SLAMA: Good afternoon and welcome to the Banking, Commerce and Insurance Committee. My name is Julie Slama and I represent District 1 in southeast Nebraska. I serve as Chair of this committee. The committee will take up bills in the order posted. Our hearing today is your public part of the legislative process. This is your opportunity to express your position on the proposed legislation before us today. Committee members will come and go during the hearing. We have to introduce bills in other committees and are called away for that reason. It's not an indication that we're not interested in the bill being presented, it's just part of the process. To better facilitate today's proceedings I ask that you abide by the following procedures: Please silence or turn off your cell phones; move to the front row when you are ready to testify. The order of testimony will be as follows: introducer, proponents, opponent, neutral, and closing. Testifiers, please sign in, hand your pink sign-in sheet to the committee clerk when you come up to testify. Spell your name for the record before you testify. Be concise. It's my request that you limit your testimony to three minutes. We do have a very handy alarm system that will go off at three minutes and 15 seconds just to make sure everybody's got a chance to share their thoughts today. If you will not be testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white tablets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. Written materials may be distributed to committee members as exhibits only while testimony is being offered, hand them to the page for distribution to the committee and staff when you come up to testify. We need ten copies. If you do not have ten copies, please flag down a page now so we can help you get there. To my immediate right is committee counsel Joshua Cristolear, to my left at the end of the table is our committee clerk Natalie Schunk. The committee members with us today will introduce themselves, beginning on my far left.

BOSTAR: Eliot Bostar, District 29.

von GILLERN: Brad von Gillern, District 4.

JACOBSON: Mike Jacobson, District 42.

KAUTH: Kathleen Kauth, LD 31.

BALLARD: Beau Ballard, District 21.

DUNGAN: George Dungan, District 26.

SLAMA: Also assisting the committee today are our committee pages, Caitlyn and Isabel. The committee will take up bills today in the following order: LB710, LB778, LB448, LB538, and LB537. With that, we will open our hearing on Senator Dungan's LB710.

DUNGAN: Good afternoon, Chair Slama and members of the Banking, Commerce and Insurance Committee. I'm Senator George Dungan, G-e-o-r-g-e D-u-n-g-a-n. I represent the people of northeast Lincoln in Legislative District 26 and today I'm introducing LB710. LB710 would provide a much needed update to our state's Credit Union Act to make def-- to add definitions, make technical changes, and offer updates to enable Nebraska credit unions to operate more effectively and efficiently in serving their members. LB710 is about preserving the dual chartering system for Nebraska credit unions, maintaining local control and oversight, and protecting the money the state receives from state-chartered credit unions. Over the years, the relative appeal of the state credit union charter has declined. As a result, the state has seen and will continue to see a migration to the federal credit union charter if legislative action is not taken. As with the dual banking system, credit unions have the choice to operate as a federal charter or a state charter. The Nebraska Department of Banking and Finance charters and supervises state-chartered credit unions. Federal-chartered credit unions are chartered and supervised by the National Credit Union Administration or the NCUA. The NCUA also administers National Credit Union-- I'm sorry, National Credit Union Share Insurance Fund, the NCUSIF, which insures all Nebraska credit unions. Unless there are meaningful, significant, and substantial changes made to the state Credit Union Act, the dual chartering system in Nebraska remains in jeopardy. Currently, there are 11 state-chartered credit unions and 45 federally chartered credit unions. Only 20 percent of our credit unions have chosen the state charter. Conversely, 93 percent of Nebraska's banks have opted for the state charter. Our neighboring states have done much better than we have in attracting credit unions to opt for their, their state charters. For example, Colorado has 49 percent state-chartered credit unions, Kansas is 72 percent, Missouri is 89 percent, and Iowa has a 96 percent state charter for their credit unions. South Dakota and Wyoming do not have a state Credit Union Act. Our neighbors have done a good job at updating their state Credit Union Act, keeping their money local while Nebraskans are sending their money to D.C. Simply put, it's more expensive to be a state-chartered credit union in Nebraska. Nebraska state-chartered credit unions receive no preferential tax treatment from the state. As a result,

state-chartered credit unions are subject to additional tax burdens, such as the Nebraska financial institution deposit tax and sales tax not imposed on their federal credit union counterparts. The state Credit Union Act has failed to keep pace with the evolutionary pressures of the modern financial marketplace. Unlike the state Banking Act, which is consistently and constantly updated, allowing for a successful evolution in a financial world of swift and dramatic changes, the state Credit Union Act has not been afforded the same opportunities. I did pass out an amendment. You'll have a chance to look at that just so folks are aware that it's very simple. We're striking some language and returning to the original language that was in the Credit Union Act so we're just getting rid of the modifications that were proposed. I also want to mention I've had an opportunity to speak at great length with the bankers. I've met with Mr. Hallstrom as well as others and the credit unions' representatives and I understand that today there's going to be some opposition, there's going to be some proponents. I'm hopeful that we can find some common ground. It does sound like after speaking with some of the bankers, that there are some, some things we can all agree on and so I just want to mention we had those conversations and we're going to continue to have those conversations. And I look forward to hearing the testimony here today to make sure that we are all clear on what some of the issues are and how we can reach some consensus. So with that, I look forward to working with my fellow committee members on this legislation and I'd urge your consideration of LB710 and I am happy to take any questions, although many more experts are going to follow me who might be better suited for those questions.

SLAMA: Thank you, Senator Dungan. Are there any questions from the committee? Senator von Gillern.

von GILLERN: Yeah, thank you, Senator Slama. Senator Dungan, as I read through this, and I'll, I'll admit I-- the intricacies of the state-chartered credit union versus federal versus banking regulations were a little-- might be a little bit over my head and get me a little bit lost. The one thing that, that felt a little bit bizarre or uncharacteristic in this was the on page 3, the reference to savings accounts being set up in schools. Can you comment to that?

DUNGAN: Yes. So there are actually folks coming after me who are going to--

von GILLERN: OK.

DUNGAN: --speak specifically-- essentially, I think the people after me are going to speak to each modification in the provision and so questions you have about some of those modifications--

von GILLERN: Great. I'll save--

DUNGAN: --would be best for them but I'm happy to sum it up at the end.

von GILLERN: Perfect.

DUNGAN: Long story short, as I said, what we're trying to do is make this a state that is welcoming to state-chartered credit unions. As of right now, I know there is just a number of hoops the credit unions have to jump through. Those were obviously put in place to make sure that consumers are being protected. I think we can all agree that consumer protection is important, but we're trying to make sure the state credit unions, the state-chartered credit unions remain competitive. And I think that's a small component in going a long ways towards that but they'll have more details about the actual functions of the program.

von GILLERN: I'll listen as we go forward. Thank you.

DUNGAN: Thank you.

SLAMA: Thank you, Senator von Gillern. Additional committee questions? Senator Jacobson. Sorry.

JACOBSON: Thank you, Senator Dungan, for, for being here. And, and some have accused me of being opposed to credit unions, I just want to be on the record I'm not. But I do have a, a couple of questions and I know you're going to have some following you and, and I certainly if you don't feel comfortable answering the question I'll ask them that question. But do you know if there's anything in this bill that would give additional powers beyond what federal credit unions would be entitled to today?

DUNGAN: I don't know the answer to that off the top of my head, I will let them first talk about that.

JACOBSON: My guess is you've got a testifier back there that will answer that question for me.

DUNGAN: There's probably some shaking or nodding going on behind me right now, so I'll let them address that.

JACOBSON: Yeah. OK. Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, thank you, Senator Dungan.

DUNGAN: Thank you. I will stay to close. Shocking.

SLAMA: Wonderful. We'll now open it up for proponent testimony on LB710. And just a note. If you are testifying on this bill, please come up to the front a few rows, it will help save us a lot of time. Good afternoon.

ANGIE SCHREINER: Good afternoon. All right. Good afternoon, Chairwoman Slama, members of the Banking, Commerce and Insurance Committee. My name is Angie Schreiner, A-n-g-i-e S-c-h-r-e-i-n-e-r, and I am the senior vice president of marketing at Liberty First Credit Union. We're a state-chartered community credit union serving those who live, work, and worship and attend school in Lancaster and Seward County and those who are related to someone eligible for membership. Liberty First provides financial services to over 31,000 members with four branches in Lincoln, one in Seward, one in Omaha, as well as a robust online platform. I am testifying today in support of LB710 and I thank Senator Dungan for its introduction. LB710 modernizes and updates the state Credit Union Act. I'm focusing my testimony on school branches. This provision, 21-1725.01(3), codifies the state statute the opportunity for the credit unions to assist in providing schools and their students with vital education and hands-on experience for learning to save, developing a regular habit of saving, and the use of savings accounts in schools who have students that reside in the same city or village where a credit union has a location. Liberty First Credit Union currently has three school branches operating in Lincoln, two of which are Title I schools, which are 40 percent of the population in that school are on free or reduced lunch. The first one opened in September of 2011. Each year, 8 to 16 upper elementary students are selected through an application process and an interview process to alternate weeks working at the school branch as tellers and are supervised by the teacher coordinator and associates from Liberty First Credit Union. Student depositors receive their first-- with their first deposit receive a $5 match from Liberty First and receive different incentives for habitual savings and for reaching savings levels. A recent long-term analysis of high school students who participated in a savings program in elementary school completed by Dr. Jennifer Davidson and Dr. William Walstad, both of the University of Nebraska-Lincoln, found that 92 percent of these students who participated in the school branch opened their own credit union or

bank account once they reached high school. Those who participated in elementary school savings programs were significantly more likely to be banked, more likely to be earning income in high school, and were more likely to be saving and they are saving at higher rates compared to students who didn't participate. Out of the participating Nebraska students, the average annual savings is just $54.76. If these students were to continue saving $55 a year from age 15 to 65 with an assumed 8 percent rate of return, they would have $381,000. A savings program like this not only encourages the habit of saving, but helps educate students on the importance of savings for a goal and building for a financial base to navigate the fickle fingers of fate life often throws at us. Watching these students' excitement and understanding how their savings grows while they visit the branch each, each week and then potentially become a teller and help instill the valuable lessons that they learned in other depositors while they themselves are learning a new skill of how to navigate job responsibilities is something amazing to witness and so important for Liberty First Credit Union to be a part of. Providing-- our mission, providing a lifetime of financial solutions really means a lifetime and starts at a young age to help them be successful in their financial goals. I want to thank you for your consideration and I urge the advancement of LB710. If you'd like to know more about how our school branches work, I'd be happy to answer any of those questions now.

SLAMA: Thank you, Ms. Schreiner. Are there any questions from the committee? Senator von Gillern.

von GILLERN: Probably knew I was going to have a question, didn't you?

ANGIE SCHREINER: I did.

von GILLERN: Yeah, thank you, this fills in some of the blanks. I, I love the idea of teaching-- I mean, teaching kids at a young age to save and teaching the illustration of compound interest and it's a terrific illustration. The schools, are the school districts on board with this, are they-- is this welcoming, is it something, something that they're asking for?

ANGIE SCHREINER: They are asking for it.

von GILLERN: OK.

ANGIE SCHREINER: The program-- so when we started in 2011, there was one branch here in Lincoln that was open and it was opened by-- at

Clinton Elementary by, I believe it was, U.S. Bank at that time, I believe. There will be someone who can clarify that if I'm wrong--

von GILLERN: OK. All right.

ANGIE SCHREINER: --on that statement. And we went ahead and opened at Hartley and then we opened three more. Since then, COVID hit, we've had one school who is prioritizing some other issues so we have three open at this time. They are asking for it. It is in the districts that for Liberty First we're only open in Lincoln. But I know there are schools in Omaha, there are schools in other western towns that have these and they want them as a way to educate their students.

von GILLERN: OK. Thank you.

ANGIE SCHREINER: Um-hum.

SLAMA: Thank you, Senator von Gillern. Additional questions from the committee? Senator Jacobson.

JACOBSON: Thank you, Ms. Schreiner, for being here. You know, I, I applaud the efforts to work within the, the schools. I know there's a lot of banks that are doing this, too, and I think it's an-- I think it's an important concept that kids need to get involved early. I, I guess my question for you would be that, that how is Liberty First organized, are you a community credit union, or what's, what's your organizational structure?

ANGIE SCHREINER: Thank you, Senator. We are a community credit union. We were started in 1935 by Burlington Railroad and received community charter, I believe, in 2003.

JACOBSON: But is it correct, though, that not all credit unions are community based, that they are employer based?

ANGIE SCHREINER: There are some who are still employer based, yes.

JACOBSON: So this bill would basically allow all types of credit unions to open school branches.

ANGIE SCHREINER: It would allow different-- yes, it would allow them all to open it. But within the school structure, it is the school that houses that account. Each student doesn't have an account. It's the school that holds the account and then each student is listed within that.

JACOBSON: Yeah, I'm familiar with how they work those. I, I guess my question becomes and my concern obviously is, is what you're-- how you're organized seems to limit your field of membership. And this would seem to be encroaching upon that field of membership to be having someone that's not employer related being a member. Because, really, we're not talking about deposits here we're talking about really shares, aren't we, in, in the, in the cooperative?

ANGIE SCHREINER: You are talking about shares, but it's one school who's opening it. It's not a bunch of students so you're really serving that school. And, yeah, that school may be outside of the field a membership of a select group but when a credit union is making a decision, along with the Nebraska Council on Economic Education and that school, they're considering whether that's a good fit for all three and if it makes sense for that credit union--

JACOBSON: Got you.

ANGIE SCHREINER: --based on their field.

JACOBSON: But let's be clear, we're talking about expanding the powers beyond what are granted today for an employer-based credit union.

ANGIE SCHREINER: For employer based, I wouldn't be the one to talk to that as we're community chartered.

JACOBSON: Appreciate it. Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, thank you very much, Ms. Schreiner.

ANGIE SCHREINER: Thank you.

SLAMA: Good afternoon.

FRANK WILBER: Hi. Thank you. Good afternoon, Chairman Slama and members of the Banking, Commerce and Insurance Committee. I am Frank Wilber, president and CEO of Liberty First Credit Union, a Nebraska state-chartered credit union headquartered in Lincoln, Nebraska, serving over 31,000 members. I'll save the rest that Angie already went through. I am testifying today in support of LB710 and I thank Senator Dungan for introduction. LB710 modernizes and updates the state Credit Union Act. Today, I'll be focusing my testimony on eliminating branch hearings and bylaw amendment hearings as related to revisions to revision 21-1725.01, subsections (3) and (2). And in our opinion, this revision is necessary to help Nebraska state-chartered

credit unions be as flexible as our federally chartered counterparts when it comes to these kinds of issues. They have no hearing requirements for either establishing a new branch or amending a bylaw. The NCUA who regulates federally chartered credit unions, as was said earlier, relies on their on-staff professionals to make an unbiased decision on such subjects based on the health and effectiveness of the credit union, along with, along with a well-documented and clear application process that is timely and, most importantly, consistent and objective. They provide a reply to a bylaw amendment request within 90 days, doing so without ever holding a hearing to gather input from unobjective third parties. In Nebraska, we're one of only three states who operate under similar hearing requirements. All of the objections that I've been witness to and have been part of have been made by a single bank or the bankers' associations who seem to look for these hearing opportunities to stall credit union growth across the state and stifle competition, specifically from credit unions, to really no benefit of the citizens and small business owners in our communities, whether it's urban, rural, or otherwise. And those folks would really benefit greatly from additional access to other financial institutions. Each year, our Legislature takes the time to carve out a wild card for all state-chartered financial institutions to put us on par with federal charters. Unfortunately for credit unions, it really does not have a lot of merit. The types of things we're asked to do we're still subjected to different ways of doing them than our NCUA peers are. So this is simply, this provision would remove the hearing requirement and put the decision in the hands of the Department of Banking where it should rest with their expertise and their ability to, to make a decision based on our ability to serve the areas we want to serve or make whatever bylaw amendments we want to make. The second part of that is the branch requirement for a hearing. With the branch requirement for a hearing, I, I know that there was no credit union branches added in the prior year. There was 18 bank branches added. I believe there was no hearings and no objectors to any of those. I think that it's likely we've reached the point we're beyond needing to post a hearing for a branch location again, the department would have the ability to look into that and see what kind of sense that makes. Otherwise, I, I really don't have much more. I can answer any questions if anyone has any.

SLAMA: Thank you very much, Mr. Wilber.

FRANK WILBER: You're welcome.

SLAMA: Are there any questions from the committee? Senator Jacobson.

JACOBSON: Thank you, Chair Slama. Mr. Wilber, I guess my question would be-- I, I know you're looking at comparisons of the bank branches and credit union branches, but isn't one of the big issues on the hearings, the question about expansion of your field of membership? And if I'm not mistaken, most of the objections that have been filed in the past have been going beyond the rules of field of membership for credit unions, because you are chartered differently because of your tax preferred status. And I think that's been a lot of the issue, I mean, is that not part of the issue that we're dealing with here?

FRANK WILBER: Well, and as a state-chartered credit union, we have no tax preferred status. Zero. There's not one tax that a bank would pay that we wouldn't pay on a state level.

JACOBSON: Let, just let me, let me follow up on that.

FRANK WILBER: OK.

JACOBSON: So you're telling me that a state-chartered credit union would, would not pay any-- would pay federal income tax?

FRANK WILBER: Well, we pay the same, our shareholders pay dividends on all their-- or interest on all their dividends, similar to how a Chapter S bank would work.

JACOBSON: But, but--

FRANK WILBER: --federally.

JACOBSON: --but, but banks would pay on at the bank level and on Sub S, the, the actual owners of the bank would pay based upon the earnings that were made at the bank level whether there was a distribution or not.

FRANK WILBER: Right, similar to credit unions are [INAUDIBLE].

JACOBSON: Similar, but not the same. Right?

FRANK WILBER: Well, our members are the owners. I, I, I draw a good parallel there.

JACOBSON: Well, let me just be clear on that.

FRANK WILBER: Sure.

JACOBSON: I, I, I don't want to be argumentative, but I guess my question to you, though, is my understanding is your members would pay income taxes on any distributions that they received, not on the amount of earnings that the credit union earns. So if you had retained earnings, if you had earnings that you retained, no one's paying any federal income taxes on those. In the bank's case, they would be. There's a distinct difference there.

FRANK WILBER: Again, I'm, I'm aware, as, as-- I will just say, I'm aware of some banks that are structured to pay exactly the way we pay. Where really the retained earnings of the banks flow through the shareholders. So it's no-- again, it's, it, it, it can be looked at to be a different kind of layout. But, but, again, I-- we obviously as a state-chartered credit union, we're not opposed to necessarily paying our fair share especially when it comes to the state and as a state-chartered credit union that's where we're looking for relief from. We're not looking to the NCUA for relief. We're looking at it-- and just, just just quite honestly, we're looking at it from a standpoint of what would be the reasoning to stay as a state-chartered credit union at this point if it's more difficult to do things that are fairly easily achievable through the NCUA at this time and with the additional taxes we do contribute to the state much like our banking peers it would be nice to feel like there was value in that. And that is exactly what Senator Dungan was, was stating at the beginning of this. There's just diminishing value to a state charter as a credit union right now. There's just-- it's, it's not, you know, I wouldn't suggest that it's anyone's intention to make sure all the credit unions become federally chartered. But the way that things are structured right now, you're steering every credit union the state that does pay sales tax that could be used for some property tax relief away from being state chartered. And I just think that that's a, a, a light that should be shining on the subject is, you know, what would the motivation be? We haven't had a, a dedicated credit union regulator for five years, the last person had left and we've been using banking regulators. So, you know, having a, a regulator that does not have knowledge necessarily of the credit union industry is a tough thing to do, but we pay extra for local regulators so that's one of the reasons.

JACOBSON: Thank, thank you. I, I appreciate that and I think you answered my question.

FRANK WILBER: All right.

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, thank you very much, Mr. Wilber.

FRANK WILBER: Thank you. Appreciate it.

SLAMA: Thank you. Good afternoon.

LINDA CARTER: Good afternoon, Chairman Slama and members of the Banking Committee. Thank you for having me and letting me speak about LB710. My name is Linda Carter, L-i-n-d-a C-a-r-t-e-r. I'm the president and CEO of MembersOwn Credit Union. I'm speaking in support of this bill to update the state Credit Union Act. Specifically, I'm speaking about Section 21-1743 geographic field of membership. MembersOwn Credit Union is a $113 million state-chartered credit union, serving 9,000 members in ten counties in southeast Nebraska with offices in Lincoln and Beatrice. We've been a state-chartered financial institution for all of our 87 years. We've appreciated being regulated by the Nebraska's Department of Banking and Finance because of the local control, and we've always felt it's given us more of a voice. And one thing, you know, I've always appreciated that we do pay state taxes and contribute to the state's tax rolls. However, year after year we do, we must use the state's wild card act to continue to do business. An update to the state Credit Union Act will give us parity with federal credit unions, including in the area of our field of membership. The current state Credit Union Act does not address geographical or communities as fields of membership for credit unions, but federal law does, and this bill would codify it then within our state statutes. In 2018, MembersOwn expanded to serve an additional eight counties in southeast Nebraska. When we made application to the Nebraska Department of Banking and Finance, we had to again rely on the parity or wild card provision in state law. The Federal Credit Union Act allows geographic fields of membership, which we already had with serving Lancaster and Gage County. While the state regulators review the federal regulations within that context, by codifying this option within our state act, it will allow for equitable treatment for the state-chartered credit unions. This update would allow our state regulator to make the decision on any update to our field of membership in relation to our geographically defined communities but would recognize what field of membership rights we have and more equitably access future membership requests.

SLAMA: Wow. Thank you.

LINDA CARTER: Thank you.

SLAMA: Thank you, Ms. Carter. Are there any questions from the committee? Senator Jacobson.

JACOBSON: I'm just curious how many Linda Carter's there are.

LINDA CARTER: I, I got upstaged by Ted Carter, the president of the university's wife, who's named Lynda Carter.

JACOBSON: I, I was going to say you're not, you're not the Linda Carter I dealt with, so. Thank you for being here.

LINDA CARTER: Some people call me wonder woman.

SLAMA: Additional questions from the committee? Seeing, seeing none, thank you very much,--

LINDA CARTER: Thank you.

SLAMA: --President Carter. Good afternoon.

ANN LOFTIS: Hi, Chairwoman, Chairwoman Slama, members of the Banking, Commerce and Insurance Committee. My name is Ann Loftis. I'm the president and CEO of First Nebraska Credit Union, a state-chartered credit union. We're the seventh largest credit union in Nebraska with $183 million in assets, five branches in Omaha and Lincoln, and we serve 17,000 members. I'm testifying today in support of LB710. And I also want to thank Senator Dungan for its introduction. LB710 modernizes and updates the state Credit Union Act. I'm focusing my testimony on board flexibility and merger requirements. This bill will enable more flexibility for credit union board meetings by allowing for a reduced number of required meetings for credit unions who have been chartered for more than five years. It will also eliminate a voting requirement from members of the continuing credit union for a merger, a vote which is not required by the NCUA, the federal charter-- or federal regulator. As a credit union member, I strongly support these changes. They would allow credit unions to operate more efficiently and effectively by giving credit union boards, which are volunteers elected by and from the membership, greater flexibility in scheduling meetings. This change would permit them to cancel a meeting if there is no business to be conducted. Credit unions would be required to have at least one meeting per quarter and a minimum of six meetings throughout the year, provided they are not a newly formed credit union. But even with this change, a regulator may require a credit union to hold monthly meetings should they feel it's warranted. Decisions made by the board would still be done in a timely manner based on the schedule of meetings. Furthermore, aligning the voting

requirements for, for a credit union merger with the NCUA guidelines will help eliminate any confusion in having different guidelines and put the state charters on par with federals. Members can still be confident that their interests are being considered because boards from both credit unions would vote on the merger and the merging members would have the opportunity to vote as well. Only the merging credit union members are impacted by the merger due to the conversion of their accounts into a continuing credit union. This change, it, it permits more efficiency in the merger process and a less burden on the continuing credit union, which in the end is a better outcome for members. I urge you all to support these changes and thank you for consideration.

SLAMA: Thank you, Ms. Loftis. First question for you. Could you please spell your name for the record?

ANN LOFTIS: I'm so sorry.

SLAMA: No worries.

ANN LOFTIS: A-n-n L-o-f-t-i-s.

SLAMA: Thank you very much. Questions from the committee? Senator Jacobson.

JACOBSON: Thank you, Chair Slama. Ms. Loftis, I'm just curious, I, I, I don't know that I have any huge objections to that at all, I'm just curious as to why that's in place today and, and what specifically, and I'm thinking now about the board meetings, what's so objectionable about having monthly board meetings or board meetings more often? What's your major, major concern with that?

