

Transcript Prepared by Clerk of the Legislature Transcribers Office  
Banking, Commerce and Insurance Committee March 3, 2025

**JACOBSON:** Welcome to the Banking, Commerce, and Insurance Committee. I'm Senator Mike Jacobson from North Platte, representing the 42nd District, and I serve as chairman of the committee. The committee will take up the bills in the order posted. This public hearing is your opportunity to be part of the legislative process and to express your opinion on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. When it is your turn to come forward and testify, give the testifier sheet to the page or to the committee clerk. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name and spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally, by anyone speaking in a neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We will be using a 3-minute light system for all testifiers. When you begin your testimony, the light will-- on the table will be green. When the yellow light comes on, you have 1 minute remaining, and the red light indicates you need to wrap up your final thought and stop. Questions from, from the committee may follow. Let me be clear on the red light. When the red light comes on, wrapping up your final thought means a sentence, not another paragraph. So you will be cut off if you go beyond that. There when-- there may very well be committee members who will ask you a question, ask you to finish your comments if you have more to say. They may give you that opportunity, but that needs to come from the committee. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills before, before us being heard. It is just part of the process, as senators may have bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committee-- committees state that the written position comments on a bill to be included in the record must be submitted by 8:00 a.m. the day of the hearing. The only acceptable method of submission, submission is via the Legislature's

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website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person will-- before the committee will be included in the committee statement. I will now have the committee members with us today introduce themselves, so starting on my left.

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

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

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

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

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

**DUNGAN:** George Dungan, District 26, northeast Lincoln.

**JACOBSON:** OK. Also assisting with me today to my far right-- or to my right is our legal counsel, Joshua Cristolear, and to my far left is our committee clerk, Natalie Schunk. Our pages for the committee are here today, also. I'm going to let them stand up and introduce themselves and tell us a little bit about themselves.

**AYDEN TOPPING:** Hi. My name is Ayden. I'm a second-year psychology student at UNL.

**KATHRYN SINGH:** Hi. My name is Kathryn. I'm a third-year environmental studies student at UNL.

**JACOBSON:** All right. With that, we'll begin today's hearings beginning with LB198. Senator Sorrentino, you're welcome to open. We lowered that chair especially for you.

**SORRENTINO:** Thank you very much. If, if I could just-- I need a high chair here. Thank you, Chairman Jacobson, members of the Banking and Insurance Committee [SIC]. My name is Tony Sorrentino, T-o-n-y, S-o-r-r-i-n-t-I-n-o., and I represent Legislative District 39, which is Elkhorn and Waterloo in Douglas County. I bring today-- to, to you today LB198, having to do with the pharmacy benefits manager industry. After spending 35 years as an ERISA attorney advising plan sponsors on

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the design of their health plans as well as providing legal advice on federal compliance along with fiduciary obligations, this is a topic I feel very passionate about. Pharmacy benefit managers, or PBMs, as I'll refer to them for the most of my discussion, originally designed to reduce administrative costs for insurers, validate patient eligibility, administer plan benefits, as well as negotiate costs between pharmacies and health plans, all very noble and necessary healthcare partners. My discussion today and my legislative bill is not to eliminate PBMs, but to bring some needed reform. Over time, PBMs have taken advantage of their strategic position between the insurer and provider to assert control over prices in most aspects of the prescription drugs transactions and have become more profitable at the expense of health plan sponsors and plan participants. The 3 largest PBMs, Caremark, Optum and Express Scripts, managed drug benefits for approximately 80% of Americans with prescription drug coverage. Let me first start out to address the constitutionality of a state's ability to negot-- to regulate PBMs. The authority of states to regulate PBMs has been challenged by PBMs in arguing that federal preemption restricts state PBM regulatory activities for most healthcare payers under ERISA, the Employee Retirement and Income Security Act. However, in *Rutledge v. PCMA*, the United States Supreme Court ruled that an Arkansas law regulating PBMs was not subject to federal preemption. Pursuant to the *Rutledge* decision, state laws regulating PBMs will likely be interpreted to view PBM pricing regulations as presumptively beyond ERISA's preemptive scope. And I would remind you that nothing is unconstitutional until the Supreme Court says it's unconstitutional. The *Rutledge* opinion notes that ERISA will only prohibit the following types of PBM regulations: (1) laws that require plans to cover specific benefits. That is not this law. Laws that bind plan administrators to specific rules for determining beneficiary status. That is not this law. And finally, laws that create acute, indirect economic effects that force a plan to adopt a certain scheme of coverage. That is also not this law. It's been suggested that state law-- state PBM laws can avoid preemption if they do not mandate what benefits ERISA plans must cover or who qualifies for such benefits, but merely regulate the cost of items and services covered or the manner in which the benefits must provide it. I believe that this bill contains permissible regulatory provisions that satisfy the *Rutledge* standard. This legislature adopted the Pharmacy Benefit Manager Licensure and Regulation Act under LB767 in 2022, which authorized the Department of Insurance to exercise regulatory and supervisory authority over PBMs until January 1 of 2023 with the passage of LB767, PBMs were virtually unregulated in this state and federal level, even though they manage numerous prescription

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plans funded by taxpayer dollars. That would include Medicaid, as in Nebraska State Medicaid. LB767 also addressed other unfair business practices of PBMs. Despite the passage of LB767, there are other PBM business practices that need to be further addressed by the Nebraska Legislature, which is the intent of this bill. So LB198 addresses the following areas of concern with PBM business practices (1) PBMs steering patients to their own pharmacies; PBMs paying community pharmacies less than they pay their own affiliated pharmacies; PBMs requiring credentialing that is more stringent than what the state requires for pharmacy licensure; PBMs reimbursement to community pharmacies below the cost of acquisition for prescription drugs; Establishing a pharmacy benefit manager duty of care, good faith and fair dealing; and finally, prohibit a pharmacy benefit manager, healthcare or healthcare benefit plan, either directly or indirectly, from engaging in, facilitating, or entering into a contract with another person involving spread pricing in Nebraska, and I will define exactly what that means. Here are some major components of LB198. Section 3 would extend the appeal, investigation, and dispute resolution process to reimbursement for-- to reimbursement for a specific drug or drugs made under a maximum allowable cost price at below the pharmacy acquisition cost. This bill would also require PBMs pay pharmacies a fair price on medications they dispense to patients. Pharmacies are receiving underwater reimbursements and PBMs are posting record earnings. The dollars generated for rebates, audits, and below-cost reimbursements are not always being passed along to the patient or the pharmacy. Section 4 of the bill prohibits PBMs from requiring credentialing that is more stringent than what the state requires for a pharmacy licensure as a condition to participating in a PBM pharmacy network. Prior to the passage of LB767, PBMs imposed more stringent credentialing requirements for participating in a specialty pharmacy network. While LB767 addressed a specialty pharmacy network, LB198 proactively prohibits similar action for other PBM pharmacy network activities that are of a nonspecialty-related. Section 5 prohibits 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. And I'll get to that. These practices steer pharmacy customers away from their local pharmacy to more costly out-of-state PBM-affiliated mail-order pharmacies. This section would further allow pharmacists to decline pharmacy services if the pharmacy or pharmacists will be paid less than the pharmacies acquisition costs. At this point, it's good to remember in many cases, insurance carriers own PBMs. PBMs own pharmacies. What we're seeing is a dissolution of the vertical horizon-- the vertical concept here. I have nothing but

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praise for people who, within the vertical chain of command, can make money at every step. That's not the issue. That's the American way. The difference is when we're talking about pharmacy, there is a fiduciary responsibility. There's not a fiduciary responsibility. When Ford assembles the car and makes the parts and buys the tires and everything else. That's not what this is. And we'll get to that in a moment. Section 6 imposes a fiduciary, good faith and fair dealing requirement for PBMs. About 4.5 years ago, the last executive order, I believe, by the Trump administration, Trump 45, that is, was to pass the Consolidated Appropriations Act. The Consolidated Appropriations Act has 4 requirements. One of them deals with pharmacy. And what that said was a PBM or a pharmacy benefit manager will allow access to all the information a plan sponsor needs to comply with the act. It was very specific as to what that information is. It's been difficult to get that information for plan sponsors. I know that because that's what I do for a living because of something called gag clauses. Care clauses are in the administrative service agreement and they restrict the access to that information. Without that information, a plan sponsor, be it private or the state or our state plan or Medicaid can't do something called benchmarking. CAA requires benchmarking. You can't benchmark information you don't have. If they have that information to benchmark, they would see that certain practices of PBMs, such as spread pricing, are causing them to pay far more money than you would in your normal health plan. This is near and dear to my heart, because I am having conversations with the Health and Human Services Department of our state regarding our state Medicaid plan, which has 500,000 participants and a drug spent somewhere around three quarters of \$1 billion. I know people who can go in there, including myself, but I have a conflict of interest. I won't do that-- can look at that, and I think there's a lot of money on the table. I won't say how much, but it's 9 figures and it's a high 9 figures. PBMs have faced state regulatory scrutiny and pharmacy lawsuits because as a result of their position in the market, they have the opportunity to retain rebates and discounts rather than passing savings on to consumers for health plans. These practices create a conflict of interest for PBMs in dealing with pharmacy health plan sponsors and pharmacy patients and may result in higher, may result in higher drug prices for patients and lower reimbursements for pharmacies. I'll talk about this in my close, but if you get bored of any testimony and I'm sure you won't, go to LinkedIn, put in pharmacy benefit litigation and see what comes up. We'll talk about that. There's one case I want to address, and that's the Navarro v. Wells Fargo. Wells Fargo was filed in July of 2024, if I remember right. It's a class action lawsuit by the employees of Wells Fargo against their employer and their PBM

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claiming fraudulent practices, and they are not doing as an employer is apt to do, and getting the information for their pharmacy drugs to make sure that they, the plan participants are getting the best deal. You don't have to have the cheapest, you don't have to have the widest network, but you have to be able to show as an employer that you did your due diligence. You cannot do your due diligence unless you have information. That case is still pending. There was one before that. Johnson and Johnson company that was dismissed, frankly, for bad lawyering. That's really why it was dismissed. Keep your eye on that case. It may become the standard. A duty of care established for PBMs under LB198 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 plan benefits-- health benefit plans. Finally, this bill addresses spread pricing. And I'll tell you exactly what that is in a moment. Spread pricing pads the pockets of PBMs to the detrimental-- to the detriment of health plan benefits, providers, and their patients. While the PBMs will likely charge an administrative fee, its spread pricing would be eliminated. The administrative fee would be preferable to continuation of PBM spread pricing practices in a spread pricing model. Here's what happens. The PBM keeps a portion of the amount or spread between what the health plan pays to the PBM and the amount the PBM reimburses the pharmacy for the patient's prescription. It's more than taking a little bit off the top. Way more. The bill 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. Every private, governmental, quasi-governmental and employer who uses a PBM that does spread pricing is risking a class action lawsuit, just like we're looking at at Wells Fargo and a whole bunch of others. We don't necessarily have ambulance chasers anymore. I can say that I'm an attorney. We have PBM chasers. They're going to chase down the health plans. Again, look on LinkedIn. There are, there are law firms, very reputable law firms who made a killing in 2008-10 in the retirement area on fiduciary who are advertising, if you worked for any of these employers-- and you would know every one of them-- give us a call. We'd like to talk to you. The main intent of LB198 is to do 3 things: Provide transparency in drug pricing, protect community pharmacies, and prohibit spread pricing. I need your help to help rein in the costs of benefit plans for Nebraska employers and Nebraska employees. I'll be happy to answer any of your questions. However, we have a lot of very capable people behind me who are willing to testify, as well. Thank you.

**JACOBSON:** Questions from the committee? Senator von Gillern.

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**VON GILLERN:** Thank you. Thank you, Senator Sorrentino. Just a quick clarification on-- regarding spread pricing. Your bill does nothing to set a markup rate. It does nothing to say-- to, to fix pricing. It's simply a disclosure that you hope would lead to more informed and wiser purchasing on, on the part of those downstream. Is that correct?

**SORRENTINO:** That is correct. I'll read this last line to you. This bill would prohibit a utilization of spread pricing mile by PBMs, and would require a PBM to disclose to health plans that spread pricing is not authorized under Nebraska law.

**VON GILLERN:** Got it. Thank you.

**JACOBSON:** Senator Riepe.

**RIEPE:** Thank you, Chairman. Thank you for being here. I can tell you're well prepared, and so that makes it easier on all of us. You talked a little bit about Arkansas. But would Nebraska be walking the-- if I may use the Navy term of walking the plank on this thing? Are we, are we going to expose ourselves to a lot of litigation, if you will, and associated with that, the expenses?

**SORRENTINO:** I would suggest that, you know, anybody can take anybody to court.

**RIEPE:** Of course.

**SORRENTINO:** We know that. But if you have a strong background or depth of ERISA, I think you would have to-- it could go to federal court under ERISA, it could go as an unconstitutional amendment or something like that. I don't see either one. And I'm not the one trying it, to those to be particularly strong cases. Again, and, and I, in my closing, I'll, I'll talk about legislation other states are adopting. And I realize this is not the only PBM bill that we're going to be seeing-- the only one from me-- this, this Nebraska Legislature. Many, many states are enacting this. I read a lot of them. Some of them go way further than this. So I think we're dipping our toe into this. As state senators, our job is to not leave the state open for lawsuits, and that's not my intent.

**RIEPE:** May I have a second question?

**JACOBSON:** Sure. Go ahead.

**RIEPE:** Thank you, Chairman. Of-- on the fiscal note, on the narrative part of it, it talks in a little bit about the federal match at 65%

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would be-- for federal funds, it would increase \$3.4 million, and for the General Fund, it would increase \$1.8 million.

**SORRENTINO:** May I?

**RIEPE:** Please. Save the hurt.

**SORRENTINO:** I'm sure the folks in the fiscal department have good reason to think that. I happen to think you should flip those around. I'll just talk about Medicaid. \$750 million of prescriptions. I know who the 3 PBMs are. That doesn't matter. I'm familiar with their contracts. I'm familiar with Lock and Access. I'm familiar with their reporting. I do know they use spread pricing, and spread pricing is never anything that's going to save a plan money. I will give you a perfect "for instance." I believe you were at the dinner Saturday night here in Lincoln. A major, major employer in our state happened to ask me about this bill, and we talked about it a little bit. And their quote to me was, well, I know we're OK because we're with such and such a pharmacy. And of course, I said, well, that's good for you. And I turned around and-- no. So it's not just for the uninitiated and those who don't know what's good. This is a-- if you remember, if you're old enough to remember 60 Minutes, in the old days, where William Proxmire would come up and the clock would tick. This would be on there every week. This is a big, big deal. And there's many, many layers of pharmacy and hospital. Of course, you know that. And it flies under the radar. And like I said, I'm not the only PBM bill, but I, I, I think just the opposite. I think the state of Nebraska and more importantly, maybe their employers, and most importantly, employees. These bills that are being brought as class actions are on behalf of the employees, not on behalf of a risk or the state or somebody else. It's the employees. Now, we need, we need a really good case to go all the way to the Supremes, and we will, but it might take a few years. But in the meantime, this is not the time to wait. We need to take action.

**RIEPE:** And you're talking about the U.S. Supreme Court.

**SORRENTINO:** The U.S. Supreme Court. Yeah.

**RIEPE:** OK. Thank you.

**SORRENTINO:** The constitutionality would be here in Nebraska.

**RIEPE:** Thank you very much. Thank you, Chairman.

**SORRENTINO:** Thank you.

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**JACOBSON:** Senator Hallstrom.

**HALLSTROM:** Yes, Senator Sorrentino, thank you for your experience and your expertise on this. One of the items, I'm looking at 26 proponent online submissions and no opponents. And one of the things that they say is PBM reform is essential to protect patient access to pharmacy services across Nebraska. Would you agree with that statement?

**SORRENTINO:** I would agree with that. There are small pharmacies. I mean that-- a lot of people think the state ends at Lincoln. It doesn't. And there's a lot of interstate out there and a lot of small-town pharmacies who cannot compete. And we need those small towns. Not everybody wants to drive 30 or 40 miles to the nearest Walmart. And the reimbursements they're getting, they, they-- they're going underwater. And there are pharmacists who are-- who will be testifying that are far better that can give you the details. But yes, I agree with that proponent statement.

**HALLSTROM:** And would you suggest that not only employers, with health insurance plans, but the state itself, through its managed care organizations, when you look at the fiscal note, probably don't understand, as you've suggested, that there really probably ought to be savings from making these changes, as opposed to cost to the state?

**SORRENTINO:** I would, I would agree with that. While there might be small ministerial charges, I think we're looking at millions and millions of dollars to the positive. And by the way, spread pricing isn't the only practice that isn't great out there, but you've got to peel back the onion one, one piece at a time.

**HALLSTROM:** And with regard to the Rutledge case, I appreciated you bringing that to our attention. Do you know how long ago that case was handed down by the Supreme Court?

**SORRENTINO:** It wasn't that long ago. I wanted to say in the last 18 months, but I could be off a month or two.

**HALLSTROM:** And have, have the PBMs fled Arkansas in droves, to your knowledge, in light of that ruling?

**SORRENTINO:** I do not believe they have.

**HALLSTROM:** OK. Thank you.

**JACOBSON:** Other questions? I just have one. I, I would just maybe note, this will probably be-- PBMs is probably-- and understanding

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that industry is probably one of the more complicated issues that this committee will, will ever hear. There are so many nuances to that, and really, the whole, whole healthcare process, when you look at from pharmaceutical companies, who control the pricing and, and control the patents and so on. Then you've got, you've got the wholesalers out there and they compete, and then you've got the PBMs. And, and I guess you look at the whole process and everybody keeping everybody else honest. And then, of course, you've got the VIPA plans that are managed by insurance companies who may or may not have a PBM that they own, as well. So you've raised a tremendous number of issues in, in your bill that most people will struggle to comp-- to understand and comprehend, unless you kind of understand how this all comes together. So I appreciate you bringing the bill and, and being able to explain it and comprehend it. The, the only question I would ask, and I know there's several that will testify and, and they'll get into this. But as I read through the bill, the only question I came back to, which is one of the complexities to trying to nail this down, is on page 3, lines 18-20, really talks about pharmacy acquisition costs and what that means. And it means that it's basically the amount that a whole-- pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice. So what keeps the wholesaler honest?

**SORRENTINO:** Typically, the competitive nature of the business more than anything.

**JACOBSON:** OK.

**SORRENTINO:** You're not going to last long if you-- if you're not.

**JACOBSON:** And we're dealing with probably 3 or 4 wholesalers that are the primary wholesalers.

**SORRENTINO:** Yeah, I would say that's probably an accurate--

**JACOBSON:** It feels a little bit like the packing industry--

**SORRENTINO:** Yeah.

**JACOBSON:** --on livestock. And that's worked out.

**SORRENTINO:** If you say so. Yeah. But that's, that's correct. It's a--

**JACOBSON:** Yeah, I--

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**SORRENTINO:** You know, and I, I want to be clear. I am not anti-PBMs. PBMs, I was glad when they came about. I was doing this, and, and they do a-- did a great service and do a great service. But things have changed, and the integration and the vertical integration, it's, it's changed things. And it's no longer what I think it was intended to be.

**JACOBSON:** I, I think you're right. And I, I-- from my perspective as the chair of the committee of one of my goals has been, after hearing this last year and the year before, that partly that-- I want to fix this and get it right and make sure that we're doing the right things with the process. And I think you-- you've given us a great start on getting there, so--

**SORRENTINO:** Thank you.

**JACOBSON:** --thank you. And any other questions from the committee? If not, I understand you'll stick around for close?

