be the birthday rule. That's something I'm, I'm willing to take out of the bill if that's the primary driver of the opposition, and that's

something I'd be happy to work with the opponents on, as well as the committee, to see if that would make it a bit more palatable. I will note for the committee that every single opponent that spoke today was from the insurance industry or insurance companies, and there was an argument that was made about rate increases and the risks of rate increases, and that seems to be a perennial argument or a typical argument on a lot of these bills. But I want to remind folks of what we're talking about here; we're talking about Medigap coverage for people in the state of Nebraska with end-stage-- ESRD that are under 65. So, that is a total population of a maximum amount of 400 people. So, we're talking a little bit here about a bit of a David and Goliath situation. We're talking about 400 people under 65 with ESRD versus the insurance industry. And the thing I also want to highlight that some of the o-- proponents highlighted as well, is that getting dialysis treatment-- first of all, it's not optional; this is something that is, is required. But second of all, it enables you to be able to be eligible for an actual kidney transplant. So, there are folks out there who are no longer eligible for even a transplant because they are unable to access dialysis. So, I want to make sure that we're kind of keeping grounded in the reality of what this bill does. I understand the concerns about increased rates and increased premiums. That said, this is a very small portion of the population of our state. You know, 400 people. So, with that, I will take any questions from the committee.

JACOBSON: Thank you. Questions? All right. Seeing none. Thank you. Thanks--

FREDRICKSON: Thank you.

JACOBSON: -- thank you for bringing the bill.

FREDRICKSON: Oh, my pleasure.

JACOBSON: All right. That will close our hearing today on LB64, and we'll move on to open a hearing on LB252. Senator Bostar. You can begin whenever, but we're going to start the clock now.

BOSTAR: Good afternoon?

JACOBSON: Evening.

BOSTAR: Chairman Jacobson-- not quite-- and fellow members of Banking, Commerce and Insurance Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, representing Legislative

District 29, here to introduce LB252, which expands access to non-opioid pain treatments by ensuring insurance and Medicaid policies do not restrict prescriber choices or disadvantage safer medication alternatives. The opioid epidemic remains a national crisis. Federal government first declared it a public health emergency in 2017, and that declaration has been renewed continuously through 2024. Opioids are the leading cause of drug overdose deaths, raising-- rising from 48% of cases in 2000 to 75% of cases in 2021. While Nebraska's overdose rates are lower than some states, the crisis is still taking a toll. In 2021, 113 opioid-related deaths accounted for over half the state's drug overdose fatalities. Provisional 2022 CDC data show that 256 Nebraskans died from poisoning and overdoses on fentanyl and other synthetic opioids. Nebraska has acted to address this issue most recently with LB1355, introduced in 2024, which allocated opioid settlement funds toward treatment. While these measures were crucial, they focused primarily on treatment after addiction has already taken hold; prevention remains a critical gap. One of the best ways to prevent opioid addiction is to reduce unnecessary exposure by ensuring patients have access to effective non-opioid pain treatments. Pain is one of the most common reasons people seek medical care, yet treatment options are often limited to two extremes: non-steroidal, non-steroidal anti-inflammatory drugs and acetaminophen may be insig-- in-- insufficient for moderate to severe pain, while opioids pose significant risks of addiction and overdose. Recently, the FDA has approved new non-opioid treatments offering safer alternatives. However, insurance policies often prioritize coverage for opioids over these newer options. Insurers also impose restrictive policies such as prior authorization, step therapy, or higher cost-sharing requirements, making it harder for patients to access innovative non-opioid treatments. LB252 eliminates these barriers by ensuring that Medicaid and state-regulated insurers do not disadvantage non-opioid pain treatments compared to opioids. Legislation prevents insurers from requiring additional authorization, imposing more restrictive step therapy requirements, or placing non-opioid treatments on higher-cost formulary tiers. The bill applies immediately to all FDA-approved non-opioid medications, ensuring that prescribers and patients have the full range of pain management options without unnecessary obstacles. Supporters of this legislation have approached me to highlight another prevention policy opportunity for Nebraska: the establishment of a standardized, voluntary non-opioid directive form. This form, completed by a patient in consultation with health provider, allows individuals to indicate in their medical records that do not wish to receive opioids. LB252 is a

critical step forward in preventing opioid addiction before it begins to make-- before it begins by making safer pain treatment options accessible. I thank you for your time and attention. I'd urge your support of the legislation, and I'd be happy to answer any questions.