ANN LOFTIS: Yeah, the-- oh, the objection would be-- well, we-- well, probably our credit union would probably still schedule 12 board meetings, but there's a couple months in the year that there is very little on the agenda that we could put the information out to the board and that would give them some flexibility to do that or in the case where we have meetings scheduled the last Monday of the month and maybe for some reason there was a blizzard, I mean, we do virtual meetings or we couldn't have the board meeting, you know, we would-- there's no flexibility at all, we need to have 12 monthly board meetings regardless. And so it just is to put some flexibility out there for a credit union to be able to do that. But at any time, the regulator could still require you to have monthly meetings. If you were, maybe you're a new charter or you financially need to be, maybe

you aren't running your credit union as well as others, I don't know what they would-- they might see something that they want to have that you-- have you meeting in person or virtually and we do both. We have that available to our board members, so.

JACOBSON: And, and I, I, I appreciate the, the answer, too. I, I mean, it's-- it is a little bit of a catch-22 and I think, you know, there are some safeguards back there. And I think you're correct that-- I think the regulators always want to make sure that they've got the ability to make sure that the board of directors is weighing in, overseeing management operations, and keeping a handle. I assume that you share financial information and so on at your board meetings, but do you serve cookies, though, is the big question or anything like that, any refreshments or--

ANN LOFTIS: It's a-- what's that?

JACOBSON: Do you serve any refreshments at your board meetings?

ANN LOFTIS: Do we serve refreshments? Yeah. Well, not everybody comes but if they come in person, in person they do get some sort of snacks, maybe a light lunch or dinner so that does, that does help them to want to come and to [INAUDIBLE].

JACOBSON: We do lunch just for whatever that's worth. That usually helps.

ANN LOFTIS: It's not alcoholic, though, it's, you know,--

JACOBSON: I, I-- no, I won't--

ANN LOFTIS: --coffee and water and, you know.

JACOBSON: I wasn't going down that.

ANN LOFTIS: OK.

SLAMA: Thank you, Senator Jacobson, for that enlightening line of questioning. Additional committee questions? Seeing none, thank you very much, Ms. Loftis. Good afternoon.

DALE KOVAR: Good afternoon. Thank you, Chairwoman Slama, for this opportunity to testify before the committee. My name is Dale Kovar. That's D-a-l-e K-o-v-a-r. I'm the executive vice president of First Nebraska Credit Union. Thank you for your time and I want to sincerely thank Senator Dungan for the introduction of this particular bill.

First Nebraska Credit Union, as Ann had just mentioned, is $183 million in assets and we serve the 17,000 members that have joined our credit union. Specifically, I'm testifying to the Benefits Pre-Funding Program that is part of the LB710. This would allow the codification of the-- basically, what we're currently doing already in terms of, of having something called corporate-owned life insurance, so on the banking side they refer to it as BOLI, this allows for the credit union to invest in various investments that otherwise they would not be allowed to invest in as a way to earn additional revenues to support some of the benefits programs that we provide, such as for 401k or medical coverage and, and whatnot. It is important to note that for our credit union, we're already investing in COLI. It's something that we got special permission from, from the Department of Banking and other credit unions do as well. Federally chartered credit unions already have that ability to invest in that. There are guardrails in place in terms of the maximum amount that can be invested in any one type of an investment, 15 percent of your net worth or 25 percent total. So with that, I'll open it up to any questions that the, the committee might have.

SLAMA: Thank you very much, Mr. Kovar. Any questions from the committee? Senator Kauth.

KAUTH: Thank you, Chair Slama. I just-- as I'm looking through the bill, the, the term financial, financial technology company, can you give me a description of what that is?

DALE KOVAR: The term you might hear most often are [INAUDIBLE] so they're either going to be the, the apps that you have on your phone that offer mobile banking, for example. In the credit union world, we refer to those as CUSOs or, or credit union service organizations, of which credit unions together might come, might come-- pull funds together to, to just start up a, a, a financial technology company to provide a service that may not already be available in the marketplace today. And that just allows, again, the credit union to make some sort of an investment in that at that point.

KAUTH: Because the bill talks a lot about the, the fact that you can invest in them, but so does that 15 percent or 25 percent apply to the financial [INAUDIBLE]?

DALE KOVAR: Sure, there would be a limit on that as well. Yeah.

KAUTH: Thank you.

SLAMA: Thank you, Senator Kauth. Senator Jacobson.

JACOBSON: Well, I, I think maybe a follow up to that-- I thank you, Chairman Slama. I, I guess my question is, you're talking about Benefits Pre-Funding Program and you're saying you're already allowed to invest in essentially a BOLI type product. So, so what are we really talking about investing in here?

DALE KOVAR: It's-- well, in terms of, of what is listed in, in, in the proposal would just allow the basically putting it in the Credit Union Act as opposed to today where a credit union would have to reach out to the Banking Department to get special permission to, to invest in that. And, actually, we, we had that, that issue a, a couple of years ago where there was some disagreement as to, to whether or not it was an investment that was allowable. And, again, we were looking at the NCUA regulations. It was certainly allowed under NCUA. In Nebraska, we had to get special permission.

JACOBSON: Sure. Well, and, and for the record, I, I don't know that I have any specific concerns at all about BOLI and the guardrails that are, that are with that. I, I guess if we were talking about, you know, invest in, in fintech companies, I'm assuming somebody is going to be lined up to make that testimony, oh, there you go. I do have a couple questions on that. Not necessarily objections, but I got some questions.

DALE KOVAR: Very good.

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, thank you very much.

DALE KOVAR: Thank you for your time.

SLAMA: Good afternoon, Mr. Luetkenhaus.

BRANDON LUETKENHAUS: Good afternoon, Chairman Slama, members of the Banking, Commerce and Insurance Committee. My name is Brandon Luetkenhaus, B-r-a-n-d-o-n L-u-e-t-k-e-n-h-a-u-s, and I'm here on behalf of the Nebraska Credit Union League. You've heard from the credit union testifiers on many of these provisions. I think I'll wait on the financial or the fintech being proposed as a question from, from Senator Jacobson. But just to kind of recap some of this, again, I think what our folks are, are saying here is we have 11 state-chartered credit unions with 45 federal charters. So the state

charter is not as viable as it could potentially be. And so what this aims to do is really codify state statute. Some provisions bring our state-chartered credit unions in par with federals, and then some-- three of these provisions would go beyond what our federals can do today to your question, Senator. Those three, I'm going to point out those three. Virtual board-- virtual annual meetings. So every year our credit unions are required to hold annual meetings of their membership. In COVID 2020-2021, it became very apparent that virtual meetings could be of great benefit, not only to-- especially to those members that maybe don't want to travel, put themselves in harm's way for viruses or other things, but also for folks who may not be able to make it to a specific place but could simply join on virtually and attend their credit union's annual meeting. So to us, that makes a lot of sense. But that would be-- our, our federal charters currently today would not be able to do that. They can hold a hybrid annual meeting where they can have virtual and in-person, but they could not do a fully virtual. And, and honestly, I don't anticipate many, if any, credit unions utilizing virtual ongoing. It would be more of this case-by-case basis. Another one would be the board of directors meetings that Mrs. Loftis was talking about. I think the importance with that provision is to understand that credit union board members are volunteers elected by and from the membership. So they're volunteering their time to serve in this capacity. And when there's cases where maybe there's not much on the agenda and the board would rather not hold the meeting and hold it the next month, I think that makes a lot of sense. I think Ann kind of indicated there that her credit union you would likely do the monthly meetings, maybe miss one if there's not much on the agenda. That's essentially what this would do. Now it would allow credit unions to hold no fewer than six, one per financial quarter. And of course, as Ann said, the department does have the ability to require a board to meet if the department deems that to be necessary. The other one would be the fintech provision and we'll, we'll get in on that. But that, that provision would allow for 5 percent investment into a fintech by an a credit union. But there are guardrails with that, of course, as you see in the bill. Couple other things I want to mention, school branches-- Senator Jacobson, you mentioned is this additional authority? Currently-- well, I'll just stop there.

SLAMA: Great. I can't imagine we'll have any questions for you, Mr. Luetkenhaus. Questions from the committee? Senator Jacobson.

JACOBSON: Why don't you finish the last thought here.

BRANDON LUETKENHAUS: All right. Thank you, sir. With school branches, currently, federals can open up school branches, federal credit unions, as well as state, because as Liberty First said they have three school branches. Trius Federal in Kearney area, they have some school branches, Centris has school branches. So there are credit unions that are currently doing it, including state-chartered credit unions. This would simply codify state statute, OK, we're just putting it in state statute. They're already-- it's already being done. The department is already allowing credit unions to do this via the wild card. And the other important thing to understand is we talk a lot about, a lot about financial literacy amongst the youth and, and even adults. And to get this kind of habitual savings started when you're young, it is so very important. And whether it is operated by a bank or a credit union or whoever, it's important for students who are financially vulnerable, especially when they're not getting this type of education or, or have it started at home that perhaps they can get that ability in their school. And so I like when I hear that credit unions are opening up branches in these low-income areas. I think that's extremely important and I know many banks are as well.

JACOBSON: Thank you. I, I-- maybe a couple of additional questions. Amazingly, so, I, I mean, you and I are probably on the same page on several of your issues. I, I don't necessarily have issues with virtual meetings, particularly if you've got individual members that can't be at a member meeting being able to call in or be there virtually unless the director is concerned about the health of the particular credit union. I don't know if that gives me a lot of indigestion. On the directors, number of directors' meetings kind of the same thing. You talk about their volunteers. Do, do you pay directors' fees, do most credit unions pay a director's fee?

BRANDON LUETKENHAUS: They do not. They, they have the ability to pay the treasurer but most credit unions do not pay the treasurer,--

JACOBSON: They're voluntary.

BRANDON LUETKENHAUS: --most of the time they're all voluntary.

JACOBSON: Other than maybe at First Nebraska, I think, did I understand they do alcohol there or is that just a--

BRANDON LUETKENHAUS: I didn't-- I heard--

JACOBSON: I, I didn't know.

BRANDON LUETKENHAUS: --coffee.

JACOBSON: Oh, coffee. All right.

BRANDON LUETKENHAUS: Yeah.

JACOBSON: OK.

BRANDON LUETKENHAUS: And probably the cheapest coffee.

JACOBSON: Thank you. Thank you. So tell me a little bit specifically in fintech, what, what, what do you, what do you have in mind there?

BRANDON LUETKENHAUS: So we know and I think, Senator Jacobson, you know as well, in the banking sector, fintech is becoming very, very important. And not only they can be a disruptor in, in ways, but they can also be a partner in helping financial institutions to deliver services to their members. And so this provision would allow credit used to invest up to 5 percent. There are guardrails. The credit union would have to be well capitalized at the time in the investment. When they take the investment off or as they invest in this company, throughout that investment they have to remain well capitalized. And, and the department would have oversight of both the department and they could have requirements on these fintech companies. So there are, there are quite a, quite a few guardrails there. But what we're talking about might be-- so, for instance, I just learned about a fintech recently that deals with AI and the AI allows credit unions to, in a more efficient and better way, to learn the behavior, the behaviors of their members to determine, you know, are these folks going to pay the credit union back? I mean, credit unions are not for profit, but they're not charity. And so it's important that when they lend their members' money out that the member will pay back that money to the other members. And so this, this company, for instance, that could be a potential one that they might invest in. Now I, I don't know that that company would be taking investments, but nonetheless, it could be something similar to that or it could be online banking or it could be any kind of underwriting fintech company. But the other important thing about that is the fintech company must be in the business of providing financial services that the credit union can or is using for their members.

JACOBSON: Thank you. And I think to that point, so to confirm you are asking the borrowers to pay the loans back?

BRANDON LUETKENHAUS: We do ask that.

JACOBSON: We have that in common. I want you aware of that. Well, here's probably my main concern, it probably isn't much, I mean, a

little bit the actual investment in fintech because we can access fintech companies without being an investor. My biggest concern probably comes back to you're talking 5 percent of your capital or 5 percent of capital or 5 percent of assets or what, what's your, what would be your limitation?

BRANDON LUETKENHAUS: It would be-- I think it's net worth in the, in the bill. I'd have to double-check.

JACOBSON: OK. OK. And, and, and I guess to me an equity ownership is a little bit different than being a member are being able to utilize that particular service. You know, I'm, I'm not, I'm not necessarily opposed, I guess I'm just, I'm, I'm kind of one of those that you walk before you run. And, you know, I think banks are dealing with the same question mark out there. And obviously here more recently, some fintech companies having done real well and so it's really a question of should we be out there in the equity business in fintechs or should we be observing from the outside or using it through a holding company or some other avenue? So, so I, I appreciate that and I just, I'm just trying to understand more about what you're looking for there. You know, I'd like to try to find common ground where we can and I think there's a lot of aspects of this bill. There's only parts of this bill I hate, you know, but for the most part I'm, I'm kind of thinking some of it's OK.

BRANDON LUETKENHAUS: Well, there's nothing in this bill that I hate.

JACOBSON: Yeah, I didn't think so.

BRANDON LUETKENHAUS: But it is 5 percent of net worth, Senator, according to the bill.

JACOBSON: Yeah. Thank you. Appreciate it.

BRANDON LUETKENHAUS: Yep.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Senator Bostar.

BOSTAR: Thank you, Chair Slama. Thank you, sir, for being here. Just briefly, you know, it seems like from the testimony that, you know, yours and, and what preceded you, is it, is it fair to say that we're getting to a point where state-chartered credit unions are going to be probably converting if we can't accomplish some of the things that are being requested, converting to a national charter?

BRANDON LUETKENHAUS: I think the state runs the risk of that. I think a lot of this, as we, as we've talked about, there's only three provisions in here that federal charters don't have the ability to do. And I can't remember which testifier mentioned the parity or wild card provision that this committee passes every year and it's very, very important for both banks and credit unions. The wild card or parity provision is not introduced every year. It's introduced to be, to be in effect while the Legislature cannot act. And so if the federal government does something positive for banks or credit unions or both, the wild card can take care of that while you all are in interim and not here able to act on those updates. But when the Legislature returns, the idea is to then update the statutes. That's what much of this is, is updating the statutes to look like what the federal credit unions can already do and what our credit unions already do via the wild card or parity provision. So it's important that this state make a statement because, I mean, honestly, if I'm a federal credit union and I look at the state act and it's just doesn't have these obvious updates, it would make you, it would, it would cause you pause to say do I want to really consider the state charter when we can't get these what would essentially be obvious updates?

BOSTAR: So, I mean, I, I certainly don't want to, you know, I don't want to reach a point where we're, we're losing all of our state-chartered credit unions and, and, you know, and I, I get that there's a risk. So I suppose the question to you is, I mean, I'm not sure that this entire bill is something that could get done. But do you, you know, do you think that you would be able with your, with your credit union members to work with folks on the committee to try to find some of the provisions within the bill that we can identify that we could maybe move forward on, that way we're not really jeopardizing the complete abandonment of all state-chartered credit unions?

BRANDON LUETKENHAUS: Absolutely. I mean, we are always more than welcome to work with this committee and whoever. I mean, honestly, I've talked to the Bankers Association about this bill as well and there's a provision that maybe they're interested in at some point. Could be now and I've talked to Senator Dungan about that specific issue and we'd be happy to amend that onto this bill to help them as well. We're very amenable to things. You know, we just want to get things done that is right for credit unions and their members and make sense to the state.

BOSTAR: Thank you very much.

BRANDON LUETKENHAUS: Thank you.

SLAMA: Thank you, Senator Bostar. Additional questions from the committee? Seeing none, thank you very much, Mr. Luetkenhaus.

BRANDON LUETKENHAUS: Thank you.

SLAMA: Additional proponent testimony for LB710? Seeing none, we'll now open it up for opposition testimony for LB710. And if you are planning to testify in opposition, please come up towards the front. Save us some transition time. Good afternoon.

BOB HALLSTROM: Good afternoon, Chairman Slama, members of the committee. My name is Bob Hallstrom, H-a-l-l-s-t-r-o-m, appear before you today as registered lobbyist for the Nebraska Bankers Association in opposition to LB710. I'll start my testimony by indicating that we have, in fact, visited with Senator Dungan, indicated the areas in which we object or are opposed to the bill as introduced, as well as some of the provisions that we do not take exception to. We've also shared that with the Credit Union League as well. And while we do have a number of concerns, what I'll focus on today are two primary objections. The first one has to do with the in-school branching. Certainly, we support in-school branching activity by banks. I think there's over 25 banks in the state of Nebraska that are currently having branches in the schools. But we have some legal concerns. The first one is whether you're a state- or federally chartered credit union, if the program is structured such that the school is the depositor we have a state constitutional prohibition against those entities taking an ownership interest in a private corporation, which is what a deposit in a member share is all about with regard to the credit unions. Second issue, as Senator Jacobson noted, is that if the student itself is the depositor, unless you happen to be a community-chartered credit union, those students would not be eligible to be members of an associational or occupational credit union. The next issue has to do with expanding the community-chartered credit union authority under state law. It is correct and accurate that the wild card has been used on occasion to allow community-chartered credit unions to be established or to be expanded at the state level. However, we have consistently opposed bringing that into state law for this reason, and that is that the standard proposed under LB710 is different than the standard on the federal level, both in terms of its actual statutory language and the fact that there are regulations and policies of the NCUA that further, at least on their face, if not on their application, are designed to further restrict the ability. The language in the Nebraska statute is somewhat similar to that of Iowa

law, which limits credit union community charters to geographic boundaries. That language has been used to allow two credit unions, Cobalt and Veridian, out of Iowa to make inroads and establish operations in the state of Nebraska. And so for those reasons, we would oppose what Mr. Luetkenhaus was referring to in terms of something that the banks might be interested in, we need to canvas our bankers to see if they, too, would be interested in removing the branch hearing and notice requirements for branch applications. And if we are, we would certainly come back next year either as part of this bill if it's to move forward in any respect as Senator Bostar suggested might be available or otherwise.

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

BOB HALLSTROM: Thank you.

SLAMA: Good afternoon.

BRIAN MORROW: Good afternoon, Chair Slama, members of the committee. My name is Brian Morrow, B-r-i-a-n M-o-r-r-o-w. I'm chief risk officer and vice president of Pinnacle Bancorp. I'm here to testify in opposition of LB710 on behalf of the Nebraska Independent Community Bankers. Thanks to Nebraska community banks, our state has an unbanked rate of just 3 percent, well below the national average of 4.5, which puts us in the top quarter of states according to the FDIC. Additionally, according to the FDIC, Nebraskans on average seek out payday loans or other type of high-interest, short-term financing, far less than citizens of other states, which again speaks to the presence and strength, strength of our community banks and their ability to serve Nebraskans' financial needs. I mention this as a preference of our opposition of LB710, which would expand credit union membership requirements because it is evident there is no financial need in the state that this expansion would address. To be clear, there are pieces of LB710 that we have no opinion on, such as updates to allow electric notice to the department and allowance of virtual board meetings and such. However, there are pieces like membership criteria expansion that we do oppose. Current state law in LB710 is clear that credit union members are to have some sort of association with each other, specifically occupation or education. We believe expanding membership allowance to persons or organizations within a geographic community goes beyond the intent and, as drafted, would allow credit unions to now open to all small businesses in the community without regard to common connection or association. Additionally, we find language of LB710 authorizing credit unions to invest in financial technology

companies a bit concerning due the fact there is no requirement that a financial technology company must offer a product or service that is beneficial to the credit union's membership. LB710 would allow credit unions to invest up to 5 percent of capital in shares of fintech companies. It's unclear to us if this is 5 percent in aggregate capital or per company. Regardless, it's our opinion this doesn't align with safe and sound risk management. Federal banking regulations, with a few exceptions, prohibit banks from investing in stocks or shares of other companies. These restrict-- restrictions exist to minimize the risk of the balance sheet and protect depositors to name a few. Finally, we strongly oppose the very last two lines of LB710 that attempts to repeal the 18 percent cap on loan interest rates that the state credit unions are authorized to assess. We would point out to the committee that the federal credit unions attempted earlier this year to raise the 18 percent cap but were denied by the National Credit Union Administration. We appreciate the opportunity to express our opposition to LB710. We would ask the committee not advance the bill any further. I want to thank you for your time and I'm happy to answer any questions the committee might have.

SLAMA: Thank you, Mr. Morrow. Are there any questions from the committee? Seeing none, thank you very much.

BRIAN MORROW: Yeah.

SLAMA: Additional opponent testimony for LB710? Seeing none, we'll now open it up for neutral testimony on LB710. Good afternoon.

TAG HERBEK: Chairperson Slama, members of the Banking, Commerce and Insurance Committee, my name is Tag Herbek, T-a-g H-e-r-b-e-k. I am financial institutions counsel for the Nebraska Department of Banking and Finance. I'm appearing today on behalf of the department in a neutral position regarding LB710. Director Lammers' schedule didn't allow him to be here today. He is off growing Nebraska. The Nebraska Department of Banking and Finance enforces the Credit-- Nebraska Credit Union Act, which is updated and amended by LB710. The Nebraska Credit Union League brought this proposal to the department prior to its introduction. We appreciate the League's consideration of our comments. LB710 impacts our 11 state-chartered credit unions. It will have no effect on the 45 federally chartered credit unions located in Nebraska. Section 5 of the bill proposes, proposes amendments to the credit union branching statute. First, state-chartered credit unions would be authorized to establish student savings programs at schools that have students in a community where the credit union has an office. Currently, there are over 50 Nebraska schools participating

with financial institutions to offer these programs, which teach young people how to save and the basics of managing money. The department has been a consistent supporter of school savings programs as part of its financial literacy efforts and believes that increasing the potential number of participating institutions and students can only benefit the future of the state. Also, in Section 5 the bill attempts to remove the ability of the department to hold hearings in connection with credit union branch applications and when a credit union proposes to change its bylaws or articles of association. For branch applications, current law provides for an administrative hearing if the director determines it is warranted by the credit union's financial condition. If the condition does not warrant a hearing, the department is required to publish a notice in the county where the branch is located. If a substantive objection is filed with the department, a hearing is scheduled. LB710 would remove both the discretionary authority of the director and the publication requirements. As described in our fiscal note, these provisions have been used sparingly, as there have only been four applications for credit union branch offices in 2012 in all-- since 2012. In all of those cases, the publication only route was used. There were no objections and no hearings were held. We believe the provisions should be retained as they could be a valuable tool in fully exploring an applicant that may not be in the strongest financial condition and because the notice, the notice promotes transparency. The department also believes hearing provisions should be retained for possible bylaw and article of amendment changes as it is beneficial for the department to gain as much knowledge as possible in order to make an informed decision. American administrative law is built upon the premise that all persons potentially affected by a government action should be able to voice concerns in an accessible form. Therefore, removing hearing opportunities may work to the detriment of all participants involved. LB7-- I guess I'll stop there.

SLAMA: Mr. Herbek, you may finish your very last thought there.

TAG HERBEK: All right. LB710 would authorize well-capitalized credit unions to invest in financial technology companies. It appears sufficient safeguards will be put in place for this type of investment, such as a cap on the investment and a contractual limitation on liability. As set out in our fiscal note, this addition to the Credit Union Act could add procedures-- could add procedures and time to department examinations. Any additional time would vary based on each investing institution and would be billed to the credit union.

SLAMA: Thank you, Mr. Herbek.

TAG HERBEK: Thank you and I'll take any questions.

SLAMA: I appreciate your respect of the red light.

TAG HERBEK: I saw that light.

SLAMA: Questions from the committee? Senator Bostar.

BOSTAR: Thank you, Chair Slama. Thank you, sir, for being here. Could you speak more to the geographic provisions that you were speaking about? Could you just expand upon that?

TAG HERBEK: In-- I mean, this would basically, would basically codify what's already available through the wild card. I mean, that's pretty much it.

BOSTAR: OK. Thank you.

SLAMA: Thank you, Senator Bostar. Additional questions from the committee? Seeing none, thank you very much. Additional neutral testimony on LB710? Good afternoon.