**SORRENTINO:** Yes, I would.

**JACOBSON:** All right.

**SORRENTINO:** Thank you.

**JACOBSON:** And I'll ask for the first proponent to please step forward, and we'll keep moving. Go ahead.

**DAVID RANDOLPH:** OK. Chairman Jacobson and members of the committee, my name is David Randolph, D-a-v-i-d R-a-n-d-o-l-p-h, and I'm the owner of Dave's Pharmacies in Hemingford and Alliance, Nebraska. I'm also the president-elect of the Nebraska Pharmacists Association. I'm here today to testify in support of LB198. We are continuing to see a national crisis unfold in the closing of community pharmacies, 6-9 a day between chains and independents. This is leaving patients without convenient access to medications, vaccinations, and healthcare advice. This is affecting on all of Nebraska, but especially rural areas, where we also help to triage patients into and through the healthcare system. There are 452 community pharmacy licensed in the state, around 30 of which are not in use by the general public. According to the Nebraska Board of Pharmacy, since 2020, we have seen 69 community pharmacies close. That's around 14%. 14 closed in '24, and 4 have closed in the last 2 months in the Panhandle. Please ask me about these numbers later. However, the CEO of CVS Caremark, David Joyner, is on record saying that there are too many pharmacies in this country. He obviously is out of touch and hasn't driven across the state of Nebraska looking for a pharmacy. My inspector visited me last

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week from Omaha and commented that he went 150 miles between pharmacies. This has got to stop. Something must be done before it's too late for both patients and pharmacies, and LB198 will help. The 2 provisions I'm concentrating on right now are the right to refuse and reverse-- reimbursement below cost. When I first started in pharmacy, you wanted to fill every prescription that you could because that was your job, that was your business, and you could help people and make a decent living doing it. Now, you must be selective as to which drugs that you stock, and there are certain patients that you'd love to help but just can't, or you won't be in business to help others. We don't stock many brand name medications anymore due to their cost and the poor reimbursements from PBMs. If I run the claim and can't purchase it for the cost the PBM pays me, I won't order it in. The problem is that when someone needs it, they need it and I need it in stock. If I get paid correctly, I'd like to have that available. But due to the leave-- "take it or leave it" contracts, which they don't allow us to stock them, because if we do have in stock, we must dispense it. So we have to make-- this bill would allow me to make the best decision for my business and patients by keeping those in stock and still being able to deny if I'm underpaid on that claim. Other states have already-- have laws like this in effect. We're not reinventing the wheel. And the same states plus Tennessee also have protection for under reimbursements of the claim. This is where it's really at. We don't want to turn the patients away. We just want to be paid a fair price plus a dispensing fee, which covers the cost to dispense. This law will give us the coverage of the medication and as we saw in Mississippi, will stop the overpayment of the PBMs own pharmacies and bring us to their level of payment. It used to be a town of 1,000 people could support a pharmacy. Now, with below cost reimbursements, patient steering, and dispensing fees way below the actual cost to dispense, we have communities of 1,500 without a pharmacy or communities of 4,000 with just one, leaving them overwhelmed and underpaid so they can't hire more help. As I've done pharmacy business across the state, I've seen pharmacists serving their communities in ways that only a local provider can. But I've also heard the horror stories of both patients and pharmacies just barely hanging on, due to the greed and lack of caring by the PBMs. We need PBM reform now in Nebraska, before more communities continue to lose their lifeline.

**JACOBSON:** Thank you. Questions from the committee? All right. Yes, Senator Hallstrom.

**HALLSTROM:** You had mentioned maybe wanting to say some more about pharmacy numbers, if, if you want to--

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**DAVID RANDOLPH:** Yes.

**HALLSTROM:** --expound on that.

**DAVID RANDOLPH:** OK. First off, you have in your handout there, the closings from the Board of Pharmacy, and it goes from 2014. And you can see how many have closed in that amount of time. And then, the 2025 numbers obviously would not have the last 4 that I mentioned, so we would be up to at least 6 in that. And then also, in the license community pharmacy handout here, you can see the 0-5 pharmacies. Well, in the last, actually 2 weeks, 2 of those counties are now with zero pharmacies. Those are called pharmacy deserts, when somebody has to drive more than 20 miles to a pharmacy, which I'm from out west, I drove 7 hours to be here today. Not much for me to drive 20 miles. However, if you don't have a car, if you limited income, if you are elderly, 20 miles is a big deal. And I literally deliver to 2 towns that are 45 miles away from me because they don't have pharmacies. So those numbers are what is going on in the state. And you can see some of those counties are not in western Nebraska. They're in areas that have population-- more population. And one of the things that the PCMA, the PBM groups are going to say in this, because they say it nationally that pharmacy numbers have actually gone up. Each pharmacy has a national provider identification number, NPI, so each pharmacy has a number. But there are pharmacies like mine that have 2, because we service retail customers and long-term care customers. So one for each one. There are some pharmacies that have 3, because they service-term care, retail, and specialty, which some of those stores that I mentioned have specialty NPI. So when PBMs come across your PCMA, which is the PBM lobbying group-- comes across and say, no, we've got more pharmacies than we've ever had before. What they're looking at is the national-- the NPI number. But what they're not saying is Dave has 2 in his store. And then when they look at closures, rather than looking at NPIs, saying Dave closed, so you lost 2 NPIs, they look at the Board of Pharmacy numbers that says Dave's closed so you lost one pharmacy. So their numbers are skewed when they come and they say, well, we have more pharmacies. No, you don't. You've got more NPI numbers, but the same brick and mortar pharmacy is the same number that it was before. So that is a very confusing, easily misconstrued statistic that they give. So I wanted to make sure that was out there so you guys understand that.

**JACOBSON:** So as you-- using that methodology, so Walgreens is one pharmacy or they get counted for every location?

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**DAVID RANDOLPH:** Walgreens? No. Walgreens would have-- like, if there was one on 6th and Main and one on 20th and Dodge, OK. That would be 2 NPIs. OK. So that would be 2 pharmacies. But let's say one of those Walgreens had a long-term care division where they serviced a nursing home. That one might have one NPI plus a long-term care NPI in the same building. So even though it's one pharmacy, it's got 2 NPIs. So the PCMA group says, oh, we got 2 pharm-- no, you don't. You got one.

**JACOBSON:** Well, well, I raise that because if I look at the banking industry over the years, I remember when I first started in banking, there were over 500 bank charters in the state of Nebraska. Today, there's about 136, but there are more banking offices than there were back in 1980, so, so it's really a matter of how many independent owners are out there. And it would be interesting to see the number of the mix of pharmacies that are out there and how that, how that compares. So.

**DAVID RANDOLPH:** Yeah.

**JACOBSON:** But thank you. Other questions? Senator Hallstrom.

**HALLSTROM:** One of the elements in the bill is to address the steering of patients to an-- a PBM-affiliated pharmacy. And another aspect is that pharmacies that are unaffiliated are being reimbursed at a lower level than the PBM-affiliated pharmacies.

**DAVID RANDOLPH:** Correct.

**HALLSTROM:** Can you explain to me how that's in the best interest of health insurance plans to steer patients to go to a higher-cost alternative just because it's affiliated with the PBM, or in fact, is that not the case?

**DAVID RANDOLPH:** Well, that is not the case, because if you're an employer or a taxpayer, if you're looking at Medicaid and Medicare, you're getting the wrong end of the deal. The PBM is the one making the money. And all you have to do is look at the top 500 most profitable corporations in the United States, and you'll see them right at the top. But it does directly affect the local pharmacy, whether it's in Omaha or North Platte or Alliance, Nebraska, because not only are they steering, in the case of North Platte and Omaha, to their retail pharmacies, but they do more steering, trying to get them to go through the mail. And what's frustrating as a pharmacist, if we cannot not steer patients according to Medicare to go to-- and I'm just going-- I'm not using these as negative terms here, but I can't

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say, well, Humana is better than CVS, or Optum is better than Express Scripts, or-- I can't do that. It's not legal for me to do that. But yeah, when Jane Doe chooses her Medicare plan, then she's going to get emails, calls, letters from that plan saying you don't want to go to Dave's, you want to go through the mail. It's easier and it's cheaper. And, and sometimes it is cheaper, but the steering still takes away from us. And we can't steer people anywhere. It's not legal, but yet they can. And also, to the same extent, they steer people to big box stores or chain stores, because chain stores will take a lower reimbursement. Because I don't know if you've been to Walmart lately, but I can't go into Walmart and not walk out with 5 more things than I should walk out with. And they count on that. If we lose money on the prescription side-- Walmart says if we lose money on the prescription side, we're still going to make it up, because Dave is going to buy a trash can and some candy. OK. I own a pharmacy, I am pharmacy and health-related only. You come into my stores, we'll take care of you every which way but Sunday, as far as your health is concerned. But I'm not selling you candy bars. So that kind of-- they push people to those big box stores because they have a contract with those big box stores saying, we're not going to pay you as much, but we're going to increase your foot traffic, which will increase your retail revenue. For me, there's no advantage if I have 1,000 people walk in my store, if I'm losing money on every prescription I fill. It's just a slower way to death.

**JACOBSON:** Well, I, I think we're kind of going beyond the question [INAUDIBLE]--

**DAVID RANDOLPH:** OK.

**JACOBSON:** So let's check and see if there's any others. Senator Riepe.

**RIEPE:** Thank you, Chairman. You talked a little bit about rural health and the risk out there. Last year, we had a bill that specifically went to pharmacies that were fewer than 6, trying to make sure that we directed that towards rural. I think it took the Medicaid felling was over \$10, compared to the 4 or something.

**DAVID RANDOLPH:** Right. The Medicaid dispensary.

**RIEPE:** But did that provide any relief at all or I mean--

**DAVID RANDOLPH:** Yes.

**RIEPE:** But are we-- do we still have a risk out there for these pharmacies?

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**DAVID RANDOLPH:** Oh, it, it, it-- Senator, it helped tremendously. But we have done a cost to dispense study in the last month. It finally came through. Now they're going to look at it. But I guarantee you that cost to dispense is going to be above \$12. And according to the cost to dispense that we're getting now for Medicaid, for, for independents, it's \$10.38. For chains, it's higher than it was, but it's still not \$10.38. But what is happening is in Medicaid, and this just happened to me last week. I filled in an Ozempic prescription. It's for diabetes and weight loss. The cost of the drug is \$1,037 for one month. Do you know what I made on that? \$0.22. It cost me over \$12 to dispense it. So I went backwards \$11.78 on a \$1,000 drug. So Medicaid right now, what's happening is the PBMs, that dispensing fee, they're giving us the dispensing fee, but they're not paying the cost of the drug. They're using that dispensing fee to cover the cost of the drug, which means I make nothing to dispense it, which means my lights, my staff, my insurance, that's on me.

**RIEPE:** Not a simple problem-- or not a simple answer, I mean.

**DAVID RANDOLPH:** Well, and fortunately, I've been around long enough that we-- before we had PBMs, you didn't have issues with pharmacies. We had 13 in my-- in Scotts Bluff County when I started. And now, there's one independent and 3 chains. There's 4, and the population of Scotts Bluff County is higher than it was.

**RIEPE:** Thank you. Thank you, Chairman.

**JACOBSON:** Other questions? All right. Seeing none, thank you. And I understand there's a blizzard coming so [INAUDIBLE].

**DAVID RANDOLPH:** Yes, yes. I'm sorry. I, I have to leave. But we've got 7.5 hours, and I hope to make it to Ogallala and go north before it hits here.

**JACOBSON:** Stop in North Platte and have a Scooter's.

**von GILLERN:** Make him think about it.

**DAVID RANDOLPH:** I may have to stay at my brother-in-law's in North Platte, so we'll see.

**von GILLERN:** Hit the ATM.

**JACOBSON:** Thank you. How are you?

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**JEFF KILBORN:** Good. Good. So my name is Jeff Kilborn, J-e-f-f K-i-l-b-o-r-n. Good afternoon, Chairman and members of the Banking Committ-- Commerce, Insurance Committee. My name is Jeff Kilburn. As I just said, I'm the owner of Elmwood Pharmacy in midtown Omaha for the past 28 years. I'm here today to speak in favor of LB198, which would put long overdue regulations in place to curb the monopolistic business practices of the 3 P-- Big 3 PBMs and their negative impact on all retail pharmacies, especially independent pharmacies, like myself. I hope my testimony will help the community see that keeping status quo will allow PBMs to continue to place profits over to access to healthcare for Nebraskans, increased costs of prescriptions, and decrease tax revenue collected. PBM monopolistic business practices have decreased access to healthcare, as Dave mentioned, healthcare deserts. Each closure of, each closure of a community pharmacy creates pharmacy deserts in both rural and urban areas in Nebraska. The creation of pharmacy desert means in rural areas, a Nebraskan has to drive further to receive life-saving medications the same day, vaccines or many other health services provided by independent pharmacies in all cases improve outcomes and reduce healthcare costs. Individuals in-- living in urban areas may not have to drive as far, but because of other social determinants of health, pharmacy deserts caused by PBMs result in the same reduction to access to health. The widespread closure of community pharmacies puts more pressure on those that survive, leading to reduced patient access, delays in prescription fulfillment and, unfortunately, an increase in potential errors amidst increasing challenging work environments. Two PBMs increase prescription costs for all Nebraskans by controlling every aspect of prescription distribution, as found by the FTC and supported by NPR episodes and The Economist article, that which I've included in my packet today. For example, a customer is left no choice but to fill a higher-priced trade name cover prescription for insulins and inhalers because the PBMs purposely do not cover the lower-priced generic version because they make less money due to lower or no manufacturer rebates for the generic. The result of increased costs forces many Nebraskans to decide to pay for food or rent, or to pay for the inflated medications due to the PBMs. I see this firsthand for my patients substantially more now than 10 years ago. It is no coincidence that the Big 3 PBMs have gained monopolistic control of the prescription drug market in the past 10 years. As owner, I am forced to fill prescriptions that are reimbursed less than my cost on about 35% of the trade name prescriptions, due to the "take it or leave it" contracts of PBMs. In closing, I would like to reiterate that there's more at stake for Nebraskans than an independent pharmacy being treated unfairly by PBM monopoly or being forced out of

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business. At the end of the day, I and all the rest who are testifying today are asking for is a level playing field. LB9-- LB198 would provide some relief for independent like myself, reduce overall healthcare costs for Nebraskans, and preserve local access to healthcare by putting guardrails-- that's all we're asking for is guardrails, on PBMs. Thank you for your time today to hear my perspective.

**JACOBSON:** Questions from the committee? Knowing the previous testifier had a little drive to get back yet before the storm, I didn't want to ask him too many questions, but I, I guess the only question I'd have for you is the, the argument that we're going to hear on the other side here is that we're trying to find the cheapest price to provide the lowest cost to the end user for pharmaceutical drugs. And, and I think part of that comes back to the earlier question I asked, in terms of how-- who keeps the wholesalers honest in terms of providing the best price with the spread, and how could we be sure of that?

**JEFF KILBORN:** Well, yeah. There-- that's a very good question. The answer is--

**JACOBSON:** Every now and then I come up with one.

**JEFF KILBORN:** Yeah. The answer is the-- if you look at the NPR article or you look at what the FTC has found, since PBMs control every aspect of drug distribution, the wholesalers are basically dictated what they're going to charge at the end user. They-- because they know what the manufacturers are. And then David respect-- or talked about spread pricing, and you know, how the bill says-- it talks about almost vertical integration. The FTC found that the Big 3 PBMs, in one of their health oversight committee meetings that they created what was equivalent of a buying group and moved that buying group overseas. So then now, they insulated. So now what happens is that buying group negotiates the price with the health plan. And then the PBM can say, well, this is, this is the best that we can do is this is the price, even though the manufacturing list price is way down here. So what they've done is they've artificially inflate-- artificially inflated that list price because they created a, a, a, a buffer, basically, if you want to call it a buffer, and that was exposed in the FTC's findings. So it's just-- it's not just take my word for it, right? And then-- so then what happens-- and you talk about controlling cost, is the manufacturers or the wholesalers-- there's 4 main ones. They're all the same. And what Senator Sorrentino spoke of. You know, if they're not giving the best price, it-- they're not-- there's-- everybody's shopping, right? You know, it's the same for any industry.

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Though, if you go to 4, 4 and-- the 4 main wholesalers, 3 or 4 main wholesalers, the, the costs are skewed here. They're basically the same for trade name. On the generic is where they kind of go up and down. There's more flexibility or more profit margin on those. But what's the biggest struggle that independents and other pharmacies struggle with is the trade name, and they're-- that's where the bigger rebate numbers are giving back to the manufact-- from the manufacturers back to the PBMs. And they're being shielded by these buying groups that are located overseas, hmm, maybe to avoid taxes? You know, those are the type of things that the FTC is asking for and is investigating on a na-- national level. But it happens every day in Nebraska. And so the, the, the PCMA is saying, well, you know, we shouldn't be regulated. All we're asking is to have some guardrails that you have to at least reimburse us the cost of the medication. And the cost of the medication isn't being taken care of by the competitiveness at the wholesaler level. And then independents, there's multiple small-- smaller secondary sources where you can buy less expensive generics. Because we have to keep our lights on, so we're not going to try to buy the most expensive price, right, just to make more-- to charge a higher price to the PBM.

**JACOBSON:** Well, I just was curious. So there's essentially 4 big wholesalers out there.

**JEFF KILBORN:** Correct.

**JACOBSON:** So--

\_\_\_\_\_ : 3.

**JACOBSON:** OK.

**JEFF KILBORN:** 3 main ones.

**JACOBSON:** Yeah. 3 main ones. So who-- so are you buying from one of those 3? Do you, do you--

**JEFF KILBORN:** So I purchase the majority of my medications from McKesson. And then we use secondary wholesalers to-- if the secondary wholesaler has something that's less expensive. And so if we're going to refute a cost, you're going to see that secondary, less expensive invoice, right?

**JACOBSON:** Yeah. And, and that's what I'm trying to figure out, and, and why I raised the question earlier, about the, the billed cost, is the incentive to find that lowest cost.

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**JEFF KILBORN:** Probably would be shouldered by the pharmacies, because the pharmacies know what our dispensing fees are.

**JACOBSON:** But my point is that it takes away your incentive to find the lowest wholesale cost, because you're going to be paid a print spread above whatever you paid.

**JEFF KILBORN:** No.

**JACOBSON:** So now, it doesn't matter what you pay.

**JEFF KILBORN:** Not-- no, not really, because the PBMs, they have this--

**JACOBSON:** Well, I'm just talking about the bill itself. I'm just talking about the language in the bill.

**JEFF KILBORN:** No. I don't, I don't feel, I, I don't feel that that takes things [INAUDIBLE].

**JACOBSON:** Well, that's really what the bill says. It says that you're, you're going to get whatever-- you're going to get a spread above what your cost is. And so that's why I'm saying, from the wholesaler on the bill-- on the invoice they send you. So what's the incentive to get the lowest cost for the patient or for that end user, P-- or VIPA plan, or whomever is out there, if you're going to get a spread over whatever the wholesale price is, when the wholesale price seems to be all over the board. That's what I'm curious about.

**JEFF KILBORN:** I, I feel like it-- what, what the end results of the bill would be is that the wholesalers will be held accountable because they know that they have to answer to a health plan. Because the health plan is going to say, you know, these, these drug costs are too high. How can we reduce those? So then the wholesaler is going to have to do a better job of purchasing from the manufacturer.

**JACOBSON:** Which brings me back to the big 4 cattle--

**JEFF KILBORN:** OK.

**JACOBSON:** --basically slaughterhouses-- excuse me-- harvesthouses, I guess basically is what they are. They harvest animals. Is, is the potential for collusion to let's all make the price this, and it's higher?

**JEFF KILBORN:** Yeah. Ultimately there's-- probably is, when-- I mean, when you--

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**JACOBSON:** I'm not alleging collusion.

