HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48, and I serve as chair of the committee. Committee will take up the bills in the order posted. This public hearing today is your opportunity be-- 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 one of these little rooms off to the side, and be sure to print clearly and 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 on that same table; these sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, and spell your first and last name to ensure we get an accurate record. We'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'll finish with a closing statement by the introducer, if they wish to give one. We'll be using a three-minute lighting system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have a minute remaining, and the red light indicates that your time is 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 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; 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, and other visual aids cannot be used, simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8:00 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at 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, but not both. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

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

HANSEN: Senator Ben Hansen, Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton County.

FREDRICKSON: John Fredrickson. I represent District 20, which is in central-west Omaha.

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

QUICK: Dan Quick, District 35: Grand Island.

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

HARDIN: And our pages for the committee today are--

SYDNEY COCHRAN: Hello, I'm Sydney, and I'm a sophomore at UNL studying history.

JADYN TIDYMAN: Hi, my name is Demet, I'm also a student at UNL, and I'm studying political science.

HARDIN: With that, we're going to begin with LB1194 and Senator Storer. Welcome.

STORER: Thank you. [INAUDIBLE]. All right, ready?

HARDIN: We are ready when you are ready.

STORER: Perfect. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Tanya Storer, T-a-n-y-a S-t-o-r-e-r. I am representing District 43. I'm pleased to be here this afternoon to introduce LB1194, known as the Real Food Act. I'm a proud Nebraskan. I'm a fourth-generation rancher, and we're very proud to say that we produce

beef not just for Nebraska, but for the world. When I learned about the new dietary guidelines that came out of USDA, I was thrilled to see that we have nationally embraced scientifically-backed, high-protein, whole-food nutrition, a depart-- a departure from the high-carbohydrate diet recommendations that have been in place for many decades in, in my childhood, and up to this point. These guidelines presented to you in the Real Food Act are a return to basics that prioritize real food for long-term health. Importantly, there is a protein-first, protein-first approach that emphasizes high-quality protein from both animal and plant sources as a foundation for health. Whole foods, like fruits and vegetables, are a decisive stand against highly-processed foods like sugary drinks and things with artificial additives. With these new guidelines, high-protein intake works in tandem, not instead of, a wide variety-- the intake of a variety of vegetables, fruits, and fiber-rich whole grains. The federal dietary guidelines are required to be reassessed every five years, with the newest version standing through 2030. LB1194 simply helps to ensure that these very simple guidelines, current guidelines in their current form, remain as a stand-- take a stand to remain in place in our state, as they shape how nutrition, food programs, agriculture, and public health policy are, are applied to our everyday life. So, codifying this basic framework gives Nebraska a single, trusted nutrition standard to use across state agencies, schools, and health programs, reducing confusion and mixed messages over time. It sets a baseline while still allowing for local flexibility, and certainly state-specific implementation of programming. This is not a mandate for consumers, and that reminds me, I have an amendment to pass out to you. Actually, two pieces of information. Thank you. Again, this is not, not a mandate for consumers or producers. You're getting an amendment where we very intentionally went through and made sure we removed "shalls," and I will talk about the one and only place that we have left a "shall" in, in the bill. These guidelines are not simply advice, but influence major programs at the state level as, as public health initiatives. This includes SNAP, school meals, nutrition programs, WIC, and other federal food programs. They have the opportunity to shape how federal and state dollars are spent, and LB1194 provides a long-term predictability in line with federal programming. The dietary guidelines affect Nebraska's economy, especially in ag and livestock, by keeping animal- and plant-based proteins front and center. Our own Attorney General's office worked diligently to help advocate for proteins as a prominent player in the food pyramid. The office celebrated the outcome as a win for Nebraska

ranchers and science because agricultural interests and nutrition advice intersect, intersect here. The new recommendations support local farmers and ranchers who produce the meats, dairy, eggs, fruits, vegetables, central to the real food reset. Perhaps most importantly, creating a statutory footprint with the dietary guidelines provides long-term stability across administrations and political cycles; this helps agencies, schools, and partners plan with confidence. LB1194 fosters sustainability and predictability, promoting better health outcomes, and, as a support mechanism for putting these guidelines into practice at the state level, LB1194 also directs state agencies, including Health and Human Services, Education, and Agriculture, as we've stated before, and helping-- and will help to promote the guidelines through public awareness, educational materials, and partnerships with local entities. This is not-- this not only supports the public health initiative, it also markets and spurs Nebraska's agricultural economy by educating Nebraskans on how the framework is not only healthy, but the foods that we produce here in Nebraska being part of the backbone of our state. I support the need to promote nutrient-dense foods such as fruits, vegetables, whole grains, and minimally-processed foods. National guidelines are updated every-- again, every five years. This just sort of helps codify a long-term-- identifying long-term these very, very broad and basic principles of dietary guidelines current-- currently in place through 2030. We have certainly worked with partners on the bill. As we, as we developed this, the intent was to keep it broad, broad enough but concise enough, and you will find in, again, the amendment, we have taken out many of the "shalls," and the only place that we have left that in place is for a "shall" in terms of Department of Education, Department of Agriculture, and Department of Health to include in any of their information, their educational information, that those distributed a list of foods commonly produced in Nebraska, and those, those are things that certainly will not likely change much over time, though. We were also very clear to put in the bill that those updates be made on the next regular revision, and I'm proud to say, you will note, there is no fiscal note on the bill. So, with that, I am happy to answer any questions that you might have.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Storer, for being here, for bringing the bill. So, I, I actually don't

know this, and I probably should. So, I-- I'm obviously very familiar with kind of national guidelines, food pyramids, all those-- MyPlate, things like that-- I, I-- I'm familiar with some of the new guidance as well. Have we ever historically, as a state, had our own plan? Is the first time we're adopting something like that, or? Help me understand that a bit more.

STORER: Yeah, this would be the first time. And I do want this to be clear that this certainly doesn't take precedence over any requirements, that agencies would have to adhere to federal guidelines.

FREDRICKSON: OK.

STORER: This is just establishing Nebraska's identification of what we believe is important and prioritizing, and continuing to educate. More, more of an educational premise under the Real Food Act than not to interfere with any federal requirements that, that may be tied to food programs.

FREDRICKSON: OK, so, so currently, for example, like school meals, for example, I think-- I believe, like, WIC, SNAP, like, they, they have to sort of adhere to federal guidelines on that.

STORER: Right, right. And they're--

FREDRICKSON: That would still remain the same and be separate from this. Is that right?

STORER: Correct. There's nothing in the bill that mandates that or that should interfere with those requirements.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I guess, of course, I have-- in building the bill, did you have the engagement of the dietitians as such? I mean, they are the quote-unquote expert on, on foods.

STORER: Yeah, I guess--

RIEPE: Or will they be here to testify behind you?

STORER: There's a couple of folks from the agricultural industry here to testify behind me. In terms of engaging with the dietitians, I guess we take the USDA guidelines as sort of a clear evidence that, that was developed with the input of dietitians across the nation. And so, that, that's the basis, really, for these broad-- really, four main broad dietary guidelines in the bill.

RIEPE: Mm-hmm. I think the part that join-- jumped out at me a little bit is, when I looked at it, I saw red meats, and I know that that's an issue with the Cattlemen, but it's also, I think, a challenge that-- that some would-- some of the dietitians-- hopefully, we'll hear from them as we go along.

STORER: Yeah. And it, and it is broader than just red meat as well.

RIEPE: Yes, I saw that too.

STORER: Yes.

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

HARDIN: Other questions? Will you stick around?

STORER: I absolutely will.

HARDIN: Thank you.

STORER: Yeah. Thank you.

HARDIN: Proponents, LB1194. Welcome.

SETH MITCHELL: Good afternoon, Senator Hardin, and members of the Health and Human Services Committee. My name is Seth Mitchell, S-e-t-h M-i-t-c-h-e-l-l, and I serve as Executive Director of the Nebraska Pork Producers Association. I'm here today on behalf of the Nebraska Pork Producers Association, Nebraska Cattlemen, and the Nebraska State Dairy Association to testify in support of LB1194. Nebraska pork producers strongly support policies that promote sound nutrition, education, personal choice, and access to nutrient-dense foods. LB1194 does exactly that: it recognizes the importance of whole foods, including high-quality protein sources such as red meat, dairy, eggs, fruits, vegetables, and whole grains as part of a healthy,

balanced diet, while maintaining flexibility for individuals, families, and institutions. I want to be very clear about what this bill does and does not do. LB1194 is not prescriptive; it does not mandate diets, restrict food choices, regulate products, or impose penalties on individual schools or health care providers. As amended, the bill replaces many "shalls," making clear this guidance is voluntary and educational, not enforceable. Nothing in this bill forces compliance with a specific eating pattern or overrides existing professional or federal standards. Even though these guidelines are voluntary, placing them in statute matters because it provides clarity and consistency for how state agencies approach nutrition education while allowing that education to reflect Nebraska's agricultural production and food system. Without mandating behavior or disrupting federal programs. The only remaining "shall" appropriately requires that educational materials be updated to include information about Nebraska-produced commodities, and we believe that is both reasonable and beneficial. Nebraska families deserve to understand where their food comes from, and how locally-produced foods, including pork, contribute to a nutrient-dense diet and a resilient food system. Several opponents raised concerns about enforcement, duplication of federal dietary guidelines, and risks to federal funding. Respectfully, those concerns are misplaced under the amended bill. LB1194 does not replace, conflict with, or supersede the U.S. dietary guidelines. It does not alter requirements for school meals, SNAP, WIC, or CMS-regulated healthcare nutrition standards. Instead, it provides a state-level framework for education and public awareness tailored to Nebraska that complements existing federal guidance while recognizing the foods produced here at home. Nebraska agriculture feeds people, not just in our state, but around the world. LB1194 affirms that reality while keeping decision-making where it belongs: with individuals, families, educators, and health professionals. For those reasons, we respectfully urge the committee to advance LB1194. I thank you for the opportunity to testify, and would be happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I guess my question would be, in, in hearing your testimony, is, is this an intent to promote education requiring diet-- dietary habits, or is it a Nebraska-specific promotion of Nebraska products?

SETH MITCHELL: I believe the intent is twofold. I think, inherently, through promoting the dietary guidelines, which by their nature put an emphasis on high-protein diets and several of the commodities that are produced here in the state, it reinforces that message to consumers through educational means and encouragement to state agencies to promote and introduce educational materials into their programs that highlight Nebraska commodities. Nebraska agriculture is very diverse; we produce many of, of the products, if not all the products, that I outlined in my testimony that are represented in the federal dietary guidelines and this bill.

RIEPE: I guess my question would be, without mandatory statutes, is it more of an information educational, as opposed to-- because we're not in any way dictate what people can or can't eat.

SETH MITCHELL: That is correct.

RIEPE: So, I'm trying to sort out why we make it a law. But that-- maybe I'll learn more as we go along. Thank you for being here. Thank you, Chairman.

HARDIN: Other questions? Thank you.

SETH MITCHELL: Thank you.

HARDIN: Appreciate it. Proponents, LB1194. Welcome.

ELISABETH HURST: Hello. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Elisabeth Hurst, E-l-i-s-a-b-e-t-h H-u-r-s-t, and I am Director of State Legislative Affairs at Farm Bureau. And I am here today in support of LB1194 on behalf of Nebraska Farm Bureau, Nebraska Corn Growers Association, Nebraska Soybean Association, Nebraska Wheat Growers' Association, and Nebraska Sorghum. LB1194 is about a healthy Nebraska. It connects public health, agriculture, and statewide agency programming in a practical Nebraska-appropriate way through personal choice and focus on quality of life. LB1194 aligns state policy with the new-- newly-developed federal standards rather than reinventing the wheel. It's not a mandate for consumers or producers; it relies on the USDA dietary guidelines as just released, which are used by schools, health providers, and nutrition programs. Prioritizing high-protein, whole-food nutrition is

scientifically sound, fiscally responsible from a healthcare perspective, and supportive of Nebraska's agricultural market. Perhaps most importantly, codifying consistent guidance improves coordination across agencies and programs, reduces confusion, and ensures Nebraska is using evidence-based policy rather than shifting trends or politics. To be clear, this bill does not override what the USDA already recommends. From an agricultural standpoint, LB1194 affirms the value of Nebraska-grown products across the food system. Nebraska producers raise and grow nutrient-dense foods-- beef, pork, poultry, grains, fruits, and vegetables-- that are already aligned with federal dietary guidelines. Codifying state-level guidance helps create consistency and long-term predictability in policy, and promotion of the ag industry. LB1195-- excuse me, LB1194 respects personal choice and local control. It does not ban foods, impose dietary mandates, or regulate producers. Instead, it provides a clear framework for education and alignment across state programs, encouraging individuals to make informed choices. Nebraska agriculture adapts to the needs of the nation. This bill reflects that same spirit, connecting what we grow with the health of the people we feed. Supporting this bill means supporting Nebraska agriculture, Nebraska families, and beyond. There's an amendment that addresses stakeholder concerns that elements of the bill as written are prescriptive in nature; we're pleased with the outcome and supportive of these changes. We appreciate Senator Storer for introducing the bill, and urge the committee to advance it to General File. Thank you for the opportunity to testify, and I'm happy to answer any questions you may have.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chairman. Thank you for being here, and for your testimony. So, I was, I was hearing some of what, what you-- and I know the introducer mentioned this as well. So, obviously, so the, the federal guidance will always override, or we'll, we'll sort of defer to them in terms of coordination and policy. So, I guess I'm a little confused. Like, so, what, what does this bill do?

ELISABETH HURST: I think codification of the federal dietary guidelines creates predictability and long-term stability as it pertains especially to political cycles and delays in implementing dietary nutritional research.

FREDRICKSON: So, in the event that we codify this and federal guidelines do shift or change, what happ-- like, we have this in statute now, though.

ELISABETH HURST: It isn't mandated, however, the piece that is mandatory would be the direction to the departments. And so, this would continue to be recommendations, and would therefore not conflict with the federal guidelines as would be newly-developed, potentially, in 2030.

FREDRICKSON: OK, so if the department is getting recommendations from us based on the statute and then the federal guidelines are saying something different, the department would have to defer to the federal guidelines?

ELISABETH HURST: As they do now.

FREDRICKSON: As they do now. OK, thank you.

HARDIN: Other questions? Seeing none. Thank you. Proponents, LB1194. Welcome.

JAKE REZAC: Good afternoon, Senator Hardin, and members of the Health and Human Services Committee. My name is Jake Rezac, J-a-k-e R-e-z-a-c, and I'm from-- I'm here today in support of LB1194. I come from this from the perspective of a son of a Nebraska row crop farmer, and I plan to be the fifth operating generation on my family's farm. My family farms corn and soybeans here in Nebraska. Every year, I see firsthand how work, science, and stewardship go into producing food. Farming isn't just about yield, it's about responsibility. Because of that responsibility, we implement sustainable practices like seeded waterways to prevent erosion, side-dress fertilizer application for efficiency, and moisture probes to apply irrigation only when it's truly needed. LB1194 recognizes something important: food and health are directly connected, and agriculture is part of that solution, not the problem. There is a growing narrative that farmers are harming the economy or poisoning the food supply. Much of that perception stems from a lack of understanding of how modern farming actually works. Today's farming-- farmers operate under strict state and federal regulations, rely on research-based agronomy, and use precision technologies to apply inputs responsibly and efficiently. The goal is not just production, it's stewardship. When people don't see these practices firsthand, misinformation can fill that gap.

Education matters, and policies like LB1194 help reconnect consumers with the producers who grow their food. From an agricultural standpoint, this bill is smart because it connects nutrition education back to Nebraska-grown food. Corn and soybeans raised by families like mine help feed Nebraska livestock, which ultimately produce beef, dairy, and protein foods that support a balanced diet. This legislation promotes nutrient-dense whole foods and science-based nutrition guidance. That matters because chronic disease doesn't just strain our healthcare system; it affects workforce participation, rural communities, and family farms. Healthier people mean stronger communities and a more resilient Nebraska. As a row crop farmer, I appreciate that this bill does not demonize any one food group. Instead, it emphasizes balance, whole foods, and quality, principles we already understand in agriculture. We rotate crops, manage soil health, and think long-term. That same mindset should apply to how we nourish our bodies. At the end of the day, farmers who want to produce food people trust, and use-- - to use-- to live healthier lives. LB1194 aligns public health policy with agricultural reality, and for those reasons, I respectfully urge your support. Thank you, and I'd be happy to answer any questions.

HARDIN: Thank you. Questions? Seeing none. Appreciate it, thank you.

JAKE REZAC: Thank you.

HARDIN: Proponents, LB1194. Welcome.

JADYN TIDYMAN: Good afternoon, Chairman, and members of the Health and Human Services Committee. My name is Jadyn Tidyman, J-a-d-y-n T-i-d-y-m-a-n. I'm a Nebraska beef producer from Chadron. My family has been involved in cattle production since 1974, and today, we operate a cow-calf operation. I'm here in support of LB1194, the Real Food Act. As a producer, I see first-hand the care, investment, and responsibility that go into raising safe, wholesome food. Ranching is more than simply an occupation for my family, as well as many others; it requires long days, management, deliberation, environmental stewardship, and a deep, deep commitment to animal health and land conservation. For generations, Nebraska producers have taken pride in producing high-quality, nutrient-dense foods that feeds families across our state and beyond. LB1194 recognizes that whole foods are foundational to good health by promoting

improved dietary guidance, nutrition education, and public awareness around whole foods. The Real Food Act strengthens not only public health outcomes, but also the connection between consumers and the agricultural community. Today, many consumers are sever-- several generations removed from the farm or ranch. There's often confusion about how food is raised, what it contains, and how it contributes to a healthy diet. This disconnect can lead to misunderstandings about modern agriculture and about the nutritional value of products like beef and other whole foods raised here in Nebraska. LB1194 provides an opportunity to bridge that gap by encouraging education initiatives and emphasizing nutrient-dense, minimally-processed foods, and the bill helps ensure that families, schools, and communities have access to accurate information about nutrition. As a beef producer, I appreciate that this conversation includes protein-rich, responsibly-raised foods that play an important role in balanced diets. Nebraska agriculture is a uniquely positioned to support the goals of the Real Food Act. Our producers raise beef, pork, poultry, grains, dairy, and fresh produce, produce that contribute directly to healthy eating patterns. When the state emphasizes whole foods and sound dietary guidance, it supports both public health and the producers who work tirelessly to provide those foods. There's also an important economic component. Agriculture is the backbone of Nebraska's economy, and policies highlight the value of real nutrient-dense foods; they reinforce confidence in the products grown and raised here. That confidence strengthens markets, supports rural economies, and ensures that family operations like mine can continue into the next generation. Additionally, this bill opens the door for stronger partnerships between producers, educational institutions, and, whether through nutrition, education, farm-to-school collaborations, or increased awareness of Nebraska-raised foods, LB1194 creates space for producers to be part of the solution. We're not just suppliers of food, we're stakeholders in the health and well-being of our communities. In closing, LB1194, the Real Food Act, supports sound nutrition, education, and promotes the value of whole foods, and recognizes essential role Nebraska producers play in feeding our state.

HARDIN: Thank you. Appreciate that. Any questions? Senator Meyer.

G. MEYER: Thank you, Chairman Hardin. Thank you for coming today. We're talking healthy foods. Obviously, I'm a big fan of

beef and, and nothing like a good pork chop, also. Your operation-- I've been through that country a time or two, I think I've seen your ranch advertised out in that part of the world. Do you use-- considering the healthy side of, of livestock production, health-- the healthy side of beef production, are, are you using implants, antibiotics, that type of thing? Or as-needed, is that-- or antibiotics, is that on an as-needed basis? And I'm not talking essentially a, you know, a antibiotic-free system. But is that something you kind of focus on, to add to the healthy nutrition of your, of your beef?

JADYN TIDYMAN: We do it as-- on an as-needed basis, yes.

G. MEYER: Do you have people that buy directly from you, with regard to buying beef right off the ranch and, and having it butchered and, and, you know, direct farm-- actually, farm-- straight from the farm to the table? Are, are you involved in anything along those lines?

JADYN TIDYMAN: We are working towards that. It's something that is new for our production, but it would be ideal to have that in place. That's what we're working towards, yes.

G. MEYER: Would you recommend grass-fed beef or feedlot-fed beef? When you sit down to a steak, what's your preference?

JADYN TIDYMAN: Well I suppose if it's, if it's done correctly, I don't know much of a difference after eating it, I suppose.

G. MEYER: If it's a title mistake, it doesn't make any difference?

JADYN TIDYMAN: Yup.

G. MEYER: All right. Well, thank you for coming today.

JADYN TIDYMAN: Thank you.

HARDIN: Senator Quick?

QUICK: Yeah, thank you. And just on what he was-- Senator Meyer was talking about, and I don't know if you can answer this question or not, but I know-- at one time we, we had cattle too. We had about 50 head, and [INAUDIBLE]. We used to put the steroid implants in the ears to-- and then you could only sell

them so many days. They had to be off of the steroids for so many days before market. Is that still part of that process, or do you know? Do they still use steroids?

JADYN TIDYMAN: Yes, it is still part of the process. On anything that you put in cattle, as far as implants or drugs or something like that, there is a withdrawal period on the labels.

QUICK: OK. And I wonder, does that [INAUDIBLE] the same way? Because we buy our beef-- and I should ask my brother-in-law, we buy a half a beef from him every year, and I don't even know if he-- I'm sure he still has to abide by that, right?

JADYN TIDYMAN: Yes.

QUICK: I mean, to even take it to a butcher?

JADYN TIDYMAN: Yes.

QUICK: OK, all right. All right, thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you, thank you for being here. I like what you said about farm-to-school collaborative. Do you do that within your own family production, or do you hear about any innovative approaches, where schools are buying directly from farms? Because I, I, I like that. I think that's good for rural Nebraskans.

JADYN TIDYMAN: Yes, I agree. I-- we do not in Chadron yet. I think it would be great if we did, but I've seen a lot of different programs. I'm an agricultural education major at University of Nebraska-Lincoln, and we visited a school actually, Hampton, and in their FFA program, they raise beef there, and they use that beef for their school lunch program. So, there are schools across the state who have direct producer-to-lunch program in place, but-- Chadron isn't one of them, but I'm sure we can work towards that, yep.

BALLARD: Perfect. Thank you for being here. Appreciate it.

HARDIN: Ms. Tidyman, shall we humiliate these senators? How many of you have been to Chadron, Nebraska? Can we see a show of hands? OK. Well, I went to school at Chadron State College, so--

JADYN TIDYMAN: That's great. That's awesome.

HARDIN: --just had to take that opportunity to jibe my fellow senators. Thanks for being here. We appreciate it.

JADYN TIDYMAN: Thank you, Senator Hardin.

HARDIN: Great. Next proponent, LB1194. Opponents, LB1194.