JACOBSON: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Can we go to the fiscal note? I think the product's a good product. I just-- I know in the last line on the one page, it says LB252 would require circumvention of the CMS-required process and jeopardize federal funding, which DHS [SIC] estimates to be $535 million.

BOSTAR: Yeah. I mean, I think, I think that's generally nonsense. I mean, not to use too much technical language, but, you know, this is a-- this is a high art, here. I-- you know, I'll say this: DHHS submitted a neutral letter. I think if there were-- I'm, I'm just going to speculate-- if there were concerns that half a billion dollars was going to go away, I think they would oppose it. So, this seems silly to me. Officially, DHHS is neutral, and I think we should all take them at their word on their position.

RIEPE: OK.

BOSTAR: That being said, the, the fiscal note does have other issues. So, I, I, I would appreciate understanding better how they get some of their numbers that they come up with. Fiscal impact between $760,000 to nearly $5 million with mid-range estimate of $2.8 million. These, these-- this inv-- this would in-- this would imply such aggressive usage of these medications. So, to be clear, currently, non-opioid-- or, or, or non-opioid but within the class of opioid pain medication is only permitted to be prescribed for acute cases. Very limited-duration prescription. So, you're looking at-- probably the most common case would be post-surgical pain management. It is, it is not permitted to be prescribed for chronic pain management. So, the, the idea that we can spend upwards of $5 million on a drug that we know the cost of-- it's listed, it's something like $12-- for something that we can only prescribe, I think, for-- it's, like, two week-- I'll, I'll-- it's very, very short-duration prescriptions. Is-- what that implies to me is that more research and understanding was needed before this [INAUDIBLE] fiscal note was created. And I'm also happy to sit down with anybody from, you know, DAS or whoever to kind of work through some of those numbers so that there's a better comprehensive understanding of what we're talking about.

RIEPE: Has this been approved by the FDA?

BOSTAR: Yes it has.

RIEPE: Oh, it has. OK.

JACOBSON: Other questions? All right. Seeing none. Thank you. I'm assuming you'll wait for your-- stick around for close?

BOSTAR: Why leave now?

JACOBSON: After, after all this, why-- that's a good question. OK. Proponents.

KRISTEN HASSEBROOK: Good afternoon, Chairman Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Kristen Hassebrook, K-r-i-s-t-e-n H-a-s-s-e-b-r-o-o-k, here today as a registered lobbyist for Haleon, a world-leading consumer health company with a large manufacturing footprint here in Lincoln, Nebraska. You might actually be very familiar with some of our products, such as Advil, Sensodyne, and Theraflu. And I'm here today in support of LB252. According to the CDC, more than 1 million people have died since 1999 from a drug overdose, with nearly 75% of those deaths in 2021 involving an opioid. The number of overdose deaths involving opioids, including prescription opioids, heroin, and synthetic in 2021 was ten times the number it was in 1999, which indicates that many measures to reduce opioid use have been unsuccessful. Opioids are an effective and appropriate treatment option for certain types of pain, certain types of surgeries, and other injuries characterized with severe pain. However, even a short-term use of opioids can in-- can increase risk for side effects, drug interactions, and most importantly, the potential for addiction. For many types of common pain, there are effective alternatives to opioids that are recommended by health care practitioners for use as first-line or frontline treatment options, both pharmacological and non-pharmacological options. At Haleon, we believe more can and should be done so that patients have all the necessary tools to ensure access to non-opioid pain options. One such option is before you today in LB252 as drafted, but we also appreciate Senator Bostar bringing forward a concept called voluntary non-opioid directives. These voluntary non-opioid directives can be filled out by patients, and it empowers them to notify health professionals that they do not want to be administered opioids. The goal of the directive is to reduce exposure on the front end to opioids, and limit the number of

prescriptions. The existence of this directive does not alter any advanced health care directive; doesn't limit prescribing, dispensing, or administering of an opioid overdose drug; and it-- and oftentimes, through a legislation, doesn't have to impose any additional liability. Do we believe that these are another essential tool when it comes to ensuring patients have true choice and options when it comes to managing pain? I would also just say that I did work with Senator Bostar to bring this legislation, and want to make it very clear that our intent was not to require removal of any necessary clinical safety edits or limit things from a safety perspective that are absolutely necessary; the intent is just truly to ensure that non-opioid drugs are not any more restricted than they are for the least-restricted opioid or narcotic drug, and that legislation either identical to this or very substantially similar did pass in 2024 in Louisiana, Oklahoma and Tennessee. So, it can be implemented at a state legislative level. With that, I am happy to answer any questions.