**JEFF KILBORN:** I mean, when you have--

**JACOBSON:** I want to be completely clear about that.

**JEFF KILBORN:** When you have fewer players, it's very easy to collude.

**JACOBSON:** Right.

**JEFF KILBORN:** You know, and so that's the other reason, as I was asked in an interview this morning, why is it so important to have independent pharmacies around. And so the reason I say that is because it's a lot easier to kick one person off the island than it is for 20 people.

**JACOBSON:** And I agree with that. And I will tell you, I'm a, I'm a huge supporter of independent pharmacies. My goal from the beginning is trying to get a bill that is closer to a, a perfect bill, or a bill that tries to cover all of the nuances that are out there and try to avoid it being gamed as much as possible. So that's why I'm asking the questions and trying to understand that, but--

**JEFF KILBORN:** So the game--

**JACOBSON:** --you've answered my questions.

**JEFF KILBORN:** Yeah. So the gaming can occur-- correctly, could, could occur at the wholesalers. It, it can occur in different spots along the distribution chain. But always remember the PBMs control every spot of that distribution channel so they can pull their levers and do whatever they want, you know, because they control all of that.

**JACOBSON:** And ultimately we want this to benefit the end user.

**JEFF KILBORN:** Correct. The patients.

**JACOBSON:** And, and, and the cost of, of providing these drugs. So--

**JEFF KILBORN:** Correct.

**JACOBSON:** --that's a challenge. Well, thank you. Any other questions from the committee? All right. Seeing none, thank you for your testimony. Next proponent. Go ahead.

**DAVID KOHLL:** Chairman Jacobson and members, I'm David Kohll, D-a-v-i-d K-o-h-l-l, from Kohll's Pharmacies, representing Nebraska Pharmacy

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Association. Being passed around to you is my, what I call my daily loss report. So that I just pulled out from last Friday, and these are just pure losses. This does not include any overhead. And so you may look at that. There's a little bit less than 60 drugs that we filled for people that we lost money on. And you're probably thinking how is that sustainable. Well, it's not sustainable. If all I did was fill prescriptions and have over-the-counter things, I would close up all my pharmacies. I've closed 3 of them. Many of the pharmacies have closed around the state. Even Walgreens and CVS have closed 20% of theirs because that's what they most-- that's what they mostly do. They do a, they do a good job doing that, but it's just-- it's not sustainable. And the reason why I'm still around is because I have about 12 other divisions within my company, such as a respiratory ventilator division, a wheelchair division, construction, a variety of things. But if the physical pharmacies went away in the small towns and in the big cities, they'd be severely missed by the communities that they served, served-- very much noticeable. If the PBMs were gone, they wouldn't be missed at all, if they did not exist. I know that's not what you're looking for, but that's reality. Drug costs for consumers, I believe if they were gone would be decreased by 40%. Why? Spread pricing. That's been explained a few times. And if they send them off to their own mail-order place, they'll pay themselves more and they'll charge the employers more. FTC saw that there was \$1.4 billion in spread income that the 3 major PBMs made and \$7.3 billion marked up pricing. Another way that they make money to lower that 40% is rebates. I know the rebates firsthand because I have a very tiny PBM, and I'm just shocked at how much rebate you can get from a branded drug. They'll take 2 manufacturers that make similar drugs. They might be \$2,000. And they say, which one of you is going to give me the highest rebate? They might get a \$1,000 rebate for-- it's like a bank credit card. Every time someone fills that, 1,000 bucks. Another way they get it is audits. They disrupt the pharmacies. They come in. Let's say we fill a prescription for a cream. That's-- we put a 60 gram. That's all we had. The patient has pretty bad dermatitis. We give it to them. They said, why don't you give them the 45-gram on the audit? They make you pay back all the money. And then when I checked with the self-insured group, did you ever see that money? Never saw it. It all went to the PBM's pocket. Optum, in the Fortune 100, is 4th, CVS Caremark is 6th, Express Scripts, one of the largest companies in the country, they're in the Nasdaq. Congratulations to them. Great business men and women taking advantage of the public. Here in Nebraska, pharmacies have zero negotiating power with the PBMs. It's, it's David and Goliath.

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**JACOBSON:** We're gonna have to ask you to wrap up and--

**DAVID KOHLL:** Yeah. I'm done, I'm done.

**JACOBSON:** OK. Thank you.

**DAVID KOHLL:** I do have one thing that you mentioned earlier.

**JACOBSON:** Go ahead.

**DAVID KOHLL:** On the-- with Jeff and how, how they collude the wholesalers. It's just not a reasonable thing for a pharmacy to work like that, because if you're going to send an invoice based on this bill and get paid more, that's a lot of labor to do that. Pull the invoice, have a staff doing that. You just add it more to your overhead. I don't, I don't see that really happening. You're going to try and buy that least expensive drug, you know, no matter what. I'm sorry. I just had to bring it up.

**JACOBSON:** Thank you. Other questions from the committee? All right. Seeing none, thank you for your testimony. Next proponent. If you're going to testify and you're back, please move to the front so we can kind of keep the hearing going. So any others going to testify, if so, plenty of room up front. How are you?

**KATIE TRAMBLY:** I'm good. How are you?

**JACOBSON:** Good.

**KATIE TRAMBLY:** Chairperson Jacobson, members of the committee, my name is Katie Trambly. It's K-a-t-i-e Tr-a-m-b-l-y. I'm speaking today in strong support of LB198. As a community pharmacist and director of pharmacy serving multiple Nebraska communities, I have seen firsthand devastating impacts of unchecked PBM practices, particularly with patients during MAC pricing and below-cost reimbursements. As the bill pertains to banning PBMs from steering patients to their affiliated pharmacies, I want to highlight the immense distress that it causes. My patients often cause-- call me gravely concerned when they receive letters from their PBM recommending they change to a preferred affiliated pharmacy. They feel pressured, feeling that they will get in trouble with their insurance if they don't comply. This is-- this coercion undermines patient choice and trust, restricting access to community-based care. Beyond steering, PBM reimbursement practices are financially unsustainable. Nebraska pharmacies are being reimbursed below acquisition costs for an alarming number of prescriptions. The reporting from our pharmacies shows 24% of our prescriptions are

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dispensed at a loss, without overhead included. Yet we have zero avenue for recourse. We do not even have the right to refuse to dispense a product when doing so results in significant financial damage. When the losses result in inevitable pharmacy closures, this creates chaos in the communities that we serve. I have personally witnessed the impact of 3 pharmacy closures from the perspective of the neighboring pharmacy. Each time, the effects have rippled through the healthcare system, overwhelmed our neighbor-- our remaining pharmacies, and directly harmed patient access to the level of care that they deserve. When a pharmacy closes overnight, the volume of prescriptions does not disappear. It doubles at the remaining locations nearby. Our staffing levels and purchasing limits do not double to meet that demand. We have made the decision to care for every patient who comes to our doors, but this has resulted in ordering restrictions that impact even our longest-standing patients and has placed an unsustainable burden on our pharmacy teams. The consequences are severe, with longer wait times, medication shortages, overworked staff, but most importantly, confused and distressed patients who have just lost the trusted professionals that they relied upon to guide them. The right to refuse to dispense a prescription at a loss is not about turning patients away. It is about ensuring that pharmacies can remain open to serve them tomorrow and for many years to come. Pharmacies, like any other business, must maintain a positive margin to survive. And if this does not pass, we'll continue down this path where pharmacies dict-- PBMs dictate pharmacy closures and Nebraskans will have fewer places to turn for the medications that they need. So let's act now to prevent some harm to our pharmacies and our communities. And I urge you to support LB198, standing up for fair reimbursement practices that will protect access to pharmacy services, pharmacy services across our state. Thank you for your time. Do you have any questions?

**JACOBSON:** Thank you for your testimony. Questions from the committee? All right. Seeing none, thank you for your testimony. Next proponent. How are you?

**JARED GLINN:** Good.

**JACOBSON:** Great.

**JARED GLINN:** How are you?

**JACOBSON:** Go ahead and be-- begin.

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**JARED GLINN:** Good afternoon, Chairperson Jacobson and other members of the Banking, Insurance and Commerce Committee. My name is Jared Glinn, J-a-r-e-d G-l-i-n-n. I'm a licensed pharmacist and head pharmacist at Medicine Man Pharmacy in Schuyler. So pharmacies in the, in the state of Nebraska have been negatively im-- affected by the pharmacy benefit managers, or PBMs, since their incept-- inception and implementation into pharmacy practice. In an effort to help regulate heath-- health plan payouts in pharmacies, PBMs have deployed several tactics such as below-cost reimbursement, patient steering, and spread pricing. Although it might sound good on paper, these strategies have further impacted an already, already struggling pharmacy landscape. One such example occurred this past week for a Medicaid patient filling in our Schuyler location. In this particular case, only a brand version of the medication was covered through the patient's Medicaid. Not only was the patient's co-payment higher than the cost of the generic medication, but the reimbursement to our pharmacy was \$35 less than the acquisition cost of the medication itself. And another example, another local patient who had been filling in our pharmacy for 5 years was forced to transfer to a chain pharmacy due to a preferred commercial insurance coverage that they had. This patient's new insurance only covered medications filled by this specific chain pharmacy where the affiliated mail prescr-- mail order prescription service. So similar instances like these occur multiple times each week at my location and the other Medicine Man Pharmacy locations. This results not only in lost revenue, but also decreased productivity for myself and my staff. Statewide, these issues have led to more pharmacy closures, specifically in the independent and commercial pharmacy sector, relating in larger pharmacy deserts and limiting the care to both rural and urban patients alike. So in closing, I'd like to say that roughly 95% of the U.S. population lives within 10 miles of a pharmacy, and for many patients, a local pharmacist is the easiest option to obtain quality and personalized care. Continued imposition of these PBM tactics will lead to greater patient steering, increased pharmacy closures, and a greater disparity of care across the state if urgent action is not taken. I respectfully ask the committee to advance LB198 for consideration by the full Legislature. I appreciate your willingness to listen to my testimony, and I will gladly address any questions at this time.

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

**JARED GLINN:** Thank you.

**JACOBSON:** Next proponent.

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**ALEX BYRNES:** Good afternoon, Chairman Jacobson and members of the committee. My name is Alex Byrnes, A-l-e-x B-y-r-n-e-s, and I am the government relations director for Hy-Vee. We operate more than 20 retail pharmacies at locations across the state of Nebraska. And I'm here today to testify, testify in very strong support of LB198, which is a critical piece of legislation that will bring much needed transparency, fairness, and accountability to the way pharmacy benefit managers, or PBMs, are operated in this state. At Hy-Vee, customer service and patient care is at the very core of what we do. Our pharmacists and our pharmacy teams are dedicated to providing personalized, accessible, and high-quality care to all Nebraskans. However, PBM practices create unnecessary barriers for patients and limit their ability to choose the pharmacy that best fits their needs. Currently, PBMs in this state engage in spread pri-- pricing, charging health plans for, for far more than what they are reimbursing pharmacies, they set unfair reimbursement rates that do never-- that do not cover the costs of dispensing medications, they steer patients to their own affiliated pharmacies, limiting consumers' choice, and they operate with little transparency and oversight. LB198 tackles these issues by eliminating spread pricing, ensuring PBMs can not take excessive margins at the expense of patients and pharmacies. LB198 also requires fair and transparent reimbursement, ensuring independent and chain pharmacies are treated equitably, compared to PBMs own affiliated pharmacies. LB198 also bans patient steering, allowing Nebraskans to choose their pharmacy based on service and trust, not PBM mandates. LB-- and finally, LB198 is-- focuses on strengthening oversight, empowering the Nebraska Department of Insurance to hold PBMs accountable. So this bill is about more than just business. It's about ensuring that all Nebraskans, whether in Omaha, Lincoln, or in a rural western Nebraska town, have access to affordable, reliable, and high-quality pharmacy care. If PBMs continue to undercut pharmacy reimbursement, many retail locations, especially those in underserved areas, will struggle to stay open, putting patients and communities at risk. LB198 puts patients first, ensures fairness, and creates a more transparent and competitive pharmacy landscape in Nebraska. I urge this committee to advance 19-- LB198 and support meaningful PBM reform. Thank you for your time and consideration, and I'm very happy to answer any questions.

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

**ALEX BYRNES:** Yes.

**JACOBSON:** Senator Riepe.

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**RIEPE:** Thank you, Chairman. Thank you for being here. One of the questions that I have that on any measure, when you take an action, there's generally a reaction. Can you speculate in terms of what the PBMs may do, in terms of if this bill would, would be passed?

**ALEX BYRNES:** Sure.

**RIEPE:** What options do they have?

**ALEX BYRNES:** Sure. So if this bill were to be passed-- and granted-- I do want to say, too, and I would like to point out, Hy-Vee, we have our own PBM. It's called Vivid Clear Rx. And it does a phenomenal job. It makes sure that they don't patient steer. They properly reimburse pharmacies. They're the best-- they're the better kind. They're what-- they're an example of what a PBM should be, in our opinion. And if this bill were to pass, it wouldn't impact our Hy-Vee-- our Hy-Vee PBM, because our Hy-Vee P-- the PBM already operates by the highest standards. And so we would expect and we would hope that the other PBMs would follow, you know, the regulations and the measures that are set by this bill. I mean, I don't want to speculate what maybe some of the Big 3 PBMs could do. We hope that they would not retaliate and that they would abide by the measure of the law. But, you know, I, I would hope that they would, again, follow the law. So.

**RIEPE:** So if I had Hy-Vee, between your PBM and your pharmacies, it's either you make your money in one spot or the other?

**ALEX BYRNES:** I can see where you would think that, but, but our PBM operates so that it's not, it's not going to make our pharmacies have any shortcomings. They're going to, they're going to work together to make sure that everyone is, you know, fairly reimbursed. You know, our, our PBM isn't going to necessarily try to, I guess, try to shortcut our, our pharmacies or any pharmacy, for that matter.

**RIEPE:** OK.

**ALEX BYRNES:** So, they work together.

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

**JACOBSON:** Yes, Senator Wordekemper.

**WORDEKEMPER:** Thank you for being here. Does your Hy-Vee PBM service other pharmacies?

**ALEX BYRNES:** Yes.

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**WORDEKEMPER:** OK.

**ALEX BYRNES:** Yep.

**WORDEKEMPER:** Not just Hy-Vee pharmacies.

**ALEX BYRNES:** Not just Hy-Vee.

**WORDEKEMPER:** Thank you.

**JACOBSON:** I just wanted to mention my, my neighborhood Hy-Vee is 100 miles away. So I--

**ALEX BYRNES:** I know. I'm still, I'm still working on that. I'm trying to, trying to get one in your neighborhood. I know.

**JACOBSON:** So your, your-- all right. You have a self-insured plan then, through-- with Hy-Vee or are you in a--

**ALEX BYRNES:** Yes. I believe so. Yes.

**JACOBSON:** OK. OK. All right. Thank you.

**ALEX BYRNES:** Yep.

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

**ALEX BYRNES:** All right. Thank you very much.

**JACOBSON:** Next proponent. How are you?

**SARAH KUHL:** Great. Thank you. Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Sarah Kuhl, S-a-r-a-h K-u-h-l. I'm the director of infusion and specialty pharmacy at Nebraska Medicine. I am testifying in support of LB198 on behalf of Nebraska Medicine and Nebraska Hospital Association. My testimony will name some provisions of the-- and some examples of the unfair PBM practices this bill seeks to prevent an impact it has on our pharmacies and hospitals. LB198 ensures that PBMs do not set arbitrary underwater reimbursement rates. Considering 3 PBMs monopolize the marketplace and cover 80% of insured lives, a pharmacy cannot practically refuse a contract on potentially 30-50% of their patients will be covered by the contract, depending on the PBM's loc up mark-- local market concentration. These "take it or leave it" contracts allow for outdated maximum allowable costs lists that permit PBMs to change the reimbursement rate for a drug at any given time after the

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contract is signed. Exception-- accepting fluctuating, arbitrary and unregulated MAC pricing as a condition of participation in PBM, PBM networks increases financial strain and uncertainty for Nebraska pharmacies. LB198 also safeguards Nebraska pharmacies from being subjected to excessive and unnecessary network access requirements. When we testified in support of L.D. 109, we shared the ongoing efforts of Nebraska medicine to gain access to specialty pharmacy and mail order networks. After the passage of the PBM Licensure and Regulation Act in 2020, two accredited specialty pharmacies in Nebraska were to be allowed to participate in PBM networks. Unreasonable terms and conditions and extensive reporting requirements are now being used to limit participation in networks, and the administrative burden diverts resources from patient care. Without legislation, PBMs are also allowed to directly or indirectly steer patients to their affiliated pharmacies. Unfortunately, the anti-competitiveness of the PBM pharmacy relationship has been exacerbated, with most PBM contracts limiting mail delivery to patients from local pharmacies. The presumed intent is to make non-PBM-owned pharmacies a less desirable option for patients who want convenience or need mail delivery to overcome barriers associated with limited mobil-- mobility, compromised immune systems, lack of transportation, or living in rural communities without a pharmacy nearby. Nebraska Medicine has fought to get into a mail order network for over a year, and continues to face new obstacles from the application. Throughout the testimony today, you're going to hear one overarching theme: PBMs have tremendous influence over patients and pharmacies. Legislative action is needed to prevent abusive behaviors. On behalf of Nebraska Medicine and Nebraska Hospital Association, we respectfully ask for your support of LB198.

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

**HALLSTROM:** I recall when we, when we did, I think it was LB767, that one of the major issues that the PBMs wanted to do was to require 2 accredited or certified-- certifications for specialty pharmacies, and we were able to avoid that, so there's only one requirement. And are you suggesting that now, they've just moved the goalpost and put different terms and conditions in that have made it even more difficult?

**SARAH KUHL:** Absolutely. So just as a protective measure, we've actually taken the effort to become accredited with 2 separate accrediting bodies for our specialty pharmacy. But-- and we started requesting the specialty application for one of the 3 PBM networks right after LB767 was passed. We are still going through negotiations.

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They had a requirement. I think I, I did include this in examples of what they asked us for. We had to show proof that we could provide our-- all of our education materials for each drug we dispense in 5 different languages. One of them was Tanglese [PHONETIC], Vietnamese-- I don't even know what country that's in. It's just random requirements. The amount of effort the software we had to get in order to meet that requirement is just excessive. It's just a way of keeping us out of the network.

**HALLSTROM:** And what was the description before? Vietnamese?

**SARAH KUHL:** I think it's Tangalese-- Tongalese.

**HALLSTROM:** OK. Oh, what a tangled web-- oh, what a tangled--

**SARAH KUHL:** I don't know if the PBM would tell us what country that is from.

**HALLSTROM:** Oh, what a tangled web we weave.

**SARAH KUHL:** Yes. And I would like to make a comment, too, about the wholesalers. You know, Nebraska Medicine buys a lot of drugs. We work and are always looking for the best wholesaler. I think the difference with wholesalers, compared to the rest of the distribution channel and the workings of PBMs, is that the wholesalers are not owned-- that's one component that is not owned by the PBMs yet. And we're, we're allowed choice. So we're always shopping to decide which wholesaler we want to go with, constantly renegotiating those contracts. We're motivated to find the cheapest product because we want the, you know, pharmacies are-- there's-- we're not-- by being mot-- reimbursed back to the cost doesn't help when, you know, maybe another PBM might have a slightly higher cost, so we're always going to look for the lowest cost product. That's how we're going to get the best margin. We're not really just looking at what will have the highest reimbursement. We want the highest margin. So that's going to drive everybody to finding the best price.

**JACOBSON:** I'm assuming that your-- that the Med Center would be on the University of Nebraska's healthcare plan. Is that right?