NIKI KUBIAK: So, I have my testimony, and then I also have an infographic that just summarizes the four concerns.

HARDIN: Do you need to have some copies made or something?

NIKI KUBIAK: No, they're all [INAUDIBLE]

HARDIN: They're all-- OK.

NIKI KUBIAK: Yep, we've got copies for all of you.

HARDIN: Alright, thank you.

NIKI KUBIAK: Thank you.

HARDIN: Welcome.

NIKI KUBIAK: Thank you. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Niki Kubiak, N-i-k-i K-u-b-i-a-k, and I am testifying in opposition of LB1194, the Real Food Act, on behalf of the Nebraska Academy of Nutrition and Dietetics. The Nebraska Academy represents registered dietitian nutritionists and dietetic technicians registered working across Nebraska in clinical care, public health, education, and community-based nutrition programs, and our mission is to improve the nutritional health of Nebraskans through evidence-based practice and policy. The Nebraska Academy appreciates that LB1194 emphasizes the importance of nutrient-dense foods as a foundation for public health, and that efforts to encourage reduced intake of added sugars are also consistent with national nutrition recommendations. However, we have concerns regarding provisions in the bill that appear to encourage increased consumption of saturated fat, including the promotion of full-fat dairy products in certain animal-based foods without appropriate context or limitations. While these foods can

contribute important nutrients, the broader scientific consensus continues to recommend limiting saturated fat intake as part of a heart-healthy dietary pattern. The Academy also questions the need for Nebraska to develop its own dietary guidelines when comprehensive national guidelines already exist. The dietary guidelines for Americans are developed through a rigorous federal process, and they are regularly updated. In addition, federally-funded nutrition programs, including school meals and WIC, are required to align with federal dietary guidance, so establishing a separate set of state dietary guidelines may complicate funding for these agencies, even shifting funding for these programs to the state. In-- if the intent of LB1194 is to encourage the purchase and consumption of locally-grown foods, there are numerous effective mechanisms to achieve that goal without creating separate state dietary guidelines. There's farm-to-school programs, local food procurement initiatives, and agriculture and rural health grant programs can strengthen local food systems while remaining consistent with the national nutrition guidance. The Nebraska Academy respectfully recommends that the committee reconsider the need for this legislation and oppose LB1194. And instead, we encourage the committee to consider legislation that would support the continuation of nutrition education in Nebraska while also expanding the access to locally-grown foods. And, the Academy would welcome the opportunity to work with the Legislature to strengthen these kinds of efforts. So, thank you for your time and consideration, and I'm happy to answer any questions that you might have.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, for your testimony. Can you-- I, I wrote down-- you started-- you mentioned something about federal funding.

NIKI KUBIAK: Yes.

FREDRICKSON: [INAUDIBLE] Did you-- I want to make sure I heard that correctly. Did you say it might be compromised?

NIKI KUBIAK: Yes.

FREDRICKSON: Can you say more about that?

NIKI KUBIAK: Yes. So, interestingly, I attended the National Food and Nutrition Expo that is held every year in October by

the Academy of Nutrition and Dietetics, and this was a heavy, heavy thing. I attended several sessions-- and this was news to me when I attended. This was, this was information presented to me, and I hadn't really put it together. But several sessions focused on the fact that if states all get separate dietary guidelines that they're all following, according to their own policies, when the federal guidelines are updated, it could be really, really challenging to create a federal system that matches all of these variances and state guidelines, and it could really complicate funding to the point that they can't. The Academy, at that time, pointed out-- so, this was in October of 2025-- that nine states had already adopted their own guidelines, and the Academy was advocating last year to, to pull the reins back on that until we can get a better picture of what's happening and what we want to do, because we want to preserve and protect the federal funding for WIC and for the school lunch program, ideally. And there's a few other programs, but those are the two big ones.

FREDRICKSON: OK. And so-- that-- that's helpful. So-- but my understanding is, based on how the bill is written-- and, and I could be incorrect here, but-- that-- it, it, it would still defer to the federal guidelines for things like WIC and SNAP. Do you have any sense of how that correlates, or?

NIKI KUBIAK: You know, I, I was a WIC supervisor. That was my first job--

FREDRICKSON: OK.

NIKI KUBIAK: --when I was a dietitian, so back in 2002 to 2006. I say green-- let me say green dietitian. But we-- I mean, there is no give.

FREDRICKSON: Mm-hmm.

NIKI KUBIAK: We, we have to follow the federal guidelines within those programs. And so, I mean, I-- I don't know that I have the answer to that. I just know that when I was the WIC supervisor there, we followed federal guidelines. And so, if there is this conflict and we are following guidelines that maybe aren't scientifically evidenced, why wouldn't the federal government pull funding?

FREDRICKSON: Sure. And then my last question for you is-- so, you, you-- I think you maybe said this. So are-- what-- other states have implemented this. Is this a new thing? Have other states historically?

NIKI KUBIAK: This is a new thing.

FREDRICKSON: OK.

NIKI KUBIAK: This is new thing that I think was driven with the change in the policy environment last year. And again, the Academy has, has been strongly advocating to, to just slow down, slow down. You know, in addition, we have the Rural Health Transformation Program that was just awarded, and there is tons of opportunity with that to follow through. I have a list of all of these nutrition, kind of food-to-table-type programs. These can receive funding. You know, we, we can work with these, with the Rural Health Transformation Program grant money, so there's a lot of opportunity to advance the economics of agriculture in Nebraska without making any complicating redundant guideline-- guidelines.

FREDRICKSON: Thank you.

NIKI KUBIAK: Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for coming today You said you were heavily involved in the WIC program?

NIKI KUBIAK: Four years. My first, my first job out of college.

G. MEYER: That's federal.

NIKI KUBIAK: Yes.

G. MEYER: So, that follows federal guidelines.

NIKI KUBIAK: Yes.

G. MEYER: In the past, eggs were going to kill us, and now eggs are OK. Actually, eggs really good for our brain. Coffee was going to kill us; if that was the fact, I'd be dead a long time ago, personally. The school lunch programs, we tear open the

package, we microwave it. It's strictly processed foods. Processed foods are the worst thing in the world for us, and we're feeding that to our kids. Why is this bill-- bad, I guess, is the word I'm reaching for.

NIKI KUBIAK: OK, so you brought up so many things I could talk about with that, but let, let me say this--

G. MEYER: That's my job.

NIKI KUBIAK: Number one, my first thought, as you were talking, is nutrition is an evolving science. That is what drives people crazy.

G. MEYER: But the science changes all the time.

NIKI KUBIAK: That's a-- that's the, that's the evolution of it. And so, with the idea-- it's-- I don't think this bill is bad. I don't think having state dietary guidelines is wise, though. The, the backbone of this bill to utilize local foods and move away from processed foods is honorable, and there's a few other dietitians that are going to support that, that statement as well. We-- we're dietitians. We want people to be eating healthy so that we can stop talking about all the diet culture myths every day and actually help people make these positive changes. But the thing is, is nutrition is evolving and changing, and it is a slow process, because with human, human science, we have to follow very ethical practices, and so it takes a longer period of time to draw conclusions and to learn about how food affects the body. So, it's a, it's a patient process. In regards to some of the ideas with school nutrition, it would be-- we would support having more whole foods within that environment, and with just funding the education programs that are already in existence. We can do that. We don't need state guidelines to, to make that happen. And we can utilize the beef products and the dairy products and things that come from this state, but we, we, we really don't need guidelines or any kind of framework to do that.

G. MEYER: If I may, just one brief question. My understanding, anecdotally, is Europe, Canada, many other countries do not accept food from the United States because of the additives, the, the things we put in our food that are not good for us but extend shelf life. Shouldn't even the state taking a very

proactive approach to a healthy food, which I believe this is-- shouldn't that be applauded rather than try to slow walk?

NIKI KUBIAK: Dietitians are applauding that kind of work. We are not advocating against this bill because we think the concepts are bad; we're trying to protect funding for the federal programs, federally-funded programs that are offering these types of foods and the education to implement them more. So, please don't be confused by that. As far as comparing ourselves to Europe, the thing we need to keep in mind is most countries in Europe are not even as big as Nebraska. And so, our food culture has been shaped quite a bit by our dimension and our geography and our population. And so, we have to approach things a little bit differently so we can make sure that we can transport food safely, that it maybe has a little of a longer shelf life to get from Nebraska to California or wherever it's going. There's ways to do that where we can, we can try to improve and make it healthy and more natural, but we, we really need to be careful not to compare our country to something the size of Vermont, because it's different. We have a different framework. So, we need to look at it from how can we, as the United States, make our food safer, more whole, more natural, and available.

G. MEYER: But it's a unified Europe.

NIKI KUBIAK: You know, I would still say we really need to look--

G. MEYER: It's a big-- it's, it's a big piece of dirt.

NIKI KUBIAK: No, that's fair, Doc-- or, Senator Meyer, but I would, I would still say let's look at the United States and see what we, we can change and improve here, and not compare ourselves to other countries that have different geography.

G. MEYER: OK. Thank you. Appreciate it.

NIKI KUBIAK: Thank you. We appreciate your question.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman [INAUDIBLE]. Thank you for being here. I appreciate that very much. I would like to have you go down the credentials of a registered dietitian so we have some

idea of the level of background and expertise that your testimony brings to us. You weren't able to offer that going in, but I'd like to hear it--

NIKI KUBIAK: Yes.

RIEPE: --to know how you-- what you-- what you've learned, what your experience has been, and, and what it is for the regular dietitian.

NIKI KUBIAK: OK. So, a registered dietitian earns a bachelor's degree in dietetics or food science, or a nutrition-related undergraduate, and then we also have to get our master's degree, which is in part with what's called an internship. So, we're doing clinical work and practice while also getting that master's degree. And then after that, we have to pass a credentialed board exam that's offered by the Commission on Dietetic Registration, which is challenging. And then from there, we have to maintain continuing education units every five years; we have to meet 75 hours every five years to maintain our RD credential.

RIEPE: I also understand that dietitians-- now many insurance companies are recognizing dietitians and they're reimbursing for their service.

NIKI KUBIAK: Yes. We have been advocating and working really hard to get better and more expansive insurance coverage, and we're making progress on that.

RIEPE: OK. Thank you.

NIKI KUBIAK: Thank you.

RIEPE: Thank you, Chairman.

NIKI KUBIAK: Thank you for your question.

HARDIN: OK. We're not well-compensated here in the Nebraska Legislature, so I'm going to get some free nutritional advice.

NIKI KUBIAK: Fair enough.

HARDIN: What should I eat? What should my diet be? What should my diet-- not related to federal funds, but if I came to you

just one-on-one and said, "Ms. Kubiak, will you please help me? What should eat?" And let's just say that we'll, we'll get whatever you say, so money's no object here, OK? What should I eat?

NIKI KUBIAK: So, assuming you are healthy, no chronic conditions, and exercising regularly--

HARDIN: You're putting a lot of conditions on it.

RIEPE: They're suggestions.

NIKI KUBIAK: Well, the, the beauty of a dietitian is that we tailor everything. So, what I tell you is, is going to be pretty general, but if I were really to sit down, it would be specific and tailored to exactly what you need. And so--

HARDIN: And that's kind of-- and I, and I don't mean to gotcha here. I really don't.

NIKI KUBIAK: No, no, you're fine, you're fine.

HARDIN: But I am hearing you say, and believe you, "Uh-oh, we change things, and the fed's going to take their money away" because, believe me, we get beat over the head with that on a regular basis in here, OK? In lots of categories. I guess what I'm trying to get at the root of is, what should we-- what should we-- life's full of "shoulds" and "oughts" and those sorts of nuances and imperatives and yadda-yadda. What should we be eating? Because for being an informational society in an informational age, it is more confusing now than ever.

NIKI KUBIAK: And trust me, the voices are loud, and we are really trying to gain some ground on that and, and help people work through all of the noise. But really, there are five food groups: fruits, vegetables, whole grains, dairy, and our proteins, which can be meat, beans, eggs, things like that. All five food groups fit into a healthy diet. Carbohydrates are not bad. There are quality-- I always say quality carbs, because we tend to classify junk food as a carbohydrate, and junk food is junk food. Let's call it what it is. So, when we look at the quality carbohydrates and we build a healthy diet that includes whole grains, fruits, vegetables, leaner proteins because of the saturated, saturated fat guidelines, which-- I have a couple of colleagues here are going to talk a little more about that-- and

then, our dairy products, you really have a beautifully balanced diet that provides energy, it provides adequate protein for muscle retention and repair. And then you have just enough fat, because if you get too much fat, you get heartburn and inflammation and things that make you don't feel very good. But if you have the right amount of fat, you have good energy, fullness and satiety, and focus, and that's what dietitians want for their patients. We want quality of life, where you're, you're well-fed, you're energized, and you can go do the things that you want to do with your life. That's what we want for people. So hopefully, that gives you a little bit of a idea of--

HARDIN: To, to tag-team with Senator Riepe-- it's, it's true we haven't really incentivized our world to do very well, and major medical companies are no help.

NIKI KUBIAK: Yeah.

HARDIN: And so, otherwise, they might help pay for services like the ones you offer. Any other questions? Thank you.

NIKI KUBIAK: Thank you very much for--

HARDIN: Opposition, LB1194. Welcome.

STEPHANIE RUPP: Thank you. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Dr. Stephanie Rupp, S-t-e-p-h-a-n-i-e R-u-p-p. Thank you for the opportunity to speak in opposition to LB1194, the Real Food Act. I am a registered dietitian-nutritionist, licensed medical nutrition therapist, and university professor who was born and raised in Nebraska and now educates future health care providers, many who stay in Nebraska. Nutrition is a topic that intersects with nearly every discipline I teach. Every day, I'm asked questions about nutrition by students, colleagues, and members of the public. Recently, many of those questions have focused on the release of the new U.S. dietary guidelines for Americans, and how they compare to long-standing evidence-based recommendations. One area already causing significant confusion is the promotion of foods high in saturated fat. While certain elements of the guidelines have merit, specifically eating more nutrient-dense foods, such as fruits and vegetables and whole grains, others conflict with decades of research. As an educator, I spend a considerable amount of time helping learners critically evaluate nutrition guidance, understand nuance, and

reconcile evolving science with established clinical recommendations. Introducing state-level dietary guidelines adds another layer of complexity that will make it even more difficult for the public to know what advice to trust. I educate future physicians, nurses, physical and occupational therapists, dentists, and pharmacists: professionals who will counsel patients on nutrition throughout their careers. Nebraska has not historically maintained its own dietary guidelines. Creating a parallel system would be redundant and counterproductive. State guidelines risk conflicting with what students learn in their professional training, and what they will encounter in clinical practice. This inconsistency increases the likelihood of misinformation, undermines confidence in nutrition guidance, and places health care providers in a difficult position when choosing between state messaging and established clinical standards. I strongly support encouraging the consumption of foods produced in Nebraska and promoting local agriculture; these goals are important and worthwhile. However, advancing LB1194 is not the appropriate mechanism. Not moving forward with LB1194 would allow registered dietitians to continue focusing on science-driven guidance without additional regulatory frameworks. In closing, while LB1194 may, may appear helpful on the surface, it will ultimately create more red tape, increase confusion, and complicate eating for Nebraskans. I respectfully urge you to oppose LB1194, the Real Food Act, and allow evidence-based nutrition guidance to remain clear, consistent, and grounded in science for the benefit for both health care providers and the public. Thank you for your time and consideration.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. I'm always interested in credentials. So--

STEPHANIE RUPP: Yes.

RIEPE: --is your doctorate in specialty in nutritional, or is it--

STEPHANIE RUPP: So, my doctorate is in education with an emphasis in nutrition education. So--

RIEPE: OK. Does the Academy of Nutri-- of whoever offers, do they-- I assume they don't even offer a-- because everybody's a

doctor in the hospital business or healthcare business anymore. But do they offer a, a doctorate in nutritional health?

STEPHANIE RUPP: They do. So, they're-- UNMC actually offers a doctorate in clinical nutrition, the DCN. My doctorate is an EdD, so my doctorate is in education, so my dissertation really focused on nutrition education for health care professionals. So, my doctorate was focused on education, but there are-- there is a doctorate now that's specific to clinical nutrition, but there's also other doctorates out there, you can get, like a doctor in business administration. The doctorates that we see, when we go see a doctor at the hospital, they have a medical doctorate, an M.D. degree.

RIEPE: I also am keenly aware that in the educational environment, a doctorate is almost a requirement.

STEPHANIE RUPP: Yeah, in a lot of educational settings, yeah.

RIEPE: Especially at the university level?

STEPHANIE RUPP: Yes. So, the terminal degree for a dietitian, as Niki was explaining, is the master's degree. Beginning in January of 2024, dietitians have to have master's degrees. If you were a dietitian before 2024, you're grandfathered in, so there may be dietitians out there that don't have master's degrees, but beginning in 2024, they have to have master's degrees. And now, we're seeing a lot of dietitians get doctorates. I went and got my doctorate because I love to teach. I've found that I can make the biggest impact by teaching other future healthcare providers than sitting and working one-on-one with patients, and so the doctorate has allowed me to go that direction with my career.

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

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank for being here, Dr. Rupp.

STEPHANIE RUPP: Yes.

BALLARD: This may be an unfair question, because I'm assuming you have not seen the amendment. But I'll just--

STEPHANIE RUPP: I have not.

BALLARD: I'll just paraphrase. It's very permissive. It says eating fruits and vegetables is encouraged. Fats, dairy is encouraged. Would that-- something like that be kind of a-- "is encouraged" kind of a framework, would that be acceptable?

STEPHANIE RUPP: So, the issue for why I oppose the bill is not the specific components of it, it's just that it's duplicating what we already have at the federal level. If we have the federal guidelines, why do we need state guidelines? And then, in five years, if the federal guidelines get updated, we now have these state guidelines-- and I think someone else was already questioning that earlier-- and then it just gets really confusing. And so, from my place as an educator, working with future health care professionals, I talk about the dietary guidelines in medical school. So, people who are going to school to become physicians, they get two hours. Literally, like two hours from 3:00 p.m. to 5:00 p.m. of nutrition education; that's all I get with them throughout their four years of medical school. And so, I touch on the dietary guidelines, but I don't have a lot of time, you know, to go into them, because I also need to teach about macros and micros and deficiencies and medical nutrition therapy and, you know, carb counting, and so there's not a lot of time to educate on additional frameworks, and it can get really confusing. I mean, the students leave lecture and they're already, like, whiplash because of all the information they got in a short period of time. And so, I don't-- like, yeah, I'm not here to argue the certain foods that are being recommended within the act. It's more just duplicating guidelines that we already have.

BALLARD: Possible confusion with-- OK. Thank you. I appreciate it.

STEPHANIE RUPP: Yeah.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Kind of piggyback a little bit on what Senator Ballard was talking about. One of your comments was contrary to the, the state guidelines, or the state standards proposed in this bill are contrary to what is learned. Isn't that evolving all the time at the federal level? I mean, from the first time you set foot on a college campus to what

you're teaching now, hasn't the food pyramid changed substantially?

STEPHANIE RUPP: So, we're always learning more. With the food pyramid-- we haven't used the food pyramid since 2011. 2011 is when MyPlate came out, and MyPlate reflected the current level of research. As Niki already said as well, doing research with humans is very involved. It has to go through an IRB; there can't be anything more than minimal risk. And so, getting actual data for nutrition is very, very challenging. One of the classes I teach at the university is, actually, the students have to do a literature review on a nutrition topic, and it's really amazing because they go out there and they're, like, I'm going to figure out everything about this and write this paper, and then they're, like, we don't know a lot. We need more nutrition research. And so, it is ever-evolving because we're getting the research, it just takes a lot of time.

G. MEYER: That qualifies as contrary to what is learned though, because it is evolving all the time.

STEPHANIE RUPP: So, we update what we teach based on what the current recommendations are. Like, for example, I believe you mentioned eggs earlier, or someone mentioned eggs. Eggs are lower in saturated fat today than they were in the past, and that's through changing the hen's feed. And so, you know, as we learn things, we're able to be able to update the research, and then also be able to update recommendations that we have. Something that's long-standing, though, is saturated fat intake and cardiovascular health. There is no way I could recommend someone who has heart disease to consume full-fat dairy on a regular basis, to consume non-lean meats or, you know, things that are high in animal fats. Just because that saturated fat is already-- it's going to compromise their clinical state that they're already in. So, we have some pieces of evidence that we have a lot of research on and will stay, and is the evidence-based recommendation, but there are other areas where we're still constantly learning. I mean, I do research, and I love it because I learn something new every day. And there's so much to learn about nutrition. It's underfunded; the FDA spends so much time focused on medicines that the amount of attention that's given to nutrition is actually just a very small portion of the pie.

G. MEYER: I think eggs were-- the primary problem was the cholesterol issue with the eggs.

STEPHANIE RUPP: Yeah, cholesterol.

G. MEYER: So now, that does not appear to be a problem. And so--

STEPHANIE RUPP: Right. Cholesterol-- yeah, it's saturated fat that increases blood cholesterol, not cholesterol. Cholesterol in food is different than cholesterol in our body.

G. MEYER: Sometimes education is a dangerous thing. I, I just have one last question. Foods that qualify for SNAP. Should processed foods be allowed in SNAP?

STEPHANIE RUPP: So, there are varying levels of processed foods. You're probably familiar with NOVA; that's one classification. Varying levels, mind you. I mean, you have green beans, then you have canned green beans, then you have, you know, the green beans that have been, like, puffed, kind of like a Cheeto-like green bean. And so, there's varying levels. Things that are minimally-processed or less-processed are still processed, and yes, they absolutely can hold a place in the diet. For example, canned vegetables with no added salt, just as nutritious as fresh, and it's more affordable for a lot of people. And, if you're going to be, like, throwing it into a casserole, they're going to get soggy anyways, and so paying more for the fresh veggies for that, like, crisp texture isn't necessarily worth it. So, depending on someone's overall diet, what their goal is with cooking, the processed foods definitely can. Things like refined grains-- I mean, the refined grains, they're enriched and fortified; there's B vitamins added. We, we did that because people needed more folate in their diet. And so, it's just about how much someone is consuming and what other choices they're making. If someone has a heavily-processed diet, if they're on SNAP and they're buying sodas, chips, frozen meals, those of course would [INAUDIBLE] be things that they should be limiting. However, if they're going to the grocery store and buying a box of minute rice, canned fruits and vegetables, you know, those foods are still considered processed, but they're very nutrient-dense. So, it really depends on the specific food that the person is purchasing.

G. MEYER: Thank you.

STEPHANIE RUPP: Absolutely.