HALLSTROM: Thank you. Any questions? Seeing none. Thank you.

KRISTEN HASSEBROOK: Thank you.

MARK FEIT: Good evening, Senators. My name is Mark Feit, M-a-r-k F-e-i-t, and I am the Lincoln director for CHAD Nebraska, Combined Health Agencies Drive. And on behalf of CHAD, I urge you to support LB252, a crucial bill that will ensure Nebraskans, especially those of us living with chronic disease and disabilities, have fair access to non-opioid pain management options. And as our state continues to confront the opioid crisis, we must remove barriers that present-- prevent patients from accessing safer and effective treatments. At CHAD, we work very closely with individuals and families affected by conditions like cancer, multiple sclerosis, arthritis, and other chronic diseases, many of whom experience daily pain. And for those individuals, effective pain management is not just about comfort; it's about maintaining independence, mobility, and their quality of life as well. We very much appreciate our insurance partners. Indeed, many of us who live with a chronic illness would not be able to afford our life-saving or sustaining treatments without them. However, insurance policies are often favoring opioids over non-opioid alternatives because of cost, and this leaves too many Nebraskans without viable, safer options. LB252 will help change that by ensuring non-opioid treatments receive equal insurance coverage, empowering doctors and patients to make medical decisions based on what's best for the individual. We all know the risks that opioids pose, and LB252 is a common-sense step toward giving Nebraskans-- especially those with

chronic conditions-- access to the alternatives that they need and deserve. So, please stand with the Nebraska patients and approve, support LB252, and thank you for your time today. I'm happy to answer any questions.

HALLSTROM: Thank you. Any questions? Seeing none. Thank you. Next proponent. Any opponents?

JEREMIAH BLAKE: Good afternoon, Vice Chairman Hallstrom, and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e, the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB252. First of all, I want to emphasize that we share your concern about the abuse of opioids and the consequences it has on Nebraska families. As the only locally-owned and operated health insurance company in the state, we are committed to addressing this crisis by working with all parties to reduce improper use of opioids. While I applaud Vertex for their efforts to develop an alternative to opioids for pain management, my opposition to this bill is that it is premature and unnecessary. Journavx, which is the drug that we're talking about, the opioid alternative, alternative was approved by the FDA on January 30; this is two weeks after LB252 was introduced. Occur-- according to the Journavx website, this drug is not expected to be available to patients until March. Even then, release is expected to be limited to major and national-- major national and select regional retail pharmacies. Our pharmacy team will be evaluating the clinical data regarding Journavx, and we will give it the same consideration we do to all FDA-approved drugs. Instead of advancing LB252, I suggest that a more holistic approach is necessary to address, address opioid misuse. My research to prepare for this hearing, I came across the Attorney General's website regarding the opioid settlement funds. As you know, the state attorney generals from across the "countrily"-- country, including Nebraska, entered into several nationwide settlements with various defendant corporations related to the opioid epidemic. As I looked through the list of companies that were subject to the settlement, I noticed there were drug manufacturers, pharmacies, a marketing company, and the three largest prescription drug wholesalers in the United States. Noticeably absent from the list were health insurers or pharmacy benefit managers. This strongly suggests that there are multiple entities in the prescription drug supply chain that influence patient access to drugs like opioids and non-opioids alike. We believe that a hol-- a more holistic approach would make opioid alternatives available to patients in Nebraska. If

the intent of this committee is to increase access to opioid alternatives and reduce opioid misuse, let's bring all the parties together to discuss how we can achieve this shared goal, and we'd welcome the opportunity to participate in that process. So, I want to thank Senator Bostar for introducing this bill, and I'd be happy to answer any questions that you have.

HALLSTROM: Any questions of Mr. Blake? Seeing none. Thank you.

JEREMIAH BLAKE: Thank you.

HALLSTROM: Next opponent.