**SARAH KUHL:** The University of Nebraska and Nebraska Medicine are actually on different health plans.

**JACOBSON:** They are.

**SARAH KUHL:** Mm-hmm.

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**JACOBSON:** OK. So do you have a PBM that you use?

**SARAH KUHL:** We do.

**JACOBSON:** OK.

**SARAH KUHL:** It is not one of the Big 3.

**JACOBSON:** I gathered it was not.

**SARAH KUHL:** And neither is the University's.

**JACOBSON:** Yeah. And one last question. I guess, as I understand it, for specialty medications and, and maybe, maybe also infusion medication, do you have any choices in terms of who you go to or does everything-- is it all controlled by a PBM?

**SARAH KUHL:** That was one of the reasons why we made the choice to look for a different PBM a few years ago, is because even as an employer trying to work with our historical PBM, they weren't giving us the choices we needed in order to make sure our employees were taken care of, but--

**JACOBSON:** Sure.

**SARAH KUHL:** --we didn't feel like they were acting in-- as the employer or the employees' best interests.

**JACOBSON:** Thank you. Other questions? If not, thank you for your testimony. Other proponents. How are you?

**HALEY PERTZBORN:** Good. How are you doing? Chairperson Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Haley Pertzborn, H-a-l-e-y P-e-r-t-z-b-o-r-n. I'm a licensed pharmacist and the CEO of the NPA, and a registered lobbyist. I just want to say thank you to the pharmacists that came today to speak. Unfortunately, this legislation is too late for a lot of our other members whose pharmacies have closed, as was mentioned by other phar-- other testifiers. I have in my written testimony the provisions and some-- I want to focus on that the provisions aren't new. There are many other states have passed these items, and frankly, Nebraska is behind in a lot of these provisions to protect our pharmacies and therefore protect patients. We have emailed you an Excel file that lists out which PBA reform provisions have passed in other states for your reference. It was way too large to print and it was very, very tiny, so I just emailed it. But that does show that there's an

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enormous push for this type of reform, and that states are seeing success with provisions like the ones in LB198. 29 states have some sort of ban on spread pricing, 5 states have enabled the right to refuse for underrunning-- underwater claims, and at least 4 other states have this provision working its way through legislation right now, including Iowa. LB198 does not present new solutions, and these solutions were needed years ago. This is urgent and it is about what is-- doing what is right for our Nebraska communities. The NPA urges the committee to advance LB198. I'm happy to take any questions.

**JACOBSON:** Thank you. Questions? All right. Seeing none, thank you very much for your testimony.

**HALEY PERTZBORN:** Thank you.

**JACOBSON:** Any other proponents? All right. Proponents? Seeing none, I'll welcome opponents to the podium. How are you?

**BILL HEAD:** Chair Jacobson, good, good, good to see you, sir. Chair Jacobson, members of the committee, I'm Bill Head, B-i-l-l H-e-a-d, with PCMA, the PBM trade association, here respectfully in opposition to LB198. We find ourselves frustrated being at odds with pharmacists, particularly rural pharmacies, because we need them. We don't want them going away. Unfortunately, we think this bill is the, the wrong solution to addressing pharmacy access. I want to highlight a couple items in, in the bill that are particularly problematic-- the ban on spread pricing. PBMs is not-- spread pricing isn't something PBMs foist upon health plans. It is in the RFP. PBMs are simply responding to what's the RFP. So the ban really isn't on PBMs. It's on health plans and employers having that choice to include that option for themselves. It is a contract between the plan and the PBM. It doesn't involve pharmacies. So I'm confused as to why it is being banned. It'd be one thing if health plans were coming saying please stop, help us from ourselves. We don't want to offer this. We don't want to request this anymore. It just seems like an odd thing to, to ban. I do want to say something on what's called patient steering. PBMs are simply implementing what they've been contracted to implement in the contract with the health plan. So this notion of steering to affiliated pharmacies is simply the PBM saying, your plan requires you to get this drug because there's a maintenance drive through mail order, because it's cheaper for the health plan and ultimately, it's cheaper for the patient. But as the gentleman said, it does take away business from the local pharmacy. So I can understand that frustration. But at the end of the day, the PBM is trying to save the health plan and the patient money. I think probably of greatest concern in the bill is

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this notion of paying the pharmacy-- you can't pay the pharmacy below its acquisition costs. PBMs don't know what the acquisition cost is to a pharmacy. Is that include the rebates and discounts they get, the front-pay discounts they get from their wholesaler? What, what does that entail? And it would be for every drug they sell. And I don't know a state that has mandated that a business is entitled to make a profit on every item that they sell. This is not to say there aren't real issues and real concerns from pharmacists. I think there are, and certainly there are. There will be items in which they are under water, but I think guaranteeing them a profit on every drug they sells is not the right solution. At the end of the day, rural pharmacies face the same challenges as rural, rural hospitals face: a dwindling population. People want to go to the bigger, the bigger cities. People want to go to the big box stores, people want to get things by mail. But what do we do about that? We want to sit down and find out how we can help them stay afloat without turning to flipping the system on its, on its head. I think the large fiscal note speaks for itself, which says nothing about the impact on the private sector. We would love to sit down with all stakeholders, as we've done in the past, try to work through the, the issues and find a-- and try to find a solution that doesn't result in higher costs for everybody.

**JACOBSON:** All right. Thank you for your testimony. Are there questions from the committee? Yes, Senator Bostar. I thought might we hear from you.

**BOSTAR:** Thank you, Chair Jacobson. Thank you, sir, for being here. It's good to see you again. You, you talked about how some of these provisions related to steering and whatnot. Is that the direction of the plan? The plan being basically insurance.

**BILL HEAD:** The payer, the payer.

**BOSTAR:** Right. So, you know, it's, it's always interesting, you know, talking about policy and legislation in, in this sort of arena when-- so here we have the, the, the PBM industry saying, well it's insurance fault. And often, you know, insurance will say, well, this is, this is a PBM issue. It's not, it's not us. And then we, we tend to go back and forth. And now I-- forgive my cynicism, but is, is it, is it all just an attempt that-- so that we don't actually pass anything?

**BILL HEAD:** No. That's-- no, that's not the intent. The intent is that we don't pass something that's going to have an unintended consequence.

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**BOSTAR:** You, you talked about plan requirements where a particular pharmaceutical could be required to be mailed.

**BILL HEAD:** Well, generally what happens is the plan will have an opt out provision. The majority will say if it's a maintenance drug that you're getting, you're using daily over a long period of time, that, that you have to receive it by mail because the plan is saving money and the patient is going to save money. So you cannot-- you can go ahead and go to your local pharmacy and get it, but you're going to pay a higher co-pay because you're not taking advantage of the savings we're getting.

**BOSTAR:** So a-- what if, what if the local pharmacy is willing to deliver the drug?

**BILL HEAD:** There are-- almost every contract with pharmacies allows for ancillary mail service. So in exigent service-- circumstances in a state like Nebraska where the weather is, you know, preventing mail or what have you--

**BOSTAR:** Well, regular delivery.

**BILL HEAD:** --or regular delivery. It is, it is offered as an exception. The, the problem comes in what ultimately the payer and the patient pay, because a mail pharmacy is getting at a bulk purchase, a discount that a, a, a single or a pharmacy owned by or 3 pharmacies owned by one person can't get those kind of discounts. That discount is then passed on to the payer.

**BOSTAR:** You just said you didn't know what the, the pharmacy pricing was.

**BILL HEAD:** I don't-- their acquisition cost.

**BOSTAR:** Right.

**BILL HEAD:** Right.

**BOSTAR:** Isn't that what we're talking about?

**BILL HEAD:** No. You're asking about the mails-- I thought you were asking about mail service.

**BOSTAR:** Well, yeah, but-- I'm sorry. You're saying that the, the, the large specialty pharmacy can acquire the drugs cheaper.

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**BILL HEAD:** At a volume discount, at a volume.

**BOSTAR:** But you also said you don't know what they acquire it for.

**BILL HEAD:** I don't know what their, I don't know what their acquisition cost is per drug.

**BOSTAR:** So you're guessing that you're acquiring it cheaper.

**BILL HEAD:** I would say it's a pretty educated guess just based on normal economics.

**BOSTAR:** Sure. OK. But we don't know. I mean, I'm just, I'm just, I'm just trying to understand the system a little bit better.

**BILL HEAD:** Sure. OK. But wouldn't it stand to reason that if I'm buying, you know, if I can buy 10,000 widgets and you can only buy 1,000, that I have a better, probably, volume discount than you do?

**BOSTAR:** I think that the perception of self-dealing within this industry is so generous that I don't necessarily know.

**BILL HEAD:** Well, can I, can I respond to that point on self-dealing? We've actually agreed to the notion of not-- of agreeing to language that would be PBMs can't pay affiliated pharmacies in an aggregate amount more than what it pays nonaffiliated pharmacies. You can't do an aggregate amount.

**BOSTAR:** Why an aggregate amount? Why not per drug? Why not--

**BILL HEAD:** Because you can't do it. Because there's going to be exceptions on drugs.

**BOSTAR:** What's the exception?

**BILL HEAD:** There's just going to be exceptions where drugs are priced differentially. And it's a very complex system. And, and I won't begin, and I won't begin to understand it, let alone explain it.

**BOSTAR:** If you can give me one example. Why, why should-- on, on a-- for a specific medication, why should the PBM specialty pharmacy have a different--

**BILL HEAD:** Well, I'm not-- I'm talking about mail pharmacies, not [INAUDIBLE].

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**BOSTAR:** Fine, fine, fine. Yeah, you're right. You're right. Correct. Why should it be different for, for specific drugs?

**BILL HEAD:** If you want a detailed answer I'll have to get back to you, but--

**BOSTAR:** Even just a--

**BILL HEAD:** There's going to-- there's-- I've been told there's going to be exceptions. But the point being, why not in the aggregate, if you're not paying.-- why is that anathema though, is that if the PBM agrees, we will not pay affiliated pharmacies more in the aggregate.

**BOSTAR:** Be-- because it allows the introduction of-- you know, we've been-- I'll tell you why. Because I've been sitting here for now, 5 years. We've been doing legislation on this for 5 years. We've been passing legislation that we've-- with, with sort of good intent that then folks just find a way around, so we have to keep coming back. Similar to the provisions related to the certification requirements. Right. I mean, I remember you were in the room. I was in the room. This was a long time ago now. But we all know. Everyone who was there and, and is speaking honestly knows that the intent was for that certification to be substantially all that is necessary to join the network. And of course, it isn't, right. Of course we've found another way around it. So when you say what's wrong with doing it in aggregate versus being very specific about--

**BILL HEAD:** Oh, I see your point.

**BOSTAR:** --the equality around drug by drug, it's because I, I don't know how that's going to be manipulated. That's the answer.

**BILL HEAD:** I see, I see, I see your point, I see your point. Well, in term-- and in terms of the accreditation after that last stakeholder meeting, which I think you, you hosted, we checked with our members and we said to make sure that doesn't happen, we said we would agree to language that the PBMs can't impose any requirement on a nonaffiliated pharmacy that it wouldn't impose on itself, to try to make-- to try to drill that down that the requirements have to be the same-- to get to your point, because all that did was deal with accreditation. And then your point was people were saying, well, then they imposed other standards. So we said, well, let's address that and say that standards have to be identical.

**BOSTAR:** I--

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**BILL HEAD:** But that's not in, but that's not in here. And instead, we're guaranteeing profits, which doesn't seem to me how that's going to help the patient at the end of the day.

**BOSTAR:** Thank you.

**JACOBSON:** Other questions from the committee? Yes. Senator Hallstrom.

**HALLSTROM:** In, in one capacity or another, I've been here even longer than Senator Bostar.

**BILL HEAD:** That is true.

**HALLSTROM:** And I hear, I hear the, the Morse code of SOS, save our ship, save our soul, from community pharmacies. And I hear every year that we come back here that we can't do this as PBMs without the community pharmacists. We need them. And while Rome burns, we're fiddling away. And, and you've said the same thing every time I've heard you sit in there, whether I'm sitting out there or whether I'm sitting here now, and I don't see any movement other than slow walking, and I think we ought to get something done this year. I certainly would look at whatever language that you have, but the buck has to stop somewhere.

**JACOBSON:** Quest-- questions of the committee? I would just have one, I guess. Going back to the previous testimony on-- from the Med Center. In terms of the roadblocks that have been put in place for them. I mean, this you got speak 5 languages and some of them are languages we've never heard of. How is that creating a level playing field for-- I mean, the Med Center is a big player. They know what they're doing, and yet they're having trouble being able to acc-- access directly certain medications. And seemingly, when it comes to special magic medication for the bigger bucks or that they seem to be blocked out. But how do we address that?

**BILL HEAD:** No, and I think that-- no, that's, I think, a legitimate issue. And that's why we said we feel that whatever the requirements are should be identical, that they shouldn't have to jump through hoops that others-- that affiliated specialty pharmacies don't have to jump through.

**JACOBSON:** So how do we fix that?

**BILL HEAD:** I think, and sometimes on the language thing, I think some because typically, states impose language requirements. And so that, that particular specialty pharmacy may have states in which they're

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required to have Tangalese interpreters, I guess. But I think the way you, you legislate that is to say, a PBM can't impose accreditation standards greater or different than would be imposed on affiliated pharmacies to nonaffiliated pharmacies.

**JACOBSON:** So in what part of the world do you speak Tangalese?

**BILL HEAD:** I have no idea.

**JACOBSON:** OK.

**BILL HEAD:** I know it's Asian, I know it's Asian, but I don't-- I couldn't identify the kind. I know it's-- I know this because I live there, but it's a California-- I know it's a California requirement for pharmacy, so.

**JACOBSON:** OK.

**HALLSTROM:** I think it's Tel Aviv.

**JACOBSON:** Senator Hallstrom.

**HALLSTROM:** Yeah, I apologize, I didn't really ask a question last time, but in response to Rutledge, what has happened in Arkansas with regard to the environment?

**BILL HEAD:** No, I'm glad, I'm glad you, I'm glad you asked that. Not a lot, actually. It's still-- they're still-- these years-- I want to say it's going on 3 years now, they're still trying to figure out how to make it work, because it's similar to the language on you have to pay the acqui--the acquisition costs. So to my knowledge, it's still-- the state is still trying to figure out how to--

**HALLSTROM:** But PBMs are still operating in Arkansas.

**BILL HEAD:** Sure. Yeah. Sure. At the end of the day, I don't think PBMs are going to go away. At the perspective we come from is we're trying to protect the resources of the payer and the patient, right. If something is going to lower their costs, we're going to support it. I think the rub comes in and I've said this before, is I think from the farmer's perspective, they understand. We say, well, don't, don't do those savings on our back, right. Don't, don't gain all their savings from us. And I can respect that. But, you know, our obligation is to the payer and to the patient and making sure they pay the least amount possible.

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**HALLSTROM:** Well, and earlier you indicated that you've got RFPs and you've got opt outs for mail order. And do you, do you seriously think that employers across the board understand what they're getting into? Aren't you suggesting and making recommendations on how those contracts ought to be carried out and the, and the options or the elections that should be made?

**BILL HEAD:** I'm not sophisticated enough in, in the contracting that goes on, but I know roughly 285 million Americans are having their drug benefit managed by a PBM. So from my perspective, I think it works for the vast majority of people and for plans. And I can't speak to the sophistication of, of the employers. But if I, if I could just digress for a second in terms of the-- that the notion of wholesaler competition seems to be OK with people, that they'll keep each other honest through competition. The big 3 wholesalers control 97% of the wholesale market and they are vertically integrated. They have, they have pharmacies and there are PSAOs. And they, on the other hat, PSAOs representing pharmacies and contracting. But somehow that's OK. The Big 3 PBMs who, who have, who-- they do 80% of the claims-- they process 80% of claims, but somehow the, the competition there isn't the same, I guess. But we just heard from people who shopped around to get a different PBM because they weren't getting what they wanted. And it makes no economic sense that a PBM would go to a client, say, look, we're going to pay our own pharmacies more so we can pocket more money, but you should still contract with us. The peop-- the employer is going to go away, saying this other PBM is not going to do that. Why should I pay you more so you can pay yourself more? The economics just don't make sense of.

**HALLSTROM:** But does that happen?

**BILL HEAD:** I can't-- ow-- if it would be, it would be--

**HALLSTROM:** No, I mean, it-- do, do affiliated PBM pharmacies get paid more than other pharmacies?

**BILL HEAD:** On the contrary, I think and I'll use an example, CV-- of CVS. They can actually pay themselves less, because they're going to be more attractive to the purchaser, right? Why would they go and paying themselves more and say our costs are higher because we're paying? On the contrary, they can go in and underpay themselves to get the business.

**HALLSTROM:** I'm not sure that's what happens.

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**BILL HEAD:** It's just-- it's economics.

**HALLSTROM:** With, with, with other states, are you aware or have you seen that other states have had significant judgments entered for their Medicaid or their managed care organizations, where PBM practices have, have resulted in judgments in favor?

**BILL HEAD:** I think Ohio comes to mind. I can't, and there may be another one. But that, that-- yeah. I think there have been some cases like that, but Ohio's the--

**HALLSTROM:** So only 1 or 2 that you would be able--

**BILL HEAD:** That I'm aware of and--

**HALLSTROM:** Thank you.

**JACOBSON:** It would seem to me, I think the concept of PBMs, I, I think most people would agree with, I think the challenge that people have is the transparency between what the PBMs are paying pharmacies to dispense drugs and then how that gets passed through to the VIPA plans, the plans that they're managing, and how much are they keeping in the middle? And that number seems to be very disguised when you consider that and the rebates and all the other pieces, which is where people start looking at earnings for PBMs and say that number must be big. And so, to the extent that there's more transparency and I'm, I've been trying to handicap as we move along here, how long Senator Sorrentino's close is going to be. I'm, I'm well north of 10 minutes now, and I'm guessing it's going to continue to grow. But, but I guess therein lies probably the biggest question that we always seem to grapple with. And did Senator Hallstrom's face not-- most of these VIPA plans, they don't know what they should be negotiating for. I think Senator Sorrentino has taken a look at the state's plan. I think if it were up to him, that contract would look a lot different.

**BILL HEAD:** Sure.

**JACOBSON:** But he has the expertise to really understand--

**BILL HEAD:** Sure.

**JACOBSON:** --what needs to be in that. And so, therein, I think, lies the biggest concern that we're trying to get worked out. And like I said from the beginning, this is a very, very complex issue with a lot of moving parts and we want to try to get it right. But, but I would agree that kicking the can down the road has not worked real well for

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us. And so, we need to try to come to grips with how we could make this work, because the, the pharma-- loss of pharmacy numbers is real.

**BILL HEAD:** Sure.

**JACOBSON:** I agree no one should be guaranteed a profit, but, but we are running out of rural pharmacies [INAUDIBLE]--

**BILL HEAD:** Sure, .

**JACOBSON:** --and all you got to do is look at the map on that. So.

**BILL HEAD:** Sure. But-- and I would, you know, I would encourage the-- don't take my word for it. But look at the, the net profit margins. Everybody in the supply chain manufacturers, wholesalers, PSAs, pharma, we're all in the profit business. Right. But look at the net margins-- net and profit margins of each entity. And again, don't take-- do it independently and look at the profit margins. PBMs are big. They're covering, you know, nearly 300 million people. So it's a significant amount of money. But profit margin-wise, we're not at-- near-- anywhere near the top.

**JACOBSON:** Well, I think you made the key point here, is that if you have 5-- 300 million customers, I don't need to make much to make a lot.

**BILL HEAD:** Well, exact-- and I would say for the vast majority of people, it works. It's not working for pharmacies and we need to fix that. I. I Just think this is not the way to fix it, though.