HARDIN: If I can-- thank you for being here, Dr. Rupp. I was just going to see if you could help me wrestle with something. I'm looking at a CDC listing that's most recent, which means it's two-and-a-half years old. I'm looking at some child health data and so forth online, stateofchildhoodobesity.org and so on and so fourth. Interestingly, our kids are, are fairly good. Our-- this shows our kids are the 41st most obese, so there's 40 states that are more obese than Nebraska. The situation doesn't look nearly so good for their parents.

STEPHANIE RUPP: Yeah.

HARDIN: We're the ninth most obese. And so, square that circle for me, because don't the kids and the parents get home at night and sort of eat together, and on the weekends, and so on and so forth? I mean, it just seems to me like we-- we've got a-- we've got disconnects that are going on somewhere, OK?

STEPHANIE RUPP: Mm-hmm. Yeah.

HARDIN: Secondly, I'm going to follow up, and I want to ask you about whole foods.

STEPHANIE RUPP: OK.

HARDIN: OK? So, start with that first part, because I have a hard time getting my farm boy head around, how does that work?

STEPHANIE RUPP: Yeah, so as we age, we have less time to run around, play. Our metabolism also starts to decrease, but we--

HARDIN: By the way, those snobs down in Colorado, they're number one in both categories.

STEPHANIE RUPP: Of course.

HARDIN: I just wanted to point that out.

STEPHANIE RUPP: Yes, yes.

HARDIN: But keep going.

STEPHANIE RUPP: So, as we age-- and it's about priorities, as well. If eating healthy, exercising is not a priority for someone, it'll catch up with them eventually. So, as kids, it's a lot easier to maintain our weight because they're growing, their metabolism is very high. However, as we transition into adulthood, there's competing responsibilities that are going on. You know, do I drive my kid to their soccer practice so they can play, or do I--

HARDIN: But that's all true, but I guess I--

STEPHANIE RUPP: --take time to work out?

HARDIN: I'm still just concerned about how it flips from one end of that spectrum to the other at, evidently, age 18-and-a-half.

STEPHANIE RUPP: So, it is interesting data. I haven't fully dug into it; I can only speak to what I've known, that I've learned thus far, but that is basically--

HARDIN: Are, are we as parents saying, "do as I say, not as I do?"

STEPHANIE RUPP: That could be a situation as well, and it's very individualized, depending on the family. You know, do they eat family meals? Research has shown that when families dine together, they're healthier; they're at healthier weights, the food on the table is healthier, the children engage in less risky behavior, they have better grades in school. And so, there are many different factors that go into it.

HARDIN: Sure.

STEPHANIE RUPP: What's so different about Colorado from here? I haven't spent much time in Colorado, I'm not overly familiar with it.

HARDIN: I'm just looking at what I'm finding on these lists here--

STEPHANIE RUPP: Yeah, yeah.

HARDIN: --as I'm-- as we're going along. Tell me about whole foods. And again, let's not-- let's not let this be anchored by the federal dollars.

STEPHANIE RUPP: Sure.

HARDIN: I did it; that's a reality. But I'm just looking at it and saying, looking ahead, how do we do whole foods better?

STEPHANIE RUPP: Whole foods. So, when you say whole food, there's not actually, like, a legal definition for what whole food is.

HARDIN: OK, so help me out.

STEPHANIE RUPP: So, it can vary from person to person.

HARDIN: OK.

STEPHANIE RUPP: In the field of diets--

HARDIN: Let me, let me put it another way. Is our current food pyramid that we've used for a long, long time inerrant? Is it perfect? Is it so good that you really can't improve on it?

STEPHANIE RUPP: So, we haven't used the Pyramid since 2011. So we've had MyPlate, and MyPlate is a great tool because it really helps you be able to portion food out. As Niki mentioned, we have those food groups--

HARDIN: So then, throw that out, let's go to MyPlate. Is MyPlate inerrant?

STEPHANIE RUPP: MyPlate is great because it gives you a lot of flexibility and you can customize based on your individual needs.

HARDIN: OK.

STEPHANIE RUPP: I like MyPlate more than the new federal guidelines simply because MyPlate is more of a visual tool. Someone can look at their plate and be, like, oh yeah, it looks like my plate. And that was one of the issues with the pyramid from back in 2010, is you look at this pyramid, and it's, like, OK, well, how does that-- how do I actually implement that? So, the MyPlate was just a little bit more visual.

HARDIN: OK.

STEPHANIE RUPP: And so, that's why that's a great tool to use.

HARDIN: OK, I see. And so, how would you define foods that are better for us, whole, as I would, in my mind--

STEPHANIE RUPP: Yeah. Absolutely.

HARDIN: What is a whole food and what is "put that back, it's not a whole food" when-- if you were to go shopping with me, how many times would you do this as I'm shopping? What is whole food?

STEPHANIE RUPP: I wouldn't do that. I would not do that, because I'm not the food police. So, a whole food is going to be fruits, vegetables-- whether they are fresh, frozen, canned-- as long as there's no added salt, no added sugar. Grains, whole grains. So, you know, the grain has the entire part, but also refined grains, there is a place for those in the diet as well. Definitely more of the grains someone consumes should be the whole grains. However, balance should be achieved. When it comes to meat, we have, of course, beef, pork, chicken, eggs, but we also have our plant-based proteins, which are whole foods as well. So, beans, legumes, nuts, seeds, those are all-- and then dairy. Dairy is going to be a whole food as well, well. Dairy contains nine essential nutrients. Dairy is a wonderful thing to include as part of your diet. The recommendation is three servings of dairy a day. One of the reasons for that is to help you get your calcium intake; calcium's really important for bone health. Milk also contains vitamin D, works in tandem with calcium for bone health. So, the food groups really are what whole foods are. We move away from whole foods once things start to become really processed.

HARDIN: Is it true that if it crinkles, put it back?

STEPHANIE RUPP: No. I eat crinkly foods.

HARDIN: No, I mean the packaging is what I'm referring to.

STEPHANIE RUPP: Oh, oh. No, not necessarily. You could have beef that's vacuum packed and, you know-- raw beef, and it makes a little bit of a crinkle.

HARDIN: I guess I'm just-- I'm referring to, to-- the snack world tends to be dominated by crinkly packaging, so.

STEPHANIE RUPP: Yeah.

HARDIN: Anyway. Senator Quick.

QUICK: Thank you, Chairman. And so one of my questions-- and it was just going off what Senator Meyer was talking about earlier, you know, with the-- so, you know, education, you know, as we go along, and then also with-- maybe there could be threats to the federal funding if we don't-- changing. But I know, even on the state level, if you have a change in administration every so often, whether it's four years or eight years, they come in with all new policies. Would you see us having to come back and, if we put this into statute, change these statutes just to make sure we're staying in compliance with the federal government?

STEPHANIE RUPP: Absolutely. If we are going to have the federal guidelines and the state guidelines, they should be the same. But then it also comes back to my original reason why I'm opposing LB1194, is why have both? If we have it from the federal level, why do we need the state level? If things are going to be turned over to the states, then yes, we should have state dietary guidelines, but if we have the national ones, then, is there really a need for the state ones? Me, as an educator, it's going to a lot easier to teach if they are the same. However, again, do we really need both?

QUICK: OK. And then, you know, with Senator Hardin talking about, you know-- I know when I graduated from high school, I weighed 135 pounds; now I weigh close to 200, so. And I eat with my grandchildren when they come over and my children-- we all eat the same food at the table. But I know they go out and play really hard and I can't keep up with them. So, I know some exercise goes into that as well, right? We should probably be exercising to try to help with obesity, and it's not just always about the food, but could be exercise as well.

STEPHANIE RUPP: Right, yeah, it's a healthy lifestyle overall. Sleep comes into it, as well. If someone doesn't sleep as well, they're likely to be snackier, research has shown. They're want to snack more, which can contribute to excessive calorie intake, which could lead to weight gain. So, it's really coming at it from a holistic perspective and having a healthy lifestyle: healthy diet, being physically active, getting good sleep, not smoking, not overly consuming on alcohol, having preventative

medical care. So, the best way to achieve health is-- it's multifaceted.

QUICK: All right, thank you.

HARDIN: Other questions? Seeing none.

STEPHANIE RUPP: Thank you.

HARDIN: Thank you. Opponents. Welcome.

CARRIE NIELSEN: All right. Good afternoon, Chairman Hardin. Do I need to turn this up a little bit more? Can you guys hear me all right?

HARDIN: Sure.

CARRIE NIELSEN: Excellent. And members of the Health and Human Services Committee, my name is Carrie Nielsen, C-a-r-r-i-e N-i-e-l-s-e-n, and I am testifying in oppose-- opposition of LB1194, the Real Food Act. I'm a registered dietitian-nutritionist and licensed medical nutrition therapist, and I serve as the former president and current delegate of the Nebraska Academy of Nutrition and Dietetics, representing registered dietitian-nutritionists across the state of Nebraska. First, we would like to thank Senator Storer for introducing this bill, recognize the importance of dietary quality for the health and wellbeing of Nebraskans, which the Nebraska Academy supports. However, we have concerns regarding LB1194, with Section 4 being the first. The second paragraph features recommendations for fat intake, stating "the bulk of fat consumption shall be encouraged from whole food sources, including meats, poultry, eggs, omega-3 rich seafood, nuts, seeds, full-fat dairy products, olives, and avocados." While this emphasizes a variety of whole foods to supply fats in the diet, it does not include guidance on saturated fat intake as a part of an overall healthy diet, or in the management of chronic nutrition-related diseases. I have worked for over 20 years providing nutrition education to individuals with chronic nutrition-related diseases. Evidence-based research has shown a direct correlation between diets high in saturated fats and the development of heart disease. When I work with patients in-- with heart disease, the framework for education includes a discussion on fat intake, specifically saturated fats. Understanding the importance of a reduction in the intake of saturated fats is essential to positive health

outcomes in an individual's health journey. LB1194 does not provide any specific guidance in this area. Our second concern pertains to second [SIC] five, paragraphs two and three, that direct all state agencies to update their educational materials and promote adherence of the state dietary guidelines to their partnerships, including health care providers. I'm employed at a hospital accredited by the Joint Commission, which is a regulatory body that ensures hospitals are following the Centers for Medicare and Medicaid Services guidelines. One of the regulations is that the hospital maintains a diet manual approved by medical staff and a registered dietitian. This manual provides evidence-based guidance for therapeutic diets for various medical conditions. If the state government were to direct what health professionals educate patients on, these guidelines would not align with hospitals, health clinics, and community health centers complying with these national regulatory standards. State dietary guidelines are not necessary to improve the health and wellness of Nebraskans, and, if passed, LB1194 will create more obstacles to achieving improved health outcomes across our state. On behalf of our nearly 400 members of the Nebraska Academy of Nutrition and Dietetics, we respectfully request that you oppose LB1194, and we welcome the opportunity to strengthen efforts to improve access to healthy whole foods while adhering to evidence-based nutrition science. I can answer any questions you may have.

HARDIN: Thank you. Questions? Seeing none.

CARRIE NIELSEN: OK.

HARDIN: Thank you.

CARRIE NIELSEN: Thank you.

HARDIN: Opposition to LB1194. Anyone in the neutral? LB1194. Senator Storer, welcome back.

STORER: Thank you, sir. That was a robust conversation, which is good.

HARDIN: It was. If I can real quick, I'll just say that we had 6 online that were proponents, 28 opponents, 1 in the neutral.

STORER: A couple things. I always just sort of take notes as I listen to the testimony and try to come back with as many

answers as I can, or as much information as I can. And I want to emphasize this, and I understand that the three clinicians here didn't have the advantage of seeing the amendment that I've offered to all of you. But what I'm, what I'm hearing is they have grave concerns about this being prescriptive and sort of superseding federal regulations. And again, I cannot stress to you enough, this is not prescriptive; this is-- the underlying intention is just sort of to put some very broad guidelines in place that provide for education and very, very general guidance. And they-- the, the-- those five-- interestingly enough, I think one of the dieticians did mention, you know, the importance of the five food groups, which are the same five food groups that are outlined and emphasized in the bill: protein, fat, fruits and vegetables, dairy, and whole grain. Those actually are the five, the five areas in Section 4. We, we very intentionally didn't want to-- we're not trying to write individualized diet plans for anyone. They-- there is no quantities, there's nothing in that kind of detail. This is just very broad, keeping in line with those five main food groups and the dietary guidelines that have recently been released, which are, are developed with tremendous input from registered dietitians, Senator Riepe. So, those, those federal guidelines didn't, didn't just fall out of the sky. Again, this is not prescriptive; this is really intended to be educational. And we talk a lot about the, the desire, I think, consumers in general-- this has been a growing trend, but even more so now-- a desire to connect to their local food systems. Most people agree that the closer you can, you can purchase, get-- purchase your foods, fresh, wholesome, and, and grown by particularly family farms and ranches, typically, that-- that's becoming more desired, and that-- that's another one of the underlying premises of the bill. So, the only, the only "shall" that is left in the bill after you would adopt that amendment would be simply including information on foods commonly produced in Nebraska when we educate people on dietary guidelines here in Nebraska. I, I can't in the-- my wildest dreams imagine a downside to doing that. You know, we take for granted-- and I, and I will be the first to confess that, you know, growing up on, on a ranch and raising, raising beef in my particular protein world, you know, we, we take for granted what's available to us. And the more-- the older I get and the more I realize, the more detached society in general becomes from agriculture, the more challenging it is to help connect people with their food sources. And, and this is really the-- again, the underlying premise of the Real Food Act. And we are an ag state. We have so much to offer the citizens of Nebraska here. And as we continue

to try and bridge that gap-- we talk a lot about the urban-rural divide, which, you know, you know, I dream of a day that doesn't exist, and this is yet one more proactive measure to help build that bridge. And so, again, happy to answer any questions, but for the-- for most of the testimony that was in opposition, there is nothing prescriptive here. This is very educational in nature.

HARDIN: Questions? Thank you.

STORER: Yes. Thank you.

HARDIN: This concludes LB1194. Next up, LB1144.

FREDRICKSON: Chair Hardin, you're welcome to open.

HARDIN: Thank you, Vice Chairman Fredrickson, and good afternoon, fellow Senators of the Health and Human Services Committee. I'm Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball, and Scottsbluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB1144. LB1144 is a simple housekeeping bill. It updates Nebraska Medicaid statutes so they line up with current federal requirements on third-party liability. During a federal audit, DHHS was notified that some of our state laws had fallen behind federal standards, and this bill simply brings us back into alignment. Medicaid is intended to be the payer of last resort, and when another insurer should have paid first, the state has a responsibility to collect those funds. LB1144 helps remove unnecessary administrative hurdles so that process works more smoothly and efficiently. At the end of the day, this bill modernizes state law and helps ensure we are good stewards of taxpayer dollars. I'm happy to answer any questions that I can, but Director Gonshorowski is here in person to further address the needs for this legislation. Thank you.

FREDRICKSON: Thank you, Chair Hardin. Are there questions from the committee? Seeing none, will you be here for close?

HARDIN: Yes.

FREDRICKSON: Sounds good. We will now take proponents for LB1144. Welcome.

DREW GONSHOROWSKI: Thanks for having me. Good afternoon, Vice Chair Fredrickson, 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, of Medicaid and Long-Term Care in the Department of Health and Human services. I'm here in test-- here to testify in support of LB1144. Thank you to Senator Hardin for introducing this bill on behalf of DHHS. This bill works in two ways to improve the efficiency and effectiveness of Medicaid operations. First, this is an effort to clean up state law to come into alignment with federal law. Having "antiquidated" laws on the books only serves to add confusion, and we are committed to simplifying state government where possible. LB1144 will make technical changes to the definition of a health plan. The expanded definition will now include managed care organizations, pharmacy benefit managers, service benefit plans, and other entities that are legally responsible for paying healthcare claims. This bill also extends the time period for recouping medical claims and cases where DHHS discovers third-party coverage. Under the proposed legislation, third parties will be required to respond to any inquiries from Nebraska Medicaid within three years of the date of service. LB1144 also improves state revenue cycle operations. Medicaid is the payer of last resort, which means that when we discover that another health plan should have paid first, we have an obligation to collect from that health plan. This bill removes many administrative hurdles in the state's path to collect those funds, making these efforts more efficient and effective. Additionally, it ensures that third parties cannot deny claims from the state due to procedural issues such as the timing of claim submissions, the format of claim forms, or a beneficiary's failure to provide documentation at the time of purchase. If the state submits the claim within three years or enforces its rights within six years of submission, these procedural restrictions will not apply. This provision helps ensure that Medicaid functions as the payer of last resort as required while also protecting taxpayer money. We respectfully request that the committee advance the bill to General File, and thank you for your time. I'd be happy to answer any of the questions you might have on this bill.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Senator Quick.

QUICK: Yeah, thank you, Chairman. Or, Vice Chairman. Would this affect anybody who actually, like, receives services, or does it just go back to the insurance provider?

DREW GONSHOROWSKI: No, it, it shouldn't affect anyone that receives services [INAUDIBLE].

QUICK: So-- yeah, they wouldn't come back on the actual person--

DREW GONSHOROWSKI: Yeah.

QUICK: --who actually-- they paid for their procedure or whatever through Medicaid. Just to make sure they're not-- they wouldn't come back on them and make them pay it back when they financially can't.

SETH MITCHELL: Yeah. Most, most of this cleanup is specifically targeted at cleaning up our processes around TPL, which is third-party liability.

QUICK: OK. All right. Thank you.

FREDRICKSON: Other questions from the committee? Seeing none. Thank you for being here.

DREW GONSHOROWSKI: Thank you.

FREDRICKSON: Next proponent for LB1144. Seeing none. Is there anyone here to testify in opposition to LB1144? Seeing none. Anybody to testify in the neutral capacity?

ROBERT M. BELL: Good afternoon, Vice Chairman Fredrickson, and members of the Health and Human Services Committee. My name is Robert M. Bell, last name is spelled B-e-l-l, and today I'm serving as an Executive Director and registered lobbyist for the Nebraska Insurance Federation. We are appearing today neutrally on LB1144. Since this is the first time before the Health& Human Services committee in this role, a little bit about the Nebraska Insurance Federation. The federation is the primary trade association of insurance companies in Nebraska. The federation consists of 50 member companies; members write all types of insurance. Nebraska insurers provide high-quality-- high-value quality insurance products to Nebraskans that provide financial protections to Nebraskans during difficult times. Insurance companies also have a significant impact on the Nebraska

economy; by any measurement, the Nebraska insurance industry is one of the largest in the nation. According to a study recently completed by the University of Nebraska-Lincoln Bureau of Business Research, the insurance industry has a $25.77 billion impact on the Nebraska economy, and provides over 32,000 jobs to Nebraskans. The average wage for a Nebraskan working in the insurance company is nearly $92,000. Nebraska insurers have no issues with LB1144, which updates state law to reflect federal law on coordination of benefits to the Medicaid program, and insurers certainly understand that Medicaid is the payer of last resort, resort. As a result, we are neutral on this bill, but one issue I just wanted to flag-- I was asked to flag by Federation members for the committee to highlight is the nature of the information received by insurers from in the Department of Health and Human Services. These coverage and coordination inquiries, or coordination of benefit inquiries for some insurers, come in paper form, and in very large volumes from the department. I had one company share a story of 2,000 individual paper requests, which is very time-consuming for the insurer; we assume that's very time-consuming for the department to put together, as well. Another insurer shared that the verification requests are so numerous that they actually show up in boxes. We're happy to do our part, however technology is a powerful tool that we would like to leverage to make the verification process smoother, speedier, and more accurate for both insurance-- the insurance industry and the department. Last Friday, the insurers and the department had a nice conversation on moving forward with electronic transmittal of verification information in hopefully the relatively near future, and we are looking forward to more conversations with the department soon, as we hopefully move to some sort of electronic verification system. I do appreciate the opportunity to testify, and look forward to further discussions in the future.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? I have one. Was-- what-- so, I-- when I heard, like, the numerous paper forms,--

ROBERT M. BELL: Right.

FREDRICKSON: Would the Federation prefer to-- for those to be digital, or is that like-- is that the kind of a--

ROBERT M. BELL: Yes. We want, we want-- so, one of the-- excuse me, I'm going to go grab a Kleenex here. Battling a little bit

of something here. Right now, as we move and we work with healthcare providers and other insurance companies and other entities on coordination of benefits or payments, what we want to do is have everything happen electronically. If you think about going to the pharmacy, you get a prescription, you know, wired in or called in to a pharmacy, that claim is adjudicated almost immediately in front of, of, of the consumer so that he can get their, you know, prescription and move along. Of course, there's always sometimes some issues related to some of those types of things. But we want that information electronically so we can utilize our IT to do it smoothly. And I think for some insurers, it does come electronically, but just not all. And keep in mind, we're just not talking about health plans, we're also talking about life insurers that would sell dental programs or other limited benefits type of insurance policies in there, and they understand that they need to-- if they have an insurance policy, Medicaid is the last one, or-- of-- it's the last payer of resort. No problem with that, but just want that information electronically, so. And we're hopeful that, you know, over the summer, more of an interim, we'll get that worked out with the department. So.

FREDRICKSON: Understood. Yeah, thank you. Other questions from the committee? Seeing none. Thank you for being here.

ROBERT M. BELL: You're welcome. Thank you.

FREDRICKSON: Anyone else to testify in the neutral capacity? Seeing none. There were 0 online comments for LB1144. Senator Hardin, you are welcome to close.

HARDIN: I would concur with Robert Bell. In fact, as I serve in BCI as well, we definitely hear lots of things about "let's update our systems" and, and "make things electronically viable" and so on and so forth. We've been hearing a lot of bills to that effect in there. And so, anyway, yeah, this is just about aligning some things, and we're trying, trying to get into the 21st century. So.

FREDRICKSON: Questions from the committee? Seeing none. I'm up next, so.

HARDIN: Oh you're up next?

FREDRICKSON: Senator Riepe, do you want to--

HARDIN: Senator Riepe, will you go? I've got to go somewhere else. OK.

RIEPE: Sure, sure.

FREDRICKSON: All right. Thank you, Chair Hardin. We'll move on to the next bill, which is me, so Senator Riepe, you'll take the reins.

RIEPE: Take the throne. Welcome, Senator Fredrickson. Please go forward.

