

Transcript Prepared by Clerk of the Legislature Transcribers Office
Health and Human Services Committee February 19, 2026
Rough Draft

HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48. And I serve as chair of the committee. The committee will take up the appointments and bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table in one of these little rooms on the side in the back. Be sure to print clearly, fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on that same table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, and spell your first and last name to ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, 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 light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining. And the red light indicates 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 of those and give them to the page. Please note: 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. And, and, and, and, and is this the part, Barb, where I have to read the new section?

BARB DORN: Yes.

HARDIN: OK. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record

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are usually-- so they have to-- a deadline of 8 a.m. But today, we have weird weather. So due to the inclement weather moving across Nebraska today, the Legislature has extended today's hearing online comment deadline to 5 p.m. If you're unable to attend the hearing and wish to submit comments, go to nebraskalegislature.gov and enter the bill number at the upper right of the home page to get started. I'd like to have the committee members with us today introduce themselves, starting with Senator Riepe.

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

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

G. MEYER: 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: Also assisting the committee today: to my left is our legal counsel, John Duggar; and our committee clerk, Barb Dorn; as well as-- ladies.

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

DEMET GEDIK: Hi. My name's Demet Gedik. I also go to UNL. I'm a political science student.

HARDIN: We're going to begin today with an, an appointment of Nebraska State Board of Health. Ryan Palmer. Welcome.

RYAN PALMER: Thank you. Good afternoon, seniors-- Senator Hardin and members of the Health and Human Service Committee. My name is Ryan Palmer, R-y-a-n P-a-l-m-e-r. I'm an optometrist, and I practice in Blair. I'm honored to have the opportunity to serve on the Nebraska State Board of Health. As a third-generation optometrist and a lifelong Nebraskan, interest in the health of citiz-- of the citizens of Nebraska started at-- for me at a young age. I've been fortunate to train and practice in urban and rural settings throughout my career. I'm excited to offer that perspective and contribute with the other

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talented members of the Nebraska State Board of Health. We are incredibly fortunate to live in a fantastic state with great people and communities. Nebraska, like many other states, has challenges in public health and health care from border to border. With this in mind, Nebraska has always made a prov-- made providing good health and well-being to the citizens of the state a top priority. I look forward to continuing to help with that goal of positioning Nebraska and its citizens with the benefit of great public health. And I'm happy to answer any questions from the committee.

HARDIN: Thank you. Senator Riepe.

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

RYAN PALMER: Mm-hmm.

RIEPE: I noted that you said that you were from Blair.

RYAN PALMER: Yup.

RIEPE: Is that a-- an urban or a rural? What do-- how does--

RYAN PALMER: I would consider us to be rural by, by standard. I mean-- because my patient base comes from all the way up in-- near Decatur, goes all the over to Logan, Iowa, and then goes all way up to, to West Point.

RIEPE: OK. And do-- did, did-- have you lived or served in other rural-- i-- communities?

RYAN PALMER: I was born and raised in Albion. And I've worked in Albion too. And then I am-- I was trained in Cincinnati, Ohio--

RIEPE: OK.

RYAN PALMER: --with my residency. So that's where-- that's my urban setting that I've been in. So-- and I worked in Omaha when I first moved back here in 2010. I worked in Omaha for about two years, so.

RIEPE: OK.

RYAN PALMER: Yeah.

RIEPE: Fair enough. Thank you for being here.

RYAN PALMER: Sure.

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RIEPE: Thank you, Chairman.

HARDIN: Wha-- what's your sense of what the Board of Health needs to do when you lean into this? Someone contacted you and said, hey, would you be open to this? And what went through your mind in terms of what does that need to be?

RYAN PALMER: You know, I, I think that when you look at-- when you look at boards throughout the state, you need good people to serve on them. Hopefully I can fill that bill. You know, I think the Board of Health is important because it helps-- again, it helps set precedent for public health, helps drive and hopefully derive policy with the help of the Le-- with the Legislature's help, if you will, so that we can continue to, to make good policy for the people of this state.

HARDIN: OK. Other questions? Yes, someone else from Blair.

HANSEN: Been waiting for this moment for a long time. Dr. Palmer's my eye doctor back home, so. Thanks for being here. I-- and I just want to at least say that I-- talk about a great candidate for the Board of Health. He's probably been one of my most engaging constituents. He has heard me vent a few times about being here for eight years. And so I just appreciate-- I appreciate you being here and at least putting your name in the hat. And so I think you're going to do great here, so. Not really any questions, but just an-- wanted to share my thoughts about this candidate, so.

RYAN PALMER: Thank you.

HARDIN: Wonderful. Well, you-- you're in Cuming County, is that right? Where are you?

RYAN PALMER: Washington County.

HARDIN: Washington. OK. But still within a stone's throw. There are far more cattle than people where you are.

RYAN PALMER: For the most part, yes. Yes.

HARDIN: OK. Very good. I understand that and can commiserate on that part. So if there are no other questions, we appreciate you being here.

RYAN PALMER: Thank you.

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HARDIN: Wonderful.

RYAN PALMER: Thanks for the time. Appreciate it.

HARDIN: Great. This concludes our appointment conversation with Ryan Palmer. Next up, Mark Bertch for the State Board of Health. Welcome.

MARK BERTCH: Thank you. I feel like this is Groundhog Day because I was here not even a year ago, so. My name is Mark Bertch, M-a-r-k is my first name spelling; last name is B-e-r-t-c-h. I'm a practicing physical therapist in Omaha, Nebraska. And first, I just want to say good afternoon to each of you. Approximately one year ago, I sat in front of you, the members of the Health and Human Services Committee, seeking nomination to the 109th Legislature for confirmation of service on the State Board of Health, thus completing the term of the preceding physical therapist member. I wanna express my heartfelt thanks to each of you for doing this. Today, I would like to respectfully request your nomination again to this same Legislature as I seek confirmation to serve a full term as a physical therapist member of the State Board of Health. During testimony on March 20, 2025, I outlined my education credentials and touched on my honorable service in the United States Navy. I will spare you this, as it is in that day's transcript, but I'm willing to answer any questions you might have about it. Over the past year, serving on the State Board of Health has been nothing short of a wonderful experience. And I'm grateful to have this opportunity. It has facilitated better understanding about the many issues facing the health, wellness, and safety of Nebraskans. In addition, I've had the opportunity to collaborate with some dynamic health care providers and professionals. I look forward to working with many of the same and newly appointed individuals as we embrace tomorrow's challenges, a few of which include the delivery of quality health care services as citizens in the face of statewide budget cuts, managing the landscape of transgender issues gripping our society, and ensuring appropriate reimbursement to providers for services delivered rather than risk denial to those in need, especially in the rural parts of our state. While it is easy to focus solely on challenges, I would be remiss if I did not share some sense of personal accomplishment serving as a board member in our great state. For example, helping with feedback in the development of an updated credentialing review program manual and accompanying PowerPoint presentation for stakeholders delivered this. A lot of time was invested working on this project, and those involved-- both past and present-- are most deserving of recognition. I encourage each of you to look at these recently published documents.

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In closing, I turned wrenches on aircraft and threw approximately 500 mishap-free hours as a naval air crewman prior to becoming a physical therapist. Patients are routinely surprised to learn about this transition and inquire about it. I share the perspective that planes require a great deal of cognition whereas humans open the door to metacognition. I am deeply passionate about facing the unknown because it forces me to explore and learn new things. This has been my experience over the past year serving on the State Board of Health. I embrace the thought of continued service to our state in this capacity and thank you in advance for your consideration.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, sir. Thank you for your service. Thanks-- you for being here. I had a question. I was going to ask you if you were a Navy corpsman or-- and it, and it looked like maybe you're a-- with the aviation side.

MARK BERTCH: You asked me that last year, Senator, and--

RIEPE: I wanted to see if you reenlisted.

MARK BERTCH: I, I did not reenlist, but I did have my first share of encounters with corpsmen. They sewed me up on multiple occasions. And so-- I have nothing but great experiences with them. But yes, I was in aviation.

RIEPE: Those-- that's the right comment, so. Thank you [INAUDIBLE]. Thank you, Chairman.

HARDIN: Other questions? So you've, you've had a taste of being there and you know that-- just for fun, this group likes to do whatever it can to have a 407 process just as often as we can. And that-- for those of you who are listening is-- well, other than Senator Hansen, the rest of us don't do this for a living. And so we need the help of professionals to chime in and to say, well, you're dealing with a medical-related thing and this is our-- these are our thoughts. And so-- anyway. Would you talk for just a moment, given that you've had a little bit of experience doing this already with-- how do we go about cooling a medical desert across a largely rural state? Can I just pick on you that way? What are some thoughts, either related to PT in-- or, or in general?

MARK BERTCH: Yeah. I-- you know, I have to be honest with you, my knee-jerk reaction is, it is a scale that is so delicately balanced

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insomuch as-- you look at some of the issues that we face not only in the rural setting but even the urban settings-- socioeconomic issues, transportation, trust in the health care system-- versus the willingness of people to take it upon themselves in order to maintain their health. Are they willing to go that extra mile to engage in a, a healthy lifestyle? So it's really hard to say, you know, what would the answer be because I think it, it really has to be leveled on both-- on the sides.

HARDIN: Very good. Thank you. Other questions? Seeing none. We appreciate you being here.

MARK BERTCH: Thank you so much.

HARDIN: Thanks so much. This concludes the appointment conversation with Mark Bertch. I'm going to read one from one other appointee. And this will be on behalf of Patri-- Patricia Kucera. And she's also appointed to the State Board of Health. Reading on her behalf. She says this: Senator Hardin, I appreciate being considered for the opportunity to serve as a representative of the nursing profession on the Nebraska State Board of Health. I'm honored to care for our veterans in an inpatient setting as both a caregiver and an advocate. My passion for nursing started several years ago at Douglas County Health Center as a nurse's aide to care for the underserved and abandoned population of those that suffer from dementia and undesirable-- that is violent-- behaviors. I knew that nursing would be a lifelong passion for me, and I obtained my LPN, and then eventually my RN. My passion for nursing is driven by the desire to improve patient outcomes by enhancing clinical practice and collaborating within the interdisciplinary team to improve quality of life and autonomy. I worked at Immanuel Medical Center on the post-op rehab unit and also on the psychiatric intensive care unit at Immanuel. I went on to earn my graduate degree in nursing and started working with our veterans at the VA Medical Center on the psychiatric intensive care unit as a staff nurse. While working on the PICU, I noticed gross discrepancies between various disciplines and initiated a research project to quantify a patient's acuity level in order to properly staff the unit to meet the patient needs. I was able to form different committees to address the different needs of the veterans while in our care and kept management and coworkers motivated over a two-year time frame to completion. The research project was successful and eventually published and is being utilized on a national level. And she cites that particular research project that took place. During the publication of this acuity tool, I was diagnosed with stage four

cancer and endured the treatment and side effects of terminal illness. I was hospitalized several times and almost passed away because of infection and hemorrhaging. The diagnosis, though brutal, was an invaluable learning opportunity to experience what it was like to be the patient, not the nurse. It made me more compassionate and understanding of the frustration and sadness that comes with living in the realm of the unknown. I'm a better nurse and clinical instructor because of my illness, and I'm fortunate to currently be in remission. I'm honored to be an adjunct professor at Creighton University College of Nursing since 2021. I lead clinical rotations for the students on both the PICU and on medical surgical units. I feel that it's important to teach my students compassion, autonomy, and advocacy for their patients. Someday, we will all need their care, and I'm focused on making them the best possible nurses they can be. Though I have a graduate degree, I feel that my own personal experiences can be just as powerful as an education. Additionally, I've served on the Board of Health since 2024 and believe that I, I have been a valuable asset to the people of Nebraska and to the integrity of the board. In conclusion, as a member of the Nebraska State Board of Health, I feel that I will be able to represent the citizens of Nebraska with the goal of being able to expand the scope of practice, promote advocacy, define and shape policies, and enhance patient-centered care. My goal is to be a part of stabilizing the ever-changing policies that will provide resources and impact multiple disciplines to promote patient-centered care for the best outcomes. Being able to instruct the next generation of nurses is an honor using my experience of a wide range of nursing disciplines that include orthopedics, traumatic brain injuries, geriatrics, medical-surgical, and psych. Regards, Patricia Kucera. MSN, GRN, RN. Concluding her letter. So that also is an appointee for the State Board of Health. So-- and with that, we are next up with Senator Cavanaugh and LB933. Can I ask how many are here-- and if I can kind of get you to sort of filter forward in the room a little bit-- who will be testifying on LB933? OK. There's not too many. So we're-- that-- we, we don't have to churn very much, so.

J. CAVANAUGH: Got a couple handouts.

HARDIN: OK. We have experts who will pass them out for you.

J. CAVANAUGH: Thank you, Chairman Hardin. Good afternoon, Chairman Hardin, members of the Health and Human Services Committee. I am Senator John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h. And I represent the 9th Legislative District in midtown Omaha. I'm here today to introduce LB933, which gives important protections to practitioners who issue

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written recommendations for medical cannabis under the Medical Cannabis Patient Protection Act. I bring LB933 here today in the spirit of seeking consensus to give the Legislature the opportunity to pass a narrow-- narrowly tailored bill that will go a long way toward making sure that medical-- that medical cannabis as medicine is accessible to Nebraskans who need it. I feel so strongly that this, that this is necessary that I've designated LB933 as my personal priority for this session. The green copy of LB933 is borrowed from the language in Senator Hansen's LB677 from last year. I do have an amendment that I just had passed around-- and I think I've shared with a few of you-- which clarifies the scope of provider protection and makes clear that nothing in this bill prevents providers who fail to properly evaluate their patient or adhere to the proper standard of care from being subject to disciplinary action. The new language is modeled after a similar provision in the law in Oklahoma. LB933 helps correct a hole in the Patient Protection Act that threatens to make medical cannabis completely inaccessible. The hole-- this hole exists because the petitions-- petitioners were required to adhere to the single-subject rule as construed by the courts much more narrowly than the single-subject rule here in, here in the Legislature. LB933 is narrow in scope and, with the amendment, makes sure that practitioners are informed and protected if they follow the law. I'm hopeful that we can reach a consensus that protects patients and providers and gives safe access to medical cannabis to those who need it. I'd respectfully ask the committee to swiftly advance LB933 to General File with the amendment so that we can have this important debate on the floor. I'd be happy to take any questions. And the other handout is a list of all of the 17 states who have a medical cannabis only program-- so not recreational states like Colorado or California-- the states who only have medical cannabis. And of those 17 states, 16 of them have a similar provider protection. And so this is-- we're not treading new territory here. This is something that is necessary and important to a functioning medical cannabis program. And again, it was not part of the ballot initiative because it would have had to be a third petition to create this protection.

HARDIN: Very good. Questions? Will you stick around?

J. CAVANAUGH: I will.

HARDIN: Awesome. Proponents, LB933. Those in favor. Welcome.

DOMINIC GILLEN: Thank you for allowing me to be here today. Appreciate it. First time in front of this committee. Good afternoon, senators.