JENNIFER DAVIDSON: Good afternoon, Chairwoman Slama, members of the committee. I'm Dr. Jennifer Davidson, J-e-n-n-i-f-e-r D-a-v-i-d-s-o-n. I wear two hats at the University of Nebraska-Lincoln. I'm an economics professor and I'm president of the Nebraska Council on Economic Education, which is a separate nonprofit housed at the College of Business. The in-school savings programs, the school branches we've been talking about today are one of our signature programs. I'm also the author of the research study on in-school savings programs cited earlier by Ms. Schreiner in her statement today. So I'm here to comment on provision 21-1725.01, paragraph (3) of LB710 and no other part of LB710. I'm here to provide additional information on the research on the programs. I brought copies of the published articles for each of you. The results of the long-term study of Nebraska's in-school savings programs show that in-school saving program participants compared with nonparticipants are more likely to have a bank account in high school and to have opened that account before attending high school. Further results show that students with bank accounts are more likely to save regularly, indicating that participation in the program contributes indirectly to saving regularly through its direct influence on getting students to open a bank account and to open it early. This type of hands-on experience, rather than reading or talking about a subject, is a very effective

education strategy. These in-school savings programs fit squarely and support the Nebraska social studies standards. In kindergarten, students will recognize money is used to purchase goods and services and satisfy economic wants and needs. In first grade, students will compare spending and savings opportunities. In second grade, students will demonstrate knowledge of currency, its denominations, and use. And third grade, students will evaluate choices and consequences for spending and savings. And in fourth grade, students will investigate various financial institutions in Nebraska and the reasons for people spending and savings choices. Given all the positive outcomes from the in-school savings programs, we need more of them. We need all Nebraska students to have an opportunity to participate and get this type of real-life, hands-on banking and savings experience. There are roughly 560 elementary schools in Nebraska. We currently have 50 programs. We need more partners, not less. We need more financial literacy, not less. With that, I will conclude. I thank you for your time today. I'm happy to answer any questions you have.

SLAMA: Thank you, Dr. Davidson. And as a student who benefited in high school, both from your work in K-12 education and in your work with FBLA, thank you very much for that and for being here today.

JENNIFER DAVIDSON: You bet. Thank you.

SLAMA: Questions from the committee? Senator Kauth.

KAUTH: Thank you, Chair Slama. Do you teach them how to use cash, like counting back change and things like that--

JENNIFER DAVIDSON: Yes, absolutely.

KAUTH: --and actual cash--

JENNIFER DAVIDSON: Yes.

KAUTH: --as well as-- well, the Monopoly, the Monopoly games now don't use cash they use credit cards so I just wondered if you were, if you ever do that?

JENNIFER DAVIDSON: Yep, let me state this is a, a cash bank, students are bringing cash from home. It is real cash.

KAUTH: Thank you.

JENNIFER DAVIDSON: It's money that they've saved, earned, did extra chores. It is real money.

KAUTH: Awesome. Thank you.

SLAMA: Thank you, Senator Kauth. Senator Ballard.

BALLARD: Thank you, Chair Slama. Thank you for being here. What other barriers do you see for participation? Is it just sponsors [INAUDIBLE]?

JENNIFER DAVIDSON: It is, it is a big undertaking for the financial institution. And it's a, you have to have a commitment from the school. So you really, you really do need this perfect storm of everybody on board to move forward as we hold the, the hands of the school and the, the financial institution. It's a six month to a yearlong planning process. When I'm talking to them about it, I'm talking it's a marriage, it's not a date.

BALLARD: Thank you.

SLAMA: Thank you, Senator Ballard. Senator Jacobson. No? Oh, OK.

JACOBSON: Yes, yes, yes.

SLAMA: Oh, yes. Got it.

JACOBSON: Oh, yes. And there's a question in here, too.

SLAMA: Oh, boy.

JACOBSON: Thank you for your testimony. I appreciate, I really appreciate the fact you're asking them to open bank accounts so that, that really is music to my ears. But I guess I would just concur with your presentation that we do need more and, and more are coming. And not only do we need it at these lower levels, but we really need-- I know the Bankers Association has promoted financial literacy really at that higher level. My bank is very actively involved in doing NebraskaLand University, which is a training of that these juniors and seniors in high school are getting before they go off to college. Probably the one thing we hear more than anything is I wished I had learned, I'd have had this training two or three years earlier, so I couldn't agree with you more about the need for financial literacy. I just think my only concern is we got to do it right and we got to keep-- make sure we're all staying in our lanes. But, but yes, I think we're going to continue to see that expand significantly. So thank you.

JENNIFER DAVIDSON: Wonderful.

SLAMA: Thank you, Senator Jacobson.

JACOBSON: Was there a ques--

von GILLERN: No, there was not.

JACOBSON: No, there wasn't a question. Your name is not Linda Carter, though, right?

JENNIFER DAVIDSON: No, it's not.

JACOBSON: All right.

SLAMA: There's a question.

JACOBSON: There's a question.

SLAMA: Additional questions? Senator von Gillern.

von GILLERN: Yes. Thank you, Senator Slama. Thanks for being here today. Quick question. The-- and I'm not asking for school district names, are, are your, most of your 50 programs, are they large districts, small districts, urban, rural?

JENNIFER DAVIDSON: Yes.

von GILLERN: All of those?

JENNIFER DAVIDSON: Yes.

von GILLERN: Oh, fantastic. OK. All right. And what is the biggest, I think, to the, to the question that Senator Ballard, what's the biggest challenge you have getting into those school districts?

JENNIFER DAVIDSON: Truly, the biggest is commitment, realizing that it's long term. They need a person at the school that's going to shepherd that program. And then the other current inhibitor is my time to shepherd the many that are-- we opened 14 this year which is unheard of.

von GILLERN: Very good. Thank you.

SLAMA: Thank you, Senator von Gillern. Additional questions from the committee? Seeing none, thank you very much, Dr. Davidson. Good afternoon.

STEVE EDGERTON: Good afternoon, Chairwoman Slama and members the Banking, Commerce and Insurance Committee. My name is Steve Edgerton, S-t-e-v-e E-d-g-e-r-t-o-n, government affairs officer with Centris Federal Credit Union. So I wanted you to, to catch that because I guess this is the contrast. We're a federal credit union that currently serves a portion of the Omaha/Council Bluffs MSA. The counties we serve in that currently are Douglas, Sarpy, Pottawattamie, and Iowa. Additionally, we serve Lincoln County. That includes North Platte. And that was a result of a merger with a telephone credit union some, may actually be 40 years ago, I think I said 30 in here. Lincoln County at that time when we became community based in 2000 was classified as an underserved area and so we were granted that county, which helps keep that branch going. We added McPherson County as a result of a requested merger by a regulator in 2018. We still have that office open. Tryon, Nebraska, has 107 people, but we're keeping it going three, three days a week. We also have a branch in Grand Island that was a result of a requested merger by a regulator also. When we became community charter, we were grandfathered ten small employee groups that that credit union had, but we did not get community base for Hall County as example. We've managed to keep that office going. It's about $25 million in assets, but it doesn't grow a whole lot but we're certain in the existing base it had. At year-end 2022, we had $1.2 billion in assets; 49,000 and, and a, a few extra loans for $992 million, that puts the average loan under $20,000; member deposits of $918 million, average per member was $7,275 for the 126,000 members we have. We have 289 full-time employees and 23 part-time. Two branches, we have a branch, one in North Platte, one in Grand Island, Tryon as I mentioned. We have two branches in "Pott" in Iowa and ten in Douglas and Sarpy. I'm testifying in neutral capacity. As any business, we continually monitor the difference between state and federal regulations, rules, statutes, etcetera. And, and I've been asked in the past and, and done the studies for our credit union, are there some advantages to be a state-chartered credit union? LB710 goes a long way in, in starting to get that, but what I can tell you is it's more advantageous for us to be a federal credit union today. So we hope that the state continues to progress. I think the biggest issue that people would say is, well, it's the tax issue. And I will tell you, the franchise tax, the deposit's tax, and sales tax, when we do our analysis that's the biggest part and that's 15 full-time employee equivalents. So with, with that, I'll answer any questions.

SLAMA: Thank you very much, Mr. Edgerton. Are there any questions from the committee? Seeing none, thank you very much. All right. Additional neutral testimony on LB710? Seeing none, Senator Dungan, you're

welcome to close. And as you approach, for the record we had two proponent letters for the record on LB710.

DUNGAN: Thank you, colleagues. It's a long day, I know we have a lot of other bills, I won't take a lot of time. I appreciate all the testimony we've had here today, both from the proponents and the opponents and the neutral. I think the through line that's evident is that we have a number of state-chartered credit unions who want to stay state chartered. One of the things we talked about a lot as a committee is ways to encourage state-chartered banks. I've understood more and more as I've been a member of this community the importance of keeping entities state chartered. I think it's good for our state. It's good for the people in Nebraska. It keeps the money in the state. So I, I think what this really does is it seeks to incentivize or encourage the credit unions that are currently state chartered to remain state chartered. And I would hope that down the road, respectfully to Mr. Edgerton, we could see more of the federal credit union state charter. I think that's going to be good for us as a state. I understand there's a lot of different competing interests here. Mr. Hallstrom is correct, we did talk multiple times prior to today's hearing. We're going to continue to talk. My hope is that moving forward we can, as we've indicated, come up with some consensus items on here. I think Senator Bostar hit the nail on the head, though, that it's important that we try to come up with the things in here that are good for everybody. I would encourage you all to take a look at that handout that was received with the breakdown of the legislation from the Nebraska Credit Union League. I think that does a very good job of going through issue by issue and talking about what the modifications are and the reason for the changes. If anybody has any questions and wants to speak with me more about that, I'm happy to have conversations with everyone, but I just hope we can come to some consensus here and do what we can to encourage further state charters. With that, I'd urge your support of LB710 and I'm happy to answer any other questions.

SLAMA: Thank you, Senator Dungan. Are there any questions from the committee? Seeing none, thank you very much.

DUNGAN: Thank you.

SLAMA: This brings to a close our hearing on LB710 and we'll give the room a moment to turn over before we open our hearing on LB778. Senator Bostar.

JACOBSON: OK, well, we're going to keep moving. We'll move on to opening the hearing on LB778 and, Senator Bostar, the floor is yours.

BOSTAR: Good afternoon, fellow members of the Banking, Commerce and Insurance Committee. For the record, I'm Eliot Bostar. That's E-l-i-o-t B-o-s-t-a-r, representing Legislative District 29, here today to present LB778. Following the passage of LB767 last year and prior to its January 1, 2023 effective date, Nebraska pharmacists, Nebraska pharmacists learned that the Department of Insurance, based on the definition of a health benefit plan health carrier contained within LB767 adopted a narrow interpretation of the scope of PBMs covered by the act. Specifically, the Department indicated that LB767 did not apply to employer-sponsored plans, insured or self-funded or to the Medicaid program. To address the narrow Department of Insurance interpretation, LB778 would clarify the definition of health benefit plan under the act to ensure it applies to employer-sponsored plans, whether insured or self-funded, and to the medical assistance program. A lot of time was spent and numerous meetings were held involving representatives of PBMs and provider groups prior to reaching consensus on the provisions of LB767 to authorize the Department of Insurance to regulate PBMs. It was the clear intent of all parties involved in the negotiation of the final version of LB767 to apply to all PBMs providing services to healthcare plans, including employer-sponsored plans, whether insured or self-funded. LB778 also addresses the several other aspects of the PBM business practice. Section 3 would extend the appeal, investigation, and dispute resolution process to reimbursement for a specific drug or drugs made under a maximum allowable cost price at below the pharmacy acquisition cost. The bill would also require PBMs to pay pharmacies a fair price on medications they dispense to patients. Pharmacies are receiving insufficient reimbursements while PBMs are posting record earnings. The dollars generated for rebates, audits, and below-cost reimbursements are not being passed along to the patient or the pharmacy. Section 4 of LB778 prohibits PBMs from requiring credentialing that is more stringent than what the state requires for pharmacy licensure as a condition to-- as a condition to participating in a PBM pharmacy network. Prior to the passage of LB767, PBMs imposed more stringent credentialing requirements for participation in a specialty pharmacy network. While, while LB767 address the specialty pharmacy network issue LB778 proactively prohibits similar action for other PBM pharmacy network activities. Section 5 would prohibit PBMs from steering beneficiaries to use pharmacies directly or indirectly owned by the PBMs and from paying network pharmacies less than the amount of reimbursement provided to PBM affiliated pharmacies. These

practices steer pharmacy customers away from their local pharmacy to a more costly, out-of-state PBM affiliated mail order pharmacy. Section 6 of LB778 imposes a fiduciary good faith and fair dealing requirement for PBMs. PBMs have faced state regulatory scrutiny and pharmacy lawsuits because as a result of their position in the market, they have an opportunity to retain rebates and discounts rather than passing savings on to consumers for health plans. These practices can create a conflict of interest for PBMs in dealing with pharmacies, health plan sponsors, and pharmacy patients, and may result in higher drug prices for patients and lower reimbursements for pharmacies. The duty of care established for PBMs under LB778 would in the event of a conflict between the parties served by the PBM provide that the duty of care runs first to covered persons, next to providers, and finally to health benefit plans. Finally, Section 7 would prohibit utilization of a spread-pricing model by PBMs and would require a PBM to disclose to health plans that spread pricing is not authorized under Nebraska law. Spread pricing increases the profits of PBMs to the detriment of health benefit plans, providers, and their patients. While the PBMs will likely charge an administrative fee if spread pricing is eliminated, the administrative fee would be preferable to the continuation of PBM spread-pricing practices. In a spread-pricing model, the PBM keeps a portion of the amount or spread between what the health plan pays to the PBM and the amount that the PBM reimburses the pharmacy for a patient's prescription. With that, I thank you for your time. Encourage you to support LB778. Be happy to answer any questions you might have. I will also note that there will be a number of individuals that they are eager to tell you more about all of the provisions I've outlined.

JACOBSON: We're, we're getting that sense. Thank you, Senator Bostar. Questions for Senator Bostar from the committee? OK. Seeing none, thank you. I assume you're going to-- well, of course, you're going to close.

BOSTAR: I'll stay to close.

JACOBSON: Sure you will. We'll ask for proponents. Are there any proponents?

MARCIA MUETING: Good afternoon.

JACOBSON: Good afternoon.

MARCIA MUETING: Members of the Banking, Commerce and Insurance Committee, my name is Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g. I'm

a pharmacist and the CEO of the Nebraska Pharmacists Association, as well as a registered lobbyist. I offer our support for LB778 and thank Senator Bostar for introducing this legislation. As a bit of a background, when pharmacies began submitting claims electronically for prescriptions, PBMs were an important partner. PBMs were positioned as the conduit between the pharmacy and an insurance company for prescription claims. Prescription claim data submission was standardized, such that all PBMs use the same format for the data. When a pharmacy submits a claim electronically, it receives a message from the PBM within seconds to confirm that the patient is eligible covered, that the medication is covered, and what the patient's cost is, as well as the amount the pharmacy will be reimbursed or the pharmacy receives a rejection message. This instant adjudication of a claim was the original purpose of a PBM. PBMs collected a fee for the service from the insurance, insurance company. Over the last 30 years, however, the role of PBMs has ballooned to much more than processing pharmacy claims. What is more interesting is that 80 percent of the prescription claims processed in the United States are handled by three PBMs. Even more interesting, many insurance companies own their own PBM, and the top three PBMs in the United States are listed as Fortune 15 companies. Now PBMs collect rebates from drug manufacturers, they conduct predatory audits which have become a profit center, reimburse pharmacies at below-cost rates, and offer contracts to pharmacies which are not negotiable. Pharmacies are receiving underwater reimbursements and PBMs are posting record earnings. The dollar, dollars generated from rebates, audits, and below-cost reimbursements are not being passed along to the patient. Since 2019, over 30 pharmacies have closed their doors in Nebraska alone. Many of these are in rural areas. It's time for Nebraska to regulate PBMs and this bill is the first step to preserve patient care for, for patients in Nebraska pharmacies. We have lined up a number of speakers who are passionate about providing care to patients. They are pharmacists who want to share their real-life stories about how PBM practices have impacted their patients and businesses. Thank you for the opportunity to testify. I'm happy to address any questions.

JACOBSON: Thank you much, very much for your testimony.

MARCIA MUETING: Sure.

JACOBSON: Questions from the committee? Yes, Senator von Gillern.

von GILLERN: Good afternoon. Thanks for being here today.

MARCIA MUETING: Of course.

von GILLERN: Just a couple of quick questions. As I'm reading through the Statement of Intent, there's a couple of comments about this would protect pharmacies from being paid below their cost of acquisition and prohibits a pharmacy or PBM from reimbursing an amount less than the amount due or the amount the Pharmacy Benefit Manager reimburses a plan affiliate for the same pharmacist services. Is there not-- and I think it's the pure capitalist coming out in me-- is there not a little bit of risk to every business? To, to me, every-- to me, in a, a business you, you commit to providing a service or a product and you commit to a price and then how you acquire it is not the consumer's concern. This seems to take all the risk out of the, the pharmacist in that they can-- in that they are certain that, that they will, that they can purchase these products and sell them for a profit, which is their business, there's no bad in that, but that seems to eliminate any risk. Am I reading that correctly or--

MARCIA MUETING: I agree with what you're saying. However, would you sign a contract if you don't know what the cost you'll be reimbursed at will be? Would you sign a contract?

von GILLERN: A cost that you would be reimbursed--

MARCIA MUETING: The, the cost isn't transparent to you, what you would be reimbursed for the cost of goods.

von GILLERN: Well, I, I did that for a long time.

MARCIA MUETING: But that's the question, that's the question--

von GILLERN: In the construction industry, yeah, I, I did because you, you couldn't quantify necessarily what future costs would be so you made your best guess effort and we took a lot of risks.

MARCIA MUETING: Yeah, and it's not future costs, it's current costs. You know, we have some, we have contracts that set prices, there's no negotiating, and if the cost is below your cost you eat it. And I think that's why there's a lot of folks here that are-- their, their, their family businesses relied on fairness in reimbursement. And you can only fill so many prescriptions at a loss before the profit-- before the business is no longer profitable.

von GILLERN: I'll listen to the, to the other testimonies, maybe the--

MARCIA MUETING: Yeah.

von GILLERN: --the, the key to this is the reimbursement process and the timing on that and maybe I'll have a better understanding of that as--

MARCIA MUETING: I think it is. One of--

von GILLERN: --testimony continues.

MARCIA MUETING: --one of the provisions, in particular, if you're not familiar with prescription pricing, maximum allowable cost is an average cost for the reimbursement of generic drugs. And if the, the proprietary calculation of the cost of a generic drug from a company, a large company, which you cannot negotiate with, is below your cost or below the cost you can purchase it at, do you turn those patients away? That's a question. But, yeah, I'm certain I have no doubt that the folks behind me are going to be able to elaborate a little bit more.

von GILLERN: Thank you.

SLAMA: Thank you, Senator von Gillern. Additional questions from the committee? Seeing none, thank you very much.

MARCIA MUETING: Thank you.

SLAMA: Good afternoon.

BRENT GOLLNER: Good afternoon, Senator Slama. Glad to see you came back because I have you as my introduction.

SLAMA: Fantastic.

BRENT GOLLNER: Senator Slama and members of the Banking, Commerce and Insurance Committee, thank you for allowing me the opportunity to testify this afternoon on LB778. My name is Brent Gollner, B-r-e-n-t G-o-l-l-n-e-r. As a pharmacist and owner of Keith's Drive-In Drugs in Hastings, Nebraska, I feel it's imperative that committee members hear about the role of Pharmacy Benefit Managers and the relationship that they play in the landscape of pharmacy in Nebraska today. First, I need to explain a little bit more on what Marcia said. PBMs have a role that they play in our healthcare system, obviously. PBMs were created as middlemen to reduce administrative costs for insurers, validate patient eligibility, administer plan benefits, and to negotiate costs between individual pharmacies and health plans. Sounds like a win for all of us, but PBMs have been allowed to consolidate into a system that now the top three PBMs control almost 80 percent of

the prescription drug market. In addition to each of these PBMs, most of them have a mail order component that competes directly with Nebraska's very own pharmacies. This vertical integration and lack of transparency have led many states to enact PBM legislation very similar to what we have today to address these egregious business practices and level the playing field for pharmacists and patients. The PBMs will argue that they're saving patients money and that if this legislation passes, premiums for businesses and patients will increase. An analysis done by the National Community Pharmacists Association, based on data from the Kaiser Family Foundation, has found that meaningful PBM reform in states that have enacted it can actually decrease premiums for patients and businesses in our state. PBMs have tremendous control over patients prescription drug benefits. They design formularies and provider networks, giving them outsized influence over the medications and pharmacies that patients may choose. PBMs and their desire to steer patients to their own mail order pharmacies are responsible for the rising cost of prescription drug benefit costs. Limiting these conflicts of interest helps patients by empowering them to make healthcare decisions for themselves, decreasing their out-of-pocket costs, and protecting access to community pharmacies in rural areas throughout our state, all without raising health insurance premiums. Meaningful PBM legislation ensures that patients have access to medications prescribed by their doctors and dispensed by the pharmacy of their choice. Thank you for your opportunity this afternoon. Any questions?

SLAMA: Thank you very much--

BRENT GOLLNER: Yes.

SLAMA: --and I was very glad to make it back for your introduction.

BRENT GOLLNER: I'm glad you were too.

SLAMA: Questions from the committee? Senator Jacobson.

JACOBSON: Thank you, Chair Slama. I guess if you could maybe-- I know I've, I've spent some time really studying this whole PBM issue and I know there's several fronts and, and I appreciate Senator von Gillern's questions because this can be a little complicated and-- but if you were going to pick out the one biggest problem that you see with PBMs, what would that be?

BRENT GOLLNER: Probably the vertical integration that's occurred. As Marcia mentioned, many of the insurers own their own PBM. And even

though they tell you they're not going to steer patients, I have had patients on numerous occasions come in and say I've been called saying you can save two months worth of prescription co-pay, for instance, by using our pharmacy mail order as opposed to going to your local pharmacy. That's probably the hardest thing that pharmacists are dealing with today and the pricing aspect of it, I think, that you mentioned earlier. The things that go on with that where we're paid below cost is extremely difficult when you don't have an opportunity to actually know what your cost-- what they're going to pay you on for a value of a medication. So those would be kind of two big things, I think.

JACOBSON: And, and to that last point, I think most retail pharmacies are buying their, their pharmaceutical supplies through a wholesaler and I presume there's some volume and so on that goes with it. So if I understand this right, the concern that, that most pharmacies would have is that if you're a smaller pharmacy, perhaps can't deal in the volume, if you're not, if you're not able to provide a price that is at the same level or below what, what the, the-- these PBMs could access it through, through their own integrated pharmaceutical partners, then you're going to be back to what was indicated before, you're going to sell at a loss or you're not going to stock that particular drug or turn away the patient and then they have to go somewhere else and you lose them as a patient. Is, is that kind of your sense of how it works?

BRENT GOLLNER: Correct to some degree. Most pharmacies are in an association of groups of pharmacies that they purchase in a buying group, for instance. So our group has about 2,500 members that is in it so I think we can buy fairly close to as low as some of the major chains would. You think of the, the Walgreens, the Walmarts, the CVSs as examples. Most of those are affiliated with an insurance company, so they have a good idea of what they're paying for their product, whereas we don't necessarily know that part of it. So but, yes, I, I think we can compete on a level. We just want it to be a fair level if that helps answer your question for you.

JACOBSON: It, it does. And, and again, I, I share the concern, obviously, I'm a rural state senator. I, I care about keeping those pharmacies and keeping that service level there. I get a little nervous about mail order. I, you know, always worry a little bit about what you're getting and whether it's getting lost or stolen or so on and having a pharmacist there to explain to you firsthand how that works. Seems to be an important aspect that people are willing to pay for, but I just wanted to confirm kind of the concepts because I know

there's several issues that are here, the spread pricing, and I'm guessing they'll be other testifiers and we can probably dig in one at a time and unpeel this onion.

BRENT GOLLNER: Sure.

JACOBSON: Thank you.

BRENT GOLLNER: Thank you.

SLAMA: Thank you, Senator Jacobson. Additional questions from the committee? Seeing none, thank you very much.

BRENT GOLLNER: Thank you.

SLAMA: Good afternoon.