**JACOBSON:** So how is the way-- what is the way to fix it?

**BILL HEAD:** I think to get us together, I think it is-- it does come down to the reimbursement. In some states we've, you know, figured out a critic-- you know, defined a critical access pharmacy, right, that's, you know, a population of 1,000 people, you shouldn't have to go more than 25 miles to get to a pharmacy, right. Some-- you know, whatever definition you want to give it and then figure out a way to bump that. You know, what, what kind of bump. And I'm not-- I'm speaking for the plants, because it's going to be the-- coming from the plants. But how can we, how can we ensure that they stay in existence without turning everything on its, on its head? Because that's-- ultimately, let's be honest. It's, it's really not about all these other things. It's about them not being so severely underwater

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on so many things. Right? But guaranteeing them a profit on everything, I think, goes a bit too far.

**JACOBSON:** All right. Any other questions from the committee? All right. Seeing none, thank you for your testimony. Next opponent. Go ahead.

**MICHELLE CRIMMINS:** Thank you. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Michelle Crimmins, spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s, and I'm the government affairs principal and registered lobbyist for Prime Therapeutics, a PBM owned by 19 not-for-profit Blue Cross and Blue Shield insurers, subsidiaries or affiliates of those insurers, including Blue Cross and Blue Shield of Nebraska. Prime helps people get the medicine they need to feel better and live well by managing pharmacy benefits for health plans, employers and government programs, including Medicare and Medicaid. Our company manages pharmacy claims for more than 300,000 Nebraskans, and our business model focuses on purpose beyond profits. We are not publicly traded or owned by a private equity firm, and as such, it is not our primary motivation to maximize profits. Our primary motivation is to do the right thing. My testimony is in opposition to LB198 because it will have the unintended consequence of raising costs for Nebraskans and it removes credentialing requirements put in place and ensure consumer safety. LB198 revises the Pharmacy Benefit Manager License and Regulations Act by requiring PBMs to reimburse pharmacies at their acquisition cost, which is the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice. It's important to note that this amount does not include the discounts received by the pharmacy from the wholesaler. This change guarantees a profit for all pharmacies, and it removes the incentive to obtain prescription drugs at the lowest price point possible. This undermines the fundamentals of a free market, where companies compete for business by offering products that meet the need for their customer base at a competitive price. There's no other industry in the United States where the government guarantees a profit for one business type by requiring another business to foot the bill. As a reminder, insured members, employers and other plan sponsors are the ones who will pay the increased cost of prescription drugs. This means that guaranteeing a profit for pharmacies comes at the expense of the average working Nebraskan. Over the last few years, we've participated in stakeholder meetings to discuss, supply-- the supply chain and need to increase customers' access to prescription drugs at an affordable cost. The conversations were missing 2 stakeholders: the drug wholesalers and their vertically integrated pharmacy services

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administration organizations, or PSAs. These entities supply drugs to pharmacies at-- and negotiate their drugs with PBMs, controlling both the drug purchase price and their reimbursement amount. I provided you with several handouts that explain PSAs role in the supply chain, the value of PBMs, and my additional concerns with the bill. Ensuring access to affordable prescription drugs for Nebraskans is our top priority and as such, I encourage the committee to consider further discussions to review the role every member has in the drug supply chain. And I welcome any questions.

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

**MICHELLE CRIMMINS:** Thank you.

**JACOBSON:** Next opponent. Welcome.

**JEREMIAH BLAKE:** Thank you. Good afternoon, Chairman Jacobson, Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, and I'm testifying in opposition to LB198. First of all, I want to thank Senator Sorrentino for his candid and thoughtful discussions on the role of PBMs in the healthcare ecosystem. I think we can all admit that his real-world experience and deep understanding of the industry will provide valuable insight into the complexities of the prescription drug supply chain, so I want to thank him for his leadership. At Blue Cross, our role in this conversation is pretty straightforward. We collect health insurance premiums from Nebraska businesses and families that are used to pay the cost of pharmacy benefits, and PBMs play a critical role in administering these benefits, ensuring that patients receive medications at an affordable cost. Over time, health insurers, working with PBMs, have absorbed an increasing share of drug costs to shield patients from the increasing costs of drugs from drug manufacturers. A report issued last year found that the median annual list price for new drugs in 2023 was \$300,000, an increase of 35% over the previous year. As a result, prescription drug spending now accounts for more than 20% of health insurance premiums, and remains one of the fastest categories of healthcare spending. Our primary concern with LB198 is that it will increase costs for our members without delivering any meaningful benefits. This bill does not improve access to pharmacists or expands services that enhance patient health or wellness. Additionally, it would reduce incentive for pharmacists to seek the lowest wholesale drug price. Ultimately, driving up prescription drug

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costs for our members is, as we've discussed, PBM reform is an issue this committee has worked on for years, but it's also an issue of-- an issue that is a priority at the federal level. In December, Congress was on the verge of enacting significant reforms to increase PBM oversight. That package also included language to prevent drug manufacturers from using patent thickets to block the release of low-cost generic drugs. While that agreement fell apart for reasons completely unrelated to the PBM or patent provisions in that bill, I expect PBM reform will be one of the few bipartisan issues that has a chance of passing Congress in 2025. And Congressman Flood, if you've been paying attention, has particularly been vocal about his belief that federal action in this area is needed. Notably, the federal reforms under consideration do not just regulate PBMs. They also target drug manufacturers for their patent strategies that keep drug prices high. I see my time's up, but I would just note that again, we would like to take a similar approach of bringing all the parties together to talk about how we can find a-- an agreement that makes sense for everybody.

**JACOBSON:** Thank you.

**JEREMIAH BLAKE:** Thank you.

**JACOBSON:** Questions? Yes. Senator Bostar.

**BOSTAR:** Thank you, Chair. Thank you, Mr. Blake.

**JEREMIAH BLAKE:** Yes.

**BOSTAR:** There are some active theories, actually, that the PBM stuff had a part to play in the federal legislation falling apart.

**JEREMIAH BLAKE:** Could be.

**BOSTAR:** So I just want to throw that out there.

**JEREMIAH BLAKE:** OK.

**BOSTAR:** Also, I-- Congressman Flood has certainly said that federal action is necessary, but was, was the implication that then state action should wait?

**JEREMIAH BLAKE:** I've never heard him say that. So if I implied that--

**BOSTAR:** OK.

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**JEREMIAH BLAKE:** --I should correct the record.

**BOSTAR:** Do you recall 4 years ago, a PBM hearing, where then-State Senator Flood thought that it was necessary to subpoena all of the insurance and PBM company executives in order to effectively get to the bottom of the problems that we are facing when it comes to this issue?

**JEREMIAH BLAKE:** I'm aware of that hearing. That predates my time at Blue Cross, so I was not a part of that hearing, but I'm familiar with it.

**BOSTAR:** I'm sorry to hear that. It was a good time.

**JEREMIAH BLAKE:** Yeah. I understand that. I read the transcript.

**BOSTAR:** It's worth a read to anyone who hasn't. Anyway, I was just curious. Thank you very much.

**JEREMIAH BLAKE:** Yeah.

**JACOBSON:** Senator Hallstrom.

**HALLSTROM:** Does Prime Therapeutics engage in spread pricing?

**JEREMIAH BLAKE:** Yes. So we do offer spread pricing for our members, right, for our groups. And, and for them it becomes a choice, right? Do they want to pay a higher administrative fee to, to administer the plan, or would they rather use spread pricing as a way to offset the, the cost of that administrative fee to administer the plans and the benefits?

**HALLSTROM:** Thank you. And in, in some of the meetings that I've been to, there's been some suggestions that if spread pricing was prohibited that then some type of administrative fee would inevitably have to--

**JEREMIAH BLAKE:** Correct.

**HALLSTROM:** --be, be in place. It would seem to me that we could maybe capitate a fee and have more transparency in terms of what those plans are actually being charged for the services, as opposed to this opaque notion of, of whatever a, a, a spread pricing might endeavor.

**JEREMIAH BLAKE:** Yeah. I mean, that's, that's a fair point. And I, and I respect that. I guess how I would respond to that is, again, that

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gets into the negotiation between the plan sponsor and the, and the health plan. And health plans, as we've talked about today, have options for which PBM they choose. We continue to hear about the Big 3. We're all familiar with that. Prime Therapeutics, who we work with is not one of the Big 3s. I can tell you one of the major state contracts that Blue Cross won for the medical benefit. We lost on the pharmacy benefit. They chose a different PBM. And I don't know what went into that decision, but I think that makes the point that there is competition and there are options. If a plan sponsor wants to go with a straight administrative fee, which because they think it's more transparent, they have that option. Whereas if they'd like to use spread pricing because it helps reduce their administrative costs, they can choose that option, as well.

**HALLSTROM:** And I believe one of the frustrations that you and I have discussed personally is the fact that we come back here year after year and we hear the same stories, and we've heard about 2 PBMs that think they're doing it right.

**JEREMIAH BLAKE:** Yep.

**HALLSTROM:** I don't take exception with that, but we never hear from the folks that have what some would think are egregious business practices. And as a result, those that are doing it right come up to the table and run cover and interference for those folks.

**JEREMIAH BLAKE:** Well, first of all, Senator, I'm going to assume in your comments that you're saying that we're doing it right. So I'm going to take that as a pat on the back today. Again, I, I think that I've been pretty transparent with you and other members of the committee that if there's a willingness and an interest in talking about these issues, we're certainly open to having that conversation. I will tell you, nobody's come to me yet. So I'm, I'm here. I'm ready to talk. But to this point in the 4 years I've been doing this, I don't remember receiving a phone call saying, hey, let's sit down and talk about this.

**HALLSTROM:** Well, and in fairness and I appreciate and many of the comments that you made are spot on, so thank you. But in fairness, we've had interim study hearings and I know we didn't get one this year. But you know, I don't I don't, in my personal capacity here, I don't want to be back here again next year having the hearing, having conducted an interim study hearing and hear the, the S.O.S. that's coming from the old from the other side I mentioned save our ship,

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save our soul. The SOS that's coming from the other side is same old story.

**JEREMIAH BLAKE:** Yeah.

**HALLSTROM:** So, thank you.

**JEREMIAH BLAKE:** OK.

**BOSTAR:** We got through it.

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

**JEREMIAH BLAKE:** Thank you.

**JACOBSON:** Other opponent testimony? Mr. Bell, how are you?

**ROBERT M. BELL:** Good. Feeling old today. 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 insurers, including most of the health plans in Nebraska. I am appearing today as in opposition to LB198. I have all this testimony, but I'm not going to read it. I think if you pass this legislation, we will be here next year, and we'll be discussing other things related to PBMs. I think-- you know, it was interesting that you heard from Hy-Vee. And I-- you know, if part of this is saving the small pharmacy, I don't, I don't know that it's necessarily a, a PBM thing as much as it is competition from, you know, big box stores and, and other-- I can remember sitting in 2019 pre, pre-Rutledge. And Senator Kolterman, I think, at the time, was talking about Ben Franklin and Ben Franklin going out of business in his hometown, that his parents, I believe, owned in Seward. And, you know, at some point, their, their differences in, in businesses and there's some economies of scale that Walmart could do or Hy-Vee could do. I, I wonder how many, you know, hometown pharmacies or local pharmacies in, in Omaha Hy-Vee has run out of business. And I know. Hy-Vee is employer-owned. I do have a kid that works at Hy-Vee, so I'll take this up with him and we'll visit about it maybe a little bit. But I do think we'll be here next year. And I would just kind of echo what Mr. Blake said, related to federal legislation going on. I, I think the landscape is, is going to change significantly. And also, I do-- I feel like there's also a business opportunity here, right? I mean, I feel that if the plans themselves, whether or not those are employer plans or, or health plans, they're losing so much money

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because of, of PBMs. Certainly, there's an opportunity for somebody else to step in and go to Blue Cross, Blue Shield or Medica as nonprofit health plans and say, hey, we can save you hundreds of millions of dollars on this, and maybe they should if, if that's the case I have no doubt that Senator Sorrentino understands this business far better than anybody else in this room. And, and I believe he's somebody-- he can correct me if he's wrong-- that he represented those employers in, in negotiating, you know, as kind of the go-between. So I'm, I'm really interested in hearing what he has to say. And if he can save, you know, hundreds of millions of dollars out of the Medicaid program, great. So anyway, with that, I will, I will end my comments. Thank you.

**JACOBSON:** Questions for Mr. Bell. Yes. Senator Bostar.

**BOSTAR:** Thank you, Chair Jacobson. Happy birthday, Mr. Bell.

**ROBERT M. BELL:** Thank you.

**BOSTAR:** I suppose my first question is to you. Is it-- do you take it personally that we-- that the committee scheduled all the PBM bills on your birthday?

**ROBERT M. BELL:** No, I don't. I, I think it was a secret that it was my birthday. So.

**BOSTAR:** It's a bad secret.

**ROBERT M. BELL:** No, it is today. So, PBM day. Happy birthday.

**BOSTAR:** With that, I, I do-- I, I like to highlight opportunities where we can agree on things. And I--

**ROBERT M. BELL:** Sure.

**BOSTAR:** --would agree that if we were just to pass this bill, we would be back here next year doing this, because I think that there are other things, additionally, that we need to do. There are other bills that we can pass along with it. And I think-- I, I agree with you that we should, we should take a broader approach to trying to deal with this than narrowly just the provisions of one single bill, so I'm glad we're on the same page.

**ROBERT M. BELL:** Sure.

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**BOSTAR:** The PBMs say that it's your fault, your members. They're why we're here. Does that-- do you, do you feel the same way?

**ROBERT M. BELL:** You know, no, I don't. I don't, I don't, I don't feel that way at all. I mean, I do-- well, I don't feel that way. Do I feel like there's blame on the health plans? Yes. Related to these high cost of, of pharmaceuticals that are going on, which are fantastic, right? I mean, they can lower your blood pressure. They can solve your high cholesterol. They can, they can cure can-- I mean, they can-- yeah, I mean, to some people, they can cure cancer. I mean, all of these great things. And how do we manage that and how do we pay for that as a society. Right. And we all pool our risk together and, you know, pay on average, what, \$25,000 per family annually to pay for these medical benefits that are sometimes hundreds of thousands of dollars to treat. Right? Yeah. And we get a lot of blame for that, because we're the person collecting the \$25,000. And so, yeah. Sorry. I kind of went off on a minor tangent there. But-- I don't know if I answered your question.

**BOSTAR:** Is the-- are-- if, if a-- if an insurance company owns a PBM, how does that work within the structure of the medical loss ratio?

**ROBERT M. BELL:** I don't know the answer to that question. That's a really good question. I would like to get back to you on that question. I do know the pharmacy benefit itself is included in the medical part of the MLR, medical loss ratio. And then administrative fees are part of the administrative portion of that. But there's some holes in there I, I don't-- I can't answer. So at this point, we'll have to get you more information.

**BOSTAR:** Earlier in testimony, it was, it was stated effectively that there's collusion in this, in this market on the side of insurance and PBMs. And in an effort-- let's-- you know, I think, in their-- they would say to drive costs down but-- or to take the entire market themselves. I, in a previous hearing, in a previous day, I think that this side of this industry was referred to as a, as a cartel by someone. I didn't say you said it.

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

**BOSTAR:** It would be great if you did. Is that-- I mean, I think this is the perception, right, that, that this is-- there's, there's something broken here.

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**ROBERT M. BELL:** I, I agree that that's the perception. I think that there's been an opportunity, an opportunity to deliver pharmaceuticals at a lower cost to our insureds. And if there was an opportunity for those companies to also make money while doing that same thing. And again, I think if we're talking about the Big 3 publicly-traded companies, I haven't looked into their-- all their financials myself. Also, if they're insurance companies, they're, you know, of course, regulated by their, their home states. All of that financial information would be publicly available, as well. But if, if you're seeing situations where-- it's, it's so interested in healthcare, because if we see situations where the insurance company believes it's getting gouged or it believes it's premium [INAUDIBLE] are, are getting gauged for whatever reason, or they see like they can provide something cheaper, they try to figure out a way to do that. And that, it's in part, you know-- I think-- I was talking with Senator Sorrentino earlier, you know. This all started off very innocent, right, trying to manage a very complex problem. And, and it, and it's gotten-- it's been so-- it, it's been to a certain degree successful. I didn't hear any Nebraskans come up, outside of people involved in either the insurance or the pharmacy industry, say, you know, dang, those, those PBMs. I-- by the way, if, if somebody came up and had to switch their pharmacy from their hometown pharmacy to CVS or Walgreens, I don't think they would be happy. Right? But there, there, there have been some cost savings and you know. Yeah. And I don't know. So when you use, when you use the word collusion, I mean collusion to lower the price of pharmaceuticals?

**BOSTAR:** Collusion to gain market share.

**ROBERT M. BELL:** And to run phar-- small pharmacies out of business. I don't know that, I don't know that, you know, Optum is looking to get into Valentine, Nebraska and [INAUDIBLE].

**BOSTAR:** What's wrong with Valentine, Nebraska?

**ROBERT M. BELL:** What's that?

**BOSTAR:** What's wrong with Valentine, Nebraska?

**ROBERT M. BELL:** Well, I don't I don't know if there's-- well, there's nothing. It's beautiful. Maybe I shouldn't speak for Optum. How about that?

**BOSTAR:** OK.

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**ROBERT M. BELL:** They're not a member company. But if somebody said that the Big 3 weren't represented. They-- I mean, they are all members of PCMA, who testified earlier, so.

**BOSTAR:** Last, last question.

**ROBERT M. BELL:** Yeah.

**BOSTAR:** If a pharmaceutical, if it's safe to deliver it, and the PBM mail pharmacy would-- does deliver it, should the local small town pharmacy also be permitted to deliver that drug?

**ROBERT M. BELL:** If they are properly licensed and can safely do so, I, I think that's an opportunity for some further discussion on, on a bill. I can't remember the bill number-- name, but I believe you were the introducer on that one. So.

**BOSTAR:** So you don't have any thoughts on that, though?

**ROBERT M. BELL:** I mean, I think I spoke my thoughts on the last time, but maybe I didn't. Maybe I, I skipped that portion of it. There were some-- I, I think we're willing, we're open-minded to having discussions on that. So.

**BOSTAR:** Happy birthday, again. Thank you.

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

**JACOBSON:** Other questions for Mr. Bell? I had no idea it was your birthday.

**ROBERT M. BELL:** Who doesn't want to spend their birthday in front of the Banking, Commerce and Insurance Committee? At least it's not Judiciary Committee. No offense, Senator Hallstrom.

**JACOBSON:** Well, no offense, but you do look a little older today.

**ROBERT M. BELL:** I feel a little bit older. I'm going to feel even a lot older after this day, I think. So.

**JACOBSON:** Thank you.

**HALLSTROM:** The only better thing would be if we were in Valentine.

**ROBERT M. BELL:** Oh, that would be. I mean-- well, maybe not today with the storm coming, but-- so. OK.

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

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

**JACOBSON:** Other opponents. Any other opponents? Would anyone like to speak in a neutral capacity? All right. Seeing none, we have-- let me look and see here. We had 26 proponent letters, no opponent letters, 1 neutral letter, and the committee did not receive any written ADA testimony regarding the bill. OK. Senator Sorrentino, you're up for a close.