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My name is Dominic Gillen, D-o-m-i-n-i-c G-i-l-l-e-n. And I am here as a proponent of LB933. My 23-year-old son Will has lived with Lennox-Gastaut syndrome-- a treatment-resistant form of epilepsy-- for his entire life. Over that time, he's been prescribed 11 different black box warning medications. A black box warning is the FDA's strongest safety warning. 11. These medication carry risks like liver damage, severe psy-- psychiatric effects, addiction, and even death. Will is currently taking not one, not two, but three of these black bok-- black box drugs. All of them are FDA approved. All of them are re-- are prescribed by his epileptologist without hesitation. Two years ago, he spent two weeks in-- at UNMC. As a result of this cocktail of drugs, he was sleeping nearly 22 hours a day. We couldn't rouse him even to eat. He ended up aspirating and developing pneumonia, from which he almost died. No one from the Attorney General's Office calls to question those prescriptions. No one steps in to say, Doctor, are you sure about this? The decision-- left where it belongs: between a physician and their patient. Yet, when it comes to medical cannabis-- a treatment that is shown promise for epilepsy and other serious conditions-- doctors will not even discuss it. Not because they believe it would do harm, not, not that they lack medical knowledge, but because they fear repercussions from the Attorney General. Think about that. My son can legally bersp-- be prescribed powerful pharmaceuticals with the FDA's highest level of warning-- drugs that can damage his liver, affect his mood, and significantly impact his quality of life-- but his specialist here in Nebraska is afraid to recommend ca-- cannabis even if he believes it might help. This is not about politics. It's about medical freedom. Doctors should not be practicing medicine with one eye on their patient and the other eye on the Attorney General's Office. They should be free to use their training, experience, and clinical judgment to recommend what they believe is best. No one is asking the state to force doctors to recommend cannabis. We are simply asking that the state stop interfering with conversations between doctors and patients. The decision about whether my son tries cannabis should be left in his medical office, not in a political office. LB933 restores this balance. It protects physicians, it protects patients, and it allows families like mine to explore every possible option for relief without fear. Please advance LB933. I appreciate the extra time. Thank you.

HARDIN: Thanks.

DOMINIC GILLEN: I-- could I add one more thing? He is on those three black box drugs. He's also on a fourth drug called Epidiolex, which is an FDA-approved form of cannabis. And Epidiolex is not a black blox--

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a black box drug. So he's on three FDA-approved drugs that don't have anything to do with cannabis that are black box drugs and he's on one that has-- that comes from cannabis that is not a black box drug. So that's just part of what we deal with, so.

HARDIN: Is there, is there THC in that fourth one?

DOMINIC GILLEN: No, it's-- this was-- Epidiolex is CBD. It's canna-- it's canna-- cannabinoid--

HARDIN: OK.

DOMINIC GILLEN: --so.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I think I've met your son--

DOMINIC GILLEN: We have. Yes.

RIEPE: How would this change your life with this-- if put into law, which allows then a physician-- do you-- or-- do you have to go to a special place to get permission at this time to get the black box drugs?

DOMINIC GILLEN: No. They're prescribed by his epileptologist here in Nebraska.

RIEPE: OK. But how would this help-- how would this legislation actually help you and your son?

DOMINIC GILLEN: Well, the legislation will allow us to be able to do-- go to a doctor and get a recommendation to try cannabis, which is what we would like to try, be-- having-- you know, putting the two together. We have black box drugs over here and you have cannabis on the other side that is not consi-- not going to kill him, whereas these other black box drugs that are prescribed by the FDA-- or, approved by the FDA-- leave that option open.

RIEPE: OK.

DOMINIC GILLEN: So it gives us an op-- another tool for our doctor in his toolkit to try and help him without pro-- the probable side effects and negativity of those black box drugs.

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RIEPE: So cannabis is not part of the black box--

DOMINIC GILLEN: No.

RIEPE: OK. OK. That's very helpful. Thank you very much. Thanks for being here. Thank you, Chairman.

HARDIN: Senator Meyer.

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

DOMINIC GILLEN: Thank you.

G. MEYER: Glad you made it here. Hope you didn't slide in. Hope you don't have to slide home.

DOMINIC GILLEN: No, I think it's going to get worse going back towards Bellevue than it is right now, so. It's all right.

G. MEYER: If this bill were to pass today and tomorrow, you could give-- would it be a prescription or a recommendation?

DOMINIC GILLEN: Would be a recommendation-- rec-- recommendation.

G. MEYER: How would that be filled?

DOMINIC GILLEN: How would that be filled?

RIEPE: How would you get access to the--

DOMINIC GILLEN: Well, as of right now, the way-- there is no specific access here in Nebraska. The way LB6-- or, 437 allows you to have up to five ounces. It-- so you could go to a state-- a neighboring state and pur-- and purchase that from a medical cannabis dispensary. And you would be un-- under the law the way it is currently, you would be able to come back with that.

G. MEYER: With regard to the ingestion, would-- could, could you make edibles out of that? Could-- I mean--

DOMINIC GILLEN: Sure. Yeah. We'll, we'll--

G. MEYER: [INAUDIBLE] dosage or--

DOMINIC GILLEN: Absolutely. And dosing is something that has been brought up a lot of different times. First thing I would say is Will

needs full-- whole plant medicine, so he needs the flour. He is not going to be smoking it. There are other ways to use the flour through heating to create oils or tinctures, and that's what he would be-- that's what he would be using. The dosing issue is-- it's-- you work with the patient, and the dosing would be what works and what doesn't work. And I can-- and I'm glad you brought that up because it brings me back to his two-week stay in the hospital, was doctors having-- our doctor having to play around with the dosages of those three black rock blocks-- black box drugs in order to get the levels where they needed to be so that one wasn't interfering with the other. So I know there's been a lot of question about dosing for cannabis. But in reality, any FDA-- any drug that we take that's from a doctor, not everybody's going to be taking it the same way. Not everyone's going to be taking the same dose. And when he was on those three drugs at the levels that he was on, that was what the problem was. We had to play with the levels of each one to try and get him to a baseline where he wasn't literally sleeping 22 hours a day.

G. MEYER: Is there any positive proof that cannabis would help or, or is this-- it-- as, as with anyone, it may or may not help. Do, do you have any indication that it would definitely be an-- advantageous?

DOMINIC GILLEN: Absolutely. I, I cannot tell you with certainty that it would. Part of the reason is Will has intractable epilepsy, which means he has three or four different seizure types. So he's not just having one kind of seizure. So we're not just treating one thing. We're trying to treat four things all at the same time. And when you treat one, it has an impact on the other. And so-- ref-- what was your-- what wa-- I think I got myself sidetracked. What was your question again about that?

G. MEYER: Whether that there was any evidence-- whether you had any indication--

DOMINIC GILLEN: Oh, OK. We know from my, my-- from-- speaking with people in other states who hav-- whose children have-- adult children have the same issue that we'll have, Lennox-Gastaut syndrome, that there have been positive impacts on seizures. That does not mean that it's going to eliminate them. We have never in the 12 years of our adca-- advocacy for this have never one time ever said it was a magic bullet. And I-- you alluded to that, and I agree with you. Our hope is to alleviate some. This is a young man who has never spoken a word. He communicates with us in lots of different ways, but-- and there's cognition going on, obviously, in his brain, but we cannot unlock the

piece-- the communication piece where he can verbally tell us what he needs or what he, what he wants or what is going on. And so our hope is that if we can lessen the seizures enough to access that part of his brain so that he can actually communicate with us, his quality of life would be so much different. This yo-- young guy-- for people who know him-- he's, he's very-- he'll give you the stink eye really fast when you're not doing something that you want. And so we know that there's-- like they say, there's cognition going on, but it's just not-- we're not able to unlock the piece to-- the communication piece. Will's brain, if you look at it from an EEG standpoint, looks like a bowl of spaghetti. OK? So is it-- for a-- an analogy. I mean, an EEG is supposed to be pretty normal lines spaced out. Will's is just all over the place because his brain is seizing almost constantly. They're not visible, necessarily, but they're see-- but they're-- that's going on. Our hope is to kind of take that bowl of spaghetti and hopefully straighten some of it out and that will unlock things. We're hoping. We pray that tho-- will unlock things that will make his quality of life better.

G. MEYER: Thank you. That, that was very informative. I appreciate it.

DOMINIC GILLEN: I appreciate the question, Senator. Thank you very much.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair. Thank you for being here and your testimony. You know, I was thinking about-- you, you were mentioning kind of the, the different black box warning drugs. And I think you-- just to-- you almost answered my question with your answer to Senator Meyer, but my think-- my question is, really, is the hope or the thinking that, should Will have access to medical cannabis, is-- is the thinking that that might open up the opportunity for him to maybe take one less black box drug or--

DOMINIC GILLEN: Abs-- absolutely, Senator. And that's our hope. Our-- you know, when we got into trouble two years ago, it was because we were-- the doctor said, we have a new drug we want you to try. Well, our opinion was, all right, if we're gonna try a new one, we want to take him off of one. Well, that caused a huge issue because taking him off of the one caused issues and interactions with the, with the new drug. So yes, in-- our goal is to get him off of those pharma-- those pharmaceuticals because that's also-- we don't know what it's doing to the rest of his body, to be quite honest with you. I mean, liver, all

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of those things, it's obviously-- those are not having positive impacts for him on his body. And he can't tell us. We have to gage him by just what he does and how he acts and, and it's-- his pain tolerance level is, like, clear up here compared to the rest of us. And so you really have to pay atten-- we have to pay attention to the nonverbal signs, so.

FREDRICKSON: Thank you.

DOMINIC GILLEN: Mm-hmm.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And thank you for being here. And I know we've met several times before--

DOMINIC GILLEN: Yes, we have.

QUICK: Always appreciate our conversations. And you probably already talked-- I know you already talked about this in your opening and also about the bill, but-- so people can, can understand, it's about the provider or the doctor being able to make that recommendation is really what this is about.

DOMINIC GILLEN: Yes.

QUICK: Because right now, as it is, they cannot make that recommendation, is that right?

DOMINIC GILLEN: Well, what we-- the fea-- there's a fear. They-- they're, they're just not willing to, especially those doctors who are associated with any of the big hospitals and those-- you know, UNMC and Children's and all that kind of stuff. They're, they're not doing it. They just won't. They won't entertain the thought. They might tell you-- they'll tell you off to the side, but they're not gonna go on the record to do it. And I think that's, that's part of the issue here with this bill, is it would hopefully-- it will make doctors, practitioners who are eligible to give recommendations more abil-- more comfortable in doing it without fear of any kind of repercussions as a result.

QUICK: Yeah. Because without those recommendations, you can't actually go to a dispensary and get it, right?

DOMINIC GILLEN: No. No, you, you, you can't.

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QUICK: Yeah. Yeah. OK. All right. Thank you. And thank you for your story too.

DOMINIC GILLEN: Yeah. Appreciate it, Senator.

HARDIN: Senator Hansen.

HANSEN: Thank you, Chair Hardin. Thanks for being here.

DOMINIC GILLEN: Absolutely, Senator.

HANSEN: I always like it because you provide a very human, personal aspect to this topic, sharing--

DOMINIC GILLEN: Well, I, I try. And I try not to get my emotions into it. Sometimes that--

HANSEN: Which is always good too because I've seen you when you're angry and that's not good. Trust me. But no, it's nice of you sharing your stories about Will and everything else. I think that's a great example about maybe how what we're talking about here can help somebody without having to kind of use some of these more potent-- I wouldn't say dangerous, but potentially dangerous drugs like you were talking about, those medications and so-- and you ment-- funny you mentioned Epidiolex. I think that was my bill that I passed about four years ago that made it legal in Nebraska. So I'm glad at least-- you at least get some use--

DOMINIC GILLEN: Yes. Yes. And the sad thing is we don't know-- because we've got so many different things, we're not sure which-- what's working the best, so. But-- anyway.

HANSEN: Good. And I think you brought up the, you know, the difference between medication and possibly using medical cannabis and even just the idea that sometimes you have to work with the patient or yourself to kind of figure some of this stuff out along with the, the me-- the medical provider even though we have no problem having, like, aspirin or NSAIDs on the shelf for anybody to take willy-nilly based on whatever they feel like and that causes 3,000 deaths a year in the United States. And so-- I-- do you think-- so-- and I-- again, I think Senator Quick mentioned this. I-- focusing on what we're talking about here isn't so much about the medical cannabis program as a whole but the idea that maybe some providers who want to provide this are worried about getting sued or something happening to them and their

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medical license based on doing something legal, I guess, in my opinion.

DOMINIC GILLEN: Right.

HANSEN: And so I, I, I would assume that'd be your same perspective here too. Like, that's what you think, like, mainly what this-- what, what we're talking about here and what this bill is about.

DOMINIC GILLEN: Yes. Absolutely. It's, it's-- I think taking the fear away from those professionals who've-- who are fearful of making those kinds of recommendations, and I think this bill would, would let them have that comfort in knowing that the law backs them up.

HANSEN: Yeah. And I, I think, looking at it from the medical provider's perspective, these are people who have years of training and a lot of school debt. You know what I mean?

DOMINIC GILLEN: Right.

HANSEN: And sometimes they even have-- I wouldn't say a tenure, but they have, you know, positions in hospitals and everywhere else. And so the idea of even risking that, you know what I mean, for something they really want to do, you can see where they might be concerned and why something-- a bill like this is important.

DOMINIC GILLEN: Yes.

HANSEN: Yeah.

DOMINIC GILLEN: Absolutely.

HANSEN: OK. Thank you.

DOMINIC GILLEN: Mm-hmm. Thank you, Senator.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin.

DOMINIC GILLEN: Yeah.

G. MEYER: Thi-- this probably isn't germane to this discussion, but does-- do the new, new rules, regs, qualifications of the aged and disabled, is that going to affect you in any way, shape, or form?

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DOMINIC GILLEN: I'm sorry I'm laughing.

G. MEYER: I just opened a can of worms--

DOMINIC GILLEN: No, it's OK, because-- yes. And I will be back-- just to let y'all know, I'll be back next week to testify again on a, on a bill that, that relates to that. And-- so the short answer to your question is, the AD waiver and all that iss-- all those issues are going to have a, a detrimental impact on Will and so many other very medically fragile, disabled adults and children in this state.

G. MEYER: I'll probably be thoroughly chastised for opening up that, that pathway, but.

DOMINIC GILLEN: You'll get a chance to ask lots of questions next week.

G. MEYER: I, I appreciate your-- I appreciate your response. Thank you.

DOMINIC GILLEN: Thank you. And it's just-- you know, one last thing. It's just sad that the most vulnerable in the state seem to be the ones that it, it feels like are being-- the bal-- balance-- or, the balanced budget on them. And it's like, we need to-- I understand there need to be things done, but I just wish we would look at the disabled and the vulnerable and, and-- not as a number but as-- literally as, as people and human beings. Because they have worth. They have worth to all of us. And they're blessings to all us, so.

G. MEYER: Thank you.

DOMINIC GILLEN: Yes.

HARDIN: Thank you.