FREDRICKSON: Thank you, Senator Riepe. All right. Good afternoon, 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 central-west Omaha. I'm here today to introduce LB1132, which is a bill that would direct the Department of Health and Human Services to file a state plan amendment to establish a specific reimbursement rate for coverage of long-acting injectable and extended-release medications for individuals with a serious mental illness or a substance use disorder in specific settings. Over the interim, I attended a Council of State Governments public health policy academy, where one of the issues discussed that stood out to me was the impact of providing an individual long-acting-- with long-acting medication at the time that they are seeking medical care. For example, someone who is experiencing an acute psychotic episode and is seeking care at a hospital, getting the medication in a long-acting form instead of releasing them with a few days supply of medication with instructions to set up a follow-up appointment could have lasting impacts on the potential health outcomes for that individual. Long-acting injectables can provide therapeutic levels of FDA-approved medication for a month or more with a single dose, and are associated with a lower risk of hospitalization than oral antipsychotics across multiple studies. Hospitals are often a primary point of contact for patients like this, and we've seen a significant increase in hospitalization rates for patients with acute mental health crises over the past couple of decades. Prior to introduction and at the CSG summit this past fall, Nebraska was not listed as a state where this is covered. However, after introducing this legislation in discussions with providers, it sounds like some may be receiving these reimbursements, but the data on how many and where is unclear. LB1132 would ensure that these medications

are being reimbursed at their own distinct and separate rates. Hospitals are typically reimbursed at an all-inclusive daily rate, which is inadequate to cost-- to cover the cost of long-acting injectables. While the fiscal note expresses skepticism from the department that CMS would approve this state plan amendment, this change has been made in states like Massachusetts, Illinois, Virginia, and Georgia. Additionally, the fiscal note acknowledges that this could-- change could result in potential savings to the budget. So, kind of to just take a step back to put a finer point on this-- so, so long-acting injectables are a fairly new form of medication. And so, what-- the, the reason that I was really wanting to pursue this legislation is that someone who's worked in, obviously, the mental health field in my-- in a prior life, I consistently saw cases where patients would come to the ER, they would be stabilized, may be given a medication, and then of course they would be discharged when they-- once they were stabilized with a, a refill, and then hopefully a follow-up appointment. Oftentimes, what can happen is that when an individual is discharged, especially an individual who might have severe symptoms-- so, so psychosis, for example. Medication adherence can sometimes be a challenge, and sometimes if a follow-up appointment takes a long time to obtain, that can be also risky if the individual might need a refill, for example. Long-acting injectables are-- it-- it's, it's almost like a vaccine. It's a, it's a-- it's an injection, and it can provide stabilizing effects for a patient for up to a month, in some cases a little bit longer than that, without the need to take daily medication or medication on a regular basis. And so, the real kind of goal behind this legislation was to ensure that individuals who were being discharged with potentially a long wait for a follow-up appointment, that they would be stable, at least from a medication perspective, during the duration of that time while they waited for their follow-up appointment. I initially-- so, again, as I mentioned in my opening, it was my understanding initially that we were not reimbursing for this as, as a state, at least it hadn't been listed as one of the states that does this. But I did hear from providers that they are, in some cases, receiving this reimbursement, which is a-- which is a positive thing. And this bill would just simply ensure that that would continue to occur. So, happy to answer any questions from the committee.

RIEPE: I'm sure we'll have some questions there. Let me go with Senator Quick.

QUICK: Yeah, thank you, Chairman. So, one of my questions would be, would, like, MAT treatment be-- are they qualified under this or not? You know? Because I know there are some where they receive a shot, it lasts for several-- you know, maybe it lasts, I don't know, two or three months, or maybe it's a month. I can't remember. But I know that's better for them than, that-- of course, there maybe isn't something they're going to-- well, there is stuff they can take over the counter. I mean, not over the counter, but be given that they can take-- they can swallow, too.

FREDRICKSON: So, this is-- this-- so, this, this would specifically be for injectables, but it would be for severe mental health diagnoses as well as substance use. It was funny, when I first was talking about this bill, someone asked me if this would be for, like, Botox, and I said no. It's, it's specifically for severe mental illness and substance use. I-- I'm not familiar enough to know whether or not some of the MAT interventions are considered LAIs or long-acting injectables,--

QUICK: OK.

FREDRICKSON: But if they were, then, you know-- and it was a substance-use-related long-acting injectable, then I, I would presume that that would be included, if, if that were the case.

QUICK: And I, I know I talked to you earlier today about this, this-- and he's 18 years old, but he has autism, and, you know, acting out. Would-- and he probably wouldn't take anything by mouth, so would something like that, for treatment for someone in that case, to maybe help him deal with those, you know, his aggression and those type of things-- would that be useful? I mean, helpful. Or would-- he would qualify for that?

FREDRICKSON: Yeah. So, you know, I, I, I want to speak sort of as my-- in my role as, like, a senator. I, I-- I'm not a prescriber, so I, I, I-- you know, I would defer to someone who, who has prescriptive authority over that. But in theory, yes, I mean, one of the benefits of a long-acting injectable would be if you do have someone who has a history of difficulty with medication adherence, if for whatever reason managing or taking daily medication is a, is a challenge for someone, long-acting injectables can be really beneficial because, again, you get the injectable and, you know, depending on the, the, the condition,

it can, it can be sort of your medication for the, for the entire month, which, which is pretty significant.

QUICK: OK, thank you.

RIEPE: Senator Meyer.

G. MEYER: Thank you, "Vice-Vice-Chairman" Riepe, "Semi-Vice-Chairman" Riepe. Meaning no disrespect. Are these for personal injectables? Do these people inject themselves? Is this something that is clinically administered? You talked about sending medication home. And, and so let's say, as an antipsychotic, generally-- and with an anti-psychotic, and given some of the challenges of that particular ailment, getting someone to take their regular medication is difficult, let alone an injectable.

FREDRICKSON: Mm-hmm.

G. MEYER: So, would this have to be administered by, by a nurse or someone specifically designated?

FREDRICKSON: Yes. So, the bill is for a state plan amendment specifically for administration within a hospital emergency department or inpatient setting, including a state hospital or state psychiatric facility. So, these would be administered in those specific clinical settings.

G. MEYER: You'd mentioned sending it home with them, but that really wouldn't necessarily be the case? They would have to--

FREDRICKSON: Oh, so, I was referring to, for example, if, if they had, like, an oral medication. So, if they were prescribed, for example, like, an anti-psychotic medication, and they were sent home with a prescription, like a bridge prescription to kind of gap them to their follow-up appointment. This would be different because it wouldn't require additional taking.

G. MEYER: I see long-acting injectable and extended-release medications.

FREDRICKSON: Yes.

G. MEYER: So, the extended-release medications would be oral, so. In all probability. All right, thank you.

RIEPE: I have some-- a couple of questions.

FREDRICKSON: Sure.

RIEPE: Mine was-- you talk about the-- so, they're not like insulin, able to the patient for just do self-injections? Because of-- they're more dangerous, or more at-risk, or is--

FREDRICKSON: So, I don't, I don't know for sure if there are ever self-administration of long-acting injectables for mental health or substance use. It's possible there are. For this bill specifically, it's looking for Medicaid coverage, split state plan amendment for the coverage of that in the specific settings indicated. So, a hospital ER. So, the-- that-- it's possible that if an individual does stabilize over time on an LAI that their provider may prescribe that for at-home use, but the specific context of this, this-- these are likely folks who are not stable because they are seeking care, like, in an emergency type of setting.

RIEPE: OK. So they might-- excuse me-- they might not be up to the discipline necessary to routinely take their injections [INAUDIBLE].

FREDRICKSON: Right. And the idea here being that-- for example, like, if you are someone who has, has, has been psychiatrically hospitalized, you know, you are-- you've been assessed to be at a level of disrepair, for lack of a better word.

RIEPE: Sure.

FREDRICKSON: [INAUDIBLE] And so, you know, one of the things that, that, that can happen with an individual, if they are not given an LAI, for example-- so, if they instead are given an oral medication, you know, they leave the hospital, if they have issues with housing-- so, if they're unstably housed, if they have chaotic home environments outside of the hospital, you know, medication can be lost. People can-- medication can be sold. You know, there's, there's so many different things that can happen in that. With an LAI, you get that injection before you're discharged.

RIEPE: Mm-hmm.

FREDRICKSON: You don't need any additional medication for, for another month. In other words, it's, it's, it's like a vaccine in a way; it's, it's something that stays in your system. And so--

RIEPE: OK.

FREDRICKSON: --you know, it, it, it-- in, in theory, you're stabilized while that medication is in your system.

RIEPE: Is there a cost variance between the LAI and what's currently done? I'm not sure what's currently done.

FREDRICKSON: That is a question that I could get back to you on. I don't know off the top of my head.

RIEPE: I'm just curious of--

FREDRICKSON: There is, though-- as you can see in the fiscal note, they do indicate possible cost savings for the state if Medicaid were to-- CMS were to approve the state plan amendments. So, to me, that would indicate-- so, the state currently-- if, if the state is reimbursing for this out of state funds, if Medicaid or CMS were to approve the SPA, then that would be federal funds that would cover that.

RIEPE: Good for you. I assume that these prescriptions are refillable too? So it's--

FREDRICKSON: Yeah, I mean that would be at the, I think, the clinical judgment of the prescriber whether or not, but yeah.

RIEPE: OK. The only other one that I have is-- I believe I picked up in your-- you said in your prior life as a mental health professional. So, does that mean that you're now a professional politician?

FREDRICKSON: Oh gosh. I, I, I-- I'm-- I serve as a lawmaker currently.

RIEPE: OK.

FREDRICKSON: How's that for a pivot?

RIEPE: Fine. OK, are there other questions? Seeing none. Thank you very much for being with us and opening.

FREDRICKSON: Thank you.

RIEPE: We are going to assume you'll stay around?

FREDRICKSON: I will.

RIEPE: OK. We'd like to now have proponents, those speaking in favor. Seeing none, are there any opponents? Seeing none. You're either very popular or not popular at all. Anyone in the neutral capacity? Well, we do have one. Thank you, sir. If you'd be kind enough to state your name and spell it for the record, and then you're approved to go process. Go ahead.

JOHN MEALS: Sounds good, thank you, Senator. Good afternoon-- what did you call him, Senator Meyer? "Vice-Vice-Chairman Riepe?" Members of the HHS committee, my name is John Meals, J-o-h-n M-e-a-l-s, and I am the Chief Financial Officer for the Department of Health and Human Services. I'm here to testify in a neutral capacity on LB1132. LB1132 would require the department to, to submit a state plan amendment and regulatory updates related to long-acting injectable and extended-release medications. The department would point out that these medications are already covered or are already a covered Medicaid benefit under 42 Code of Federal Regulations 440, as covered outpatient drugs under Section 1927 of the Social Security Act. As a result, the bill does not necessarily create a new coverage category but layers statutory and regulatory requirements on top of benefits that are already authorized and available within the state of Nebraska Medicaid program. So, as the bill would mandate Medicaid coverage of these injectables and extended-release medications when they are administered in hospitals, emergency departments, inpatient settings, and then state psychiatric facilities, including the regional centers, this requirement directly conflicts with long-standing federal law prohibiting federal financial participation or federal funds for services that are provided to individuals aged 21 to 64 in institutions for medical-- for mental disease or IMDs under Section 1905 of the Social Security Act. The-- thus, under current federal law, HHS is prohibited from claiming any federal match for these medications when they are administered at the Lincoln and Norfolk regional centers, as they meet the defin-- as those locations meet the definition of an IMD. However, if

the federal government were to approve the state plan amendment, then a portion of the costs that are currently funded through state general funds would become partially federally-funded. However, as this conflicts with long-standing federal law, it is not likely that the SPA will be approved. Thus, the department would recommend that any budget impact is not recognized until after approval from CMS is obtained. Thank you for your time, and I'd be happy to answer any questions.

RIEPE: Thank you. We'll see if we have some questions. Senator Meyer.

G. MEYER: Thank you, "Vice-Vice-Chair" Riepe. So, the Lincoln and Norfolk regional centers, they are considered too large? As I look at the fiscal, it, it delineates that facilities with more than 16 beds would, would be excluded. Is that the specific reason why they are excluded?

JOHN MEALS: I don't know about the bed size, but it's because they're an IMD; they're, they're a, a institution for mental disease, and that's what's prohibited. They're a state psychiatric hospital, and that's what is the sticking point here. So, I mean, as far as, like, any hesitance from the department, it's-- that's where CMS would likely not approve; it's paying for these medications with Medicaid funds for individuals that are in a state institution. So, like, right now, we have-- I believe it's 87 people was the number I got yesterday-- people that are either at LRC or NRC that are receiving these types of injections or injectable medications, and the cost is around $2.8 million a year right now; that's all general funds. If the SPA were approved and the feds would allow us to charge Medicaid for those medications-- and obviously, just over half of that cost would become federal funds, and that's to Senator Fredrickson's point, where there could be a savings here, that's just been a long-standing federal law that it's not likely to pass. And, and, I mean, the one thing that we would point out is, while that could be a benefit to the state, it is not just a simple process to complete a SPA, which is why we haven't already done this, because there's not a huge chance that it gets-- that it gets approved by CMS. I would say-- I mean, I, I think the department is more than happy to work with Senator Fredrickson on-- if there's something that we need to change within the current state plan that would alter what is already approved for these, you know, injectable medications. But from what I understand from our pharmacy people, this is

already a covered service, so we would have to work with Senator Fredrickson on anything that would be able to be changed.

G. MEYER: So-- and, and it, it may not be within your purview, and, and-- or anyone in the room. Some-- is there some reason why the difference in beds makes a difference? Is there another program that's funding in the plus-16 bed facilities? Is there, is there some other payment structure that they're receiving as opposed to the Medicaid?

JOHN MEALS: I don't know the answer to that, Senator, but we can get back to you.

G. MEYER: OK. I just thought it was interesting that there's a delineation there--

The 16-bed?

G. MEYER: --at 16 beds or, or more, so.

JOHN MEALS: We can get you back to.

G. MEYER: Thank you.

RIEPE: Senator Quick?

QUICK: Yeah, yeah. Thank you, Chairman. So the-- does the-- are you saying the state actually pays for-- who's-- who pays for the medications now?

JOHN MEALS: So they're a covered service in the Medicaid plan. So if, so if a hospital is administering these, they can already bill Medicaid for it, right?

QUICK: OK.

JOHN MEALS: I mean, a person has to be eligible for Medicaid. That is all already in place. To Senator Fredrickson's point, I think he mentioned once or twice that, that this actually is a covered service now.

QUICK: OK.

JOHN MEALS: So, if there's something we can work on with him to-- I don't know if we even have any room to expand it. If it's

already covered, I think it largely depends on the drug being administered. You know, I, I-- there's-- I don't want to say a ton of these, but there's probably a wide variety. I mean, when we talked to our pharmacies, they say there's a, there's a wide variety of these drugs that have all different costs associated with them. But at a high level, they're covered under our Medicaid state plan and would already be reimbursing the Medicaid portion for people that are eligible.

QUICK: And, and then the facilities, who-- where, where does the-- where-- who pays for that? I mean, if there are-- I mean I know many people--

JOHN MEALS: At LRC and NRC?

QUICK: Yeah.

JOHN MEALS: So, it's just all state general funds. So, the issue is whether or not--

QUICK: Oh, so that-- so they're still paid for, they just [INAUDIBLE].

JOHN MEALS: Yeah, they're still paid for. Like I said, we spent about $2.8 million last year--

QUICK: OK.

JOHN MEALS: --on the 87 individuals in the last fiscal year. So, if the SPA were to be approved, then roughly half of that would become federal funds instead of General.

QUICK: OK.

JOHN MEALS: That's where the savings comes from, but--

QUICK: OK.

JOHN MEALS: --it's not likely to get it, yeah.

QUICK: It, it's kind of a-- I was just trying to get up straight in my head, and I--

JOHN MEALS: Yeah. Yep, yep.

QUICK: You, you explained it a couple of times now, so. I'll get it there.

RIEPE: OK. Thank you. I have a-- maybe a couple of questions.

JOHN MEALS: Sure.

RIEPE: In the third paragraph of your piece, you note that the bill would be mandatory for Medicaid coverage and for the injection, and I'm, I'm questioning that, because, quite frankly, the real cost may come in here just to do an emergency visit. And, and under the managed care organization plans, if it's not designated an emergency, they will cut the price in half. I'm saying, does this really have to be in it-- mandated that it be in a hospital, which translates into inpatient, or hospital translates into emergency department, or hospital that translates into an urgent care center, all of them extremely expensive. So, they add on to the cost of this particular therapy which may or may not be necessary if one walks away from the mandated that it be there. And in today's environment in healthcare delivery, we're moving a lot of ways, things away from the hospitals or the emergencies if they're not, because they're clogging up the system, too. Is there any way to work with the managed care organization-- both managed care organizations because of Medicaid patients, or just patients in general to make sure that this doesn't become, by statute, a mandatory which will then last for 30 years?

JOHN MEALS: I want to make sure I answer your question, Senator.

RIEPE: It was a long one.

JOHN MEALS: I-- it's the bill-- my understanding-- the paragraph in the bill mandates coverage for all of those different institutions, if I remember correctly, in the last paragraph of the bill. So, it's not the MCOs that are mandating it; it's, it's LB1132. That's my understanding.

RIEPE: Oh, so we have some flexibility in maybe loosening that? We'll talk to the--

JOHN MEALS: We would have to work with Senator Fredrickson.

RIEPE: --the sponsor of the bill.

JOHN MEALS: OK. I believe.

RIEPE: OK. I have no other questions. Does anyone else have anything? Thank you very much for being here.

JOHN MEALS: Thank you.

RIEPE: Are there any other neutral testifiers? Seeing none. Senator, you're welcome to take the two steps back to the chair.

FREDRICKSON: Aww.

RIEPE: And we do have-- well, you're going too fast. Those long legs, you get there too quickly. We had 0 online comments for LB-- whoops. We had 5 proponents and 1 opponent, and 1 neutral.

FREDRICKSON: I think that was maybe the wrong bill. I think I have six.

RIEPE: No, that's my bill. Who could be opposed to my bill? 6 proponents, and none for yours. That doesn't seem right.

FREDRICKSON: OK. Thank you, Senator Riepe. I'll, I'll keep this fairly brief. So, you know, I, I, I appreciate the department's work. I-- and as I-- I'm obviously more than happy to work with the department. You know, my, my real goal, kind of as I said in my opening of this, of bringing this legislation initially, was trying to ensure that there was no disincentive from when you have a patient who is-- who has a very severe mental health concern or substance use concern, if you have them in the hospital, if you have them in ER, making sure that they're getting the best care available to them that gives them the highest likelihood of, of stabilization and success in the long term. So, I initially brought this bill because, again, when I was at this-- I was at a mental health policy academy, and they were-- Nebraska was not a state that was listed. Again, as I said, after I brought this bill, I found out from providers that they are being reimbursed for this. That, that-- that's, that's good news. I mean, that, that-- that's always a, a pleasure-- a pleasant thing to find out when you, when you bring a piece of legislation. I, I-- and I hear the department's concerns. I, I-- you-- again, I don't want to put unnecessary work on the department. They are-- they're very busy, and they're only going to get more busy in the months to come, so I, I, I know a, a state plan amendment is no short ask. And so, if, if there's a

way around that, then that's certainly something I'm open to discussions related to. As I said in my testimony as well, there have been some cases of states, including Massachusetts, Illinois, Virginia, and Georgia who have been successful with this initiative. So, not impossible; maybe a long shot, but it is something that is possible out there. But happy to answer any questions.

RIEPE: OK. Are there any questions? Must have done a good job.

FREDRICKSON: I hope so.

RIEPE: Thank you very much for being here.

FREDRICKSON: All right. Thank You.

RIEPE: That concludes the LB1132 hearing, and I would now joyfully return the Chairmanship, the-- to Senator Fredrickson.

FREDRICKSON: OK, thank you. We are now moving on to LB732. Senator Quick, when you are ready, you are welcome to begin.

QUICK: Good afternoon, Vice Chairman Fredrickson, and members of the Health and Human Services Committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35. And today, I'm introducing LB723. LB723 directs Nebraska DHHS to adopt certain strategies in their implementation of the upcoming Medicaid expansion work requirements to ensure they work efficiently for our state and for Nebraskans enrolled in Medicaid. First, I wanted to start with some background on the new Medicaid expansion work requirements. As I'm sure you remember, Congress passed a federal budget reconciliation package in July of 2025. There are a number of names for the bill; you may recognize as the One Big, Big, Big Beautiful Bill Act, the Working Families Tax Cut Act, or H.R. 1. H.R. 1 included historic changes to the Medicaid program, one of which is first-- is the first ever federal requirements for work requirements in Medicaid. The work requirements are called community engagement requirements in H.R. 1 and in LB723. The work requirements will be, will be required only of Medicaid expansion-- of the Medicaid expansion group, which provides necessary health carry-- health coverage for low-income adults ages 19 to 64. Under the 138% of poverty level, about 70,000 Nebraskans are currently enrolled in the Medicaid expansion category. Generally, the new federal rules will require Medicaid expansion enrollees to demonstrate that

they have participated in 80 hours of work or other qualifying activities in a month, or meet an exemption to the work requirements. There is a lot that still needs to be decided about how Nebraskans will meet the work requirements or exemptions to the work requirements. This bill aims to provide some direction and reliability as our state enacts these historic changes. Enacting work requirements for our Medicaid expansion population will be a massive undertaking for our state with lots of moving pieces. When individuals lose medical coverage, it can make it even harder to stay employed. In order to promote the health of our communities, this bill aims to ensure DHHS is able to implement those requirements efficiently and effectively while also preventing any unnecessary coverage loss. I'll briefly explain, explain a few of the most important provisions of the bill. First, LB723 directs DHHS to adopt all the optional short-term hardship exemptions to the work requirements. Per their website, Nebraska DHHS has already stated their intent to adopt all these exceptions. The short-term hardship exemptions include the following situations: people who are hospitalized or living-- or lived in a nursing home; people who, people who had, had to travel outside their community to receive care to treat a serious health, health condition for themselves or a dependent; and people who lived in a county that was under an emergency declaration, or in a county with a high unemployment rate. Second, LB723 directs DHHS to adopt the broadest and most comprehensive definition of medically frail as possible. Under H.R. 1, certain individuals will be exempt from the work requirements if they are medically frail. This bill directs DHHS to be broad in the definition of this exemption. The purpose of the work requirement is not to kick off people who are sick, disabled, or otherwise unable to work; instead, folks who have health conditions should be able to readily assess-- access the exemption and maintain their needed healthcare coverage. Third, LB723 directs DHHS to accept an applicant's or an enrollee's statement about their work activity or exemption status to the maximum extent possible. This is an efficiency measure that will ensure that reliable information from applicants and enrollees can help DHHS make timely decisions about eligibility in health care coverage. Additionally, accepting client statements acknowledges that some of the information DHHS will request is not available via data sources. For example, accepting client statements will allow folks who are gig workers, self-employed, or caregiving provide reliable and timely information. Fourth, LB723 directs, directs DHHS to improve automatic processing of eligibility or exemption information by utilizing all available data sources. Efficient

and effective automatic processing minimizes coverage gaps for eligible enrollees, reduces administrative burdens on DHHS, and lowers costs at a-- of administration by preventing improper terminations. Fifth, the federal law, H.R. 1, requires that a person who has income in a month greater than or equal to the amount of 80 hours multiplied by the federal minimum wage, which is currently $7.25, are determined to have met the work requirement. With today's federal minimum-wage, that monthly income would be $580 in a month. LB723 requires that DHHS apply that income proxy automatically to individuals subject to the work requirement. And then, finally, LB723 requires that Nebraska DHHS does not implement the work requirements earlier than required by the federal law. The federal deadline for implementation is January 1 of 2027. States will need to work at, at a breakneck pace to manage all of these moving pieces in, in time to meet that deadline. Enrollees and applicants will need to-- will need time to understand the changes and comply in order to get and keep necessary health coverage. While the governor has indicated a goal of implementing this major program overhauled by May 1 of 2026, the common sense approach is to make sure that we, that we take the-- all the time we can to set up a stable and workable work requirement program. LB723 sets our state up for an efficient and effective implementation of the federally-required Medicaid expansion work requirements. These common-sense directives will also ensure that Nebraskans do not lose their health care coverage unnecessarily. I urge the committee to support and advance LB723, and I would be happy to try to answer any questions you may have.

