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HARDIN: --to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48. And I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table in these side rooms over here. Print clearly, fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. 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 tes-- testify, please speak clearly into the mic, tell us your name, spell your first and last name to ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We'll be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the light is yellow, you have one minute remaining. And the red light means your time's finished. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It's just the 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 a dozen copies and give those to the page. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists of signatures, and similar items will not be accepted as exhibits for the record. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please turn your cell phones off or silence those. 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 committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at legislature.nebraska.gov [SIC]. Written position letters will be

included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. You may submit a position comment for the record or testify in person, not both. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

RIEPE: Thank you, Chairman. I'm Merv Riepe. I represent District 12, which is Omaha, Millard, and the fine, little town of Ralston.

FREDRICKSON: Good afternoon. I'm John Fredrickson. I represent District 20, which is in central west Omaha.

G. MEYER: Good afternoon. I'm Glen Meyer, District 17: Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: I'm Dan Quick, District 35: Grand Island.

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

HARDIN: Also assisting the committee today: to my left is our committee legal counsel, John Duggar; as well as our committee clerk, Barb Dorn. Our pages for today are--

SYDNEY COCHRAN: Hi. I'm Sydney. And I'm a sophomore studying history at UNL.

DEMET GEDIK: Hi. My name's Demet. I'm a senior at UNL, and I'm studying political science.

HARDIN: Today's agenda's posted outside the hearing room. And with that, we will begin today's hearing with LB926 and Senator Andersen. Welcome.

ANDERSEN: Thank you.

HARDIN: Take it away.

ANDERSEN: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. I am Senator Bob Andersen, B-o-b A-n-d-e-r-s-e-n. And I represent District 49, which includes northwest Sarpy County and Omaha. I'm introducing LB926 to apply commonsense principles to the Temporary Assistance for Needy Families, TANF,

program. Improvements to TANF are for the purposes of fiscal responsibility and to facilitate efforts to assist with the workforce challenges we face in our state. LB926 is the result of work over the interim to LB379, introduced-- I introduced last session. As in LB379, the bill will modernize the program eligibility from 60 to 36 months, harmonizing this bill with Nebraska Statute 68-1-- 68-1721, which allows for vocational training for up to 36 months. This creates a responsible framework to support families in their quest to get quality work skills, employment training, and create their pathway to meaningful employment. There is dignity in work, and this is one way to help overcome the significant workforce challenges our state is currently facing. LB926 removes the transitional benefits after a recipient create-- completes the generous 36-month training period. LB926 redefines recipient adults in the family to simply just the parents and siblings. Why is this important? How many taxpayer dollars the recipients receives are determined by the number of family members identified in the family. Lastly, LB926 decreases financial support pursued from parents of minor, minor parents by lowering the exempt threshold to 200% of the federal poverty guidelines. Based on 2025 anecdotal data, implementing LB926 would reduce those currently receiving TANF from 1,781 to 1,592 Nebraskans. This equates to an estimated annual savings of over $1.2 million. LB926 offers an opportunity to engage in fiscal responsibility at the state level and the personal level. Nebraskans believe in the dignity of work, and we want to be good partners our people deserve for the security, stability, and pride that comes from earning a paycheck rather than relying on the government. I thank you for your time and attention. I'm happy to take any questions at this time.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator Andersen. It's not often that I open a page on the fiscal note and see brackets. So I-- that's a, that's a new experience for me.

ANDERSEN: Senator Clements--

RIEPE: My question, I guess, gets to be is, is this reduction or-- where the new benefits would pay? Is that rather common in what I would call our pure states, other-- or is that-- are we leading the charge on this?

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ANDERSEN: Great question. I, I don't know the answer to that. I have not polled the other states.

RIEPE: OK.

ANDERSEN: I just looked at it as a commonsense measure to me, to-- my older son graduated college in four years. Right now, the entitlement's out to five years. As a matter of fact, we actually polled across the state and looked at within 24 to 36 months how many programs are there for actually credentialing, a diploma, or a, a certification, and there's actually 306. And that's what kind of led me to the commonsense saying, well, if there's 306 programs out there that people can get a certification, a credential, or diploma, then there's no need to take it out to five. We need to encourage-- help with the workforce development challenges we have in the state. I think this is a great measure to, to do that.

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

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Andersen, for being here. I, I, I had a couple questions. So-- you know, I-- I guess the general premise of the bill is to reduce kind of lifelong benefit or access to TANF from 60 months to 36 months. A couple of the things I was a little confused about-- page 6 on the top of it, it strikes-- it says, the department shall develop policy guidelines to allow for cash assistance to persons who have received the maximum cash assistance provided by this section who face extreme hardship without additional assistance. So in other words, current statute indicates that, you know, if an individual reaches that 16-month period, for example, but there is extreme hardship, wherever that might be, that there's sort of this-- a way to work with them around that. Can you help me understand-- should this bill pass as written, what would happen in those circumstances?

ANDERSEN: Sure. That's a great question. And I had the same question when I met with DHHS multiple times about it. And I asked them, I said, what constitutes extreme hardship, right? Because it's all relative. Your extreme is different than mine.

FREDRICKSON: Sure.

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ANDERSEN: And what it comes down to is they said extreme hardship means that they're, they're not making enough money to pay their bills. And I look at it and say, well, if you've gotten 36 months of, of training and employment training and skill training and certifications and all that stuff, then you-- then, you know-- there isn't gonna be a hardship. Then you're now poised to go get a job. And then the trajectory of your life will, you know, be changed forever. So it's just like, well, I don't have-- I want more money.

FREDRICKSON: Right. So with, with, with TANF to remain eligible, you do have to be employed. So these are individuals who, who are employed and, and have jobs. And so I guess my question is-- you know, it's not like this person's, like, sitting at home on their couch, right? They are-- they're working--

ANDERSEN: Yes.

FREDRICKSON: --but their wage is at a level that is-- that they're unable to afford things like child care, for example. I-- I'm, I'm just kind of trying to grapple with what individuals who are in those circumstances are, are to do. Are we kind of hoping that their wages just increase or--

ANDERSEN: I think it-- I think it's really relative, right? Your-- you, you-- your standard of living is different than somebody else's standard of living-- Sen-- Senator Meyer's. If you look at what the qualification is now, if-- it's all determined by the number of people in the family, right? So if you look and you say, well, you have two parents, you have mom and dad, and you have two kids-- which is probably average for most, most families-- based on the standards right now, they would be eligible to receive $66,000 a year. So $66,000 a year--

FREDRICKSON: I, I don't think that's accurate. The, the--

ANDERSEN: I have the 2026 chart right here.

FREDRICKSON: Yeah. The $66,000 is the qualifying income for the household, I think. I don't think-- that's not the paid benefit, though.

ANDERSEN: OK. Well, we can double-check into it. I mean-- because then it also talks about with a increase where they have grandma and

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grandpa and aunts and uncles and cousins, it goes up to ten people in the family, which increases the amount of money they get in their, their allowance. And it-- assuming this is accurate, that takes it up to over $130,000 a year.

FREDRICKSON: OK. And my, and my other question for you is on, on, on page 5, line 13. It strikes the ability to have [INAUDIBLE] child care related expenses. So in Nebraska, the majority of TANF recipients are, are single moms. So these are individuals-- single-parent households. You know, I, I, I can appreciate your, your, your efforts here or your goals to ensure these people are in the workforce. If child care is unavailable-- I'm just curious wha-- how we envision that individual holding a job successfully if they don't have a place for their children.

ANDERSEN: Well, the premise is that they have 36 months with which to get their certification or diploma and then they step out on their own, right? So once they complete the 36-month-- right now, a 60-month program-- and the way the statute is now is that if they're not making more money than what they're authorized, then they get additional medical and they get additional child care and they get additional money and-- from my perspective, it's like when the generous taxpayers of Nebraska, you know, give them 36 months worth of entitlement, right? At that point-- at some point, it's gotta stop. If you've gotten the, the 36 months-- what I'm proposing, 36 months-- and you have your diploma and certification, at some point, you need to start paying for your own food, your own clothes, your own child care, your own medical, right? And that's really the premise, is that if it's a 36-month program, let's not make it a 36-month program, then add another 12 months here and then another 12 months after that, because it goes on to-- in-- basically into perpetuity the way it is now.

FREDRICKSON: Right. Well, do you, do you, do you envision or do you, do you sort of see where I'm coming from, though, where if an individual is employed-- so they, they got their job, they-- they're, they're working, so-- and again, to requalify, you do have to have a job. So an individual's working, they're currently benefiting with child care assistance so that they can go to work.

ANDERSEN: Sure.

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FREDRICKSON: Your, your bill explicitly strikes the child care benefits. So you no longer have child care. I, I don't think you're able to go to work anymore. And so I'm worried-- like, how is that person supposed to continue to make money?

ANDERSEN: Sure. As a small business owner, I had plenty of employees that also used child care. And, and that's what they did when they decided they wanted to have a family and they had children. They had to figure out, how am I going to take care of my child and keep working if I have to? I mean, that's the-- at some point, it's the responsibility of the individual, not the responsibility of the state.

FREDRICKSON: So if that individual can no longer afford child care, they're, they're just supposed to not work anymore?

ANDERSEN: Well, I think there's plenty of examples around Nebraska and around this country of people that have figured it out. Like I said, at, at some point-- you're talking about 36 months that the, that the state is paying them-- at some point, it becomes a personal responsibility of them to, to pay for their own, their own children, their own family, their own food, their own rent. At some point, it can't, it can't keep being our bill to pay forever.

FREDRICKSON: Right. OK. Thank you.

HARDIN: Other questions? Will you stick around?

ANDERSEN: Yes, sir. I do have a bill over in Government, so I may step out. But my LA is here if--

HARDIN: OK.

ANDERSEN: --if I have to waive. But I'll make all efforts to be back.

HARDIN: Very well. Thank you.

ANDERSEN: Thanks.

HARDIN: Proponents, LB926. Opponents, LB926. Welcome.

KATIE NUNGESSER: Thank you. Thank you, Chairperson Hardin and members of the Health and Human Service Committee. My name's Katie Nungesser, spelled K-a-t-i-e N-u-n-g-e-s-s-e-r. And I'm here representing Voices

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for Children in strong opposition to LB926, which would reduce families' access to the Aid to Dependent Children program. It would make it harder, not easier, for participants of the program and their children to find stability. I want to note that nearly 60,000 children in Nebraska are living in poverty, and almost 27,000 of those are living in extreme poverty, which means their family is surviving on less than half of the federal poverty line. To put that into perspective, the families-- a family of three that's participating in this program, their income has to be just over $1,000 a month or less to be par-- participating. So we're talking very, very low-income Nebraskans. Shortening the time from 60 months to 36 months, eliminating transitional benefits like the child care, and eliminating biological family members' access to the program is cutting off supports before families can stabilize. Reducing this timeline increases the risk of failure, homelessness, and continued poverty for Nebraska's kids. I'm gonna be honest, I'm a little frustrated and sad that we're back here this session. Last session, I did testify on a similar bill about my personal experience participating in the program. As Senator Andersen was sharing, for example, his son making it through a four-year program, I just wanted to highlight that a lot of people on this program are climbing back from generational poverty, from domestic violence, from trauma, also living in remote and rural areas, where these things aren't so easy-- like Senator Fredrickson mentioned, child care. When I was on the program, it took months for me to even find a spot in Garden County. So I didn't get to hit the ground running. As much as I appreciate you're trying to see that programs are a certain length and so we should shorten this, there's a lot of extra stuff that goes into that between the life crisis and then just all of the sidestepping what it's like to be in remote Nebraska on this program. So that said, I also wanna really quick shift over to the child welfare part of this. It's noted in the fiscal note that this would save money by removing people from the program faster, but it could increase Nebraska's cost by increasing child welfare cost. Putting money into programs like this reduces the amount of neglect cases, the amount of kids that have to be removed from their home. The other thing is we had a hearing last week, I believe, in this committee about kinship care, and we heard a lot of good testimony how important that is. And by removing those biological family members from the people eligible to access this I think is going to have an impact that-- you will see more calls coming into the center, but you will also see more kids being removed from their home

for poverty issues. And so we just wanted to highlight that there's savings, but there's potentially spending that could happen. Overall, we would just like Nebraska to continue to look at ways that this program can be more effective instead of trying to pare it down. The investment of our public dollars should be leveraged most effectively to build interges-- intergenerational cycles of resilience, and unfortunately this bill does the opposite. It sets kids and parents up for failure. So I urge you to reject-- I urge you to vote no on this LB926. Thank you.

HARDIN: Thank you. So give me a notion or two. How do we do it better than what this bill is suggesting?

KATIE NUNGESSER: I think, one, like, recognizing-- I understand wanting to take people from this program and get them into the workforce, because we want to fill these positions. But when someone's in crisis-- I'm a very capable person. I'm a very personal responsibility person. I was-- had a newborn baby coming out of a really traumatic domestic violence incident. I moved from the city out to the rural area. Can we just take a pause and recognize that giving people a little bit of time to work with that caseworker to come up with their plan to figure out their strengths instead of trying to operate in this crisis mode? So I would say a little bit of grace, understanding how that works. I would also say being realistic. We've got to continue to work on this child care situation. What good is it to have me on that program in Garden County when there's only ten day care spots for the whole county? And so I wasn't a failure. There just wasn't available child care and jobs at the time. So continue to work on child care. I would say increasing the benefit. I think we talked last session a lot about how long it's been since some of that stuff has been updated. And so make this program actually work for people. I think if you have a little bit more money in the program and a little bit more leeway, a little bit more strengths-based approach, you could really help catapult people like me that just needed that minute, that support, and that help with the direction. I think you could see that. I will say the amount that you're reducing this to, I would not have been successful. Luckily, this program did help me go from a poverty situation-- an extreme poverty situation with my newborn to where I'm at today. But if you lessen this timeline, I just don't see it being possible for someone that was in my situation.

HARDIN: Thank you. Questions? Thank you.

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KATIE NUNGESSER: Yes. Thanks.

HARDIN: Opponents, LB926. Welcome.

CONNOR HERBERT: Good afternoon, Chair Hardin and members of the Health and Human Services Committee. Thank you for the opportunity to speak today. My name is Connor Herbert, C-o-n-n-o-r H-e-r-b-e-r-t. And I serve as a staff member for the Nebraska Commission on African American Affairs. The commission supports the core goal behind LB926: promoting work, responsibility, and long-term self-sufficiency for Nebraskans. We agree that public assistance should be temporary, transitional, and structured in a way that moves families towards independence rather than de-- dependency. However, we respectfully oppose the changes proposed in this bill because we believe they would actually undermine that very goal. Reducing lifetime eligibility from 60 months to 36 months may sound like a way to tighten the system, but, in practice, it risks cutting families off before they have had a rea-- a realistic opportunity to complete job training, stabilize employment, and fully transition off assistance. The employment-first model Nebraska already uses is built around active programming, including work preparation, education, and training. Participants are required to move towards employment, and many are doing exactly that. For families with children, stability during that transition period is what allows parents to stay in the workforce. Relatably, we understand that child care support is not a side benefit. It is one of the primary tools that allows parents to work. Removing that prod-- tri-- provision does not reduce dependency. It rem-- makes it harder for parents to hold jobs, complete training, or accept additional hours. Nebraska included this support in its Welfare Reform Act in 2000 precisely because work requirements only function when parents have a reli-- have reliable child care. If that support is removed, the state risks pushing families backwards, not forwards. We also have concerns about the proposed reduction in the income threshold. Nebraska has made a policy decision to increase the minimum wage to $15 an hour. Reducing eligibility-- the eligibility threshold I just-- threshold, I should say-- from 300% to 200% of the federal poverty level-- which is to-- tied to the 2009 adopted federal minimum wage of $7.25-- creates a mismatch between a-- between state wage policy and benefit policy. That gap can produce a cliff effect, where families who increase their earnings lose support too quickly, making work advancement financially unstable rather than rewarding. Strong welfare policy should be structured to encourage work, reward upward mil-- mobility, and

prevent families from falling back into crisis just they are getting on their feet. In our view, shortening timelines and removing work-- work-enabling supports risks doing the opposite and can make it harder, not easier, for families to achieve permanent independence. For these reasons, we respectfully ask the committee to vote against LB926. Thank you.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Good to see you, Connor.

CONNOR HERBERT: Good to see you too.

G. MEYER: [INAUDIBLE] the other day. Do you have any idea-- and, and maybe this isn't a number you, you would have-- how many people coming off the 60-month program are considered a success, essentially graduating after-- at, at-- off the 60-month program?

CONNOR HERBERT: Well, I, I don't have that number, but I, I also think it's important to note that, like, the change is, like, a lifetime number. So-- I mean, I, I-- I'd have to look further into this, but I'm pretty sure it's not just, like, graduating from a five-year program, you know? People come off it transitionally at different times. And they may fall back into it because of a loss of job or something like that. So moving that from 30-- from 60 months where, you know, maybe over the course of someone's entire lifetime, they ta-- take over six, you know-- they, they are, are using TANF for 60 months in that entire period. Taking that from 60 to 36 would, you know, necessarily reduce access and also cause other, like, pro-- like, structural issues with our approach to welfare.

G. MEYER: Graduation probably was poor, poor choice of words on my--

CONNOR HERBERT: It's OK.

G. MEYER: But, but you understand--

CONNOR HERBERT: Yeah, I do.

G. MEYER: --where I was going with that--

CONNOR HERBERT: Yeah.

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G. MEYER: --so. OK. Thank you.

CONNOR HERBERT: Mm-hmm.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman. So just kind of on that too, I mean, someone could be in it for, I don't know, three to six months, and then they, they get employ-- gain employment again, and then they would go off the assistance.

CONNOR HERBERT: Yeah. That's my understanding. Yeah.

QUICK: Right? And then maybe two years later, now they're in another situation where they-- so-- OK. I just wanted to clarify that, that--

HARDIN: OK. Any other questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. Good to see you, Connor. Can-- you said something about the cliff effect. Can you unpack that a little more for me? I, I try-- I was trying to follow, but can you just-- a little bit more detail?

CONNOR HERBERT: So it's a general term when we're talking about, like, welfare programs. So basically, like-- like I said, the federal minimum wage is $7.25. Oftentime-- like, the reason that there are transitional pro-- benefits like child care, medical assistance, those kinds of things is because-- let's say-- Nebraska doesn't use the federal minimal wage, but let's say for the sake of argument we do. Let's say I'm now making $7.50 and my benefits are capped at 100% of-- like, that benefit that was adding to my income-- and not just adding to my income but making it possible for me to access other resources and, like, utilize my personal, like, funds in a different way, if that's taken from me in tha-- in that immediate moment, that's $7.50 that I'm making per hour, plus my benefit that is actually allowing me to make use of-- like, actually live is taken away. And now I'm back to basically just-- like, it-- the, the problem is, like, it's a transitional thing. So cliff effects are prominent and not just, like, TANF. They're also prominent in--

BALLARD: Yes. Of course. I'm just trying to figure out, like-- we have some of the high-- we have the high-- one of the highest minimum wages in the country.

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CONNOR HERBERT: Right.

BALLARD: And so how do you--

CONNOR HERBERT: Well, I think the-- the thing is, like--

BALLARD: How should we think about this currently?

CONNOR HERBERT: Right. The other thing is, like-- you're right to say that we have one of the highest minimum wages currently, but the effects of that probably won't actually come about until, like, some time from now. You know, we can't expect that, like, people will get out of poverty with $15 an hour in, like, 2020-- 2026 and-- like, just, like, at a snap of a finger, you know?

BALLARD: Mm-hmm.

CONNOR HERBERT: And that's why these things are transitional, right?

BALLARD: OK.

CONNOR HERBERT: So that's the main, main thing about cliffs.

BALLARD: I appreciate it. Thank you.

HARDIN: Any other questions? Seeing none. Thank you.

CONNOR HERBERT: Absolutely.

HARDIN: Those in opposition, LB926. Welcome.

JENNIFER MONROE: Thank you. Good afternoon. My name is Jennifer Monroe, J-e-n-n-i-f-e-r M-o-n-r-o-e. I'm a former participant in the ADC programs that are being discussed here today. As a young, single mother, I was successful in utilizing ADC cash assistance grants in order to provide for my son while obtaining my bachelor's degree at Chadron State College. I used the full 60 months of assistance in order to complete my degree. Without the ADC program, I am certain that I would still be struggling to earn a livable wage with only a high school diploma. Had the program been limited to just 36 months when I attended classes, I would have been forced to drop out of college and work multiple low-paying jobs in order to keep up with life expenses, thus minimizing the amount of parenting time with my

child, which would have left me relying on expensive child care centers to raise him in my absence. Before I was a young mother, I was in foster care until I aged out of the system. I had no concrete family support system. If the ADC program had not been available to me or if it had been limited to the proposed 36 months of assistance, achieving a bachelor's degree would have been nothing more than a pipe dream. My son and I would have remained in poverty for all of his life. Being in the ADC program and pursuing my degree helped me-- helped give me the knowledge and tools to pass along to my son so that he was set up for success to pursue a college degree of his own. If you allow this bill to move forward, you will certainly be robbing future families of the opportunity that changed our lives. I am asking you to keep the pathway open for those who come behind me. If you move forward with these detrimental changes, you will be causing an economic trickle effect that is difficult for many to predict unless you have personal experience within these programs. I have no doubt in my mind that these changes will negatively impact the families in Nebraska who are grasping at straws to make ends meet. As you likely already know, Nebraska receives over $56 million in federal tax dollars every year to fund ADC and other programs but has failed to fully utilize that funding because the ADC program has so few participants. In fact, the number of families requesting ADC benefits has declined by half from 2019 to last year, with only 2,500 families on the ADC program in December of 2025. With this knowledge, we should be asking ourselves why so few families are utilizing the program. Let me tell you why. And please hear me when I say that the number of participants is reducing because the program is incredibly complicated to navigate, not because families do not need the support. Families in poverty need the support desperately, and they need lawmakers to stop reducing access to the very programs that can foster their path to becoming financially sufficient. When access to supportive opportunities is reduced, families remain stagnant in a state of poverty and will continue to rely on other means of state assistance. This reality will continue to negatively impact the children of our great state and, as a byproduct, will also negatively impact our communities in the long run. I urge you to discard the changes proposed in this bill and focus instead on assembling a interim study or a committee of people with lived experience who can recommend guidance and solutions for how to help ensure that the families in Nebraska who use ADC will actually benefit long term through self-sufficiency. I'm happy to take any questions you might have.

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HARDIN: From one Chadron State eagle to another, welcome.

JENNIFER MONROE: Thank you.

HARDIN: You said the program's hard to navigate.

JENNIFER MONROE: Incredibly hard to navigate.

HARDIN: Give us, give us a brief example or two.