DOMINIC GILLEN: Thank you, Senator.

HARDIN: Appreciate you being here.

DOMINIC GILLEN: Have a great rest of the day. And everybody be safe.

HARDIN: Proponents, LB933.

CRISTA EGGERS: Good afternoon. I-- my name is Crista Eggers, C-r-i-s-t-a E-g-g-e-r-s. And I'm here today on behalf of Nebraskans for Medical Marijuana. I'm also on-- here on behalf myself, someone

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who has spent almost a decade speaking with patients, caregivers, and health care practitioners across Nebraska. I'm here today in support of LB933 because, without meaningful protections for practitioners, Nebraska will not have a functioning medical program. Right now, the political climate in our state has created a level of fear amongst both patients and health care practitioners. Providers want to be able to move forward in recommending medical cannabis to their patients, which is now legal under Statute 437. However, understandably, they worry about their licenses, their employment, and professional consequences for recommending. It's been nearly 15 months since 71% of voters spoke in support of medical cannabis, yet to our knowledge there are no physicians in the state currently providing recommendations. When I attempted to identify practitioners willing to come and speak today about patient care and implementation and how this bill would provide clarity for them, it proved nearly impossible. I believe today's hearing is proof of the fear that is out there because they were all too scared to come in and speak. Providers privately acknowledge the need, but many say they cannot risk being public associated with medical cannabis under the current uncertainty and what they perceive as a threat from the Attorney General last May, who has voiced his desire to investigate the licenses of practitioners who choose to recommend. Just at lunch today, I spoke with dozens of nurses in the cafeteria who are here for Nebraska Nurses Association Lobby Day. Although many of the nurses I spoke to do not have the credentials and they will not be recommending, each and every one of them express their concerns for the sickest of patients in our state and whether they will truly ever see help from this program. Why? Most-- every major medical system in Nebraska has instructed their physicians that they will not be providing recommendations. When the systems that employ most providers in the state have shut the door on having a, a ability to recommend, you really shut the door on a successful medical program. I'd like to highlight that medical-- every single medical cannabis state in the nation besides Georgia provides protections to their practitioners. It's not a new or novel concept, and it's not uncharted territory. In short, Nebraska is the only state with a full program that currently does not provide this simple protection. LB933 is a simple bill that provides practitioners ability to be able to discuss treatment options openly and excess-- ex-- exercise their medical judgment without fear of retaliation. It does not say that practitioners are immune from intentional wrongdoing or making recommendations that go against good faith medical standards. It does not approve-- or, it does not expand access beyond what voters

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approved. It simply provides a foundation necessary for a medical cannabis system to exist. The medical cannabis system currently under the commission has no authority to be able to put into place practitioner protections, and so it is the sole responsibility that the Legislature do that. I don't believe this is an optional provision. I believe it's essential to this program. If Nebraska truly intends to implement medical cannabis, then the Legislature must take this meaningful step and support the system that the voters created. So I ask for your support today on LB933. Thank you.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for taking the time to testify. So I, I certainly understand the, the function of the bill. I'm just kind of curious to hear-- and we heard from the last testifier as well-- a parent of a, a-- of a child who could potentially benefit from medical cannabis. How, how would, like-- so let's say this bill does pass, right? It go-- it gets into law. How does that-- I mean, on paper, I'm thinking, OK, providers might feel an increased sense of comfort with recommending this. Can you just, like, translate how would that affect, like, like, your son, for example, like, a, a, a-- family?

CRISTA EGGERS: So, you know, right now I have a son-- so he's a minor-- and we cannot get a recommendation for cannabis for him. It's been 15 months, and he deserves access. He deserves for his health care practitioners to feel comfortable acting in good faith. Those that, that know him and, and, you know, do testing on him, follow his medications. I believe they want to be able to recommend. But right now, they can't. And so I believe we're gonna stay in this, this, you know, stagnant nature where patients that I-- I believe probably everybody, you know, sitting up there today believes should have help, believes that, that cannabis should be an option for their doctor to recommend. I don't believe they're gonna get recommendations. So this-- you know, for my family, and as you heard from Mr. Gillen, this has the ability to change our children's lives for the better. That's our hope.

FREDRICKSON: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I just want to thank you for being here today. I know you've put a lot of time and effort into

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working on this issue and, and it's basically for the children and for your son and for all the children who need these, these-- this medicine. So thank you.

CRISTA EGGERS: Thank you.

HARDIN: Other questions? Seeing none. Thank you.

CRISTA EGGERS: Thank you.

HARDIN: Proponents, LB933. Welcome.

LIA POST: Thank you. My name is L-i-a, Lia; last name Post, P-o-s-t. I live in Springfield, Nebraska. I've been advocating for medical cannabis for 11 years in this state. And I just had my birthday yesterday, and I'm just really grateful to be alive and able to fight for myself and for others. I am a proponent of LB933. I want my doctor who can legally prescribe me Marinol, dronabinol, or Syndros-- which is synthetic THC for my disabling illness-- to also be able to recommend the plant to me. My doctor isn't scared, he just wants to follow the law. And the law would normally entail the Attorney General contacting the Department of Health and Human Services who would then give the information to the health care providers. And my doctor's office has had medical cannabis on its weekly meeting update for a year-- over a year with no update. I'm disabled with a rare illness called complex regional pain syndrome. And I was on opioids, benzodiazepines, and sedatives, along with 12 other medications. I almost died in the not only opioid epidemic but the polypharmaceutical approach to pain management. I appreciate my doctor. I have an amazing health team here in this state, but I have had to go out of state to both Missouri and South Dakota to procure medical cannabis cards, which I've done. I go across state lines to a legal state and purchase my cannabis. And then I illegally transport it across state lines and use it because I know that cannabis has helped me. And it's hard for me to come up here. And I do not like to do this. And I know there's so many other people that can't that-- I will be awkward and uncomfortable in front of all of you until the day I die. I do this based on love, and I know that's something that's not normally done here at the Capitol. But I love the people in this movement and I care deeply for them and I care for their children who can't be here. And I wish that you all understood that we are truly patients that are just trying to help others. We don't want others to suffer. Thank you.

HARDIN: Thank you. Questions? Senator Quick.

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QUICK: Yeah. Thank you, Chairman. Not-- mine's not a question, but just thank you for being here and thank you for testifying. We've talked over the last couple years, and I appreciate your story. So thank you.

LIA POST: Thank you. I appreciate you very much.

HARDIN: Other questions? Seeing none. Thank you.

LIA POST: Thank you.

HARDIN: Proponents, LB933.

SHANNON CORYELL: Hello.

HARDIN: Hello.

SHANNON CORYELL: My name is Shannon Coryell, S-h-a-n-n-o-n C-o-r-y-e-l-l. And in 2007, I suffered a traumatic brain injury. An AVM burst in my brain. It had left me partially paralyzed and has caused severe muscle spasms. I am a patient with a medical card from another state. Unfortunately, health care providers in Nebraska have not gotten clear guidelines, so I had to go out of state-- not because I need a specialist from another state but because providers here have so far been unwilling to engage in that conversation. I have also had to go out of state to access the medication, which can be a risk in itself. Which way do I travel to minimize the risk? The older I get, the more I appreciate a smaller pool of doctors for my care. So while in theory I have my bases covered at the moment, it would be nice to be able to continue with a doctor I have an established relationship with and who continues following my care throughout my life. Please vote to advance this bill. Thank you.

HARDIN: Thank you.

SHANNON CORYELL: Short and sweet.

HARDIN: Questions? Thanks for being here.

SHANNON CORYELL: Thank you.

HARDIN: Proponents, LB933. Welcome.

BILL HAWKINS: Welcome, Chairman Hardin, members of Health and Human Services. My name's Bill Hawkins, B-i-l-l H-a-w-k-i-n-s. I'm a

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lifelong Nebraskan. I'm with the Nebraska Hemp Company that's been working on this issue for about 15 years. I'm the person who ran down Senator Tommy Garrett in the hall and got the first medical cannabis bill introduced because I saw a New York Times article on hundreds of families fleeing to Colorado for this medicine that was working for seizures. I've been at it ever since. Even though I don't really consider myself a patient, I've had Lyme disease for 35 years. And the last month or two, it's really been affecting my neck even worse. I've had tremendous muscle mass loss and other issues, but I just deal with it. I've got over 50 years of real-life, practical cannabis experience. I'm an herbalist, so I research medical cannabis and plant medicine extensively. You heard the side effects of-- Will Gillen, that he goes through. We are-- we prescribe those medicines to anybody, and yet we are so afraid of this medicine. So I want to thank Senator Cavanaugh for bringing this bill because right now in law, the Patients Protection Act, a patient has a right to possess five ounces of marijuana-- cannabis-- medical cannabis-- with a recommendation from a physician from any state for any ailment. That's law right now. And I recommend to patients I'm a caregiver for, and I can become a caregiver in that same law with a written recommenda-- or, a signed affidavit. So this bill is essential for medical cannabis patients-- which 70% of the voters approved of-- to protect many physicians here in Nebraska that really want to recommend cannabis. They're educated on it. And they really want to recommend it to their patients, but they can't. I've reached out to many patients. So I would appreciate you prioritizing this bill as a committee and moving it forward very quickly so that the patients and their physicians can be protected in the state of Nebraska. So I appreciate your time. And I would entertain any questions you might have.

HARDIN: Thank you. Questions?

BILL HAWKINS: Under the red light, so that's good.

HARDIN: Thanks. Questions? Seeing none.

BILL HAWKINS: Thank you.

HARDIN: Proponents, LB933. Proponents. Opponents, LB933. Those in the neutral. Those named Senator Cavanaugh.

J. CAVANAUGH: It's 50/50. Thank you, Chairman. Thank you, committee, for your attention. And thank you to everyone who came and testified on this bill. And I did want to give a little bit of context. You

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know, I realize that a lot of these issues have not been in front of this committee before. So as Mr. Hawkins just pointed out, the ballot initiative, 437-- so there are two ballot initiatives: 438 and 437. 438 created the Medical Cannabis Commission. So it's the regulatory act. The regulatory act gave the commission authority over growers, manufacturers, distributors. Patients and doctors are neither of those things. And so the commission doesn't have authority to provide this protection to doctors and doesn't have the authority to regulate them. And so that's why we're in front of this committee on this, because it's-- it is not something that's under the jurisdiction of the Cannabis Commission. This is something that would be under 437, which is the Patient Protection Act portion. And the Patient Protection Act has a number of parts to it, but the part that we're talking about here is currently enshrined in 71-24,104. And specifically, this-- it-- the Patient Protection Act says that a patient can possess up to five ounces of cannabis for medical purposes with a recommendation from a medical professional. And it, it includes a list of who those medical professionals can be. And those can be medical professionals in Nebraska or other states that have a licensing requirement. So have to be a-- basically, a licensed medical professional. Let's see. Phy-- health care practitioner means a physician, osteopathic physician, physician's assistant, nurse practitioner licensed under the Uniform Credentialing Act or who is licensed in any state and practicing in compliance with the Uniform Cre-- Crede-- Credential Act. So you heard Ms. Post and Ms. Coryell talk about how they got a recommendation in another state. And that is legal under the Patient Protection Act that was passed by the voters. And I-- Ms. Post did-- I think allude to the fact that she was breaking some law. I don't know what law Ms. Post would be breaking. We had a hearing one time in the General Affairs Committee. I did ask the State Patrol and a number of sheriffs what law anyone would be breaking by getting a recommendation and carrying cannabis across state lines. They would be in compliance with both, say, Missouri's law and Nebraska's law. And so there would be no violation of either state law in those actions. So I think she, she is in compliance with the possessory standard in the state of Nebraska under that act. There-- the secondary part is-- so that's the list of doctors who can make a recommendation. Then it says, written recommendation means a valid, signed, and dated declaration from a health care practitioner stating that, in the health care practitioner's professional judgment, the profess-- the potential benefits of cannabis outweigh the harms for the alleviation of a patient's medical condition, its symptoms, or side effects of the condition's treatment. A written recommendation is valid for two years

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after the date of issuance and for any period of time specified or-- any period of time specified by the practitioner. So this is the written recommendation portion, and that's what this really is talking about, is saying that a doctor still has to follow all of those parts. But if a doctor follows that in their professional judgment and they adhere to the standard of care, they cannot be held liable just for making that determination as long as they followed all of the other aspects of the law. And as Ms. Eggers pointed out, there-- as far as we know-- there are no physicians in the state of Nebraska who feel comfortable making a recommendation at this point, either from their employer standpoint or from fear of legal ramp-- re-- repercussions. So we are seeing that people who have recommendations have them from out of state. And I know there are people in this body who would like that to not happen. And so we need to make sure that there are-- the medical professionals in our state feel like they can make a recommendation and not risk their license. I did want to point out-- I looked up when Mr. Gillen was talking about black box. And so I looked up-- Johns Hopkins Public Health has, what is a black box warning? Black box warning are added only when substantial clinical data shows that drugs can cause severe harm, hospitalization, or death. And I-- maybe-- did I write this down right, that Will is on 11 black box medications? Maybe I-- I might have wrote that down wrong, but I'm not su-- sure that could be-- but that's the same standard, is that his doctors have to make a determination that, in their professional judgment, that the potential benefit to Will outweigh the potential harm of these severe-- this potential harm for severe harm, hospitalization, or even death. So doctors are making this judgment about life and death for these patients on these other drugs. The-- we're just asking that doctors be afforded the opportunity to exercise their judgment and make a recommendation in light of all of those circumstances in compliance with state law. And so-- I'm trying to think-- I wrote down a couple questions here. Senator Meyer, you asked some good questions about dosing. And, of course, I think Mr. Gillen answered that question very well, which is that, on a lot of these serious drugs, we have to dial them in or figure out what's the exact right dose for so many other medications that we are very comfortable with. And I appreciate Senator Riepe's question and Senator Fredrickson's questions about what this means to these patients, these family members. I mean, to Will and to Colton, it doesn't mean that the doctor's definitely going to make a recommendation. It just means that their doctor's lack of recommendation is not based on their fear of legal repre-- repercussions. It has to do with what the doctor thinks is right for their patient. And so this is, you know, a very

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simple bill. And as I said and Ms. Eggers said, 16 other states that have medical-only programs have something like this. States that have recreational programs have something like. So in the United States, something like 46 of the other states have a protection for providers that, to-- if they make this recommendation in their judgment, will not be subject to liability exclusively for that purpose. So happy to answer any other questions. I did hand out that other amendment. I guess I would just point to your attention that the amendment is the-- Section 2, paragraph 1 is the original bill. Paragraph 2 is the new ada-- added language, which is, nothing in this section shall prohibit a health care practitioner from being subject to civil pena-- penalty or disciplinary action for failing to properly evaluate the medical condition of the patient or for otherwise violating the patient-- physician-patient standard of care. So doctors still have to do their job before they make a recommendation. Happy to take any questions.

HARDIN: Questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Senator Cavanaugh, is there any ailment or any, any particular malady, any particular health condition that should be excluded from having a recommendation of medical cannabis for treatment?