FREDRICKSON: Thank you, Senator Quick. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Is this-- your bill, LB723, is that at the request of the governor?

QUICK: No, it's not.

RIEPE: Oh, it's not. OK. So, does he have a competing bill that you-- or do they have someone introducing a competing bill?

QUICK: Well-- no, I think they're-- the-- DHHS is implementing the H.R. 1 in-- on-- in May 1--

RIEPE: As-- just as policy, not under statute?

QUICK: As policy, yeah. And this would-- I'm saying we want to delay it to make sure we're going to-- it's going to be done right, done correctly, and that we're not going to see any lack in coverage for people who are--

RIEPE: So, you want to buy some time?

QUICK: We want to buy some time.

RIEPE: OK. And I don't know how that will fit with money coming down, or penalties, and-- OK, thank you, Chairman.

QUICK: Yeah.

FREDRICKSON: Other questions? Seeing none. We'll see you at close.

QUICK: Yeah, I will. Thank you.

FREDRICKSON: First proponent for LB723. Welcome.

KELSEY ARENDS: Thank you.

FREDRICKSON: Oh, I'm sorry, 7-- yeah, LB723, yeah. Go ahead.

KELSEY ARENDS: OK. Thank you, Vice Chair Fredrickson, and members of the Health and Human Services Committee. My name is Kelsey Ahrens, K-e-l-s-e-y A-r-e-n-d-s, and I'm the Senior Staff Attorney for the Health Care Access Program at Nebraska Appleseed, testifying today in support of LB723 on behalf of Nebraska Appleseed, because this bill establishes necessary and responsible guidelines for implementing the new federally-mandated work requirements for the Medicaid expansion category, Nebraska Appleseed supports this bill. LB723 includes a number of provisions that maximize efficiency and minimize unnecessary coverage loss, as you've heard. First, LB723 establishes a reasonable timeline for implementation of the work requirements; LB723 directs our state to implement these new requirements by the federal deadline of January 1, 2027, but not before, as this committee has heard. If DHHS wants to implement work requirements in less than three months from now, Nebraskans should already know all the information they need to keep their coverage, including basic things like how qualifying activities and exemptions are defined. For example, what counts as volunteering or attending school half-time. How will DHHS check

for compliance or exemption status? What data sources will be used to check for work hours, income, medical frailty, parent caregiver status, or others? And how will those ex-parte checks, automatic checks, be communicated to applicants and enrollees? How will enrollees submit their information? What does the form look like? Can they submit it online through the portal? Will there be staff available to answer questions, or a dedicated call line? To date, DHHS has not clearly communicated any of this information in meaningful or understandable ways to Nebraskans with Medicaid, much less stakeholders or providers who are positioned to assist enrollees and applicants with this massive change. The outreach notice DHHS has sent out to enrollees was long, complicated, hard to understand, and folks have lots of questions. We have heard DHHS say in, in hearing testimony that they would like to recreate the collaboration that existed with stakeholders during the Medicaid unwind; we share that, and we would like to see that happen too, but that took months and months of coordination, investment, time, and clear communication. So far, with the work requirements, there simply has not been enough information or time allotted to, to make that happen here. I have lots more information in my testimony about the other provisions in LB723, including maximizing the short-term hardship exemptions, adopting the broadest definition of medically frail, using participant statements to the maximum extent possible, maximizing ex-parte processes, automatically applying the income proxy; those are all really important efficiency measures that, again, will help DHHS implement effectively, and ensure that folks don't unnecessarily, unnecessarily lose their coverage. I know I'm at the red light. I'll just say I have one more section in my testimony about the financial impact, and, and a concern about the fiscal note here, which does not seem to complement-- contemplate any of the cost of implementation, which has cost tens of millions of dollars in the other states that have done this. So, I know I'm at the red light. I'll stop there, but I'm happy to try to answer any questions.

FREDRICKSON: Yes. We'll see if we have any questions. Yeah, any questions from the committee? Senator Riepe.

RIEPE: Tell me more about the financial implications.

KELSEY ARENDS: Yes. So, on the last page of my testimony, and also in the work requirements brief I've provided you, there's some explanations of what other states have experienced.

Arkansas and Georgia are the two states who have fully implemented work requirements for Medicaid before. Arkansas did for a short time between 2018 and 2019, and in that period of about 18 months, the program cost taxpayers about $24 million to implement. So, a really significant investment to stand up this administratively costly program to check work requirements. Georgia implemented work requirements in 2023, and by the end of 2024 had spent $86 million just in administrative costs alone, more than double what they were paying for actual health care coverage for the folks enrolled in the program. So, these are, by the two states we have who have experienced doing this before, extremely expensive programs to implement. I'm concerned because I think the fisc-- my read of the fiscal note is that it mischaracterizes anticipated savings because of anticipated coverage loss as expense of implementing the work requirements on the federal timeline instead of early. But under LB723, nothing changes from our current practices until January 2027 when we're required by federal law to implement anyway.

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

FREDRICKSON: Other questions? Senator Meyer.

G. MEYER: Thank you, Vice Chair. What was the time frame that Arkansas and Georgia tried to implement their, their plans?

KELSEY ARENDS: You know, that's a really good question. I'm not sure from the time they decided until they set it up. That's a good question. I'm not sure. I can look into that, and would be happy to follow up. I know Arkansas only implemented for a short period of time, about 18 months, 2018 to 2019, and eventually stopped their program in part because of litigation related to the work requirements. Georgia is the only state currently operating work requirements.

G. MEYER: It'd be interesting to know just what kind of lead time they had, and--

KELSEY ARENDS: Yeah.

G. MEYER: --and where they were at, actually, with some of the requirements of their current plans that were in place. And that's one of the questions I have. You've listed many concerns about the implementation, the reporting requirements, qualifications.

KELSEY ARENDS: Yeah.

G. MEYER: I'm not going to repeat them all, because I don't remember them all, quite frankly, and I didn't write them down. But are many of these things currently required for recipients of any of our current state programs? Are these the same things that are required? And, and if they are, then why would it be so complicated to stand up the same requirements for this particular plan?

KELSEY ARENDS: Yeah.

G. MEYER: If we're already doing that, we have the framework, we got the paperwork, we got the process, we have the people. Why would that not work implementing for this plan?

KELSEY ARENDS: Yeah. It's a great question. I will-- just to follow up, I will circle back on lead time, and if I find an answer, I'll be sure to share that with you. As far as other programs that have work requirements, there are other public assistance programs that have work requirements. This is the first time that they will be required for Medicaid, and my understanding is they are, are separate. There is some overlap; for example, if someone is meeting the work requirement for SNAP, for example, they should be deemed to be meeting the work requirement for Medicaid, so that might help in some of the processing. But this is the first time that Medicaid has had these work requirements, and this will be all new to stand up. There are some of these things that we have recommendations about how to improve automatic processing, improving the data checks that happen. There are already requirements when folks get their annual renewal for Medicaid that, that the department should be checking all the data sources available to them. In recent years, in 2025, even though it's required that the department try to check data sources first, only 34 percent of Medicaid cases were checked via ex-parte, that automatic processing. This work requirement system will require so much more work and so much additional data to be checked that we really want to see those processes be improved, invested in, working a lot more efficiently, not just for work requirements purposes, but for Medicaid broadly. So, there is a lot of overlap, and, and a lot this will impact regular Medicaid functions, but standing up the work requirements is something totally new that's never been required in Medicaid before.

G. MEYER: I think we all want everything to work as efficiently as possible and, and be as least cumbersome as is humanly possible to, to implement, so. Anyway, thank, thank you for that.

KELSEY ARENDS: Thanks.

G. MEYER: And, and I would like-- I would like to get some oversight, get, get some understanding of what the implementation period from the time that you cited to where they implemented it to see if, if there's any correlation what we're trying to accomplish here.

KELSEY ARENDS: Yeah, I'll see what I can find out. I'll follow up.

G. MEYER: All right. Thank you.

KELSEY ARENDS: Yeah.

FREDRICKSON: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. I know you cited two that were not very favorable, and I know it's been a short implementation period, and I think Nebraska has prided itself on being out on the front of the, if you will, on the front of the ship. Of-- are there any that you've had-- are aware of that have had a favorable, say-- I'm not looking for a cost-saving, I'm just looking for a-- even a break-even.

KELSEY ARENDS: So Arkansas and Georgia are the only states that have fully implemented work requirements,--

RIEPE: OK.

KELSEY ARENDS: --and those are prior to H.R. 1. So, before this new federal requirement. Since now H.R. 1 has passed, states know they have to implement work requirements if they have a Medicaid expansion or similar program. No other state has committed publicly to an early implementation deadline, only Nebraska. So--

RIEPE: And so, Arkansas and Georgia, because it's federal legislation, don't have the opportunity to walk away from it.

KELSEY ARENDS: Well--

RIEPE: Are they-- they could change it.

KELSEY ARENDS: So, their programs were before the federal--

RIEPE: OK.

KELSEY ARENDS: --the federal change. So, Arkansas isn't currently operating theirs; Georgia is, and, and has a Medicaid expansion-like program, so. I-- I'm not an expert on what's going on in Georgia, like, what their Medicaid's program is, just what has been experienced for their work requirements. So, I, I would assume they need to bring their program up to what H.R. 1 requires, if there's any difference. But again, those were before H.R. 1. Since H.R. 1 has said states who have Medicaid expansion need to implement work requirements, no other state has publicly committed to an early implementation date like Nebraska has.

RIEPE: Have you had the opportunity to talk on the phone or any other way with people from Arkansas or Georgia?

KELSEY ARENDS: Not about this specifically, yeah.

RIEPE: I'd like to learn from them so we don't walk down the same path.

KELSEY ARENDS: Yeah. I can see if I have folks who'd want to talk to you from there, from those states. I can look into that.

RIEPE: OK, thank you very much.

KELSEY ARENDS: Yeah. Or resources about that, too.

FREDRICKSON: Senator Meyer.

G. MEYER: Thank you vice-chair Do you have any idea what their programs look like, compared to each other, and then compared to H.R. 1? You know, are we, we looking at totally different programs and totally different implementation challenges as opposed to H.R. 1? You know, we're, we're kind of shooting in the dark here, comparing apples and oranges, perhaps. And so, to use them as an indication of potential failure right out of the

box, probably, there-- there's not enough visibility to really make that determination, is there?

KELSEY ARENDS: Well, they're the only other states who have done work requirements. My understanding is they're similar. You know, work requirements for a lot of public programs can often be very similar. I'm not sure exactly; I haven't compared side-by-side exactly what H.R. 1 requires and exactly what these states require. What I do know is that standing up this significant of an administrative oversight of digging into all, all Medicaid expansion enrollees' work status or caregiver status or exemption status has taken other states a lot of investment to stand that up. Those are new things that, that our state will have to do in order to implement work requirements.

G. MEYER: OK, thank you.

FREDRICKSON: Other questions? I have some. So, thank you for being here. So, the cost, you said, with Georgia, when they did this, it was an additional $86 million, and was it $24 million for Arkansas?

KELSEY ARENDS: That's right. Yes, in administrative costs.

FREDRICKSON: OK. And that is over how long of a time period?

KELSEY ARENDS: Arkansas, 18 months; Georgia, 2023 is when they started, by the end of 2024, so I think about two years

FREDRICKSON: OK. Will we receive any federal funds to help cover any of the costs associated with H.R. 1, the mandates?

KELSEY ARENDS: So, there are federal funds. H.R. 1 designated federal funds available to help with work requirements implementation. That's a pending question I have for the department, is how those-- whether those have been applied for or granted, and what the status is of, of federal funds coming in to help them with implementation.

FREDRICKSON: OK, so the amount of the funds that-- we're not--

KELSEY ARENDS: I don't know that.

FREDRICKSON: --maybe not sure. OK. My other question is-- so, obviously, with H.R. 1 going to-- into effect, this bill would obviously delay this until we're absolutely required to do that.

KELSEY ARENDS: Correct.

FREDRICKSON: How-- help me understand how that's-- how it's-- I mean, because I'm thinking, for example-- I mean, look, it's-- I have concerns about, obviously, going first. I don't like the idea of Nebraska being a guinea pig. But I do also think that-- are these costs going to-- and challenges going to be inevitable, given that this will happen once H.R. 1 is required? Obviously, there's benefits of waiting for federal guidance to sort of work out some of the challenges that, that, that might present, but should we expect, as a state, to have a number of unforeseen costs regardless?

KELSEY ARENDS: What we've seen in other states is that work requirements don't work. They're expensive to implement, they don't increase workforce participation, they, they destabilize families who need access to health care. So, yes, I think there will be. No matter what, Congress has set us with this, now we must implement work requirements; there will be disruptions and costs and, and harm to families in Nebraska. I think the benefit of waiting the eight months that the states have to implement, waiting the reasonable amount of time that every state is scrambling to set up this requirement, is to make sure that we're doing everything we can to prevent that-- any unnecessary harm, any unnecessary coverage loss, make sure the systems are working well and Nebraskans have the information they need to provide all of the information to the department, to be in compliance or to make sure they know how to, how to demonstrate their exemption status. That's the benefit we get. I think it's-- it's our position that work requirements are going to cause harm, but we should do everything we can to minimize that harm.

FREDRICKSON: Understood. All right. Thank you. Other questions? Senator Meyer?

G. MEYER: Thank you, Vice Chair. Would you agree that we have, as part of our Medicaid programs and, and, and any of the programs-- we have social programs in the state-- we have those that need the program, and then those that just want the program. And shouldn't we have some mechanism to try to find which are which? Shouldn't-- are, are you-- or do you have an

assumption that everyone that gets benefits in the state need them?

KELSEY ARENDS: I would say, by far, folks who are utilizing Medicaid coverage are relying on that for life-saving access to health care.

G. MEYER: [INAUDIBLE].

KELSEY ARENDS: I-- the data shows that, of the folks who would be subject to the work requirements, over 90 percent are already working, or would likely meet an exemption. And so, for 90 percent of the folks, work requirements in, in this manner are going to be extra red tape they have to jump through in order to keep health coverage that we all need. You can't control when you're going to need to go to the doctor or when an emergency might happen, and health coverage is really, really critical.

G. MEYER: I absolutely want to provide help to those that, that need our help. I, I think that's a, that's a primary obligation of anyone in the state. But I think we also need to be responsible as taxpayers, especially given the economic times we have. But, but whether our economic times are difficult or not, we should always be responsible with the taxpayer dollars, and, and so I think making a determination of wants and needs is critical with regard to any of our programs, so. But I, I appreciate your perspective. If you'd like to elaborate on that, please go ahead.

KELSEY ARENDS: Could I? Yeah, the other thing I would just say, Senator Meyer, is that Medicaid and Medicaid expansion is a really effective public program. And so, when people lose their coverage from Medicaid expansion, what we're seeing in the fiscal note is a decrease in a line item in the state budget, but those folks are still going to need health care, and they're going to show up at a hospital and have emergent, expensive, uncompensated care that will land on the shoulders of our hospitals or our counties in the form of general assistance. So, Medicaid is really effective at providing what people need and, and doing it efficiently. Taxpayers are going to pay the cost of uninsured folks, too, so there are costs to weigh here. I would say Medicaid is an effective way to make sure that folks have the coverage that they need to, to manage their health.

G. MEYER: Thank you.

KELSEY ARENDS: Thanks.

FREDRICKSON: Other questions? Seeing none. Thank you for being here.

KELSEY ARENDS: Thanks.

FREDRICKSON: Next proponent for LB723. Welcome.

TREVOR TOTEVE: Good afternoon, Vice Chair Fredrickson, and members of the Health and Human Services Committee. I'm Trevor Toteve, that's T-r-e-v-o-r T-o-t-e-v-e, a policy analyst with OpenSky Policy Institute. We support LB723 because this bill implements community engagement requirements in a flexible manner. It protects eligible Nebraskans from losing coverage due to paperwork, reduces administrative costs for the state, and preserves access to healthcare, supporting growth in our state's workforce and economy. Medicaid expansion has been a positive investment for the state of Nebraska. It has reduced the uninsured rate, and helped relieve financial pressures on the healthcare system while enabling Nebraskans to protect their health so they can work and contribute to their communities. The uninsured rate in Nebraska has fallen from a high of nearly 10 percent in 2014 to 6 percent in 2023. Reducing the percentage of people without health insurance through Medicaid expansion has yielded important economic benefits, including improved economic mobility for Medicaid enrollees and the stabilization of hospital budgets. It's important to be clear about the risks of implementing community engagement requirements and why this bill matters. Research does not show that Medicaid work requirements lead to higher or more stable incomes, increased insurance coverage, increased employment, or greater self-sufficiency. In fact, evaluations from across the country show the opposite. Georgia's Pathway to Coverage program, the most similar to the requirements laid out in H.R. 1, enrolled only 6-7 percent of eligible adults in the first two years while costing taxpayers more than $110 million, of which only one-third went to health care services. Arkansas, whose requirement was limited to adults aged 30 to 49 only, saw over 18,000 disenrollments in the first six months. In both instances, there was no evidence of increases in employment, increased income, or increased non-Medicaid insurance coverage. However, there was evidence that thousands of eligible beneficiaries were being denied coverage or lost coverage due to procedural issues, increasing costs to the state and potentially leading to higher uncompensated care

costs down the road. Restrictive work requirements do not improve beneficiaries' self-sufficiency, but they do increase administrative complexity for both the state and for eligible individuals trying to maintain coverage, ultimately leading to a poor stewardship of taxpayer dollars. This bill recognizes the evidence from other states and limits implementation strictly to what the federal law requires. It adopts all optional exemptions, maximizes the ex-parte process, defines medically frail in the most comprehensive manner, creates an income proxy to determine compliance with the law, and gives us time to implement. By adopting the least-restrictive approach under federal law, such as in LB723, we have an opportunity to protect eligible Nebraskans from losing coverage due to paperwork, reduce administrative costs for the state, and preserve access to care that allows people to remain healthy and able to work, care for their families, and contribute to their communities. For these reasons, we support LB723 and urge the committee to advance the bill. Thank you, and I'm happy to answer any questions.

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

TREVOR TOTEVE: Thank you.

FREDRICKSON: Next proponent. Welcome.

TAMI SOPER: Good afternoon, Senator Fredrickson, and members of the Health and Human Services Committee. My name is Dr. Tami Soper, that's T-a-m-i S-o-p-e-r, and I'm the Advocacy and Policy Advisor for Boys Town. I'm here today to testify in support of LB723 on behalf of the Nebraska Hospital Association and the Nebraska Association of Behavioral Health Organizations. I do want to thank Senator Quick for introducing LB723. This bill really represents an important step towards strengthening the health and wellbeing of Nebraskans who rely on Medicaid by encouraging meaningful engagement with the community while maintaining access to needed care, particularly for those who are medically frail. As you know, LB723 requires the Department of Health and Human Service to, to execute specific processes and to enforce certain exemptions while implementing the work requirements for Medicaid expansion-- the Medicaid expansion population that are required under H.R. 1. This bill would also prohibit the department from implementing other medical work requirements unless required by federal law. Overall, it would

help to ensure that Nebraska's community engagement policies remain aligned with federal expectations, which prevents hospitals from implementing requirements before final guidance is available. Most more-stringent state-level requirements may lead to coverage disruptions for patients who are already facing challenges such as unstable employment, caregiver responsibilities, limited transportation, or fluctuating work hours, and they may also interrupt access to coverage for medically-frail individuals with critical needs for care. For hospitals, coverage loss due to reporting or paperwork barriers is something that we see firsthand. Community engagement requirements historically lead to people losing Medicaid, often because of the paperwork and the reporting barriers rather than the employment status. This contributes to more uninsured patients, to increased hospital charity care, and to a reduction in the reimbursement services for-- that are already-- for services that are already being delivered. Hospitals rely on Medicaid to help reduce the burden of uncompensated care, so when coverage drops, the cost shifts back to the hospitals. They don't go away. Nebraska hospitals and behavioral health care providers stand ready to work with the Department of Health and Human Services, with policymakers and community partners to support thoughtful implementation that is consistent with federal guidance, and that minimizes unnecessary coverage disruptions. Thank you for your attention, and I will try to answer any questions that you might have.

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

TAMI SOPER: Thank you.

FREDRICKSON: Next proponent for LB723.

HARDIN: Welcome.

JUNE RYAN: Thank you, Chair Hardin, and members of the Health and Human Services Committee. My name is June Ryan, that's J-u-n-e R-y-a-n, and I'm here today as a 10-year, almost 15-year volunteer, testifying in support of LB723 on behalf of AARP Nebraska. LB723 provides Nebraska with a careful federally-aligned framework for implementing community engagement requirements under the Medical Assistance Act only when mandated while prioritizing coverage stability, broad exceptions, and protection for medically-frail individuals and older adults.

LB723 requires DHHS to, to adopt all possible exemptions allowed under federal law, accept participant statements as verification to the maximum extent possible, use automatic verification through existing data sources such as SNAP and managed care claims, and implement community engagement requirements only when and as federally required, preventing premature rollouts. These built-in protections are lifelines for older Nebraskans who would be harmed by unnecessary administrative barriers often related to paperwork. In states that implemented community engagement requirements without strong safeguards, thousands of medically frail or older adults lost Medicaid coverage, and we heard about this earlier. LB723 directly addresses paperwork barriers by guaranteeing automatic exemptions, acceptance of participant statements, broad definitions of medically frail, and automated eligibility checks. These are exactly the safeguards needed to prevent Nebraska from replicating the harm seen elsewhere. A growing number of Nebraskans age 55 to 70 provide unpaid care to spouses or older parents, and I'm one who has done that in the past. Without strong exemption pathways, like those that the bill mandates, these people risk losing Medicaid coverage because caregiving is not always recognized as community engagement. LB723's directive to apply all exemptions ensures that "caregiveners"-- caregivers are not penalized. LB723 establishes a carefully-constructed framework that protects older adults, medically-frail individuals, and caregivers from losing essential health care coverage due to administrative obstacles. Thank you to Senator Quick for introducing this legislation, and thank you for the opportunity to provide comments. We would like to ask you to support and advance this legislation to the floor, and I would be happy to answer any questions.