JENNIFER MONROE: When I was utilizing the program, which-- I stopped using the program in 2014 when I got my degree. And I 100% vowed to never need the program again, and I have not ever needed any assistance again. So I do see the value in this program. It's, it's incredibly complicated because it requests families to do things that are so far above and beyond what a normal family would have to do if their income was already sufficient. For example, one of the requirements was every single week that I attended classes, I had to go to a professor and ask them to sign a piece of paper that said that I did in fact show up. That is not only tedious, but what if I-- what if my child was sick that week and I didn't go to class? I risk being sanctioned every time I don't have those signatures. And sanctioning means less food stamps, loss of the grant-- the financial grant, et cetera. So the fear and the excessive monitoring of, of the individuals who are on the program is far more stressful than it needs to be, but it also puts you in a constant position of being judged. The number of times I had professors make comments to me about where their tax, tax dollars were going because I needed that signature was really demoralizing.

HARDIN: OK. Thank you for sharing.

JENNIFER MONROE: Mm-hmm.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your willingness to share your story. I-- I'm curious, how-- what-- how long ago were-- was it that you were last on the program?

JENNIFER MONROE: So I initially was on the program during my pregnancy--

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FREDRICKSON: OK.

JENNIFER MONROE: --which is something else I would love to address because the 36 months did not accommodate for time when you're caring for a tender-aged child. And you cannot work and you cannot grow your skills during that time when you're focusing on raising an infant. But I was initially on the program in 2002 during my pregnancy in the third trimester and then for the first roughly four months of my son's life. And then I became employed and I stopped utilizing the program.

FREDRICKSON: Mm-hmm.

JENNIFER MONROE: And then at a future time, I-- what-- I fell on hard times at a different time when my son was about five years old. And at that time-- and this is another reason why this is so complicated to navigate-- if you don't fully understand the scope of the program-- which the general civilian does not-- you are just thinking, I'm just using this help right now, and you don't know the, the path that you could put for you-- before you. So I used another several months of the program in the volunteer capacity. You're allowed to volunteer your time somewhere in exchange for this grant. And so I was doing that while I was trying to learn what the program's purpose was, and that's at the time when I decided to get a college degree. So I had already spent probably ten or so months of the grant opportunity before I was able to realize I could get a degree with this program. And that's when I began college classes. And so from 2009 to 2014, I used the rest of it. However, I had to make choices to waive my grant during certain timeframes so that I could complete college because I had already used so many months.

FREDRICKSON: And, and for your family, it was you and, and, and, and your child, is that right, the family of two?

JENNIFER MONROE: Mm-hmm.

FREDRICKSON: And what was your-- what-- how much money did you receive a month?

JENNIFER MONROE: $293.

FREDRICKSON: OK. So on a year, that would be about 24-- well, I'm terrible at math.

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JENNIFER MONROE: Very small amount of money--

FREDRICKSON: OK.

JENNIFER MONROE: --that we were living on.

FREDRICKSON: The-- OK. So that's helpful because I, I was just looking at the state of Nebraska's website on what TANF benefits are, monthly maximum--

JENNIFER MONROE: They've changed.

FREDRICKSON: --TANF bene-- benefit for a family of four is $678 a month, which would be $8,136 a year. Very different from what we heard in the introduction of $60,000.

JENNIFER MONROE: Correct. When I heard that, I, I almost fell out of my chair.

FREDRICKSON: OK. OK. Thank you.

JENNIFER MONROE: Of course.

HARDIN: Are there questions? Thank you.

JENNIFER MONROE: Thank you.

HARDIN: LB926, those in opposition. Who else do we have for opposition? Can I just see some hands? Great. Would you mind kind-- migrating up towards the front? We tend to have full houses here in HHS, so it helps us navigate a little bit. Welcome.

KAY WAGS: Hello. Thank you. Hello. My name is Kay Wags, K-a-y W-a-g-s. I am a proud resident of LD 20. So. I have some testimony written here, but I'm so appalled by Senator Andersen's inability to actually understand the program that he's cutting and to-- able to just read basic charts on income thresholds. I-- I'm like-- I'm, I'm shocked. I'm shocked that you think that, that 100-- over $100,000 a year is the income of somebody who's on TANF. I mean, I'm, I'm-- I am shocked. So I will try to get through this, but I would really hope-- and I understand, Senator Riepe, that you like to see the brackets, but will you do me a favor and please check those numbers? Because now I'm really worried that these numbers are not correct. All righty. For

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good reason. So basically, I just want to-- I'm going to reiterate what everybody said. I do have some lived experience with this, but I'm choosing not to talk about my lived experience. My lived experience is different because I am-- I come from a family that has some privilege, and so it was easier for me to pull myself out of poverty when I was a young, single mother. I'm happy to report that my daughter is 19 years old. She just completed her first semester of college, honors college, got a 4.0. And I raised her by myself. I'm, I'm appalled. I am appalled at Senator Andersen's lack of empathy and understanding of what poverty actually looks like in Nebraska. I'm appalled. Senator Andersen, you claim that this, that this fixes any hardships. So the hardship, you know, component isn't even important. Because after 36 years, see what happens-- there's a magic bullet. It must be-- it's a 36-month magic bullet, some sort of magic program. And after 36 months, no more hardships. You're done. That's it. Three years. The hardships are gone. I mean, that's just unreasonable. And if you have any, any understanding of what especially parents, women primarily who are parenting alone, deal with when it comes to poverty and the safety of their-- of our children and, and good, safe child care-- any understanding of that or any empathy, all of this would be appalling to you. I'm not going to take up any more of the committee's time. I'm not even going to read what I wrote. I mean, I know-- you and I are not best friends, Senator Andersen, but this takes it to a whole new level. I really hope that this committee decides to check his math. Thank you.

HARDIN: Questions?

KAY WAGS: Who's asking-- questions? No? OK.

HARDIN: Seeing none.

KAY WAGS: Thanks.

HARDIN: Thank you. Those in opposition, LB926. Welcome.

MADELINE WALKER: Hi. My name is Madeline Walker, M-a-d-e-l-i-n-e W-a-l-k-e-r. And I'm the Human Trafficking Program coordinator for the Nebraska Coalition to End Sexual and Domestic Violence. I'm here to testify in opposition to LB926 on behalf of the Nebraska Coalition and our network of programs that serve survivors of domestic violence, sexual assault, and human trafficking across the state. And I'm hoping

to kind of speak to some of the, like, life circumstances that are out of a person's control that can interrupt their ability to gain and maintain employment as well as save money and achieve self-sufficiency. Lack of financial resources is a primary reason survivors choose to stay with or return to their abuser. A 2018 study of domestic violence survivors found that 73% of respondents stayed with or returned to their abusive partner because of limited financial resources. One of the most commonly cited reasons specifically was their inability to support their children on their income alone. In addition, 50% of respondents cited the inability to afford child care as a reason they stayed with their abusive partner. Survivors often struggle financially because abusive partners and traffickers intentionally sabotage their victims' employment stability. In that same survey that I quoted above, 83% reported that their abusive partner disrupted their employment. These disruptions could include reducing the numbers of hours a survivor is available to work by withholding transportation or disrupting child care arrangements, harassing the survivor while at work, doing things to get them fired from their job. Research has shown that survivors can experience job insecurity for up to three years after leaving an abusive relationship. So obviously, maintaining employment during the abusive relationship is very difficult. And then it's difficult to get that stability in order to gain and maintain employment after leaving as well. Limiting the time period for cash assistance to 36 months would hinder the ability of survivors to meet their basic needs and those of their children. Eliminating transitional benefits, particularly those related to child care, would jeopardize the progress a recipient made while receiving assistance. Again, back to that study that I quoted earlier, child care-- lack of access to child care is a very big barrier for survivors of domestic violence, and so that-- eliminating that transitional benefit is particularly concerning. Survivors who are unable to recover financially within three short years will face the impossible decision between living in poverty or living with abuse. And if they've utilized those benefits at any other time in their life, they have an even smaller window to achieve self-sufficiency and they could be trapped in a cycle of poverty and violence. You know, direct cash assistance is a really important tool for survivors achieving safety. And we urge you to not vote this bill out of committee.

HARDIN: Thank you. Questions? Seeing none. Thank you.

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MADELINE WALKER: Thank you.

HARDIN: LB926, those in opposition.

ALICIA CHRISTENSEN: OK. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. I'm Alicia Christensen, A-l-i-c-i-a C-h-r-i-s-t-e-n-s-e-n. I'm here in opposition to LB926 on behalf of Together, an organization that works to ensure everyone in our community has enough nutritious food and a safe, affordable home by both addressing people's immediate needs and supporting their long-term stability. The purpose of ADC is to provide assistance to needy families so that children can be cared for in their own homes and to reduce the dependency of needy parents by promoting job preparation, work, and marriage. For very low-income families across Nebraska, ADC means keeping up on rent and utilities, being able to buy weather-appropriate clothes that fit, affording personal hygiene products, school supplies, or other essentials. Nebraska families already have a hard time making end me-- ends meet. We see this at Together, where community members made over 73,000 visits to our Omaha pantry in 2025, which is a 14% increase from 2024. Reducing time and transition benefits so dramatically runs counter to ADC's purpose and would negatively affect children's health and well-being, impose economic and mental stress on families, and increase costs borne by our communities and state. This is because only extremely low-income families are eligible for ADC benefits. To illustrate, consider a single parent who works full time at minimum wage with a school-aged child. If that child goes to a relative's house for before- and after-school care, the family's not eligible for ADC benefits. However, if the parent pays $300 out of pocket each week, the child care of the family would be eligible for ADC. I just realized that this is using old minimum wage numbers, but the premise still stands depending on-- you know, you can make too much and then child care can be the difference whether you have in-home care or whether you have to pay for it out of home. Can make the difference of whether you are eligible for ADC or not. So apologies. And I can email the committee with an updated chart for you. It's also important to look at this in context. So you can see on the second page of your hand-- handout that earnings cap for ADC is significantly lower than the state's median monthly income and falls well below the federal poverty level. And these are updated. In fact, the standard of need is akin to 50% of the federal property level, which is considered extreme poverty. As you might imagine, such limits mean that every-- very few families with

children qualify for this assistance. For these families in extreme poverty who are able to access the program, ADC benefits can be a critical lifeline during periods of acute need, ensuring families make it through hardships instead of getting stuck in them. Therefore, Together urges the committee to stand up for children in extremely low-- families by opposing LB926. We ask you to vote against advancing the bill and instead support an important program that families and service providers rely on to facilitate the transition from poverty to economic self-sufficiency. Thank you.

HARDIN: Remind me, where all do you guys serve?

ALICIA CHRISTENSEN: We do have a pa-- we have a pantry in Council Bluffs as well.

HARDIN: OK.

ALICIA CHRISTENSEN: We keep separate numbers for them. So those are just for the Omaha area, but.

HARDIN: OK. Very good. Other questions? Seeing none. Thank you.

ALICIA CHRISTENSEN: Thank you so much.

HARDIN: LB926, opposition. Welcome.

DIANE AMDOR: Thank you. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is Diane Amdor, D-i-a-n-e A-m-d-o-r. And I'm a senior staff attorney for the Economic Justice Program at Nebraska Appleseed. Nebraska Appleseed opposes LB926 because Nebraska's TANF funds should be used to make sure that Nebraska's lowest income families with children can meet their basic needs and because direct cash assistance should be the top priority for our state's TANF expenditures. Instead of advancing these goals, LB926 would create additional hardships for families who need our support the most. I'm not gonna read all of this at you, but the-- I want to flag the ha-- the fact sheets that I've handed out do provide some information on just context on ADC. I think you've heard most of it before. It also has some of those numbers that I hope will cla-- help clarify those income limits and then the benefit amounts that I believe were somewhat inaccurately stated earlier. And it is complicated. So hopefully that helps clarify that. And so I wanna just highlight the things that others have shared here today already and

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then add a couple of more points. As noted by Katie Nungesser from Voices for Children, financial assistance reduces stress on parents and it lowers child maltreatment rates. As several others indicated, especially Alicia just now from Together, Jen in her testimony about her personal life, and-- as well as Andrea Evans, who testified here last year about her personal experience, who I talked to on the phone yesterday. And she says hello and was sorry she couldn't be here because she's working-- and the other individual who testified today whose name I apologize I didn't catch-- providing cash assistance to families has immediate and long-term, positive impacts on their children. Additionally, as Maddie from the Coalition to End Sexual Domestic Violence noted, adequate TANF cash assistance helps survivors of domestic violence both build financial stability necessary to leave abusive relationships and to rebuild their lives following violence. I would also add, providing adequate cash assistance to families with low income saves money for everybody. I've provided also a, a visual aid that I think helps demonstrate that, that Chapin Hall roadmap that really shows how many different policies put together, combined, really play, play a part in making sure that we're using tax dollars efficiently as a part of a comprehensive system to help people get to economic stability and then get to the point where they don't need all of those things anymore. But the thing I would add to that picture is I would make it into a little circle because right now we have a lot of things that hend-- send people back to that square one on that drawing there. Senator Hardin, you asked about solutions. I would suggest that you, number one, focus on Nebraska-based solutions with Nebraska-based partners; two, adjust the ADC standard of need annually instead of every other year; increase the ADC maximum benefit amount; and four, completely end the child support penalty in the ADC program, which is something this committee and the Legislature has taken great steps towards. I see that red light is on, so I will stop talking. And I'd be happy to answer any questions to the best of my ability.

HARDIN: Questions? Senator Ballard.

BALLARD: Thank you. Thank you for being here. Can you unpack the child care penalty? You mentioned at the very-- you-- tell me more about that.

DIANE AMDOR: Yeah. So the LB233 from, I think, 2023, I believe, helps to address that issue. So that's-- it's called a cost recovery measure. So in order to access ADC, parents are required to assign

their right to receive child sub-- child support over to the state. And then the state takes that money and keeps it to offset the cost of people receiving public assistance. So the state is balancing our budgets to the tune of multiple millions of dollars by taking money away from our state's lowest income families with children instead of advancing that child sort-- support money to support the children for whom it is intended. And the bill that passed a couple years ago will pass at least $100 to $200 of that money directly to-- through those low-income families.

BALLARD: OK. Thank you.

DIANE AMDOR: Yep.

HARDIN: Other questions? Thank you.

DIANE AMDOR: Thank you.

HARDIN: Opposition, LB926. Those in the neutral, LB926. Senator Andersen. We have online 2 proponents, 68 opponents, 0 in the neutral.

ANDERSEN: Thank you, Chairman Hardin and members of the Health and Human Services Committee. I'm introducing LB926 to right-size the duration a family qualifies for cash allowance on our TANF program. We need to recognize there's dignity in work and assist those in need with expediting training and finding a job. This bill simply realigns the TANF eligibility duration from 60 months to 36 months. As I stated earlier, across our great state, a, a cursory survey revealed there are over 300 programs that can be completed in 24 to 36 months which yield a diploma, certificate, or a, a certification. This would also realize an annual savings of $1.2 million based on what the DHHS has submitted in their, in their fiscal note. And I do find that it's interesting that of everybody that came, there was nobody from the government side and, and six from nonprofits. I found that kind of curious. One of the, one of the comments made from the Voices from Children lady was about the child wer-- welfare costs. I would point you to the fiscal note, which DHHS did reference it, and they said that it is currently unknown. There was another comment about-- oh, talking about the, the parent of the parent-- a-- the parent of a child-parent, and what that comes down to is who actually-- at a certain level, the state has the parents of the child-parent paying the bills for the child-parent. Right now, that's at 300% of poverty.

And what I am proposing, it takes it down to 200% of poverty so that it rotates more of the responsibility to the parents of the child-parent as opposed to the government paying more of the money for the child-parent. If that's crystal clear. Maybe not. There's some, some question about what the monthly entitlement is. I get that, and we'll figure that out. But that still doesn't change the, the, the premise of taking the number of months from 60 down to 36 and that the transition dollars, once you've already completed this generous 36-month program, that your transition should be while in progress. And the number of family members is questionable. In statute, it still says that the family members that you can qualify for getting additional funds as part of the TANF program includes grandparents, aunts and uncles, and cousins. And my premise is that the family should be confined to the parents and the children and siblings. And with that, I urge the committee to support LB926, passing it out of committee to the rest of the body to vote on. And Chairman Hardin, thank you for your time. And I'm happy to answer any other additional questions.

HARDIN: Questions? Seeing none.

ANDERSEN: That's easy.

HARDIN: Thank you.

ANDERSEN: Thank you, Chairman.

HARDIN: This closes our hearing for LB926. Next up, LB773, Senator Dungan. We'll wait just a moment for the room to move about. I think we are ready to go. Senator Dungan.

DUNGAN: Thank you. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. I'm Senator George Dungan, G-e-o-r-g-e D-u-n-g-a-n. And I represent Legislative District 26 in northeast Lincoln. Today, I am introducing LB773, which amends the Nebraska Prenatal Plus Program. As many of you know, I introduced this legislation to create this program for mothers enrolled in Medicaid in 2024 with the purpose of reducing the incidence of low birth weight, preterm birth, and adverse birth outcomes while also addressing lifestyle, behavioral, and nonmedical aspects of an at-risk mother's life that may affect the health and well-being of the mother and the child. All of that is to say a healthy mom equates a healthy baby.

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Prenatal Plus in its current iteration provides for case management, which involves personalized care plans; regular check-ins; referrals to community services and ongoing support; counseling and support, including mental health and substance abuse counseling based on medical and-- need and necessity; general health and education, covering prenatal, childbirth, breastfeeding, postpartum, and infant health topics; nutrition counseling, up to six sessions with a licensed nutrition therapist, either in person or telehealth; and breastfeeding support, including education, breast pump access, and referrals for lactation counseling. Proud to say the Prenatal Plus Program just completed its first full year. In their report to the Legislature that was required by my initial bill, DHHS identified 68 people who had utilized the program. Only one actually gave birth during that time, so those outcomes will be noted in the 2026 report. I would say this is a strong start for the program in year one and is in line with other states that have implemented similar programs. Folks in this Legislature have often heard me talk about the need for upstream investments that reduced the cost for states in the long run. This is one of those investments. I remember when I spoke to this committee about the original Prenatal Plus Program, a analysis of Colorado's Prenatal Plus Program from the year 2000 when it was first implemented found a $2.48 saving for every dollar spent. And that program runs similar to this, so we know that there is an actual savings on the money that's invested into the program. It's a proven fact that when you address the health of mothers during the prenatal period, the baby has a higher birth weight. And with a higher birth weight, you have hi-- far fewer long-term illnesses for that baby, and that's where we ultimately save the money. LB773 makes a few small changes to this program. One of those is that it extends the program's services up to the 60th day postpartum. Obviously, the first two months of life are some of the most important and most difficult for newborns and their parents, and those are some of the things that I think we need to make sure we provide for the most. The 60-day expansion is also intended to provide a warm handoff for many of these programs. When you're receiving targeted case management, counseling, therapy, things like that, having a cliff effect upon providing birth can, I think, have detrimental impacts to both the baby and the mother, which ultimately is counterproductive for the savings that we're trying to accomplish with the Prenatal Plus Program. In addition to that, it also provides for a minimum of two breastfeeding sessions-- which is more of a clarification because we already had the

breastfeeding included in there, lactation counseling. This provides a little more clarification. And finally, we are seeking to remove the sunset date for the Prenatal Plus Program. Currently, if we do nothing, this program is set to sunset in 2028. This is an agreement that I reached with Senator Clements and a couple of others years ago when this was my priority legislation. I think that that was a good policy at that point in time, and it was put in place in order to determine whether or not the Prenatal Plus Program was successful. We did not want to fund a program that ultimately didn't show any kind of benefits or any kind of success, and so that was put in place to ensure that we gave it a serious look by a certain period of time. Having talked to DHHS and many stakeholders over the last couple of years, I believe this program is not only viable but an incredibly important investment in the future of Nebraska. I know that many in this Legislature tend to disagree on certain issues, but on one thing I think we've all been able to agree on, it's that we need more healthy moms and healthy babies. The Prenatal Plus Program did pass with bipartisan support, and it's something that I think we can continue to focus on as a Legislature altogether. I've also moved in this bill the reporting requirement from 2029 with regards to a sunset to 2034. This was intended to continue to gather data and information about the success of the program until 2034. Obviously, I'm open to talking about numbers and whether or not that's the appropriate amount of time. But what I want to make sure we're doing is continuing to gather information to determine whether or not the Prenatal Plus Program is continuing to show growth and success. The department has correctly pointed out that the amount of reports they have to compile is often onerous and oftentimes does not serve an original purpose. I do think, however, it's important for this program that we ensure accurate recording and data so we can make sure that we can identify changes as they arrive. My hope is that by year ten of implementation, we should have a good idea of the program's health. And this is essentially a balance between my love for data and information while also trying to be reasonable and not adding onerous burdens for the Department of Health and Human Services when they're currently trying to streamline certain processes. I have many testifiers behind me who are going to, I think, have a lot more real-world experience both with how the program is implemented with the boots-on-the-ground implementation of it for the practitioners and also be able to talk about some of the benefits that I think this program has continued to provide. While I understand that there's not been that many folks that

have been enrolled in the last year, we're seeing growth. I had a chance to meet with some of the representatives from the MCOs-- at least one MCO a couple days ago. They currently have, I think, about 100 people that they ensure that are enrolled in Prenatal Plus, which would imply to me that there is continued growth beyond the 65 that were originally noted by DHHS. One thing I will point out, as I'm sure people have questions about it-- and we can continue to talk about it-- is the fiscal note. I guess I very respectfully would push back on part of this. I understand that fiscal notes have to assume essentially 100% usage and compliance, but they're estimating on here 8,836 individuals benefiting from the Prenatal Plus Program. As I indicated, there were 68 last year. If that continues to grow at the current rate, I do not think we're gonna reach 8,000 individuals anytime soon. And I do understand there's some conversation on there about how much it also costs per the individual. I think the original fiscal note estimated the cost of these targeted case management and other services being up to $120 a month. This estimates it at $150 a month. I genuinely am just curious as to what that shift is or what that change is. But certainly, I don't think that it's going to be anywhere near the cost that is being anticipated here. I would also remind the committee, as with many of these bills, this is Medicaid population talking about. So there is federal money that we're receiving. This is not all coming out of the General Fund. So when you see the fiscal note, that is involving a broadly-- more money coming in from the feds than at the state level. I understand they have that blend of the 63.24% FMAP. We had a conversation with the initial bill about who's on the expansion population and whether they benefit from that 90/10 reimbursement versus those who don't. People coming after me are more of an expert in that, can probably answer more questions about it. But suffice to say, I do not think that it will cost as much as is being anticipated in the fiscal note. And I'm happy to have conversations about ways that we could potentially tweak the legislation in an effort to reduce that fiscal note. My main goal-- and I think a goal that I share with the Department of Health and Human Services from my conversations with them, as well as many others in the perinatal community-- is to keep providing these services. It's been documented that it helps. It's been documented that it works. And so to let this program sunset would be a great detriment to moms across the entire state. With that, I'm happy to answer any questions.

HARDIN: And the questions are-- Senator Fredrickson.

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FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Dungan, for being here and bringing this bill. I remember when you first got this passed. I, I, I had a little bit of a question about the, the data and reporting specifically. So I know-- what was-- was the reporting on this one of the reports we eliminated last year with our cleanup bill?