J. CAVANAUGH: I think it's possible. I'm not a doctor, so I couldn't tell you which pa-- I couldn't tell you what ailments--

G. MEYER: I come in and my elbow hurts-- really hurts, Doc. Could, could I get a recommendation for medical cannabis?

J. CAVANAUGH: I-- that would be-- it's-- under the current--

G. MEYER: I was hoping to have a doctor here so that I could ask that question.

J. CAVANAUGH: Yeah. Between-- that'd be between you and your doctor. And I think that-- you know, again, not a doctor, so I couldn't tell you what the-- what considerations they would make. But it would be ag-- under statute, the se-- it is-- that it has to be in their judgment that the benefit of taking cannabis outweighs the risks associated with it, which is really the standard in any medicine. Again, the standard-- the black box medicine that Will is taking-- explicitly, the ba-- the, the, the distinction of black box is the severe-- the risk of severe harm, hospitalization, and death. And the doctor has to balance those risks versus the, the benefit. So in an

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instance of something like that, the doctor would have to weigh whether that is something that, one, is treatable by that, right, in, in their judgment based off of their research and expertise and training and whether the side effects associated with that medicine. I mean, it's the same if you get a steroid. You know, if you go to the doctor-- I went to the doctor and got a steroid earlier this year when I was sick, and they did weigh the benefits of, you know, taking a steroid for those ailments versus the side effects which-- you know, I have a-- many different side effects to steroids-- and they decided in their judgment that giving me that steroid outweighed-- the benefit of me taking that outweighed what the risks were. They make that judgment in all sorts of situations. In your situation, a, a tennis elbow, maybe a steroid would be better for it.

G. MEYER: I thought I did notice you bulk up a little bit [INAUDIBLE] earlier this year.

J. CAVANAUGH: That, that just has to do with my eating habits.

HARDIN: Senator Hansen.

HANSEN: Is there a reason why somebody from the commission didn't come here and testify? Do you know?

J. CAVANAUGH: I don't know. I-- they have not testified. They didn't come testify in General Affairs on the, the bill that was brought on their behalf either. I, I guess-- I would point out again that this doesn't touch anything that's under their authority.

HANSEN: Yup.

J. CAVANAUGH: So 437, this is-- it's specifically addressing 437, which is the 71-24,103 through 105. Commission doesn't have authority over that. Their authority begins in, I think, 106.

HANSEN: Yeah, because this doesn't really affect the la-- I would say the regulatory process of the, you know, medical cannabis. But usually-- it's not uncommon to have somebody from kind of a corresponding commission, whether that's gambling or something else, come and say, hey, look, this-- it doesn't-- you know, come out in a neutral capacity or something else.

J. CAVANAUGH: Yeah.

HANSEN: So I, I didn't know if they communicated to you at all.

J. CAVANAUGH: I haven't heard from them on this issue, but, you know, I've had many conversations with them about many other issues. And, and I would say-- I guess I forgot. One of Senator Meyer's questions was about-- I think it was about accessibility. And so the thing here is this doesn't change-- right now, i-- even if the commission sets up an effective, regulated growth, distribution, manufacturer, sale, there's still no patients. So they could, you know, issue-- I think they've issued three licenses. Somebody-- they could grow whatever they're all-- allowed to, process it, and then they could issue licenses for dispensaries. No one's gonna be able to walk in and, and purchase from those dispensaries because no doctor is going to make a recommendation in this state. And so this is just addressing that side of it. It's not addressing which-- you know, how many dispensers there are, where they-- what, what delivery mechanisms, whether flour or edible or tincture. It doesn't address any of those things. Those are all things that are still up in debate in other aspects. This only addresses that one hurdle of the fear the doctors have about recommendation.

HANSEN: Yeah. I think that was my next question. Like, this, this in no way expands the use outside of wha-- you know, what's already determined by the commission or on the legislation already. This doesn't expand the use of medical cannabis or change any-- who can use it and how it can be used and for what conditions. Like, this bill has nothing to do with any of that.

J. CAVANAUGH: Right. It doesn't touch any of the work the commission has done.

HANSEN: And here-- here's the great thing: if there's still practitioners who don't want to prescribe it, they just don't prescribe it still.

J. CAVANAUGH: Right.

HANSEN: This does not change that.

J. CAVANAUGH: Right.

HANSEN: So if people are-- you know, if the people who really think-- nobody in the state wants to prescribe this, medical doctors don't want to prescribe it-- this doesn't change any of that. They just won't still.

J. CAVANAUGH: Right.

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HANSEN: So. Thanks.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you, Senator Cavanaugh. So I just-- you touched a little bit on your closing. I just want to be crystal clear in my mind. Is there anything-- is this a-- is this special language just for cannabis recommendations? Does anything else-- and health care practitioners, do they get this protection when they prescribe any opioids, anything-- or is this just special for cannabis?

J. CAVANAUGH: Yeah. The, the-- again, to Senator Meyer's quest-- comment. I wish there was a doctor here who could answer that question for you. So this is specific to cannabis. Cannabis is different in statute for a number of reasons. We all keep saying prescribed, but it is explicitly recommended.

BALLARD: Yes.

J. CAVANAUGH: And recommend is, is-- because prescribed is sort of a term of art, and that is they can prescribe things that have been FDA approved and, and scheduled. And so cannabis is different in that respect. Although President Trump has made a move to reschedule cannabis to Schedule III, which then would make a number of changes in federal law on that and would be helpful, but-- so that's-- there's that reason that this is explicitly different in statute. But it is also-- it is a companion to the ballot initiative. It is, it is essentially saying you-- the doctors follow this language that was passed by the voters by 71% in the ballot la-- initiative. They follow that standard set up by the voters, then they won't-- can't be liable specifically for following that standard. They can still be liable for other things-- if they don't follow the standard of care, if they are, you know, just willy-nilly doing things. But they'd still be held to a professional standard.

BALLARD: OK. So it's not the opinion-- this-- the bar's higher for-- if you recommend cannabis over-- your, your protections are greater if you recommended cannabis over other--

J. CAVANAUGH: No. Yeah, it'd be the exact same standard. So if a doctor recommends a steroid and something bad happens and they didn't follow whatever the standard of care was for recommending the steroid and then you have a-- an adverse reaction, then they'd be held liable

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for that in the same situation as here, is if they don't follow the standard of care and, and, of course, give the advisements about those things. They would also still be held liable. It's just the-- the only difference is that we don't hold people liable if some-- if a doctor-- again, to use the steroid example-- we don't say you risk your license if you prescribe steroids at all. We would say you only risk your license if you are prescribing it in a way that is not following the standard of care.

BALLARD: OK. And who makes that determin-- that's-- Health and Human Services that make the determination?

J. CAVANAUGH: I would-- I mean, I don't know specifically. I mean, there's the medical-- the board practitioner--

BALLARD: So I guess my question is, doctor-- it says unprotected by LB933. I don't care what the department says. That-- that's not, that's not the, the goal of this--

J. CAVANAUGH: No. No. I mean, the-- yeah, the goal-- I mean, they're-- doctors are risk averse, as I think Senator Hansen-- somebody brought up about how much they go through and how much debt they take on and all the risk and-- associated with all these things. So they're inherently risk averse, right? And-- you know, I've, I've got a lot of friends that are in that trial practice area, right, that are suing-- they'll sue doctors in malpractice suits. And so there's a lot of risk associated with doctors ta-- you know, doing something novel, right? And so they do have an, an aversion to that. This just is saying that you could-- there's still all the other aspects of liability associated with any type of performing practice of medicine. It is just saying that the, the, the only basis for a penalty or repercussion cannot be that you prescribed it. So, like, say somebody just goes and says-- files a complaint and says they prescribed cannabis. There has to be, they prescribed cannabis, comma, not in compliance with. So there has to be an additional se-- allegation besides the cannabis.

BALLARD: OK. And then this doesn't touch malpractice, doesn't touch--

J. CAVANAUGH: Doesn't touch anything like that, no.

BALLARD: OK. Perfect. Appreciate it.

HARDIN: Senator Quick. OK. Very good. Senator Hansen.

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HANSEN: Ju-- just for cla-- clarifying-- I get to play the attorney this time.

J. CAVANAUGH: Oh, right.

HANSEN: I went to a Holiday Inn, so. This is according to the National Association of Attorney Generals.

J. CAVANAUGH: OK.

HANSEN: And so this might help kind of clarify this. Medical doctors have broad legally protected authority to prescribe approved medications for both approved and off-label uses based on their professional judgment. The authority is not absolute. They can face criminal charges to liability or license suspension for improper prescribing, particularly regarding controlled substances. So I think-- it seems to me like this language almost mirrors that kind of approach.

J. CAVANAUGH: Yeah.

HANSEN: And you're talking about a risk av-- averse, you know, appro-- the most probably risk averse profession there is. We have classes, I think-- when I go to college, it just says how-- that you're going to get sued any decision you make. And so we're always scared about getting sued for anything we, we do. And so I think risk averse, you know, makes a-- is, is pretty important in this particular circumstance, but it seems to me like the-- this language mirrors what happens in the medical community with prescription medications--

J. CAVANAUGH: Right.

HANSEN: --so.

J. CAVANAUGH: Yeah. And, and again, as I pointed out-- I handed out, this mirrors language in 16 other medical-only states, the 16 of the 17 other medical-only states.

HANSEN: Thanks.

HARDIN: Seeing no other questions. Thank you.

J. CAVANAUGH: Thank you.

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HARDIN: This concludes LB933. We did have 23 proponents, 1 opponent online, 0 in the neutral. Next up, LB1016 with Senator Raybould. We'll switch the room around and start in a moment. I think we are ready, Senator Raybould.

RAYBOULD: Thank you. Good afternoon, Chair Hardin and the members of the Health and Human Services Committee. My name is Jane Raybold, J-a-n-e R-a-y-b-o-u-l-d. And I represent Legislative District 28. And I am also the chair of the State-Tribal Relations Committee. I am here to introduce LB1016, a bill that directs the Nebraska Department of Health and Services to submit an 1115 demonstration waiver application for the reimbursement of traditional healing services under Medicaid. This bill was brought to our attention by the tribes in their efforts to improve the health and well-being in their communities. There are states-- or, tribes in other states like New Mexico, Oregon, Arizona, and California that have received this 1115 waiver, have seen positive health outcomes in their communities, and that is why we're hoping to get a waiver on this matter as well. American Indian and Alaska Native populations have long experienced significant systemic health disparities. They experience the lowest life expectancy compared to other U.S. racial and ethnic groups. Additionally, disparities are also documented in higher rates of diabetes, mental health and suicide, maternal and infant health, and infectious disease. The reasons are complex and connected to historic and ongoing racism, poverty, poor education, limited access to quality health care, forced relocation, and forced assimilation into non-Native culture. In 1883, the federal government established the Code of Indian Offenses to prosecute American Indians who participated in traditional ceremonies. The cultural identity of American Indian tribes was restricted by such methods until 1978, when the American Indian Religious Freedom Act legalized traditional spirituality and ceremonies. As a cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, AI/AN, the Indian Health Care Improvement Act, IHCA, was permanently authorized in 2010 to promote traditional health care practices, fulfill special trust responsibilities, and ensure the highest possible health status by providing all resources necessary to implement that policy. Federal officials have called for Medicaid to improve its ability to provide culturally competent services to AI/AN beneficiaries. And many tribes have incorporated traditional healing services into their health care delivery. While Congress granted the Indian Health Service's ability to build-- bill Medicaid, traditional healing services are not currently a Medicaid-covered service. Accordingly, Section 1115 waivers provide a

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path forward. In October 2024, the Centers for Medicare and Medicaid Services, CMS, approved groundbreaking Section 1115 demonstration waivers for Arizona, California, New Mexico, and Oregon, allowing reimbursement for traditional health care practices. The waivers that were awarded in these states are not permanent but will lay the important groundwork for improved outcomes when traditional healing is included as part of a treatment plan. They document and follow prescribed data points to see if these plans are actually succeeding. The state of Washington is also putting forward an 1115 demonstration waiver for traditional healing and hope that, if approved, services can begin as early as July of this year. By asking Nebraska DHHS to submit a waiver this year, our state can be part of this groundbreaking health care treatment for members of our federally recognized tribes. Traditional health practices are extremely important for American Indian and Alaska Native populations, incorporating sacred healing practices that have been used and trusted for generations, could decrease health gaps for Native Americans. Traditional healing practices have proven health benefits such as sweat lodges, which have been documented as helpful in mitigating infections from the body, helping with pain relief and rheumatic diseases like arthritis, alleviating insomnia, and promoting healthy skin. As stated in the fiscal note, the annual cost per individual of \$2,853 for traditional healing services appears to be reasonable, although it is unclear what this estimate is based on, and that is something that I have flagged. We've looked at what other states have been incurring in costs, and they have far larger tribal populations as compared to the state of Nebraska, and their costs are not near as high as those that have been estimated in the fiscal note. DHHS notes CMS reimburses Medicaid 100% for services provided to tribal members through the Indian Health Service or tribal facilities. As such, the only fiscal impact to the state is half the administrative costs for reporting and actuarial support. I have not had the opportunity to discuss the fiscal note with the department, but I do question their annual cost for carrying out this bill. Lastly, the weather may have impacted many of our testifiers who intended to speak in support of the bill today. My office has encouraged them to submit online written testimony, and I would ask that you take some time to read through their submissions. Thank you so much for your time. And I'm happy to answer any questions.

HARDIN: Questions? Senator Hansen.

HANSEN: So the definition of traditional healing services, it is-- say-- it's already defined in U.S. Code?

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RAYBOULD: I--

HANSEN: Do you have a copy of that or do you know wha-- where I can see-- where I can see that?

RAYBOULD: I, I do not have a copy of the code, but typically, under the waivers, each tribe and facility decides which tribal healing services to offer for reimbursement. Services can take place at sacred sites and not necessarily inside one of the clinics. And this-- it-- this varies, as you can imagine, from tribe to tribe and their traditional healing practices that they have been using for centuries.

HANSEN: OK. Because-- [INAUDIBLE] curious. I'm sure maybe somebody afterwards can answer it, about how, how, how they get reimbursed. Like, usually it's like, OK, we have a diagnosis code or we have an ICD-10 code and we fill it and we get reimbursed and so I'm kind of curious--

RAYBOULD: So this is part of the-- the waiver process requires the state to submit for the waiver process, but they need the data and the recommendation and input and feedback from the tribes in Nebraska. What are those traditional healing practices that have been used to successfully treat diabetes in the-- their community? It might be reverting back to some of the historical, traditional nutrients of berries and fruits that were commonplace in their diet a hundred years ago but that practice has been diminished. Or it could be reintroducing vegetables and squash and gourds that were a really traditional part of their diet but have lost the impact. We know by-- anecdotally that some practices that have embraced their traditional nutritional diets from years ago have noticed a decrease in diabetes and improved health outcomes. And so it's really up to each of the tribes to submit with their waiver those traditional healing practices that they want to be considered as part of the waiver.