GARY RAHANEK: Thank you, Senators and committee, for being able to testify today. My name is Gary Rahanek, G-a-r-y R-a-h-a-n-e-k. I come to you today as, first of all, as a citizen in Nebraska and a normal customer of our Medicare system. I am also a retired pharmacist, used to own Wagey Drug, which is now owned by Kohll's, my favorite pharmacy, which is where I love to get my prescriptions filled. Last fall, I'm on insulin, I take Tresiba, or I did, and talking to Mr. Kohll, as we always do, because I like to hear about the business, he informed me that the DIR, DIR fees had gone past the cost of the medication and he was losing $120 every time he filled my Tresiba. So I could not ask him to continue to do that so I, I asked for generic, found out Tresiba was generic. OptumRx, which is the PBM we're dealing with in this case, UnitedHealthcare is the insurance, they're all intertwined, refused my generic request saying I had to have brand name or prove that I had an anaphylactic reaction to Tresiba, which I would have an anaphylactic reaction to the generic. I'm not that uneducated. So the thing that became obvious to me was number one, the PBM gets a kickback from the company that makes Tresiba. Number two, they're able to charge the pharmacy 10 percent on the direct and indirect renumeration [SIC] fee, which meant they took $375 away every time they filled that thing. I don't know where that money went. And so those things affected me. I could, I could no longer-- excuse me, I could no longer go to my favorite pharmacy. I spent four and a half hours on the phone with four different UnitedHealthcare people. Nobody knew what a DIR fee was. Nobody knew what pharmacy I could go to that would be able to be reimbursed adequately. Their only suggestion was to do mail order, which I told them, have you ever received a biological through the mail? I wouldn't. You have no guarantee that

it's been kept at the proper temperature. The thing of it is, a three-month supply of this stuff costs 3,500 bucks. So if it gets run over by a mail truck or frozen or too hot and it's not any good, OptumRx is not going to replace it and so then I have to pay $3,500 to get medicine so I don't have blood sugar issues. So that's just the tip of the issue, but that's, that's what I as a consumer have had to deal with.

SLAMA: Well, thank you very much, Mr. Rahanek.

GARY RAHANEK: Um-hum.

SLAMA: Are there any questions from the committee? Senator Kauth.

KAUTH: Thank you, Chair Slama. You mentioned the DIR, and then you did say direct and indirect remuneration.

GARY RAHANEK: Right.

KAUTH: Can you walk me through what that looks like?

GARY RAHANEK: Oh, I-- if I knew.

KAUTH: OK. I'll ask again.

GARY RAHANEK: There may be some other people that can behind me that-- I know just enough to make me dangerous about it and upset. OK?

KAUTH: Thank you.

GARY RAHANEK: It's just a fee that just-- it's between 1 and 10 percent and it's been rising up to 10 percent and the stuff that I was able to get from the Kohll's computer department, the ones that are all 10 percent are HUMIRA, XELJANZ, all of your brand name insulins. I mean, they just hit the top, on some of them they're taking almost $1,000 back on them. Yes, sir.

SLAMA: Senator-- thank you, Senator Kauth. Senator Jacobson.

JACOBSON: Thank you, Chair Slama. If I could dig in a little further. OK, you're, you're telling me that you're on Medicare now?

GARY RAHANEK: Yeah.

JACOBSON: OK, thought you could get in early.

GARY RAHANEK: I'm a lucky American ain't I?

JACOBSON: You must have got in early so--

GARY RAHANEK: No, I'm 70 years old.

JACOBSON: The-- I guess to kind of walk us through, so you're on Medicare and you have a physician.

GARY RAHANEK: Yes.

JACOBSON: OK, and I'm just going to want to peel the onion back here a little bit.

GARY RAHANEK: Right.

JACOBSON: You have a physician who has prescribed this medication to you.

GARY RAHANEK: Yes.

JACOBSON: So that physician has said this is the medication to be on.

GARY RAHANEK: Right.

JACOBSON: So why can't the physician prescribe a generic?

GARY RAHANEK: He did.

JACOBSON: And, and so how did UnitedHealth get involved?

GARY RAHANEK: They let me have one month's supply, then denied my request.

JACOBSON: And UnitedHealth was in that role because they're-- how are they, how are they--

GARY RAHANEK: They're the primary, they're the health insurance side of it.

JACOBSON: For Medicare?

GARY RAHANEK: For Medicare.

JACOBSON: Gotcha.

GARY RAHANEK: Um-hum.

JACOBSON: So, so then, they then decide that they're going to have this program where one of their PBMs are going to-- or one of their companies are going to be involved in actually selling you--

GARY RAHANEK: Right.

JACOBSON: --the prescription drug that you-- that, that they're saying you need because you have to have the--

GARY RAHANEK: Well, they're just saying it is a nonformulary product. It's a nice way of saying, no way, Jose. I also receive every month a phone call from OptumRx offering me free home delivery for all of my prescriptions. I also received a letter after my last call to them, which was a four-and-a-half-hour call, four people, and it has right on it UnitedHealthcare, OptumRx, the PBM Optum, and saying they'd be happy to fill by mail all of my prescriptions for me, I would have no problem.

JACOBSON: Wow.

GARY RAHANEK: So I have that in here, I didn't make copies for you, but would you like that?

JACOBSON: I'm assuming I can deliver your groceries, too, just to the pharmacy, so. Thank you.

SLAMA: Thank you, Senator Jacobson. Senator Dungan.

DUNGAN: Thank you, Chair Slama. And thank you for your testimony.

GARY RAHANEK: Yes.

DUNGAN: Oh, I have a question for you real quick.

GARY RAHANEK: OK.

DUNGAN: Sounds like-- if you want to go, you can.

GARY RAHANEK: No.

DUNGAN: What I, what I appreciate is it feels like you bring a unique perspective, both as a participant in receiving drugs and also as somebody who's worked in the pharmacy industry. One of the things we heard from the Nebraska Pharmacists Association is that over time the PBM's role has changed and that the PBMs sort of started as this go between but it's ballooned, I believe, was the terminology they used.

Did you yourself see sort of an evolution of the way that PBMs operated in your time that you worked in the pharmacy industry?

GARY RAHANEK: Yes. Yes. So if you can imagine-- I, I quit five years ago and so even at that time, it was really starting to ramp up then. But prior to that, the fees were like 1 percent, 2 percent, which is sharp because it's like putting a frog in hot, warm water and then heating it up, right? Because you don't pay attention to it, well, then finally when you get sharp enough-- here's the other thing is these, these fees come like up to six weeks to three months later. So, I mean, you've got to be on your game to keep track because they just subtract it from your payment. So you've got to go through every payment to see what money they took out they took back.

DUNGAN: Did something change in the last five years to sort of create that modification of their role or is that just something you observed?

GARY RAHANEK: I, I think it is something that they initiated and saw they could get by with 1 percent. And then they just, you know, once you're greedy, you just keep going until somebody yells. OK. Now I'm a capitalist at heart and but I, I-- this is just totally unfair to tell you they're going to pay you something and then take 300 and some bucks back or 1,000 bucks back three months later.

DUNGAN: Thank you, thank you. I appreciate that perspective.

SLAMA: Thank you, Senator Dungan. Additional questions from the committee? Seeing none, thank you very much for being here. Additional proponent testimony on LB778? And my request is if you're planning on testifying on LB778, please make your way up towards the front of the row so we don't have a staring contest for who's testifying next. Good afternoon.

DAVID KOHLL: Good afternoon, Chairman Slama and members of the committee. My name is David Kohll, D-a-v-i-d K-o-h-l-l. I'm a pharmacist and member of the Nebraska Pharmacists Association. My family owns Kohll's pharmacies. We have nearly 200 employees and are celebrating our 75th year serving Nebraskans. About two years ago, Kohll's started turning away some patients' prescriptions when we realized the cost of the drug was greater than the amount the PBMs paid for the prescription. And thank you, Gary. And like I said we realized it because, as Gary said, we don't know how much they're going to take back. And it's, it's not 10 percent, it's now 18 to 21 percent and you don't know which you're going to fall into. This does

not even include the other expenses, you know, that we have, such as labor, supplies, utilities, etcetera. So this move of, of turning away prescription totally pains me. We've never done anything like that in our 75 years. Just this week, one of Kohll's patients had a prescription for Focalin, a drug used for attention deficit disorder and hyperactivity. We told the mother we couldn't fill the prescription because the PBM pays us less than what we buy the medication for. There is a shortage of this drug if you kept up with the media, but my pharmacy's pretty good at hustling and getting the medications for our customers that we serve. So although if Kohll's is paid less than what it purchases the drug for Kohll's can't serve anyone. The family came to Kohll's because many pharmacies could not obtain the medication and their physician recommended that they come to us. So you may ask yourself, why doesn't Kohll's negotiate its contract better with the PBM? Well, when we request any type of contract that is fair, the PBM's response is we don't negotiate contracts. When the PBMs are ranked in the top 15 of the Fortune 100, I guess the PBM can, can bully pharmacies. Getting this bill passed will stop the PBMs from the pharmacy accessibility issues for Nebraska that they have created. The Department of Insurance's misinterpretation of the definition of an insurance company and the PBM bill, LB767, which was passed unanimously last session, makes the provisions of that bill unenforceable and that without this bill the provision in LB767 will not be enforced by the Department of Insurance. So, Senator von Gillern, you mentioned that the Rx's that the prescriptions that they own the pharmacy and, you know, why don't you-- I'm sorry.

SLAMA: No worries. Thank you, Mr. Kohll.

von GILLERN: I'll be happy to ask you to continue on that thought.

DAVID KOHLL: OK. So, you know, when you're reimbursing, when you're signing a contract, you know what you're going to be reimbursed. Well, well, for one thing, we can't negotiate it and we don't really know for sure what we're going to be reimbursed because it's-- the generic pricing changes up and down depending on how-- because there's many manufacturers in the market and so the generic price you buy the drug for one day could be much higher the next day or, or, or lower. But, overall, it's going in the wrong direction where we have to actually send prescriptions away. And when we send them away, we send them to the, the vertically integrated insurance. So like Gary mentioned, with UnitedHealthcare we send them to Optum and then they reimburse their own, their own entity at a higher level. Fortunately, I've seen some of the reimbursements and they reimburse them at a higher level than,

than we have. And so I hope that makes sense, they just-- they have no regulation and so they can do those things.

von GILLERN: So it-- presume a question over here?

SLAMA: Yes, reference.

von GILLERN: That, that helps. So what I'm beginning to understand is you don't have the option to go, if you don't like the price from, from-- I'll use the term vendor, vendor A, you just can't go to vendor B or vendor C, it's already, it's dictated by the patient's insurance coverage that, that drives where you have to buy that, that product from?

DAVID KOHLL: No, we can, we can use multiple sources, although with your primary wholesaler you're committed to a certain level through them so you, you try to do as much through them as you can. So you'll, you'll buy the drug at what, what you think is the lowest price, you know. And as the pharmacist from Hastings mentioned, we're, we're in large buying groups so we can compete with a scalable volume. But when you're getting reimbursed less than what they would pay the pharmacy that they own, then, you know, it really doesn't matter. And so, of course, the consumer and the, and the employers are paying more, too, because they're going to their-- that-- the pharmacy owned by the, you know, the UnitedHealthcares, you know, even the Blue Cross Blue Shields, they have their own.

von GILLERN: So I'm, so I'm going to use maybe a dirty word. The only way that this works is if the, the big three are colluding on their pricing. Is that essentially what you're saying?

DAVID KOHLL: Well, the big-- they are, they are. And, and you can't negotiate with any of the big three so you got 20 percent less left, left of them that you can negotiate with. I would say that, like, a, a pharmacy such as Walgreens and CVS, they do have a little negotiating power because they may lose, you know, 40 percent of their net worth or 30 percent of their net worth so they can negotiate a higher reimbursement than everybody else.

von GILLERN: OK. Thank you.

SLAMA: Thank you, Senator von Gillern. Senator Kauth.

KAUTH: Thank you, Chair Slama. So [INAUDIBLE], you said if you-- sometimes you're surprised by them charging or taking too much and so

you have to send patients away. Have you ever been surprised the other way where they don't charge you quite as much and had--

DAVID KOHLL: You mean where they pay me more?

KAUTH: Right. Right. Has it ever happened in reverse?

DAVID KOHLL: It happens once in a while.

KAUTH: OK, not to balance it out?

DAVID KOHLL: Oh, no. I've already closed three of my pharmacies.

KAUTH: OK.

DAVID KOHLL: And, and fortunately for me, I, I do other things besides just fill prescriptions and but--

KAUTH: So it's fairly lopsided?

DAVID KOHLL: Not fairly, but unfairly lopsided. It's, it's, it's, it's huge.

KAUTH: Thank you.

SLAMA: Thank you, Senator Kauth. Additional committee questions? Seeing none, thank you very much, Mr. Kohll.

DAVID KOHLL: Thank you, everybody.

SLAMA: Thank you. Good afternoon.

DAVID RANDOLPH: Good afternoon. Yeah, I've seen some of you guys before.

SLAMA: Yes.

DAVID RANDOLPH: Good afternoon, Chairperson Slama and other members of the Banking, Insurance and Commerce Committee [SIC]. My name is David Randolph, D-a-v-i-d R-a-n-d-o-l-p-h. I'm the pharmacist owner of Dave's Pharmacy in both Alliance and Hemingford, Nebraska. If you don't know where that is, seven hours west of here. I'm representing the Nebraska Pharmacists Association as well as rural pharmacies throughout the state. I'm here to testify in support of LB778. My fellow colleagues have testified regarding several areas in which PBMs hurt local pharmacies, decreased access to healthcare, and hamper patient outcomes, and there'll be more to come. I want to speak to you

today about the appeals process which is allowed where a pharmacy can contest an underpayment by the PBM, that a medication has already been dispensed then we can go ahead and contest that. The pricing is based on MAC as you've heard, the maximum allowable cost. The issue with that MAC pricing is each one of the PBMs has a different list for that specific drug. So you really can't track down what is the true maximum allowable cost. The other thing about this pricing is it's not updated on a regular basis. For my pharmacy, we get pricing updates every day. For the insurance of the PBMs, what happens is they'll have a price in there from a month ago. So with the supply chain issues that we've seen in the last three years, we're underpaid for that drug because things are harder to get, the price has gone up, and they're still paying for off a price three months ago that no longer applies. Our systems update daily, there's need update daily, too. A lot of times, like I said, it may even be on the second or third refill. They do do price adjustments, but I have never seen a price adjustment in my favor. It's in theirs. When you do an appeal, you send in a copy of the low-paid claim of your invoice with the prescription with the date it was processed. Ninety-eight percent or higher of all appeals I've ever done have been rejected. One PBM, in particular, in nine years, I have never-- well, excuse me, I got one, one appeal that was approved. I turn in five to ten claims a day on appeals that are underpayments by at least $10. The explanation is never given and when I've inquired, they told me you should be able to buy it cheaper. However, they don't give a manufacturer or a source where that price is available. The NDC, or the National Drug Code, is not given for the medication and each NDC code is specific for a certain manufactured drug strength and size. They don't give that. So we're left in the dark, underpaid, trying to take care of our patients on where we can find this cheap medication that's in Zimbabwe or Mexico. When all the independent pharmacies, small chains, grocery store pharmacies are gone, the PBMs will be happy. But what about the communities where they're located, the Nebraskans out of jobs, the patients without access to timely prescriptions, vaccinations, and quality care provided by more than just an 800 number? And what about the already overworked, overworked, quick-care clinics and hospitals where these patients will be forced to turn when the vaccination, medication, questions, and insurance problems that these pharmacies are serving are no longer there?

SLAMA: Thank you very much, Mr. Randolph. And as always, thank you very much for making the very, very long drive completely catty corner across the state.

DAVID RANDOLPH: At least there's good weather today, so.

SLAMA: Absolutely. I mean, compared to last time for sure.

DAVID RANDOLPH: Yeah.

SLAMA: Questions from the committee? Senator Kauth.

KAUTH: Real quick one. Thank you, Chair Slama. Five to ten appeals per day, how long does it take to file each?

DAVID RANDOLPH: Well, one of them, one PBM, I can fax them so that's faster. The other one, I have to turn it in digitally, digitally and it takes a little longer and, legitimately, I am at the end of the day, 20 minutes to an hour every day.

KAUTH: Thank you.

SLAMA: Thank you, Senator Kauth. Senator Jacobson.

JACOBSON: Thank you, Chair Slama. I can identify with the geographic issue. I think many people see North Platte as being on the Wyoming side of the border and you would be on the Montana side of the border.

DAVID RANDOLPH: Yeah, we're about halfway there [INAUDIBLE]. Yep.

JACOBSON: Yeah, you're about halfway.

DAVID RANDOLPH: Yeah.

JACOBSON: Well, thank you for being here. I, I guess, again, maybe trying to understand this. So are you part of a buying group with your-- where-- how do you access the, the med-- the, the pharmacist--

DAVID RANDOLPH: Yeah, I'm, I'm part of the buying group. In fact, the buying group is with the pharmacies in North Platte as well, the U-Save buying group.

JACOBSON: OK.

DAVID RANDOLPH: And so there are several thousand, I couldn't tell you exactly how many in that buying group. And even with the power of the buying group, we are still underpaid that amount by that many claims. And, and that's, that's just the $10 claim. If I lose, if I lose $5, yeah, I don't like losing a quarter, but it's not worth my time or my family's time for me to stay, you know, three hours at the end of the night.

JACOBSON: I'm assuming that when you say you're losing $10, it's not just on one patient, it's on anyone purchasing that particular--

DAVID RANDOLPH: Any-- right. Yes. Yes. And, and that's just, like I said, $10 is the minimum. But, yeah, I've had one like Mr. Kohll said, I had one earlier this week 150 bucks lost.

JACOBSON: Thank you.

SLAMA: Thank you, Senator Jacobson. Senator Ballard.

BALLARD: Thank you, Chair Slama. Thank you for being here. Thank you for making the drive. So previous testifiers have said they had to turn customers away, is that similar in your case?

DAVID RANDOLPH: Well, if I don't have the drug I can't, I can't dispense it and I won't order it in, obviously, for, like, a $150 loss or even a $50 loss. I can't take that kind of loss and stay in business. So if I don't have it on my shelf and I run a claim through, because you can run a claim through to see, and it's smart to do that because you don't want to-- like, there are drugs literally that are thousands of dollars. I don't want to carry that on my shelf unless I know I have a patient that I'm going to dispense it to. So I may not have it, so you bring in your prescription for an expensive drug, OK, I will run it through your insurance, see if it's actually covered, because a lot of times they don't cover expensive drugs, they require prior authorizations or like he said, sorry, Charlie, and then at that point, I will order the drug in because we get everything next day. OK? But, yes, if I run a claim through and I see that I'm going to lose that kind of money, I'm sorry I can't fill this drug, you know, I'm not going to order it in so then, yes, I will have to send you elsewhere. And out where we're at, we got 50-- well, in, in Alliance there is one Safeway, but in Hemingford there's nothing, I'm it, and we're 50 miles away from the nearest chain.

BALLARD: OK, because that was my next question is--

DAVID RANDOLPH: Yeah.

BALLARD: --do, do they resort to mail order then if--

DAVID RANDOLPH: They, they would go through mail order and, and, yes, then that's an issue. I just this year I've had two patients come in with frozen insulin and they-- like, I think, you said they did, they did not cover it. They, they said too bad so sad. And in the case of those insulins, it was $400 and $700.

BALLARD: OK.

DAVID RANDOLPH: And we've luckily the, the prescriber had samples and we were able to get them through.

BALLARD: OK. Thank you for being here.

DAVID RANDOLPH: Yeah.

SLAMA: Thank you, Senator Ballard. Additional questions? Seeing none, thank you very much, Mr. Randolph.

DAVID RANDOLPH: OK. Thanks.

SLAMA: Welcome, Mr. Otto.

RICH OTTO: Welcome. Good afternoon, Chairwoman Slama, members of the committee. I'm Rich Otto, R-i-c-h O-t-t-o. Thanks to Senator Bostar for introducing LB778. I'm testifying in support of this legislation on behalf of the Nebraska Retail Federation and the Nebraska Grocery Industry Association. Again, we are appreciative to Senator Bostar for his work and his continuous work the past two years. I do just want to go back a little bit to Senator Kolterman's LB767, which we did get done last year, thought it was a big step at the time. That step has gotten smaller and smaller as we've seen the assessment from the department. But I do want to just say the time that Senator Kolterman had to put in to get that first step made, this was a multiple-year process working with all parties, those that will come in in opposition and painstakingly got something done. But I just want to emphasize to the committee how much effort had to be done by Senator Kolterman. We are appreciative of Senator Bostar for continuing that effort, but the work still needs to be done on PBM reform, and it is going to require all of the committee to be behind this to get anything accomplished. And so we just really want to reiterate how much time and effort is required to get big types of legislation like this done. The proponents have done an accurate job of outlining all of the, the things that are in this new legislation. All of these types of things, spread pricing, cost of acquisition, all of this has been done in other states. It's been vetted in other states. From our retail pharmacist perspective, many of them are important. But, again, it is consumer choice of being able to pick their pharmacy and the continuous effort of pushing patients away to other pharmacies, mail order to the PBM pharmacies is our number one concern, market share. And so that is a huge piece of this legislation. The others are very important, but I just wanted to reemphasize that even from the chain

standpoint that marketshare is essential. The other point that some brought up is time, the time of our pharmacist. And they have-- proponents have gone over how they are losing money on, on many of these. Well, many of the, of the losses are not worth pursuing because of the time aspect. And we just at the retail pharmacy level continue to want our pharmacists to be spending more time helping patients, improving outcomes, and navigating the complex system that has been set up by the PBMs is very hindersome in doing that. Again, at some point it is going to get so bad that consumers are going to really start to feel the pain. And in western Nebraska, it will be the first and then we'll have less and less choices for our pharmacy. And eventually, I guess maybe the hospitals will be in here supporting it when they have too many people coming in to the emergency room for pharmacy-related issues. Happy to answer any questions.

SLAMA: Thank you, Mr. Otto. Any questions from the committee? Seeing none, thank you very much. Additional proponent testimony for LB778? Good afternoon.

MELVIN CHURCHILL: Good day.

SLAMA: Go, go right ahead.

MELVIN CHURCHILL: Madam Chairman Slama and Senators, thank you very much for letting me testify today. I'm Dr. Melvin Churchill, M-e-l-v-i-n C-h-u-r-c-h-i-l-l, middle name is Albert, if anyone wants to know. At any rate, it's a fairly English name, by the way. I'm here on behalf of the Nebraska Medical Association, which represents approximately 3,000 physicians across the state and the Nebraska Rheumatology Society, representing 90 percent of all rheumatologists in Nebraska. I'm an active, ongoing rheumatologist. I have practiced here for quite a long time. I've helped develop these products that we're talking about today, in terms of rheumatic disease and biologicals. I've had the opportunity to see the lifesaving benefits of these particular products. These newer biologics really change the plane of battle for rheumatic, rheumatic disease. In the past, I would see patients deteriorate. We had all borrowed drugs that didn't work well. At this point in time, we're able to prevent joint damage, maintain quality of life, combined with increased functionality in many cases and reduction in mortality. The PBMs, as they're called, negotiate rebates and discounts with drug manufacturers, based on the list price of the drug. The higher the list price, the larger the discount and rebate can be negotiated-- that can be negotiated. The PBMs are the intermediary-- intermediaries between insurance and drug pharmaceutical manufacturers. Unfortunately, there's no place in this

equation for the patient. Cigna's Express Scripts, Aetna's CVS Caremark, UnitedHealth Group Optum RX capture 80 percent of the PBM marketplace, as we've already heard. The PBMs determine formularies for a given insurance company, indiscriminately altering access to a particular product, which the patient may have been using for quite some time. And I'll point out a specific case. The rebates and fees PBMs received from drug manufacturers are incentives for the PBMs to place the manufactured drug on the formulary, which may, may not be in the patient's specific best interest. The case in point, one of our patients recently, within the last couple of weeks, was denied access to medication, which she had been utilizing since 2007. She's been on this commercial agent for many years with an incredibly positive response. She's still a functioning, actively employed individual because of that. She was denied this product simply because when the insurance company decided to no longer provide this particular preferred product-- this was no longer provided as a preferred product. Excuse me. Despite dictating appeals and personal phone-to-phone, peer-to-peer calls from my office and my staff and myself, she's been denied access to this treatment. The patient has pursued every exception. We put hours in on this one. This is not the only one. She's also can't contact the Nebraska Department of Insurance to file a complaint. Though the original function of the PBMs was to bring costs of, of medication down, this has not been the result, by any means. Despite the negotiations, the insurance companies and the PBMs have this formula: list price, discount, number of prescriptions filled, in the formula, etcetera. I'm done. Somebody like to ask me question, I have a couple more things to say.

SLAMA: Thank you very much, Dr. Churchill. Are there questions from the committee? Senator von Gillern.

von GILLERN: What else would you like to say?

SLAMA: Thank you.