DUNGAN: It was brought up in that. I don't-- I'm going to be honest with you, I know that it was mentioned in there and I think it was originally part of what was being proposed to be terminated. I don't remember if it was in the final version of that bill, but I do know that we've received data from DHHS about who was enrolled in this program. I don't know if we'll continue to do so moving forward.

FREDRICKSON: OK. Yeah. I saw some heads shaking, so I'm, I'm assuming it was to be-- took that out.

DUNGAN: I, I think, I think so, yeah.

FREDRICKSON: And you're still wanting the report, as I'm understanding from the legislation. We hear from DHHS a lot about reports, similar to what you said, kind of being onerous, you know, some-- I've, I've heard before as well, like, some reports that we've had them do haven't been requested for decades in some cases. So this obviously being a new program, I-- I'm, I'm curious-- like, is that something-- I mean, I believe in measuring data. I think that helps us with our investments, but-- I-- go ahead and give you an opportunity to speak more of that if you had any--

DUNGAN: Yeah. No, I really appreciate that. I mean, couple of thoughts on that. I'll try to be brief. I know we all have a long day. One, I went to a conference the summer after I got elected. And granted, it wasn't about health and human services issues, but they handed out a packet that had every state and data from that state about the issue we were there about. Nebraska was one of the only states that had a bunch of N/A or question marks. And when I talked to the people from that conference, they said, yeah, we can't get any information from Nebraska. And it was a CSG conference. And so they were essentially saying that, generally speaking, it's difficult for them to get information, not because Nebraska's not cooperating but because we don't have it. So generally, I think it's important to make sure that we share that data because it helps us make informed decisions. That being said, I do think that we can cut bloat and red tape when

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necessary. And if there's reports that haven't been looked at for decades that require DHHS to have folks work on, I get how that's onerous. The thought here was to implement a program with a sunset and then simultaneously get rid of the reporting seems counterproductive. The point of the sunset is to make sure it's working. We can't make sure it's working if we don't have that information. And so I think with a new program that is seeing small but exponential growth in the people that are enrolled, it's really vital that we have that data to know the benefits. And if there are problems with the program-- for example, if we're seeing less people taking part in the program than what we'd expect to see, having that data can help identify some of those barriers. You know, one of the things I've heard, for example-- which you may hear about today-- is some practitioners have found the application process for this program to be a little bit onerous. You know, the original intention was to allow the billing codes for these kind of things that are provided by Prenatal Plus, not necessarily to have people fill out a ten-page application to get accepted into it. But I understand that applications can be necessary to document the data that we're requesting. So it's always a give and a take. I don't think it's inherently bad to have reports. I also don't think it's inherently bad to get rid of some. For this program, I think having the information is vital so we can make sure it's actually doing what it's supposed to do.

FREDRICKSON: Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank you, Senator Dungan. Ca-- you can correct me if I'm wrong, but I believe you used excess profit funds for this.

DUNGAN: Yes.

BALLARD: You did? OK.

DUNGAN: Yes.

BALLARD: Is there any-- and I think that was where Senator Clements said with the sun-- we wanted the sunset. Is there any hesitation to, if we get rid of that sunset, we're going to obligate ourselves to general funds if the excess profit funds are not there?

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DUNGAN: So that's a good question that I think people behind me can continue to talk about some of the health of those funds perhaps better than I. You were a part of the briefing that we had the other day about the Appropriations' proposed budget. I have sort of gone down the rabbit hole about the Managed Care Organization Excess Profit Fund over the last couple months to understand where we currently are. Big picture, 70,000 foot view, I agree that it makes sense to have a more consistent funding source for this than a potentially volatile profit fund. I think that's-- we can all agree on that. DHHS in my conversations has represented that they think this has been so successful it makes us-- makes sense to put Prenatal Plus as part of their normal budget. I know there's been some discussions about that this year where there's maybe not those excess profit funds that can be used, so would be, be using DHHs funds for that. That's more of the appropriation side of it. I think that the program has demonstrated already enough return on investment that it makes sense for DHHS to wrap this into their budget, generally speaking. As it pertains to the Excess Profit Fund, your guess is as good of mi-- as mine as to whether or not there's going to be money in that moving forward. I know originally there was projected to be upwards of $30 million this year, then there was no money, then there was $3 million that was going to be released to the domestic violence services. Now I'm hearing there may be as much as $10 million released in the next 30 to 60 days. So big question marks on that one. I hope that we can kind of get to the bottom of it and understand how much is going to be in that fund. But certainly, I think, regardless of where the funding comes from, this program is not only important to keep serving these populations, but it also saves us money in the long run.

BALLARD: OK. Yeah. I don't disagree with the policy. I, I think it's a good policy. It's just-- I'm trying to figure out-- wrap my head around-- we get rid of the sunset, are we by nature saying this is going to be a General Fund expenditure moving forward?

DUNGAN: And I think that that is possible. Granted, it wouldn't be until fiscal year 2029, as is noted in the fiscal note. And so, you know, I think there's a little bit of time to figure out what that profit fund looks like and how things can be moved around. We had a couple bills last year that I know didn't have an implementation date until 2029, which meant they had no General Fund impact until 2029. And so certainly we have a history of being able to say these bills can move forward and we can try to look at the budget at that point. I

don't believe in kicking the can down the road, so I appreciate you being fiscally responsible to figure out how this can be funded. But for right now, I think we would be fine based on the recommendations from DHHS and the Appropriations Committee in their proposed biennium adjustment.

BALLARD: OK. Thank you.

HARDIN: Other questions? Senator Hansen.

HANSEN: Thank you. In your fiscal note, it says general funds are going to be used next year. You said 2029? So general funds would be used next year and then the ongoing years after that, right?

DUNGAN: Yes. So we can-- I can touch on that if you'd like me to.

HANSEN: Sure.

DUNGAN: The 2029 pertains to the getting rid of the sunset and whether or not there'd be an obligation moving forward to fund this. I think some of the General Fund impact that's-- let me take a step back. Because this bill does two separate things-- I'm, I'm gonna break it down into two parts, right? There's the 60-day expansion postpartum and then there's getting rid of the sunset. I think if we were to just get rid of the sunset and not change anything else about the program, everything in our fiscal situation would look the same until 2029, because that's when the program would continue to exist. Expanding the Prenatal Plus Program past the birth period into those 60 days postpartum is where you might see that increase in the General Fund use that you're noting in the fiscal note. When I got the fiscal note yesterday, that was part of my confusion, is trying to understand where the, the, the General Fund impact is in the most recent-- like, next couple of years because-- it's already been accounted for in our budgets moving forward until 2029. So I'm trying to make sure I can digest the fiscal note properly as well, but I don't think if we just got rid of the sunset there would be any additional General Fund impact.

HANSEN: OK. And you-- this does end June 30, 2028.

DUNGAN: Currently.

HANSEN: Yeah.

DUNGAN: Yes, with the sunset.

HANSEN: Do you think it's premature to get rid of the sunset now instead of waiting until 2028-- the session of 2028 so we have a better idea of whether it's working or not?

DUNGAN: I don't. I think we've gathered enough data at this point with the uptake of folks that have already been benefiting from the program. And in talking with providers and in talking with DHHS, I know they've been touting the success of this program pretty openly. These were not just in meetings that I've had. They've had large conferences and gatherings where they've talked about the benefit of the Prenatal Plus Program. And so based on my conversations with the people administering this, I think we've seen that it works. And I think that looking to other states-- specifically Colorado, Florida, other places that have implemented similar Prenatal Plus programs that have been around for decades-- they've been able to show a benefit.

HANSEN: Yeah. I, I, I think I advocated for this when we first passed it.

DUNGAN: Which I appreciated. Thank you.

HANSEN: Yes. Yes. We're in a different fiscal situation now than we were then, which, you know-- which I think lends a bigger magnifying glass on this, on this bill particularly. Now, you said 68 people used it-- I'm gonna make sure I get this right. 68 people used it. How much funding was used for that first year?

DUNGAN: That is a good question. I don't have the answer to that off the top of my head. Maybe somebody after me can answer that. And if not, I can try to get that information.

HANSEN: I'd be curious because that gives me a better idea of, like, how much we're paying per--

DUNGAN: Yes.

HANSEN: [INAUDIBLE] fiscal notes for a future--

DUNGAN: Correct.

HANSEN: [INAUDIBLE] 8,000 number maybe doesn't sound very accurate.

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DUNGAN: And I think in my email somewhere, if I were to pull my phone out and make you wait, I could find that answer. I just don't have it written down in front of me. So some folks after me can give you that. I know it's far less than what is projected with regards to the usage annually.

HANSEN: OK. Yeah. OK. And I'm trying to figure this out because this seems counterproductive to the purpose of the Prenatal Plus Program, but you said 68 people used it and one birth. Is that because people were still pregnant at the end of the year or-- wha-- what am I missing?

DUNGAN: Correct. Yeah. Just timingwise.

HANSEN: I'm assuming so.

DUNGAN: Yeah.

HANSEN: OK. I'm like, what am I missing here?

DUNGAN: The majority of births take nine months, and so depending on when you get enrolled. It, it can just take a little bit of time.

HANSEN: [INAUDIBLE] when we first advoca-- advocated for it, there was people who were, like, already in line, ready to go, and they were pregnant already, and so I'm like--

DUNGAN: Correct. And that-- I think you're kind of getting to the other point of the unintentional-- and I want to be very careful because I'm not trying to assign malice or anything at all, but the unintentional hoops that people have had to jump through to get involved in this program. That was one of the first feedback that I got from practitioners was, oh, this is actually a lot more difficult to fill out these ten-page applications that we anticipated. We've since heard, though, that our applications here in Nebraska are actually much less onerous than some in other states. So I know they're walking a fine line to make sure they gather that data, but I do think the one birth is just by virtue of when people got enrolled in the program.

HANSEN: Sure. Yeah. And that makes sense. I was making sure [INAUDIBLE]. Oh, I thought I had another question for you, but I don't think so. That's good. Thanks.

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DUNGAN: Thank you.

HARDIN: Are there questions? Will you stick around?

DUNGAN: I am third in Judiciary, but their first two bills seem to be taking quite some time, so I will try to stick around.

HARDIN: OK. Very well. Thank you. Proponents, LB773. Can I see how many proponents we have for LB773? Just to give me a sense. OK. Very good. Welcome.

ROBERT WERGIN: Welcome. Thank you. Chair Hardin and members of the committee, my name is Robert Wergin, R-o-b-e-r-t W-e-r-g-i-n. I am currently president of the Nebraska Medical Association. Before I retired last year, I worked as a family physician in rural Nebraska for over 25 years in both Milford and Seward. My practice included full-service OB, and I cared for numerous mothers and children, many of whom would have benefited from the Nebraska Perinatal Plus Program. I'm here to testify in support of LB773 on behalf of the Nebraska Medical Association. In Nebraska, adverse neonatal outcomes such as low birth weight, less than 2,500 grams, preterm birth before 37 weeks of pregnancy, and adverse birth outcomes drive admissions to the neonatal intensive care units. This care requires not only intensive medical resources but also considerable financial resources, including the cost of round-the-clock care. More importantly, many of these infants carry the consequences of these adverse outcomes for a lifetime. Infants aren't the only ones to bear the burden of adverse perinatal outcomes. Mothers with hypertension, obesity, and diabetes are at increased risk for delivery by C-section, post-operative infection, postpartum hemorrhage, and long-term cardiovascular disease. The Prenatal Plus Program addresses these issues through prebirth intervention to assist at-- at-risk mothers. The program includes nutrition counseling, psychosocial counseling and support, health education and promotion, breastfeeding support, and targeted case management. This type of support is critical for reducing negative outcomes. LB773 ensures that this is-- that this valuable work will continue. LB773 also expands the Prenatal Plus service to 60 days postpartum. In my experience, this extension is critical. The period after delivery is often when the most serious, preventable complications emerge, particularly for women at risk of these adverse outcomes. In clinical practice, we rutunely-- routinely see conditions such as hypertension, cardiomyopathy, diabetes, complications,

infection, postpartum depression worsen or become apparent weeks after the-- a patient has left the hospital. Extending case management through 60 days postpartum reflects the medical reality that pregnancy-related care does not end at delivery. LB773 would support the health of both mothers and families during this very medical-- vulnerable transition period. The Prenatal Plus Program improves outcomes for Nebraska mothers and babies. Continuing this program will have an important positive impact on maternal health and Nebraska families. It is a fiscally responsible investment in low-cost interventions that have the potential to decrease preterm delivery and adverse maternal and neonatal outcomes with lasting consequences. The NMA appreciates Senator Dugan's [SIC] work to support mothers and infants in Nebraska and urges the committee to advance LB773.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Seeing none. Thanks for being here.

ROBERT WERGIN: Thank you.

FREDRICKSON: Next proponent for LB773. Welcome.

LANA TEMPLE-PLOTZ: Hi. How are you?

FREDRICKSON: Good.

LANA TEMPLE-PLOTZ: Good. Pa-- passing on some information. All right. So members of the HHS Committee, my name is Lana Temple-Plotz. And I am the CEO of Nebraska Children's Home Society. I'm writing in support of LB77--

FREDRICKSON: Sorry. Can you spell your name, please?

LANA TEMPLE-PLOTZ: Oh, sorry. Lana, L-a-n-a; Temple-Plotz, T-e-m-p-l-e-P-l-o-t-z.

FREDRICKSON: Thank you.

LANA TEMPLE-PLOTZ: I'm the CEO of Nebraska Children's Home Society. And I'm here in support of LB773, introduced by Senator Dungan. NCHS is a statewide, accredited child- and family-serving nonprofit focused on prevention, early intervention with three core programs: family support including home visiting, kinship navigation and self-sufficiency, early childhood education and adoption and

post-adoption services. So our focus is on moms and babies, prenatal all the way-- yeah. So we start at prenatal. Parenting is challenging under any circumstances, and pregnancy in the early postpartum period represents a critical window when families need support. LB773 strengthens Nebraska's commitment to maternal and child health by extending Prenatal Plus Program services to the 60th day postpartum and removing the sunset. The Prenatal Plus Program addresses lifestyle, behavioral, and nonmedical factors that affect at-risk mothers and their children, helping to reduce low birth weight, preterm births, and adverse birth outcomes, like the doctor before me mentioned. This comprehensive approach, nutrition counseling, psychosocial support, health education, breastfeeding, this is essential care during a var-- very vulnerable time. I don't think any of you have had babies, but it is not for the weak at heart. It is a big deal, so. I'm sure you have wives and husbands and, and children yourself, and so you understand that. This is-- extending services into the postpartum period is critical. Strong maternal health during pregnancy and postpartum prevents adverse health and developmental outcomes-- like the physician mentioned-- for both mothers and babies. This reduces the need for deeper system involvement later. First 60 days after birth are particularly important for establishing breastfeeding, identifying additional health concerns, and supporting new moms as they adjust to this parenting demand. This pro-- program only recently began, as the senator mentioned. Removing that date ensures the program can reach more families, demonstrate those sustained outcomes, and become an established part of our maternal health infrastructure. Extended reporting requirement through 2034 were-- will pri-- provide that valuable data. For this reason, NCHS supports LB773 as an important investment in prevention, helping mothers and families during pregnancy and early parenthood to reduce costly interventions down the road and ensure all Nebraska families have the opportunity to thrive from the beginning.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Seeing none. Thank you for being here.

LANA TEMPLE-PLOTZ: Thank you.

FREDRICKSON: Next proponent for LB773. Welcome.

BRILEY PATTERSON: Hello. Good afternoon, members of the Health and Human Services Committee. My name is Briley Patterson, B-r-i-l-e-y

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P-a-t-t-e-r-s-o-n. And I am a registered nurse and current clinic manager of the Olson Center for Women's Health at Nebraska Medicine in Omaha, Nebraska. I am here today to testify in support of LB773 on behalf of Nebraska Medicine. Currently, we have 31 mothers enrolled in our Prenatal Plus Program. I want to speak specifically about how the Prenatal Plus Program helps reduce maternal morbidity and mortality not just through medical care but through early connection, trust, and mental health support. In the first year of the program, I worked with a young, first-time mother who was enrolled in the Prenatal Plus Program. At the beginning, she was shy and very hesitant to open up. For nearly two months, I consistently reached out for our monthly check-ins, building rapport and ensuring she stayed connected to care. Through the program, I was able to help get her scheduled for nutrition counseling and lactation support-- services that are critical during pregnancy and postpartum but often inaccessible to-- for at-risk mothers. Later in her pregnancy, she reached out to me directly and told me she was struggling with anxiety and depression. Because of the relationship established through the Prenatal Plus Program, she felt comfortable enough to ask for help. When I called her and listened to her, she shared how overwhelmed she was feeling. I was then able to connect her with appropriate resources and coordinate with social work to discuss long-term support and solutions. Without the Prenatal Plus Program, this connection may have never happened. She may not have had a trusted point of contact. Her mental health concerns could have gone unnoticed and untreated, which would increase her risk of serious maternal health complications. LB773 supports exactly this kind of early intervention. By expanding access to care coordination, mental health screening, and supportive services, this bill helps identify risks before they become emergencies. These are the kinds of interventions that save lives, reduce preventable complications, and improve outcomes for both mothers and babies. For these reasons, I respectfully urge you to support LB773. This program is not just about services. It is about connection, prevention, and ensuring Nebraska mothers are not navigating pregnancy alone. Thank you for your time and consideration. I'd be happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Are there any questions from the committee? Seeing none. Thank you for sharing the--

BRILEY PATTERSON: Thank you.

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FREDRICKSON: --story as well. That always helps. Thank you.

BRILEY PATTERSON: Thank you.

FREDRICKSON: Next proponent. Welcome.

SYDNIE CARRAHER: Hello. Thank you. Good afternoon-- I guess Ch-- Senator Hardin's not here-- but members of the Health and Human Services Committee. I am Dr. Sydnie Carraher, S-y-d-n-i-e C-a-r-r-a-h-e-r. I am a neonatal nurse practitioner and the executive director of the Nebraska Perinatal Quality Improvement Collaborative. NPQIC is a statewide network committed to improving health care and outcomes for all Nebraska mothers and babies. I am here today to testify in support of LB773 on behalf of NPQIC and in my role as a private citizen. In my 26 years caring for Nebraska's smallest and most vulnerable patients, I have seen firsthand what happens when risk factors go unaddressed during pregnancy. Nebraska's preterm birth rate has risen from 9.1% to 11.1% over the past decade. Mothers on Medicaid face higher rates of preterm birth, low birth weight, severe maternal morbidity, and mortality. In Nebraska, the Medicaid preterm birth rate is 12.6% compared to 10.4% for private insurance. Babies born preterm or with low birth weight face increased risk of del-- developmental delays, impairments, and even death. So what drives these outcomes? As a member of Nebraska's Maternal Mortality Review Committee, I have personally reviewed many of these tragic cases. The 2025 MMRC report determined that nearly 90% of pregnancy-related deaths between 2014 and 2023 were preventable. The most common contributing factors were access and financial barriers, continuity of care and care coordination, as well as substance use disorder. Obesity was present in nearly half of pregnancy-related deaths, and mental health conditions contributed to one in five cases. Nearly half of these deaths occurred during pregnancy, and an additional third occurred within 42 days postpartum. Medical risk factors, including obesity, diabetes, mental health conditions, and substance use along with nonmedical barriers such as housing and transportation instability, complicate pregnancy outcomes. Among Nebrath-- Nebraska mothers, obesity has increased by 17.4% from 2015 to 2024, gestational diabetes by 57% and pre-pregnancy diabetes by nearly 60%. Preterm birth rates have risen across all three categories. Improving birth outcomes in Nebraska requires upstream solutions, interventions that address risk factors during pregnancy before they lead to an adverse outcome, before a preterm birth, or before a NICU admission. The Prenatal Plus

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Program was created to do exactly that: improve maternal health and reduce preterm and low birth weight births in Nebraska. Nutrition counseling addresses modifiable medical risk factors such as weight and diabetes. Targeted case management connects mothers with clinical care coordination and community resources to address social drivers of health, including housing, transportation, and food si-- insecurity. In the program's first six months, 68 mothers were connected with targeted case management. LB773 removes the June 30, 2028 sunset and assures that the Prenatal Plus Program remains available to bre-- Nebraska mothers and their babies. The bill extends the program to cover 60 days postpartum-- a critical period for both mother and baby-- and extends the program's reporting requirements through 2034, allowing us to continue tracking whether the program delivers results. I thank Senator Dungan for introducing this bill. And I urge the committee to advance LB773. Thank you for your time. And I'm happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Are there any questions from the committee? Seeing none. Thank you for being here.

SYDNIE CARRAHER: Thank you.

FREDRICKSON: Next proponent for LB773. Welcome.

MADELINE WALKER: Hi. Hi again. My name is Madeline Walker, M-a-d-e-l-i-n-e W-a-l-k-e-r. I'm the Human Trafficking Program coordinator for the Nebraska Coalition to End Sexual and Domestic Violence. And I'm here to testify in support of LB773. Pregnancy is an especially risky time for people experiencing domestic violence. Domesci-- domestic violence victimization is linked to poor maternal and neonatal health outcomes. Access to health care is a protective factor against domestic violence victimization because providers can meet privately with patients and offer support and referrals to resources. Survivors are nearly three times more likely to never receive prenatal care and two times more likely to delay prenatal care than women not experiencing domestic violence. Survivors of domestic violence face barriers to accessing prenatal care due to the actions of their abusive partner and systemic challenges such as lack of transportation, inability to afford care, and lack, lack of support from their partner for caregiving and household responsibilities. Poverty increases these barriers, of course. The Prenatal Plus Program meets the needs of pregnant survivors of domestic violence by

connecting them with a variety of services that support their health and safety. History of or current experience with domestic violence is one of the qualifying risk factors for ma-- individuals enrolled in Medicare to receive services through the Prenatal Plus Program. Patient care coordinators can work with survivors to reduce their barriers to receiving prenatal care and connect them to other critical resources such as mental health care. The program also eliminates financial barriers to accessing care. Participation in the Prenatal Plus Program increases the likelihood that a pregnant survivor of domestic violence will experience healthy pregnancy outcomes. We support this bill, and we encourage you to vote it out of committee.

HARDIN: Thank you. Questions? Seeing none. Thank you.

MADELINE WALKER: Thank you.

HARDIN: Proponents, LB773. Welcome.