HANSEN: OK. Thanks.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator. My question goes to-- and I quote in here-- it says, CMS re-- reimburses Medicaid 100% for services. You mentioned that?

RAYBOULD: Yes, that is correct.

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RIEPE: My question is, that is Medicaid rates or is that cost plus? Because Medicaid rates still fall short of the actual cost. So I, I don't know whether it's, it's a cost plus thing.

RAYBOULD: I, I don't have the answer to your question, but I can look it up in between the testifiers to figure out what is that rate of reimbursement, so.

RIEPE: Is there a cost sharing here between the Indian Health Services, the feds, and then the state?

RAYBOULD: It depends on the state. Some, some of the tribes do have a cost sharing from the funds that they have available to them to help offset this.

RIEPE: Do you anticipate that Nebraska would be in [INAUDIBLE]?

RAYBOULD: I would like-- in order to be able to answer that correctly, I would need to have the tribes start the process of specifically outlining those traditional practices that they would like to see incorporated in our waiver application. This is just an application for the waiver. This takes-- it can take months, it can take a couple of years because the program does require you to provide what you anticipate are some of the costs. So that's a lot of research that we have to work along with HHS in, in including on the application process.

RIEPE: Because the tribes are in rural-- generally in rural, would this qualify in some way, in your opinion-- we still don't, I guess, know-- all know how it fits into the, the rural \$218.5 million that's coming our way that we have to have some of this out the door before October 31.

RAYBOULD: Well, I would, I would love to think that if-- we can work with the tribes and if their requests would be considered applicable for this grant money and grant funding application. I know that-- I think we just met with HHS last month and-- when they announced the-- you know, the big announcement of the waiver funds, and I think that we need to have more information about what are the qualifying elements that can be applied for.

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

RAYBOULD: You bet.

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RIEPE: Thank you, Chair Hardin.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome today, Senator Raybould. Seems like I've run into you in the--

RAYBOULD: All the time. All the time.

G. MEYER: I have a question regarding the Indian Health Services. Why aren't the Indian Health Services providing payment for traditional healing practices of the tribes?

RAYBOULD: I, I don't have an answer to that question.

G. MEYER: You know, you would, you would think that would be a natural fit for them with regard to following through with, with Native traditions. And, and since it's part of the Indian Health Services program, providing health services to the tribes, you would think that would be a pretty easy fit for them, wouldn't it?

RAYBOULD: I think-- I agree with you. I think it's a terrific fit, and I, I think that's why we wanted to, to get this waiver process initiated, because we have to work closely with them on outlining, defining those critical programs that would be able to qualify for that federal dollar match. I know that there's nothing that is stopping the Indian Health Services from doing this on, on their own as well if they're-- if they feel that that treatment is, is an appropriate one, ha-- and has been successful. I know with a lot of substance abuse issues, particularly among the teens, they have shown that participating in, in sweat lodges sort of reengages them and grounds them and helps as part of their treatment program. Just one element as part of their treatment program gives them additional hope. We've heard from some stories of young people that have gone through that-- something that they had never experienced before in their life until they were at a point where they needed help with their, their substance addiction.

G. MEYER: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Here comes the hard question. Do you have a priority designation from someone on LB1016?

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RAYBOULD: We do not have a priority designation on this. The, the, the tribes have already stated their priority, which is on tribal adoptions. That was out of Judiciary.

RIEPE: So it's pretty late in the game.

RAYBOULD: It's-- well, from my-- this is just the beginning of the game, sorry. So, you know, we need you to all approve this. It's the beginning of the application process. Just because you approve it today doesn't mean, voila, we get a waiver. This is a lengthy process. But we have seen the success in other states, and that's why the tribes in Nebraska brought this to our attention, because they want to achieve that same level of success. And they also would appreciate the additional qualifying federal dollars that would help them get to those health goals that they have for their community. So this is, this is not a, a one-and-done vote here today. This takes time. But if we approve this, then we-- that starts the process of working with DHHS on this to, to-- and work with the tribes. The tribes are integral part of telling and coordinating with HHS on this application process. This is, this is, like, step one.

RIEPE: Given the fact that we're halfway through the short session, do you think you have any opportunity to be able to get this scheduled? I-- I'm asking you-- obviously, you brought it here. You have some optimism about it, but.

RAYBOULD: I am super optimistic about it. I was so optimistic about it I already gave it to Speaker Arch to consider as one of his Speaker priority bills because it's, it's an application. It's a start. So fingers crossed he will have included it in his list of a Speaker priority because it's an application process. It's a, a waiver process.

RIEPE: OK. Thank you.

RAYBOULD: So that's, that's the game plan on that one.

G. MEYER: Thank you, Chairman.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Do you think there's a real opportunity here, although there is a fiscal on it, indicating-- on a year-over-year basis-- much of the money's provided by the federal, federal government. But do you think there's an opportunity for

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savings here regarding the tribal healing practices doing-- taking the place of some of the other more conventional healing, the, the dollars we spend in, in, in Medicaid and those types of things? Perhaps there's a very good trade-off of the dollars spent on the Indian health practices as, as opposed to our conventional health practices. There could be-- do you think there could be a offsetting savings there?

RAYBOULD: I, I do believe there is an-- a, a savings and cea-- health care improvement based on some of the early results from those other states. You know, in treating diabetes-- which is really a chronic problem with a lot of tribal members-- it i-- it's just not traditional medical treatment. It has to be a whole consortium of looking at your diet, looking at exercise. And so it's just one of the many tools that help advance better health. And that's what we're trying to achieve. It's that whole combination that gets that success. And so, yes, it's a combination with the, the standard medical practices for a lot of the systemic, problematic, chronic diseases that our tribal members seem to be experiencing. But it-- in, in combination, we know that there is improvement.

G. MEYER: A good-- an opportunity for a good return on investment and a cost-benefit analysis that it could be very beneficial.

RAYBOULD: I, I agree with you 100%.

G. MEYER: OK. Thank you.

HARDIN: Other questions? Will you stick around?

RAYBOULD: I will.

HARDIN: Proponents, LB1016. Welcome.

COLY BROWN: Thank you. Good afternoon, Chairman Hardin and members of this committee. My name is Coly Brown, spelling C-o-l-y B-r-o-w-n. I currently serve as the chairman of the Winnebago Tribe in Nebraska. I am here to testify in support of LB1016. And I, I would like to thank Senator Raybould for introducing this legislation. This bill is an important step toward improving health outcomes for Native Americans, honoring tribal sovereignty and promoting continued partnership between tribes and Nebraska. For tribal communities, tradi-- traditional healing is not alternative care. It is foundational care. These practices are-- sustained Indigenous peoples for generations by addressing physical, mental, and spiritual health in an integrated and

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culturally grounded way. Yet despite their continued use and demonstrated value for our people, traditional healing services are not currently eligible for medical reimbursement, limiting access and long-term sustainability. This bill does not presume, presume outcomes or mandate coverage. It merely directs DHHS to pursue a demonstrate waiver to the state can evaluate whether these services may improve health outcomes and reduce downstream costs. We believe it would be helpful to consider the services of traditional providers that fall into the following three core roles. First, traditional healers who support individuals experiencing illness, imbalance, trauma, or spiritual distressed using traditional medicines, ceremonies, rituals, prayer, and other culturally specific healing practices. Second, knowledge keepers who preserve and transmit essential cultural teachings, including language, stories, ceremonies, laws, and values. Third, natural helpers who provide culturally grounded health, recovery, and social support, who often work under the guidance of our traditional healers, our knowledge keepers, and serve as trusted community-based support. Consistent with Nebraska's efforts around making rural Nebraska healthy again, the Winnebago Comprehensive Healthcare System has made it a point [INAUDIBLE] to incorporate many of these services into its programs. These services aligned with Medicaid's broader goals of prevention, early intervention, trauma-informed care, and community-based support. They also help reduce adverse childhood experiences and chronic diseases while also mitigating reliance on crisis services, emergency and-- departments, and introduce-- in-- institutional care by addressing root causes of distress and supporting holistic healing. I respectfully urge the committee to advance this legislation. And I support the submission of the Medicaid demonstration waiver for traditional healing services. Thank you. Pinangigi-- in my language-- Coly Brown.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome, Chairman. It's good to see you today.

COLY BROWN: Thank you, Mr. Meyer.

G. MEYER: Hope you had a good trip down. Currently, there are traditional tribal practices, healing practices going on right now in the community. Is that, i-- is that on a regular basis? Is that connected with perhaps the-- any of the treatment programs or spiritual-- is there anything going on right now with regard on a regular basis with traditional tribal healing?

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COLY BROWN: Their-- sweat lodges go all week, sometimes during the weekdays, every week. Every weekend, we have Native American church services that include [INAUDIBLE] Native American church building and, and teepees that we have and care for.

G. MEYER: I think a-- most of us are familiar with the, with the sweat lodges and, and-- I, I think that has a lot of benefit for, for, for everyone, actually, so. Thank you.

COLY BROWN: Great. Thank you.

HARDIN: Other questions for the chairman? Seeing none. Thank you.

COLY BROWN: Thank you. Thank you for your time.

HARDIN: Proponents, LB1016. Proponents. Welcome.

CHEYENNE ROBINSON: Thank you. My name is Cheyenne Robinson, spelled C-h-e-y-e-n-n-e R-o-b-i-n-s-o-n. And I serve as the treasurer of the Omaha Tribe of Nebraska. Thank you for allowing me to testify on LB1016 today. LB1016 directs the Nebraska Department of Health and Human Services to apply for a federal Section 1115 waiver to allow limited reimbursement under Medicaid for traditional healing services, integrated alongside conventional medical care. I wanna speak to you not only as a tribal leader responsible for fiscal oversight but as someone who sees every day how policy decisions translate into real outcomes for our families, our children, and our future. This bill's fiscally responsible. And not only in Medicaid expansion-- and it's not Medicaid expansion. It does not create entitlement or broaden eligibility. A 116-- 6-- excuse me-- 1115 waiver must meet strict federal budget neutrality standards, meaning CMS would not approve it unless it demonstrates that costs remain within existing Medicaid spending. It is not a-- excuse me-- it is a structured pilot: measured, evaluated, and accountable. LB1016 addresses the reality of rural health gaps. Many of our communities lack consistent access to bavor-- behavioral health providers, maternal care, and long-term recovery support. When people cannot access early care, their struggles do not disappear. They escalate into emergency rooms, foster care systems, incarceration, and generational instability. These outcomes are not only costly to the state, but they are devastating to families. I want to share what we have learned through lived experience in Indian country. Our tribal members are most successful in recovery when they are supported in ways that are culturally relevant and grounded in community. Too often individuals are sent off

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their reservation into programs built around a one-size-fits-all curriculum-- far from their families, their identity, and cultural teachings that help them rebuild with purpose. We see people struggle to stay in those programs not because they lack the will to heal but because the model itself was never designed with them in mind. Native communities continue to carry the weight of intergenerational trauma, from boarding schools, forced removals, and policies that disrupted family structures and community continuity. Healing from that history is not simple, and nothing we do in our community is easy. But when recovery includes culturally grounded supports, when individuals can reconnect to identity, ceremony, language, and community accountability, participation increases, trust grows, and outcomes improve. This bill does not replace clinical care; it strengthens it. It acknowledges that healing is both medical and cultural and that integrating traditional practices alongside modern treatment can stabilize families in way that-- in ways that reduce long-term system involvement. For maternal and infant health, Native women face disproportionately-- disproportionately higher risk. Increasing culturally responsive prenatal engagement and postpartum support reduces preventable crisis and improves long-term health care outcomes. For substance abuse recovery, culturally grounded programs improve retention, reduce relapse, and help individuals reenter the workforce and care for their family. LB1016 is voluntary and, and accountable. If the data does not demonstrate value, the waiver can sunset. This is a careful fiscal-- fiscally responsible approach that allows Nebraskans to test whether-- excuse me-- Nebraska to test whether culturally integrated prevention strategies can reduce higher cost crisis spending while strengthening rural health systems. This bill's not about expanding government. It's about expanding an understanding. It recognizes that the one-size-fits-all system have not always served Native communities effectively and that healing often begins when people feel seen, respected, and connected to who they are. Thank you for your time and consideration to a solution that supports healthier families, stronger communities, and better outcomes for Nebraskans. I would be happy to answer any questions. Wopila. Thank you.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. Is this a new program?

CHEYENNE ROBINSON: No, wha--

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RIEPE: Is there an existing healing kind of program that's under Medicaid?

CHEYENNE ROBINSON: I am not sure specifically.

RIEPE: OK. Where I'm going with that is it, it-- in your comments, you say limited reimbursement under Medicaid. And then in a following paragraph, you said, is not Medicaid expansion. If it spends more money in Medicaid, it's Medicaid expansion. I just-- you can react to that.

CHEYENNE ROBINSON: Yeah. No, that's a really good question. And to elaborate on-- and it kind of connects with earlier's-- where are the cost reductions here, and what we see from our commun-- or, tribal members is they're most likely to have long-term recovery and be, you know, productive citizens of our society when they receive culturally grounded medical-- it's not really me-- medical, but tradit-- traditional healing services compared to when we send them off the reservation to get the, you know, like I said, one-size-fits-all systems, where they're most likely reoccurring because it doesn't-- it's not culturally relevant to who we are.

RIEPE: OK. Thank you. Again, thank you for being here.

CHEYENNE ROBINSON: Thank you.

RIEPE: Thank you, Chairman.

HARDIN: Other questions? Seeing none. Thank you. LB1016, proponents. Proponents. Welcome.

JUDI GAIASHKIBOS: Thank you, Senator Hardin-- Chairman Hardin. This is one of the few times I've ever testified before this committee, and it's an honor to be here today as the executive director of the Nebraska Commission on Indian Affairs. My name is Judi gaiashkibos. That is spelled J-u-d-i g-a-i-a-s-h-k-i-b-o-s. And I'm here to support LB1016. I want to thank Senator Raybould for supporting the tribe's desire to request this waiver. And I think some of the points that I would say-- I am not an expert on Indian health services, but as a citizen of the Ponca Tribe of Nebraska and Santee Sioux, we are dual citizens. And so anything that helps our tribal nations helps Nebraska. And this-- as I understand it, the fiscal is minimal and this would come from what other states have received. Four other states ha-- are-- have enacted this. And-- Arizona, California, New Mexico, and Oregon. So I think that we all know that Native people

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face different challenges by virtue of our history. And we love our country. We love Nebraska. But as a survivor descendant of the Genoa Indian Boarding School, things happened in our lives in this country that have put us at risk and made us vulnerable to long-term impacts to our well-being-- intergenerational trauma that we all still try to recover from. And so I think that this is something that would be-- I would hope that you would support DHHS putting in this waiver request. As you've heard, it's not a one-and-done deal. It's going to take time. But if there's a way that we can provide some support through traditional ways of healing-- and there are all different types of traditional ways of healing. Through the equine program that I understand the Omaha Tribe has-- whatever we can do to find a way to se-- to be more balanced in this crazy world we live in right now, whether that's through yoga, through your church. And Native people live throughout the state, not just on the reservations-- more live off. So you have people in the city of Omaha and Lincoln that benefit from the Ponca wellness services that they would also be able to benefit from this LB1016. And as wa-- as is said, this isn't something that's going to happen right now. It's a slow process. I did reach out to my colleagues at the federal level, Reyn Archer, who works for President Trump under this administration, and he used to work with Congressman Fortenberry. So I tried to get some inside information from Reyn-- who is a long-time colleague and friend of mine-- and I haven't heard back from him yet. But if I, I do hear anything, I would share that with the committee as well. So with that, I hope you don't ask me any questions because I, I-- the experts are from behind and they can answer those.