MELVIN CHURCHILL: Well, I think the reality is, you know, this, this practice by PBMs has altered physicians' right to prescribe specific medications. It's interfering with the doctor-patient relationship. And unfortunately and this is the real thing for me, when a patient is denied access to a drug they've been on for no good reason other than someone decided somewhere in another office that they're not going to make that preferred product anymore, this patient is at, is at risk for a serious flare. Not all these drugs are equivalent. There are biosimilars, all kinds of things going on out there, but they're [INAUDIBLE] used, but they're not exactly the same. These are very

complex proteins. They're immunoglobulin-like proteins that function as a biological warfare, if you will. I call them cruise missile drugs. They interfere with specific pro-inflammatory proteins, which stimulate the disease. You suddenly alter that balance that you created with this new product, this disease may flare and life can be threatened. Rheumatoid arthritis, for example, if you alter their treatment very much and if they're really a highly ill individual, they have-- may have a sudden flare of pulmonary disease and pass away quickly. It's a life-threatening situation, when someone tells you, you can't do this anymore. And they'll say, well, these other drugs are just as good. The problem is there are no-- there are very few head-to-head studies integrating all these different agents. And I probably know as much about it as anybody. I've been doing this research for 30-some years. And I know exactly what these products are like. They're, they're not easy to use, they require specific handling and specific, you know, adjustments. And we really have to make sure the patient is taken care of. This whole process is interfering with-- this whole process is interfering with medicine and our ability to do what's right for the patient. I mean, this is being looked at, at the congressional level on an oversight and accountability committee in Washington, as we speak. This practice, it's become, kind of, incredibly com-- complex and, yet, totally transparent. There's no way, as the pharmacists have said, there's no way we can know exactly what it's going to cost. We've had to stop giving several drugs in our office, because the costs provided doesn't cover the costs we have to pay for the products that we give.

von GILLERN: Thank you.

MELVIN CHURCHILL: You're welcome.

SLAMA: Thank you, Senator von Gillern. Additional questions from the committee? Seeing none, thank you very much. Dr. Churchill.

MELVIN CHURCHILL: It was my pleasure. Thank you very much.

SLAMA: Come back anytime. Good afternoon, Mr. Schaefer.

MATT SCHAEFER: Good afternoon, Chair Slama, members of the committee. My name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, appearing today in support of LB778 on behalf of the Nebraska Hospital Association and the Pharmaceutical Research and Manufacturers of America. LB778 will help patients better access and afford their medicines by addressing several practices of PBMs that shift costs to pharmacies, employers, and patients. As you will see from the handout that the page is

distributing, in recent years, the three largest PBMs have combined with health insurers, order pharmacies and provider groups to form large, vertically integrated organizations, giving them extraordinary bargaining leverage and control over patients' access to prescription medicines. The three largest PBMs are responsible for pharmacy claims of about 80 percent of medicines dispensed in the United States and they use this leverage to maximize their profits, often in ways that harm patients and others. Measures, measures in this bill that reform PBM compensation, like implementing a duty of care and ban-- banning spread pricing, can assist in removing these misaligned incentives that pad PBM bottom line at the expense of employers and patients. By explicitly imposing a duty of care on PBMs, this bill would ensure that PBMs act transparently and place their duties to patients and their clients before their own financial interests. LB778 would also prohibit spread pricing, which enables PBMs to profit from the difference between the amount they reimburse pharmacies and the amount they charge their plan sponsors and insureds for medicine. Ohio investigated spread pricing in its Medicaid program recently and found that PBMs used that practice to make over $200 million a year from taxpayers in that state. It inflates drug spending at the expense of the state, employers, and patients. And a result-- as a result, 21 states have banned this practice in the commercial market. I would urge the committee to advance LB778. Thank you.

SLAMA: Thank you, Mr. Schaefer. Are there any questions from the committee? Seeing none, thank you very much.

MATT SCHAEFER: Thank you.

SLAMA: All right. Additional proponent testimony for LB778? Last call. Proponent? OK. We now-- we will now move into opponent testimony for LB778. And please, if you're testifying on LB778 in any capacity yet today, please move up to the front few rows.

BILL HEAD: Good afternoon.

SLAMA: Good afternoon.

BILL HEAD: Chair Slama and members of the committee, my name is Bill Head, B-i-l-l H-e-a-d. And apologies to the clerk. I think I actually wrote William on the paper. Thank you for the opportunity to testify today on LB778. We are in opposition. I'm sorry. I represent PCMA. We are the national pharmacy benefit manager trade association. And we are in opposition to the bill. Before I get into specifics on the bill, I do want to address a couple of statements that were mentioned

earlier. First, on DIR, the direct-indirect remuneration-- easier said than done. But happy to get into specifics. But that's actually a federal Medicare requirement. The PBM does collect the fees, but they're not our fees and they can be high. Happy to get into the program itself, but those are not PBM-specific fees. The other thing and I mention this because it was brought up a couple of times, that PBMs are top 15 fortune companies. That is not true. And I, I, I would urge you to check your phones and look at the top 20. Interestingly enough, two of the top ten are, in fact, drug wholesalers. McKesson and-- which I think it's number one, actually, on the fortune-- and AmerisourceBergen, I believe, is at ten. CVS Health is, I think, an eight or nine, but CVS Health is not a PBM. The top three PBMs are Express Scripts, Optum, and CVS Caremark, none of which are in the top 15. And I mention this, because there is a lot been made about the top three PBMs having 80 percent of the market. The top three drug wholesalers have 95 percent of the market. So they-- so the pharmacies really are at their mercy, much more than they are at the mercy of, of PBMs. With respect to the bill itself, going back to LB767 and the comments we've made, which were accurate, which were-- there were numerous stakeholder meetings, both telephonically and in-person. Senator Williams and Kolterman did yeoman's work getting, getting that done. I, I thought at the time it was like sincere, good faith negotiation. But I find ourselves back again, addressing many of the issues that were taken off the table or, or dealt with. So I, I, at this point, question the sincerity of those negotiations. And by way of example, accreditation for specialty pharmacy was one issue. We had asked for at least two national, independent accrediting organizations to, to accredit, especially pharmacies. The other side asked for one. Eventually, that's where it came down to one accreditation. Now, they're saying no accreditation. And these are organizations that accredit, accredit hospitals, the Joint Commission, URAC, and so forth. These are completely independent organizations. And these aren't about finance or money, these are about patient safety. We would not go to a orthopedic surgeon who wasn't board certified, but certainly there's no state law that requires a orthopedic surgeon to be board certified. So from us, this is really a clinical safety issue. And then the other, the other issue I'll raise with respect to the, the bill and this goes to your point, Senator Gillern-- von Gillern, is that-- is on the reimbursement and the contracting. I understand their, their concern about the Mac list and you know, how that comes out and their ability to purchase-- can I finish my sentence? I apologize.

SLAMA: Yes, you may, Mr. Head.

BILL HEAD: And I understand that, that concern. But their solution is just to make sure that we make a profit on every drug we dispense. And I, I think that would be unheard of for the Legislature to enact a law that guarantees a profit on every single item a business sells in, in their store. Not to say that there aren't legitimate issues. And I do take issue with the fact that we want to see independent pharmacies go away. Far from it. We, we need them in our networks. So with that, I will conclude and happy to answer any questions.

SLAMA: Thank you, Mr. Head. Are there any questions from the committee? Senator Dungan.

DUNGAN: Thank you, Chair Slama. And thank you for being here, sir. You've been helpful in prior discussions with me, understanding the entire process and procedure. And in fairness, I was not here during those earlier negotiations that happened. So I'm kind of new to this conversation. I understand that maybe, from a 30,000-foot view, it feels sort of like the-- there's an argument here of are PBMs good or bad. Right? And I understand that maybe that's part of the discussion that we're getting into. But when I look at the actual-- the bill that we're talking about here, LB778, and we're looking at some of the actual provisions that it's attempting to implement, many of these strike me as things that are, for lack of a better word, sort of just basic consumer protections. Right? Prohibiting the pharm-- the PBM from reimbursing a pharmacy or pharmacist an amount less than the amount that the PBM reimburses a plan affiliate, creating, for example, also, a, a duty of care, essentially, a good faith and fair dealing with respect to the performance of PBMs, beyond just an argument of are PBMs good or bad. What specific provisions in the bill do you see that are going to harm PBMs' ability to actually do their job? Because it seems like, to me, these are simply basic protections being laid out to prohibit some of the actions we've heard from the proponents earlier today.

BILL HEAD: Sure. No. And, and, and fair, fair question. So keep in mind, we're, we're an extension of the health plan. We're contracted by the health plan to administer their drug benefit. So everything we do is under very strict and limited contract provision. So if there, if there is-- it's called steering, right, to make them go to the mail order or make them go to the CVS or something like that, that's in the contract. And it's in the contract because the payer, the health plan, has determined it will save them money. Right? So if a person has a mail provision that requires them to get-- and these are for maintenance drugs-- and requires them to get their, their prescription via mail, the mail facility is shipping nationally. Right? So they can

buy at a volume that a single pharmacy or set of pharmacies can't buy at. And that savings is passed on to the payer and to the patient. So when you say, you know, consumer protection, we say actually these provisions are causing consumer harm by increasing their prices. Yes, it would be great that a person can choose to go to any pharmacy they, they want, whether it's in network or not, but there's going to be a price to that. And at a time when we're always talking about higher drug costs and getting-- expanding access, this bill is moving in the opposite direction. We're going to add to the cost. Right? And, you know, I should have prefaced my comments. You know, every single state employee program in this country hires a PBM. Virtually every single-- including Nebraska and virtually every state Medicaid program hires a PBM. So either we're pulling wool over every-- 50 states' eyes or we're actually bringing value to the table. I get that the pharmacists have reimbursement issues. Let's have a discussion about that, but let's not guise it in, sort of, these provisions that actually do more harm than good.

DUNGAN: But you would be willing to continue conversations regarding the reimbursement issues?

BILL HEAD: Absolute-- absolutely. Particularly for the rural pharmacies. In, in Illinois, for example, they actually set it-- they set up a general fund, which everybody contributes to, to help, particularly, you know, well-defined rural pharmacies. And I recognize, you know, having, you know, family here, I recognized that Nebraska, the pharmacy in some areas is much more than the pharmacy. Right? It is, it is a cornerstone of the community. We don't want them-- we don't want them to go away. It doesn't serve us any good for those pharmacies to, to cease to exist, if for no other reason than self-interest. Right? The PBMs are competing against each other. And one of the ways they compete is on network adequacy. Right? If I have a broader network, if I have a more robust pharmacy network, I'm going to be more attractive to the health plan.

DUNGAN: And then the last thing I'll ask and then I'll move on to the next. We can move on to the next. I don't want to take too much time. But the part that does speak to me loudly, I suppose, is this duty of care and, and the requirement for good faith and fair dealing. I mean, do the PBMs have an issue with that?

BILL HEAD: Well, we, we do with respect to-- because we have a contractual obligation to the plan. Right? So if you, if you then create a, a statutory obligation we have to the prescriber and to the patient, then that is, that is creating a, you know, potential

conflict of, of interest, if you-- if he will. The health plan has a fiduciary responsibility to their beneficiary. Right? So if we act against that, the plan is on the hook. Right? If somehow, contractually, the plan has done something that, you know, disrupts the-- their fiduciary obligation to the, to the beneficiary or patient, they're on the hook. And, and health plans, as entities, are, are sued in class actions all the time for, you know, doing just that, that they've, they've mismanaged their beneficiary requirements under fiduciary. And, certainly, I think the plans could testify in more detail about that. But our concern is the conflict that it might create. Because, again, we're really just an extension of the plan, acting as the plan, if you will.

DUNGAN: Thank you. I appreciate those clarifications.

SLAMA: Thank you, Senator Dungan. Senator Ballard.

BALLARD: Thank you, Chair Slama. Thank you for being here. Can you give me just a brief history of PBMs? And then, I'm reading this letter from the House Oversight Committee and it seems like they're blaming a lot of rising healthcare costs on PBMs.

BILL HEAD: Yeah. We're, we're--

BALLARD: So can you just kind of-- I'll give you a minute for a marketing pitch. Are PBMs necessary?

BILL HEAD: I, I think the fact that, you know, they're-- we're, we're administering the drug [INAUDIBLE] for 275 million Americans. And I think our position, generally, is if we don't do it, you're-- somebody's going to have to do it. It, it-- we're, we're filling a need. Right? It's not like we're interjecting ourselves. I know we're often called the middlemen, but we were invited in. We weren't-- we didn't force our way into this. Now, I think it was described earlier and accurately by, I think, one of the pharmacists, back in the '70s, PBMs were just claims, claims processors. Right? Somebody would collect, you know, get their receipts from their drugs and put them in a shoe box and mail them in and get a-- and get a check. Right? And it was that. But as we know, prescription drugs continued to, I, I guess, multiply, if you will, in terms of the diseases that they treat and, and good thing, for all of us, right, but they've increased in costs exponentially. Right? And that's really what, I think, the biggest problem we, we face is the high cost of prescription drugs. And so the plans-- the payers started to look at the PBMs more and more, as how can you help us manage this cost? What can we do to manage this cost?

And so that's why you have things like mail order. That's why you have things like step therapy and prior auth. And for the vast majority of people, it, it-- the system works, right? But because of the higher cost of drugs, because of the tightening of payers' belts, if you will, I don't think there's any doubt that some pharmacists have been, have been challenged. But to suggest that we're the cause of that, that somehow we've created this inflation of drug pricing is, is absurd. We, we have a-- we have a role to play and I think we do it very well. I think if you look at the sheet that I shared on the, the Nebraska fact sheet, the amount of money we saved the state is in the billions, right, over a ten-year period. On average, we're saving, we're saving people $1,000 a year if they have a PBM versus somebody who doesn't. So I think the short answer is if we don't do it, the, the need to manage the drug benefit doesn't go away. Right? You could, you could hire a bunch of people internally, but you would still have to manage that benefit because it's a significant amount of what you're paying.

BALLARD: Thank you.

SLAMA: Thank you, Senator Ballard. Senator Kauth.

KAUTH: So I'm trying to take up your challenge of searching.

BILL HEAD: Oh, yes. Good.

KAUTH: I'm not doing, I'm not doing a great job of it.

BILL HEAD: No, please. Please. Please.

KAUTH: So. OK. Just a couple questions. Who owns-- like, if you look at Caremark, who's the eventual owner of that? And is that group in the top 15?

BILL HEAD: Yes. So CVS Health--

KAUTH: OK. So CVS Health.

BILL HEAD: --which is the parent company, I think-- I want to say is eight or, eight or nine. But they are not-- CVS Health is not a PBM, but they, but they have a PBM in the-- with--

KAUTH: But they own a PBM.

BILL HEAD: Yes. Correct.

KAUTH: So is that, is that happening with like-- I mean, this little sheet that we got from Mr. Schaefer, shows a lot of the, the big insurers. It looks like they all have PBMs which, I mean, makes sense, but is that where some of the consolidation is happening and how is that affecting--

BILL HEAD: Yeah. We think it's-- we-- and I'll let the plans speak more to this, but we think that the integration is better for the patient. Right? Because, again, whether you're a health plan or you're a PBM, the healthier you keep a patient, right, you're keeping them out of the ER, you're keeping them out of the hospital, you're keeping them on drugs. You know, patient adherence is a big PBM, you know, objective, keeping people on their medication. Everybody stops their antibiotics, you know, a week early. The more we can do that and coordinate with the plans, the more we're saving and keeping the patient healthier.

KAUTH: So the coordination is what keeps people healthier?

BILL HEAD: Ab, ab, ab-- absolutely. Right? If there-- if there's, you know, if, if somebody is in a position-- because let's face it, if you're, if you're undergoing a, a, a medical treatment on the medical side, particularly a surgery, the odds are you are going to leave the hospital with medication. Right? So being able to, to, to marry those two and, and to coordinate those two activities and, and, again, keep, keep the patient as healthy as possible, I think makes a lot of sense. You know, I don't know. You don't have it here, obviously, but Kaiser Permanente in California, example is, is the ultimate, sort of all-inclusive, you know, integration, if you will.

KAUTH: Thank you.

SLAMA: Thank you, Senator Kauth. Additional committee questions? Senator von Gillern.

von GILLERN: Thank you. Quick question. Are there-- do the PBMs play well with Medicare, Medicaid? Are, are there claims back and forth, because that's like a whole different-- we've talked a lot about the private buyers--

BILL HEAD: Right.

von GILLERN: --and the local pharmacies and so on.

BILL HEAD: So we have very strict rules under, under Medicare: the formulary, the pricing, everything is actually done more than a year

in advance-- a year and a half advance of getting everything approved by CMS. So we are-- it's a very highly regulated area, Medicare, in particular. So we don't-- I don't [INAUDIBLE] back and, back and forth, but we-- but we're contracted by plans who then offer, you know, the Part D benefits, the drug benefits for Medicare beneficiaries. And the PBM is implementing that drug benefit as well. But it's under very strict, if you will, or very controlled federal regulations.

von GILLERN: So it sounds like that's a different pricing environment than what our local consumers and local retailers are, are under. Is that true?

BILL HEAD: No, it, it is. And as I mentioned earlier, the DIR thing, for example-- fees, for example, are, in fact, a Medicare program, not a PBM program.

von GILLERN: OK. OK.

SLAMA: All right.

von GILLERN: All right. Thank you.

SLAMA: Thank you, Senator von Gillern. Additional questions from the committee? Seeing none--

BILL HEAD: And can I just thank Senator Bostar, though, because he's kept a very open door and been open to my complaints.

SLAMA: I appreciate that very much. The Legislature prides itself on having open doors for complaints. Good afternoon.

ALEX SOMMER: Good afternoon, Chairman Slama, members of the committee. My name is Alex Sommer, that's A-l-e-x, Sommer, S-o-m-m-e-r, for the record. I represent Prime Therapeutics, a pharmacy benefit manager owned and operated by 19 not-for-profit Blue Cross and Blue Shield plans across the country, including Blue Cross and Blue Shield of Nebraska. First, I also want to echo what Mr. Head said and thank, Senator Bostar, for having an open door to having some conversations with us, been wanting to discuss this bill, both last year and this year. We always appreciate that because sometimes, that door is more closed than open. So I want to start off by noting something that Senator Bostar said in the opening and that was noting, noting LB767, and going back to some of the proponents, talking about this notion of PBMs being unregulated. That, coupled with the fact of what Senator Bostar mentioned about LB767, is patently false. PBMs are heavily

regulated across the nation, but then, specifically, in Nebraska, via the regulatory scheme that was passed by this committee in this Legislature just last year. The proponents, though, I think, will call us unregulated, until they get the one thing they've been after throughout these past few years of negotiations. And that, straight, plainly, is more money. End of the day, that's what this is about. And we are in the business of making healthcare dollars go as far as possible. Paying more money for the same thing that we already get today, which is prescription drugs, for the members that we serve, is simply not a way to stretch those health-- healthcare dollars and get Nebraskans the prescription drugs that they need, to live better and feel well each day. The main thing that we are trying to do with those healthcare dollars is get the right treatment to patients, at the right time, for the best possible price. Doing this, paying pharmacies more money, again, for that drug, is not a way to go about doing that. That's a way to make those healthcare dollars go [INAUDIBLE]-- not, not go as far, provide less care, and make those patients less healthy. And as Mr. Head said, that having a, a healthy-- an unhealthy patient and not getting the care they need, ends up being a more expensive patient. And that, ultimately, is in nobody's best interest. Patients aren't as healthy, health plans are paying more money, consumers are paying more money, in the way of more expensive treatments that they didn't need. And health plans are paying more money by way of increased-- again, those increased premium-- those increased costs, that then feed into higher premiums of-- over the course of the next year. Now, getting back to the bill that was already passed last year. One of the things that was said by the proponents was around maximum allowable cost and that these are not updated even like, you know, on a monthly basis, whereas their prices are updated on a daily basis. The law that you passed last year requires those prices be updated every seven days, so those prices are updated, at a minimum, every seven days. Additionally, as stated by the proponents, that those prices or that they-- when we reject an appeal, that we do not provide an alternative NDC, showing where they could actually get that drug. Again, the law that was passed, last year, requires an alternative NDC be provided. So the answer is not additional laws. It's an enforcement problem if you have an issue with the law, because the law is already on the books, requiring those very things that were stated by the proponents. One more thing to note. There was a lot of talk about rebate dollars. We, at Prime, passed through all, 100 percent of our rebate dollars, to our plan sponsors, so that those dollars can offset the costs of healthcare in the state of Nebraska. Again, that's a way of making sure that healthcare dollars can, overall, go as far as possible and not just-- you know,

it's not-- these, these rebate dollars aren't allocating to us as a way of just, kind of-- as a profit-making scheme that's a way to drive down the overall cost of care. So I see the red light's on. I will wrap up and say for these reasons and a myriad of other reasons, we oppose this bill. And I'm happy to answer any questions.

JACOBSON: Any questions for Mr. Sommer from the committee? So are you a publicly traded company?

ALEX SOMMER: We are not. Privately held by those 19 not-for-profit BlueCross and BlueShield plans.

JACOBSON: Got you. All right. Thank you. Thank you for your testimony.

ALEX SOMMER: Yep. You guys are making it too easy on me, I guess. No questions. Thanks, guys.

JACOBSON: Further opponents?

JEREMIAH BLAKE: Good afternoon, Vice Chair Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB778. PBMs provide a valuable service to Blue Cross members by administering the plan's prescription drug benefit, with the goal of providing our customers coverage for medications they need at an affordable cost. Working with our partners in the PBM industry, health plans have been absorbing a larger share of the cost of prescription drugs over time, largely shielding patients from price increases from drug manufacturers. A recent study of prescription drug claims, from 2014 to 2019, found that while the cost of prescription drug benefits increased by 14 percent for employer-sponsored health insurance, the patient's cost sharing declined by 5 percent. This shows that PBMs, PBMs have successfully bent the cost curve, despite the upward pressure on prescription drug prices and increased drug utilization. PBMs accomplish these savings by encouraging the use of generic drugs, increasing medication adherence and obtaining price, price concessions from drug manufacturers. Despite the best efforts from PBMs, prescription drug costs continue to rise, due to the price increases from drug manufacturers. Last year, the price of new drugs for chronic conditions approved by the U.S. FDA reached a new record high, with a median price of about $257,000. More recently, three-gene and cell therapies approved by the FDA have a list price between $2.5-3 million each. There's no question that these new drugs have the potential to

treat complex, complex conditions and offer a better life for patients, but they also add significant costs to the healthcare system that is already the most expensive in the world. Unfortunately, this bill does nothing to address the skyrocketing costs for prescription drugs. Instead, this bill is more likely to increase healthcare costs for Nebraska businesses and families, by guaranteeing a pharmacist make a profit on every prescription they fill and adding significant new compliance burdens to PBMs. As you know, PBMs, as we've discussed, PBMs are already regulated by the state. Instead of discussing new mandates on PBMs only month-- months after the current state law took effect, we would welcome the opportunity to work with this committee to conduct a review of the prescription drug supply chain, including PSAOs, which were discussed earlier and drug manufacturers. However, we cannot support additional regulatory burdens that will only increase costs for our members. For that reason, we are opposed to LB778. Thank you for your attention. And I'm happy to answer any questions you have.

JACOBSON: Thank you, Mr. Blake. Questions from the committee? If not, I've got one question.

JEREMIAH BLAKE: Yes.

JACOBSON: I guess, obviously, we've heard a lot of testimony here today and there's a lot of strong feelings on these issues. So are you folks open to, potentially, an interim study to really research this issue more in-depth this summer or what's your view there?

JEREMIAH BLAKE: Sure. You know, again, pharmacists play a really important role in the healthcare delivery system for our members, so we want to see them succeed. There's no question about that. So any way that we can sit down and have an honest conversation about what their frustrations are and how we can address those in a way that is cooperative and collaborative, we're happy to have that conversation.

JACOBSON: Thank you. As you've noticed, this session's, kind of, not moving on overly rapidly, at this point, so we're probably going to some time this summer to talk. So thank you.

JEREMIAH BLAKE: I look forward to it. Thank you.

JACOBSON: Thank you very much. Thank you. Other pro-- other opponents?