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

JUNE RYAN: Thank you.

HARDIN: Proponents, LB723. Any more proponents? Opponents, LB723. 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, of Medicaid and Long-Term Care in the Department of Health and human services. I am here to testify in opposition to LB723. LB723

requires the department to implement Medicaid work requirements only to the extent that federal law requires. Aside from a few specific concerns, the requirements under this bill largely align with what the department is planning to implement. DHHS is working to implement a work requirements program that is as efficient as possible to administer. This includes a focus on using data when possible. We are also planning to utilize all federal allowable exemptions to completing-- for individuals to complete work requirements. This will help ensure that as many Nebraskans maintain their coverage as possible. Our opposition to this bill relates in part to the provision that would delay implementation of Medicaid work requirements until January of 2027. I've previously, previously shared with the committee DHHS's concerns with delaying our planned implementation from May 2026. Doing so would delay offering our beneficiaries many advantages of Medicaid work requirements, such as helping them become more active members of their communities. Delaying implementation would also forego the opportunity our state has to serve as a model for the rest of the nation in implementing Medicaid work requirements. In addition to the delayed implementation date, DHHS also has concerns about the language that would require adopting a maximally broad and comprehensive definition of medical frailty. This would provide some beneficiaries with an exemption from completing work requirement activities. While the department does not necessarily have any concerns with this approach, we would note that both current federal regulations and to-be-released federal guidance may place some limitations on what the program can implement. As this picture is unclear at the moment, the department opposes this language. For these reasons, we ask that the committee not advance this bill to General File. Thank you for your time. I'd be happy to answer any questions on this bill.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, director, for being here. I've got a handful of questions for you, so--

DREW GONSHOROWSKI: Happy to answer them, sir.

FREDRICKSON: So, I understand from a previous testifier-- so, one of the concerns, obviously, that's been brought up is some of the administrative costs that other states who have implemented--

DREW GONSHOROWSKI: Of course.

FREDRICKSON: --programs like this in the past have, have felt. H.R. 1 has designated federal funds for administrative costs for the implementation thereof. Do you have any insight into what that looks like for Nebraska?

DREW GONSHOROWSKI: Yeah. So, so there are-- I think they-- I believe-- I always mess up the language on this specifically, but I believe the language from the statute was innovation grants. It's a small amount of money. It's-- I, I believe it's $2 million that's already been awarded to most states; this is for just implementation processes. There's also an advanced planning document exercise that happens across all Medicaid programs as you stand up, stand up programs, which unlock-- generally unlock higher federal match on systems improvements. This would be something along the lines of-- if you're familiar with Medicaid programs, which you are-- certain systems improvements have this 90-10 match rather than the traditional match, and both of those are in place as we move through work requirement implementation.

FREDRICKSON: OK, so at least $2 million.

DREW GONSHOROWSKI: Yeah, at least.

FREDRICKSON: Possibly more--

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: --for help with that. OK, that's helpful. Thank you. Have we received federal guidance yet?

DREW GONSHOROWSKI: We, we are constantly receiving federal guidance as we move through this process. In terms of the interim final rule, the, the sort of broad, public, full document or full guidance document, that, that, that will likely come in June of '26.

FREDRICKSON: OK. Do we--

DREW GONSHOROWSKI: That's the deadline for CMS.

FREDRICKSON: Do we need that in order to move forward with this?

DREW GONSHOROWSKI: I, I don't believe so. Ultimately, states are in active, active conversation with CMS to help develop that IFR. So, the expectation would be we would, we would know most of that guidance ahead of then.

FREDRICKSON: OK. You said in your testimony, kind of one of the benefits that the department sees as this having on Nebraskans is that this would help get more Nebraskans engaged in their communities or in the workforce. Do you-- does the department have an estimate of how many Nebraskans that are currently on Medicaid that, that, that, that, that that would apply to? In other words, that are either not working currently, so-- or are, or are physically able to work, right? In other words, are not disabled to a level what-- that prohibits--

DREW GONSHOROWSKI: Yeah. So, so in terms-- we, we have done estimates around sort of the impacted population and the population that you would expect to have compliance. I'm happy to produce a document for, for this committee and, and also brief on it [INAUDIBLE].

FREDRICKSON: Do you have a sense of the number, or?

DREW GONSHOROWSKI: Yeah, and, and in the, in the sense of the number, the expectation in terms of folks that would be expected to compliance after you go through all the exemptions, met frail, cross-checking with the SNAP work requirements, we're, we're estimating in the range of, you know, 13,000 to upwards of 20,000 that would have to sort of demonstrate compliance. And, and I'm happy to provide further documentation on that as we continue to develop that-- those estimates.

FREDRICKSON: OK. And then, I'll just ask one more question, then I'll let some other committee members. So, the other thing is, I'm, I'm kind of looking at the fiscal note here, and, and the components here. I mean, so obviously the department is-- it, it-- you know, assuming we-- assuming this bill were not to go into effect, in other words, if the department were to move forward with the implementations earlier, you know, the federal money is around 30-- was it $36 million or something? It was a pretty high number.

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: So, you know, obviously, these are still individuals that are going to have health care needs that are going-- so, is-- I guess I'm trying to figure out, you know, it's not like that money just, like, disappears, right? So, like, the services or the need of these individuals will still exist,--

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: --and is the idea just that they're no longer going to receive care, or is the idea that-- who's going to pay for that?

DREW GONSHOROWSKI: Correct. And, and I-- and speaking to previous testifiers, I, I think that it is correct that there will be some disenrollment that does not result in someone gaining coverage either through the exchanges. So, the, the work requirement goal in this, right, is to give people an opportunity to, you know-- it's extend a hand down, find-- help, help them find work, help them find community engagement. And, and some folks will find employment that brings them up the income scale, they-- they'll receive coverage in the exchanges. It is true that within that estimate there would be folks that would, would be disenrolled from the program for not being compliant, correct? And, and I'm not sure we have an exact number on the expectation there, because that's harder to predict.

FREDRICKSON: So, is the-- I guess, is the thinking kind of with that train of-- like, that, that line of thought, is, is the-- is it kind of like we're just kind of-- is the, is the hope that, like, hospitals will just sort of write off these costs? Is the hope that providers will write off the costs? Because I'm, I'm just thinking when that individual who does fall through the cracks gets in a car accident, has a medical emergency, you know, they were dropped from Medicaid, that money-- I mean, I'm thinking about how we hear all the time about how medical costs can, can literally financially destroy a person. And, you know, Medicaid exists to serve as a safety net for some of our most-- the most vulnerable people in our state. And so, you know, thinking about an individual like that who's just going to have to-- I mean, what do they do?

DREW GONSHOROWSKI: Yeah, and, and I, and I, I really appreciate this comment. It's, it's ultimately within the Medicaid

expansion population, right? It's, it's a-- it is a good question to under-- to, to ask where, where sort of the health costs will flow in the system. And, and the hope is that community engagement would, would-- you know, folks would find a path to, to get compliance. And the, and the division is, is strongly committed to, to helping along that journey, but, but I think it is true that this, this creates some disenrollment that would be, would be this, this cost that you describe on the system, yeah.

FREDRICKSON: OK, so part of it's, like, kind of hoping maybe the private sector might step in--

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: --in a way. OK. And then, my understanding, too, is-- so, if an individual does get kicked off Medicaid for failing to meet work requirements, they no longer qualify for subsidy for the health exchange. You mentioned these individuals that get kicked off can just go to the health exchange, but if they're penalized for that, how do they go there?

DREW GONSHOROWSKI: So, so this, this would ultimately-- and, and this is, this is such a great question too, and this is a question I've actually posed to CMS as well, which is this area that, that is-- OK, if someone gains employment and moves into an income scale that results in them being eligible for the exchanges,--

FREDRICKSON: Uh-huh.

DREW GONSHOROWSKI: --that would mean that they would gain coverage, right? But the, the scenario you're describing-- really interesting question-- I think that it, it probably falls into the-- that sort of guidance where it would be viewed as sort of moving up the income scale and gaining coverage. That's an open question with CMS that I've asked as well.

FREDRICKSON: OK, so awaiting response.

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: OK. Thank you.

HARDIN: Other questions? Can I just ask the fun part of why now? Why, why-- what do we-- what do we gain that way? Coming back on the other side, I'm going to ask a different question, shall we say, pushing the envelope the other way, which is, do we have strong enough parameters in place, or do we, do we have a situation that's going to be taken advantage of? Is there an opportunity to game the system, so-to-speak? And so, those are the two questions I have that are not related to one another, but it's the whole world of what happens if we don't pass this type of thing?

DREW GONSHOROWSKI: Right. So, so I think I've "speaken"-- spoken a little previously on, on why now, and why, why we would want to move faster, and I, and I truly do believe it is an opportunity to help get this right nationally, and I think that Nebraska is uniquely situated. One, one thing that I'd like to raise too: we're uniquely situated compared to other states in terms of implementation of work requirements just because we are a state-owned eligibility solution. We don't have a big box third-party vendor that, that, that some of these other states have had. I do believe that that affords us an opportunity for, for savings compared to others implementing. Ultimately, y'all have been around the block long enough to know that Medicaid has a little bit of a contracting problem in, in some situations, where, you know, certain legacy vendors have probably secured larger contracts than they should have for, for different arrangements. As we implement work requirements, we don't have that issue. That's, that's ultimately a benefit, too. And it also means that we have the benefit of the, the folks that are forming the rules and working to ensure that we do this correctly for Nebraskans are my staff; they are my people that we know are good, that we can put in the seat, and we can ensure that-- how they are enacting this has an impact that's far-reaching.

HARDIN: OK. What's life look like in two years, three years, if we don't-- if, if, if this passes and you're concerned, you know, we've got a $35 million fiscal note from the feds, about a tenth of that on the state side. At this point, these things shift. What does life look like? If we, if we pass it both from a fiscal perspective, what does life look like for people? Paint a picture for us, if this passes, I mean, from your position, because you've got a, a unique position of kind of seeing all of it at once that the rest of us kind of don't see.

DREW GONSHOROWSKI: Yeah. In, in two or three years, H.R. 1 would be, would be law, barring anything that would change, so we would be operationalizing--

HARDIN: By then.

DREW GONSHOROWSKI: --the work requirement. Yeah.

HARDIN: I see. Yeah.

DREW GONSHOROWSKI: Yeah.

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

DREW GONSHOROWSKI: Thank you.

HARDIN: Opposition, LB723. Those in the-- those in the neutral, LB723. Senator Quick, can you quickly run up here?

QUICK: Yeah. Yes, I can.

HARDIN: Welcome back.

QUICK: Well, thank you, Chairman, and members of the committee. And really, you know, this bill is just looking to slow the process down a little bit, and I don't feel like maybe we've had all the answers yet, and we want to make sure it's implemented properly. And then, you know, one of the things the bill does do in there is it, you know, it make sure that the requirements weren't greater than what the federal government was-- is going to currently require from our-- from us. You know, there's the question about the medically frail; I think that's a, that's a really concern for a lot of people who maybe-- whether they have some type of a disability, or if-- you know, who all qualifies underneath that? So, I look at-- and another example of this would be, like, someone who is going to-- she's-- a woman who's pregnant. And now the next thing, she's-- her doctor's telling her she has to have bed rest. So, what happens in that-- she has-- she is on Medicaid, but now she's not working anymore, she's on bed rest until she has the baby, and then, you know, just to-- because she-- she's not going to be able to work, how does that process work for her? Because she's not probably going to be able to-- she's going to in bed. Maybe she can do it on her computer. I don't know what the requirements are going to be. So, the-- these are just, like, a situation that I'm

thinking of that could happen. And then, once the baby's born, that's-- you know, when you go in, you're one patient. So, does that baby have to-- do they have to apply for Medicaid for that baby when it-- after it's born, how does that whole process work? So, I know those are just all questions that I have about what this would look like. And then, you know, with all the-- you know, what's happened on the federal government with everything that's coming down. So, we're looking at-- there was no more-- you know, they're not doing subsidies for the marketplace insurance. So now, we're looking at people who are probably not going to pay for that marketplace insurance, so they're not going have any health care coverage. And now that-- you know, whether they end up in an emergency room for something. And then, you know, most hospitals, what they've done in the past as they've-- you know, when they find out they don't have insurance or they don't the money to pay for it, then they apply, you know, fill out the application for Medicaid for them to receive Medicaid. And then, we're also looking at-- and that's not in this bill, but there's that look-back, too, where the federal requirements are going to go-- it was three months for a look-back; I think the federal government is saying two-- one month or two months, I can't remember. But our state is looking at going to zero months' look-back. So, if someone's in the hospital for-- you know, maybe they're in the hospital for two days, or maybe they're in the hospital for one day, and then they apply for the Medicaid after the fact, that look-back, that's not going to pay for any of that coverage that-- when they go to that hospital, when they're receiving that care. So, I have some real concerns about how that all works out with , you know-- and this bill doesn't really address that, but these are some of the things that are going to happen with some of requirements that we're being asked to look at. So, I'm just asking us to maybe slow down a little bit. This bill does not say it's going to stop what's, what's currently happening with H.R. 1; it's going happen by the first of the year. I'm just saying maybe we need to slow it down a little bit until we make sure we're going to be doing it right and making sure that we're not hurting people in the process, so. That's all I'm looking to do here.

HARDIN: OK. Senator Riepe.

RIEPE: Thank you, Chairman. You're painting a picture of making being a member of the Legislature look like a cream job compared

to being a hospital administrator. But how long do you want to slow this process down?

QUICK: Well, the--

RIEPE: And what-- when-- what do you anticipate the-- there's probably a cost to doing that.

QUICK: Yeah. Well, it only slows it down to the first of the year. So, it still takes effect on the date that the federal government requires.

RIEPE: OK. So, you're saying just don't be ahead of the-- don't overdrive your headlights, just be there.

QUICK: Yeah. Just be there when we have it. And you can look at all these things while we're going through that. I mean, there's no-- nothing says we can't, like, work on all these areas and make sure we have everything that we need to have implemented, and have-- be able to answer questions to people who have-- you know, what's going to happen to my Medicaid? You know, what-- where-- what do I do? You know? So, this is going to happen in, what, the end of May? I mean, and there's really no answers for people who are currently on that type of health coverage, so.

RIEPE: Have you had an opportunity, either coming into this, to, to speak with the director of, of Medicaid, the Division of Medicaid and Long-Term Care?

QUICK: No. I've just been in some of the briefings for some of those, you know?

RIEPE: OK.

QUICK: You know, we've all been invited to some of the briefings. I think I've only been to maybe one briefing, but then I was also on the briefing for the hospital association. So, different groups have had, but-- you know, I can sit down and talk to them and figure out how-- if there's answers, because I don't think they even have all the answers from the federal government, what the guidelines are going to be.

RIEPE: Probably-- I would think it'd optimistic to think that they would have.

QUICK: So, those are some of my concerns. If we're, if we're setting this up and we don't even have all the guidelines from the federal government, I mean, how do we know how to figure that out? And then, do you have to change some of your process? If you've already implemented something now, would we have to go back and change all that? And that can cost dollars, too.

RIEPE: To me, before we would exec on it, I would be interested in saying these are the things that, with the plan that's in existence with the division, and these are the things where we maybe have a difference of opinion, and that might be implement-- obviously, the implementation date. But I don't know whether it goes beyond that. That would make a difference to me as to whether we want to wait and let the division do it, or whether we want to go with your bill to try to slow it down.

QUICK: Yeah, yeah. And like--

RIEPE: Does that make any sense? Not much, but--

QUICK: Yeah, yeah, yeah. You know, and with the-- I'm just saying, since we don't have all the federal guidelines, you know, we're, we're starting something and not knowing if we're even have to change it after we start the process, so.

RIEPE: OK, fair enough.

QUICK: Yeah.

HARDIN: OK. Other questions?

RIEPE: Thank you, sir.

HARDIN: Seeing none. Thank you. This concludes LB723. And there were, online, 33 proponents, 1 opponent, 1-- 0 in the neutral for LB723. Next up, LB1212 and Senator Riepe. We'll wait for the shuffle to end.

RIEPE: Thank you.

HARDIN: I believe we are ready.

RIEPE: Thank you, Chairman Hardin, and members of the committee. My name is Merv Riepe, it's M-e-r-v R-i-e-p-e. I represent District 12, and I am here to open on LB1212. We are all

familiar with the taxi driver who immigrated to the United States and who, in their country of origin, was a nuclear physicist, an engineer, or a physician. While often told as a joke, it reflects a real structural problem: highly-trained professionals whose credentials and skills are underutilized because our systems, systems are not designed to integrate them effectively and efficiently. In healthcare, this problem is not hypothetical. Internationally-trained physicians already provide a significant share of primary care in underserved and rural communities nationally, yet Nebraska's current licensing structure effectively limits most of those physicians to starting over from scratch in the residency match process, even when they have years of safe, independent practice abroad. Under the current system, foreign medical graduates must obtain the ECFMG, which is the educational commission's foreign medical graduate certification, and then compete for a U.S. residency position. Residency slots are capped at the federal level, and Nebraska has to compete for a fixed number of positions we do not control. Foreign medical graduates who are outside the traditional U.S., Canadian, or Caribbean pipelines are statistically far less likely to secure one of these limited positions, regardless of their prior experience or competency. That leaves the physicians who are educated, trained, and practiced independently abroad stuck on the sidelines, or forced to effectively start their careers over. At the same time, Nebraska is losing ground on access, particularly in rural areas. Many rural communities and counties have very low or no primary care physicians present at this time. Large portions of the state are designated as medically underserved, and our existing providers are aging and unevenly distributed. Rural communities feel that shortage every day. LB1212 is a tool to responsibly move these physicians into a viable pathway to practice in Nebraska while avoiding a duplicative and difficult to obtain residency. It creates a structured three-stage pathway for internationally-trained physicians who already meet high baseline standards. To qualify, physicians must hold a medical degree from a foreign school recognized by the Educational Commission for Foreign Medical Graduates, have substantially similar training as determined by the Board of Medicine and Surgery, hold a foreign license, have at least three of the last five years in practice, hold legal immigration status that authorizes them to work here, and pass all three steps of the United States Medical Licensing Examination. Here is the pathway. In brief, first, a limited license allows supervised practice under the board-approved employers such as hospitals and federally-qualified health centers. These employers must

provide structured access and evaluation, use licensed-- Nebraska-licensed supervising physicians in the same specialty, and carry malpractice coverage for the limited-licensed physician. Second, after three years of successful supervision of practice and satisfactory evaluations, physicians may receive a restricted license for independent practice in healthcare professional shortage areas designated by the Nebraska Rural Health Advisory Commission. Third, after at least three years with a limited license and three years with a restricted license, physicians become eligible to apply for a full unrestricted Nebraska license to practice anywhere in the state. LB1212 is not, I repeat, not a shortcut to independent practice; it requires supervised in-state practice, passage of all three USMLE steps, going-- reporting to the board-- ongoing reporting to board, and demonstration of competency at each stage. There are clear off-ramps; supervisors and employers may remove participants who do not meet expectations, and the Department of Health and Human Services retains full disciplinary authority including suspension and revocation, if performance or conduct raises concerns. If a physician in this pathway proves to be a risk, we expect supervisors, employers, and the Board of Medicine and Surgery, albeit "Nebraska nice," to be "Nebraska no" on that particular situation. It is also important to emphasize legal status in the United States is a prerequisite for participation. LB1212 does not change immigration law or create any pathway to lawful presence; it, it simply provides a licensure pathway for individuals who are already legally authorized to live and work in this country. Finally, LB1212 contains what I would call a rural duty. During my 2024 rural health interim study, we joked that most-- the most reliable way to get health professionals to stay into rural Nebraska was to get them to marry a farmer. That drew some laughter, but it reflects a serious, long-standing challenge. By tying the restricted license to practice in health professional shortage areas, LB1212 ensures communities with the greatest need and the fewest options to see real benefits. It is designed to steer these practitioners to rural and underserved areas, giving them time to put down professional and personal route-- roots, and expand access to care where it is urgently needed. One of the testifiers you will hear from today is Mr. Mike Zimmer who flew in from Michigan to be with us. Mike is a consultant with the World Education Services whom my legislative aide met at a CSG meeting in New Orleans. He is one of the premier and preeminent experts on these pathways, and I would also ask that you lean on him with any questions about how these processes look and function in practice, and how related issues such as credential

evaluation and implementation have been handled in other states. He has watched similar bills progress past and move into implementation, and bring a valuable national perspective to your deliberations. Plus, he flew all the way here from the Michigan at, at his own expense, so let's make him feel welcome, please. Nebraska would not be alone in taking this step; 22 other states and others that he will share with you who are moving forward on this particular piece of similar type of legislation have enacted or are implementing additional licensure pathways for internationally-trained physicians that lead from supervised practice to a fully licensed, based on in-state experience and demonstrated competency. That group includes neighbors like Iowa and Colorado, and politically very different states, such as Texas and Massachusetts, which agree on little else, but have both concluded that carefully designated and designed alternative pathways are a responsible way to address physician shortages. LB1212 adapts that emerging best practice model to Nebraska's regulatory framework and rural realities. LB1212 balances workforce needs with patient safety, accountability, and common sense. I personally have no interest in having a second level of medical care in rural communities as we oppose-- or, as we experience it in our urban markets. It reflects Nebraska's longstanding approach: pragmatic, cautious, and focused on solving real problems. LB1212 gets physicians into rural communities. I respectfully ask the committee to advance LB1212. Thank you, Mr. Chairman, committee members.

HARDIN: Thank you. Senator Quick?

QUICK: Yeah, thank you, Chairman. And you may not be able to answer this question, but--

RIEPE: Oh, probably so. Go ahead.

QUICK: But-- OK, so currently we have a priest in Grand Island. He's from Pakistan, he has a, a religious exemption. So, do they get to come here, like, on some type of an exemption for medical, or is it just they have to have a, you know, kind of immigration status, like maybe a green card, or what do they have to have?

RIEPE: They have to-- the immigration process is totally separate and apart from this bill.

QUICK: OK.

RIEPE: They have to get here, so they don't come here on a 1B or a, you know, another process and then this is a shortcut to beat other people who are seeking to immigrate here.

QUICK: OK.

RIEPE: So we're, we're trying to-- we want to be-- we're not trying to get them to the front of the line, we're just saying if you're already out there-- and Mr. Zimmer will talk to you it. He says that of all the states that are doing-- I think we even-- we talked over lunch, and I think he shared that in Nevada they have 147 that are interested. Now, that's a big number. They're not all going to go to Nebraska-- or, Nevada.