HARDIN: Thank you. Is there anyone that dares to challenge her and ask her a question?

G. MEYER: I almost did, but I know--

HARDIN: Senator Meyer.

G. MEYER: I will not. I will not.

HARDIN: OK. OK. Thanks so much for being here. We appreciate it. Question?

JUDI GAIASHKIBOS: OK.

RIEPE: I have, I have a question. You can skip it over or what-- you know, with the reported recently, I think there was a spinoff from War

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Horse Casinos of some \$214 million, of which the state received \$54 million in taxes. And I'm saying, does any of the gambling proceeds go to any of the reservations' health plans, or is that strictly by tribe and-- I don't even know for sure who-- which tribe owns the War Horse Casinos.

JUDI GAIASHKIBOS: Oh boy.

RIEPE: There's a hand.

_____ : Winnebago Tribe does.

RIEPE: OK.

JUDI GAIASHKIBOS: I believe--

RIEPE: I di-- who-- I mean, did they play anything in terms of-- because obviously the-- they have more money than the state has, I think.

JUDI GAIASHKIBOS: You, you think Winnebago has more money than the state?

RIEPE: Well, yeah. Well--

JUDI GAIASHKIBOS: I don't know. I can speak a little more to Prairie Flower, the Ponca's casino, which, you know, is in Iowa. And that has had a positive impact on the health of, of our tribal members that we don't get enough-- tribes are all underfunded from Indian Health Service and-- at the level of less than what prisoners are funded in the state of Nebraska.

RIEPE: Sounds like Medicaid in general.

JUDI GAIASHKIBOS: So through Prairie Flower, we've been able to help children on education, prevention, elders. There's a lot that-- now they are able to provide from that little casino. So I can't speak for the Winnebago Tribe. I would not want to say anything improper or incorrect, but I do think that it's had a major impact. They are like the jewel of the United States of America what's happened over on their reservation. Every rural community in Nebraska would like to look like what Ho-Chunk and Winnebago has done. That is an amazing place. A tribal college. They have so many wonderful programs. I'm so proud. In my 30 years as the director of the Indian Commission, I have seen major, major growth over there. And it's just really something

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that I'm very happy for our people. And any Native person can go to that hospital, the Twelve Clans at Winnebago, or if you're eligible to be enrolled in a tribe, so. I think oftentimes Nebraskans-- there's so much that they don't know about us. And we don't know everything about you either, but we all try to live in harmony and-- so please, please try to find a way to support LB1016.

RIEPE: And I know you're building a major clinic in my district, which I appreciate very much. District 12.

JUDI GAIASHKIBOS: Thank you.

RIEPE: Thank you.

JUDI GAIASHKIBOS: And a-- they employ a lot of non-Natives as well at all of those facilities and even in Winnebago. So it's a win-win. It's a win-win.

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

HARDIN: Any other nonquestions for what we're doing here? Thank you.

JUDI GAIASHKIBOS: Thank you so much.

HARDIN: Proponents, LB1016.

BILL HAWKINS: Chairman Hardin, members of the Health and Human Services. My name is Bill Hawkins, B-i-l-l H-a-w-k-i-n-s. I'm a lifelong Nebraskan. And I'm here to thank Senator Raybould for bringing this bill to the attention of this committee. I'm an herbalist that has spent most of my life studying plant medicine and Native, traditional medicines. I've spent decades with the Indian center here in Lincoln and reaching out 15, 20 years ago, went up to Macy to-- with Ron Brown [PHONETIC] on an outreach deal and, and realized just the, the problems that the reservation has on-- with gangs coming in and preying on the youth. The last ten years, I've been up at Pine Ridge because of Whiteclay and the devastation that the state of Nebraska caused selling 4 million cans of beer a year. That just doesn't disappear in an instant. So you have generational continuation of these problems. Having the ability to go back to the traditional ways really benefits these people. I work with the Bear Project up in Pine Ridge that outreaches all the districts and the schools out there and works with the youth. The traditional medicines have been around for eons. These first people behind me and in the state of Nebraska had these traditional medicines for centuries before

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the colonization and militarized occupation, but we don't want to get into that. So real quickly, to answer maybe Senator Riepe's question on how to get this bill expedited, the committee itself has priority bills. And I would highly recommend that the committee itself-- you've heard the discussion of the benefits this would have to the reservations, the Native people, but also to the state of Nebraska economically that the committee itself consider prioritizing this bill, getting it out of committee, on the floor, and working with the Speaker to expedite this because we see the benefits of it. So I appreciate your time and I appreciate my Native brothers and sisters coming here and testifying in front of you. So I would be happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none. Thank you for being here. Next proponent for LB1016. Seeing none. We will move on to any opponents for LB1016. Seeing none. Is there anyone here to testify in the neutral capacity for LB1016? Seeing none. Senator Raybould, you are welcome to close. And on your way up, we did have online comments. We had 3 proponents, 5 opponents, and 1 in the neutral capacity. Welcome.

RAYBOULD: Well, thank you so much. Thank you for listening carefully to this. I also want to thank the tribal members for traveling here today. I want to just remind you that the-- waiver 1115 is a very powerful tool. It allows those that receive Medicaid benefits to work with the federal government on innovative programs, policies, treatments that have proven health outcomes. There are ver-- there are two really important core principles when we-- we're talking about the funding from the federal government. And I hope this partially answers Senator Riepe's question. I di-- wasn't able to get all the nuts and bolts of it. The two core principles of getting granted a Section 1115 waiver. Number one, promote Medicaid objectives. The demonstration must be likely to assist in promoting the objectives of Medi-- of the Medicaid improgram-- of the Medicaid program, improving health outcomes, increasing efficiencies, or improving access to care. Number two, budget neutrality. The waiver must be budget neutral to the federal government. This means that, over the course of the demonstration, the total projected federal Medicaid spending for the state cannot exceed what it would have been without the waiver. So these are very effective tools to-- for different states and different entities to try to, to bridge that gap on disparate health outcomes. I want to say that the fiscal note, based on what was provided, that only gets triggered-- is-- i-- if the program is implemented and approved after the waivers. Getting the waiver is the first-- well,

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the first step is you're approving this and execing it out of committee. We've requested the Speaker make it a priority so that it can be heard. That part requires no fiscal dollars. It's up to us to start the process after that of the tribes working with HHS on developing the game plan. This is not something that HHS will do solely on their own but in partnership with the tribes detailing the appropriate types of traditional healing practices that they want to track and collect data on. These programs are temporary. Again, they're temporary. But the approval process can take up to two years. If the waiver is approved, then the program starts and then they can start implementing and tracking the data. If after five years this program has not proved fruitful, it is not budget neutral, then it won't be continued. It will be terminated. So there is a lot at stake on trying to do more for our tribes in our state of Nebraska that is budget neutral. So I ask that you approve LB1016 so we can start this waiver process. And if there are any other questions, I'll try to answer them.

FREDRICKSON: Thank you, Senator Raybould. Questions from the committee? Seeing none. Thank you for being here.

RAYBOULD: Thank you all.

FREDRICKSON: That will ta-- conclude our hearing for LB1016. And we will move on to LB944. Senator Dorn, we'll wait for folks to kind of transition out a bit. Yeah. All right. Senator Dorn, we're ready when you are.

DORN: OK. Thank you. Thank you, members of the Health and Human Service Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n. And I represent District 30. I am presenting LB944 today for your consideration. And-- when a person who resides in a nursing home and is on Medicaid, the reimbursement is 100% and payment is sent to the nursing home. If this same person decides that he or she is nearing the end of life and they opt to have hospice, the billing changes under the Social Security Act. The hospice now receives the payment at 95% of cost for room and board even though the services to, to the patient does not decline and the hospice provider does not provide any nursing home services. It is the hospice provider who bears the financial burden of their reduction in reimbursement even though there is not an-- reduction in services. This bill is patterned after the law in Virginia to seek 100% reimbursement, so hospice wor-- providers do not bear the financial reduction in payments. So Nebraska would not be out of line in implementing this law. It was brought to my

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attention that there is a federal Social Security law that impacts this bill. I've-- we've attached a copy for your review, which-- it says Social Security law, and then it's in yellow highlighted and stuff. So. We've attached a copy. I would point out the sentence that reads, there shall be paid an additional amount to take into account the room and board furnished by the facility equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. I would note it states at least 95%. The 95% is not absolute. The state needs to accept its financial responsibility and not pass it off to providers. I also have AM2181 that is cleanup in nature. We found some things in there that-- basically, that-- the, the dates and some other wordage need to be changed. There-- the page with the red highlights indicate the changes made in the amendment. I would ask your approval of LB944. There are testifiers following me that can seek-- speak to the hospice services and burden this reduction in payment places on their business. With that, I will take any questions.

FREDRICKSON: Thank you, Senator Dorn. Questions from the committee? I have one. So you mentioned 100% reimbursement. And then once someone decides to go on hospice care, it goes down to 95%. I'm curious, has it, has it always been that way? Was there a time where we changed it? Or maybe that's a question for someone-- yeah.

DORN: I, I do know there's a lady behind me that could sure answer that. She doe-- deals with the hospice all along, and they were the ones that brought me this bill.

FREDRICKSON: OK.

DORN: Our question is, why do they get just 95% instead of the 100%?

FREDRICKSON: Sure.

DORN: So that's why we brought this bill and decided to see if there's something that could be done about it.

FREDRICKSON: Sure. Great. All right. Seeing no other questions. Will you be here to close?

DORN: Yes.

DORN: All right. Thank you, Senator Dorn. We will now hear proponents for LB944. Welcome.

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MARILEE MALCOM: Thank you. I'm Marilee Malcom, M-a-r-i-l-e-e M-a-l-c-o-m. I'm the director of Nebraska Hospice and Palliative Care Association. Thank you, Senator Hardin and fellow members of the committee. And thank you, Senator Dorn, for introducing this LB944. I'm here to-- on behalf of Nebraska Hospice and Palliative Care in support of LB944. LB944 addresses a structural flaw in Nebraska's Medicaid payment process for hospice patients residing in nursing facilities who receive Medicaid room and board. While the intent of the policy may have been administrative, its real-world impact has been creating barriers to hospice access for some of Nebraska's most vulnerable residents. Under current policy, when a nursing home resident receiving Medicaid room and board elects their hospice benefit, the responsibility for billing the room and board then shifts to the hospice agency. And that is part of the Social Security Act. And then Medicare-- Medicaid reduces that payment by 5%. And the hospice agency is then required to bill Medicaid for that room and the board and reimburse the fa-- nursing facility 95% of what they were previously getting for that room and board. The arrangement does not reflect, however, what care is given. Nursing facilities are still required to provide the same services-- staffing and regulatory compliance as they did prior to the resident electing hospice. Hospice election does not reduce the nursing facility's cost or obligation in any way. As a result, nursing facilities cannot absorb a 5% reduction in payment. I have seen in my career of hospice some nursing homes not refer Medicaid recipients who have their room and board paid by Medicaid-- not refer them to hospice because they can't afford that reduction of 5% on one or two or maybe ten people in their building who are on Medicaid that may qualify for hospice. In practice, many hospice agencies have started routinely reimbursing nursing homes for the full room and board rate using their own revenue. They do this within 30 days while waiting more than 90 days-- and often significantly longer-- for Nebraska DHHS to pay them for the room and board claims at only 95%. These claims are often frequently rejected, refiled, and delayed or deleted, and the payment is delayed for months. At the same time, hospice agencies are still federally required to provide the full hospice benefit to these nursing home residents, including nursing, social work, spiritual care, medications, supplies, equipment, and 24-hour on-call availability, just as they would to a, to a patient who lived at home or an assisted living facility. There is no reduction in hospice workload or cost. The result is a system in which hospice agencies are fronting Medicaid room and board payments at a loss, absorbing administrative burden and financial risk that was never intended under the hospice benefit. For

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some providers-- I know of at least one-- it's become un-- unsustainable. As a result, that provider has sto-- has made the difficult decision to not serve nursing home residents who have Medicaid room and board.

FREDRICKSON: And you're in the red zone here. So if you might be able to finish up your thoughts, see if we can see if the committee has questions.

MARILEE MALCOM: OK. This is not a clinical decision. It's a consequence of fal-- flawed payment and mechanics. LB944 would correct this problem by eliminating the pass-through and allowing Medicaid to pay room and board directly to the facility without the arbitrary reduction. This would change administrative complexity, stabilize provider participation, and protect access to hospice care for Medicaid beneficiaries in nursing homes. The cost would be no different than if the resident was not offered hospice at all.

FREDRICKSON: All right. Thank you for your testimony. We'll see if there's any questions from the committee. Senator Quick.

QUICK: Yeah. Thank you, Chairman. Do you know how many of the facilities in Nebraska would provide hospice care? I mean, a lot of it's done in the home too, right?

MARILEE MALCOM: Right.

QUICK: Is it-- and is it the same--

MARILEE MALCOM: So every nursing home that I am aware of will allow hospice to serve within their facility.

QUICK: OK. And is it the same way for in-home hospice too? I mean, is it the same--

MARILEE MALCOM: Same services.

QUICK: And the same challenges, though, with the, with the Medicaid?

MARILEE MALCOM: No. Hospice is typically covered by Medicare for anyone over age 65. But in Nebraska, Medicaid will also offer the same services at the same Medicare rate for people who are Medicaid recipients that don't have Medicare for their health insurance.

QUICK: OK.

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MARILEE MALCOM: So if you are under age 65 or not eligible for Medicare, you can get hospice through Medicaid.

QUICK: OK. So really, it's for the ones tha-- in the facility that are--

MARILEE MALCOM: Just those people who have--

QUICK: --spend down their assets and they're on Medicaid--

MARILEE MALCOM: Medicaid for room and board. Mm-hmm.

QUICK: OK. All right.

FREDRICKSON: Senator Riepe.

RIEPE: Thank you, Chairman. I have a couple questions, if I may. First question is, on the-- it says 100% for nursing homes. Is that on a cost plus basis or is that on DHHS rate schedule? What, what is the 100%?

MARILEE MALCOM: So it's the-- with their room and board, it's set on their level of care. So when a nur-- a nursing home resident has Medicaid paying for their room and board, the nursing home does a level of care assessment for that patient and submits it to the state. And the state determines what their level of care payment will be per day.

RIEPE: OK.

MARILEE MALCOM: And that is decided by the state. And then that's what they pay that nursing home.

RIEPE: OK.

MARILEE MALCOM: And then usually that resident also has a share of cost, which is, like, all but \$50 or \$70 of their Social Security payment.