MARION MINER: Thank you, Chairman Hardin and members of the HHS Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r. And I am here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. We're here in support of LB773, consistent with our support for the program when it first got started under LB857-- also at the introduction of, of Senator Dungan. Catholic social teaching in accord with sacred scripture affirms the preferential option for the poor, that the poor, the marginalized, and, in all cases, those whose living conditions interfere with their proper growth should be the focus of particular concern. The preferential option for the poor has a special form of primacy in the exercise of Christian charity and applies not only to our individual actions but to our broader social and political responsibilities. All of, all of this is related to building what you often hear in, in the church and outside the church too as relevant to building what is often referred to as, as a culture of life. And pursuant to a consistent ethic of life-- another term that you hear sometimes-- which really focuses on the dignity of the human person but particularly vulnerable, vulnerable human persons, which is why the church shows up to speak on behalf of vulnerable persons-- persons in need of defense, persons whom society has failed, and traditional points of contact in society, people who have responsibilities for

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people where they have failed, where family has failed, where spouse maybe has failed, or local points of contact in the community have failed. Our broader social and political responsibilities kick in in those moments. Mothers of preborn and newborn babies who are without adequate family and social support ought to be of special concern and must be a special focus for a society attempting to realize this culture of life. This is the basis for the conference's continuing support of Nebraska's existing Prenatal Plus Program and for LB773. We support the Prenatal Plus Program-- to skip to the end of my testimony here-- the elimination of the program's sunset date to make it permanent and, if possible, the expansion of the program to cover moms and babies up to 60 days postpartum. We respectfully request that the committee advance LB773 to General File. Thank you.

HARDIN: Thank you. Questions? Seeing none.

MARION MINER: Thank you.

HARDIN: Thanks. Hi.

SANDY DANEK: Good afternoon, Chairman Hardin--

HARDIN: Good afternoon.

SANDY DANEK: --and members of the committee. My name is Sandy Danek. And I am the executive director for Nebraska Right to Life. I'm submitting this testimony in support of LB773 as it is presented to this committee. Our mission at Nebraska Right to Life is to restore legal protection to innocent human life, from fertilization through natural death. We work on policies to oppose abortion, infanticide, euthanasia, and unethical biomedical research. And we work to promote a culture of life. When the Nebraska Prenatal Plus Program first came before this committee, we felt the concept of the bill fell within our scope of promoting a culture of life by assisting at-risk mothers with a no-- number of supportive measures. These methods are providing the tools necessary during the challenging circumstances they may face when bringing their child into the world. We strongly believe that when parents are given support and compassion, they can rise to provide appropriately for their child, and this program provides that opportunity. We support continuing the program utilizing reporting measures to determine its success and ask that you advance it further. Thank you.

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HARDIN: Thank you. Questions? Seeing none.

SANDY DANEK: Thank you.

HARDIN: Thanks. Proponents, LB773. Welcome.

CLEO ZAGURSKI: Thank you. Chairman Hardin and members of the Health and Human Services Committee, thank you for the opportunity to testify today. My name is Cleo Zagurski, C-l-e-o Z-a-g-u-r-s-k-i. And I am the policy fellow and lobbyist for the Reproductive Health Collaborative Nebraska. Reproductive Health Collaborative Nebraska works with a statewide network of ten health care agencies in 22 counties, including 30 clinics, to advance access to high-quality reproductive health care for roughly 25,000 clients across Nebraska annually. We are here to ensure access to high-quality health care, which is why we urge the committee to support LB773. LB773 is about building a reproductive and maternal health system that recognizes a simple truth: pregnancy is not an isolated episode of care. It is one point within someone's reproductive health journey, which begins long before pregnancy and continues well after delivery. The lack of an adequate health workforce across our state often requires pregnant people to travel long distances for support. For instance, in the Panhandle region, there are only three OB/GYN providers available to serve Nebraskans. This lack of workforce coupled with a system that treats pregnancy as a standalone event leads to people lacking consistent care after delivery. Healthy pregnancy spacing, postpartum care, and contraception-related health services are all connected. When Nebraskans are supported between pregnancies, we know that outcome-- outcomes improve in future pregnancies, complications decline, and children and families are healthier. In rural communities, this continuity of care is especially important, as our rural Nebraskans face larger geographic barriers and limited access to high-quality and necessary medical care. LB773 supports this approach by making the Prenatal Plus Program permanent, allowing providers to coordinate care across pregnancy and postpartum periods. Permanency makes it possible to design care plans that follow a person through different stages of their reproductive life rather than dropping support at delivery and restarting only when the next pregnancy occurs. This stability also strengthens the rural clinics that anchor care across Nebraska's reproductive health care deserts. When programs are predictable, clinics can maintain services, preserve care continuity for patients, and focus on prevention rather than emergency response. LB773 moves

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our state toward a system that supports Nebraskans while they meet their reproductive health ambitions regardless of income or zip code. We urge the committee to advance LB773. Thank you for your time.

HARDIN: Thank you. Questions? Seeing none.

CLEO ZAGURSKI: Thank you.

HARDIN: Thanks. LB773, proponents. Well, it's good to see you.

SARA HOWARD: It's nice to see you as well. And this is my last visit to you this year. I promise. I know. I'm so sorry. OK, Barb. You ready? OK. Thank you for allowing me to testify today. My name is Sara Howard, S-a-r-a H-o-w-a-r-d. And I'm a policy advisor at First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children. I focus on maternal and child health policy at First Five. I'm here to testify in support of LB773. And I want to thank Senator Dungan for his work on this bill. I think, Senator Meyer, you might be the only one of us who wasn't here when we were working on the Prenatal Plus Program. And it was so interesting because, in 2024, it was concurrent with the hospital assessment. And when we were doing the hospital assessment, they were looking at our maternal and child health outcomes. And it was so interesting because we found out that about 38% of births in Nebraska are paid for by Medicaid. And about half of those births have an adverse birth outcome, which meant that mom had an issue at birth, a, a bleeding issue or some-- something bigger. And then it also could be that that baby was born preterm or low birth weight. Average cost of a NICU stay-- buckle up-- is $35,000 at Nebraska Medicine, with a 19-day average stay. And so when you're trying to think of, well, what services can we get in there that are cheap, that can reduce that out-- that NICU outcome? We looked at the Prenatal Plus Program to say, OK, moms aren't being connected to the services that they need. And that's why when we talk about targeted case management, that's the main billing code that's being used. Senator Hansen, let's talk fiscal note. So the 68-- the number of moms who were enrolled-- that was only for six months. So that was from January to June of 2025. And during that time, from January to June of 2025, 68 moms enrolled, all of them got case management. A few of them got the mental health services and a few got nutrition counseling. But there was only one birth in that six-month period. Makes sense. From January to October, out of the

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Medicaid Excess Profit Fund, about $800,000 was expended on this program. So for all of the mothers who were enrolled, that's the entirety of the amount. In October, when I got sort of information about the Excess Profit Fund, the estimates that they were looking at in perpetuity was around $1.6 million because the number of mothers who are eligible for this program is quite low. And when we talk about the intake, that ten-page intake assessment is something. One of the questions on there is, has anybody ever hit you ever? And when I was reading that, I was like, the baby just hit me. I'd have to tell them about that. And so once you get through the intake, that's actually when you're allowed to bill. And so because the intake is a high bar, it's a little bit difficult. I think this fiscal note exclusively contemplates that postpartum coverage. And it contemplates the 60 days' case management for every single mother enrolled in Medicaid, which is 8,800. That's quite high, I would think, considering in our first six months we were able to enroll 68 mothers. We're hopeful that we'll get into the hundreds in this next year. But the ideal would be that we would be able to remove the sunset and really dig into the program and make sure that providers are aware of it. I-- I'll pause there if there are any questions for me.

HARDIN: Since Colorado's been at this lo-- longer than we have, do you know how things are tracking there?

SARA HOWARD: Oh, my gosh. Col-- so Col-- so I will say-- everybody will tell you-- and dir-- the MLTC director is here, so I-- if you've seen one Medicaid program, you've seen one Medicaid program, you've seen one Medicaid plan. It's like they get tattoos of it when they become directors in Medicaid. The Colorado program is structured differently. It's more of a team-based approach as opposed to a billable.

HARDIN: Hard to compare.

SARA HOWARD: And so that makes it a little bit challenging to compare apples to apples. However, the services are similar in the sense where they're designed to reduce costs in Medicaid overall, by reducing those adverse birth outcomes, reducing those NICU admissions.

HARDIN: OK. Other questions? Senator Hansen.

SARA HOWARD: I'm ready.

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HANSEN: Colorado act also allows for home birth.

SARA HOWARD: That's not even a question, sir.

HANSEN: I had to do it for Senator Ballard. He's always waiting for home births [INAUDIBLE].

SARA HOWARD: Oh, OK. You're making him nervous.

HANSEN: So-- OK. So-- let me see.

SARA HOWARD: Yeah.

HANSEN: So 800,000?

SARA HOWARD: 800,000.

HANSEN: For 68 people.

SARA HOWARD: Well, it wasn't 60-- it was 68 people for the first six months.

HANSEN: Yeah.

SARA HOWARD: And then I think there were some startup. So they did some staff time around telling people about the program and figuring out how to do it. And so presumably, there were more enrollees after June--

HANSEN: So from June to October.

SARA HOWARD: Mm-hmm.

HANSEN: Even then that's-- you'd have to have a lot of enroll-- because that's, like, $12,000 a person for 68-- 800,000 divided by 68.

SARA HOWARD: And targeted case management is actually one of the cheaper billing codes in Medicaid, so I don't know why that number is so high.

HANSEN: And I think that is why I'm, like, a little hesitant on, you know, getting rid of the sunset [INAUDIBLE] not even one year or-- like, where-- [INAUDIBLE] Senator Dungan said we had a report yet or not.

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SARA HOWARD: We, we have this one report, which is-- well, we have two reports, actually. We have one report that says they submitted [INAUDIBLE], and then they have a second report for six months that says 68 people enrolled and we had one birth.

HANSEN: Yeah.

SARA HOWARD: Yeah.

HANSEN: So I'm trying to fig-- I'm just trying to figure out the numbers. It doesn't make a lot of sense for $12,000. For what--

SARA HOWARD: For what we're offering--

HANSEN: --the, the qualifications are for the Prenatal Plus Program, it should not cost $12,000 a person, so.

SARA HOWARD: I agree.

HANSEN: Unless we're either paying somebody a lot for consulting or--

SARA HOWARD: Or we're doing something wrong.

HANSEN: Or something else. I don't know.

SARA HOWARD: Yeah, yeah.

HANSEN: So-- anyway.

SARA HOWARD: It's a very strange-- it's-- yeah. I'm with you.

HANSEN: Yeah. All right. Thanks.

SARA HOWARD: Yeah.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome.

SARA HOWARD: Thank you for having me.

G. MEYER: I got a totally unfair question to ask you--

SARA HOWARD: Hi-- hit it.

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G. MEYER: --but I'm going to shoot anyway. This seems like a very, very important program. Senator Hansen indicated the cost on it. A, a startup and everything probably contributed to the large amount of expenditures up to this point. Given our budgetary constraints and the probability that the Managed Excess Profit Fund will have zero funds in it going forward-- at least for something other than the Medicaid program-- what trade-off-- what program do we trade off to fund this? And I told you it's an unfair question, but you have a tremendous amount of experience on this committee. And so there are very needy programs, very valid programs, perhaps some that we have funded in the past that perhaps doesn't merit that attention right now. And, and if you care not to answer, I totally understand. But, but we have to try to figure out on a priority basis-- what are we going to fund? And I'm at a loss because I, I know we-- we're going to have to cut some things in order to fund some things. But you've got a great deal of experience.

SARA HOWARD: I have some. A little bit. Can I first talk about the Excess Profit Fund for a hot minute?

G. MEYER: Sure.

SARA HOWARD: Just-- I don't want to-- I, I keep-- there's somebody who knows quite a bit more than I do. They're not done reconciling last year. So the way that it works, right, with our MLR, or our medical loss ratio for the Excess Profit Fund, is that we put into our contracts that 85% of what we give to them has to be spent for services. 15% can be for admin and profit, but only, only 2% can be used for profit. So anything above that would be returned to the state. At the end of every calendar year, it takes about three months to reconcile. And so when we have a stable Medicaid program, stable enrollment, not a lot of churn, when we don't have a lot of system utilization in an en-- emergent way-- and so this last year-- and the director may tell me something different-- we did have sort of stable enrollment from when I read the Medicaid reports. It's very likely that there will be funds returned, and it's very likely that they'll be in the millions. Now, what will happen is, in this next year, as we look at some of the work requirements and the-- or-- when they have to check eligibility again, reauthorizations for eligibility-- apologize. This sinus infection is slowing me down-- you may see people come off the rolls and you may start to see that churn that leads to the MCOs not making as much money. So the Excess Profit Fund is very likely

that there will be funds in it-- in March, I would say. Now, what happened last year was, obviously, all of those funds were swept out but for these programs that were included. I think what's hard about your chair-- and I've sat in that. I was in that spot for, like, my first two years. It's a great spot-- is that what we're weighing out here with Prenatal Plus-- one, it's funded. It's funded through June 2028. We've already contemplated that. So you don't really have to weigh that out. But what you do have to weigh out is the merits of a program that reduces those expensive costs. I think that's why director-- or, CEO Corsi has gone around and said, I, I like Prenatal Plus, is because if you can reduce one NICU admission, you start to pay for the program very quickly. And so I, I think it's one of those things where if you're asking me to trade off within the Medicaid program-- I won't ask you to do that because, anything with a match, I want you to draw down your match. Right? We make money off of the match.

G. MEYER: Given the enrollment compared to the profitability coming back from the MCOs, that thing is roller coaster. You're--

SARA HOWARD: It's a roller coaster.

G. MEYER: --that the enrollment follows in arrears, from my understanding. And I've been involved with it just a little bit in arrears from, from, from what availability is. And so it appears there's funds there. They get swept. The following year, we probably need those funds, and they might not be there. And then historically, from what has been in there for the last five or six years-- and I think COVID played a part in that of avail-- available funds and things of that nature. We can look at our cash reserves. We just had a budget hearing. And you look at cash reserves and you look at, at, you know, $1.2, $1.3 billion in cash reserves and we're down to the 600s now. I think that's part of much of the funding that's gone on in the past, the extension of programs and the initiation of new programs with funds that were not sustainable. And so that's where we find ourselves now, with substantial budget deficits. And so we have to make some decisions.

SARA HOWARD: Yeah. You know-- and I wouldn't ask you to make that decision on LB773, only because I think it's funded, right? If you pulled out the postpartum period, there's probably not a fiscal note on this bill anymore. I think you need to work very closely with the

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Appropriations Committee. When I was in, in Senator Hardin's seat, I would do sort of weekly meetings with our Appropriations chair and say, OK, what bills are coming from my committee and what are we doing in terms of each of these cash funds to make sure that we are aligning our work together? But no, you don't have any easy, easy answers this session.

G. MEYER: I told you I was going to ask you a totally unfair question. I'm sorry to put you on the spot.

SARA HOWARD: You know what? Next question better be, I wanna see a picture of that baby. That's what, that's what the question should be.

G. MEYER: The last time you were here, I saw a picture of your baby.

SARA HOWARD: He's the cutest guy in the world.

G. MEYER: Cute, cute as a-- cute as a button. Yes, absolutely. So-- thank you.

SARA HOWARD: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So for the program-- I mean, now that it's basically set up, those costs are basically within the program now, right? I mean--

SARA HOWARD: Yeah.

QUICK: I mean, unless we eliminate and then have to come back and start all over again, right?

SARA HOWARD: Right.

QUICK: So how did that work when the first-- I mean, you're working directly with-- its people-- well, are you wor-- working di-- directly with providers or-- to get, you know, people who go out and do checks or things like that or--

SARA HOWARD: Yeah. This is a good question. So I-- my understanding of how it works-- and Briley Patterson from Nebraska Med can explain it better-- but when a provider has a mother come in for, like, an OB

visit and says, oh, my gosh, this mother had a, you know, a really difficult birth last time or has a previous history of preterm birth, then that mother will get referred from the provider to the clinic manager or the nurse case manager who can help them enroll in the program. Once they're enrolled, all of that case management support that she gets can be billed as a service. And so-- but the case management has to be done by a clinical provider in a clinical setting. Targeted case management is one of the only billing codes in Medicaid where you cannot be a credentialed provider. I look at you because sometimes you like things that are outside of the credentialing system. So you can offer a service like targeted case management from a social worker or a layperson. And so that's-- that-- I-- it doesn't quite answer your program, but it's basically a referral from the OB to the person who can help them enroll that's in that clinical setting.

QUICK: And do they-- I'm gue-- and I guess-- do they work with the hospitals too?

SARA HOWARD: Mm-hmm.

QUICK: OK. All right.

SARA HOWARD: But the hospitals have been kind of slow were-- to take it on because they needed to figure out their billing.

QUICK: OK. All right. Thank you.

SARA HOWARD: Yeah.

HARDIN: Other questions? Seeing none. Thank you.

SARA HOWARD: Thank you. It was a delight. Thank you for having me.

HARDIN: Proponents, LB773. Opponents, LB773. Those in the neutral. There's Senator Dungan.

DUNGAN: I'm still here.

HARDIN: He's still here. Online, we had 22 proponents, 0 opponents, 1 in the neutral.

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DUNGAN: Well, thank you, Chair Hardin and the rest of the committee. I also want to say thank you to all of the folks that came in and testified here today. Senator Howard obviously is incredibly well-versed-- sorry-- well-versed in a lot of these topics. And so if there are any follow-up questions, I would encourage you to continue to ask her, myself, or any of the other members here-- or, folks here who testified. Big picture, this program's incredibly important, not just to me but to Nebraskans. I think we've made that point pretty well. The first time we had the hearing on Prenatal Plus, Senator Hansen, I think you mentioned that it was one of the more kumbaya hearings you'd ever seen. We had all of the folks there in favor that we had here today, and I appreciate that this is a nonpartisan issue. I work really hard to bring bills that I think are commonsense, nonpartisan issues, and to me this is one of those things we can all work together to help the state. I also-- please-- know and fully aware of the fiscal situation we find ourselves in. I know it's very difficult. Happy to work with the committee on changes or modifications we can or need to make in order to get no fiscal note on this. Continuing this program, though, I think is, is vital. Very, very helpful for the moms who are enrolled but also the babies and ensuring that we continue to save money. The app on my phone tells me that my wife is due in 26 days. So I know my life's about to change. I have not personally benefited from the Prenatal Plus Program, but I have seen how difficult it can be to work through this entire process. And I can't imagine somebody who's struggling financially having to go through this process with all of the different barriers that have been talked about. So anything we can do to make life a little bit easier and have healthier moms and healthier babies I'm in favor of. So with that, happy to answer any final questions. But I appreciate your time here today.

HARDIN: Questions? Senator Hansen.

HANSEN: Yeah. I think with the fiscal note, that's something probably the committee will have to address. Because any-- anything with a fiscal note coming out here right now is probably going to be DOA. And so I think if we're looking to kind of make this moveable in any form, I think we'll have to look at some of the things that you mentioned earlier about postpartum care, something we have to kind of look at. Obviously not too concerned about it until 2028, because I think we did have it funded since then. But my only concern that I have-- and I've been saying this with a lot of bills coming out that are

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federally funded, is-- and you've heard me say this before-- is the idea that I don't trust the federal government to say they're going to continue paying 63%. I wouldn't be surprised, eventually, when they get to a point where they say, we're going to pay 50% or 40%. And that's where we might be a little stuck, which is why I might be a little hesitant to kind of pushing that to 2030-something. Because eventually-- you're already starting to see with the FMAP that-- that's why we're $100-some million in debt for the next two years, is because the federal government. So I wouldn't be surprised they start going after programs like this. But I think it's something we'll just both have to kind of keep an eye on.

DUNGAN: Yeah.

HANSEN: You more than me, I guess.

DUNGAN: Well-- no, and I appreciate that. And I think that, you know, working together is-- wi-- with the committee and-- I'm happy to work with legal counsel. We already have some ideas drafted up with our office of some changes we could make to take care of that fiscal note. I too remain generally-- I'll, I'll say curious. My therapist says it's better to say curious than anxious. I'm curious about how the federal government is going to continue to fund certain things. But I think that for the time being, we know the program is successful. And if we can, within our, you know, confines here in Nebraska, control as much as that as we possibly can, we should continue to provide and, and make sure these folks have these services, because it is making a, a difference. So I'll, I'll work with the committee on language, and hopefully we can get something agreeable in the near future because we do only have, what, 40 days left in this session or something like that? So I want to try to get something figured out quickly.

HARDIN: Other questions? Thank you.

DUNGAN: Thank you very much.

HARDIN: This concludes LB773. We will move on to LB1043. Welcome, Senator Meyer.

G. MEYER: What, no welcome?

HARDIN: I just gave you a welcome.

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G. MEYER: Oh, OK. All right.

HARDIN: But I will give it again. Welcome, Senator Meyer.

G. MEYER: I'll take what I can get. I'm going to fire away here. Good afternoon. My name is Glen Meyer, G-l-e-n M-e-y-e-r. LB1043 allows the Nebraska Department of Health and Su-- Human Services and the Pharmaceutical and Therapeutics Committee to approve antidepressant prescription drugs, antipsychotic prescription drugs, and anticonvulsant prescription drugs for the Medicaid Preferred Drug List. Nebraska Statute 80-- 68-953 creates the Pharmaceutical and Therapeutics Committee. The purpose of that committee is to work with DHHS to develop and maintain a preferred drug list for Medicaid patients. Doctors and physicians are required to start their treatment with drugs that are listed on the preferred drug list. That preferred drug list should ensure both appropriate treatment and cost-effective pharmaceutical care for our state's Medicaid patients. The Pharmaceutical and Therapeutics Committee consists of 15 to 20 members. According to subsection 3 of that same statute, at least one of those members must be a psychiatrist or a neurologist. According to Nebraska State Statute 68-954, the members of the Pharmaceutical and Therapeutics Committee are directed to review therapeutic class reviews, also known as TCRs, in order to make informed decisions about which drugs to recommend for inclusion on the preferred drug list for the state's Medicaid program. That same statute directs DHHS to only include a drug on the preferred drug list that-- if it is therapeutically equivalent to or superior to the current drug on the list or the brand-name drug and is more cost-effective than the brand-name drug. Subsection 1 of the Nebraska State Statute 68-954 prohibits the Pharmaceutical and Therapeutics Committee from recommending antipsychotic drugs, anticonvulsant drugs, and antidepressant drugs for the preferred drug list. LB1043 strikes language from that subsection of the state statute in order to enable the committee to consider these kinds of drugs for, for the preferred drug list. LB1043 is intended to save money for our state's Medicaid program by allowing the Pharmaceutical and Therapeutics Committee to recommend prescription drugs for the preferred drug list which treat these psychological and neurological conditions which are therapeutically equivalent or superior to the brand-name drug and are also cost-effective. In other words, LB1043 would allow the Pharmaceutical and Therapeutics Committee to consider recommending generic drugs for the preferred drug list, which could save the

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state's Medicaid program a lot of money. An objection has been brought to my attention that a genetic drug may not always work the same or have the same effect on a patient as the brand-name drug. In some cases, this may result in having to wean the patient off of the generic drug or result in complications requiring hospitalization. However, the committee members should remember that the Pharmaceutical and Therapeutics Committee is required by state statute to only place drugs on the preferred drug list which are therapeutically equivalent or superior to the brand-name drug. I introduce this bill because I trust that the Pharmaceutical and Therapeutics Committee can accomplish this task with antipsychotic, antidepressant, and antica-- anticonvulsant drugs with competence and excellence. I ask you to please advance LB1043 to the floor.