**SORRENTINO:** I've had 2 birthdays just waiting. Well, thank you. First of all, to all those who testified, both in favor of and against the bill. I appreciate it. Out of deference to the committee's time, I know you've got more than this bill today, I will be brief, but let me just give you up-to-date on just a couple of states. Iowa just is in the process of working on a PBM reform bill. Part of that bill presented-- there was a press conference, and it had a poll. And in the state of Iowa, 80% of Iowa voters agree it is important that the state legislature take action to address concerns related to PBMs. 70% of them said that the state legislature should consider PBM reform to be must-pass legislation in 2025. One other state, Indiana, passed Senate Bill 140, described as the most aggressive PBM reform legislation seen, aiming at lowering drug prices by addressing conflicts of interest within the pharmaceutical supply chains, including, but not limited to, prohibiting PBMs from working with insurance companies that have a, a financial stake in the PBM, preventing PBMs from owning pharmacies, and creating a firewall to enhance transparency comp-- competition. Finally, the FTC, the Federal Trade Commission, has investigated and taken action against PBMs for anti-competitive practices that increase drug costs and limit patient costs. Specifically, high, high markup on specialty generic drugs, paying higher rates to their own pharmacies and to affiliated pharmacies, unfair reading-- rebating practices, and have taken action against the Big 3. That started back in 2022. So I'll just reiterate, the main intent of LB198 is to do 3 things: provide transparency in drug pricing, protect community pharmacies, and prohibit spread pricing. And with that, I will close and be open to any questions.

**JACOBSON:** Thank you. Questions for Senator Sorrentino? All right. Seein0g none, thank you for bringing--

**SORRENTINO:** Thank you.

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**JACOBSON:** --the bill. Thank you for being here. This concludes our bill and hearing on LB198. And we'll move to the next bill, LB158. Senator Wordekemper, welcome to your committee. You're welcome to open on LB158.

**WORDEKEMPER:** Thank you. Chairman Jacobson, fellow members of the Banking, Commerce and Insurance Committee. I am Senator Dave Wordekemper, D-a-v-e W-o-r-d-e-k-e-m-p-e-r. Today, I'm here introducing LB158, a bill that would prohibit health insurers from unfairly increasing cost-sharing burdens on patients by refusing to count third-party assistance towards patients' cost-sharing contributions. Most insurance plans use cost-sharing requirements like copays and deductibles. When they can, patients pay these costs themselves, but many Nebraskans simply cannot afford these expenses and rely on assistance from pharmaceutical manufacturers, then family members. This financial help was working as intended up until about 2019. That year, PBMs and insurers began implementing what are called accumulator adjustment programs. Under these programs, third-party financial assistance is no longer counted toward patients' deductibles or out-of-pocket expenses. Patients can still use copay assistance, but when it runs out, typically only a few months into the year, they are suddenly responsible for their full deductible and maximum out-of-pocket costs. Let me be clear about who this impacts. This primarily affects Nebraskans with chronic and rare diseases who already face significant health challenges and high treatment costs. When facing these enormous cost burdens, patients often make dangerous choices, skipping doses to save money or abandoning treatment altogether. This endangers Nebraska's lives. The impact is compounded by limited medication access. The Hospital Association surveyed their members to see who stocks specialized medications, like those for hemophilia. Out of 43 facilities that responded, only 8 carry these medications; 7 of them are in Omaha or Lincoln. If you live in western Nebraska, you face even greater barriers. Not being able to receive medication from the local pharmacy due to PBM and insurance company policies immediately jeopardizes patients' lives. Now, let me address a few of the arguments you'll hear from the opponents on this bill. First, opponents will claim that copay assistance incentivizes patients to use expensive brand-name drugs when lower-cost generics are available. This is verifiably false. For most conditions affected by the accumulator program, no generic alternatives exist. A recent study from USC found that 71 out of 90 high-expenditure, brand-name drugs for which copay assistance is offered had no generic equivalents. For hemophilia patients, all available treatments are expensive biologics with no generic alternatives. Second, opponents

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will argue that manufacturer assistance programs are designed to gain a competitive advantage. Again, this is false. For conditions like bleeding disorders, every manufacturer offers copay assistance. There are simp-- there simply is no competitive advantage to be gained. Third, opponents will claim that this is a similar to Medicare's prohibition on copay assistance. This misleads by proposing a false equivalence. Medicare does allow copay assistance from nonprofit charitable organizations. More importantly, Medicare does not accept assistance from those organizations and then turn around and make patients pay their full deductibles, which is exactly what current accumulator programs do. In short, Medicare does not penalize the patient. Fourth, opponents will suggest that patients won't have skin in the game if they can use assistance programs. This ignores the reality that the patients with cross-- costly chronic conditions face numerous other expenses: doctor's visits, lab work, ancillary supplies, and the lifetime burden of managing a serious "in-ju-ly"-- in-- surrey-- serious illness. Having the illness is skin in the game. Fifth, opponents will claim that these programs increase drug utilization and drive up premiums, but research shows that medication compliance actually saves money by preventing hospitalizations, emergency room visits, and disease progression. Finally, opponents will argue that health plans need these programs to hold drug companies accountable, but what actually happens is a double dip. The insurers collect both the copay assistance from the third parties and the deductible when they force patients to pay out of their own pockets the same amount over again to satisfy the deductible. Patients who are on-- patients who are the intended beneficiaries of these third-party assistance are losing those benefits to the copay accumulator policies. LB158 would ensure that Nebraskans with state-regulated insurance plans are protected from these harmful practices. In passing this legislation, Nebraska would join 21 other states that have already enacted similar legislation with bipartisan support, recognizing that their constituents' well-being transcends partisan policies. I would urge the committee to advance LB158. Thank you for your consideration. I'll be happy to answer any questions.

**JACOBSON:** Questions from the committee? Yes, Senator Riepe.

**RIEPE:** I have a question. Thank you, Chairman. Thank you, Senator, for being here. You know, my question is, is I know that you can gift someone \$15,000, I believe. Someone may be more familiar with taxes. I think that number is right. Why wouldn't an individual give the individual, say, \$15,000, and that individual then turns around and, and pays off that deductible?

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**WORDEKEMPER:** I, I don't know specifically if that's legal, if, if they can do that or if that runs under some federal laws. I guess somebody might be able to speak to that behind, behind me. But, you know, realistically, if a drug manufacturer is going to give-- basically it's a debit card. And so when the pharmacy fills that prescription, they use part of that debit card to pay part of the copay. And then the insurance company is billed less money, so, so they save that copay money. So they'll, they'll do that as a pharmacy until that runs out. And what the insurance companies have started to do is say, well, now you need to pay your copay. So when you go to order your medication, you're, you're susceptible to paying your \$5,000 deductible or \$7,500, whatever it might be, before you can pick up that medication. So that's where it gets to patients' noncompliance.

**RIEPE:** It just seems to me that if you gave me \$15,000, which is a very good idea, and I can take that money and do with it as I will, pay bills or buy a new truck--

**WORDEKEMPER:** Correct.

**RIEPE:** --part of a new truck.

**WORDEKEMPER:** Correct. And, and meet me afterwards. But I'll get that right to you. But I, I guess to your point, it, it makes sense that-- I, I don't know why the insurance companies would care who is paying the deductible.

**RIEPE:** Yeah.

**WORDEKEMPER:** They certainly don't care who pays the premium, as long as they're getting their premium dollars. So.

**RIEPE:** Yeah.

**JACOBSON:** Any other questions? I, I guess I would just ask one. I-- it, it seems to me as I look at this, the concern has not-- that if someone wants to give you \$15,000 and you get your deductible paid, that's one thing. It seems that we have somewhat of a conflict of interest when you have a high deductible plan, and the insurer who are the, the phar-- pharmaceutical company who has this high-cost specialty drug is giving coupons to be able to pay the deductible so the deductible goes away, and then the insurance company picks up all the costs going forward from that particular pharmaceutical company. And so I think therein lies the problem and I think we're going to hear that maybe through testimony. But I'm waiting to hear what the testimony is. I'm really not asking you to answer that question.

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**WORDEKEMPER:** Sure.

**JACOBSON:** But I don't know whether you've heard that concern, but that's what I've heard.

**WORDEKEMPER:** I, I, I would say I have heard that concern. And, and to be clear, these, these are not-- I wouldn't consider them coupons. They're, they're to be used as a-- I guess, a debit card. Because I think-- for me, I would say a coupon is used for a lower-cost medication. And, and they will state that they have to pay the costs sooner for the plan because you've met your deductible. Well, I guess the alternative is that in the long run, they're saving money because if these individuals are not on this medication, they're going to probably be in a hospital, having a hospital visit, going to the emergency room, and missing work. It's more of a detriment than just-- I guess it's preventative maintenance for these people to stay on their medication.

**JACOBSON:** Yeah. And, and I-- we hear that argument a lot in here. And, and some would argue if we made all the healthcare and everything free, then nobody would be sick. And, and so, that's probably the other side of that coin. So but I, I think that the rub that I've heard again, with the bill, is that very thing. If you have a high deductible plan and you run into heavy expenses in the early part of the year that exhausts your copay, then you've got free medication and free healthcare for the rest of the year because the high deductible plan takes care of it. If it takes you 6 months to exhaust your copay, then you're paying along the way and there's not as much cost. And so, I think that's what the rub is. Again, I'm interested to hear that from the other testifiers. But, but again, thank you for the open, and I assume you'll stick around for the close since you're part of this committee.

**WORDEKEMPER:** I will be here--

**JACOBSON:** All right.

**WORDEKEMPER:** --unless you throw me out.

**JACOBSON:** Oh, no. That's not going to happen. Yes, [INAUDIBLE].

**HALLSTROM:** Senator Wordekemper, just one second. Maybe this is for somebody else, and I need to listen to the testimony. But is there any element to your knowledge of this having to do with those who select drug formularies and rebates and discounts that might be available,

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and the coupons are being provided by the companies that don't get on the drug formulary? Is there any--

**WORDEKEMPER:** I, I would maybe defer to somebody after me to, to answer that.

**HALLSTROM:** OK. Thank you.

**WORDEKEMPER:** Yep.

**JACOBSON:** So one of the 50 testifiers behind you. Thank you.

**WORDEKEMPER:** Yeah. Yeah. And I can get some more.

**JACOBSON:** All right. Thank you. I was afraid you might say that.

**WORDEKEMPER:** Maybe Senator Sorrentino can come back.

**JACOBSON:** All right. With that, let's invite the first proponent up. First proponent. OK. How are you?

**DALE GIBBS:** OK.

**JACOBSON:** Go ahead and begin.

**DALE GIBBS:** Thank you. Thank you, everyone here. Chairman Jacobson and members of the Banking, Commerce and Insurance Committee, thank you for the opportunity to testify in support of LB158. In addition, I'd like to thank Senator Word-- Wordekemper for introducing the bill and Senator Bostar for his work on this issue last year. My name is Dale Gibbs, D-a-l-e G-i-b-b-s. I live in Kearney, and I'm a board member of the Nebraska Chapter of the National Bleeding Disorders Foundation. Additionally, I'm a father of a hemophiliac who has to rely on medication that restores his ability to create a blood clot to prevent constant bleeding. Without this medication, he's in danger of severe disability or death if he experiences a severe bleeding episode. This medication is far superior and much safer in controlling his bleeding than the natural blood products that were used prior to this development-- to the development of this medication. Hemophilia is a generic disease that's passed down through generations. My son had a 50% chance of inheriting the gene causing hemophilia when it was passed to him by his grandfather, a hemophiliac through his, his mother, my wife. She was a carrier. My father-in-law, like thousands of other hemophiliacs in the 1980s, utilized massive amounts of blood products to overpower bleeding episodes. And if you remember history, this was a time of tainted blood supply. And consequently he developed

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HIV and hepatitis through those blood transfusions. Both he and my mother-in-law died as a result of HIV. My son has never had to utilize blood products to control his bleeding, and the anti-hemophilia medication he relies on is superior in stopping bleeding, but the cost of the medication is much more than those previous products. Depending on the severity of the disease, the cost of maintaining a normal life and infrequent bleeding can be as high as \$300,000 a year. I fully support efforts to lower the cost of our nation's healthcare program, and I do believe insurers and pharmacy benefit managers would save money by steering patients to utilize generic or other lower cost as effective medications. But to make a blanket policy of not allowing third parties to pay my son's copay amounts in order to steer him to cheaper medications is shortsighted. There are no generic alternatives to this medication, and in pri-- and paying an approximately \$800 co-pay each time is a huge financial issue. If my son is to have a normal life of few or no bleeding episodes that endanger his life, he needs this medication. If he or any hemophiliac cannot afford their medication and face a threatening bleeding event, their only recourse will be receiving care in an emergency department that may or may not have the medication in their pharmacy due to the rarity of hemophilia in the general population. And the emergency department care is the most extremely-- is most costly of all healthcare. Passing of LB158 will not increase the cost of healthcare since insurance companies and PBMs will still receive their copay amounts. However, it will help ensure my son has access to the medication that can save his life. Please, I ask that you pass LB158.

**JACOBSON:** Thank you. Questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. Your \$800 copay each, each, each time, each time of treatment or is that an annual copay?

**DALE GIBBS:** No, that's, that's treatment. No, that's--

**RIEPE:** That's what, per treatment?

**DALE GIBBS:** Per dose. Now, that, that could vary because the medication is based on weight-- 50 units per kilogram, so the older a person gets, the bigger they get, the more they require. So that's just a ballpark figure. That doesn't, that doesn't count for all hemophiliacs. There are hemophiliacs, hemophiliacs with a higher cost than that.

**RIEPE:** I assume this is part of an overall health insurance, as well.

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**DALE GIBBS:** Yeah.

**RIEPE:** And does the overall health insurance have a premium? Because, you know, we're seeing in the market now, \$3,000, \$5,000 copays.

**DALE GIBBS:** Yeah. He-- I mean, does he have a premium for the health?

**RIEPE:** Does he have a-- is this just per treatment, but he also has maybe a copay for all of his medical care?

**DALE GIBBS:** No. Just the hemophilia.

**RIEPE:** Just that.

**DALE GIBBS:** I mean, the copay assistance for just the hemophilia. But yes, he has copay for the rest of everything. Yeah.

**RIEPE:** OK.

**DALE GIBBS:** He has to have copays. Yeah.

**RIEPE:** And that \$800 covers--

**DALE GIBBS:** No, the \$800 is just for the hemophilia. Yes.

**RIEPE:** OK. Thank you, Chairman.

**JACOBSON:** But doesn't that \$800 count towards the copay?

**DALE GIBBS:** Well, yeah.

**JACOBSON:** And the copay is what, 30-- a little over \$3,000?

**DALE GIBBS:** Well, again-- yeah. Probably, yeah. I think that's what-- exactly what it is. Now, he's not affected by the copay accumulator yet with his insurance plan. However, I believe I think 3 of 4 insurance plans in Nebraska have the copayer language in them. If he wants to be covered under that, then he would be sorely unable to perhaps afford to be able to get his, his medication.

**JACOBSON:** But I'm trying to understand. I-- if I recall, I'm on a high deductible plan and I think that they just changed the copay maximum down to \$3,600 for a, for a high deductible plan. So by my math, once I hit \$3,600, I'm done paying. OK. Insurance company picks up everything from all the services, drugs, et cetera, so we're really talking about who's going to pay the \$3,600. And then, if you've got these copay accumulator plans where you got somebody coming in and

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helping to cover the deductible then-- and, and the copay, then you're, you're done with that early, and then the insurance company is paying everything that you get treated for. Would that, would that be your understanding?

**DALE GIBBS:** That's my understanding. Our-- the problem is the insurance comp-- companies with a copay accumulator then come back and say, after that's been paid by a third party, saying we got that, but you didn't pay it, so you still owe this.

**JACOBSON:** Right? But we're talking about \$3,600, though, right? Annually?

**DALE GIBBS:** Yeah.

**JACOBSON:** Yeah. And, and again, you're talking about this could cost as much as \$300,000 per year.

**DALE GIBBS:** And it depends on the weight of the patient.

**JACOBSON:** Right. And-- which means the insurance company's picking up \$300,000 or 296-some-odd-thousand of the total cost. Right?

**DALE GIBBS:** If the insurance is good enough. Yeah.

**JACOBSON:** Yeah. All right. Thank you. Other questions? Yes, Senator Riepe.

**RIEPE:** May I ask one-- may I ask you, what is your son's monthly premium to get-- even to get the \$800 copay?

**DALE GIBBS:** You know, I don't know what that is. I'm sorry.

**RIEPE:** If he has an individual plan, it's, it's well over \$1,000 would be my guess--

**DALE GIBBS:** Yeah, I, I don't know what that would be.

**RIEPE:** --just having some experience in that.

**DALE GIBBS:** Sorry.

**RIEPE:** It's OK. We'll get someone that we'll ask--

**DALE GIBBS:** OK.

**RIEPE:** --what, what we should expect.

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**DALE GIBBS:** OK.

**RIEPE:** Thank you, Chairman.

**DALE GIBBS:** Thank you.

**JACOBSON:** Thank you. Other questions? If not, thank you for your testimony.

**DALE GIBBS:** Thank you.

**JACOBSON:** Sorry to hear that your son is dealing with that. Other proponents. How are you?

**KELLY HILLABRAND:** Good. How are you doing?

**JACOBSON:** Great.

**KELLY HILLABRAND:** Thank you for hearing me. I'm super nervous, but try to get through this. So, Chairman Jacobson, Banking, Commerce Insurance Committee. This is for LB158. I-- my--

**JACOBSON:** Will you give your name and spell it?

**KELLY HILLABRAND:** Oh, my name is Kelly Hillabrand, K-e-l-l-y H-i-l-l-a-b-r-a-n-d. So I am from Douglas County. My son Brad Hillebrand is 24. And he was diagnosed with hemophilia A at birth. He's very, very healthy. We've been very lucky with him. For most of his life, we really didn't have to deal with this whole accumulator deal. We would pay our \$5,500 and-- or we would have the \$5,500, it was taken care of. We could just, you know, be with him in the hospital, deal with other-- deal with our other children, and so on. I had no clue what had happened a few years ago when I had called in to get our copay assist and I was kind of given the runaround by the manufacturer and the insurance companies. You know, everybody would say it was paid already. And, you know, I'd call the insurance company and they would say it was paid, but it wasn't counting. They continued to bill me and send me invoices, saying that we owed the \$5,500. So anyways, long story short, it's 2025 now. My son is thriving. He's a homeowner. He is getting ready to turn 26 and he will then have his own insurance policy. So as a parent-- sorry-- my fear for him is that he'll stop infusing because he won't be able to afford it. Things are so out of control nowadays. He has a good job. He's gone through college. He's done everything that he was supposed to do in life. And he's just not going to have the money to be able to afford his healthcare, and I think he'll just not pay it and he'll do without his

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medicine. Without his medicine, he will surely have knee damage, elbow damage, spontaneous bleeds. It's more than just money. Anyways, sorry. This said completely [INAUDIBLE] things, but as a parent, it's emotional. So, any questions? I'll try to answer them.

**JACOBSON:** Wow. First of all, thank you for your courage to be here today. And I can certainly empathize with what you're dealing with. And it's-- these are tough situations to deal with. And you're not the first to come here and testify on a child. And that's, that's more difficult than anything else. If it were you, it would be different, but nobody wants anything happening to our children. So thank you for being here.