ROBERT M. BELL: Good afternoon, Vice Chairman Hallstrom, 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'm here today in respectful opposition to LB252. As a reminder, the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies, including most of the health plans operating in the state of Nebraska. And again, I also would like to thank Senator Bostar's attention to this issue of opioid addiction, and I would like to thank him for reaching out before the legislative session on this bill. It would--- this would place various requirements on health insurers to treat non-opioid painkillers in a manner that they are not disadvantaged or discouraged, and would limit the insurers' ability to place heightened scrutiny with prior authorization or other utilization controls. As I told him in December-- and I'm going to tell you now-- I believe this legislation is premature. Journavx-- if I'm saying that right-- was approved-- there's a lots-- there's a lot of consonants and not a lot of vowels-- was approved in January by the FDA for use, meaning that it met the safety and efficacy standards of the agency. There is no indication that insurance companies would not add the drug to its formularies. However, the drug has not hit the market as of yet. According to reports I read, the cost of Journavx is around $15 a pill, compared to about $0.50 a pill for other drugs used to treat acute pain. According to its most recent presentation to stockholders, Vertex, the manufacturer of Journavx, is working with 2,000 high-volume hospitals and associated health systems to fast-track the pharmaceutical committee process within those hospitals, and working with payers, such as insurance companies, to add Journavx to formularies. Also, it is noted-- not that I begrudge them necessarily for doing this as a lobbyist-- but Vertex lobbying efforts were also mentioned both in Washington, D.C. for Medicare

purposes, and to the other various state capitals similar to LB252. I-- as the drug hits the market and begins its use across the United States, I sincerely hope it is successful and other competitors also hit the marketplace, so there's downward pressure on the price. It may be useful for the Legislature to continue to monitor these developments over the course of the next ten months to determine whether or not a parity legislation such as LB50-- LB252 is, in fact, needed for the people of Nebraska. For these reasons, the Nebraska Insurance Federation respectfully opposes the passage of LB252. Thank you.

HALLSTROM: Thank you. Any questions of the committee? Seeing none. Thank you, Mr. Bell.

ROBERT M. BELL: You're welcome.

HALLSTROM: Any other opponents? Anyone in a neutral capacity? We received 10 proponent letters, 1 opponent letter-- whoops, excuse me. I have to continue. 1 neutral letter, no ADA testimony. Senator Bostar, you may close.

BOSTAR: Thank you, Vice Chair Hallstrom, members of the committee. This is a-- while it's true that this drug, which is frankly fairly miraculous, since right now pain management-- it-- the opposition talked about how this drug costs more than other drugs to treat acute pain management purposes, and those are all opioids, to be clear. They're all opioids, every single one of them. So, if you're someone with a history of addiction, or you're someone that is susceptible to opioids, or some other good reason-- there's a lot of good reasons why you wouldn't want to take opioids. Currently, that is-- that's the only thing you have. And we're seeing the fentanyl epidemic spread across our country, take countless lives with it, and, by and large, that starts with prescribed opioids. That's how that-- that's how that kicks off in a large share of cases. Someone gets into an accident or has a surgical procedure or something else and gets prescribed opioids, and, and they become addicted. And while the prescription will run out, their drive to relieve that addiction does not. And so, that is why we have a tremendous amount of fentanyl being smuggled over our southern "borda," border, where it is manufactured in China, and then the cartels, through a money-laundering scheme, then push it into the United States, where it kills our residents. That's bad. We should stop doing that. Also, there has been a huge amount uncovered through numerous investigations about the opioid-producing companies themselves. And so, while it, it can be convenient to say, "look,

here's this cheap drug we have," the costs associated with that drug are not captured in its list price. Not to our society, not to our neighbors, not to our friends, not to our loved ones. And to be honest, this other drug that they have now made is actually fairly cheap, all things considered, when you look at what prescription medication costs. And again, this is short-duration only; it's all they're allowed to prescribe it for. And it was brought up that this is premature because they're not even-- it's not even going to be available until March. They're, they're prescribing it now. It's being prescribed currently. So, I'm not quite sure what the March date is, but there are active prescriptions being serviced for this drug currently, and I think the, the sooner we get a handle on the opioid epidemic that our country faces, the better. With that, I'd be happy to answer any final questions.

HALLSTROM: Any questions of Senator Bostar? Seeing none, the hearing is concluded for the day. Thank you for coming.