HARDIN: Thank you.

G. MEYER: I would welcome your questions that I-- a-- any that I am capable to answer.

HARDIN: OK. Questions? Will you stick around?

G. MEYER: I certainly will.

HARDIN: Awesome.

G. MEYER: Thank you for not complicating my life with questions.

HARDIN: Oh, you're not done here yet today.

G. MEYER: I'm certain of it.

HARDIN: Proponents, LB1043. Welcome.

LEE STUTZMAN: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Lee Stutzman. I'm the pharmacy director at Nebraska Medicaid and Long-Term Care in the Department of Health and Human Service. I'm here to testify in support of LB1043. Thank you, Senator Meyer, for introducing this bi-- this bill on behalf of the, of the department. So LB1043, as mentioned, would add antipsychotic, antidepressant, and anticonvulsant drugs to the Medicaid Preferred Drug List, or PDL. The PDL consists of a list of medications separated by drug class that are available by prescription and preferred by Nebraska Medicaid. These three classes

of drugs are used for mental health and seizure disorders. The PDL allows DHHS to provide appropriate pharmaceutical care to Medicaid recipients in a cost-effective manner. Nebraska has a unified PDL for our PDL-- for our fee for service and three managed care organizations based on recommendations of a group of medical professionals who are members of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee. When the PDL was created, these three classes of drugs were expressly prohibited from being included. However, since that time, changes to the Medicaid program at both the federal and state levels now make it advantageous for our state to allow drugs in these classes to be added to the PDL. Currently, each managed care plan has its own list of preferred drugs in these three classes of medications, as these medications are not allowed to be included on the state's unified preferred drug list. Many behavioral health providers have told us that it's difficult to keep track of which drugs are preferred by each plan. Adding these three drugs-- classes of drugs to the state's unified PDL would mean that the same coverage criteria would acro-- would exist across all three plans and the traditional fee-for-service. This would reduce administrative burden on our state's behavioral health providers. And Medicaid beneficiaries would likely have a better experience in receiving prescriptions with the passage of this bill, as the number of prescription delays for drugs in these three classes should decrease. And beneficiaries can still access nonpreferred medications when approved as medically necessary. By allowing these three drug classes be placed on the state's PDL, DHHS would negotiate cost-containing savings through supplemental rebates above and beyond the required federal rebate from manufacturers of medications in these classes, resulting in a reduced total net cost of more than $1.2 million annually. In conclusion, allowing antipsychotic, antidepressant, and anticonvulsant drugs to be included on the Nebraska Medicaid PDL would lessen the administrative burdens on providers and protect the interest of taxpayers by reducing the net cost of medications in these three classes of drugs. We respectfully request the committee advance the bill to General File. Thank you for your time. And I'd be happy to answer any questions on the bill.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your testimony. So I just-- I, I guess I'm curious. Do, do you have

any sense of just, like, the legislative history behind this? Why were these exempt before?

LEE STUTZMAN: Well, from-- a, a little bit from what I've kind of asked some people about-- and I've been a pharmacist-- I worked in retail pharmacy for 16 years prior to, to coming over here. At that time, there were a lot of manufacturers that were going around telling prescribers in the nation that the generics weren't as good of medications, and they pushed really, very strongly to not have these included. I think there's also a-- kind of a misconception that when drugs are on the preferred drug list, if they're not preferred, then the-- then patients can't have access to them, and that's not true. If it's nonpreferred, patients can still have access to those medications just by proving that they're medically necessary.

FREDRICKSON: So ye-- I gue-- and I guess that's where my question comes from. So I, I, I-- I'm thinking specifically as it relates to antipsychotic medication. So, so I'm a mental health provider and I've worked with a number of patients who've been on these types of medications, and oftentimes finding the right fit for a patient can be really challenging and-- in, in different ways. And I guess my concern with this is that I've-- so I've worked with folks who have changed that type of medication, and it's resulted in, in pretty severe regression. And so my, my understanding of the PDL list is, like, in order to-- and maybe I'm incorrect, but in order to be given a medication that might not be on the list, one has to sort of fail the medication on the PDL list. Is that a correct understanding?

LEE STUTZMAN: That can be the case. There-- they can also submit other-- it depends on what the criteria is on the, on the PDL. Sometimes it is where they would need to fail a certain therapy. But there-- there-- it's gonna go as a prior authorization, so you would need to fill out some paperwork to send that in to say why it's medically necessary.

FREDRICKSON: OK. So kind of hypothetically-- I, I know hypotheticals are the worst, but let's say we-- there was a individual who was stabilized on a medication that was not on the PDL list. They became a Medicaid recipient. What would that person have to go through in order to maintain the medication that they're currently stabled on-- stable on?

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LEE STUTZMAN: It de-- it depends on the medication, but they would need to-- so I-- and I'll, I'll [INAUDIBLE] this because I wore the pharmacy hat. So we would be in the pharmacy, you would write the prescription for it, they would come in and-- we would get a denial initially, right? We can provide up to 72 hours, though, at-- regardless of if it's covered or not. We can do an override. And then the pharmacy would need to fax you and say you need to say why this is medically necessary. You would send that in. And then the MCO wou-- or Medicaid would have a certain amount of time which is lower than that 72 hours to be able to respond to that. So the patient would not go out with-- without their medication.

FREDRICKSON: OK. And do you find that that response is typically timely where patients are not having a gap in treatment?

LEE STUTZMAN: Typically. It-- we have a requirement of our MCOs that they need to respond within-- I-- and I apologize. I can't remember the exact time frame, if it's 24 hours or 72 hours, but there is a, a time frame that they need to respond in. We have that in our MCO contracts.

FREDRICKSON: OK. Thank you.

LEE STUTZMAN: Yeah.

HARDIN: Other questions? Senator Hansen.

HANSEN: Can you explain to me again-- maybe I'm just not getting it. I think I am. How is this saving the taxpayer money?

LEE STUTZMAN: So on-- when a medication is on our PDL or allowed to be on our PDL, we can collect supplemental rebates from the manufacturers. If there-- these medications are not on our PDL, we're not able to collect supplemental rebates.

HANSEN: Who provides the rebate? Do you know?

LEE STUTZMAN: Pharmaceutical manufacturer.

HANSEN: The pharmaceutical manufacturer or the PBM?

LEE STUTZMAN: The manufacturer.

HANSEN: OK. Good. Because that-- when we get rid of PBMs, I want to make sure that doesn't affect [INAUDIBLE].

LEE STUTZMAN: We can still get this. Yes.

HANSEN: Thanks.

LEE STUTZMAN: Yep.

HARDIN: Do you know what changed federally that kind of allowed this-- these classes of drugs to be included?

LEE STUTZMAN: I don't. I'd have to get back with you on that.

HARDIN: OK. Very well. Other questions? Thank you.

LEE STUTZMAN: Yeah. Thanks.

HARDIN: Proponents, LB1043. Opponents, LB1043. Come on up. Don't be shy. Welcome.

KIMBERLY CLAWSON: Thank you. Chairman Hardin and members of committee, my name is Dr. Kimberly Clawson, K-i-m-b-e-r-l-y C-l-a-w-s-o-n. I am a double board certified adult and forensic psychiatrist. Although I work for Nebraska Medicine and UNMC, I'm not here today representing either of those entities. I am testifying today on behalf of the Nebraska Association of Behavioral Health Organizations, or NABHO, in opposition to placing antidepressant, antipsychotic, and anticonvulsant medications onto the preferred drug list. A preferred drug list means that some medications require prior authorization. Some medications require patients to fail first on other medications, and some medications may be switched for nonclinical reasons. In the field of psychiatry, our patients are often medically complex and live with serious and severe mental illness, substance use disorders, and other co-occurring conditions. Medication stability is often the foundation that allows therapy, employment, housing, and recovery to succeed. Behavioral health medications are incredibly complex. And we are not able to approach treatment from a one-size-fits-all perspective. Each individual patient responds differently to medications, and side effects can vary widely and be extremely severe. It can take weeks, months, or sometimes even years to stabilize patients on the correct medication, and a trial-and-error approach destabilizes care and results in longer durations of active symptoms.

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Fail-first requirements lead to delays in effective treatment, meaning increased psychiatric hospitalization, increased emergency room utilization, increased crisis system strain, and increased justice system involvement. When stability is achieved, that stability can be incredibly fragile for patients living with severe and persistent mental illness. Any medication change can trigger a relapse, hospitalization, or behavioral health crisis. Changing medications for cost reasons can reverse months or years of progress. And even short gaps in medication availability can trigger a relapse. We understand the state's responsibility to manage Medicaid expenditures. However, short-term pharmacy savings can lead to long-term increases in hospitalization, crisis services, and correctional involvement. Medication access is almost always less expensive than the acute care costs that would arise as a result of this type of legislation. Recently, in my role as a forensic psychiatrist, I was evaluating a patient with a history of bipolar disorder who had been stable for many years on her antipsychotic medications. Due to a change in her insurance, she was no longer able to access her medications, and she destabilized very quickly. She had a severe relapse in symptoms, which ultimately led to her arrest and her hospitalization. She required months of treatment to return to her previous stability. And as a result of this temporary loss of medication, she lost her job, her housing, her partner, and ended up with charges in the legal system. This case illustrates the downstream effects that we see often with legislation such as this. Medication stability supports recovery, workforce participation, public safety, and long-term Medicaid cost-containment. We respectfully urge the committee to maintain current exemptions for these medication categories or to ensure that any preferred drug list placement includes broad clinical exemption processes that, that protect patient stability. Thank you so much for your consideration. And I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: OK. So your whole testimony was about what happens when it-- it's bad--

KIMBERLY CLAWSON: Mm-hmm.

HANSEN: --that the-- that you have to change medications.

KIMBERLY CLAWSON: Yes.

HANSEN: What's wrong with this bill specifically?

KIMBERLY CLAWSON: So this bill, it would require pay-- providers to potentially have to change medications that people are on to medications they're on the preferred drug list or have to get exemptions to be able to keep their patients on their current medications if they're not on the preferred drug list. And that could cause significant instability with patients who have been on medications and stable on those medications for a long time.

HANSEN: Because, like, similar to what Senator Fredrickson said, that they fail it first.

KIMBERLY CLAWSON: Exactly. Fail-first would require them to be on medications they may have tried in the past and not been successful on. They may have comorbid medical conditions that wouldn't allow them to be safe on those other medications. And so having medications on a preferred drug list like this would really delay care and delay patients' symptomatic recovery.

HANSEN: What would you do-- I-- I'm sorry. [INAUDIBLE] I'm curious.

KIMBERLY CLAWSON: Yeah.

HANSEN: So if you had a patient and then-- say this law passes, right, and then you can now put them on a different kind of medication, a generic one, how would you monitor them? Like, were-- like, what-- would you let them fail? Like, I don't get-- like, I-- I'm assuming, like, the clinician understands that the-- what happens to a patient when you have to change medications and they would monitor them.

KIMBERLY CLAWSON: I would hope so. Yes.

HANSEN: Yeah. And, and then that-- so I'm putting a little trust in the clinician to recognize when they change medications to recognize if they're gonna fail or, or that something's going to happen with the patient and they would take care of that. Like, is that not always the case?

KIMBERLY CLAWSON: Yes. So my concern is that this would cause patients to be on medications that the clinician wouldn't necessarily have tried them on initially or wouldn't have necessarily put them on first. And so this bill would actually be taking some of that power

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and some of that control and some of that autonomy away from the patient and the clinician.

HANSEN: See, that's why I'm confused, because can't, can't they just keep on the same medication?

KIMBERLY CLAWSON: Not if the insurance company says no.

HANSEN: OK. All right.

KIMBERLY CLAWSON: Yeah. Not if Medicaid says no.

HANSEN: OK. All right. Thanks.

HARDIN: Other questions? Senator Quick.

QUICK: Kind of on that-- thank you, Chairman.

KIMBERLY CLAWSON: Mm-hmm.

QUICK: So if they're on a medication now, would they have to still-- if this bill passes, would they have to switch to something else to prove that that fails before they could go back to their previous one or-- how does that work?

KIMBERLY CLAWSON: My understanding is that that is possibility. If the medication is not on the preferred drug list, then they would require prior authorization. And if the insurance company does not grant that prior authorization, then they would not be able to continue on that medication due to cost for the patient.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

KIMBERLY CLAWSON: Thank you so much.

HARDIN: Opposition, LB1043. Welcome.

TAISA BRUMAGEN: Hi. My name is Taisa Brumagen, T-a-i-s-a B-r-u-m-a-g-e-n. And I work at Wellbeing Initiative. I'm a certified peer support specialist. I'm here on behalf of Nebraska Association of Behavioral Health. Today, I'm here to share my lived experience related to wellness and recovery as a person with lived experience

with substance use and mental health as it relates to LB1043, which includes antidepressants, antipsychotics, and anticonvulsants on preferred drug lists for all state-funded behavioral health services. As a person who has been in recovery since 2016 from substances and mental health, I found courage to seek support in recovery from my mental health along with this journey. It included several medication changes to find the right fit for my diagnosis beyond a substance use disorder. While access to medications to support my wellness halted my treatment and recovery due to shame and fear due to cost and availability of the medications from the time I was released from incarceration to finding Medicaid, to finding my own private pay insurance, to being put back on Medicaid, along with those changes came medication changes. I did not have an identification card or license for a while into my recovery, which caused a barrier to receiving medications also. I found cost to be a barrier as well. Due to being on problem-solving courts and other community corrections programs, there was a limit already to the list of medications I was allowed to take due to the classifications of the mental health medica-- ment-- medications. I found myself going back and forth with what could or would not work for wellness and recovery. I felt a sense of hopelessness for my mental health due to barriers that already existed with medication. There was a point where I stopped taking my medications altogether and found myself in crisis and feelings of not wanting to live due to unsupported medication management. When we create barriers for those who find hope and bravery with medication as a pathway to their recovery and wellness, as a community we close doors and create gaps in behavioral health. Advocating for wellness is brave and should be accessible to all. I believe that creating certain barriers for such medications for mental health will create shame and we'll see more dollars being spent in our crisis areas as opposed to continuum of care or community care. As a person who finds hope in her antidepressants every day still since 2016, this is not just another medication. It's a lifeline for my overall wellness and recovery and is essential to keeping me safe. I started receiving services for medication in 2016. There was a lot of challenges that I faced: stopping, starting, having to start over. The side effects were horrible. Sometimes I couldn't even drive myself to work. There was a problem in the pharmacy. If it didn't get approved at the pharmacy, they-- I would have to wait. They would have to call in a different medication. A lot of times, it wa-- if it wasn't available at the pharmacy, I would have to call the doctor. The doctor would have to

find something else. It was a very long process for me to get my medication sometimes. And if it fell on a weekend, I would go a weekend without my medications. I began receiving medication management at a time in my life where I felt hopeless and unwell. I do believe that switching medications and how it has changed many times in my past in the side effects, the process for medication to work and stop during the process seemed impossible and I felt hopeless. I did experience severe side effects, physical health, and sometimes, like I said, made it impossible to drive to work. The idea of being required to switch medications for nonmedical reasons is really scary. I know how important stability is to my life today, and I'm a better person for the community as a whole because of my medications. I respectfully ask the committee to consider how this policy could impact individuals like me who rely on stability and their trust in their medication management to maintain recovery and crisis management.

HARDIN: Thank you. Questions? Seeing none. Thank you. Those in opposition, LB1043. Those in the neutral, LB1043. Senator Meyer. Welcome back. Online, we had 6 proponents, 0 opponents, 1 in the neutral.

G. MEYER: I had to step out for a minute after I, I opened. I heard a little bit about fiscal note. And so-- I think it was addressed, the opportunity to save approximately $1.2 million a year utilizing an alternative to the brand-named drugs. I don't know that there's anything in the bill that precludes providers from not using the brand name. When I read through the bill, I don't see that. If a provider is currently using a brand-name drug and having excellent therapeutic results from it, I don't see there's anything in there that's gonna require them to go to an alternative. Having served six years on the Behavioral Health Board, I have a, a very clear understanding of our providers and how much they care about their patients. I'm not a doctor, but I've been in a doctor's office a-- quite a little. I, I-- and, and-- and psych-- psychotic drugs, antipsychotic, anticonvulsive-- I haven't, I haven't been involved in those things. I know frequently when a diagnosis is made, there's a number of prescriptions that a doctor can try at different levels of, of dosage. Perhaps that's not the case with these types of drugs. I don't know. But generally, there is no one silver bullet that-- that's going to provide the therapeutic care that we're looking for. I want our providers to have every opportunity to use the most effective drug there is. If there can be an alternative to a generic drug and have

some savings, that's what we're trying to realize here. And once again, we're, we're not trying to reinvent the wheel. What we're trying to do is find some cost savings, but we certainly want to be-- make sure we're taking very good care of those people that require the services of our providers. So I would welcome any other questions that you may have, but I would appreciate seeing this voted out of committee and get to the floor of the Legislature, so. Thank you.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Meyer. So I, I think-- I, I, I think you have a-- I think the goal of the bill is, is, is positive. I think, you know, when-- if, if there is an effective medication that's a generic, then, you know, obviously that seems to be the-- a, a, a preferred option from both the fiscal perspective but-- for a number of reasons. But I guess-- kind of-- you touched on this a little bit in your closing-- and, and I-- you know, I don't see this as your intent, but I, I guess my concern is sort of some of the testifiers in opposition were discussing those instance-- instances where you might have a patient who has only responded to a nongeneric option and the possible hoops this might cause someone to go through or-- in, in, in this medication and-- I, I can't think of it off the top of my head right now-- maybe after we engage stakeholders-- but just out of curiosity, would, would you be open to an amendment that, like, say, for example, if an in-- individual was stabilized on a certain medication that-- I don't know what it would look like, but the preauthorization process was all-- automatic, for example or-- I, I-- I'm, I'm just kind of brainstorming here, but.

G. MEYER: Oh, absolutely, and I think that'd be the responsible thing to do.

FREDRICKSON: Yeah.

G. MEYER: You know, we all-- we can, we can present-- two of us-- you and I could present with-- lis-- with a very similar problem. We could have very similar prescriptions provided to-- for us. And each of us metabolizes these substances differently. Something may work great for you and absolutely nothing for me. I've had that experience with-- after surgery-- I had a bone graft one time. I was pre-- prescribed painkillers. Didn't touch it. I got relief from aspirin. The good painkillers, didn't touch it, didn't take it. And, and so we all

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metabolize these things differently. We respond to different chemicals, different, different treatments. And so-- absolutely. I-- I'm, I'm more than open to finding an opportunity to primarily do no harm.

FREDRICKSON: Yeah.

G. MEYER: If there's an opportunity to find some savings here, absolutely, we should probably-- we should probably look into that. But we definitely don't want to do any harm here, so. I, I appreciate the question.

FREDRICKSON: Thank you.

HARDIN: Other questions? Seeing none. Thank you.

G. MEYER: Thank you.

HARDIN: This concludes LB1043. We will transition over to LB929 and Senator Fredrickson.

FREDRICKSON: We're good?

HARDIN: We are good.

FREDRICKSON: All right. Let's do it. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. For the record, my name is John Fredrickson. That's J-o-h-n F-r-e-d-r-i-c-k-s-o-n. And I represent District 20, which is in the-- central west Omaha. I am here today to introduce LB929, which is a bill that puts limitations on co-pays paid by Medicaid recipients. LB929 sets practical limits on cost-sharing like co-pays in Medicaid, which provides health insurance coverage to over 335,000 low-income Nebraskans to ensure that health care is affordable for all Nebraskans. This bill does two main things. First, it prohibits DHHS from requiring low-income Nebraskans to pay co-pays that aren't required by federal law. And second, it provides parameters for your DHHS in implementing co-pay requirements for the Medicaid expansion population set forth in the budget bill Congress passed last summer. Medicaid co-pays deter individuals who need care from seeking necessary medical treatment. Co-pays are associated with financial barriers, delayed treatment, and worse health outcomes. People with Medicaid coverage, by definition, have extremely low incomes and live at or just above the federal poverty level, making

affording basic necessities a daily struggle. So even nominal co-pays of $1 to $5 deter people from seeking care. It is my understanding that Nebraska Medicaid used to have some nominal co-pays but voluntarily eliminated those in 2024. And at that time, two of the three managed care organizations elected to cover the co-pays for Medicaid enrollees so that it was not a barrier for care for individuals. Turning to LB929, I'll briefly explain a few of the key provisions of the bill. First, in recognizing the deterrent effect the-- that co-pays have on low-income families seeking care, this bill prohibits our state from adding cost-sharing for Medicaid expansion enrollees unless it is required by federal law. This prohisi-- provision is particularly important, as Nebraska DHHS has recently proposed in their budget request that low-income Medicaid enrollees should be required to pay co-pays despite their harmful impacts. Second, this bill sets limits on cost-sharing measures that were just recently required by Congress in the federal budget bill, H.R. 1, which was passed last summer. The co-pay requirements in H.R. 1 only apply to the Medicaid expansion group, which provides necessary coverage for low-income adults ages 19 through 64 under 138% of the federal poverty level. About 70,000 Nebraskans are currently enrolled in the Medicaid expansion category. H.R. 1 requires Medicaid expansion enrollees pay co-pays of up to $35 but gives states the flexibility to decide the amount of co-pays they will ultimately require. H.R. 1's co-pay requirements are complicated. The co-pays only apply to a certain portion of the Medicaid expansion group-- so those who have income between 100% and 138% of the federal poverty line-- and to certain nonexempt services. This will make it difficult for people to know if and when they will have to pay co-pays and will be administratively challenging to administer and collect. LB929 requires the state to set the co-pays at the lowest amount possible, permits managed care organizations to cover the costs-- as they have done in the past-- and makes sure that people aren't turned away if they cannot afford co-pays. LB929 recognizes that co-pays and other cost-sharing will deter low-income families from seeking the health care they need. These practical limits on co-pays will ensure that Nebraskans can afford to access the care they needed while also keeping us in compliance with the new federal legislation. I urge the committee to support and advance LB929. And I'd be happy to take any questions that you may have.

HARDIN: Thank you. Questions? Senator Riepe.

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RIEPE: Thank you, Chairman. Thank you for being here, Senator. I have a question on the co-pays. Is this along with-- is this coming with the One Big Beautiful Bill? So it's not here, but it's coming?

FREDRICKSON: Yes. So historically in Nebraska, we have charged nominal co-pays on Medicaid, but we stopped doing that in 2024. The-- H.R. 1, the One Big Beautiful Bill, has-- that-- that's part of the-- impleme-- part of that bill.

RIEPE: I'm looking to get educated here. Is the stipulation that you're aware of on the One Big Beautiful Bill, is that a may or a shall?

FREDRICKSON: I believe it is a shall.