ROBERT M. BELL: Good afternoon, Vice Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and

registered lobbyist for the Nebraska Insurance Federation, the State Trade Association of Nebraska Insurers, including most of the health plans in Nebraska. I am here today to testify in opposition to LB778. I would point out, I did check out the top-- the Fortune 10 list and there are three Federation members on that list. So I take that as a, as a sign of pride, particularly Berkshire Hathaway, which is a Nebraska domestic company. I-- I'm going to-- this isn't step one or step two of the PBM debate. I mean, we've, we've been having this debate in Nebraska for quite some time. In 2019, Senator Kolterman first introduced PBM regulation in Nebraska. And there were some negotiations related to some things that the health plans and, and pharmacists and PBMs and all could kind of agree, that maybe there were some things that needed to change. And, and as well, the federal government had been acting at the same time. And so we all took steps to make sure-- you know, gag clauses were, were taken out of contracts and that, that-- well, we allowed the ability of pharmacists to share various cost information with, with consumers, which had also been prohibited in some of these contracts. In 2021, there was a hearing that, admittedly, didn't go very well for insurance companies and, and our business partners in the PBM industry. And this committee prioritized a bill that, that ended up not moving. But we did enter into those negotiations at that time and had numerous conversations, including, I think, a few of those involved Senator Bostar and we came together last year to-- on LB767 which, again, was a second session bill and we're talking about LB778. So you do have quite the workload in front of you for this session, given those numbers. But that bill just became operative January 1. I, I think Mr. Kohll said that that law is unenforceable. That is not true. That law is enforceable. I think what they're concerned about is the scope of enforceability, and there's some uncertainty related to that because of interpretation by the Department of Insurance. And had this legislation dealt solely with that particular issue, I think you would have heard different opposition or more let's work on this kind of opposition from, from PBMs and from health plans, in general. We're certainly open to discuss any kind of issue that's occurring in the marketplace. Pharmacists provide important services to, to health plan members. They're, they're needed in our networks. And we-- if there are business practices that are going on, that are, that are-- need to be addressed, let's, let's address them. But first let's let LB767 actually become effective and be operative and, and see how that works. Thank you for the opportunity to testify.

JACOBSON: Thank you, Mr. Bell. Questions for Mr. Bell from the committee? I, I guess I just have one. Again, I, I hear what you're

saying. I know there's a lot of frustration and I've gotten it from pharmacies in my district that are concerned, you know, really about that enforcement mechanism. And I, and I don't disagree that let's don't make new laws without enforcing the ones that we have--

ROBERT M. BELL: Sure.

JACOBSON: --but I think there are challenges on the enforcement side. And I don't know whether that's Department of Insurance, is that the first line of defense? Where is the enforcement mechanisms today?

ROBERT M. BELL: Well, for the provisions of LB767, yeah, it is the Department of Insurance. Now, the question I think that, it was kind of hanging initially is, you know, does this apply to employer-sponsored plans or to ERISA plans or NCOs and those types of questions. And, you know, they looked at the statute and they, they looked at the plain language of the statute and decided it did not. It's my understanding. I was, actually-- I was not involved in those discussions, just from what I've picked up in the lobby, right, and, and from listening to the testimony. But if it's a-- if it's a fully insured-- if it's a plan you buy off the exchange or a small group plan or, or some of those other types of plans, I believe that there are the ability-- there is the ability to call the Department of Insurance and talk about it. One of the things I mean, just-- we heard about denials of health claims, right, from, I believe, it was Dr. Churchill talking about that. And, you know, that always makes the, the hair on my neck stand up just a little bit to hear that, you know, an insurance company isn't providing lifesaving care to, to an individual or an insured. Right? I mean, that would-- if I was sitting in your seats, that's what I would be concerned about. But I do want you to know there are a myriad of laws on the books already related to adverse determinations by insurance companies and the ability to appeal those to either the Department of Insurance if it's a state-regulated plan or the Department of Labor if that is a federally regulated plan, like an ERISA plan. And, you know, at the end of the day, if it's an emergency, those happen very quickly. And at the end, it's not the Department of Insurance that makes that decision, it's an independent review organization that's not employed by health insurance or the department or the provider. Right? These are independent folks that make those determinations. So, I mean, that, that allows me to sleep at night, that at least other organizations are looking at these determinations that are sometimes adverse to consumers. That wasn't your question.

JACOBSON: Well, no, but, but I appreciate the response. I, I truly do, because I, I do think that there are issues out there. And--

ROBERT M. BELL: Of course.

JACOBSON: --you know, again, sometimes, you know, we could look at new rules, but if we're not going to enforce what's out there, why bother? And so it really comes-- becomes down to is this a role of the Department of Insurance? Does there need to be an independent third party? How can we get some kind of resolution on some of these practices that are being alleged to really get to is there really fire there? Is this just smoke? And so I, I think that's one of the things I'd like to find out. And I guess I would ask you the same thing I asked Mr. Blake, which I assume you're going to tell me yes, that you'd be open to.

ROBERT M. BELL: Always.

JACOBSON: I knew you would. I knew you would.

ROBERT M. BELL: I look for-- I would be disappointed if we did not. Seventy-nine days. That's how long LB767 has been in effect. Right? So it's been in effect for such a short amount of time. I couldn't look up and see how many have been licensed already, PBMs, under, under LB767 law. Now they were all licensed under third-party administrator laws already, but, you know, give it a little bit of time. We will know more this summer. Right? So-- and it would allow us to better address the issues.

JACOBSON: And, and that's kind of where I'm at. I, I would just tell you, it, it, it, it-- you know, we've-- we're in a 90-day session now. It feels like we've already been through 180 of them. But I'm told it's not.

ROBERT M. BELL: No. You've been, you've been in here 79 days for-- just so you know.

JACOBSON: All right.

ROBERT M. BELL: It's been a-- it's been a long-- it's been a long session already.

JACOBSON: Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: And, and as-- I don't know whether-- if the Department of Insurance is going to be here, I'll wait to see if they're going to be in the neutral capacity or whether they're testifying.

ROBERT M. BELL: Don't know.

JACOBSON: I got a couple of questions for them. So thank you. I think you answered my questions and I'd ask for any other opponents. No one else in opposition? Are there-- is there anyone speaking in the neutral capacity? How are you?

CARISA SCHWEITZER MASEK: Just fine. How are you?

JACOBSON: Great.

CARISA SCHWEITZER MASEK: Good.

JACOBSON: Welcome.

CARISA SCHWEITZER MASEK: Thank you. Good afternoon, Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Carisa Schweitzer Masek, C-a-r-i-s-a S-c-h-w-e-i-t-z-e-r M-a-s-e-k, and I am a pharmacist and also the deputy director of Population Health for the Division of Medicaid and Long-Term Care with the Department of Health and Human Services. I'm here to testify in the neutral capacity for LB778, which creates new requirements for pharmacy benefit managers and their pharmacy networks. LB778 makes a variety of changes related to how PBMs conduct business and this testimony will highlight just a few. The largest fiscal impact of this bill on the Medicaid program is the requirement that PBMs reimburse pharmacies at a price that is above the cost of acquisition of a medication or device. Federal law provides Medicaid with the use of multiple methodologies to determine reimbursements to pharmacies for medications dispensed to recipients. For Nebraska Medicaid, for fee for service, we use national drug acquisition cost pricing. And if that's unavailable, then we will use maximum allowable cost along with any other methodologies, as necessary. Reimbursement methodologies are designed to encourage pricing negotiations between the pharmacy-- pharmaceutical product wholesalers and the pharmaceutical companies, and then to pass those savings along to the purchasing pharmacy. This bill would require Medicaid to pay claims at the pharmacy's actual acquisition cost, if that cost was above MAC pricing. For some medications, as I mentioned, NADAC is used to determine that reimbursement. And it's unclear if Medicaid would be required to follow MAC pricing instead of NADAC. Our best estimate is that the

fiscal impact would be $5 million per year in total funds for payments that are in excess of the MAC pricing. This bill also requires the adjustment be applied to a similarly situated pharmacy, which is not defined and may lead to higher payments in instances where a pharmacy's wholesaler previously negotiated a role-- a lower actual acquisition cost. The requirement to reimburse above the pharmacy's actual acquisition cost, based on an invoice submitted by the purchasing pharmacy is operationally complex. Pharmacies will often receive discounts or rebates later, in subsequent months, based upon previously dispensed volumes. These discounts or rebates would not be reflected in the invoice that was sent-- submitted requesting reimbursements above the MAC and it may result in unwarranted reimbursements. Thank you for the opportunity to testify today. And I'd be happy to answer any questions.

JACOBSON: Thank you for your testimony. Any questions from the committee? I would-- I guess I just have one. I, I, I appreciate your testimony today. And, and I, and I understand some of the issues that you're raising. I, I would tell you that I'm-- I am concerned and I'm kind of curious with the department how you deal with these rural areas. I-- my-- probably one of my biggest concerns and I would ask you, as you particularly look at elderly-- more elderly people, if, if they're going to end up relying upon mail order and they no longer have that personal pharmacist there to really direct them and help them with their prescriptions and that kind of thing, does that concern you at all or what-- what's your answer to that?

CARISA SCHWEITZER MASEK: Medicaid is a program. We have the option of mail order. We do not require mail order for any medications.

JACOBSON: I, I-- I'm not saying it's a requirement. I think that's what it's going to go to if these smaller pharmacies in rural Nebraska who are likely going to have to struggle, struggle because of transportation costs and so on, their cost of that medication is probably going to be above what they can sell-- what they have to sell it for. They then, in turn, don't offer that drug. That person then, in turn, has to go to mail order, in all likelihood, because of the distance between these towns and where they're located. So what's the answer to that?

CARISA SCHWEITZER MASEK: Yeah. Because Medicaid does have members in both rural and frontier areas. It is a concern to us. As a couple of individuals mentioned, the best thing to do is to try to keep the individuals healthy. The best way to do that is to make sure that they have access to those medications. The concern for the department is

the language on reimbursing above MAC does not address, what I think the bill mainly is trying to get at, which is PBM transparency.

JACOBSON: So-- and that's, again, I think that gets back to the interim study. But that's one of my concerns as well, is that we probably need to come to some kind of a common denominator of definitions. What makes sense? I understand both sides of this equation. But, clearly, we've heard that there are some problems with the way it's working today. And I'm going to take Mr. Bell on his word that it's new and we'll get there. But, you know, I like to trust but verify. So thank you.

CARISA SCHWEITZER MASEK: Yes, thank you.

JACOBSON: All right. Thank you for your testimony. Others speaking in the neutral capacity? OK. Seeing none, there were for the record two proponent test-- letters and two opponent letters. And with that, Senator Bostar, you're welcome to close.

BOSTAR: Thank you.

JACOBSON: Thank you for your patience, too.

BOSTAR: Oh, well, thank all of you. You know, it was mentioned that this isn't step one and that we've, you know, been on a journey here. And that's true. And, and then I realized that everyone sitting at this table, this is sort of your step one in this process since so much of the Banking, Commerce and Insurance Committee was termed out or otherwise unable to, unfortunately, return to the Legislature this year. So to provide some context to that whatever step number this is, two steps before it, it was mentioned by Mr. Bell. Two years ago, there was a hearing where things were so acrimonious that it's the only time that I've seen in the, you know, the three years of, of legislative hearings that I've been doing this, where a state senator threatened to subpoena insurance company executives to drag them before this very committee to hold them accountable. And that was then Senator, now Congressman Flood, who did that, on this very issue. And so I would just like to say that I think we've made a lot of progress. This hearing, I thought it went really well. It was also mentioned that, you know, the, the enactment of the legislation that was passed last year has, has really only just started to take effect-- 70-something days. And so we should wait and see, you know, if, if the problems that we are perceiving are genuine or, I suppose, phantom. And so I-- I'll-- you know, I certainly wasn't in the Legislature in 2008, but I-- it reminds me, when I hear things like that, about the

2008 Nebraska Legislature. And they passed a law during their regular session that was a safe haven law to protect children. And the way it worked was you could-- you know, it was well-meaning. You could drop off your children, essentially, at a hospital, I believe, no questions asked. And you wouldn't be held responsible for any child abandonment, you know, charges or liability. This was to ensure that children were, you know, instead of being neglected or abused, they could be surrendered and, and, hopefully, put into a better situation. Well, the intent of that legislation wasn't necessarily what happened because I think over 100 children were surrendered. None of them were infants, as I think everyone was imagining would be the case. But the law was written in a way where up to the age of 18, you could bring your child to a hospital and sort of absolve yourself of any parental responsibility and leave your teenager at the door, then becoming the responsibility of the state. And folks were coming in from around the country to Nebraska to drop off their kids. It didn't take long to figure out that that bill was broken. We didn't have to wait. A special session was called to immediately fix it. So the idea that sometimes you got to just give it more time, I don't think is a good argument. I think it's a strong argument. Sometimes we pass things. When it hits the real world, we know. Is it working the way it's supposed to or is it not? This is not. And so we can fix it. We don't have to wait to fix it. We can fix it. A few other notes. I, I think I want to just take a macro view of this a little bit. We talked about a lot of details. There's a lot in this legislation, a lot of back and forth. But, you know, a gentleman who testified, who is a retired pharmacist, you know, he talked about capitalism, which I thought was interesting. And, you know, capitalism relies on a free market and a truly free market relies on perfect information for all participants. We don't have that here. The participants in this market do not have, forget perfect information, they barely have any information. So what we're trying to do is ensure that we have a playing field that is level and accessible to all participants. Because, as I'm sure everyone here would agree, we believe in the principles of capitalism. And right now, we don't have that. So we should fix it. A few more notes. We heard from some of the proponents-- well, we heard from some of the proponents that pharmacies are going out of business. They're being asked to pay more for something than, effectively, what they can sell it for. And then we heard from opponents that this is just all about money. Well, to some extent, yes, absolutely, this is about money. The pharmacies are going out of business. They're closing down. We can see that happening. When was the last time you heard of a PBM going out of business, not making enough money to keep their lights on? Has that ever happened? I don't think so, certainly not with the

modern PBMs that we deal with today. I think they're doing quite well. I think their parent companies are doing quite well. So, sure, the PBM itself may or may not be on a fortune list, but their owners are. We know that, some of the biggest companies in the country. Rural access, this was brought up. I think this is really important for a state like Nebraska to consider. If you're sent away because the pharmacy just absolutely can't cover the-- eat the cost of providing you with medication, so you're turned away because they just can't do it. Where do you go in some of the places in our state? What options do you have? And then we heard about mail order. What happens then if there are no options? You go to mail order. You end up with frozen insulin. You're supposed to just die? Is that the option? Maybe that would be more convenient for some, but I think we can do better than that. And we should. Mr. Sommer talked about making healthcare dollars go as far as possible. That effectively defined the mission of the PBM. And that's interesting, because I think we need to talk about making those healthcare dollars go where. Far, sure, but where? Someone's making the money. I'm not sure it's the pharmacies that are closing down. It was also brought up that lack of enforcement was the problem, that the law doesn't need to be changed, just needs to be enforced. But, you know, as we talked about, one, in the opening and, two, throughout the hearing, to some extent, the narrow scope that the Department of Insurance has placed upon the regulations that we passed and have recently been enacted, is part of the problem here. So it's, it's the fact that enforcement cannot happen for much of the, the healthcare space that we are responsible for here in this committee. So we'll continue to work on this. Oh, one last part, the, the-- Mr. Bell brought up that if you have a, you know, an adverse determination, right, for any sort of insurance coverage and they come in and they deny something and it's, it's, it's critical for your, your health and well-being and your life, you can appeal. And they, they talk about the, the appeals are quick. So let's, let's think about the system we've built where you need something to live. The person who has it tells you, no, you can't have it. You're then, in this particular position, where who knows what sort of medical state you're in, you're then invited to go through a bureaucratic process, fill out paperwork to appeal it, to then hope that someone else will give you what you need to save your life. Again, I think we can do better. With that, I thank you all. I appreciate you all joining this journey that has been years in the making. And I'd be happy to answer any final questions.

JACOBSON: Questions from the committee? Thank you, Senator Bostar,--

BOSTAR: Thank you.

JACOBSON: --for your closing and bringing the bill. And that will conclude our hearing on LB778. And believe it or not, you're-- we're going to open the hearing on LB448, and turn it back to you, Senator Bostar.

BOSTAR: All right. Twelfth? No. Eighth, eighth bill in this committee this session and last.

JACOBSON: But nobody's been counting.

BOSTAR: I certainly have.

von GILLERN: We were told not to apply.

JACOBSON: Please continue.

BOSTAR: Good afternoon or-- yeah, we'll go with it. Good afternoon, Senator Jacobson, fellow member 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. I represent Legislative District 29. I'm here today to present LB448, a bill to prohibit certain provisions in a health plan related to the administration of medication by a clinician, a practice also known as white bagging. I introduced LB448 on behalf of the Nebraska Hospital Association, as well as the countless healthcare professionals that are concerned about this practice. Health insurance companies have adopted policies that limit patient choice and reduce the timely access to care for critical specialty medications administered in Nebraska hospitals. This insurance practice, called white bagging, don't ask me why, requires that certain medications be dispensed by a separate pharmacy outside of the hospital, often owned by the insurance company. Patients do not get to choose if their medications are subject to white bagging, as this practice is wholly determined by a health insurance company. During this process, medications may be required to be dispensed by a distant pharmacy at a remote location from the hospital on a patient-by-patient basis. While some insurance cost-saving schemes can benefit consumers, the real world impacts of white bagging can negatively impact hospitals, providers, and patients. White bagging has caused delays, delays in patients getting their medications and has even resulted in hospitals being sent the wrong dose or the wrong medication. In some instances, hospitals don't receive the shipment on time, if ever, and are forced to cancel and reschedule patient procedures until the next dose arrives. This leaves many hospitals in Nebraska at risk of liability and costs associated with this process. White bagging can cause serious, potentially harmful disruptions to patient care. This

disruption to care results in insurance companies making decisions that belong to doctors and their patients. Lawmakers in 11 states across the country have introduced bills that address white bagging. Three states, Louisiana, Arkansas and Virginia, passed legislation to end the practice. Nebraska should follow suit. I introduced this legislation last year and our committee advanced the bill to the-- to General File, signaling our intent to monitor the practice to ensure it is not misused. However, patients are still experiencing delays to this insurance practice. Last year, in provided testimony, insurance companies stated that they were not aware of any adverse impacts relating to this practice. This can no longer be true. We all want to find ways to lower the cost of healthcare, but none of us should do so at the risk of harm to a patient. With that, I thank you for your time. I ask you to support LB488 [SIC--LB448]. Happy to answer any questions.

JACOBSON: Questions for Senator Bostar? OK. Seeing none, thank you. And we'll ask for proponents.

BOSTAR: Thank you.

OLIVIA LITTLE: Thank you, Vice Chairman Jacobson. My name is Olivia Little, O-l-i-v-i-a L-i-t-t-l-e. I appreciate the opportunity to testify before you today. I am here on behalf of Johnson County Hospital and the Nebraska Rural Health Association. I am here in support of LB448, which would limit the practice known as white bagging. Johnson County Hospital is an 18-bed critical access hospital, along with a rural health clinic located in Tecumseh, Nebraska, which has a community population of 1,700 and a county population of 5,000. Our access area also extends into Gage County, as we have a rural health clinic in Adams, Nebraska. When we first encountered the process of white bagging from an insurance company, we weren't really even sure what it was or if we could even say, no, we will not do it. It seemed very unfair that we would have to do all the work, pay for everything included in the service for the patient besides the cost of the drug and, basically, all we would-- could charge for was a room charge and if any supplies were used. We would have to call the insurance company or the distributor, distributor to ship the drug, schedule the patient when the drug arrived, store the drug, take and monitor temperatures on the equipment the drug was stored in, admit the patient, pay professionals to enter and verify orders into our electronic health record. If needed, prepare the drug, administer the drug, feed the patient if they came at lunchtime, monitor the patient, which could be several hours, depending on the drug, chart all the information in the electronic health record, pay

for all the software, equipment and personnel, meet all regulatory and documentation requirements and we wouldn't even be able to charge for the medication. It didn't seem fair or even right. We also had safety concerns, since this process would deviate from our current drug procurement and administration process. We worried about the drug arriving on time so the patient's treatment wasn't delayed, what we would do if the drug arrived damaged or if we had an issue in preparing the medication, as we would only be receiving one dose, compliance with the Drug Supply Chain Security Act, how we would be notified by the distributor in the event of a recall and the safety checks that would have to be bypassed and the change in process for administration because the medication would not be able to be put into our medication dispensing cabinet. We reached out to other local hospitals to see if they shared the same concerns as we did and if they administered medications through white bagging. They did share the same concerns. And one even said they would absolutely not do white bagging and send their patients elsewhere. We wanted to serve our patient and give them access to care without the burden of the parent and child having to travel or for the parent to have to figure out transportation for their child to receive the medical care needed. We also didn't want the child to miss any more school time than they would have to. So we decided to do what was best for our patient, even though it wasn't best for us and we served our patient. While I spoke about the processes and concerns we had when we first encountered white bagging, those processes and concerns still remain current and valid in what we are encountering today. Critical access hospitals operate on a very thin margin and continuing this process, if it would expand to high-use drugs and more patients, I mean, that would be-- have a huge effect on us.

JACOBSON: Thank you. Thank you for your testimony. Questions for the testifier? If not, I think there's-- I'm, I'm kind of anxious to hear the opponents because you make a very compelling argument. So I'm really anxious to hear what the opponents have to say. So thank you for being here.

OLIVIA LITTLE: Thank you. Thank you for having me.

JACOBSON: Other proponents? You're back.

MELVIN CHURCHILL: Thank you very much.

JACOBSON: Go ahead.

MELVIN CHURCHILL: Vice Chair-- Senator Jacobson, thank you for letting me speak today.

JACOBSON: We are going to need to give you a running start so we can get you to the finish line.

MELVIN CHURCHILL: Thank you. Well, for the record, my name is Dr. Melvin Churchill, M-e-l-v-i-n C-h-u-r-c-h-i-l-l, and I'm here on behalf of the Nebraska Medical Association, the Nebraska Rheumatology Society, and as an active practicing rheumatologist, I'm here, also, on the basis of my practice in the Arthritis Center of Nebraska, which has been in existence for over 40 years to take care of autoimmune disorders ranging from rheumatoid arthritis to lupus, gouty arthritis and others requiring systematic and consistent management with various agents known as biological products. That term is probably foreign to you but, basically, they're antibody-like structures that interfere with a function that reduces inflammation which, in turn, makes the patient better. We've-- over the years, we relied on a lot of products that were ineffective, borrowed drugs from other disciplines. And some of you may remember gold shots. Well, we don't do-- use those anymore. The goal of our infusion center, which we've had in existence for quite an amount of time, provides continuity of care of patients, under direct supervision of my clinical staff, which are well-trained and within a few feet of my door, literally down the hall-- I can do almost throw a paper wad that far-- allows us to monitor these individuals in a comfortable environment, consistent basis and the white bagging idea, really, is going to be extremely timely and cost ineffective, which increase our administration burdens and costs immensely, not to mention our liability. When we order these drugs directly, we have complete control over the chain of custody. We're able to provide the agents, knowing full well they've been handled properly and stored properly. Temperature control is critical for all these agents. It's important that they're coming in from reliable sources. When the patient might receive this products and we don't know how it has been maintained or handled-- it, it may have, as this other person said, been frozen or whatever. So it's really a matter of safety and making care of the patient appropriately and not taking any chances. I certainly wouldn't want-- I'd say-- I have a lot of things delivered to my front door and I don't always know how-- and oftentimes, they're broken, they're frozen and, thankfully, they're not my medications. We do approximately 500 infusions a month in our clinic. And we provide this service at a bargain cost, if you compare our cost to what it costs in other centers, particularly hospital centers. As a rule, we-- we've seen, from our patients, the, the difference in cost and we try to do it as cost-effective as we

possibly can. If the drugs are designated for a given person and they don't show up or they're sick or something needs to be changed, we'll have to waste the product. We-- if the medical history changes, the patient walks it with an infection or just walks in and say, I'm still on some antibiotics for pneumonia, I just got out of the hospital last week and that-- they want their biological, we can't use it. So it's really difficult to maintain consistent care when you don't have your own supply and can make adjustments on the fly. That's really, really important. So I think it's all important that we control our access and control our supply, so we can take the very best patient care we possibly can.

JACOBSON: I'm going to ask you to just wrap up, if you're-- you know, you're done here.

MELVIN CHURCHILL: Yeah. I, I, I-- one of my, one of my APPs that works with me says that this would be like going to a restaurant and bringing your own steak and asking them to fix it. I don't think that most Nebraskans, Nebraskans would appreciate that. No, we really want to make sure this is safe and consistent. And having control over what we do allows us to do it well and effect-- effectively. It's quite a process. And, and these patients are, you know, so willing to come and, and help take care of themselves. Compliance and safety is critically important.

JACOBSON: Thank you.

MELVIN CHURCHILL: Thank you very much.

JACOBSON: Questions from the committee? Senator Dungan.

DUNGAN: Thank you, Vice Chair Jacobson. And thank you, again, for your testimony. One thing and I know you didn't really get a chance to get to it in here, but I'm just curious if you could briefly, because I know we have a lot of other testifiers, talk about is the liability concerns for hospitals here. Does the hospital take on the liability concern?