**KELLY HILLABRAND:** Yep.

**JACOBSON:** Questions from the committee? All right. Seeing none, thank you again for being here--

**KELLY HILLABRAND:** Thank you.

**JACOBSON:** --and for your testimony. Other proponents.

**SAMANTHA CLINKINBEARD:** Good afternoon. Thank you. My name is Sam Clinkinbeard, S-a-m C-l-i-n-k-i-n-b-e-a-r-d. I'm here-- similar story, but you're going to hear a little bit of difference and variability. I'm here to share about my 13-year-old son, Oliver, who has severe hemophilia A, a serious bleeding disorder. This mean-- means his blood does it clot the way it should, putting him at constant risk of life threatening bleeds. Once a week, Oliver receives preventative medication called Hemlibra. This is the little tiny vial of miracle drug. The medication is a lifeline for him, allowing his blood to clot, maybe not as well as most of yours even with the medication, but enough to make a huge difference. Thanks to Hemlibra, Oliver can do many things kids his age enjoy, like playing sports, as long as we monitor him very carefully and provide additional treatment at the first sign of injury or bleeding. This was unimaginable not too long ago, when kids with hemophilia often had to avoid most physical activity to prevent joint, joint damage and internal bleeding. Despite the enormous improvement this medication brings to his life, accessing and affording it has been a significant challenge. Insurance has always been a bit of a nightmare to navigate, but for years our monthly copays ranged from \$30 to \$150 a month, very reasonable, and we had no problem paying them. We thus far have been lucky because our insurance has worked well for our son and our situation. But in January, that changed dramatically. Our copay for a single month's

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supply of Hemlibra, again, 4 of these little vials, shot up to \$10,000 for 4 vials. Quick math for you, 10,000 times 12, \$120,000 a year. That's more than I make annually. Thankfully, we were able to secure a grant from the Hemophilia Assistance Fund, which will cover up to \$60,000. However, this is only a short-term solution. Come July, I'll be back at square one: researching, making calls, advocating to ensure my son gets the medication he needs, or having to break my son's heart when I tell him he can no longer participate in many of the activities he loves and excels at, because it's too dangerous for him and the long-term health of his joints. Hemlibra is not just about allowing him to have an active life, which is extremely important for a 13-year-old. It's also a safeguard against emergencies like car accidents. These are dangerous for anyone, but they're catastrophic for somebody like my son. Without this lifesaving medication, I'll have to tell my vibrant, active son that he can't do P.E. He can't participate in sports. Hell, he can't even play outside with his friends. It would break his heart and mine, too. Now, this bill won't help me because I'm a little screwed. I have no out-of-pocket max on my prescription coverage. Maybe you can work on that in the next section-- session. However, I wanted to give you an idea of the cost and the importance of these drugs for others who may be on these accumulators that are not allowed to count towards that assistance. If I did have one, when my assistance plan ran out, I would then have to pay the other \$60,000 or whatever for the rest of the year. While hemophilia is relatively rare, I'm also part of the sandywood-- sandwich generation caring for my mother, who is dying from Stage 4 cancer. She recently had a copay of \$3,000 a month for a drug, more than her entire Social Security benefit. Thankfully, though, the Inflation Reductions Act has recently put a \$2,000 out-of-pocket max on those drugs. So because that took effect recently, that's reduced her financial burden. But of course, most of us-- you know, I'm, I'm not on Medicare. I'm not old enough yet. I-- so I guess my story highlights the urgent need to have better solutions to ensure life-saving medications. OK. I'm done. I'm happy to answer questions. I will just say, so you see I'm not making this up, I did put January and February's--

**JACOBSON:** We, we don't allow props, so thank you.

**SAMANTHA CLINKINBEARD:** Oh, OK. Well, I've included it in your packet.

**JACOBSON:** Yep. That's fine. Perfect. Questions? Yes, Senator Dungan.

**DUNGAN:** Thank you, Chair Jacobson. Thank you for being here today. I appreciate you highlighting the cost of some of these things. I think

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it's astronomical. And we hear about it a lot, but I think tangible examples are really helpful. Did you have any idea that your insurance was going to change between these months, when your copay shot up from \$294 to \$10,000?

**SAMANTHA CLINKINBEARD:** No. In fact, it's the exact same. It changed 2 years ago, so we've been through the first year of dealing with it. So it's the same company and everything as it was last year. So no, we were shocked in January. We spent hours on the phone every day trying to figure out-- they're like, yeah, your bill is, you know-- the-- actually, the insurance has a copay assistance, but they maxed it out in January. So now in February, they're like, well, you still owe \$10,000. And I was like, I don't have \$10,000.

**DUNGAN:** And that also got rid of your out-of-pocket maximum, as well?

**SAMANTHA CLINKINBEARD:** We don't have one.

**DUNGAN:** Did you have one, did you have one before?

**SAMANTHA CLINKINBEARD:** I don't know. So I've-- you know, I've never noticed because it's never been an issue. Major medical has an out of pocket. This falls under our prescription drug plan. And when I started looking into this, I was like, surely the \$10,000 at least would hit that out-of-pocket, right? My insurance card says on it, no out-of-pocket maximum.

**DUNGAN:** And if you don't mind me asking, are you through like an employer or how are you insured?

**SAMANTHA CLINKINBEARD:** Yeah. University of Nebraska.

**DUNGAN:** OK. That's a lot of money out of pocket. I, I appreciate you bringing this example. That's really helpful. Thank you.

**SAMANTHA CLINKINBEARD:** Yeah. Thank you.

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

**RIEPE:** Thank you, Chairman. Did you say you have a major employer--

**SAMANTHA CLINKINBEARD:** Yeah. University of Nebraska.

**RIEPE:** --that has a major policy?

**SAMANTHA CLINKINBEARD:** Yeah.

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**RIEPE:** Do they have preexisting requirements--

**SAMANTHA CLINKINBEARD:** No. So we're--

**RIEPE:** --that knocked him out?

**SAMANTHA CLINKINBEARD:** No.

**RIEPE:** And you still have that kind of a copay?

**SAMANTHA CLINKINBEARD:** Yeah. And I think-- it's because if this was covered under major medical, which some, some-- but sometimes it is, we would hit. And we pay the deductible, we pay the out-of-pocket every year. And we actually have a reasonable out-of-pocket on the major medical side. But the problem is this falls under the prescription part of the plan, which has no out-of-pocket max.

**RIEPE:** OK.

**SAMANTHA CLINKINBEARD:** So again, this doesn't help me because I have no out-of-pocket max, so it doesn't matter. I'd never hit it no matter how much assistance I got. But I was hoping to give you kind of an idea of how much the cost can be and how serious it is if people go without drugs, like you heard from previous.

**RIEPE:** I'm trying to recall on our hospital, which we had a lot of employees, and it seemed to me like we accepted everyone's preexisting conditions, just because of the volume that we had.

**SAMANTHA CLINKINBEARD:** Yeah.

**RIEPE:** OK. Thank you for being there. Thank you, Chairman.

**JACOBSON:** Thank you. I do have a bill to present on another committee, so I'm going to turn this back over to, to Senator Hallstrom, our vice chair.

**HALLSTROM:** Any further questions? Seeing none, thank you for being with us today. Next proponent. Welcome.

**BILL ROBIE:** Senator Hallstrom, members of the committee, thank you very much for the opportunity to testify here today. My name is Bill Robie, B-i-l-l R-o-b-i-e, and I'm the senior director of state government relations for the National Bleeding Disorders Foundation. I'm happy to be here today. I apologize if this is a little repetitive from Senator Wordekemper's comments, but I do want to address some of

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the more popular arguments of the bill's opponents. (1) Copay assistance is a coupon that lowers the price of the drug for a patient. That's not true. Copay assistance is not a coupon or any other type of point-of-sale discount. It does not lower the price of the drug for the patient. The price that is paid for the drug is the same for the patient, with or without copay assistance. (2) Copay assistance incentivizes patients to use expensive brand name drugs when lower cost generics are available. Again, that's not true. Copay assistance has no impact on the drug that is dispensed to the patient. The determination of the most appropriate drug for the patient is made by the patient and their physician based on efficacy. The prescribed drug then goes through the scrutiny of utilization management by the payer or the PBM. The drug that the patient pays for, with or without copay assistance, is one that everyone involved has determined is appropriate for the patient and covered by their insurance. Also, as Senator Wordekemper pointed out, nearly all copay assistance programs are for drugs with no generic alternative. And unlike most rare diseases, people with hemophilia or related bleeding disorder have access to many effective therapies. All of them are expensive biologic medications with no generic alternative. Bleeding disorders patients want the most effective option that controls their bleeding. They don't seek out the most expensive ones. (3) Copay assistance incentivizes increased prescription drug utilization, which ultimately may be passed on to health plans and members in the form of increased premiums. I would say yes and no to that one. Research has shown that copay assistance increases medication adherence. In other words, patients remain on their medication, which increases utilization. Isn't robust drug utilization what we want? There's no benefit to prescription drugs if no one is taking them. Lower utilization is not a good thing and doesn't save anyone any money. In fact, it's the opposite. Studies have found that morbidity and mortality associated with poor medication adherence costs the U.S. healthcare system \$528 billion annually. LB158 is a commonsense solution to the problem of health plans and PBMs double dipping by forcing patients to meet their annual deductible and out-of-pocket maximum twice. We urge your support of the bill. Thank you very much.

**HALLSTROM:** Thank you. Senator Riepe.

**RIEPE:** Thank you, Chairman. My question would be is, and I should maybe know this, but is there gene therapy or modification that they might be able to eradicate this particular disease?

**BILL ROBIE:** There are currently 3 FDA-approved gene therapies for hemophilia on the market: 2 of them are for hemophilia B, 1 for

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hemophilia A. We don't refer to it as a cure as much as a durable treatment alternative, simply because no one's going to know if it's a cure until you get to the end of your life and you, you haven't had any fatal bleeds. So essentially, every patient who is on it is sort of in a clinical trial. But there are gene therapies for hemophilia and they're more under investigation.

**RIEPE:** OK. Thank you. Thank you, Chairman.

**HALLSTROM:** I just asked a question earlier and maybe I'm going down the wrong path, but is there any element associated with this that if there's drugs that are on drug formularies and the folks that aren't on drug form-- formularies are, are providing the copay accumulators, that somehow it's distorting the, the intended marketplace with putting drugs on the formulary?

**BILL ROBIE:** Yeah. I'm-- I don't know about that. If that's the case, I would-- I have heard payers argue that the availability of copayment assistance undermines formulary design. But again, as I pointed out, copayment assistance only comes into play when the patient's going to pay for the drug. So everything is already gone through UM and it's determined it's been covered by the formulary. So I, I don't think it could influence upfront. That would be a negotiation between the manufacturers and the wholesalers and the PBMs, as to what ends up on formulary.

**HALLSTROM:** [INAUDIBLE] thing that's going through my mind is that if my drug's not on the formulary, I can push market share by paying the copay accum-- the, the copayment on behalf of the patient.

**BILL ROBIE:** Yeah. Again, that's a possibility. Again, for our drugs, they all have copayment assistance because there's no generics.

**HALLSTROM:** OK.

**BILL ROBIE:** So.

**HALLSTROM:** Thank you.

**BILL ROBIE:** Yeah. You're welcome.

**HALLSTROM:** Thank you for being here today.

**BILL ROBIE:** Pleasure.

**HALLSTROM:** Any other proponents on LB158? Any opponents?

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**ROBERT M. BELL:** Good afternoon, Vice Chairman Hallstrom and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, appearing today in opposition to LB158. As you know, the Nebraska Insurance Federation is the state trade association of Nebraska insurance companies, including most of the health plans that write in Nebraska, who would be impacted by the provisions of LB158. We are committed to financing high-quality healthcare for Nebraskans at the most reasonable cost policy. One planned design feature used by health plans to keep premiums down are called cost utilization tools, such as deductibles, copayments and co-insurance. Utilization tools used by health insurers are used to share costs and risk with consumers, and it can share and encourage consumers and consider not only the health benefits of a particular treatment drug or provider, but also to consider the financial implications as well. High-deductible plans and health, health savings accounts, as an example, are popular with consumers who want to take more control of their healthcare spending. In the pharmaceutical arena, cost-sharing tools are used to encourage customers to utilize as an example, certain generic drugs that are safe and as effective as their name-brand equivalents. I imagine the members of the committee have experienced having a \$5 generic copay versus a much higher copay for the name brand variety. This is an example of utilization tools-- of how utilization tools attempt to control the, the cost of healthcare. And we believe that LB158 would effectively eliminate these tools for health insurers, effectively raising the healthcare costs for all Nebraskans paying health insurance premium. Coupons and out-of-pocket assistance programs encourage consumers to choose higher-priced pharmaceutical options. Health insurers do not necessarily oppose the use of these point-of-sale coupons or other types of programs which can provide great savings to consumers, but the industry strongly opposes having those savings apply to the deductible or other cost-sharing tools. I see I'm running low on time. I, I, I did pass out a coupon. So, I know the proponents said this doesn't apply to coupons. I don't see that in the bill. And certainly our desire is not to have somebody who, say, is a family member or something like that. If they wanted to pay the cost-sharing, we wouldn't be opposed to that. We would be opposed to consumer assistance from somebody that makes money off of that decision. So I know Senator Wordekemper mentioned that we don't care who pays the premium. That is absolutely not true. We do care who pays the premium. We have run into situations where medical providers have paid premiums for individuals and, and good for them. But typically, then they choose the plan that reimburses them at the highest level.

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If we are concerned about hemophilia and those-- the plight of those patients, perhaps we should have further discussions on-- aimed at that. But as this is written, it's very broad and we oppose. Thank you.

**HALLSTROM:** Thank you. Any questions? Seeing none, thank you.

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

**HALLSTROM:** Next opponent. Mr. Blake. Welcome.

**JEREMIAH BLAKE:** Thank you. Mr. Vice Chairman, members of the committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska, testifying in opposition to LB158. I'll be brief. I just want to say that the rising cost of healthcare is a serious concern for many Nebraskans. However, LB158 does not address the rising cost of prescription drugs. Instead, it would require health insurers to count prescription drug coupons towards the member's cost-sharing requirement, a policy that has been banned in federal healthcare programs. Federal anti-kickback laws prohibit the use of drug coupons in Medicare and other federal programs because they encourage the use of expensive brand-name drugs to cover when their lower costs equal-- equally effective generic drugs. You can see this, this is reinforced by the fiscal notes from the Department of Administrative Services and the University System, which both indicate that this bill would lead to increased costs for those health plans. So I appreciate Senator Wordekemper's intent here to provide some relief to consumers, and I certainly appreciate the, the families who came in and testified. However, we believe that LB158 would ultimately increase healthcare spending and result in higher insurance premiums for our members. And for these reasons, we oppose the bill. Thank you. I'd be happy to answer any questions that you may have.

**HALLSTROM:** Any questions of the committee? Just one if there's no others.

**JEREMIAH BLAKE:** Yes.

**HALLSTROM:** If the fed-- if the rationale for the federal rule is to avoid utilizing higher brand-name drugs, I, I gathered that some of the witnesses in support said there are no generic alternatives. Does that make a difference in the landscape?

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**JEREMIAH BLAKE:** It, it might. Again, as Mr. Bell alluded, the bill is very broad the way it's currently drafted. But if that's something the committee wants to look at, we can certainly discuss that further.

**HALLSTROM:** Thank you. Nothing further. Thank you.

**JEREMIAH BLAKE:** Thank you.

**HALLSTROM:** Any other opponents? Welcome.

**BILL HEAD:** Vice Chair Hallstrom, members of the committee, Bill Head, B-i-l-l H-e-a-d, with PCMA here, respectfully in opposition to LB158. I'll echo just a couple items, keep this short. I think this, this bill speaks to the problem of the high cost of drugs, frankly, which I think are the cause of a lot of the issues we've discussed earlier, and how do we, how do we address those? I don't know if you recall that somebody testified earlier and I've seen the, the, the report as well, where the FDA is reporting the average price price of a new drug to market is now \$300,000. And you've heard from the proponents of the bill and very empathetically, the costs that they're dealing with, and what do we do about that? Unfortunately, just-- the-- this bill is I, I, I think wrongly addressed. Because remember, these payments are only benefiting people with insurance. It's not means-tested. If manufacturers really wanted to help patients, that would, instead of giving them \$1,000 credit for that drug, just lower the cost of the drug by \$1,000. That way, everybody benefits, whether you have insurance or not. And I think the other problem is the fairness issue, which-- for everybody who has insurance. So if you have a high deductible, you benefit from this, right, because you'll never have to spend out of pocket. The plan will eventually have to pick up the entire cost of the drug. But you're basically telling somebody who purchased a low deductible policy, if you're on this high med-- high-priced medication, you should go for a high deductible plan because then you won't have to spend anything out of pocket. We're all for the patient using that prem-- using the, the copay coupon. By all means, use that thousand dollars, lower the cost, right, of that drug-- of, of your out-of-pocket, eventually. But then you also shouldn't get credit for that same thousand dollars toward your deductible, because you really didn't paying the out of pocket. And I think, as Mr. Bell said earlier, it's one thing if your uncle Bob gives you \$1,000 to help you out to pay for the drug, but your uncle Bob doesn't have a vested interest in that particular drug and making money from that drug. The manufacturer who is giving that assistance does. For these reasons, we respectfully ask you not to advance this bill.

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**HALLSTROM:** Any questions? I'll ask my question differently.

**BILL HEAD:** I don't-- I--

**HALLSTROM:** What's the motivation for paying the copay?

**BILL HEAD:** Is, is to get the patient to-- through their deductible the quickest. Right. And then once they're through their deductible, there's 2 issues. One is then, the manufacturer is free to raise the cost of the drug because the plan is on the hook for the entire amount. And it's true, there, there aren't generic equivalents available. But if and when a generic does become available, that patient is gonna be conditioned to want to stay on that brand drug.

**HALLSTROM:** That goes to my question earlier, and maybe had the wrong--

**BILL HEAD:** Oh, on, on the formulary?

**HALLSTROM:** Is, is there an element of driving them to that manufacturer's drug?

**BILL HEAD:** Well, absol-- absolutely.

**HALLSTROM:** OK. Thank you. Next opponent. Welcome.

**MICHELLE CRIMMINS:** Thank you. My name is Michelle Crimmins, spelled M-i-c-h-e-l-l-e C-r-i-m-m-i-n-s, and I am the registered lobbyist for Prime Therapeutics. I'm going to keep my testimony brief as well. I think you've heard a lot about copay coupons, why insurance and PBMs are opposed to them being applied to a member's deductible. I'm just going to share with you a couple statistics that come from the National Bureau of Economic Research findings, and the profitability of manufactured drug coupons. It's a report that came out. I'm happy to share it via email if that would be helpful. Data point number one for every \$1 million in manufacturer cost-sharing coupons for branded drugs that are competed against the generics, so we're talking about where there's a brand name drug and a generic drug and a coupon is offered, manufacturers reaped more than \$20 million in profits. And I think that speaks to your question, Senator Hallstrom. The prices of drugs for which manufacturers offer coupons are going up 12-13% per year, as compared to 7-8% for noncoupon drugs. So, again, they're able to increase the list price at a much greater rate over time. And then, last data point is coupons cause an average of 3.4 percentage point reduction in generic drug utilization in preference of branded drugs with a coupon, so again, this is changing behavior over time. I think, generally, the industry has preferred to have more consumers on

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generic drugs. It saves money across the board. We've heard a lot of concerns about the cost of drugs. That includes out-of-pocket costs, impacts to premiums, you know, all of it is expensive for all of us, and having a tool that is driving consumers away from utilizing generics is increasing costs. With that, Prime Therapeutics is opposed to this bill. Thank you.

**HALLSTROM:** Any questions? Seeing none, thank you. Any other opponents to LB158? Anyone in a neutral capacity? If not, that will complete the hearing for today. For the record, we had 9 proponent letters on LB158, no opposition, no neutral, and no ADA testimony. Senator Wordekemper to close.