QUICK: Yeah.

RIEPE: And I don't know how many will come here, and he can maybe speculate a little bit on that. We've talked some; maybe we think five or six. It's not going to be a massive number.

QUICK: Yeah, yeah. And if--

RIEPE: But if we can get just a few for our workforce, that's what we-- that's what we're desperately trying to get to.

QUICK: Yeah. And I think you touched on the education piece. So, they would have to come from-- I mean, the-- their education would have to be approved to be, you know, for coming to the United States, for their practice, right?

RIEPE: Well, they would have to have been licensed and, and passed everything in their former foreign country.

QUICK: Yeah. Former countries.

RIEPE: And that training in that foreign country has to be acceptable to the medical board in this country. So, we're not getting someone that's, you know, a barefoot doctor out of China that wants to come here.

QUICK: Yeah, yeah. Because I know even-- we had two doctors in Grand Island, and I thought they're-- they had their education in India, and then they came in. But I think they had to go through the whole education, or some of it again, to practice in Grand Island, so.

RIEPE: I think on this, in terms of LB1212, we do have a total of six years to kind of observe and see how they're doing, and we will, we will be attentive to it, that we're not here to provide any second level-- secondary level of, of healthcare.

QUICK: All right. Thank you.

HARDIN: So what quality of person do we get? Is there a list out there of which states you mentioned? But in terms of boards, looking for a standard, I guess, looking for a measuring stick. How do we know that they measure up with what--

RIEPE: They're going to have to measure up to our standards.

HARDIN: OK.

RIEPE: Not newly-created-- we're not going to have a double standard that says these are standards for American grads and these are standards for foreign grads coming in. That's why there's going to be a six-year oversight, if you will, to make sure that they do meet those standards. We-- we're not going to-- we're not going to lower the-- we do not intend to lower, or will lower, the standards just to get, get manpower.

HARDIN: Sometimes in Nebraska, and I know you've never heard of this concept, but sometimes we will do something called a compact; that's state-to-state, not international. I get that paradigm difference. But sometimes, our standards in Nebraska are so high we can't find any other children to come play with us in the play-- in the sandbox. Have you ever come across that phenomenon here in Nebraska, where we say we'll be reciprocal with something in some way, and then it doesn't happen? And so, I, I-- I'm-- but I also look at this and go, we, we have these needs, and how else are we going to cool down that medical desert? It's tough to find and make a doctor.

RIEPE: I think a lot of times, because we're from the Midwest, from Nebraska, we like people that look and think and talk like we do. And quite frankly, in a multicultural environment, we have to broaden, we have to become less parochial, and we have move beyond it.

HARDIN: Other questions?

RIEPE: If we are to grow.

HARDIN: Yeah. Will you stick around?

RIEPE: And the other thing I'd like to add, Chairman--

HARDIN: Yeah.

RIEPE: --is also the communities that would be the recipients have to be welcoming, and they have to make this-- a physician that would be assigned to their community or invited there would have to be probably interviewed by them to make sure that we get a bonded relationship. And our hope would be, is that maybe if they spend enough time, they'll settle into that community and say, you know what, you know, living around Glen Meyer is not too bad. I'll-- I could maybe put up with that.

HARDIN: OK. Well, that's good. Will, will you stick around?

RIEPE: Yes, I will, of course.

HARDIN: OK, great.

RIEPE: Thank you, sir. Thank you, committee.

HARDIN: Proponents, LB1212. Welcome.

HUNTER TRAYNOR: Good to be here, Chairman Hardin, members of the Health and Human Services Committee. For the record, my name is Hunter Traynor, that is spelled H-u-n-t-e-r T-r-a-y-n-o-r. I appear today on behalf of the Nebraska Chamber of Commerce and Industry. At our organization, and when we talk to communities and business leaders around the state, workforce remains the state's north star for economic growth and economic development. And in many communities around the state, medical providers are the anchor of that community's employment base, with the hospital in town oftentimes one of the largest employers. Despite that, research from UNMC released in 2022 at the time indicated that 13 counties in the state of Nebraska were without a primary care physician. And based on demographic trends, not only at the macroeconomic and population level, but certainly in the medical industry specifically, that trend will likely worsen in future years before it gets better. Additionally, on the point of demographics, our foundation at the state chamber has done extensive research, and we certainly know this from conversations with leaders around the state, that immigrant neighbors here in Nebraska have played a significant role in

growing our workforce and, in many instances, supporting rural communities, that without that infusion of bodies and work and help in their communities, those communities would be dwindling. And it's not lost on us; we, we hear this from manufacturers, about the taxi driver story that Senator Riepe shared in his opening, of a neighbor here in Nebraska who maybe came in a refugee or asylee status that was a medical professional or perhaps a civil engineer in their home country, and is now unable to participate in the workforce due to some arbitrary barrier that may be limiting their full economic potential. I trust that there will be concerns raised about how this can be implemented, but it's in keeping with our policy at the chamber, and some of the ideas that we think the Legislature and certainly this committee specifically should engage on, to think outside the box about how we grow the pie, grow our workforce, and find ways to reduce barriers that limit folks' ability to participate in the workforce, to contribute to their communities, and to continue growing this great state. With that, I'd be welcome to answer any questions, though, as Senator Riepe said, I think Mike Zimmer, who will speak later, can address some of the technicality questions that you may have. But I'd certainly try to give it my best effort. Thanks.

HARDIN: OK. Questions? Do you have any numbers for us? I, I mean, we are familiar with a few that we often toss out. UNMC often runs through and terrorizes us with numbers like we're only 5,400 RNs short, don't trip. How about other kinds of doctors, though? Do we know how many doctors we're-- we might be short in the way of primary care, for example.

HUNTER TRAYNOR: I don't know that number offhand. I can cite for you some broader numbers about-- or broader trends about immigration in particular and the role that's played in bolstering our population growth in the state and fulfilling--

HARDIN: OK.

HUNTER TRAYNOR: --communities that would otherwise be declining, but I think you're asking more specifically about physician statistics. I don't have that research on hand, but I can certainly find it and provide it to you.

HARDIN: Thank you.

HUNTER TRAYNOR: I can't imagine the numbers are great, though.

HARDIN: All right. Thanks so much.

HUNTER TRAYNOR: Thank you all.

HARDIN: Proponents, LB1212. Welcome, from Michigan.

MICHAEL ZIMMER: Yes, where it's colder than it is here, so.

HARDIN: Wow. You know we're warmer, we're warmer than Florida in some days. Maybe not today.

MICHAEL ZIMMER: From what I can tell, you're also nicer. My name is Michael Zimmer, M-i-c-h-a-e-l Z-i-m-m-e-r. Chair Hardin, Vice Chair Fredrickson, and member of the committee, I'm a senior policy consultant at World Education Services, testifying in strong support of LD1212 [SIC]. WES, just by way of introduction, is a nonprofit social enterprise that works on working with states and community leaders on finding pathways for internationally trained, educated, and experienced workers to utilize their skills in states. From a personal level, I am kind of a self-professed license geek. I was a licensing director in Michigan for a lot of years, and if I start going down that rabbit hole and talking license talk, feel free to shut me up. As was, as was indicated early, since a large number of states are working on ITP legislation, since 2021, 13 states have adopted, finished their rules, and are now implementing and accepting applications, and I think on one of the sheets I sent out there is a map identifying where those states are. There's further seven other states where it has passed but is awaiting implementation because of rule promulgation delays. Virginia, just by way of information, has the longest rule promulgation process in America; I think they passed their bill. They're probably the third person to pass a bill that's not implemented yet. But at any rate, there's 20 that have passed since 2021, 2 that preceded that, so we're at 22 already. And there are-- is legislation right now pending in 19 states now; when I prepared my remarks it was 18. And Wyoming dropped a bill this morning, which pushes to 19. Ohio's coming in next week, so it'll push us to 20. Joining Nebraska with pending legislation is such disparate areas as Arizona, Georgia, Guam, Kansas, Maine, Maryland, my own state of Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, South Carolina, Vermont, and West Virginia. The model created in LD1212 [SIC] follows these successful legislative efforts by creating a pathway for eligible, previously licensed IMG's to

work. And just in terms of terminology, IMG means international medical graduates. You'll hear a lot of people talk about how there's a significant number of international medical graduates already practicing in, in Nebraska. That is true. ITPs is a subset. ITPs, which is what this legislation is focused on, are previously-licensed international medical graduates. So, there are international medical graduates practicing here now, but as the Senator indicated, to be able to practice, they've had to repeat their residency, they've had to secure a U.S. residency to get licensure. Under this pathway, the ITPs would work under the supervision of a fully-licensed Nebraska physician and an eligible hiring entity to meet the health care needs of the state residents while providing safeguards to assure health and safety. The legislation contains an innovative two-step approach that creates supervised practice under a limited license, followed by a restricted license, requiring a duty to participate in a shortage area, rural. This has occurred in a number of the states I've talked about. Massachusetts was the first one out of the gate to do this two-step; Nebraska's a little bit longer.

HARDIN: You're in the red, Mr. Zimmer. Can I ask you--

MICHAEL ZIMMER: Oh, I'm sorry, I wasn't looking at my light. I'm done.

HARDIN: Speak about, speak about the standards thing for me, from your perspective.

MICHAEL ZIMMER: Sure.

HARDIN: How does this work? Because if I look at just how does it work when we go from Iowa to Nebraska, generally speaking, Nebraska can find plenty of reasons not to allow them here. It's not just for medical things; we do that with teachers, we do with technical trades, we find lots of reasons why you're just not quite tall enough to work here.

MICHAEL ZIMMER: Mm-hmm.

HARDIN: It's a personal axe that I grind. And so, help me understand, how do we stay safe? Because in this case, we're not talking about people coming from very far-flung places like South Dakota, we're talking about continents away.

MICHAEL ZIMMER: Mm-hmm, mm-hmm.

HARDIN: And so, how the standards work out in these other states? Granted, it seems to be going on, but help us understand and ease our fears through [INAUDIBLE].

MICHAEL ZIMMER: You mentioned earlier, I think, educational credentialing. ECFMNG [SIC], which has been referred to earlier, the Education Commission for Foreign Medical Graduates, certifies the education of both US programs and international. So, if I'm an ITP, I first of all have to have my schooling, my medical schooling, certified by ECFMNG [SIC] as equivalent. The trick comes in the training. After you get your degree, you then go in-- in the traditional pathway, you go into a residency, and those residencies are certified by a group called ACGME, which I would tell you what it is, but I always screw it up. That group, however, only certifies US residences; there is no international group right now that certifies international residencies. So, what the bill does is basically say your postgraduate training, meaning your residency, has to be substantially similar to that offer in the United States, meaning substantially similar to an ACGME-approved residency program. Now, there are two screening points here. Number one, the, the provisional sort of license pathway is very market-driven in the sense that you cannot even file for an application unless you've had a bona fide offer of employment from an eligible hiring entity. So, the hospital FQHC, whatever, is going to screen the candidates and screen their post-graduate training to make sure they will provide adequate and safe care in their institutions. After all, they have to carry the malpractice insurance. In addition to that, the board itself has to make that same determination that the training was equivalent.

HARDIN: Can I ask a question on that?

MICHAEL ZIMMER: Yep.

HARDIN: Because I'm unfortunately a bit of an insurance wonk.

MICHAEL ZIMMER: Yep.

HARDIN: Do they have higher malpractice when they come in for that? Because that would tell me something about the actuarial risk that's involved.

MICHAEL ZIMMER: Let me be as, as careful with that as I can. While a whole host of states have implemented, there are one, two, three, four states that have issued licenses so far.

HARDIN: OK.

MICHAEL ZIMMER: In those states, that has not been an issue, because essentially, the provisional period-- think of it more-- it's not a residency; think of it as a fellowship.

HARDIN: OK.

MICHAEL ZIMMER: So, the malpractice insurance, like the reimbursement rates, which is probably another question I'm going to get, tend to track that. There has not been an issue in those other states securing malpractice insurance because the actuarial risks are akin to a fellowship.

HARDIN: And these are basically since '21?

MICHAEL ZIMMER: Yes.

HARDIN: Is that right?

MICHAEL ZIMMER: Well-- yes, since 2021.

HARDIN: OK.

MICHAEL ZIMMER: Washington is a little-- Washington was the first one out of the gate, and they probably licensed 45 people, but they don't have a permanent pathway to full licensure, so to be perfectly candid, Senator, I wasn't including them in the mix.

HARDIN: OK. Understood. Senator Frederickson.

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

MICHAEL ZIMMER: Yes.

FREDRICKSON: --and for taking the time to testify. So I, I, I had a couple of questions for you.

MICHAEL ZIMMER: Yep.

FREDRICKSON: So, I-- the way I'm reading the bill, so, we're talking a lot about immigrant-- immigrants who might be practicing here. Would this also include-- if there was, for example, like a US citizen who went to medical school abroad, I mean, and, and just-- and came back, this, this would be--

MICHAEL ZIMMER: Great question. Great question. It is anybody who's an internationally-trained physician, meaning you could be a resident of Nebraska, have gone to University of Nebraska for your medical education, and then did your post-graduate training in Saudi Arabia. Absent this pathway, even though you're a Nebraska resident, you would have to get another residency in Nebraska to be licensed. So, to cut to where I think you mean, it benefits individuals who receive post-graduate training internationally, regardless of their country of birth.

FREDRICKSON: My other question for you is, you, you-- and you touched on this a little bit, I just want to ask if you can repeat it a bit. So, you have ITPs here, internationally-trained physicians, that's who this legislation is targeted towards.

MICHAEL ZIMMER: Yep.

You-- then, there's international medical graduates. What's the difference there?

MICHAEL ZIMMER: The international medical graduate is a person who received their medical education, but not necessarily their training abroad.

FREDRICKSON: So, they went to medical school but didn't do residency.

MICHAEL ZIMMER: They went to medical school internationally, but they, they either didn't do a residency, or didn't did a residency-- no, they didn't do a residency.

FREDRICKSON: OK. And an internationally-trained physician is someone who did medical school, but as well as the residency.

MICHAEL ZIMMER: Postgraduate training and was previously licensed or otherwise authorized to practice internationally.

FREDRICKSON: Understood. OK. Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank for being here and making the trip. So, so the language says substantially similar medical training--

MICHAEL ZIMMER: Yep.

BALLARD: --and that's determined by the licensing board?

MICHAEL ZIMMER: The board. Mm-hmm.

BALLARD: OK, perfect. And then-- so, the-- so, make sure I understand this right. So, you have layers of licenses for--

MICHAEL ZIMMER: Mm-hmm.

BALLARD: And so, I'm curious about the reimbursement rate. So, is, is it all the same across the board? Is there any confusion with licensing from departments in the implementation?

MICHAEL ZIMMER: There has not been, in terms of the steps. When you come in for your restricted license, because you're operating under supervision-- and I look at Medicaid, because that's where we've been working more. The Medicaid reimbursement rate full-- is essentially the same as those given to a fellow or a resident, because they're not yet fully licensed. Once they've reached that restricted level, where they're no longer under supervision-- and to be perfectly honest, the restriction is only geographic; it's not on scope of practice, it's that requiring supervision, is just a geographic restriction. The thinking being is that for insurance reimbursement, those people are fully licensed and should have no issue.

BALLARD: OK. I appreciate it. Thank you.

HARDIN: Other questions? Thank you.

MICHAEL ZIMMER: That was easy. Thank you.

HARDIN: Proponents, LB1212. Welcome.

MATTHEW GREGORY: Good afternoon, Chair Hardin, and members of the committee. My name is Matthew Gregory, M-a-t-t-h-e-w G-r-e-g-o-r-y, and today I'm representing Nebraska Farmers Union here

in support of LB1212. I want to thank Senator Riepe for bringing this thoughtful bill forward. Nebraska Farmers Union is part of the Nebraska Alliance for Thriving Communities, a broad statewide alliance of more than 70 associations representing hundreds more individual organizations and small businesses across agriculture, health-- healthcare, aging care, education, hospitality, construction, organized labor, faith institutions, and communities of all sizes. And as for Nebraska Farmers Union, we're the second oldest and largest general farm organization in the state, serving family farmers and ranchers since 1913, with about 4,000 family memberships. And our members have been struggling with physician shortages in rural Nebraska, and this bill recognizes that qualified immigrant Nebraskans can help fill the gaps of health care services in rural Nebraska for many years to come. Specifically, as we've heard a little bit, LB1212 allows physicians who have trained and worked in another country after passing the requisite medical exams earn a medical license while working under the supervision of a U.S.-trained doctor rather than having to start over with a, a residency program, and this would ensure we're using the talents and skills of Nebraska community members over community members who previously worked as doctors in other countries, and helps ensure that medical residency programs are more available to graduate-- to graduates of schools like UNMC and Creighton. So, the-- LB1212, as I understand it, you know, compared to other states, and the Nebraska version of it adds a three-year rural restricted window where a doctor can go into independent practice but must be in a rural need area, and exposure and time in rural areas is the best way to convince them to move to, plant roots, and remain in our small town rural areas. Who knows, maybe they'll meet the love of their life and raise their family there, so. Nebraska Farmers Union has been attuned to rural health care for decades, so we want to thank Senator Riepe for trying to give us another tool in the toolbox for bringing physicians to rural communities. So, with that, we ask the community to advance LB1212, and I'll try to answer any questions if I can.

HARDIN: Thank you, questions? Seeing none. Thank you.

MATTHEW GREGORY: Thank you.

HARDIN: LB1212, proponents. Welcome.

ARTURO ACEVES GONZALEZ: Good afternoon, Chair, members of the committee. My name is Dr. Arturo, A-r-t-u-r-o, Aceves, A-c-e-v-

e-s, Gonzalez, G-o-n-z-a-l-e-z. I serve as the head of Health Equity and Economic Opportunity for the Latino Economic Development Council. We're here to testify in strong support of LB1212. I'm testifying today not just as a researcher or an advocate, but as a physician currently navigating the various systems this bill seeks to improve. I'm currently studying to validate my medical license in the States. Since arriving in this country, I have dedicated myself to the nonprofit sector, building networks, volunteering, and donating to causes I believe in, because I cannot yet do the one thing I was trained to do: treat patients. To me, medicine is not just a profession or a set of skills I learned in a classroom; it's a vocation. It is what I strongly believe I was called to do in this lifetime, and I did not become a doctor to watch a community struggle and sit in the sun on the sidelines. And when I say community, I want to be very clear: I do not just mean men, Latinos, or U.S. citizens; I mean every individual living in the same geographic space I proudly call home. When a rural Nebraskan cannot find a doctor, that is to my community's suffering. LB1212 is the bridge between the suffering and the solution. Right now, we have a bottleneck of qualified talent. There are individuals like me, skilled, trained, and ready to serve. We're blocked by redundant pathways. This bill creates a streamlined safe passage for our community, and for us to fulfill our purpose. Nebraska is facing a crisis of access that is measured in distance and delay. Currently, 13 out of 93 counties have zero primary care physicians. In these communities and in the high-poverty urban pockets my organization often serves, the ratio of patients to doctors far exceeds the federal crisis level of 3,500 to 1. We're not asking to reinvent the wheel; we're simply asking for the ability to use the wheels we already have. LB1212 does two critical things. First, it brings care to where it's missing. The restricted license proposed in this bill is a strategic tool. It allows these physicians to practice independently only if they serve in a designated health profession shortage area. This ensures the new supply of doctors goes directly to the rural and underserved communities that need them most. And two, it honors expertise and safety. To be, to be even eligible, candidates must graduate from a university recognized by the world directory of medical schools, ensuring that education meets rigorous U.S. standards. These physicians must still pass the USMLE steps one two and three, the exact exams U. S. students have to pass to practice. Furthermore, they are required to practice under supervision for up to three years before they can even practice. The safety checks are rigorous. I urge you to see this bill not just as a workforce legislation,

but a moral imperative to let willing hands do the work they were created to do. Please advance LB1212. Here to answer any questions you may have.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome. I'm glad you came today-- here, here today, doctor. You say there are many-- you're part of a group, there are quite a few of you. Do you have any idea how many you're working with in a similar situation as you?

ARTURO ACEVES GONZALEZ: I do not have that number with me. Maybe there's someone else that could answer that question.

G. MEYER: And, and I probably was remiss in not asking the gentleman from Farmer's Union, but how are you selected to go into rural communities? Is there a lottery system? Not, not, not to make light of it, but, you know, with so many communities in need, you know, how, how are, how are prospective doctors placed in a rural community?

ARTURO ACEVES GONZALEZ: To my best understanding is that one would submit their application, and we would be interviewed by the specific hospitals or health institutions that would require those physicians to be licensed under.

G. MEYER: OK. Thank you.

ARTURO ACEVES GONZALEZ: Mm-hmm.

HARDIN: Can I ask, tell me your story. Where are you from? And where did you go to school? And what does this process look like for you? What has, what has life been like?

ARTURO ACEVES GONZALEZ: Of course. I've been in the United States for about seven years.

HARDIN: OK.

ARTURO ACEVES GONZALEZ: I studied in one of the most prestigious universities in Mexico, it's La Universidad de Guadalajara. We have very rigorous eligibility requirements; over 4,000 individuals apply on a national level, and only 10 percent get in. That's why I made emphasis on the World Medical Directory,

because it's not just any school in Mexico that can apply to be a medical physician here in the States. I moved here due to multiple unfortunate circumstances, and I, I thought I knew the language when I first moved here, but that was one of the biggest barriers, and I've had multiple years to try to make my communication skills better in English, but because of that barrier--

HARDIN: Better than mine. You're good.

ARTURO ACEVES GONZALEZ: I appreciate that. I was unable to practice in any-- I couldn't even go through an interview. But with hard work and resiliency, I was able to be one of the first interpreters for the governor-- well, currently U.S. Senator Pete Ricketts. It was the first press briefing that was put in Spanish because of the COVID-19 pandemic. So-- and with that, I received one of the highest honors, civic honors, that you-- one can receive here in Nebraska. I am a Nebraska-- proudly a Nebraska Admiral, and with that, I started expanding my social capital and continue my leadership in the nonprofit world, currently serving as the head of Health Equity and Economic Opportunity for the Latino Economic Development Council.

HARDIN: Thank you.

ARTURO ACEVES GONZALEZ: Mm-hmm.

HARDIN: Any other questions? Thank you. Next proponent, LB1212. Welcome.