RIEPE: So it's rather arbitrarily set by the state.

MARILEE MALCOM: Right. Everyone's share of cost is different.

RIEPE: My second question is, because when it goes to hospice-- and I assume this is-- hospice is both-- can be inpatient and outpatient. I

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assume this is restrictive-- the 95% is restricted-- cost reduction is restricted to the inpatient. Is that correct?

MARILEE MALCOM: That's correct.

RIEPE: OK.

MARILEE MALCOM: I-- it-- sorry. It's restricted to people who are living there as a in-home hospice patient. So if they're a general inpatient, that Medicaid does not pay for their general in-patient care in a nursing home.

RIEPE: Let me ask this question then. To get to the 95%, do the services decrease for this patient?

MARILEE MALCOM: They do not.

RIEPE: OK. Would a nursing home [INAUDIBLE] have the prerogative of not accepting the 95% and asking that patient to then move out?

MARILEE MALCOM: No.

RIEPE: They don't-- is that because of their mission or is that because they're legally not allowed to?

MARILEE MALCOM: The nursing home can not-- can not offer the hospice, I believe. I mean, if the patient asked for hospice, I think they would, they would be required to either offer them hospice or offer them to move them to a facility that would offer them hospice. But typically, they just don't get hospice for them--

RIEPE: OK.

MARILEE MALCOM: --so.

RIEPE: The-- they're not mandated to keep the hospice patient. You said they could move them to another facility.

MARILEE MALCOM: Yeah. They could offer them--

RIEPE: I'm not talking about--

MARILEE MALCOM: I thi-- I think-- I'm not the nursing home expert, so I don't want to say for sure, but my experience has been that they're on a tight-- very tight budget with what they get paid from Medicaid for reimbursement for room and board. And so typically what I've seen

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happen is if they aren't going to get-- like, if hospice A will give me a 100% of room and board-- say they get \$200 a day for room and board-- just using a number out of the air. So they're gonna lose money by putting that patient on hospice. They're gonna, they're gonna be losing, you know, 5% of that every day. They just won't offer that patient hospice.

RIEPE: I have one more question, if I may, Chairman.

FREDRICKSON: I don't know if you can.

RIEPE: Thank you. And that question is this-- hospice used to be fundamentally with six months of expectation of remaining alive. Anymore, that doesn't seem to be the case.

MARILEE MALCOM: It is still the case. And our average length of stay in Nebraska is actually much less than that. In Nebraska, our average length of stay-- I-- I'll forward you a paper with our data on it so that you can look at our 2024-- 2025 data for Nebraska.

RIEPE: OK.

MARILEE MALCOM: I'll send it to your email.

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

MARILEE MALCOM: Yes. Thank you for allowing me to be here.

FREDRICKSON: I have a question.

MARILEE MALCOM: Yes.

FREDRICKSON: So the reimbursement rate-- 95% for the hospice versus 100%, wha-- has, has that always been the case? Was there a time where we were reimbursing 100% for hospice and it went down to 95%? Do you know the history behind that?

MARILEE MALCOM: So there's a little bit of, of misunderstanding in that-- in how that's worded. It's not for the hospice care. It's for the room and board. And that came from the Social Security Act. So when a inpatient elects hospice, it's actually the room and board that isn't re-- reimbursed at 100% anymore. So I'm not-- I, I don't even understand how the Social Security Administration ever came up with that rule, but Anne has a lot more information in her explanation because of her, her business as a hospice owner on how that's

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affected-- so I'm gonna let her answer that. But as far as I know-- I've been doing this since year 2000-- and it's been that way in Nebraska that entire time.

FREDRICKSON: Great. Thank you. Senator Ballard.

BALLARD: Thank you, Vice Chair. Thank you for being here. Are-- can you help me under-- are the costs different at all for a room or between a nursing home and a hospice? Are the costs very similar?

MARILEE MALCOM: So there is no room on board for hospice, because we don't have any license-- we have-- we had one licensed inpatient hospice in Nebraska, and that was at Josie Harper. And they're in the process of doing-- making some changes. So yes, that's an inpatient hospice there. An inpatient hospice is only while you have a symptom that needs frequent management. And it gets billed through the hospice back to Medicare. And it's very short term. So that's inpatient hospice, when you have a symptom that needs frequent intervention of a medical team. Otherwise, you're taking care of either in a nursing home, in an assisted living facility, in, in-- at-- in your own home, one of those places. You can live in a hospice house, and you usually privately pay for that. So Medicaid wouldn't pay for you to live in the hospice house. So if you're living in a place where Medicaid pla-- pays for you, it's in a nursing facility.

BALLARD: I see. OK.

MARILEE MALCOM: And so it is based on your level of care, based on something called the MDS form that-- that nursing home does the assessment and sends in to determine how much you get paid for your room and board for that particular patient based on their level of care, the diagnoses they have, the medications, the-- all the things that they need to have done for them. And so when they come onto hospice, they tell us what their-- what their room and board fee is. And then the hospice agency has to submit that claim to DHHS now. So my hospice biller had to now become a new biller to de-- submit the claim to DHHS. So--

BALLARD: I see. OK. Thank you for that. I appreciate it.

MARILEE MALCOM: You're welcome. Thank you for your questions.

FREDRICKSON: Other questions? Senator Quick.

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QUICK: Yeah. Thank you, Chairman. So I know there's, like, a-- certain nursing homes or facilities that will only take a certain percentage of Medicaid and-- what happens with the people who, who can't get into a facility or-- maybe you can't answer that. I mean--

MARILEE MALCOM: I-- you know, that's a great question. I, I do see a little bit of it when we have people who are looking-- like hospice social workers. Someone-- you know, sometimes I hear from them, like, do you know where we can go? I work some with the Nebraska Health Care Association, and they're also helping with that. It's a problem. Where I live at Cozad, Nebraska, we've seen-- I, I think maybe there's 17 that have closed in the last few years of facilities out in that area because-- I called one of our providers where I live today to ask what their percentage of Medicaid patients was, and it's 85%.

RIEPE: 80--

MARILEE MALCOM: 85% of their residents are Medicaid. So that's huge. You know, if they-- they-- if they have 40 people in their building and 85% of them are Medicaid and they have 5 on hospice, that's a huge amount for them to take a hit if they don't get 100% back. So where do they go? They might have to go to Omaha. You know, if they live in Cozad, they might have to go to Omaha or they might have to go to Lincoln or they might have to go to-- a long ways away to find a place to go because there's not very many places left.

QUICK: I've visited some, some nursing home facilities that won't take any Medicaid--

MARILEE MALCOM: Yeah.

QUICK: --based on the fact that it's too cost prohibitive. And then there's those that will only take in, take in a cer-- a certain percentage. So wha-- that's a high number of-- and I commend them for that, but they've got to be taking a loss.

MARILEE MALCOM: One of the ones that we-- I was serving in as a hospice director before it closed was 100%.

QUICK: Wow. OK. Thank you.

MARILEE MALCOM: Mm-hmm. Thank you for your questions.

FREDRICKSON: Senator Riepe.

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RIEPE: Chairman, thank you. Emphasis on 100% would put you out of business. The one that has 85% Medicaid, have they considered selling to the state of Nebraska?

MARILEE MALCOM: I have no idea. I just know that-- I just called today to say-- just because I was curious, like, what percentage of your residents are? And-- just for a basis of how that would impact them if they were not to get 100% from their hospice provider. Because they do get 100% from one provider but not from another provider who serves in their building. So, you know, that's, that's-- it makes a difference.

RIEPE: Yes. Thank you.

MARILEE MALCOM: Yeah.

RIEPE: That's stunning.

FREDRICKSON: Seeing none. Thank you for being here.

MARILEE MALCOM: Thank you.

FREDRICKSON: Yeah. Next proponent for LB944. Welcome.

ANNE PAULMEYER: Thank you. My name's Anne Paulmeyer, A-n-n-e. Last name's Paulmeyer, P-a-u-l-m-e-y-e-r. I just wanted to thank you all for taking this topic on because it's a very complex and kind of difficult to understand all of the, the policy and how it's actually written, so. I'm actually a physician assistant and the administrator at Cottonwood Hospice in Beatrice, Nebraska. We're a small, locally owned and operated hospice agency serving Gage, Jefferson, Pawnee, Richardson, Saline, and Johnson Counties. I'm here today to ask you for your support of LB944. Because of how the Social Security Act was originally written, when a patient living in a Medicaid-certified nursing facility elects hospice services, Medicaid reimbursement for their room and board automatically drops from the 100% to the 95% despite no reduction in services provided by the facility. In fact, state and federal regulations require that residents continue to receive the exact same care that they were receiving from the facility staff in addition to hospice services. So while nothing about the patient's care decreases, payment to the facility does. In addition to the 5% reduction in reimbursement, the hospice agency also absorbs the administrative time and cost of managing room and board billing. This includes entering patient data, verifying rates, levels of care, share of cost amounts with the facilities and DHHS, tracking payments, and repeatedly modifying and resubmitting claims to meet state and federal

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requirements just to pass the funds to the nursing facility. At Cottonwood Hospice, this averages out to be about an hour to an hour and a half a day, creating unnecessary administrative and financial burdens for hospice providers without improving care oversight or payment accuracy. The impact is felt in most rural-- in-- most in rural Nebraska. At Cottonwood Hospice last year, 37% of our facility patients were Medicaid room and board. With over \$1.4 million in Medicaid room and board pass-through payments in 2025, you would think that this would be about a \$70,000 loss. But because of the way that the share of cost is applied, that 5% reduction is applied before the share of cost. It actually ended up being about \$107,000 for our small agency. I can get in the math later, but. In rural Nebraska, including the counties we serve, there's a large Medicaid population and the aging demographic that heavily depends on long-term care services. Closures of facilities in the counties that we serve in the last seven years include Wymore Good Samaritan in 2019, Belle Terrace in Tecumseh in 2021, Premier Estates in Pawnee City in 2024-- all of these facilities citing financial pressures and low Medicaid reimbursement rates as reasons for their closure. Colonial Acres is a, is a city-owned nursing facility in Humboldt that continues to operate on thin, if any, margins, but does so to provide this necessary service to their community. The policy the way that it's currently written unintentionally penalizes nursing facilities for supporting hospice care and honoring patient choice at end of life. We as the hospice simply act as a billing conduit for-- while the facility receives a 5% or less reduction in room and board reimbursement for Medicaid. It's purely a structural artifact of federal language written decades ago. LB944 offers a straightforward, commonsense solution: remove hospice as the pass-through for Medicaid room and board payment and allow Medicaid to reimburse the skilled nursing facility directly at 100% of the approved rate, just as it does when a patient is not on hospice.

FREDRICKSON: And you're in the red zone, unfortunately, so we'll see if there's any questions for you from the committee.

ANNE PAULMEYER: OK.

FREDRICKSON: Any quest-- committee? Senator Riepe.

RIEPE: Thank you. Thank you for being here. I guess my first question would be-- is, how many beds do you have?

ANNE PAULMEYER: We don't have beds.

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RIEPE: You don't have beds.

ANNE PAULMEYER: So we're a hospice service that goes into the facility or into the home. So when you think of-- I want you guys to think of this as, like, two different buckets here. We have hospice services that's predominantly paid through by Medicare, and then there's room and board, which is the issue that we're discussing today.

RIEPE: OK.

ANNE PAULMEYER: So with room and board, when a patient lives in the nursing facility and they are at end of life and elect to go into hospice, that's when this problem starts occurring. So rather than the patient on day ten of their stay at the facility receiving-- the facility is receiving 100% of the Medicaid daily rate, they're now on hospice and a-- and receiving only 95% of the daily rate. Hospice services don't change-- our payment does not directly change from what we get from Medicare or from Medicaid. It's the 5% reduction that we are then asked to pay to the facility to make up that difference for that patient to be on hospice.

RIEPE: OK. So if a nursing home gets paid 95%-- so it's a 5% reduction-- but then they have to-- some way you have to get paid. But they don't have-- they don't pay you the-- you separately bill. Is that correct?

ANNE PAULMEYER: Yeah. We bill for our hospice services to Medicare, for the most-- for majority of patients to Medicare.

RIEPE: So you have Medicare and Medicaid. Or, or-- I would--

ANNE PAULMEYER: Typically, most-- for the services, most is for Medicare. For room and board is where Medicaid comes into play.

RIEPE: OK. And are-- some of those are dual. They're on Medicaid and Medicare.

ANNE PAULMEYER: Yep. Exactly. Yep. So the service is--

RIEPE: Do you still lose-- do you lose money when it's a-- when they're on both Medicaid and Medicare?

ANNE PAULMEYER: We get paid for our hospice services. That pays for our labor, for the nurses, the aides to go out to help provide baths, do the visits. We pay for the medications.

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RIEPE: OK.

ANNE PAULMEYER: So any medication related to the terminal illness is paid for by hospice.

RIEPE: Let me ask this, if I might. Are, are, are you the owner of this or do you--

ANNE PAULMEYER: I'm one of the owners, yeah.

RIEPE: One of the owners. But you're not a national or-- organization.

ANNE PAULMEYER: No. We have about 40 to 50 patients on average in-- yeah.

RIEPE: How long have you been in business?

ANNE PAULMEYER: We actually took over from the Beatrice Community Hospital-- Hospice because they were no longer able to financially make it, which--

RIEPE: You're pretty brave.

ANNE PAULMEYER: I know. We're dumb. One of the two. But one of the-- the hospice director had approached my husband and I about trying to do this with another hospice nurse. And we're like, it was-- I mean, we're one of only five-star hospices in the state. And they just had a great reputation and we couldn't watch it go, so.

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

FREDRICKSON: Thank you. Other questions? Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. So do, do, do all filcility-- facilities use a, a, a hos-- like, like your type of service or do they have-- sometimes have a hospice nurse in their facility?

ANNE PAULMEYER: They all-- I don't know any facility that has a hospice--

QUICK: OK.

ANNE PAULMEYER: I guess there probably are that have both the fi-- the long-term care and a hospice. I know that there are companies that do that but not around where we are.

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QUICK: So you also would do it-- like-- so my mom was in hospice, but she was at home.

ANNE PAULMEYER: Yup.

QUICK: So you would also do that-- those types of services along with the services for the facilities themselves.

ANNE PAULMEYER: Correct. So about 50% of our patients are home, and the other 50% are in the facilities. And of that 50% in the facilities, about 37% was last year's number, so.

QUICK: So when the facility's at that 95% on the Medicaid side, did-- and maybe I misheard you, but do, do you tra-- do you-- are they asking you to reimburse some of that 5% out of what you're getting to cover that cost? Is that--

ANNE PAULMEYER: Exactly. Yup.

QUICK: OK.

ANNE PAULMEYER: Yup.

QUICK: OK.