**WORDEKEMPER:** Thank you, Vice Chair Hallstrom, members of the committee. I'll just start with a couple comments on the opponents. And when, when I spoke to-- insurance companies don't care who pays the premium, I guess-- they're going to collect the premium whether it's from your employer and the employee, or if you're just-- have to go out on the open market and you pay it yourself. So to that point, the premium is being paid, you sign up for an insurance policy, you have a deductible to meet, and they're to provide reimbursement for medical expenses. So, so that's the, the part there. And we heard a lot about the coupons. The-- this is not like the drug manufacturers are giving you a coupon and you buy your, your prescription cheaper. It's not like going to the grocery store. This, this is a set amount of money to help alleviate the cost for the patient, and that money goes to the insurance company. They, they-- that's off their top end so that they don't have to pay as much right off the bat. So let's say your deductible is \$5,000 and you get a copay assistance card for \$15,000. Well, the insurance company is going to get \$15,000 of reduced payment out-of-pocket, and then they want your \$5,000 also, versus if you didn't have the copay assistance card, all they would get would be your \$5,000 deductible. That-- that's what this comes down to. And the patients that are on these high-cost meds with no generics, they're meeting their deductible the first month in January. And that-- that's where we have to get to. So I can speak personally on this. I have twin boys that have hemophilia. Been dealing it-- with it all my life. They learned to infuse themselves intravenously at age 7. They had to do it 3 times a week to get on this product. That's, that's a-- it's a shock. So to think that-- I, I don't know what we would've did if we didn't have the copay assistance that helped pay the deductible. And, and when you're talking about the cost of these meds, I know the one that my son's currently on is \$85,000 a month, so think about that. And, and I know that the insurance companies have to pay out of their pocket to cover these costs. Well, that's their

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business. They're, they're in the business to collect premiums, pay claims, and help patients. And to Senator Riepe, your, your question on gene therapy, they, they've been trying to develop the gene therapy for 30 years. And they're, and they're kind of to a point now-- my son looked into it. He has some antibodies. It's not going to work. But, but just to do that is over \$1 million, and, and, and you don't even know if it's going to work. You don't know how long it's going to work. You have to modify your lifestyle. So they're, they're making a lot of good progress in this field. And I can speak to hemophilia. And I would guess these meds are-- somebody that has Aids, cancer, things like that, where this is the only alternative to where you can have a normal lifestyle. And so, I, I guess I don't understand why it matters-- Mr. Bell spoke-- they don't care if your uncle pays the \$5,000-- or the \$1,000 copay or whatever. Well, then why do they care if it come from a prescription manufacturer-- or I'm sorry, a pharmaceutical manufacturer? It should not matter where that money comes from and how you're using it, because there's only a limited amount of pharmaceutical companies that are making these products. I'm going to say probably a handful that are looking into this. And I shopped around when my kids were on-- we, we got them on the best product. You have to find a product that's going to work for them, so it's not like you're switching products every other week. So to me, it's unrealistic to think that, well, we just got your \$15,000 from your copay assistance, but now pay another \$5,000, because we're going to stretch this out to month April, if you want to say your deductible's \$5,000. It, it makes no sense. They're still paying the cost of the med right off the bat, month one. And the importance of-- and, and my kids want to camp. And there's a lot of kids that were noncompliant, whether their families could afford the med and they didn't do it-- they, they bleed spontaneously into their elbows, ankles, knees. And what that does on these slow bleeds is deteriorate that bone. So then they're doing joint replacements. And, and I saw many kids that were teenagers that couldn't hardly walk because they weren't on their meds like they should be. And so, the purpose of this bill is to allow these people to get their med, stay compliant, and stay out of the health system. That's the ultimate goal of this bill, and I'd appreciate if we could get this to the floor to pass.

**HALLSTROM:** Thank you, Senator. Any questions? I just have one. With regard-- and, and I understand from the testimony that there's, there's an issue here of the drug formulary product versus the product that the copay accumulator applies to or copay assistance applies to. But setting that aside for the moment, if I go to price a-- an insurance plan with a \$5,000 deductible, it's going to cost me a

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certain amount. And I'm, I'm guessing or gathering from what you're saying is, in essence, I now have a \$10,000 deductible, and that should ostensibly reduce my cost of insurance premium, but I'm not getting credit on the front end for that, either.

**WORDEKEMPER:** Correct.

**HALLSTROM:** OK. Thank you.

**WORDEKEMPER:** And, and I'll touch on a little bit-- other thing. Merv, I believe the law was changed a few years ago, that preexisting conditions cannot be turned down by insurance companies. I, I-- it seems to me that there was something changed along those conditions that if you have a preexisting condition, insurance companies cannot deny you on that. But I thought something changed on that, but I'm not sure.

**RIEPE:** I, I don't know either.

**HALLSTROM:** OK. Thank you, Senator.

**WORDEKEMPER:** Yep. Thank you.

**HALLSTROM:** We'll move next to LB533. Senator Kauth is here to introduce the bill. Welcome, Senator Kauth.

**KAUTH:** Thank you. It's good to be back in Banking, although there's only half of you here. Good afternoon, Vice Chair Hallstrom and members of the Banking, Commerce and Insurance Committee. I'm Kathleen Kauth, K-a-t-h-l-e-e-n K-a-u-t-h. Today I'm introducing LB533, a bill I was asked to introduce by the Nebraska Insurance Federation. In brief, LB533 places commonsense guidelines on the delivery of clinician-administered drugs by a specialty pharmacy to a clinical setting, a practice commonly referred to as white bagging. Oftentimes, the white bagging of a drug is done at the request of a health carrier who can secure the drug at a significantly lower cost than if the drug is provided by the administering healthcare provider. The guidelines in LB533 include requirements that the shipping of the drug comply with federal law requirements on shipping, as well as track and trace, specifically for compounded drugs. LB533 also requires a specialty pharmacy to provide access for the healthcare provider, either a pharmacist or a nurse, 24 hours a day, 7 days a week. Additionally, the specialty pharmacy must allow a refill for the covered person, subject to the utilization review procedures of the health carrier. Further, LB533 provides that if a health carrier selects a specialty pharmacy to deliver the drug, the requesting healthcare provider needs

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to provide the date, time, and place of delivery at least 5 days prior to delivery. Notably, LB533 also requires the specialty pharmacy to acquire a signature upon delivery. If the specialty pharmacy fails to deliver the drug in accordance with provisions of LB533 or if the healthcare provider finds an immediate one time need for the drug, the health carrier shall establish and disclose a process which allows a healthcare provider to appeal and have exceptions to use of the specialty pharmacy provided drug. Finally, LB533 provides that a PBM or health carrier cannot ship a drug to the consumer with the intent for the consumer to deliver the drug to the clinic. White bagging processes of insurers save premium payers significant costs. I've handed around a document from America's Health Insurance Plan that outlines the savings. And actually, I will pass that out in a second. I'm certain you'll hear more examples from testifiers to follow. During my time on Banking, Commerce, Commerce and Insurance Committee, I heard the attempts of hospitals to ban white bagging in the name of safety. LB533 specifically addresses these legitimate safety concerns. I'm open-minded to further safety parameters or refinement of the language, but the savings to the healthcare financial system and the Nebraskans who pay health insurance premiums are too significant to outright ban white bagging. I look forward to future discussions on LB533, and I urge your advancement to the Legislature for further discussion. Thank you.

**HALLSTROM:** Thank you, Senator Kauth. Any questions of Senator? Seeing none, thank you. Proponents of LB533.

**ROBERT M. BELL:** Good afternoon, Vice Chairman Hallstrom and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm an executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies, including most of the major medical plans in the state. I'm here today in support of LB533, and I would like to express my gratitude to Senator Kauth for agreeing to sponsor LB533 on the Federation's behalf. LB533 is the Federation's response to ongoing discussions the past, past few sessions on the issue of clinician-administered drugs provided by specialty pharmacies or clinics, called white bagging, that provide great savings to both the patient and plan members. Hospitals and others have sought to essentially ban the practice of-- health plans-- of sourcing those drugs from a specialty pharmacy in the name of safety. The legislation establishes practical, commonsense guidelines that a specialty pharmacy must follow, including compliance with federal laws, communication between the healthcare provider and the specialty pharmacy, compliance with federal track and trace

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requirements, and a variety of other transparency requirements that you already heard about from Senator Kauth. In general, the health plans do not care where the drug is sourced as long as it is safe and in compliance with the various laws related to such drugs. However, plans must object to overcharging that is currently occurring in the market. I think you have previously heard some outrageous examples during previously-- previous white bagging bills. Had a new one that was shared with me by a plan-- about a member using Crysvida, which is-- which they have found nearly a savings of \$2,000 per month by having injections at a pharmacy rather than their local hospital. I've also handed a-- well, you actually already have a sheet from AHIP with more examples. The health plans have long been willing to work with medical providers to put in place practical, commonsense guidelines on white bagging into law. LB533 is our good faith attempt to show our willingness to agree to such guidelines. And one final note: With all the discussions on the federal government's 340B program, please note the health plans and, and PBMs, per Nebraska Revised Statute Section 44-4609, cannot discriminate on reimbursement related to 340B entities or non-340B entities. Essentially, we are blind to whether or not a drug was acquired for a lower 340B cost. With that, the Federation is looking forward to working with the committee and other stakeholders on advancing the safety provisions contained in LB533. Appreciate Senator Kauth for introducing this bill, and the opportunity to testify.

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

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

**HALLSTROM:** Next proponent.

**JEREMIAH BLAKE:** This chair feels a little different than it normally does. Good afternoon, members of the committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska. I appreciate the opportunity to testify in support of LB533, and I want to thank Senator Kauth for introducing this important legislation. As Senator Kauth and Mr. Bell outlined in their remarks, LB533 establishes critical process requirements and shipping standards for physician-administered drugs to ensure that they arrive on time and in good condition. By requiring early communication between the treating physician and specialty pharmacies, this bill helps both parties coordinate effectively, reducing the risk of delays and ensuring patients receive treatment. Additionally, if a shipment is

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delayed or a patient requires immediate care, LB33-- LB533 allows providers to use an existing inventory to pre-- prevent treatment disruptions. You may recall in recent hear-- hearings on a different bill, hospitals raised a number of concerns about white bagging. LB533 directly addresses those concerns while preserving access to low-cost specialty drugs. In previous testimony, I've shared examples of some of the unreasonable prices we've seen from hospitals on some of these very expensive drugs, including a claim for over \$6 million on a single drug, with a list price of \$2.4 million. And it's not uncommon for us to see hospitals mark up the cost of drugs by 3, 4, or 5 times, compared to what we can get these drugs through specialty pharmacies in our network. And LB533 would ensure that the proper handling of these drugs while maintaining cost efficiency for Nebraska families and businesses. Furthermore, LB533 would preserve healthcare access, particularly for rural patients. Some Nebraska providers ask us to ship physician-administered drugs directly to their clinics because they lack the capacity to stock them. This bill would ensure that we continue to-- can continue to fulfill those requests, allowing patients to receive high-quality care closer to home. For these reasons, LB533 strikes an important balance between the needs of providers, payers, and patients. I appreciate Senator Kauth's leadership on this important issue, and I urge the committee to support this bill. I'd be happy to answer any questions you have.

**HALLSTROM:** Any questions of the committee? Based on your comment, do you find the chair less warm when you're supporting bills?

**JEREMIAH BLAKE:** Yeah, it's ,it's almost like it's got air conditioning in here. It's great.

**HALLSTROM:** Thank you, Mr. Blake.

**JEREMIAH BLAKE:** Thank you.

**von GILLERN:** This is awkward for. All of us.

**HALLSTROM:** Next proponent.

**SAMANTHA CLINKINBEARD:** Hello, again. And this time, I'm on the same side as the insurance providers. My name is Samantha Clinkinbeard S-a-m-a-n-t-h-a C-l-i-n-k-i-n-b-e-a-r-d. Good afternoon, again. I want to take a moment to reiterate just how vital lifesaving medications like Hemlibra, which I talked about before, Advate, or NovoSeven are to my son that do have no generic alternatives-- Oliver, who has severe hemophilia A. As I mentioned earlier, accessing and affording

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these medications can already be a challenge, but the way they're distributed in emergency situations can pose even greater difficulties. So I'm just going to share a couple of examples to illustrate why LB533 can be helpful. When Oliver was just 10 months old, he developed an inhibitor, meaning his immune system started attacking the medication, his lifesaving medication, as though it was a threat. In emergencies, he had to use another, even more expensive drug called NovoSeven. On one occasion, his daycare called about a bump on his head. We rushed him to the ER, CT, all that kind of thing, to make sure there's not a brain, brain bleed, where doctors administered the drug that he needed. He had just been diagnosed, so we didn't have a supply on hand yet. The specialty pharmacy located in California overnighted additional doses because he would need more the next day. But because the hospital, not the specialty pharmacy, provided that initial dose, we were hit with a bill-- our coverage was denied and we were hit with a bill of about \$15,000-20,000. That was when he was 10 months old. Somebody said earlier, these drugs go by weight. So now at 13 and 100 pounds more, it would be more expensive. While it was eventually resolved through appeal, the process was incredibly stressful during an already stressful time. The issue isn't limited to emergencies. For routine procedures or surgeries requiring large doses administered via continuous IV, we've had to order the medication ourselves and bring it to the hospital to avoid astronomical charges. I'm guessing this is called white bagging, maybe. I didn't know that term before. But I'm sure you'll agree, asking families to act as both logistics managers and pharmacists for critical medicine-- medications isn't a safe or practical system. His medications have to be temperature-controlled and things like that. You know, if you were getting-- if you were going in to get surgery, you wouldn't bring your own morphine, so I don't think you should bring your own other drugs. LB533 would help address these challenges by allowing specialty pharmacies to ship directly to doctors, enabling doctors to administer necessary drugs in emergencies, even before securing them from specialty pharmacies. These changes could make a world of difference for families like mine, ensuring timely and controlled access to lifesaving medications. Thanks for your attention. Happy to answer questions.

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

**SAMANTHA CLINKINBEARD:** Thank you.

**HALLSTROM:** Thank you very much. Any further proponents? Any opponents?

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**ELIZABETH BOALS-SHIVELY:** I'm back again. Thank you for the opportunity to testify in opposition to LB533. My name is Elizabeth Boals-Shively, E-l-i-z-a-b-e-t-h B-o-a-l-s-S-h-i-v-e-l-y. I'm a critical access hospital pharmacist for Henderson Healthcare Services. LB533, as written, doesn't provide adequate safeguards to ensure that all patients receive high-quality care or that they will receive access to the medications that they need. While I don't believe that the language in LB533 will directly cause any additional harm to patients, it also doesn't provide any actual guardrails to prevent del-- dis-- delays or disruptions in care. Excuse me. It also doesn't place any additional onus on those PBMs or those PBM-owned pharmacies to ensure that the patients are getting the medications they need when they need them. Hospitals like mine, we're willing to do some compromises, but this bill just isn't the right starting point in our opinion. LB533 doesn't adequately address the safety of medications being able to be dosed in real time when they're lab or weight dependent. And for my rural patients coming in a week before their infusion to take another half day off work, traveling 20 to 60 miles, just really isn't reasonable for them on a regular basis when they're getting these every other week or maybe once a month. The bill also doesn't address what happens when the med doesn't show up or comes in an unusable state. Even with their provision for that process to appeal, it doesn't help my hospital. I can't afford to stock a "just in case" dose. And LB533, it does provide the 24/7 access to a nurse or a pharmacist. However, the specifics are very vague, and I have a lot of concerns about actually being able to reach the person you need to, to reach. I had a-- talked to a PBM-known pharmacy, and it took me 2 days, accumulation of 2 hours, 3 phone numbers, 5 different people to talk to just to figure out what happened to a person's prescription. How much time should that have taken? Probably 10 minutes if I could have talked to the right person at the right time. In addition to that, the pharmacy hadn't even called the patient. He thought the medication they shipped was actually for a diabetes. He was taking 2 blood thinners at the same time and not taking any diabetes medication at all. I just don't think that I have a lot of faith that a PBM is going to give me a good contact information and be able to access the right information when I need to access it. Our healthcare system is already really difficult to navigate for patients. They're frustrated. Every day, I get phone calls at least 3 times a week with Beth, can you figure this out? And I don't want to make it any more frustrating than it has to be. Please ask me about Crysvita. With that, I'll take any questions.

**HALLSTROM:** Any questions? Yes, Senator.

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**von GILLERN:** Yeah. Thank you for being here today. You find a-- I heard a lot that you don't like about the bill.

**ELIZABETH BOALS-SHIVELY:** I do.

**von GILLERN:** I heard-- you referenced a lot about PBMs, which the-- I don't know that this bill-- we, we talked a lot about PBMs in the last 2 bills.

**ELIZABETH BOALS-SHIVELY:** And insurance.

**von GILLERN:** I don't know if this one--

**ELIZABETH BOALS-SHIVELY:** Right.

**von GILLERN:** --moves the needle dramatically on PBMs, but I'll, I'll just call your-- to one of your comments. It says--

**ELIZABETH BOALS-SHIVELY:** OK.

**von GILLERN:** --LB533, as written, does not provide adequate safeguards to ensure all patients receive high-quality care. Have, have you met with Senator Kauth? Have you shared ideas on where your specific concerns are?

**ELIZABETH BOALS-SHIVELY:** I, I personally am not the NHA, which-- who I work with. They have reached out to Senator Kauth to try to work out where we can meet in the middle. Like I said, I do think there's compromises. I think right now where I am and my fellow colleagues are, and probably where the insurance company, the PBMs are, we're just really on far ends of the spectrum, and it's been really difficult for us to try to find some common ground where we believe safety is, is really at the forefront.

**von GILLERN:** OK. And then, and then you--

**ELIZABETH BOALS-SHIVELY:** I think this bill is paved with good intentions. I really do. It's just I don't think it has--

**von GILLERN:** Right. Right.

**ELIZABETH BOALS-SHIVELY:** --enough teeth to it.

**von GILLERN:** And then your-- I think your fourth paragraph says what happens if a med doesn't show up or shows up in an unuse-- unusable state? What I know about LB533, which is not super in-depth, but it's specifically to address those concerns.

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**ELIZABETH BOALS-SHIVELY:** It says there's a process to appeal for payment. I don't know what that means.

**von GILLERN:** OK.

**ELIZABETH BOALS-SHIVELY:** That is there-- is that a 6-month process? Is that a 12-month process?

**von GILLERN:** But isn't LB533 intended that meds do show up and show up in a usable state? Isn't that the intention?

**ELIZABETH BOALS-SHIVELY:** They did. I mean, but life happens, right? There's blizzards in the middle of March. I have specialty pharmacies for-- not for white bagging, but even for me, in a regular course of administering medications, they got shipped out of Tennessee, and then they landed in a snowstorm and froze. And they couldn't come to me. And I guess I had to reschedule that patient. So things happen, and there's going to be times when they don't come in a usable state. How often that happens, I couldn't tell you. I don't do white bagging. My other colleagues that testified in earlier bills would probably be a better resource for that.

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

**ELIZABETH BOALS-SHIVELY:** Yeah.

**HALLSTROM:** Any other questions? You'd asked us to ask about something, if you want to expound.

**ELIZABETH BOALS-SHIVELY:** OK. Crysvita. I found it very interesting Mr. Bell brought up Crysvita. I don't give many rare drugs, but that's one I do give. And it just so happened that I was on both the payer side and the hospital side at the same time. We ended up saving money by forcing the insurance company to use a clinician-administered drug.

**HALLSTROM:** OK. Thank you.

**ELIZABETH BOALS-SHIVELY:** So.

**HALLSTROM:** Anything else from the committee? Seeing nothing, thank you for being here today.

**ELIZABETH BOALS-SHIVELY:** Thank you.

**HALLSTROM:** Any other opponents? Seeing none, anyone in a neutral capacity? As Senator Kauth is coming up on LB533, we had 2 proponent

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letters, 1 opponent letter, 1 neutral letter, and no ADA testimony regarding the bill. Senator Kauth.

**KAUTH:** Thank you very much. And thank you, committee, for sticking around and hearing the last bill of the day. We did talk with NHA on Friday, so we're waiting on some language-- Nebraska Hospital Association. So we are very willing to make adjustments. Again, the safety is the biggest part of this. When this bill was introduced last year, there were significant concerns about how to actually put those guardrails in place, and I think LB533 addresses all of those. So I thank you for your consideration.

**HALLSTROM:** Thank you, Senator. Any questions? Seeing none, that will close the hearings for the day. Thank you all for coming.