NICK GRANDGENETT: Thank you. Well, good afternoon. My name is Nick Grandgenett, spelled N-i-c-k G-r-a-n-d-g-e-n-e-t-t. I'm a staff attorney with Nebraska Appleseed, testifying in support of LB1212. As the committee knows, this bill creates a licensing process through which internationally-trained physicians, if they demonstrate they have the requisite expertise and knowledge, may be licensed to practice medicine through a supervisory program. LB1212 complements Nebraska's existing residency process by effectively creating a parallel track. We appreciate this bill because it recognizes the valuable contributions that immigrant community members make to the healthcare industry and looks to develop that partnership. Already, Nebraska, as we've heard today, is facing a serious physician shortage. 58 of the state's 90 [SIC] counties are designated as shortage areas for family physicians; at least 21

counties in Nebraska don't have a primary care physician, while 83 percent of all of Nebraska's diagnosing and treating practitioners are located in the city areas. In meatpacking towns like Crete, Grand Island, or Wakefield, a bill like LB1212 would help ensure the immigrant community has access to qualified physicians that share a common language and culture. Unfortunately, as we've heard today, many immigrant Nebraskans have the training experience to serve as physicians, but the, the residency process is a barrier to that. While 93.5 percent of U.S. medical school graduates match into a U.S. residency program, because of those limited slots, only 58 percent of IMGs do, even though they have that ECFMG certification. In the last five years, many states, including Washington, Idaho, Colorado, Iowa, Wisconsin, Illinois, Virginia, Tennessee, Louisiana, and Florida have enacted laws to address and reduce the bottleneck effect created by the, the, the residency process. Importantly, as we've also heard, this bill has a lot of safeguards to ensure the system works well. First, the Board of Medicine and Surgery ultimately retains rulemaking authority. An internationally-trained physician must complete the ECFMG certification which signifies, again, they have the skills necessary for a residency program. The internationally-trained physician must be evaluated and supervised by a doctor, and they have to continue to submit those evaluations on a six-month rolling basis, and there are processes to ensure that the internationally trained physician is covered by malpractice insurance and can be stripped of their license if there are issues. One friendly amendment we just want to flag is to potentially change the language regarding immigration status on page four, line three. [INAUDIBLE] cite to the federal regulation, 8 CFR 274a.12. This basically just identifies all the categories of people who are authorized to legally work in the United States. It's a little bit cleaner than trying to use language like lawful presence or lawful status, which aren't actually defined in law. So, it's that, that federal regulation the committee might want to look to to kind of identify who is legally allowed to work in Nebraska. Thank you, and I'm happy to answer any questions.

HARDIN: Thank you. Questions? We appreciate it. Thank you.

NICK GRANDGENETT: Thank you.

HARDIN: Proponents, LB1212. Welcome.

ITZEL LOPEZ: Good afternoon. Buenas tardes. My name is Itzel Lopez, I-t-z-e-l L-o-p-e-z, and I serve as the CEO of LEDC. Thank you for the opportunity to testify in support of LB1212. At LEDC, we believe that immigrants empower Nebraska's economy, especially in meatpacking towns where immigrant families make up significant portion of the workforce. These communities are essential to our state's food supply chain, tax base, and small business ecosystem. Yet, they often experience some of the greatest barriers to accessing healthcare. LB1212 recognizes a simple but powerful truth: diversity in our healthcare workforce, is not-- it's not symbolic, it's structural. It builds trust, and trust saves lives. In meat-- meatpacking towns, many residents are first-generation immigrants. They may speak Spanish, Vietnamese, Somali or other languages. They may come from other countries, where healthcare systems were inaccessible or even corrupt. Some carry trauma from migration; many are mixed-status families who live with constant fear and uncertainty. When individuals walk into a clinic and see providers who speak their language, understand their culture, and reflect their lived experience, it changes its outcomes. They ask questions, they follow up, and they seek preventive care. They are more likely to disclose symptoms, mental health struggles, and workplace injuries. Without that trust, people delay care; they rely on emergency rooms, they avoid reporting workplace injuries, et cetera, et cetera. The cost of delay is not only human, it is economic. Nebraska healthcare workforce shortages are especially acute in rural communities, especially those that have a meatpacking plant. Like State Senator Riepe already shared, we cannot afford to ignore the talent already present in these communities. These are bilingual students, first-generation Nebraskans, DACA recipients like myself, and children of immigrants who aspire careers in nursing, medicine, behavioral health, and public health. Policies like this help remove structural barriers so that more Nebraskans like Arturo can enter and remain in the health care workforce if they choose to. When we invest in diversifying our health care system, we're not creating special treatment; we are strengthening the system for everyone, a system that reflects the demographics of its future as well. LB1212 is about workforce development; it's about rural sustainability; it's a about public health infrastructure. And ultimately, it is about whether we're willing to build systems that meet people where they're at. And as an immigrant myself, I can tell you that when communities trust healthcare, they engage earlier, comply more consistently, and experience better outcomes. Thank you.

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

ITZEL LOPEZ: Thank you.

HARDIN: Proponents, LB1212. Welcome.

CARTER MATT: Thank you. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Carter Matt, that's spelled C-a-r-t-e-r M-a-t-t. I'm here today as a volunteer and long-time supporter of CareerLadder. CareerLadder applauds the Health and Human Services Committee's efforts to explore solutions to Nebraska's physician shortage, including through consideration of LB1212. CareerLadder is a Nebraska-based nonprofit that advocates for professional opportunities and the advancement of internationally-trained professionals while fostering economic opportunity and dignity through professional development. As other testifiers have talked about, the United States faces a substantial and growing shortage of physicians, with a projected shortage of 86,000 by 2036, and these projected shortfalls are even greater in rural areas. The University of Nebraska Medical Centers, the status of the Nebraska health care workforce in 2020 reports that 13 counties in Nebraska do not have primary care physicians, and with many Nebraska physicians nearing retirement, the need to expand our provider pipeline is urgent. At present, 25 percent of physicians across the United States are internationally-trained, many of whom completed postgraduate education or residence-- residencies in the U.S. Still, many more are unable to get licensed without redoing their medical education again in the U.S. Internationally-trained physicians could help address Nebraska's shortage of physicians, but existing barriers often prevent them from obtaining licensure in the United States and practicing in the medical field. Internationality-trained physicians are physicians who have completed their medical degrees and clinical training outside the U.S.; many of these professionals bring years of experience and training from reputable institutions abroad, and often meet the rigorous standards required to practice safely and effectively in the U.S., however, many are unable to obtain licensure due to structural barriers that require them to repeat their medical training. And LB1212 provides an alternative pathway to licensure for internationally-trained physicians without creating competition against Nebraska-educated medical graduates. It would allow Nebraska to benefit from the education, skills, and experience of a larger pool of qualified

practitioners while still upholding the same rigorous standards for high-quality and safe medical care. The bill establishes a structured framework, including provisions for limited and restricted licensing, leading to unrestricted licensure after meeting existing requirements, including supervised practice, passing relevant USMLE steps, ECFMG certification, and employment in qualifying settings like health care profession shortage areas. And similar alternative pathways to licensure have now been enacted in over 20 states, including Iowa, Wisconsin, and Tennessee. These pathways do not compromise quality or safety; instead, they allow states to retain control over licensures while tapping into a broader pool of qualified professionals. However, as implementation efforts progress across the states, internationally-trained physicians increasingly seek out states where they can contribute meaningfully in practice, and this bill allows Nebraska to compete for these physicians and provide them pathways to practice here in Nebraska. And thank you for affording CareerLadder the opportunity to testify in support. Thank you.

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

CARTER MATT: Thank you.

HARDIN: Proponents, LB1212. Opponents, LB1212. Welcome.

JODANNE HEDRICK: Welcome. Good afternoon. Chairperson Hardin and members of the committee, I thank you for the opportunity to speak today. My name is Dr Jodanne, J-o-d-a-n-n-e, Hedrick, H-e-d-r-i-c-k, and I'm here on behalf of the Nebraska Board of Medicine and Surgery. We recognize and share the Legislature's concern about access to care in rural Nebraska. Many of our communities face significant physician shortages and long travel distances to care. Patients in these areas deserve timely access to those services and stable healthcare workforce. We appreciate the intent of those bill-- of this bill to address those needs. The board's first and foremost responsibility, however, is public safety. Our statutory mission is to ensure that all physicians practicing in Nebraska meet consistent standards for safe, competent, high-quality care. For that reason, we must respectfully oppose LB1212 in its current form, and recommend several important revisions to ensure that any pathway forward maintains the highest standards of patient care. First, the bill does not clearly require verification of board certification or equivalent specialty certification in the physician's home

country. While many internationally-trained physicians are exceptionally well-trained, confirming specialty certification or equivalent is an important measure to ensure consistent standards of medical expertise and clinical readiness. Including this requirement would strengthen public confidence and help ensure that patients, particularly those in rural communities, receive care from highly-trained professionals. Second, the bill does not specifically state that the physician must have practiced medicine within the past 12 months. Recent active clinical practice is an important indicator of current competence. Adding language requiring recent practice would help ensure that physicians entering Nebraska's workforce are clinically current and prepared to deliver self-care-- safe care from day one. Third, we recommend revising the terminology used in the bill. The current language referring to a limited or restricted license may create confusion, as those terms are presently associated in Nebraska with disciplinary actions. We suggest instead the use of term "provisional license to practice," which more accurately reflects a structured transition period and avoids unintended implications for physicians and the public. We want to be clear, the board supports thoughtful pathways that welcome qualified internationally-trained physicians into Nebraska's workforce. These physicians contribute greatly to health care across our country, but rural communities deserve more than a temporary solution to health care shortages. They deserve competent, highly-trained professionals who are prepared to practice safely within the U.S. health care system. Expanding access and maintaining high standards are not mutually exclusive goals. We can, and must, do both. The board stands ready to collaborate with the Legislature to strengthen this bill so that it both improves access to care and preserves the safeguards that protect patients. Public safety must remain the foundation of any licensure pathway. Thank you for your time and your commitment to the health of Nebraskans. I would be happy to answer any questions.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here. It's good to see you. So, first of all, I appreciate-- I always appreciate when opposition comes with tangible suggestions that, that can help sort of make the bill better. I don't want to put you on the spot here, but I, you know, I don't-- I certainly don't want to speak for the bill's introducer either, but,

should these recommendations be adopted, would that be something that the board could get behind removing opposition? Or--

JODANNE HEDRICK: You know, I think our-- the board's biggest concern is that-- you know, for example, for those of you who don't know who I am, I'm a OBGYN, I'm an assistant professor at Creighton University, and I practice in Omaha, Nebraska, and I have served our community in Nebraska for the last 25 years. For me to maintain my board certification, I have to pass an exam every year called maintenance of certification, and every three years, I have to do 60 hours of continuing education so that way I can continue to practice, not to mention on top of whatever the hospital requires for credentialing, as well as what the state of Nebraska requires as well. This bill, as it stands, doesn't really provide that clinical competence. We know that board certification actually makes doctors better, safer clinicians, and is required as much as it is expensive and problematic and time-consuming. However, this bill doesn't provide for those provisions, and so I think that there's some nuances that need to be addressed so that that way we ensure that physicians that come into our state practice safely, effectively, and competently, especially for people who are at risk.

FREDRICKSON: That's helpful. Thank you.

HARDIN: Other questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome. Glad to see you here today. One of the problems I have-- I'm in my second year here, lifelong rural Nebraskan, and I see us losing providers in our rural communities. Just about every, every issue we deal with here, providers are saying, "I've had it, we're done. We're not going to provide services in the rural community anymore." And so, we try to do things. Senator Hansen had a, had a midwifery bill that I supported; I thought it was probably a very, very good solution to some of our problems. And yet, the Nebraska Medical Association says no. And so, I have reached out and said, bring us something we can work on. Crickets. What have you proposed to expand medical care in the rural community? Because I don't see anything. And so, here we have an opportunity with some specific guidelines to provide medical care in rural communities, and the Nebraska Medical Association says "No." Bring us something to work on. Bring, bring us something positive. We're, we're trying to provide medical care in the

rural communities, here's an opportunity, and yet "No" is all we get.

JODANNE HEDRICK: Well, if-- some of this is, again, you know, is me representing-- I've served on the Nebraska state board for the last seven years. I served two-- one five-year appointment, now I'm in my second five-year appointment, which is a volunteer position. I think that this is a multi-layered problem. For example, residency slots within the United States are restricted. The federal government is not increasing federally-funded residency positions, which allows us to retain more physicians. We know that a lot of physicians tend to practice in states where they trained. Same thing with nurse practitioners. So, some of the problem could that. The other problem might be, if you-- if I said to you, Senator Meyer, "work/life balance;" some of it is that. We are training people to protect their personal time. You know, for, for people like me, I graduated from my residency in 2001. There were no work-hour restrictions, there wasn't an 80-hour work week as a resident. I, in some weeks of my residency training, had logged up to 122 hours per week. So, some of our workforce shortage is going to come from that we are training people to work less because we know it's safer. You know, when we're overtired, we actually cause medical errors, which we don't want. So, I think that there's numerous problems with trying to influx people into those areas because the concept of-- you know, part of me being a physician is being a part of the community. I've raised my children that way. Just don't live in your community; no matter what you do, be a part it. Give back to what has given you so much, and trying to foster that through our educational process. But they want their time home with their families, and they want to protect that. So, for a rural community, you're not just going to have that doctor who's taking care of the community for 30, 40, 50 years all by themselves, never taking vacation. That is not what we are currently training, at least our U.S. physicians, at this time. We are teaching them to draw a line; you work when you work, and you're home when you're home, and that's somewhat creating an access problem. You know, at Creighton University, we've tried to find a rural community that meets requirements to create a rural track in our OB-GYN residency, and we have failed to do so partially because of the politics in some of the smaller-town hospital systems and trying to navigate that, and finding funding. We just increased to five residents per year at Creighton University, but now that fifth spot is now privately-funded, not federally-funded. And so, we have to get more creative. I appreciate that wanting to get individuals who

trained in foreign countries to come here and provide access to areas, and hopefully stay and grow in those areas-- I, I love that concept, but I have to think of the public safety first, and are these people competent. I mean, I met an OBGYN from China, and she was a lovely woman. And when I asked her, you know, "How do things look in China?" All she does is C-sections. She couldn't come here and clinically and competently practice medicine. She doesn't do vaginal delivery, she doesn't do hysterectomy, she doesn't do D&Cs for pregnancy loss. And so, she's very niche, and would not be able to make it here in a rural community, even with supervision, even though she is a highly-trained and was the number one physician in Beijing, China, because it's different in other countries. We currently have a resident from Lebanon. She's done a four-year residency in Lebanon, and she's wonderful, but there are definite gaps in her education, as we do more minimally-invasive surgery here than they did in her country. And so, she's here because she wants to do an MFM fellowship and then go back home to practice, and she has to do a U.S. residency in order to do so. So, I think that there are a lot of nuances to this that we haven't discovered. And because this is new across the United States, as far as medical liability goes, we aren't going to see that yet because, from a surgical complication, they have two years to file a medical malpractice suit. So, this is so infantile yet that we might not know-- are there legal aspects to this that we haven't discovered yet because it's too new? You know, for me as an obstetrician, you know, someone can file a lawsuit for a child up to 18 years of age.

G. MEYER: I don't need to be educated on the challenges of medical personnel in the rural community, and you have volunteered nothing of providing medical delivery services in a rural community. Thank you.

HARDIN: Senator Hansen.

HANSEN: OK, a couple questions about your testimony. So, one of your concerns was it does not clearly require verification of board certification or equivalent specialty certification in the physician's home country. Is that the, the certification that you're referring to, the ECMFG certification? Or is that, like-- what, what kind of verification are, are you-- is creating doubt?

JODANNE HEDRICK: So, they're just saying that they are going through their-- the medical schools are verified, they're passing their USMLE, but they're not, they're not verifying their clinical competence as the result of their residency.

HANSEN: OK. OK. And do you know if they require people coming in here under these qualifications-- do they need CE hours in the other countries where they come from, or?

JODANNE HEDRICK: I-- you know, the-- I would, I would guess that the licensure requirements, however every country does it, is probably so different I could not speak with any kind of competence as to what each country would require. And once they come here, because they're not under any kind or specialty board like I am, they would not be required to have the same continuing medical educations that you or I-- or, you or I would, based on our specialty boards.

HANSEN: OK. OK, I think that's-- I thought I had another question, but I think that's it. Thank you.

JODANNE HEDRICK: Thank you.

HARDIN: Seeing no other questions, thank you.

JODANNE HEDRICK: Thank you.

HARDIN: Those in opposition to LB1212. Welcome.

WESLEY ZEGER: Thank you. Chair Hardin and members of the committee, thank you for the opportunity to speak today. My name is Dr. Wesley Zeger, W-e-s-l-e-y Z-e-g-e-r. I'm an emergency medicine physician in Omaha. I also serve on the Board of Medicine and Surgery. Today, I'm testifying on behalf of the Nebraska Medical Association. The NMA supports the position of the Board of Medicine and Surgery, which is opposed to LB1212 in its current form. NM-- the NMA shares the board's desire to work with the-- with Senator Riepe to make some changes that we believe could help this new pathway for up-- set it up for long-term success. The NMA appreciates Senator Riepe's leadership in addressing the physician shortages across Nebraska. We share the goal of increasing access to high-quality care in rural and underserved communities. Nebraska patients deserve timely access to well-trained physicians close to home, and we agree that internationally-trained physicians can be a part of that

solution. This approach must be thoughtful and carefully structured. Internationally-trained is not uniform category. Postgraduate medical education systems vary dramatically across the countries in length, rigor, supervision standards, some specialty structure, and evaluation processes. In some countries, specialty certifications require years of structured training and national examinations; in others, pathways may be shorter, less standardized, or not competency-based in the same way that U.S. graduate medical education is. Without clear statutory parameters, the Board of Medicine and Surgery would be placed in difficult position of fundament-- comparing fundamentally different training models without sufficient guidance. Lack of these clear parameters increases the risk of inconsistent standards, and may undermine the capa-- the credibility of that pathway. This standardization is especially important if physicians are entering through this pathway-- are intended to practice in rural or shortage areas where they may have fewer specialist colleagues on site and more limited systems of support. Transitioning into the U.S. practice involves more than clinical knowledge; it includes familiarity with care coordination models, documentation requirements, prescription regulations, liability frameworks, and patient communication norms. Evidence of-- from physicians' re-entry licensure shows that even experienced physicians who have been out of practice require structured supervision to safely reintegrate due to skill degradation and systems of unfamiliarity. A pathway that lacks defined supervision freight-- phases, "compety" assessments, and accountability safeguards may inadvertently place both patients and physicians at risk. The NMA stands ready to work with Senator Riepe on the committee and the Board of Medicine and Surgery to strengthen this proposal. I propose a list of recommendations which I'm happy to walk through, or to answer any questions.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thank you. In the states that have incorporated this, do you know, has there been safety issues with those physicians that are graduates who have come in there under this? Do you know? Have you heard of any?

WESLEY ZEGER: I am not familiar with the med mal risk overall with the-- with these, with these pathways. Again, these are relatively new in most states. If you look at the FSMB sites, with the Federation of State Medical Board website, they list

about 22-ish-- I think you mentioned earlier-- states have either enacted or have pending legislation to enact this. Those sites, it's unclear what those will be long-term. Again, you know, every state has varying levels of, like, timelines to file med mal claims. It'd be difficult to make an assessment on that. But I don't really have any [INAUDIBLE]

HANSEN: But usually with surgery, it's going to happen pretty quick, isn't it? Like, [INAUDIBLE] statute of limitations like, what, two years or longer? [INAUDIBLE]

WESLEY ZEGER: I think in every-- yeah, every state's a little bit different--

HANSEN: If they're incompetent, I think they would probably be sued pretty quick.

WESLEY ZEGER: Yeah. Depending on the complication, yeah.

HANSEN: Yeah, OK. I'm just curious. Like, like, one of the benefits of Nebraska not being the first in a lot of stuff is that we get a chance to see maybe what's happening in other states, and if we're seeing issues happen there.

WESLEY ZEGER: Yeah.

HANSEN: I mean, how can we relate that to maybe what might happen in Nebraska? This is one of reasons why I ask that question is [INAUDIBLE].

WESLEY ZEGER: Yeah, no, it's a good question. I would say that this fault is that, you know, I guess I haven't heard anything one way or the other, so.

HANSEN: Thanks.

HARDIN: Other questions? Seeing none, thank you. Those in opposition to LB1212. Those in the neutral, LB1212. Senator Riepe. Online, we had 9 proponents, 1 opponent, 1 in the neutral. Welcome back.

RIEPE: Thank you, Chairman Harding [SIC] and, and committee members, and thank you. I'd also like to thank all those that testified today, regardless of their position. It's part of the democracy that we live in, and I respect and appreciate that.

I'm also an Omaha senator, and in my eighth year on the Health and Human Services Committee, so I obviously have a commitment to health. And being a hospital administrator, I have a commitment to health care delivery as well. And my staff, in the last two interims, we have conducted studies on rural health care in Nebraska. While I don't have the answer to what are really the needs from all the needs in the rural healthcare delivery model, what I do know is we have a-- we have to start. We have a problem. We're experiencing a decline in the number of physicians in rural Nebraska of 57 that were lost-- not lost in passing, but lost out of practice between 2017 and 2023. We must act, and we cannot simply hope that the problem of ignoring the situation, and that occasionally someone will graduate either from Nebraska or Creighton, on a longshot, that might go out to a rural community. Physicians have and will continue to be the captain of the ship in any health care delivery model, as I see it, so that's where we start. And LB1212 is one key opportunity to move forward. That's all I have, Senator.

HARDIN: Thank you. Questions? Question for you.

RIEPE: Yes, sir.

HARDIN: You had a couple folks come in in opposition. Did they contact you before today?

RIEPE: Yes.

HARDIN: OK, good.

RIEPE: Yes.

HARDIN: Good for you guys.

RIEPE: We're very respectful-- we agree to disagree. It's-- you know, it's-- I respect that there's politics.

HARDIN: Reasonable people can disagree with one another. That's fine. Though I still would like to see more doctors where I'm from, because I'm tired of going to the veterinarian for my medical [INAUDIBLE].

RIEPE: No comment.

HARDIN: Senator Hansen.

HANSEN: You said in your closing statement that physicians are the captains of the ship of any health care delivery method. That's kind of what you're trying to propose, but they came out opposed to your bill.

RIEPE: Well, you know, I have great respect for physicians. I've worked with them for 40-some years. And it's an old term that was back, probably in the 60s, even, when physicians were the captain of the ship, that's why I threw that in there a little bit.

HANSEN: Yeah. I like it, though. I think it's good.

RIEPE: And it's been-- it's moved more to a team thing, but even in programs like in Australia, the hub is built around the physician because they generally have that broader perspective and more training, and, and, and somebody has to be in charge, and that's good. But there, in Australia, they make it a point that they try to make sure that everyone works to their maximum training skills and capacity, and that is one thing that we lack in this country. But that's a whole-- that's a whole 'nother bill.

HARDIN: Seeing no other questions. This concludes LB1212 and our hearings for today. Thank you.

RIEPE: Thank you.