RIEPE: It's shall. OK. And that's, that's a big difference. I would say this too, is-- you talked about on-site decisions as to whether patients could pay or not pay. Is that-- do-- am I hearing you right? Was there-- something that you said that, that-- if they go into-- for an appointment, they don't have the co-pay, that they can make a decision-- oh, wait-- they-- what are they going to do? Usually, they ask for the co-pay in advance--

FREDRICKSON: Right.

RIEPE: --of service.

FREDRICKSON: Right.

RIEPE: Would they deny them service or--

FREDRICKSON: So part of LB929 would, would protect from that, right? So a, a, a patient would not be denied care should they be unable to--

RIEPE: So they have to show some kind of proof that they don't have the $35 co-pay?

FREDRICKSON: Well, so-- it-- the-- with-- so H.R. 1 allows for a co-payment of up to $35 for, for the visit. So my-- I-- LB929 would say that we as a state can, can charge a co-pay but at the lowest amount required by federal law.

RIEPE: OK.

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FREDRICKSON: So in other words-- and again, to remind-- the-- this is specifically for folks who ar-- who are on Medicaid. So by definition, low-income adults--

RIEPE: On Med-- Medicaid.

FREDRICKSON: Yes. So low-encome adults and individuals who--

RIEPE: But they don't get to waive that at the point of service.

FREDRICKSON: No. I mean, I think, I think it's-- yeah. But it would-- the goal of this is to make the co-pay as nominal as possible so that individuals are not-- I mean, a $35 co-pay even for someone who is employed can add up and-- so.

RIEPE: As long as you don't try to pay in pennies, right?

FREDRICKSON: Well, if they take cash, I don't know. We'll see.

RIEPE: The other one-- and this is maybe the tougher one-- is, do you have a response to the $4.4 million fiscal note?

FREDRICKSON: So-- yeah, I--

RIEPE: [INAUDIBLE] stacking the deck against you [INAUDIBLE].

FREDRICKSON: Well-- so, so, so the fiscal note is-- it's interesting. So we currently don't take co-pays on this population. So we are not currently-- so the fiscal note would indicate that we are-- I've always viewed a fiscal note as, as an appro-- like we're, we're spending money on this. We're not currently receiving this. The fiscal note is almost what they anticipate that they will be receiving from Medicaid recipients even though we're not currently doing that. So I think it is kind of interesting because if you look at the fiscal note, it says around $2 million, '26-27; $2 million, '27-28. And then it also has some federal dollars as well. So around, like, $4 million total. I mean, if that is in fact accurate, then what this fiscal note says is that DHHS intends to charge Nebraskans on Medicaid an additional $4 million for health care.

RIEPE: OK.

FREDRICKSON: That they're not currently paying, so.

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RIEPE: OK.

FREDRICKSON: Yeah.

RIEPE: Thank you.

FREDRICKSON: You're welcome.

RIEPE: Thank you, Mr. Chairman.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I'm-- you may not even know this-- the answer to this but-- so-- and I, I think Senator Riepe [INAUDIBLE] if someone needs health care and they go and they can't afford to-- the co-pay, is this something that maybe either the physicians or hospitals would say, well, we, we know you need the care, but we'll just wri-- have to write it off?

FREDRICKSON: Possibly. So, so different hospitals, different organizations, I think irrespective of this bill, have, have, have plans for this type of circumstance, right? So whether that's-- I mean, oftentimes, hospitals will report on their write-offs that they have to-- that they, that they-- that-- costs they have to absorb, right, for, for cases like that. Worst-case scenario, individuals go into severe medical debt, right? So they get sent to collectors, you know, things like those circumstances as well.

QUICK: OK. All right. Thank you.

FREDRICKSON: Mm-hmm.

HARDIN: Other questions? Director-- Senator Riepe.

RIEPE: Thank you. I have a follow-up question here. With some experience in the arena, the difficulty of collecting those co-pays from people that are-- some people can write a checkbook and, bam, it's over. A credit card, and bam. I'm not sure that this clientele can. And the-- that can-- in a clinic operation, that could really cause some great distress. If somebody gets it, somebody else doesn't get it. Yoy know, I'm sure not that I'm-- that $4.4 million might be a, a dream, but-- I'd give you a chance to respond to that. I don't know.

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FREDRICKSON: Yeah. So I mean-- I, I, I, I anticipate that the department will be here to testify in opposition, so that might be a appropriate question for, for them. They provided the fiscal note, so.

RIEPE: OK.

FREDRICKSON: Yeah.

RIEPE: Well done. Thank you. Thank you, Chairman.

QUICK: One more question, please.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman. Do you know within H.R. 1 if-- I mean, I know on some things, there's going to be that requirement from the federal government that you do this or they take the money back.

FREDRICKSON: Mm-hmm.

QUICK: Is-- do you know-- is there anything in H.R. 1 that says that?

FREDRICKSON: So with, with a-- with this bill, LB929, it-- basically, it-- it's still-- it, it, it-- it's in compliance with the bill in the sense that it says that we will charge the least amount allowable by H.R. 1. So H.R. 1 says up to $35 can be collected for the co-pay. So they set a cap at the maximum amount collected for that. But this bill says that we will collect the minimum amount that they require.

QUICK: OK. So we could charge zero if we want to.

FREDRICKSON: I believe it requires some charging. So it would-- you know-- and again, this goes back to-- and I'll defer the depar-- the, the, the-- to the department on this as well. I think guidance from CMS is, is, is sort of what a lot of states are awaiting on this, on, on what that looks like. And perhaps we've received that guidance. I, I just don't know at this point.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Will you stay with us?

FREDRICKSON: Will, will certainly do that.

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HARDIN: Wonderful. Proponents, LB929. Welcome.

SARAH MARESH: Hello. Chair Hardin and members of the Health and Human Services Committee, I'm Sarah Maresh. That's S-a-r-a-h M-a-r-e-s-h. And I'm the Health Care Access Program director at Nebraska Appleseed. Testifying in support of LB929. One of our core priorities is working to ensure all Nebraskans have equitable access to health care. And because this bill keeps affordable care for low-income Nebraskans, we support this bill. As Senator Fredrickson talked about, requiring low-income people to pay co-payments even in low amounts results in delayed care and worse health outcomes, increased financial burdens for patients who can't, who can't pay them, burdens and reductions in payments to providers often, and little state savings. And unfortunately, the people who would bear the brunt of these costs are people with high health needs, including those people who are older and those who are disabled and have chronic conditions. LB929 puts commonsense guardrails on cost-sharing requirements like co-payments to keep health care affordable for low-income Nebraskans. Just to give a little bit of background on what Medicaid currently requires for co-pays and then a preview of what H.R. 1 is going to require: under federal law, states are permitted but not required to assess co-payments on Medicaid enrollees with certain limits currently existing. As you've heard right now, we don't have co-pays in Nebraska. We've eliminated those. And even before that, our MCOs were covering them because, as we heard frequently from community members, even those nominal co-pays amounts deter people when they're having a hard time even putting food on their table. And then in H.R. 1-- so the big budget-- One Big Beautiful Bill, the budget bill that passed last summer, requires that, starting on January 1, 2028, each state has to start charging co-payments for Medicaid expansion enrollees of up to $35, but they can be lower than that. And again, they are complicated-- these co-pay requirements are-- because it only applies to people who make 100% and 138% of the federal poverty level. And I'll tell you from experience: a lot of people we talked to don't even know they're on the Medicaid expansion category. So it would be even more confusing for them to figure out if they have to co-- pay co-pays under this new requirement. And there's certain exemptions as well that folks won't have to pay co-pays for. We have flexibility to do this, and this bill is in full compliance with H.R. 1 as required. So there'd be no risk of, you know, federal, federal issues coming back on us. And due to the complexity, like I mentioned, it'll be difficult

for providers too, who will bear the brunt of likely having to collect these co-pays. Just like I mention-- I just wanted to pull out a few stats here I have bulleted. I know I'm running close on time, but analysis predict under H.R. 1 that adults aged 50 through 64 could pay an average of $736 a year under the co-pay requirements because they are frequent users of the health system. And people who are disabled or have a lot of chronic conditions could pay up to $1,200 or more per year, which is a very high amount for people who are low income who this applies to on Medicaid expansion. So this bill provides commonsense guardrails on cost-sharing. It holds a status quo for what we have right now in Medicaid and makes a commonsense approach to implementing H.R. 1. And I see I'm at time, so I'm happy to take any questions. And thank you all for your time.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. Do you know right now-- and maybe that's a question for this-- for the department, but are they planning to implement this like-- the same time they're implementing all the Medicaid things that we have coming up, like May 20-- in May?

SARAH MARESH: Yeah. That would be a great question for the department. I know-- we haven't heard anything about it. This bill does require implementation by the federal deadline and not sooner than that. And unfortunately, H.R. 1 has a lot of different implementation dates for Medicaid stuff. So this one is a different date than even the work requirements, which are required by January 1, 2027. The co-pays are required to be implemented by January 1, 2028. And so I think, I think-- we, we don't know the answer to that, so they would be the best person to ask. I would also say the fiscal note seems to reflect decisions that have been made by the department about future use of co-pays, how much they're planning to charge under H.R. 1 that have not been made public. So those are questions we have too about the fiscal note. So unfortunately, I can't answer your question.

QUICK: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I, I think I heard-- and correct me where I'm wrong in here-- someplace on-- I think you said you have a certain level of flexibility?

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SARAH MARESH: Yes, so--

RIEPE: And, and, and the follow-up to that, I think that you said-- correct me where I'm wrong-- no fear of the feds to come back on us?

SARAH MARESH: Yes. For un-- for under this bill, yes. I believe that-- sorry. I believed that to be the case. So we have flexibility under H.R. 1 to implement certain things for Medicaid, and that includes the work requirements, which I know y'all have heard about. That also includes a provision for co-payments. So the law does require states that says, yes, you must collect-- or, must-- require co-payments for the Medicaid expansion population of up to $35. But like Senator Fredrickson just mentioned, we can set them lower than that. So the state can choose how much they do.

RIEPE: And, and we're-- as a state, we're not obligated then financially for the balance of-- say if we reduced it from 100 to 20-- just picking a number for simple math for me-- we don't have to pay-- make the $80 makeup--

SARAH MARESH: Correct

RIEPE: --state.

SARAH MARESH: Correct. That's my understanding. Correct.

RIEPE: OK. Because that would be a real fiscal note for us.

SARAH MARESH: Yes.

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

HARDIN: Are there questions? Seeing none. Thank you.

SARAH MARESH: Thank you.

HARDIN: LB929, proponents. Welcome.

ANDREW CARLSON: Thank you. Good afternoon. Good evening. My name is Andrew Carlson, A-n-d-r-e-w C-a-r-l-s-o-n. And I am a third-year medical student at Creighton University and a Nebraska constituent. I'm here in support of LB929 because I see in the hospital and in clinic how quickly medical plans fall apart when people are already

living on the financial edge and how adding cost-sharing on top of that makes things worse. Over the last four weeks on internal medicine, I've sat in multidisciplinary rounds every morning with nurses, social work, pharmacists, and case managers. We ask, why is this patient still here? Or, why are they back already? A lot of the time, it isn't that we don't know what to do medically. It's that real life gets in the way. Unstable transportation, time off work, housing insecurity, and constant financial trade-offs. When someone's already stretched thin, even the possibility of extra charges at the pharmacy, the front desk, or through an unexpected bill can push them to delay medications or skip follow-up until the ER becomes the only option. I also work with patients at the Magis Clinic, our student-run, free health care clinic at Creighton. Many of our patients have coverage, including Medicaid. However, they still hesitate when we talk about meds or schedule follow-ups because they're worried about what they'll be asked to pay and whether they can handle it. That hesitation turns into delays, and delays turn managle pro-- manageable problems into crises. That's why LB929 is a practical, patient-centered bill. It prevents DHHS from requiring Medicaid deductions or cost-sharing unless federal, federal law requires it. And if federal cost-sharing under 42 USC 1396 must be implemented, LB929 delays it no earlier than October 1, 2028. Requires the lowest amount permitted, allows managed care organizations to pay on behalf of enrollees, and prohibits providers from denying care, items, or services if an enrollee does not pay a required charge. I know some will argue that cost-sharing reduces overuse. What I see is that financial pressures cut out high-value care first-- medications and follow-up appointments-- then shifts patients into the most expensive setting: the emergency department and inpatient floors. That cycle drives readmission, strains hospitals, and contributes to burnout among the providers caring for the patients who keep returning for preventable reasons. At Creighton, we're taught curas personalis-- care for the whole person. Financial barriers are medical barriers. LB929 helps keep Medicaid from being another hurdle for people who are already doing their best. Thank you for your time. I urge you to support LB929. And I'm happy to answer any questions.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you. Is this your first time testifying?

ANDREW CARLSON: Can you tell?

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RIEPE: Pardon?

ANDREW CARLSON: It's my second time.

RIEPE: Oh. I, I was going to say you've done a good job, but.

ANDREW CARLSON: Thank you.

RIEPE: Thank you. That's all I have, sir.

HARDIN: Thanks. Any other questions? Thanks for being here.

ANDREW CARLSON: Thank you.

HARDIN: Proponents, LB929. Welcome.

JIM ULRICH: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Jim Ulrich, J-i-m U-l-r-i-c-h. And I am the CEO of York General in York, Nebraska. I'm here to testify in support of LB929. York General is a rural health care system in York, Nebraska proudly serving patients in need of health care in York County and the surrounding area. We have a critical access hospital as the base of our organization, also offering family medicine, urgent care, dialysis, skilled nursing or nursing home care, assisted living, independent living, home health, and even dialysis as a part of our system. Because of eligibility requirements outlined in H.R. 1, we are already preparing to have more Medicaid patients in need of health care services making tough decisions to postpone their care due to lack of Medicaid coverage. Also due to the loss of Medicaid coverage, we are preparing to provide an increased level of uncompensated care for Medicare-- Medicaid patients that should not, for health reasons, postpone their care any longer. To protect our local access to care for these Medicaid patients, we certainly want to minimize this cost-share amount, which would make these care decisions for Medicaid patients even more difficult. Plus, we know that hospitals such as ours have a di-- difficulty collecting this co-pay for Medicaid patients. York General collects most commercial insurance co-pays, but Medicaid co-pays are rarely recovered. So for rural hospitals like York General, the enactment of co-pay or cost-sharing amounts for these Medicaid patients essentially serves as further reduction in reimbursement to our facilities. This is in addition to the expected increase in uncompensated care that I mentioned earlier. The current law, H.R. 1,

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imposes cost-sharing for Medicaid expansion adults beginning 10/1/28. With certain ex-- exemptions, co-pay-- cost-sharing-- can be up to $35 per item or service, or service, but LB929 says the department cannot require additional co-pays that are not required by H.R. 1. Furthermore, it also requires the department to set co-pay at the lowest amounts possible under law, as Senator Fredrickson said as well. Rural hospitals in Nebraska are already fighting the headwinds of H.R. 1 cuts to Medicaid. Thus, we are in support of LB929 to help limit these negative impacts both on access to care for our Medicaid patients and reimbursement for our Nebraska hospitals. So thank you for listening to this testimony in support of LB929. Be happy to answer your questions.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. In your existing situation, if you have a Medicaid patient who's not able to pay at the point of service, do you pursue that bill then or do you just simply write it off?

JIM ULRICH: I, I can't answer every single time, but generally, we're-- if they need the care, we're going to provide it.

RIEPE: Oh, of course.

JIM ULRICH: And, and that's what that uncompensated care is, what I mean is whether it's a bad debt or whether it's charity care.

RIEPE: But you don't--

JIM ULRICH: We don't, we don't--

RIEPE: You don't chase down because it's probably not affordable for-- or, not worth the money.

JIM ULRICH: Correct. You know, generally, at, at a rate that this would-- the lower level, it wouldn't pay for us to go after that.

RIEPE: Yeah.

JIM ULRICH: It would cost us more to collect that amount, which means we just--

RIEPE: If it's a $35 co-pay.

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JIM ULRICH: --write it off. Yeah. I can't speak for everybody on that, but that's generally what--

RIEPE: I think that's generally the business.

JIM ULRICH: Yep.

RIEPE: We used to say at Children's when we-- if we got a Medicaid patient from Missouri, we would take payment in the rocks, but that was a [INAUDIBLE]. Thank you, Chairman.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So-- and I'm going to reference a little bit. So Medicaid rates, as they are now-- and now if you have a co-pay you can't collect, what's that going to look like for you on collecting-- I mean, you're-- the reimbasement ra-- reimbree-- reimbursement rate's already low. So what's that look like for your hospital?

JIM ULRICH: We would lose out on-- you know, this is a Medicaid expansion population, so, you know, it's not all the Medicaid, but, but we would, we would just lose a little more, I guess, you know, on that. It's-- it-- it's not a-- a low rate is not-- it's not going to be just detrimental probably for that, but it's already stacked on top of the H.R. 1 cuts to Medicaid that we're-- we'll be shouldering in. The other part of it, though, really is that-- and it was mentioned earlier in testimony too that if these patients know that they're going to have to have-- ahead of time, when they figure out they're gonna have a co-pay, let's say, it depends on what that amount is or how much they've already paid in other co-pays, right? They may decide, well, I'm not going to go into this appointment which would be more preventative in nature. I'm going to postpone a little bit. Then they may end up in the ER, and then it's a much bigger, uncollectible thing for us, you know, if we're not-- the rates don't cover near as much there.

QUICK: Yeah. And then also, you know, with the, the federal government not doing anything with the subsidies-- and I think you're going to find people who aren't going to take-- who aren't going to buy the-- they aren't be-- going to be able to afford to buy the insurance on the marketplace. Do you-- I know other hospitals do this where if

someone comes in, now they don't have insurance coverage-- do you try to, you know, help them apply for Medicaid dollars and then--

JIM ULRICH: Absolutely. We would try.

QUICK: Yeah. OK.

JIM ULRICH: You know, and, and try to work through the system the way, the way it is or-- you know, one of the other bills coming up discusses that too, a little bit about, can we navigate exemptions that are available for them for some of the requirements and things like that? We just have to work through the system. And that's-- one of things with these regulations, we've had more and more of those kind of care coordinators that have popped up, you know, to help navigate the system and everything, so.

QUICK: Yeah. Because-- that's-- I think that-- and maybe what you're referring to, it-- be-- you'll see an increase of Medicaid patients because of, of that--

JIM ULRICH: Quite possibly yes. Mm-hmm.

QUICK: OK. All right. All right. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Do you have a process at your hospital that you call patients in advance of their app-- if it's a scheduled appointment and not a walk-in? And with that, telling them, by the way, there is a X co-pay. Bring the money along. Not necessarily a check, but bring the money. Do you do--

JIM ULRICH: Well, we, we, we tried that through care coordination, that we're calling and saying, hey, you're due for this or not. But I can't say we reach every single one, because they may be coming in urgent carewise too and, and then we don't know.

RIEPE: It's a more difficult population too.

JIM ULRICH: Yes. It is, to get ahold of [INAUDIBLE].

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

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HARDIN: York serves a-- take a guess, about how large of a population do you serve?

JIM ULRICH: Oh, jeez. It's going to be in the 20,000s--

HARDIN: Ish.

JIM ULRICH: --you know, ar-- area. Yeah. Service area.

HARDIN: OK. Thank you.

JIM ULRICH: Yep.

HARDIN: Appreciate it. Proponents, LB929. Welcome.

JINA RAGLAND: Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. Today, I'm testifying in support of LB929 on behalf of the AARP in Nebraska. As you've heard, by the age of 50, the likelihood of living with multiple chronic conditions such as diabetes, arthritis, hypertension, or heart disease increases significantly. These conditions are often require-- re-- often require medical visits, ongoing prescriptions, and preventative services. Even small cost-sharing amounts add up quickly when a person needs recurring care. Many in this group also are more likely to be on fixed or reduced incomes, especially if they have experienced job loss, reduced work hours, or an early retirement due to health issues, or even caregiving for a loved one. A sudden introduction of new or higher cost-sharing requirements could force older enrollees to delay or skip care. National studies consistently show that even modest co-payments result in reduced medication adherence or in fewer necessary health care visits among lower income adults. Households are already facing rising prices for food, rent, utilities, and transportation. And as costs rise, families have fewer resources to absorb new or higher co-pays or cost-sharing, making medical bills more likely to become overdue, forcing people into medical debt or the inability to seek care. Delaying implementation even further ensures adequate time for system modernization within DHHS and managed care organizations, clear public communication to prevent confusion, and avoid individuals losing access to care because they do not understand the new requirements and provider readiness, particularly in rural communities, where clinics operate on thin margins and serve aging

populations more. Introducing new and/or increased cost-sharing too quickly and beyond the federal requirements could worsen these pressures and create unnecessary health and financial stability-- instability. When people age 50 delay care due to cost, the rils-- result is often serious health crises, higher long-term Medicaid spending, and greater burden on emergency services. A responsible delay in ensuring caps are in place that do not permit allowance beyond those set forth through H.R. 1 ensures Nebraska implements changes only when systems, providers, and recipients-- especially older ones-- are fully prepared. For Nebraskans over 50, abrupt cost-sharing changes could pose serious barriers to care and negatively affect both health outcomes and long-term Medicaid spending. The existing statutory delay in LB929 acknowledges the need for caution, but further postponement is justified to protect some of the mo-- our most vulnerable residents. Thank you to Senator Freder-- Fredrickson for introducing the legislation, for the opportunity to comment. And I would be happy to try and answer any questions.

HARDIN: Thank you. Questions? Seeing none. Thank you. Opponents, LB929. Welcome.

PROKOP: Good afternoon. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Matt Prokop. That's spelled M-a-t-t P-r-o-k-o-p. And I'm here today representing the American Diabetes Association to express our support for LB929. The ADA is the nation's leading volunteer health organization fighting, fighting to bend the curve of the diabetes epidemic. For more than 80 years, ADA has been driving discovery and research to treat, manage, and prevent diabetes while working relentlessly for a cure. People living with diabetes continue to face significant financial barriers when treating their disease. Americans with diabetes have medical expenses approximate-- approximately 2.6 times higher than those without. In Nebraska, diagnosed diabetes costs the state an estimated $1.9 billion each year. The true cost of diabetes, however, is measured in negative health outcomes. Diabetes is the leading cause of adult blindness, nontraumatic lower limb amputations, and kidney fail-- kidney failure in the United States. When people cannot afford the tools and services to necessarily manage their diabetes, they scale back or forgo the care they need. That is why access to affordable, adequate health care coverage is critically important for all people with and at risk for diabetes. Medicaid coverage is vital for individuals and families living with diabetes

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and other chronic conditions to manage their health, prevent costly and life-- prevent costly and life-threatening complications. For example, research presented at the American Diabetes Association Scientific Sessions showed a reduction in leg amputations among patients who resi-- resided in states that adopted Medicaid expansion. We thank Senator Fredrickson for introducing this legislation and encourage this committee to advance this bill to-- for General File for further consideration. And happy to answer any questions that you may have.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. I, I want to question your-- explain to me the 19-point-something billion as a cost to the state for diabetes.

PROKOP: Yep. That's $1.9 billion. So that's--

RIEPE: I thought you said 19.