MELVIN CHURCHILL: Well, if they're administering a drug. If you provide the drug-- you plug an IV in, these-- most of these are given intravenously or some subcutaneously. We don't provide oral products in our infusion center. So it's really up to you to make sure it's accurately and properly provided, prepared and given by a professional who has been trained to do that. And that's what we provide. We make sure the drug is, in fact, what it's supposed to be. We bring it in

and we have all sorts of refrigeration that we have monitored 24/7. We have to make sure that-- and we have that monitor on that temperature gauge hooked up to an alarm system when it's out of range. So we might get a call in the middle of the night to run in and I-- to make sure something's not wrong and I'm-- sometimes have to do that.

DUNGAN: And so part of the concern it sounds like you have, is that if these drugs, the white bag drugs, are incorrectly provided or there's an issue with them that that could potentially shift liability to the hospital, that they wouldn't have to deal with if they were doing it, maybe, their entire-- the entire process themselves.

MELVIN CHURCHILL: Yeah, it's basically, if we have control over it as it comes through the door, we know where it came from and we can store it properly and, and we have it there so we can adjust dosage, too. We have to make changes on a given moment in time, but it's impossible to do that when something is sent. And, oh, patient's not doing well or they have a side effect or a reaction and we have to make some adjustments, then the product is wasted. When we have control of that, we have better control of how the patient received the product safely and accurately. That's the bottom line. We really want to make it safe for the patient.

DUNGAN: Thank you.

JACOBSON: Other questions from the committee? Thank you for your testimony.

MELVIN CHURCHILL: Thank you very much.

JACOBSON: Other proponents.

MANDY OGLESBY: Vice Chair Jacobson and members of the committee, my name is Mandy Oglesby, M-a-n-d-y O-g-l-e-s-b-y. I have been a registered nurse for almost 24 years and fortunate enough to have spent the last 20 years in rheumatology as an infusion nurse. I am here to testify in support of LB448 or LB448. It is extremely important that we continue to have access to the medications that we provide to our patients in our office. We need to continue to be able to adjust a dose of the patient's medication on the same day of an infusion. Many of our drugs are dosed based on the patient's current weight. If the dose would need to be increased to be in a therapeutic range, we would need to have our own supply of drug on hand to do so. If the patient would need to discontinue therapy and we, and we only have drug available for that specific patient, we would have to waste

the medication, creating unnecessary waste, in turn, being very costly for everyone involved. Another important reason to have our own supply of drug available would be if the patient is not doing well at their current dose, we are able to increase their dose on the same day. If we would only have the patient's supply of drug, we would not have access to additional medication on hand to increase the dose, causing the patient to suffer and wait until their next infusion to receive the new dose. This could be anywhere from four weeks, eight weeks or sometimes as long as six months, depending on the medication dosing regimen. Having our own supply of drug allows-- also allows us to infuse new infusion patients on the same day. This saves the patient a trip back to the office and allows them to have relief from swollen and painful joints, sooner than if they had to wait for their own supply of drug to arrive. Having our own supply of drug that we order ourselves allows us to have full control of purchasing from one supplier. This ensures that the drug is safe for the patient, because we know it has been handled and stored properly at the correct temperatures from the time the drug is received from delivery to the time the patient is given the medication. By ordering drug in bulk, this also ensures that the patient's drug is here on time for their appointment, as many of our patients come from all over the midwest to receive care in our office. If the patient's drug shipment was delayed due to weather or other unforeseen circumstances, the patient would have to be sent back home without receiving their medication, which would not be in the patient's best interest. In 2022, we administered a total of 5,823 infusions in our clinic. If we would have to order drugs, specifically, for each of those 5,823 infusions, most of those patients being infused monthly, it would be a logistical nightmare. We would have to keep track of approximately 500 patients to ensure that the drug is here on time monthly, calling each patient and patient's individual pharmacies, tracking and logging each patient's drug. This would take valuable time away from monitoring and caring for our patients. Our office would not have the staff or the extra time it would take and would be very costly. In fact, it would be, would be devastating to our office. I have experienced, on a smaller scale, of what this would be asking of us, having just a few patients that utilize patient assistance programs to receive free drug. And I've had to monitor and keep track of their individual drug for each monthly appointment. More times than not, I have had to make several additional phone calls per patient, after already having completed and faxed forms, to follow up as to why shipments have not yet been received for the patient's scheduled appointments. It's very time consuming on a small level and I can't imagine if it were to be done on a larger scale.

JACOBSON: Thank, thank you.

MANDY OGLESBY: Um-hum.

JACOBSON: Questions for the testifier. OK. If not, thank you for your testimony.

MANDY OGLESBY: Thank you.

JACOBSON: Further proponents? Now, let me just caution everyone, too. We are running late, so we would encourage you to, when the yellow light comes on, you start thinking about your close. When the red light comes on, we'd really like you to wrap up those comments so that we can keep going and stay on schedule. So thank you.

AMANDA PEKNY: Good afternoon, Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Amanda Pekny, A-m-a-n-d-a P-e-k-n-y. I'm the pharmacist in charge at CHI Health St. Mary's, an 8-bed-- and 18-bed hospital that serves the community of Nebraska City, Nebraska. We are fortunate to offer a variety of outpatient specialty, specialty care services, including infusion and injection treatments to our patients. Thank you for the opportunity to express my support for LB448, and efforts to increase patient access to timely and affordable medications by discontinuing the practice known as white bagging in Nebraska. I am one of many critical access hospital pharmacies that have been affected by payer-mandated white bagging policies. These policies are impacting our business practices and patients, including delays in care and expensive medications being wasted. The following three specific patient cases highlight these examples. Patient A was prescribed a medication to be infused weekly, but was required to utilize the white bagging process with their insurance. The designated specialty pharmacy refused to ship their medication until a prior authorization was approved. Our facility called the specialty pharmacy when we expected approval to arrange for shipment. With-- but with a short work week due to a holiday, the specialty pharmacy was, was closed. The patient had to wait an additional week before they received their medication. Patient B was prescribed a medication that was to be administered every 4 to 8 weeks. The specialty pharmacy autoshipped the medication every four weeks, regardless if the medication was administered. The patient had the medication discontinued. And as a result, several vials that were shipped had to be wasted, as they could not be returned to the specialty pharmacy that had sent them and could not be used for another patient. Patient C was prescribed a medication that costs approximately $50,000 per dose. In this case, the specialty pharmacy

did not ship the product until the date it was due to be infused. Because of this, the hospital had to purchase a vial of this medication that we may not be reimbursed for to prevent a delay in the patient's care. In summary, LB448 is important for hospitals like mine to deliver high-quality care to our patients. Thank you to Senator Bostar for introducing LB448, and for the Banking, Commerce and Insurance Committee for your consideration of this important patient care and safety issue. I welcome any questions the, the committee may have.

JACOBSON: Thank you for your testimony. Questions from the committee? Senator Kauth.

KAUTH: Thank you, Vice Chair Jacobson. Are, are hospital pharmacies higher priced than these outside pharmacies? Is that the reason why they're trying to use the outside pharmacies?

AMANDA PEKNY: I, I don't-- maybe someone else can answer that question.

KAUTH: OK.

AMANDA PEKNY: I, I don't know.

KAUTH: OK. Thank you.

JACOBSON: Other questions from the committee? If not, thank you for your testimony. Other proponents?

ANDREW RADUECHEL: Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in favor of LB448. My name is Andrew Raduechel, A-n-d-r-e-w R-a-d-u-e-c-h-e-l. I am the director of pharmacy at Boys Town National Research Hospital and a member of the legislative committee of the Nebraska Pharmacists Association. Boys Town National Research Hospital is located at 14,000 Hospital Road on the campus of Boys Town, Nebraska. Our healthcare services include acute pediatric inpatient hospitalization, surgical services, inpatient psychiatric hospitalization, and residential medical treatment programs for children and adolescents with behavioral disorders. Our medical clinics include primary pediatric care with five Boys Town pediatric locations in the Omaha metro area and specialty care clinics for children and adults across Nebraska, Iowa, and South Dakota. We also provide telehealth services to six rural sites. During my tenure at Boys Town. I have watched the practice of white bagging continuously grow and witnessed it negatively affect pediatric patient care time

and again. It has been, hands down, the single most disruptive payer-directed practice we have seen as a hospital pharmacy. One of the issues with white bagging is the shipping of the specialty medications. It is not done through a distributor and a courier, which are normal distribution channels for a hospital, pharmacy, or clinic. We recently had a large box of temperature-regulated specialty biologics delivered by USPS on a Friday night that sat on a dock all weekend because it was delivered to the wrong place and no one was there to receive and unpack the medications. Tens of thousands of dollars of drugs had to be thrown out and this happens often. As we have no control over the shipping, it's a logistical nightmare and-- to locate where boxes are being delivered and where they go, this also causes delay or missed therapies. Boys Town's clinics' medication refrigerators are full of biologics that are white bagged. We are taking precious square footage in our clinic space and paying for refrigerators and temperature monitoring for inventory that is not ours. Essentially, a for-profit insurer, PBM and specialty pharmacy are transferring the cost of holding inventory, space, equipment, monitoring and personnel to Boys Town, which is a not-for-profit, disproportionate share pediatric provider in our community. On numerous occasions, we had a patient show up for an infusion appointments, but the biologic was never shipped. The first time this happened, we took the biologic out of our pharmacy stock so the patient wouldn't miss the important therapy. The insurer refused to reimburse us for the medication cost and, therefore, we had to absorb $22,000 in an unnecessary medication cost. After this event, we had to change our policy and will no longer use our stock when the specialty medication does not show up. This has caused, caused delays and missed therapy not only for this patient, but other patients on biologic therapies. Pharmacists are dedicated to getting the right medication to the right patient at the right time. We strongly support LB448 on behalf of our children and families. It is a much needed bill to protect the many extremely sick children from insurance practices that disrupt important lifesaving therapies and cause serious barriers to care. Thanks for your time.

JACOBSON: Thank you. Questions for the testifier? Maybe just a follow up, I think, to what Senator Kauth was asking earlier.

ANDREW RADUECHEL: Is, is, you know, the reason-- go ahead, I'll let you ask it.

KAUTH: Yeah. Yeah, that's-- it is.

ANDREW RADUECHEL: Yeah. Yeah. OK. So--

KAUTH: If you could answer that question, that would be great.

ANDREW RADUECHEL: --your question was, is it-- that's, that's hard for me to guess. And that's certainly what they would say is that we charge more, but with the waste and the individual packaging and sending it, it's, it's-- the, the care is really our focus. And I-- you know, I, I-- we'd have to go, go dig into the billing, but I think that's typically what they're saying, is that we-- I would say that we are open to negotiating or talking about that. I mean, we're-- let's talk about it, then. You know, if that's the, if that's the big barrier, because we're willing to lower that for good patient care.

JACOBSON: Thank you.

ANDREW RADUECHEL: Thanks.

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

JEROME WOHLEB: Thank you, Vice Chair Jacobson and members of the Banking, Commerce and Insurance Committee. I appreciate the opportunity to talk about this very important legislation. LB448. My name is Jerome Wohleb, J-e-r-o-m-e W-o-h-l-e-b. I speak today on behalf of Bryan Health and as an advocate for the Nebraska Hospital Association. I've been a practicing pharmacist for 43 years, serving Bryan Medical Center for the last 12. Bryan Medical Center is located here in Lincoln and provides services for Bryan Health System, which represents communities across Nebraska. Our vision is to elevate quality of life through better health. Insurance companies' white bagging practices compromises our ability to do so and it tells providers what medications they can order and where the patients have to receive care. Our patients deserve better, a safer alternative that is being required by insurance companies and PBMs. Access to lifesaving medications are in the balance of this discussion. One of the issues with white bagging, you've already heard, is the supply chain component. It's very important that supply chain isn't disrupted. I'll go through the details here, but I want to get to the patient examples that I've got following. So in particular, white bagging doesn't allow the normal supply chain security, quality, safety, all the elements you've heard testified by two of the presenters previously. And so what's the outcome of this? So if you come to-- if a patient comes to the hospital and expecting to receive cancer treatment and they find out that the insurance company sent the wrong dose or the wrong drug or worse, a shipping error, as we just heard, who carries the burden of this decision? Well, frankly, our patients do. The practice may require them to drive to an entirely

different town, receive their care and/or their, their site, of where the insurance companies drive them to, for their own personal provider could provide that in their hometown or the medical center could provide that in their hometown. So the patient really is being compromised with this burden. Following me, there's going to be a provider providing information about patients and RSV and that is important for our patients. We have 30 patients that provide white bagging in our facility, right now. So our hospitals carry this burden of just managing the labor resources. You've heard some of those already. The storage, inventory management, product integrity, patient safety, all those are in the balance here. So what we're really looking for is to make a difference in our patient care and safety here in Nebraska. So I ask for your support of LB448, on behalf of our most vulnerable Nebraskans. Please help us keep patient care and safety first for our patients, providers, and members of our healthcare team. I thank you. And I want to end with the point that our Governor said in his State of the State address, our children come first. Let's keep that part of this legislation. Questions?

JACOBSON: Thank you for your testimony. Did we get your name spelled out at the beginning?

JEROME WOHLEB: I, I did spell it out, but I'll do it again.

JACOBSON: Perfect. All right. I might have missed that part. Thank you. I figured our clerk would have kept me on track-- focus here so thank you. Questions for Mr. Wohleb from the committee? None? Thank you very much for your testimony. Further proponents?

STESHA SCHNEIDER: Good afternoon, members of the Banking, Commerce and Insurance Committee. My name is Stesha Schneider, S-t-e-s-h-a S-c-h-n-e-i-d-e-r. I am a neonatal nurse practitioner and I have been a registered nurse in the state of Nebraska for over 14 years. Today, I am here to advocate for Nebraska's most vulnerable babies and the care they fight to receive due to white bagging practices. I ask that you please vote in support of LB448. In my role, I help coordinate the Bryan Medical Center's Synagis, Synagis Clinic. Synagis is a medication with proven results to help prevent and/or lessen the symptoms of RSV, a respiratory virus. Bryan Medical Center is the only location in Lincoln to offer a Synagis Clinic. In 2021, we administered Synagis to 62, 62 infants. Families come from surrounding communities outside of Lincoln, driving, at times, hours to get here and many have limited resources. Several families miss a day of work each month to obtain this lifesaving medication for their child, risking their income and jobs to do so. Infants must get their Synagis

injection every 28-30 days for it to be effective. The following is a real life account. A mom goes into labor at 24 weeks, 16 weeks earlier than a full-term, 40-week pregnancy. Her baby survived pre-term delivery and spent four months in the neonatal intensive care unit before being discharged home. During their NICU stay, both babies required a tracheostomy and have been sent home on a ventilator, making them extremely fragile. Mom must work full time to maintain her health insurance, while balancing being a single parent with limited resources. Due to insurance requirements, mom will receive calls from the pre-authorization team, the insurance company and the specialty, specialty pharmacy the insurance company contracts with to get her babies this lifesaving medication, all before even making it to the clinic for treatment. On the day of the appointment, the mom takes time off work, loads her babies with their ventilators and their other medical equipment. When they arrive, the babies are undressed to be weighed, as Synagis-- as each Synagis dose is based off their weight. Given the medical equipment, you can imagine, this is no easy task. The insurance company guesstimated what the babies weigh when preparing their dose at their specialty pharmacy. Their estimate was off and they did not send enough medication. Mom has now wasted several hours out of her day, put her infants at risk to learn that they will not be fully covered in their protection from RSV, because the medication could simply not be supplied at the hospital she was attending clinic. Synagis Clinic requires countless hours from staff to run efficiently. Our staff make multiple phone calls for pre-authorization. The medication order gets sent to the specialty pharmacy for the medication to be filled, where the dose is sometimes filled incorrectly. Next, the specialty pharmacy calls the parents to get permission to ship the drug. If the parents are not reached, they are confused-- if the parents are reached, they are confused as to why they are being called and asked to give permission to ship this drug. If they don't get a hold of the parent, the drug is delayed in being shipped. There are times a specialty pharmacy is unsure where to send the medication. Is it to the baby's home, the pediatrician office or to the Synagis Clinic? I've listed three routine instances where the result delays care and inappropriate dosing directly affects fragile infants. Nebraska gives-- Nebraska never gives up on its kids. White bagging leaves multiple areas for error, disruption and poor outcomes at the expense of our most vulnerable. As you hear from myself and others impacted today, I urge you to vote in support of LB448. Our kids are counting on it. I welcome any questions. Thank you.

JACOBSON: Thank you for your testimony. Any questions from the committee? Yes, Senator Dungan.

DUNGAN: Thank you, Vice Chair Jacobson and thank you for your-- I think your example here is illuminating as to why this might be an issue. You were in the room, obviously, when we heard the other testimony on this. There was a circumstance we heard about from Boys Town National Research Hospital where a patient showed up and they didn't have the biologic, but they opted to go ahead and use their stock, which ultimately cost them $22,000. Is-- obviously, that's a huge detriment to their finances. Are there other circumstances where that's not even an option to administer Synagis from your own stock? Because it sounds like you don't even have that ability here, as well.

STESHA SCHNEIDER: Yeah. We, we do have some infants that we do give Synagis to from our own hospital pharmacy stock. There's been some, some times where we've borrowed, if you will, with hopes that we'll still be reimbursed. I can't speak to that, if they are. I don't see the behind the scenes of costs and gains, I guess. I'm not sure if anyone else could, but.

DUNGAN: But, ultimately, the concern there is that Bryan or your clinic is going to be out that money if they're not reimbursed by the insurance company?

STESHA SCHNEIDER: Yes.

DUNGAN: Do you know off the top of your head and it's OK if you don't, how much one dose or therapeutic treatment of Synagis costs?

STESHA SCHNEIDER: Yeah. I actually had that in here and then I was trying to make the time. So the reason pre-authorization is such a big deal for Synagis is because each injection is $2,000. Some children, I mentioned, it's based off their weight, so some children require two injections. And so that's $4,000. And each infant comes five months consecutively through the months of RSV season, which is November through March. So $4,000 times five months is $20,000 that goes to the family, if you will, so.

DUNGAN: Yeah. Thank you. I think one of the larger issues here is that that costs $20,000 or $22,000 in the other circumstance, but we can address that another time. But, certainly, I, I appreciate you illuminating this with the, the example there. Thank you.

STESHA SCHNEIDER: Um-hum.

JACOBSON: Other questions? I just have one. I, I would just want to comment. In fact, my wife and I had a 24-week baby, 20-- 38 years ago.

STESHA SCHNEIDER: OK.

JACOBSON: Unfortunately, he only lived for five weeks. But I cannot begin to thank you for the work that you do and people like you do. I appreciate it.

STESHA SCHNEIDER: Thank you.

JACOBSON: Thank you. Other proponents?

ELIZABETH BOALS-SHIVELY: Hi, members of the Banking, Commerce and Insurance Committee. Thank you for this opportunity to testify in favor of LB448. My name is Elizabeth Boals-Shively, E-l-i-z-a-b-e-t-h B--o-a-l-s-S-h-i-v-l-e-y. I'm a critical access pharmacist. I've been practicing for about 11 years, the last six have been at Henderson Health Care. It's a 13-bed critical access hospital. We do inpatient, ER, and outpatient services. First and foremost, I want to iterate that LB448 is about improving patient care. It's about providing high quality of care. It's about providing access to medications. But, you know, we're here for a reason. And it would be a disservice to say that this isn't about revenue for my facility and for facilities like mine. We have a lot of limited options in how we generate revenue to cover costs. And it's basically, if the current insurance practices continue, we're going to be forced into one of two decisions. We either are going to not give those medications at all and we're only going to give them if we're paid under the buy and bill model or we're going to increase our administrative fees. And that just offsets the supposed cost savings that the PBMs will tell you that they're achieving. We have to pay for the extra administrative work, temperature-controlled storage spaces and even FTEs, that's if we can find them at all. I can really empathize with cost containment and healthcare. I spent a year as a resident with Blue Cross and Blue Shield, Nebraska, post pharmacy school graduation. I saw the dollar amounts going out the door and I know of these cost containment strategies and their appeal is really appealing. I, I understood them. I was like, yes, let's do it. But then I moved into the real world of practice and their theoretical and the reality, they were, still are, miles apart. They're not actually saving money, it's just cost shifting to the hospitals. Thank you for your time today. I encourage the committee to advance LB448 to the General File.

JACOBSON: Thank you for your testimony. Questions for the testifier? If not, thank you. Other proponents? Go ahead. Welcome.

MARCIA MUETING: Thank you. Good afternoon, again, members of the Banking, Commerce and Insurance Committee. My name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. I'm a pharmacist, the chief executive officer of the Nebraska Pharmacists Association, and a registered lobbyist. And I'm only going to do about half of my testimony. On behalf of the members of the Nebraska Pharmacists Association, I offer our support for LB448, and thank Senator Bostar for introducing this legislation. I'm sure a lot of people will think this is not a big deal, but pharmacists are the drug experts and we are really particular about how drugs are stored and shipped. And in 2013, Congress enacted the Drug Supply Chain Security Act to enhance the FDA's ability to help protect consumers from exposure to drugs that might be counterfeit, stolen, contaminated, or otherwise harmful. The DSCSA, as we call it, requires that pharmacies and hospitals purchase medications from certified distributors. They have to do their homework and make sure that they're certified and that supply chain records have to be provided. Requiring a hospital or clinic to administer medication supplied outside of their normal supply chain could be considered a violation of this federal act. Thank you for the opportunity to comment. I'd be very happy to answer any of your questions.

JACOBSON: Questions from the committee? Seeing none, thank you for your testimony. Other proponents? Any other proponents? Anyone wishing to speak in opposition? If there are other opponents, if you could, maybe, make your way to the front row. I figured there might be a couple more.

BILL HEAD: Vice Chair Jacobson and members of the committee, thank you for the opportunity to testify today on LB448. I'm Bill Head, B-i-l-l H-e-a-d, with PCMA, the national pharmacy benefit manager and trade association. I am in opposition to-- we, our association is in opposition to LB448, because we are concerned about the, the price impact. Senator Kauth asked the question about the price of hospital pharmacy drugs versus other pharmacy drugs and that's really what it comes down to for us. And I think you have to, sort of, look at this in two pieces. One is the source of the medication; where is the medication coming from? And then secondly and this is where I think the hospitals actually have a, a legitimate point, is the storage, the handling and, and the administration of that. Separate issue from the source. Right? And, and I do take issue with the suggestion that the source of the drug, in this case, specialty pharmacies, that are, as I testified in previous testimony, the nationally accredited, so the handling, the storage, the shipment, the federal law that was referred to earlier, these are all things that are adhered to. Right? So these,

these-- tamper-proof packaging and so forth. Our members also, when they ship a, a medication-- because there can be patients who are subject to weight changes, right, so they get-- they're prescribed the ten milligram dosage. The PBM will often ship 15 milligrams to account for any change in, in weight or what have you. And the source of these medications are, are the same source that the hospitals are getting from. The hospitals aren't manufacturers, so they're getting them from the same sources that the, the specialty pharmacy is, is obtaining them from. They're not any less safe, so the notion that they are in some, in some way, in some capacity, is, is just unfounded. And we take issue, issue with that. At the end of the day, it is about the patient, so there are often-- a health plan will often have procedures in place that if the shipment is late, delayed, it is, for some odd reason, in rare-- and we were unaware of instances, although I heard a couple today, I guess, the wrong, the wrong medication, they will have workarounds, right? That they will reimburse the, the hospital for the drug and apparently, maybe not happen in all cases, but there are those, there are those workarounds in those rare instances. But they are, in fact, rare instances. And I, I would also say that, you know, I, I guess, you know, to my knowledge, I'm assuming that the delivery driver who delivers their supply of medication is probably the same delivery driver whose-- UPS or FedEx driver, who's delivering the specialty pharmacy medication, as well. And in closing, I would point out that the bill also prohibits brown bagging, just to make things more confusing. Brown bagging is when the medication is delivered to the patient's home. And in, in that case, because-- and then, they will have-- they can either take it to the physician, but particularly doing COVID, they were having the, the nurse practitioner or the, the, the medical professional come and administer the drug at their home. And there was an uptick of that during, during COVID, during COVID. So I, I think eliminating that and eliminating white bagging as options is really doing a disservice to the health plan and to the patient at the end of the day. And with that, would happy-- be happy to answer any questions.

JACOBSON: Questions for Mr. Head? I, I, I just have one, I think. I guess, I'm, again, I'm trying to understand. So if, if I'm going to get my car repaired, the-- that car repair shop has certain overhead costs. And part of their business model is that they're also going to buy the parts from their parts supplier, mark the parts up and that's part of their model to get really paid for the services they provide. If I go to the parts or if I go to the repair shop and say I've got the parts in the back. I want you to put them on and then I want you

to warranty them afterwards. That would be problematic, would, would it not?