PROKOP: No, $1.9 billion.

RIEPE: 1.9.

PROKOP: Yup.

RIEPE: [INAUDIBLE].

PROKOP: Sorry for that. Just to clarify that. So that's data produced by the American Diabetes Association. So that's lost--

RIEPE: --I just couldn't-- if I had my 19, I'd say--

PROKOP: Yep. It's lost productivity and then direct medical costs associated with treating diabetes in the state. So happy-- we have a fact sheet that lays out state-specific data. I'm happy to share that with you as well.

RIEPE: That sounds reasonable. Thank you, sir.

HARDIN: I'd like to see that.

PROKOP: Yep.

HARDIN: Other questions?

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PROKOP: Yep.

HARDIN: Thank you.

PROKOP: Yep. Thank you

HARDIN: LB929, proponents. Welcome.

MARSHALL BIVEN: All right. Take two. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is Marshall Biven, M-a-r-s-h-a-l-l B-i-v-e-n. I'm a Creighton University medical student, native Nebraskan, and co-director for Magis Clinic, a free-of-charge, student-run health clinic primarily serving unhoused patients in Omaha. While I do not represent my organizations in an official capacity today, the experiences they have afforded me lead me to support LB929 as a necessary protection for my patients and the families of our state. As you may know, some 66% of bankruptcies are related to medical debt or illness. Increasing cost-sharing shifts responsibility from the managed care organizations-- who market their ability to protect us from financial ruin-- to a growing number of everyday Nebraskans struggling to survive to their next paycheck. Just last year, a group of students at Creighton helped eliminate over $2 million in medical debt for 1,500 Nebraskans across 20 counties. Despite the initial pride in our accomplishment, my sense of disenchantment grew as I pondered that tens of thousands of other Nebraskans still afflicted by not only their astound-- outstanding debt but their avoidance of much needed care. Co-pays are a tactic that burdens Nebraskans seeking care. And by adding these additional costs onto preventative visits, we are disincentivizing our neighbors from addressing health problems before they become unavoidable, often with disastrous consequences. I would never tell my patient, I know your blood pressure is high, but I think we should wait until you have a heart attack before I treat you. In reality, what happens when we add additional costs to the visits that exist to keep patients healsy-- healthy is that more of our patients are forced to contemplate whether that $30 co-pay would be better served on groceries and gas. And for our patients at Magis Clinic, there is no choice when you're living without housing, when the odds are already stacked against you, and there's no money laying around for extra expenses. Our team spends most of our time building trust with patients so we can connect them with consistent care. Would it not be especially cruel-- would it not be an especially cruel act to

refer them for treatment for lacerations, frostbite, and cancer only to be denied care because they lack the cash in hand? Minimizing co-pays means patients are kept healthier, are more adherent to their medications, and the state pays less for emergent, high-cost care. I appreciate your time and attention today. Thank you. And I'm happy to answer any questions. And actually, one thing I wanted to add was that the cost of an emergency visit for, you know, a health care system, what they charge, is anywhere from $600 to upwards of $1,300, depending on the level-- complexity of care. For an outpatient visit, that's often $150. So you can imagine that, as patients are avoiding outpatient care because of the cost of co-pays and they're now seeking emergen-- emergency care, the amount of uncovered costs skyrockets for a lot of health systems. And that's what we're starting to see. That's why, you know, we were able to limit-- eliminate $2.2 million in medical debt across the state, is because there's already a lot of care going unpaid. And, you know, I think that when you shift a lot of things to emergency care, you're going to see those sko-- I mean, those costs skyrocket for a whole systems.

HARDIN: Questions? Are you and Mr. Carlson in the same class?

MARSHALL BIVEN: He's an M3 and I'm an M2, but we, we do a lot of work together.

HARDIN: Wow. Awesome.

MARSHALL BIVEN: All right. Thank you.

HARDIN: I love that you guys come and do this.

MARSHALL BIVEN: Trying to get active, you know?

HARDIN: Yes. Thank you. Proponents, LB929. Welcome.

PEGGY REISHER: Good afternoon. I'm Peggy Reisher. Peggy is spelled P-e-g-g-y; Reisher, R-e-i-s-h-e-r. And I'm the executive director for the Brain Injury Association of Nebraska. I could essentially say ditto to everything that's already been said. I-- I'll just add that-- for those that we represent with brain injury across the state of Nebraska, on average, there's about 14,000 Nebraskans that are on what's called the Traumatic Brain Injury Registry in our state every year. Those are folks that are being admitted and discharged into the hospital after having a brain injury. Those numbers are really large.

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However, that's not also representing those who've had strokes, tumors, aneurysms, noxic injuries. Those are all the folks that we, that we represent in the work that we do as a nonprofit in our state. We do-- again, ditto to everybody else. A lot of our folks are on very fixed income. I spent 14 years at Madonna Rehab Hospitals as a social worker on the Brain Injury Unit, where my very first conversation with almost every family and every patient was, it's great that you got insurance. Let's sign you up for Medicaid because brain injury can oftentimes be a chronic condition. And that's what we're finding is-- in the work that we're doing, is this really is-- for us, many of our folks are, are living with a chronic condition because a brain injury. They oftentimes look fine, but cognitively they don't have the ability to do the things that they need to do. Going through more, you know, co-pays and paperwork becomes very, very challenging for a lot of them. So I really appreciate Senator Fredrickson bringing this up and-- because I, I really do feel like this will be a, a great support to the folks that we serve and that we try to meet their needs for. Happy to answer any questions.

HARDIN: Questions? Seeing none. Thank you.

PEGGY REISHER: Thank you.

HARDIN: Proponents, LB929.

***TANYA ENCALADA CRUZ:** I support the bill because Medicaid is intended to provide healthcare coverage for individuals who cannot afford it. However, mandating co-pays could result in a substantial decrease in the number of people seeking medical attention. What may appear as a small amount of money to some could force them to make a choice between visiting the doctor, paying their bills, or eating. It is essential to ensure that healthcare remains accessible to everyone, as a healthy population is more likely to be productive and engaged in various activities.

HARDIN: Opponents, LB929. Welcome.

DREW GONSHOROWSKI: Thank you for having me. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i. And I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in

opposition to LB929. LB929 would require DHHS to impose Med-- Medicaid deductions, cost-sharing, or similar charges at the lowest amount permitted under federal law and would prohibit the denial of services for nonpayment. While DHHS recognizes the intent of minimizing financial barriers for Medicaid enrollees, enactment of LB929 raises concerns regarding the lacks of fle-- fe-- flexibility it affords to the department to thoughtfully address member service utilization. Recent federal re-- legislation in H.R. 1 implements a requirement for states to impose cost-sharing and co-pays. Though it does not dictate a specific rate, it spells out an amount greater than zero. Specific amounts were not specified so that states would have the flexibility to be thoughtful in their implementation. If the intention is to shape member utilization, it must be determined what cost is going to encourage appropriate utilization for each service and situation. We understand that there are concerns with the potential barriers presented by cost-sharing. However, if DHHS is not able to be purposeful, cost-sharing will not only represent a potential barrier, but we also forfeit any benefit that might come for the member and the state. In working to meet the new federal requirement, DHHS would only consider doing so in a manner consistent with federal law, with a focus on service areas identified as high-risk misuse or overutilization and while maintaining all required beneficiary prote-- protections. DHHS is concerned that the enactment of LB910-- LB929 could create compliance and operational challenges, increased administrative burden, and diminished program integrity tools while providing limited oper-- operation value from collections. We re-- respectfully request that the committee not advance the bill to General File. Thank you for your time. I'd be happy to answer any other questions on this bill.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. And specifically in your second paragraph-- it looks like it's maybe even the first line-- it's-- and I quote, it says, would prohibit the denial of services for nonpayment. But I thought we heard earlier that you might have some patients that can't pay and sounded like-- for example, the hospital at York as one example would find it necessary to write that off. So it's-- to me, the key concern here is to prohibit. Because under EMTALA, you're not allew-- allowed to prohibit. You'd still have to see them.

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DREW GONSHOROWSKI: I, I, I believe that's our understanding of the function of LB929. I think that's a piece of, of the legislation there.

RIEPE: Do you think that would--

DREW GONSHOROWSKI: I'm trying to say--

RIEPE: --supersede the EMTALA law?

DREW GONSHOROWSKI: No. I'm, I'm saying he's prohibiting-- the, the way the-- it-- Senator, Senator Fredrickson's bill is, a piece of it prohibits the dia-- denial of services.

RIEPE: Oh.

DREW GONSHOROWSKI: Yeah.

RIEPE: OK. Well, we can check that out.

DREW GONSHOROWSKI: Mm-hmm.

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

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So are there plans for when you're going to implement this?

DREW GONSHOROWSKI: So, so this is in consideration. And you can see on the, the fiscal note that there are impacts in the 2026-27-- the department was considering this alongside our other H.R. 1-- or, Working Families Tax Cut Act implementations and working with CMS. So in this year-- obviously, there is a lot of work to do collaboratively with CMS on guidance. I think one specific item that I can highlight here that is in Senator Fredrickson's bill that, that probably highlights a, a good, a good question around guidance right is this question of who bears the cost. So it's true that cost-sharing previously in Nebraska was effectively borne by the MCOs. There's still an open question. We've asked it of CMS, you know, in terms of opera-- operationalization of, of this provision. Would the cost be borne on the MCOs or is there going to be a direct requirement that individuals have to have the cost-sharing? There's also sort of

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questions around the, the, the distribution of, of co-pays, right? So the bill explicitly says-- H.R. 1 explicitly says that it's something greater than zero. But in terms of guidance, something greater than zero is a penny, right? So is that actually what they will provide in terms of guidance? That's sort of the nature of this opposition too. We, we, we have no intent to implement work-- or, implement co-payments beyond outlined in H.R. 1. It's about assuring that the division has flexibility to implement co-pays in ways that are thoughtful about the system.

QUICK: OK. But on the-- like, on the fiscal note, does that reflect, like, the highest amount you could ask for for a co-pay, like, $35 per person? Is that--

DREW GONSHOROWSKI: I, I can get the specific underlying-- my, my, my bel-- my, my rem-- remembering the specific estimate, I don't believe that it does.

QUICK: OK. And so you're still waiting for guidance from CMS too then, right? Is that what you're telling me?

DREW GONSHOROWSKI: Yeah. Correct.

QUICK: So would it be best to wait until you get that guidance before we implement in, in May? Because what happens if we don't have their gui-- their guidance until then?

DREW GONSHOROWSKI: Yeah, and I, and I think that's-- that is a-- that's a fair point in terms of-- I, I have the confidence that we would have the, the guidance in order to implement.

QUICK: OK. All right. All right. Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Director. I'm, I'm curious about this word "utilization." So is there-- I know you've done extensive research in this ar-- arena. Is there, is there a curve where a dollar amount drops utilization? I'm not holding DHHS [INAUDIBLE] where that dollar value is.

DREW GONSHOROWSKI: Yeah. It-- that-- that's a great question, Senator. And I, and I think that the characterization around the academic

research on co-pays that you've heard from proponents of this bill, at least my understanding of it, is that's, that's pretty true. Like, that's, that's a fair characterization. I believe that-- I'm, I'm thinking specifically about-- I think Wisconsin has one of the better studies around it in terms of willingness to pay on these sort of broad-- broadscale-- or, broad stroke co-payments. And I, and I-- you know, in terms of just sort of every visit is $1 or every visit is $10 or even a premium on Medicaid, that's not necessarily what we're talking about here as well. It's, it's-- I, I-- referencing previous testimony yesterday, it's-- it all kind of fits together, right? This is-- you know, you can think of a, a space where a, a member utilizes the ER for a non-- nonemergent use. The flexibility afforded in this law allows a co-pay to be applied there. Whether or not that goes to the individual or the MCO is an open question. Either way, that co-pay does provide a signal that says, you know, maybe this individual should be wrapped up in a service or, or lifted up in a service-- catch them outside of the going to the ER, right? That's where this flexibility is, is afforded. And, and I, and I will just say-- looping back to your original question, yeah, it is-- I, I think that a lot of the research shows that these co-pays that-- I, I would say aren't necessarily as applied as carefully-- can have these, these downside risks. And, and the department acknowledges that that-- that that's a reality.

BALLARD: OK. Thank you.

HARDIN: Other questions? Thank you. Opposition, LB929. Those in the neutral, LB929. Senator Fredrickson. We had an, an ADA letter. Health and Human Services Committee received written ADA testimony from Tanya Cruz in Lincoln, Nebraska in support of LB929. And this testimony will be included in the official hearing transcript and the testifier included on any committee statement that is published. The testimony has also been provided to all members of the committee. In addition, we had 75 proponents, 0 opponents, 0 in the neutral. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you to the committee for listening to the bill and the testifiers. I'm also appreciative of everyone who came out to testify, to my staff, and everyone who's worked on this bill. So a, a few questions kind of came up during the hearing that I wanted to try to address now. And of course, I'm happy to answer any questions the committee might have. Senator Riepe, you,

you were asking a little bit about the-- this idea of, like, the co-payment and sort of ability to pay, can people be denied-- you know, kind of all the minutia with that. So I did a little research into this. So when we previously did require co-payments for Medicaid, from what I understand, is that-- let's say we had a Medicaid rate, just for simple math, of $100 for a service that would be paid to a hospital on Medicaid. Let's say at the time we had a $20 co-payment. So when we had a co-payment before, the Medicaid reimbursement, even though the rate set by the Legislature would be $100, the hospital would be reimbursed $80 because there's a $20 co-payment there. Now, if a Medicaid patient was unable to pay that $20 co-pay, the hospital would either have to absorb that, write that off, et cetera. Since we don't currently have Medicaid co-payments, the hospital would be getting the $100 reimbursement rate. So that's sort of-- I hope that kind of clarifies those questions a little bit. I don't know if that's currently the plan for the results of H.R. 1 from the department, but that's, that's what previously has happened in the state when we did have a Medicaid co-payment. The other thing I just want to reiterate as well, just for clarity, is, is LB929, it, it, it is in full compliance with, with H.R. 1 in that this is not here to walk back what H.R. 1 does. Essentially, what it does is it says, H.R. 1, the changes and shifts occur once they're required to occur. So currently-- and we heard this, I think, in some hearings yesterday-- we are the state-- we're no-- I think we are the only state who is volunteering to kind of go first with, with a lot of the changes from H.R. 1. And I, I, I, I have some concerns about that. And I appreciate Dr. Gronchowski's [SIC]-- hope I said that right-- Gronchowski's testimony as well that-- and I know the department's working hard with CMS on trying to get a little bit of guidance and clarity around this, but I, I-- you know, it does give me a bit of a concern to make Nebraska kind of the guinea pig for the rest of the country to sort of see how this turns out. I worry that they're going to try to see what happens here and, and, and learn from us. And the reality is-- I don't know that our constituents should be the test case. I think that-- I would like to see us wait until we get full and clear guidance from CMS on how to roll these things out so that we're doing it responsibly, so that we're doing it in line with what we expect. Hopefully that changes. Hopefully we get more guidance from CMS. But at this point, with all the uncertainties, I think it's prudent to have some guardrails in place to ensure that folks who are on Medicaid are, are not unintentionally harmed by, by changes before we have more

clear guidance. So with that, I'm, I'm happy to have-- continue to have conversations with the department. I know they had a-- they-- a couple of concerns. I mean, if there's, if there's specific things to tweak here, I'm happy to have those conversations. But I'm also happy to answer any questions from the committee as well.

HARDIN: Questions? Thank you.

FREDRICKSON: Thank you.

HARDIN: This concludes LB929. Next, LB1221 from Senator Ballard. We'll, we'll mix the room up a little bit, Senator Ballard. Everyone move one seat to the left. We are ready.

BALLARD: Ready to roll? All right. Good afternoon, Chairman Hardin, member-- and fellow members of the Health and Human Services Committee. My name is Beau Ballard. For the record, that is B-e-a-u B-a-l-a-r-d [SIC]. And I represent District 21 in northwest Lincoln, northern Lancaster County. I'm here today to introduce LB1221, a bill designed to provide clarity to the implementation of the federal One Big Beautiful Bill Act. In December last year, government-- Governor Jim Pillen announced that Nebraska intended to be the first state in the nation to pursue work requirements established under H.R. 1 for Medicaid enrollees, detailing Nebraska's intent to implement these requirements by May 1, 2026. While federal law permits temporary hardship exemptions for patients undergoing treatment, the Center for Medicare and Medicaid Services will not provide per-- specific definitions for these exemptions until June 1, 2026. This leaves a gap for Nebraskans' implementation date and the receipt of federal guiance-- gui-- guidance. Let me be clear: LB1221 supports Nebraska's early implementation to the Medicaid community. Engagement required by providing clear definitions for key temporary hardships exemptions underline federal-- underlined in federal law. LB1221 provides clarity to the Nebraska Department of Health and Human Services, staff, hospitals, and providers and reduces administrative uncertainty for patients whose medical circumstances temporarily interfere with their ability to meet community engagement requirements. So why does this matter? Without the definitions provided in LB1221, we risk leaving valuable neighbors in a state of limbo. Consider this example. Sarah [PHONETIC], a constituent from Garden County, was diagnosed in localized, aggressive cancer. Her treatment requires her to travel to Omaha for inpatient surgery, followed by six months of intensive daily

radiation therapy. Under current federal ambiguity, Sarah could face loss of, of Medicaid coverage while lying in a hospital bed because she isn't meeting community engagement hours. LB1221 establishes four clear objectives-- definitions to ensure those with legitimate medical hardships are protected. One, inpatient hospital service. Includes a full cycle of care from admission to necessary follow-up and recovery, ensuring patients can focus on healing. Two, extended period of time. It is defined as overnight stays or repeated medical trips away from home that realistically interfere with work and community engagement. Three, outside of the community means traveling outside the individuals' county or residence for care. And finally, serious or medical me-- serious or complex medical condition ties Nebraska's standards to existing federal medical, necessary, clinical benchmarking-- benchmarks, including any conditions for which Medicaid coverage is medically necessary. This bill's about efficiency and clarity. H.R. 1 allows states to exempt individuals from community engagement requirements during per-- periods of inpatient care, serious or complex medical treatment, or extended travel outside their community for medically necessary services but leaves important terms undefined pending federal-- future federal glui-- guidance. LB1221 defines inpatient services, extended absences, traveling outside an individual's community, or serious complex medical negations-- conditions for this narrow set purpose. As we work to imper-- implement the One Big Beautiful Bill, state agencies, patients, and providers must understand the framework in which we will be operating. LB1221 helps ensure that we encourage work and community engagement, where we do not accident-- accidentally exclude Nebraskans who are working hard just to get healthy again. Finally, I want to emphasize that LB1221 intends to be helpful to Department of Health and Human Ser-- Health and Human Services and providers as they work together to carry out implementation of H.R. 1. We remain open to working with the department to refine these definitions, and they believe they improve clarity in administration. And welcome their engagement in the bill moving forward. I do have one amendment. Working with ALS, AM1984, I thought medical hardship-- ALS would be included in that, but working with their, their or-- their association, they wanted just some clarity on, on this. People with end-- end-state renal disease, ALS typically fall within the medically frail definition used in this bill. This amendment would make it abundantly clear that both would be exempt, helping department to expedite the process and making it clear for medical staff as they process exemptions. With that, I'd urge the

committee to advance LB1221 to General File. And I'd be happy to answer any questions, but there are experts behind me as well.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Ballard. OK. Don't hate me. This is kind of a niche question. But-- so-- I, I think this is-- I-- so I-- what I understand your bill to do is that basically you're saying this is going to provide more clarity for what these definitions mean. So since we're kind of going early with this, that it's-- there's clarity for the department.

BALLARD: Correct.

FREDRICKSON: Once we do receive more clarity from CMS or, or the federal government around this, what-- i-- is that, like, a federal preemption thing? Like-- so it's different than ours? Like, would the-- would their definition-- I know that's really in the weeds. I just don't--

BALLARD: Yeah. That's, that's going to be in the weeds. I, I think DHHS is here to testify--

FREDRICKSON: OK. I'll ask them.

BALLARD: --in opposition. But yes, absolutely.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. Thanks. My question would be is, is there some financial incentive for us to be the lead dog of-- on this particular-- I'm trying to be-- said in the-- it's always a little dangerous when you're the first program going out. A second would be is, was that instrumental in our getting a fairly-- because I think we got a fairly high rating. And, and of course, [INAUDIBLE] financial reward in our application to the credit of DHHS. But did either of those play in this-- the reason we wanted to be number one or we just, we just wanted to be number one?

BALLARD: I-- it's my understanding-- I, I think we, we wanted to be number one and, and lead the state in the, the Nebraska way, how it can be done.

RIEPE: OK.

BALLARD: Yes.

RIEPE: OK. Thanks.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I probably should already know this answer, but is there-- for the work requirements and the community engagement, is there an age where you no longer have to qualify for those? Or is it just based on the fact that you're medically frail or maybe you're in a nursing home or--

BALLARD: They-- let me get back to you on the age, but my, my bill's mainly focused on the hardship, medically frail. But I'll-- I can get back on the age, or someone behind me can, can answer that question.

QUICK: OK. All right. All right. Thank you.

BALLARD: Yes.

HARDIN: Senator Hansen.

HANSEN: You'll have to excuse the consternation of my colleagues on this board for being number one because we're usually the last in everything.

BALLARD: Including home birth.

HANSEN: Whether it's home birth or mandating fluoride or-- you know.

BALLARD: Or heel pricks.

HANSEN: Heel prick tests. Yep. So it's-- we're in a-- we're in a unusual position of being first, so we're a little uncomfortable here. But with that, are we-- and this might be one you can answer or somebody else behind you might be able to answer. So are we expecting more people because of these changes to be covered under Medicaid or less people?

BALLARD: I, I, I don't know if there's a number, per se. I think it's just mainly-- my bill's focused on clarity. It's-- I think some of these are just clarifying federal definitions. And so just making sure

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that as we get to the-- that January 1 date that there's not that ambiguity and folks aren't left in limbo. So I don't think it is going to impact numbers, per se. And I think the fiscal note addresses that as well because it-- there is no fiscal note.

HANSEN: Yeah. And it might be, because I think when you're clarifying, like, exemptions that sometimes maybe-- allows people to have more exemptions, so it might actually keep people on Medicaid a little bit more or it might not? I don't know. So. Somebody else can answer that.

BALLARD: Yeah.

HANSEN: Thanks.

HARDIN: Other questions?

BALLARD: Thank you, Chair.

HARDIN: Will you stick around?

BALLARD: I'll be here.

HARDIN: OK.

BALLARD: Appreciate it.

HARDIN: Proponents. Mr. Ulrich.

JIM ULRICH: Hello again. Ready for me to start?

HARDIN: Please.

JIM ULRICH: All right. Good afternoon, Chairman Hardin, members of the Health and Human Services Committee. My name is Jim Ulrich, J-i-m U-l-r-i-c-h. I'm the CEO of York General, York, Nebraska. I'm here today to testify in support of LB1221 on behalf of the Nebraska Hospital Association. As I mentioned earlier in testimony, York General is a rural health care system in York. And because of eligibility requirements outlined in H.R. 1, we are already preparing to have more Medicare patients in need of health care services as well as an increased level of uncompensated care that should not, for health reasons, postpone their care any longer. So we're already expecting more of that. For my hospital, LB1221 is important to help

us provide guidance to our providers and our patients to understand what the parameters are for the very narrow set of exemptions that are in H.R. 1, as, as was explained earlier. So we see and care for Medicare-- Medicaid patients both as inpatients and outpatients in our critical access hospital. Of course, we see Medicaid patients in our family medicine and urgent care clinics and our nursing home as well. Medicaid patients who receive care in the hospital at times-- Med-- the Medicaid patients receiving care in the hospital at times need to continue their care outside of the York area and at larger health systems for that higher level of care. And what was passed out to you is a sheet like this that goes over some of those things that senator just talked about as well. And so these very Medicare patients-- ho-- hold on a second here. OK. Medicai-- these very Medicare patients in great need of this continued care are in jeopardy of losing their Medicaid coverage if they are unable to qualify for one of these short-term, temporary hardship exemptions. LB1221 helps to eliminate the guesswork-- the department, patients, and medical providers along the-- along this way. We know-- it's important to say, just to add into this, to say that, again, the guesswork. It's not just by the department and the determinations but also the patients and the medical providers that are trying to make these decisions-- and the care coordinators I talked about before too, to help guide along the way. I have a couple of York General Medicaid patient examples for you too. So we do see plenty of patients age 18 to 50, more the working ones and, and who could potentially lose Medicaid coverage. For the first example, a patient who is on Medicaid and employed recently had a stroke and needed a skilled stay for two to four weeks for rehabilitation purposes. This results in the patient not being able to work. Under the new requirements and not specifically defined-- and not specifically defined ex-- exemptions, a patient could lose their Medicaid coverage. The loss of Medicaid coverage turn-- could turn-- in turn could result in them not being able to afford their rehabilitation, period. A second example is a Medicaid patient after an inpatient stay being discharged home on oxygen for respiratory illness or newly diagnosed COPD or cons-- congestive heart failure. The patient--

HARDIN: Mr. Ulrich, if-- we're in the red. If I could--

JIM ULRICH: Oh. I'm sorry.

HARDIN: That's OK.

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JIM ULRICH: OK. I'm sorry. Sorry.

HARDIN: Go ahead and sum up, if you--

JIM ULRICH: Yes, I will. Sorry about that. The patients work in an environment where they're wearing oxygen masks and the-- their work won't allow them to do that because of the dangerous situation of oxygen. So again, they'd be in a place where they wouldn't be able to-- they would probably lose Medicaid if they wouldn't be able to work and wouldn't be able to afford their care. So I know that the state intends to care for sick patients and healthy patients, and I just go back to what was said before, that this provides the clarity needed for those caregivers, the patients, and the department as well.

HARDIN: OK.

JIM ULRICH: Thank you.

HARDIN: Questions? Seeing none.

JIM ULRICH: All right.

HARDIN: Thank you.

JIM ULRICH: Thank you.

HARDIN: LB1221, proponents. Welcome.

NATALIA BOELHOWER: Thank you. Good morning, member-- good afternoon. We're already way past morning-- members of the Health and Human Services Committee. My name is Natalia Boelhower. That is N-a-t-a-l-i-a B-o-e-l-h-o-w-e-r. I am the community health navigator at Community Medical Center in Falls City. And I am testing in support of LB1221 on behalf of the Nebraska Hospital Association. Thank you to Senator Ballard for introducing this bill. LB1221 supports Nebraska's early implementation of the Medicaid community engagement requirements by providing clear definitions for key temporary hardship exceptions. The health care system is complex, and my job is to work directly with patients every day to help them navigate this complex system. I serve as a patient advocate, especially for individuals who are already struggling to stay healthy while managing complex life circumstances. I collaborate with providers, help patients understand treatment plans, connect them to applicable resources, and help patients gain

and maintain health insurance coverage. Many of the patients I work with technically do not meet the narrow definition of disabled, yet they are undergoing chemotherapy, radiation, dialysis, or managing conditions like severe autoimmune disease, heart failure, or advanced diabetes. Their ability to work fluctuates week to week, sometimes day to day. Side effects, hospitalizations, fatigue, pain, and transportation barriers are very real and often unpredictable. These are not conditions that can be treated with a one-time prescription. This is continuous, exhausting care that does not follow a timeline. And recovery does not happen on a predictable schedule. These issues are even more pronounced in rural Nebraska. While our rural critical access hospital provides many health care services, there are some we simply cannot offer due to finite resources, which means pace-- patients must travel to seek that care. Depending on the diagnosis, we have referred patients to Lincoln, Omaha, or even Kansas City, all of which are about a three-hour round trip from Falls City and the closest options that we have. Since terms like "outside of their community" or "extended period of time" are still undefined by CMS, when Nebraska implements early, individuals could face a loss of Medicaid coverage while in a hospital bed because he or she cannot meet the community engagement hours. In my experience, what happens when patients lose coverage is that they delay care, skip medication, and end up sicker, leading to avoidable emergency room visits and hospitalizations. Maintaining coverage for these patients who are too sick to work aligns with the intent of H.R. 1, supports better health outcomes, and is more fiscally responsible. Thank you for your time and consideration. I'd be happy to answer any questions.

HARDIN: Thank you. Questions? So you play shortstop is what you're saying.

NATALIA BOELHOWER: Yes.

HARDIN: Got you.

NATALIA BOELHOWER: Didn't play softball, so.

HARDIN: OK.

NATALIA BOELHOWER: But yeah.

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HARDIN: All right. Well-- and that's an important role. The medical system is not an easy one to navigate. Doesn't matter where you engage it.

NATALIA BOELHOWER: Yeah.

HARDIN: It's-- does not come with a-- an easy button. And so are you seeing a lot of people-- because you, you gave us some examples of things that are far away. And I get it. I'm from the other side of the state, and a lot of people where I am cross the border into Colorado for care. In this case, we're talking about Medicaid. And so do you have a lot of people who come to where you are from, shall we say, north of you or west of you?

NATALIA BOELHOWER: Mm-hmm. Yeah. We do have quite a few of Kansas, like, natives. Hiawatha is, like, 20 minutes from us.

HARDIN: OK.

NATALIA BOELHOWER: So yeah, we, we do. They have a hospital, but a lot of them do come to us. I-- we don't particularly-- I'm not working with them in my role, but they do come through the ER.

HARDIN: I see. OK. Very good.

NATALIA BOELHOWER: Mm-hmm.

HARDIN: Thank you. Appreciate you being here.

NATALIA BOELHOWER: Yeah.

HARDIN: LB1221. Welcome back.

JINA RAGLAND: Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Jina Ragland, again, J-i-n-a R-a-g-l-a-n-d. I am here today testifying in support of LB1221 on behalf of AARP Nebraska. Senator Quick, real quick to address your question, it's 64 is the work requirement in community engagement age. LB1221 provides a list of defined options for short-term hardship exemptions to the work and community engagement requirements as set forth with H.R. 1. Establishing defined criteria in the bill language is helpful to begin to set the framework for this new requirement. While we still believe-- as you heard me say yesterday-- that

implementation should not be expedited and it continues to be in the best interest of Nebraskans to adhere to the timeline set forth by the passage of H.R. 1, we're committed to being part of the conversations and resources for implementation of the requirement. Today, I'm here before you in addition to what is included within LB1221 as exemptions. I would like that-- to ask the committee to consider amending the bill language to explicitly exempt family caregivers, using the definition in Section 2 of the RAISE-- which is the Recognize, Assist, Include, Support, and Engage-- Family Caregivers Act, as cited in the OBBA, and consistent with congressional intent. We have discussed this amendment with Senator Ballard, and we feel it is a friendly amendment for the consideration of the committee. Based on the RAISE definition, Nebraska's regulations and guidance, we feel should surely-- should clearly exempt-- and I have it listed in the, the information from the public law-- an adult family member or other individual who has a significant relationship with and who provides a broad range of assistance to an individual with a chronic or other health condition, disability, or functional limitation. In Section 71119 of the OBBA, states determine the definition of specified excluded individual-- which is an individual not subject to the Medicaid community engagement requirements-- in accordance with standards specified by the Secretary of Health and Human Services. The law's definition of specified excluded individual includes an individual who is the parent, guardian, caretaker, relative, or family caregiver-- again, as defined in Section 2 of the RAISE Family Caregiver Act-- of a, a dependent child 13 years of age and under or a disabled individual. As cited above, Section 2 of the act defines family caregiver as an adult family member or other individual who has a significant relationship with and who provides a broad range of assistance to an individual with a chronic or other health condition, disability, or functional limitation. Congress specifically used this definition of family caregiver that includes those caring for an individual with a chronic or other health condition, disability, or functional limitation, not just caregivers of a dependent child 13 years of age or younger, or a disabled individual. In closing, I would say we've also urged the state of Nebraska-- you'll see the letter we've sent to the director. We've also been in touch with Dr. Oz, and we're working with CMS through that avenue before Nebraska announce their plans to move forward. And so we feel we've been at the table. We've been having the discussions. We [INAUDIBLE] part of a Medicaid coalition and brought this up on a call with them a month ago. And so

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we feel like this is an important thing for you to consider as part of the committee and as at-- the exemptions going forward. I would like to thank Senator Ballard for introducing the legislation as well as being willing to entertain this possible amendment, as well as you as the committee. And I'd be happy to answer any questions.

HARDIN: Thank you. Questions? Thank you for giving us lots to ponder.

JINA RAGLAND: Sorry. Papers.

HARDIN: No, not at all.

JINA RAGLAND: Thank you very much.

HARDIN: We appreciate it. Thank you. Proponents, LB1221. Welcome.

JOEY ADLER RUANE: Thank you, Chair Hardin, members of the Health and Human Service Committee. My name is Joey Adler Ruane, J-o-e-y A-d-l-e-r R-u-a-n-e. And I appear today before you as a registered lobbyist for Fresenius Medical Care. Fresenius Medical Care serves 637 Nebraskans with end-stage renal disease-- also known as ESRD-- and eight outpatient dialysis clinics. Fresenius Medical Care, along with the dialysis provider DaVita, the ALS Association, and the American Kidney Fund, Chronic Disease Coalition, Dialysis Patient Citizens, and the National Kidney Foundation support LB1221. And we appreciate Senator Ballard passing out the amendment earlier. Individuals with ESRD and ALS have a special federal entitlement for Medicare regardless of their age. Most of these individuals find work difficult due to the amount of time spent on their medical treatments. For dialysis patients, dialysis involves a four-hour treatment three times a week. It is also not uncommon for them to experience short-term hospitalizations. Senator Ballard's amendment clarifies that individuals with ESRD and ALS do meet the definition of a serious or complex medical condition. The code referenced in the bill 42 CFR 440.315 includes a list of exemptions recognized in federal law. This list includes individuals entitled to benefits under any part of Medicare, individuals who are medically frail, those with serious or complex medical conditions, and individuals with a disability determination based on Social Security criteria. The Social Security Administration has specific criteria for determining disability for people with ESRD. We believe that the individuals with ESRD and ALS meet all of these exemptions. However, identifying them in the bill as

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meeting the definition of serious or complex medical conditions may make it easier for Medicaid staff as they are processing exemptions to community engagement and will be reassuring for people with ESRD and ALS that their Medicaid eligibility will not be interrupted due to any work requirements. We'd be happy to work with the committee, and appreciate Senator Ballard's willingness to work with us on this amendment. And we'd be happy to take any questions.

HARDIN: Thank you. Questions? Seeing none.

JOEY ADLER RUANE: Thank you.

HARDIN: Thank you. Proponents, LB1221. Opponents, LB1221. Welcome back.

DREW GONSHOROWSKI: This is the-- I think this is the last one.

HARDIN: Well, we can start and do it again if you missed it. This time in French.

DREW GONSHOROWSKI: Let's start it from the beginning, from the top. All right.

HARDIN: OK.

DREW GONSHOROWSKI: Good afternoon, Chairman Hardin and members of the Health and Human Se-- Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i. And I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB1221. LB1221 provides certain limitations on the department's upcoming implementation of work requirements for the adult expansion group, which is required under federal law. H.R. 1 provides exemptions for certain individuals in the adult expansion group who will not need to complete work requirements as part of keeping their Medicaid eligibility. This bill seeks to define criteria for short-term hardship exemptions, which will allow certain beneficiaries to be exempt from participating in work requirements for a limited period of time. Half of the short-term hardship reasons included in H.R. 1 relate to seeking medical care, such as inpatient care and needing to seek care outside the community for an individual or their depar-- of their dependent. Nebraska, like all other states, is waiting for-- on more detailed guidance from the Centers for Medicare and Medicaid

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Services related to many components of our Medicaid work requirements program, including definitions around short-term hardship events. Our opposition to this bill is tied to this uncertainty. Department believes it would be premature to legislate these definitions on the state level before more federal guidance is available. The department is concerned this bill could create a conflict between a definition in state law and upcoming federal guidelines. Our program does not necessarily disagree with any of the terms des-- defined in this bill. And we appreciate this bill's aim to provide some guidelines for this component of the Medicaid work requirements program. However, due to the timing consers-- con-- considerations we've raised today, we ask that the committee not advance this bill to General File. Thank you for your time. Be happy to answer any of your questions regarding this bill.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here.

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: Should sit on the end next time. Could get up and--

DREW GONSHOROWSKI: Need a few extra steps.

FREDRICKSON: Yes. So a, a couple of ques-- so ye-- I mean, I, I, I feel like this has kind of been a little bit of a theme of the last couple days, but, you know, I, I, I, I continue to have concern about not having kind of clear federal guidance and, and us kind of building the plane while we're in air almost. It feels like it's kind of by the seat of the pants a bit. I-- I'm curious-- like, just for the people that are gonna be most affected by this, does the department have, like, a timeline in terms of when they're going to be communicating to recipients what the new requirements are going to be, what that's gonna look like, that process? Like, when does the department expect to--

DREW GONSHOROWSKI: Yeah. So, so some of that communication has happened already. There was outreach before January 1 of this year. I believe it all went out on December 30 to our expansion members. There's also-- we have a website. So it has sort of the top-line discussion of what the bill is, where the exemptions are. I think it

highlights the, the optional short-term hardship exemptions. And, and, and I just want to highlight too that, that in the bill, the-- LB1221 is sort of addressing the short-term hardship exemptions. The bill's written that those are optional for states to adopt. And, and I just want to sort of make a point here for, for our purposes that, you know, it kind of ties into the questions around, why, why go first? But it's-- if you're going to go first, you have to do it right too, and that means operationalizing all optional short-term hardship exemptions, right? So that's, that's-- that-- I just wanna make sure that I make a point there too that, you know, this is-- and to your point on guidance, coming back to the original question-- because I want to make sure I give you a good answer on that-- this is about that conversation with CMS on how to do this right. And that's what we're actively engaged in now.

FREDRICKSON: Yeah. So-- and, and I think we had that shared goal, right? I, I mean-- what I mean when I say a shared goal is, like, I think we all-- I think everyone on this panel probably wants this to be done right, right? I mean, I think--

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: And I, and I think we all know that there's gonna be learning curves, there's gonna be bumps in the road. I, I, I guess my heartburn is that I have not yet heard what-- like, specifically what that will actually look like. And this is coming up. And so, and so that's, that's, that's--

DREW GONSHOROWSKI: Yeah. And I, and I, and I take that feedback and-- I won't-- I, I guess I will. I, I, I think it, it definitely warrants more-- especially more conversations with--

FREDRICKSON: OK.

DREW GONSHOROWSKI: --with the committee.

FREDRICKSON: And, and I guess my other question too and-- is-- once these new requirements do go into place, once the state requires to do this, i-- is it-- is there go-- is it going to be kind of like, OK, this starts on this day. And then if you don't meet these requirements, you're off, you're-- is there going to be a grace period

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for people to get together the new requirements, reporting stuff? I mean, what's that going to look like?

DREW GONSHOROWSKI: Yeah. And the-- that's a, that's a great question. So, so there's still sort of ongoing conversations with, with, with CMS in terms of what early implementation looks like. It-- your, your sort of question seems like there's a possibility of that kind of option, understanding that you're, you're sort of implementing in order to understand what-- to make sure that you are complying ahead of that January 1 timeline. That-- that's something that most states are still asking a question around too.

FREDRICKSON: All right. Thank you.

DREW GONSHOROWSKI: Yeah.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I have a late question, but are you going-- and maybe, maybe you've answered this-- are you gonna have to staff up for this?

DREW GONSHOROWSKI: No.

RIEPE: Good luck. OK. Thank you. That's all I have, sir.

HARDIN: I'm just going to make a comment. And sometimes you and I talk about these things, but when the Affordable Care Act was passed, that took four years before we actually saw any traction on the ground. And so we're a, a mere seven months out of H.R. 1, so. Just have to point that out as-- I see heads nodding over there. And so philosophically, you want to talk a little bit more about why number-- we're number one. To Senator Hansen's point, we're usually used to being, we're number 49. We're number 4-- so would you talk about being number one?

DREW GONSHOROWSKI: Yeah, for sure. And it's a, it's a, it's a great question. I, I sort of-- I've been-- I think I've been on the ground-- Medicaid directors age in dog years, but, but I've been here 14 months. And I've, I've sort of-- I-- I'm not sure if I've said this to anyone on this committee so far, but I've had this front row seat to just see the absolute exemplary work that folks in my division do every single day. And it's thankless work. They, they, they are true public servants at the end of the day. Rural Health Transformation

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Fund is separate from work requirements. Going early on work requirements didn't give us extra points in the Rural Health Transformation Fund, but that did not change the level of quality and work that was poured into that every day. And that-- and that's work of the heart, folks that dedicated every waking hour to that on an incredibly short timeline with CMS guidance up to two days before-- two working days. Have to be precise there-- two days before to ensure that everybody in the state of Na-- Nebraska got the most that we could possibly get. And it paid off. That, that was a DHHS-wide initiative led by really good folks that come every day and, and lead with heart. It's no different on Medicaid work requirements. It's no dedi-- different in Medicaid. Every day, I get to come in and just watch folks all the way down my org-- so smart people-- sit and go toe-to-toe with CMS. Every time I talk to CMS, they say, we have some of the best people, we have the best market. And then they come to Nebraska and they say, man, you guys can read policy. And, and that I get to be proud about. And, and that's the thing that is the reality here in going first, is that we have the ability to make sure that we get this right for us and then we have the ability to make sure we get this right for the nation.

HARDIN: Other questions? Seeing none. Thank you.

DREW GONSHOROWSKI: Thank you.

HARDIN: Opposition to LB1221. Those in the neutral, LB1221. There's one coming, Senator Ballard. Just wait. Just wait. Welcome.

SARAH MARESH: Hello. Chair Hardin and members of Health and Human Services Committee, I'm Sarah Maresh. That's S-a-r-a-h M-a-r-e-s-h. I'm the Health Care Access Program director at Nebraska Appleseed. Our core priority is ensuring that we have exible-- equitable access to quality, affordable health care in Nebraska. And while we certainly impor-- support the intent of this bill, we are testifying in the neutral capacity, as we have two simple suggestions to make the bill more comprehensive. And with those-- but not without them-- we would support this bill. So that's why we're coming in with the neutral capacity here. And so as you've heard-- I won't go over the requirements of the community engagement or work requirements in H.R. 1, but we have chosen an early implementation date. I will say-- to answer one of the questions, the Governor has stated that our work requirements will cost 30,000 Nebraskans to lose coverage out of the

70,000 enrolled in Medicaid expansion. And Nebraska simply can't afford that, so we do support measures such as delaying. And also are extremely concerned by, by some of the conversation we've heard today about the fact that we have really no details about what's going to be implemented as of May 1. A notice did go out to enrollees, but it was at 14th level grading-- like, reading level for 14th-- I'm saying it wrong, but you had to have 14th level grade education to read the notice. So typically, when, like, you're talking about health literacy, you want it, like, fifth grade or below. This was 14th grade. So requiring more postsecondary education to understand the notice that was single page-- multiple pages of notice. It also lacked a lot of key information that we're getting asked from concerned community members. When am I actually going to be kicked off from coverage? And as we just heard, people don't even know that now. We don't know when people are going to be kicked off from coverage. Am I going to be considered medically frail? We don't know the answer to that, right? And so we're getting questions from Nebraskans who are terrified that they're going to lose their coverage, their care, their medications, what they need to survive because we don't have these definitions and we're just a couple months out from implementation. So just going to say we are very concerned about those pieces of it. But turning specifically to LB1221, it does provide some definitions for optional short-term hardship exemptions, which is very helpful to have. We would also recommend adding a short provision in this bill directing Nebraska DHHS to opt-- adopt all of the short-term optional hardship exempts and to grant them for folks automatically. DHHS's current plan-- the parts that we do know about already contemplate that they are going to take that up, so this should be a simple addition that's not controversial. And second, one of the terms defined in LB1221 is medically frail. Our concern with defining it just in reference to federal regulation is in part alignment with the Medicaid director. We don't know exactly what the guidelines are going to be, so we would recommend an addition to make sure that we aren't unnecessarily boxing ourselves or limiting ourselves to a, a medically frail definition that's too narrow. So we would suggest some language to say any additional condition or circumstance to the maximum extent allowed under federal law should also be included in the medically frail definition. Defining the comprehensive and "inclusious" exemptions and ensuring they're automatically applied to the maximum int-- extent possible is really important to folks who rely on Medicaid to get the coverage they need. And it's also going to be

critical in preventing massive coverage losses our hospitals and health systems just can't sustain. I know I'm out of time, so I will stop for questions. But thank you very much.

HARDIN: Thank you. Questions? Seeing none. Thank you.

SARAH MARESH: Thank you.

HARDIN: Anyone else in the neutral? LB1221. If not, Senator Ballard, welcome back.

BALLARD: Thank you, Chair. And mem--

HARDIN: In the meantime, let me just say we had 3 proponents, 1 opponent, 0 in the neutral.

BALLARD: Thank you, Senator Hardin and members of the committee. I-- my goal with LB120-- LB1221 was just to provide definitions, parameters, I-- just to kind of clarify that ambiguity before patients and providers. There's a lot of-- a lot of concern around Nebraska, especially with the hardship definitions. And so that was the goal with LB1221. I, I stated in my opening that implementation's in May, and we're not getting these definitions until June. And so just trying to work through some of that-- those issues. But happy to work with DHHS. I really appreciate the director. I think he spent the last several days with us, and so I know he has a thousand things to do. And so providing-- his insight is greatly appreciated. So any, any work I can do with the department is, is valuable to me. And so with that, I'd take any questions.

HARDIN: Questions? I think there were two or three amendment pleas that took place. And so-- I know some of those have already been in contact with you.

BALLARD: Yes.

HARDIN: So just to point that part out as well. If there aren't any other questions, this will conclude LB1221 and our hearings for today. Thank you.