BILL HEAD: Well, let's think about who's paying for the parts. If somebody else is paying for the parts, though, and they can get the exact same part from the exact same vendor and get-- so it's-- the quality is not at issue, but the price is less.

JACOBSON: But, but, but I think the quality could be an issue. And that's, and that's what we're concerned about exactly.

BILL HEAD: Well, and I take, I take issue with this notion of the quality being any, any different.

JACOBSON: I'm not talking about the source of the, of the product--

BILL HEAD: OK. OK.

JACOBSON: --I'm talking about the product getting to your door. You raised the question that they're getting their own deliveries. I can tell you that if my guess is that the hospitals themselves or, or whoever the, the provider is, is going to control when they receive those, those shipments and they're there to take care of them. When they don't control the timing of that shipment, then you run into some of the problems we've heard. I mean, it's hard to ignore what the testifiers have said today. These are the people that are on the ground--

BILL HEAD: Sure.

JACOBSON: --that are seeing it. And it's very frightening, to say the least, in terms of what's happening in this practice, all to save a buck. And I think that gets concerning. And, and so to me, in the bigger scheme of things, in what we heard in a previous bill and this one here, I am kind of concerned to just, you know, kind of dismiss it as it happens very rarely. I think we heard a lot of testimony today that it's not a rare occurrence. And, and how do we fix that? And how do these, how do these hospitals, in particular, get paid when they've got to reach into their own stock or when there's a problem. And so I'm anxious to hear from the insurance testifiers, is it worth how they handle [INAUDIBLE]?

BILL HEAD: Well, if I, if I could in response, Senator. And in all deference, the URAC, national accrediting organization, did a study and found that mail order, and this is mail order broadly, it's not just specialty, but mail order, the error rate was like 0.0000009,

something just infant-- infinitesimal, which is not to say when a patient is affected, that's not a big deal, because, because it is. But the notion that they, that-- because the hospital isn't controlling the supply chain, right? They're not the driver, they're not the wholesaler. So they, you know, they're putting their trust into a system. When the, when the, when the accredited specialty pharmacy is shipping something, it's tamper proof. And if it is tampered with, they will know that upon delivery. Now, which is not to say that the-- what, what has been described isn't real. But I think you have to look-- I think what this comes down to is what do-- you know, because the health plan is going to go with the highest quality, lower price-- lowest price, at the end of the day. Right? They're going to-- they'll kick us to the curb, if it-- when it comes down to it. So and, and I, I appreciate what they said. I mean, obviously, the hospitals were front line, you know, workers and through, you know, not just in COVID, but all the time. So we're not unsympathetic. But at the end of the day, what are we really doing about the cost and the quality?

JACOBSON: You know and I think therein that lies-- therein lies the question. When you receive shipments that have sat on the dock over the weekend and freeze, we got a quality issue.

BILL HEAD: Right.

JACOBSON: So I think that's--

BILL HEAD: Well, yes. But there's, there's workarounds for, for most of that and when there's not, then maybe that's what we should be talking about.

JACOBSON: I, I, I don't disagree. Thank you.

BILL HEAD: Thank you.

JACOBSON: Oh, you have, have--

DUNGAN: I had one brief question. I apologize. I keep being a little too subtle with my hand. I'm sorry.

JACOBSON: You need to be more. Senator Dungan.

DUNGAN: Thank you, Vice-- thank you, Vice Chair Jacobson. Just to make sure I understand this, too. These specialty pharmacies, these accredited special-- who owns those?

BILL HEAD: Different-- there's, there's all kinds. P-- there are affiliated specialty pharmacies with PBMs. There are some specialty pharmacies that are stand-alone specialty pharmacies.

DUNGAN: OK. And, and they become the specialty pharmacies through this process by a contract with the PBM or with the underlying payer?

BILL HEAD: Well, first, they have to be accredited. For the PBM to contract with them, they have to be nationally accredited, typically, by two national accrediting organizations, because the handling and the, the shipment and everything else has to be precise.

DUNGAN: Right. I'm just trying to figure out who, who becomes those specialty pharmacies and how that process works.

BILL HEAD: Right. And, and then, in terms of networking and determining which specialty pharmacies are, are in the network, it's going to be a matter of, you know, who's, who's providing the best service at the lowest cost. You know that-- we know that the pharmacy is safe and trusted and what have you. And under LB767 now, the other pharmacies can become accredited and as long as they accept the terms and conditions, be in network.

DUNGAN: And just-- and I know you probably can't speak on behalf of all of your members, when I spring things on you. So you've heard these stories, these real-life circumstances of these times where, for example, a therapeutic has been administered and the hospital has not been reimbursed for that like $22,000 or that $4,000 for the shots or things like that. Would you be-- do you think that you would be open to legislation requiring that kind of reimbursement?

BILL HEAD: Well, I think-- well, not when they can get it for a lower price. I would think you'd almost look at it the opposite way, if the hospitals are willing to accept what the other-- what the plan would otherwise pay, you know, that the plan is contracted to pay for that drug through other means and accept that-- and accept that reimbursement. But you don't want to put yourself at the mercy-- by taking away white bagging, you're basically saying the plan is at the mercy of whatever the hospital wants to charge.

DUNGAN: I-- but it just-- in these circumstances we've heard, I guess--

BILL HEAD: Well, rather than, rather than the reimbursement, let's have a, a-- I, I think that it's more of a plan question, frankly, because, you know, the PBM can do a workaround in terms of delivery,

wrong dosage, kind of thing like that. The reimbursement really is on-- going to come down to what the plan decides its choice is.

DUNGAN: OK. Thank you.

BILL HEAD: Our work, our workarounds are mostly around the drug itself: if it's the wrong dosage, it's late getting there, we're going to reimburse that-- most of our members are going to reimburse that hospital for the drug, The administration and the other things are going to be separate from that.

DUNGAN: Got it. OK. No, I appreciate that. Thank you

JACOBSON: Further questions from the committee for Mr. Head? If not, thank you for your testimony. Other opponents?

ALEX SOMMER: Good to see you all again. We're still here. Thank you for having me back. Alex Sommer, again, for the record, A-l-e-x S-o-m-m-e-r, representing Prime Therapeutics. I do actually want to touch on something that Senator Dungan was just asking about first, before I answer anything else and that was around what the, you know, the cost is and kind of like that, the $22,000. I think that $22,000 is misleading because we're talking about $22,000, like, that's the fixed price of the drug, anywhere and everywhere you get that drug. Twenty-two thousand dollars is the submitted cost of the drug or submitted for reimbursement cost of the drug, from the hospital. But the actual cost of that drug is significantly lower than what was actually submitted for reimbursement. Oftentimes, if it's going to be paid through, like, the specialty pharmacy, that drug would be many thousands, thousands of dollars less than what that $22,000 submitted cost is. So I think we're kind of talking about it's not a drug X, cost Y. It's not a fixed in time and place kind of cost here. It is something that is based on what the hospital submits for reimbursement. So getting that out of the way, as far as what the drug costs itself, because in that-- that's a variable. Really, the question comes down to who is getting paid and how much. And when we see the who, being the hospital, that how much, coming back to that $22,000, that how much is thousands of dollars more per claim. We're not talking about $5 or $10 on the margins, we're talking about thousands of dollars more per claim. And when you look at the entire book of insurer's business, the-- all of the claims are going through, that adds up to millions of dollars over the course of, you know, a plan year. End of the day, that is, going back to what I said earlier about stretching healthcare dollars, it's, it's really trying to make sure that patients have access to that care. And when you're spending

that much more on each and every single claim, you are really limiting the ability to provide care to as many people as possible throughout that plan year. Next, I do want to note that the bill that we have in front of us was-- we've heard a lot about patient safety. Mr. Head talked about the sourcing of the drugs and that being something separate and, again, that those specialty pharmacies are, in fact, safe sources of the drugs being provided. The bill here isn't about safety at all, anyways. The bill here is about what hospitals are being paid for the drugs and what practices are allowed to ensure that they, again, are getting paid for those drugs to, to protect that revenue stream. If we had-- if it was really about patient safety, we could have a discussion about what that is and what that bill looks like, but what we have in front of us is more of a hospital revenue bill than it is a hospital or a patient safety bill. So I want to make sure that we're focusing the discussion on the bill that's here and not a bill that, you know, doesn't exist right now. That, that bill we can discuss. This one is, again, about hospital revenue. To highlight one example, there's one drug in particular, MVASI, so we're talking not just about white bagging, we're talking about alternative sites of care, where patients can get the same treatment, just at a higher cost. Where we can provide this drug, MVASI, at a home infusion clinic, that drug costs $414. When it's billed through the hospital outpatient system, it is $7,067. That's each and every time that their drug is administered, that one drug, one claim, costs that much. These are real dollars, real claims, and they add up. And they make it very difficult to provide comprehensive healthcare for all Nebraskans. For those reasons, we oppose this bill. And I will happy-- be happy to answer any questions.

JACOBSON: Questions from the committee? If not, I do have one. So I just want to understand. So if you're a provider and especially with a shipment coming from the specialty provider gets there and the, the product is damaged, frozen or whatever, would you agree that the hospital needs to be reimbursed for that if that is, in fact, what happens?

ALEX SOMMER: If the hospital paid for that, yeah. I mean, whoever is paying for that drug would be reimbursed. I don't think we would double bill for that, that, that product.

JACOBSON: And if it doesn't get there on time and the hospital needs to administer out of their own stock, would you agree that they should be reimbursed for that?

ALEX SOMMER: I think we can have a conversation about where, where that comes from. I, I don't know. It depends on who, again, who's being reimbursed and for what and where [INAUDIBLE].

JACOBSON: So they should tell their patient to just, you know, just--

ALEX SOMMER: I-- I'm not saying that at all.

JACOBSON: --come back or what, what are you telling us?

ALEX SOMMER: Senator Jacobson, that's not what I'm saying. What I'm saying is that they should-- yes, we want to make sure-- I'm, I'm going to back up for a second. I'm going to repeat myself from earlier, where I said that we're not in the business of denying treatment and making people get sicker and have a disease take-- progress.

JACOBSON: I'm glad to hear that.

ALEX SOMMER: Because that, like I said, a sicker patient is more expensive. There-- there's no-- it's in no one's best interest, the patient especially and the payer's interest, for them to be sicker, because a sicker patient is more expensive. So we are in the business of making sure that they get the treatment they need, when they need it, for the best possible price. So I want to make sure that we're very clear about that, that that is not at all what we are in the business of doing. So as far as, you know, turn that patient away, absolutely not. That's not, that's not what we would want to happen. I think as far as the mechanics of making sure they get that care and who's paying for that care, I think we can have a discussion about that. Absolutely. I'm happy to have that, that conversation, you know, where we can really address what that looks like. I, I can't sit here and say I know exactly-- yeah, like I say definitively, yes, this person paid for it, it should look exactly like this. But I'm happy to have the conversation that, again, ensures that people are getting the care they need.

JACOBSON: Well, I, I would just point out that, that obviously hospitals run a large part of their operations are-- they lose serious money in. If you run an emergency room, an emergency department, you're going to give a lot of free care, because you're going to have people that you, you take care of, you don't get paid. But you're also going to keep people in your hospital who are able to be checked out, able to be released, but you're required to keep them there, unless there's a safe place to deliver them to. Somebody has got to pay for

that. OK. And if we-- and if the hospitals can't get paid somewhere along the way, they're going away. They're out of business. And as a, as a rural resident in Nebraska, I'm concerned about the loss of rural healthcare. And, and so, when we sit here and you give us that, that answer about it's all about cost savings, I think it's about saving lives. It's about saving providers, as well. And that's why I think this is going to take more discussion. And I'm, I'm refusing to believe that it's all about cost, because at some point we've got to maintain those providers as well. Thank you. Other questions? If not, thank you for your testimony.

ALEX SOMMER: Thank you.

JACOBSON: Further opponents.

JEREMIAH BLAKE: Good evening, Vice Chairman Jacobson--

JACOBSON: It is evening. It is evening.

JEREMIAH BLAKE: --members of the committee. It most definitely is. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs associate and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition of LB448. I'd like to use this opportunity to share with you a story about a situation we experienced last year and how it impacted one Nebraska family. I'm going to describe the situation in very general terms, as not to identify the family or the providers involved. What I will say is this took place in greater Nebraska. It did not take place in the Omaha metro or in Lincoln. So a few years, years ago, we had worked with a specialist who was managing the care for a child with specific healthcare needs to establish a site of care where the child could receive their regular drug therapy. The family had been traveling multiple hours each way for the child to receive treatment, because there isn't a provider in the area of specialization within 100 miles of the family's home. So working with the child's doctor, we found a local physician who administered the prescription drug, which is an injectable medication, at the local clinic, located in the family's community. This worked for a few years until last year when we received a call from the mother stating that the local clinic could no longer administer the child's prescription drug. The child was scheduled to receive a treatment the following day and the parent was asking if we would allow the local hospital to administer the prescription drug instead. Given the circumstances, we agreed and the child got the treatment they needed. However, we wanted to understand why the clinic had canceled the child's appointment, so we contacted

the physician to get more information about it. As it turns out, the physician was also an employee of the local hospital and the hospital had determined it was a conflict of interest for this physician to offer infusion services at the clinic. And this will kind of help you understand why we think the hospital came to this conclusion. So when the child was receiving care at the local clinic, the cost of the drug and related services was about $5,300 per injection. When the same kid received the same treatment by the same doctor at the local hospital, the cost of treatment skyrocketed to more than $30,000, six times the cost. In addition to the stress this event caused the family, I would also note that the patient's, patient's cost sharing typically increases when the care is delivered at the hospital, as opposed to a low-cost setting like the clinic. Unfortunately, our experience shows that hospitals are prone to inflating the price of the most expensive prescription drugs. Many of the new specialty drugs coming to market cost hundreds of thousands, even millions of dollars. One, one drug, called Spinraza, is estimated to cost $125,000 to $140,000 per dose and requires three doses a year. Watching my Light. Based on our experience, some hospitals are charging almost two and a half times the cost of the drug. Another drug, which I'm not going to try to pronounce, hospitals are charging more than three times the cost of the drugs, about $2 million a year, for something that we would normally reimburse about $700,000 for. So that--

JACOBSON: Go ahead and finish.

JEREMIAH BLAKE: OK. So, again, I just want to say that I appreciate the, the gentleman from Boys Town testified that they'd be willing to work with us on this issue. Again, that's what it comes down to is we-- you know, again, we can't justify to our members spending multiple times the cost of a drug when we have alternative sources. If the hospitals are willing to work with us to bring down those costs to a reasonable level, we're certainly willing to work with them on that issue. So with that, I'll shut up.

JACOBSON: Thank you. Questions from the committee? I, I guess, I'd just ask one, again. I, I, I, I and I've said this many times in this committee and, and I'm, I'm very-- I recognize the challenges that, that the insurers have. I'm also very sensitive to the fact that we've got to keep providers out there. And, unfortunately, the regulations that are out there on hospital providers today, is there's a lot of people that are getting free care. And so, ultimately, the hospitals can't continue to absorb all those costs and that's why you're seeing that differentiation. And so I am concerned about where our providers are going to come from, I don't think the insurance companies should

bear all that burden. Obviously, we need Medicare-Medicaid reimbursements higher. We need to see this more as a societal issue. But, but I, I think, to share some of the concerns on the cost differential, it's because they're spreading this cost over the entire operation, many parts of which are losing lots of money, why you got to look at, at the model today, with hospitals. They're-- many of them are losing money under this model. So what happens to our providers is my concern.

JEREMIAH BLAKE: Yep.

JACOBSON: Would you agree with that, that, that this is an issue?

JEREMIAH BLAKE: Yeah. You and I have had this conversation, particularly about Medicare and Medicaid reimbursement. And that's certainly an issue that you're probably more suited to address than I am, personally. But it does affect our members and the rates that we have to charge.

JACOBSON: Yes.

JEREMIAH BLAKE: And, and again, I, I feel like a broken record in saying this, but we have members in rural areas that require care. We want to make sure they have access to care. And just as a general rule, we do reimburse our rural hospitals more than we do the urban hospitals for that reason, because their cost structure is different. And so, you know, again, we're happy to work with our partners in the hospital community. But again, you know, you're kind of squeezing a balloon here and, and, and it's, it's driving up costs for our members. We need to work more collaboratively with our providers, instead of coming to the Legislature and debating over where a drug comes from and how much the reimbursement rate is.

JACOBSON: Thank you and thanks for your testimony. Any last minute questions? Because we're going to get Mr. Bell next. Thank you.

JEREMIAH BLAKE: Thank you.

ROBERT M. BELL: Presuming I was an opponent, Senator Jacobson.

JACOBSON: I-- just a wild guess. Just a wild guess.

ROBERT M. BELL: Vice Chairman Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell, last name is spelled B-e-l-l. I'm an executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of

Nebraska insurance companies, including most of the health plans in Nebraska. I'm here today to testify in opposition to LB448. I'm not going to reiterate everything that you have already heard. I'll, I'll, I'll share a quick anecdote, though. In the evening, if you watch the news or sports, there's, of course, pharmaceutical commercials on. And one of the, the things that I-- since I've taken this job-- my wife works in insurance, as well, so we don't get invited to career day at school. But we I, I-- I'll ask her, it's like, how much do you think that drug costs? And she's like, I don't know. And you know, it's the $5, $5 coupon coming in and it's Humira. You know, Humira, it's all over the place right now. It's a wonder drug. It's $7,000 a dose, you know, something that's delivered to a patient's home, brown bagging, you know. And I don't, I don't know exactly how many doses a, a consumer would receive in a year. I don't think it's 12. I think it's a lesser number than that. And, you know, let's say it's four, right, that's $28,000. For me, that's a car. That's a car. I think the average Nebraska family-- so we're a family of five in the Bell household. If we ran through the healthcare exchange, our premium would be close to $30,000 a year just to provide us that risk coverage. I mean, it's, it's very expensive. And so you see health plans doing a variety of things to get their hands around that cost. And you're right, we got to have the providers. If the providers aren't there, you know, we're not able to provide those, those services and so we need them to stay in business as well. And it's, you know, you see the, the friction at the edges of this, you know, where we can provide a, a drug for-- that is tens of thousands of dollars, for half the cost or a third of the cost or, or whatever. We, we want to be able to do that. Don't want to be able to tie our hands, but we need to make sure that our patients are safe as well. And so it's always concerning again, when, when you hear this. And by the way, Senator Dungan, we're on, we're on the risk if that patient gets sick, right? If that drug is incorrect, the hospital's not going to be liable, it's the insurance company. We're going to pay for that care for that, for that patient. And we don't have a cap like a hospital does, which if they capped that, of course, we would support, for our medical providers. But just, just know that insurance companies [INAUDIBLE] as you know don't have caps. So anyway, with that, I just wanted to say, also, thank you. I mean, this is my last time I'm going to testify, I think, this year, before this committee. I got to go to Judiciary on Friday. But you're always attentive, good questions. You got some of the best closers in, in the business sitting on this committee. So it's, it's always fun to-- so thank you. You know, I go to other committees, too. They're not this good, so.

JACOBSON: For the record.

ROBERT M. BELL: And I don't think my kids are watching, but they might be. Anyway.

JACOBSON: For the record, you haven't been car shopping lately.

ROBERT M. BELL: I know. I got a, got a 15-year-old and I got to do that this summer. And I don't buy new cars.

JACOBSON: Go look at the junkyards if you're paying that price.

ROBERT M. BELL: OK. OK.

JACOBSON: Questions for Mr. Bell?

DUNGAN: Can we have him say more nice things about us? Is that--

KAUTH: I would just say, you know that's on the record, right, that we're the best.

JACOBSON: I think that's-- I think, I think he's had a lot of nice things to say [INAUDIBLE].

ROBERT M. BELL: Oh, I, I know it's on the record, Senator, so.

JACOBSON: All right. If not, thank you for your testimony.

ROBERT M. BELL: You're welcome.

JACOBSON: Any other opponents? I got to ask, are there anyone wishing to speak in the neutral capacity? Thank you. Senator Bostar, we have 15, 15 proponent letters.

BOSTAR: Excellent.

JACOBSON: And with that, hey, welcome to the close.

BOSTAR: Hey.

JACOBSON: I, I, I you've got all the time you want, as long as you do it in the next few minutes.

BOSTAR: That's right. I appreciate the discussion that was had in this hearing. You know, Senator Jacobson, I think you're absolutely right, that the, the transportation, the logistics side of this is a, is a serious cause for concern and one of the chief challenges that we have

to fix through this. You know and, and a lot of things were said, but I think what might be valuable, in trying to put all of this into context, because, you know, the last two bills have some similarities, as do other pieces of legislation we've heard this year. And maybe this will be helpful. So imagine we wanted to start an insurance company. So we did. We, we created an insurance-- all of us. And then in that endeavor, we wanted to make a lot of money because why not? So we started making a lot of money. And then we're hit with regulations, regulations that limit how much money we can make, right, in the form of a medical loss ratio, which says something along the lines of, you know, at least 80 percent of the money you make, that you take in through, through your premiums collections, must go back out in the form of, essentially, medical care. And you can't make more than that, so that's really limiting. It's a big bummer if you want to make a lot of money. So, you know, you wonder how-- what are you going to do? How do you get around that? So you think, well, we should create a PBM. Why don't we have our own, because it doesn't work the same way for the PBM. So if we have our own PBM, we can make money off of spread pricing, for example. Right? So if we own it, I mean, sure, the PBM is the one generating all the profits, but they're our profits. So we can make more money that way. OK. So we do that and we're making more money and more money. And then we realize, you know, if we had our own pharmacy, too, we could make even more money. Right? So we create our own pharmacy. We do that to drive more revenues and profits to ourselves. But we got a little bit of a hiccup, right? Because at the end of the day free will, the people we want to buy from our pharmacy can buy from other pharmacies and that's also a bummer. So we create policies that force everyone to buy from our pharmacy. It's amazing, because we control the plan, we control the PBM, and we control the pharmacy. So in the plan, we require the drugs to come from the pharmacy we want, which we own. That way, we can get around all of that. Medical loss ratio doesn't mean anything when it's only a fraction of your business and everything else you get to use to actually create the profits that you want. White bagging may or may not have something to do with that hypothetical scenario I just said. You know, I might leave it there. That was a fun exercise, I think, for us to go through. Be happy to answer any final questions.

JACOBSON: Thank you for taking us down that journey. Questions for Senator Bostar? OK. Thank you.

BOSTAR: Thank you.

JACOBSON: And that concludes our hearing on LB448. And what is the plan for LB538?

JOSHUA CHRISTOLEAR: This one is [INAUDIBLE].

JACOBSON: Perfect. Perfect. All right.

JOSHUA CHRISTOLEAR: Proponents.

JACOBSON: We're going to move on to open the hearing on LB538.

KAUTH: Julie said we were supposed to grill you?

JACOBSON: Welcome. Welcome.

TORI OSBORNE: What?

KAUTH: Said we were supposed to grill you?

TORI OSBORNE: I don't remember that part. Well, good evening, Vice Chair Jacobson and members of the committee. My name is Tori Osborne, T-o-r-i O-s-b-o-r-n-e, and I am Senator Julie Slama's legislative aide and I'm introducing LB5--

JACOBSON: 38.

TORI OSBORNE: --38 on behalf of Senator Julie Slama. This will be quick. LB538 is a shell bill. That's all I have. Thank you for your time.

JACOBSON: Thank you very much. Any questions? If not, [INAUDIBLE]. We, we won't ask you questions. So thank you.

TORI OSBORNE: Perfect.

JACOBSON: Are you going to stick for close or are you going to waive-- well, you're going to waive close.

TORI OSBORNE: I'll waive it. Yeah.

JACOBSON: OK. So are there anyone wishing to speak in-- as a proponent? Anyone wishing to speak in the opposition? Anyone wanting to speak in the neutral capacity? There's no letters. There's no closing. So we're going to close the hearing on LB538, and we're going to open the hearing on LB537. You're welcome to open.

TORI OSBORNE: Well, good evening, again. My name is Tori Osborne, T-o-r-i O-s-b-o-r-n-e, and I am Senator Julie Slama's legislative aide, introducing LB537 on behalf of Senator Julie Slama. Again, it's a shell bill. So that's all I have. Any questions?

JACOBSON: Thank you very much for that great opening. Are there any proponents? Seeing none, are there any opponents? Seeing none, does anyone wish to speak in a neutral capacity? Seeing none, there are no letters. You-- we're not going to have you close, so thank you very much. We're going to close the hearing on LB537. And if only Senator Bostar could have [INAUDIBLE] this quick, but thank you very much.

von GILLERN: Imagine a scenario--