ANNE PAULMEYER: And that's-- it-- for me, it's more of just, like, why is this fair for a patient at the end of life-- or, why is it fair for the facility to have to take the 5% hit just for a patient wanting to be on hospice? And I think that's really what this bill is about, is trying to remove hospice as a middleman and-- the facilities that are doing the same service and the same care and providing that same caregiving to the patient, why are they having to take a 5% reduction in payment? Or why are we having to foot that bill just because they're on hospice? There's not an overlap of-- we're not there giving baths. They still have to give their baths every week to that patient, what's on their care plan. We still have to give the baths that's on our care plan. There's, there's no change in the care that they're given except for they're getting a little bit extra at the end of life but the payment is decreasing.

QUICK: OK. All right. Thank you.

ANNE PAULMEYER: Mm-hmm.

FREDRICKSON: Senator Riepe.

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RIEPE: Thank you, Chairman. I have a follow-up question.

ANNE PAULMEYER: Sure.

RIEPE: Obviously, in the hospice business, you're at the end of life.

ANNE PAULMEYER: Mm-hmm.

RIEPE: Do you ever get abandoned patients?

ANNE PAULMEYER: From--

RIEPE: They have, they have no family, they have no--

ANNE PAULMEYER: Oh. All the time. Yeah.

RIEPE: All the time.

ANNE PAULMEYER: Yeah. And a lot of those are in the rural facilities that we'll see. They-- a lot of those-- those patients don't want to leave their home. They've been in rural Nebraska and Pawnee City for their entire life but family's moved away. And maybe they're somewhere in Lincoln or Omaha, but, a lot of the times, they're on the coast. And so if they're in their home, they have to have a caregiver to be on hospice. And so that may be a neighbor, it may be a church member. And we come and check-- you know, do our nursing visits and our aides, and we try and schedule it as much as we can. But we're not the caregivers. And so once that happens, that's when they move to the facility and Medicaid may or may not kick in.

RIEPE: Do you end up at times-- and I'm assuming when they come to you, they are-- they're either on Medicare or on Medicaid.

ANNE PAULMEYER: Mm-hmm.

RIEPE: You, you don't have to go out and apply for them and--

ANNE PAULMEYER: We do.

RIEPE: You do have to--

ANNE PAULMEYER: So we have-- yeah. So we have social workers that will help with Medicaid applications.

RIEPE: OK. Then do you have an obligation to help with their other finances, the end of life estates or anything like that?

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ANNE PAULMEYER: As far as, like, attorney's fees for estate planning?
No.

RIEPE: Yeah. I'm just, I'm just curious how expansive--

ANNE PAULMEYER: No. I mean, we try--

RIEPE: Because if-- you're the only one that's out there kind of to
look out for them, because they've been abandoned.

ANNE PAULMEYER: Yep.

RIEPE: And a--

ANNE PAULMEYER: Yeah.

RIEPE: They-- these-- all these little legal details wrap up at the
end of life.

ANNE PAULMEYER: Sure. Yeah. I mean, we, we have, thankfully, good
attorneys that we have in our area that will do kind of consulting, if
you will--

RIEPE: Pro bono kind of stuff.

ANNE PAULMEYER: --for-- yes. Exactly.

RIEPE: That's good for lawyers. OK. Thank you.

ANNE PAULMEYER: Yeah.

RIEPE: Thank you. Thank you, Chairman.

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

ANNE PAULMEYER: Thank you.

FREDRICKSON: Next proponent for LB944. Seeing none. We will move on to
opponents for LB944.

MATTHEW AHERN: Good afternoon.

FREDRICKSON: Good afternoon. Welcome.

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MATTHEW AHERN: Good afternoon, Senator Fredrickson and members of the Health and Human Services Committee. My name is Matthew Ahern, M-a-t-t-h-e-w A-h-e-r-n. And I'm a deputy director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB944. The department opposes the bill's requirements to change the entity receiving the payment for the hospice room and board services from the hospice care provider to the long-term care facility. Federal law requires that Medicaid pay the hospice agency for clients who are dually eligible for Medicaid and Medicare. The federal law establishing this requirement in 2013 was enacted as a result of audit findings by the OIG, or Office of Inspector General, and program integrity concerns around inconsistent and duplicative billing for clients receiving hospice services in long-term care facilities. Additional information can be found in the attached preamble to 42 CFR Part 483, the final rule. This provision of LB944 puts federal financial participation at risk and deviates from the federal changes enacted in Medicare and requirements bestowed upon Medicaid, which are intended to coordinate delivery of services and strengthen program integrity. We respectfully request the committee not advance the bill to General File. Thank you for your time. I'd be happy to answer any questions on the bill.

FREDRICKSON: Thank you for your testimony. Senator Riepe.

RIEPE: Thank you, Chairman. My question is this, were the-- was this audit a state audit or a federal audit?

MATTHEW AHERN: It was a federal audit.

RIEPE: Federal audit.

MATTHEW AHERN: Yes.

RIEPE: So in their audit, did they say that we're out of line with, what, the whole nation?

MATTHEW AHERN: So I, I believe it was a nationwide finding and it was around the duplicative billing for clients receiving the hospice services in nursing facilities. So as a result, they set up the expectation in 42 CFR 483 to establish a required sort of contractual-type relationship between the hospice provider and the nursing facilities. And they communicated their expectations that the, the hospice provider be paid and then they pay the nursing facility out of the money received.

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RIEPE: Now, in 2013-- you may have not been here yet.

MATTHEW AHERN: I was not here yet, no.

RIEPE: So you're an innocent soul.

MATTHEW AHERN: Absolutely.

RIEPE: OK. So the question that I have with it is, just because you get an audit doesn't mean you don't challenge the audit.

MATTHEW AHERN: Sure. I totally get that. And at the same time, I wasn't here and I wasn't in the federal government who set forth the regulations here to, to outline the expectation of who gets billed first. Though, though one of the factors that comes into play here is that it isn't necessarily around the OIG finding-- that's the impetus-- but part of the concern is that the service being provided for out of a Medicare service to the hospice provider and then, because of the coordination of benefits, they don't pay for the room and board, but it's the trailing coordination to make sure we get in alignment there, that the payment goes to the, the provider receiving the primary-- or, providing the, the primary service-- or, the payment for the provider providing the primary service.

RIEPE: As I think we both understand, 2013 was a long, long, long time ago in the health care business.

MATTHEW AHERN: True.

RIEPE: My question gets to be-- and my experience in auditing is, if they find a finding, they're likely to come back in a year or should to see if in fact compliance has been met.

MATTHEW AHERN: Mm-hmm.

RIEPE: And if not, it seems to me that they may have set this standard and walked away from it and we've never challenged it since 2013.

MATTHEW AHERN: Entirely possible. That said, nobody's changed the federal law since, so we're still going--

RIEPE: [INAUDIBLE] possible. Yes. Thank you. Thank you. I, I just-- you know, I want a fair deal is what I want here.

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MATTHEW AHERN: Yup. I totally get it. I think our, our intention is that the, the law and the communication from our federal partners clearly communicates that we have to pay the hospice provider first. And we can't pay the nursing facility first for the room and board. And that's, that's what we're doing. It-- a-- as he mentioned, there's the, the factor of the 95% because it says a minimum of. If we're having a rates conversation, that's one thing. Our opposition isn't about a rates conversation. It's about the mechanism of the billing, which has clearly prescribed the way we can do it and the way we can't.

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

FREDRICKSON: Other questions? Senator Meyer.

G. MEYER: Thank you, Vice Chair. Simple terms-- I'm a simple man. So if we would enact this law, what are the financial jeopardies that we face?

MATTHEW AHERN: Well, we, we couldn't enact it as written, because we have clear federal law that would trump the state law.

G. MEYER: Yeah, we could enact it as it's written. It just means we're out of our minds--

MATTHEW AHERN: We couldn't. We would, we would potentially lose federal funding, yes.

G. MEYER: OK.

MATTHEW AHERN: So I don't know the, the, the degree to which the feds might choose to revoke federal funding. Sometimes it can be in, in broad, sweeping terms they'd pull back federal funding. Sometimes they might narrow that to a particular case. But that would be up to them to decide, and we, we really couldn't predict exactly what that would be.

G. MEYER: OK. Thank you.

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

MATTHEW AHERN: All right. Thank you guys.

FREDRICKSON: Other opponents to LB944. Seeing none. We'll move on to the neutral capacity for LB944. Seeing none. Senator Dorn, you are

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welcome to come close. While he's on his way up, we did have online comments. We had 9 proponents, 5 opponents, and 2 in the neutral capacity. Welcome.

DORN: Thank you. Some good questions. Number one is the interim director-- or, interim person there that just testified for DHHS, I do not agree with the fact that they say they could possibly use federal funds. In my opening comment, it says that Virginia's already acted 100% of that federal funds. This issue is not the hospice issue. It's when they go on hospice and they are in a nursing home and that room and board. Previously, the department had to pay the nursing home 100% of that fee what-- is a calculated number that comes up to each nursing home is a different fee. But they paid 100% to that to the nursing home. Once they go on hospice, now instead of paying the nursing home, they get to pay 95% to the hospice provider. That hospice provider then-- many of them do-- they pay 100%. Part of that 95% fee that they get, they take money out of that and pay 100%. Some of them don't. Some of them can't. So that just depends. But the fact that he says they lay-- may lose federal funds, it's been shown that most state-- or, one state for sure, Virginia, does not, or whatever. This was brought to me by Ms. Paulmeyer because, like she said, they have a-- I call-- I would call it generally a smaller hospice service in our area. It-- a, a, a smaller one, I call it, for statewide hospice service. In our area, the-- they do a very good job. They have about the 40 or 50 patients or whatever. But for them alone, it amounts to \$107,000 that they're-- if they reimburse the nursing home, that's-- comes out of their pockets. Or the nursing home doesn't get it, somebody can short that \$107,000 when they go on hospice. So that's why we brought the bill, to have that discussion so that people are aware of the fact of what is going on here and stuff. So I thought Senator Riepe had some very good questions about that. One last comment I'll make is, between five and ten years ago, both of my in-laws went on hospice. As I was growing up, I always had a fear of hospice and that it-- you didn't want to be on it. I will say this: the last several months of their lives, it was a blessing. And hospice does such a good job of taking care of those patients at the end-of-life stages. It is fantastic how they have developed that, I call it, program or that level of care. And it puts them so much at ease and so much, I call it, almost pain free. Not completely, but they are able to give them medication to have a lot less pain and stuff. It's a peaceful time instead of a struggling, struggling with end-of-life time. So they do a very good job. I thank you all for listening, so. Yeah.

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FREDRICKSON: Thank you. Questions from committee? Senator Meyer.

G. MEYER: I apologize for not being here for your, for your opening and, and getting in late. And so you probably covered this, but my understanding is that Virginia in all probability has to follow the same federal law we do.

DORN: Yeah. Mm-hmm.

G. MEYER: Is that a safe assumption? I, I have suspicion it is. And so you modeled your bill off Virginia's bill.

DORN: That is one that we looked after and that we modeled it somewhat after, yes.

G. MEYER: OK.

DORN: And if you look at the fiscal note, I think it was \$890,000--some a year of state funding. And then there was a corresponding to-- I can't remember the exact amount-- of federal funding that would come with it if this was paid at 100% instead of 95%. So that's the estimate of the fiscal note. Most people know how the fiscal notes are put together, so.

G. MEYER: Thank you.

DORN: Yeah. Thank you.

FREDRICKSON: All right. Oth-- other questions? Senator Quick.

QUICK: Yeah. Thank you, Vice Chairman. So-- and I know-- in my area, we've seen a loss of nursing home facilities, you know, care facilities like that. And I'm sure you've faced it in your area too, so. I know-- several times we've talked about Medicaid reimbursement rates and really how do we provide that great care for people that-- who, who need that care. So-- I don't know-- how mu-- do you know how many you've lost in your area?

DORN: I, I don't know in my area. She did talk about Pawnee-- excuse me-- Wymore that closed down about two years ago. I know statewide there was a period of three years statewide that we had 15 nursing homes close, and the majority of them were out in rural areas. Not all of them were, but the majority of them were. She's also said-- in the last five years, there's been one at Tecumseh, which I'm aware of, and one at Pawnee City also that I'm more. Many times-- not always-- but

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many times, part of the reason they-- is financially that they have to close. If they just get too many Medicaid patients, they're not able to-- they don't have enough oth-- other patients paying to make up that difference, and they're not. So some of the issues all-- that-- why nursing homes have closed has been staffing also, just not enough in certain rural areas, especially if you don't have the staffing there to meet the levels that you have to have to have so many patients and all that stuff, so. Yeah.

QUICK: Yeah. And I think some of that has to do with the reimbursement because--

DORN: Yes.

QUICK: --they're not able to pay and compete with some of the wages for those-- wages and benefits to keep those employees emp-- employed there, so. And I know this has been going on for a while because, even when I served those first four years, we were facing clo-- facing closures of, of nursing homes and assisted living facilities, so. Thank you for bringing this bill.

DORN: 30 years ago, I didn't worry about it. Now that I'm at my age, I'm going, oh.

RIEPE: [INAUDIBLE] still a young guy.

DORN: OK.

QUICK: Yeah. Thank you.

DORN: Yes. Thank you. Thank you much.

HARDIN: Any other questions?

DORN: Yeah.

HARDIN: Thanks. Appreciate it. Thi-- this concludes LB944. Everyone be careful. The Clerk of the Legislature has actually invited staff who can to go home because of the weather. And so, gang, we will not be execing tonight. We're going to try and button it up as quickly as we can. And so be careful. We'll wait for the shuffle, Senator Rountree, to conclude. Senator Rountree, are you prepared to go with LB843?

ROUNTREE: Most certainly, Mr. Chairman.

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HARDIN: Awesome. We look forward to hearing about it.

ROUNTREE: Thank you so much. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Victor Rountree, V-i-c-t-o-r R-o-u-n-t-r-e-e. And I represent District 3, which is made up of Bellevue and Papillion. Today, I'm here to introduce LB843, which would have the state apply for a federal waiver to SNAP eligibility changes made in H.R. 1 last summer. The Supplemental Nutrition Assistance Program, or SNAP, is a vital lifeline to many in our communities. Last year, I was before this committee with LB319. And during that hearing, we were told repeatedly that there is a greater need now for food assistance than even during the COVID pandemic. Since last year, need has continued to grow, and our food pantries are stretched thinner and thinner. Grocery prices continue to rise, and budgets are unable to meet the needs families experience. That reality becomes that much harder when vital food assistance programs are cut. Under the changes made by Congress last year in H.R. 1, thousands of Nebraskans would become ineligible for SNAP and be forced to find new ways to afford their basic needs. H.R. 1 eliminated all categories of refugees, asylees, and UNT visa holders-- which are victims of trafficking and domestic violence-- from being eligible for SNAP. Many of these groups have been eligible for SNAP for decades, including refugees, which have been eligible since 1977. These changes are a drastic change in policy and will harm some of the most vulnerable people in our state. Since these changes were made, 10,000 Nebraskans have lost their food assistance, and 7,000 more are expected to be disenrolled due to the changes this bill addresses. These are refugees from Ukraine, Afghanistan, Iraq, and many other countries around the world who fled persecution for a better life for their families and now are unable to feed those families. LB843 is a very simple bill. This bill simply requires DHHS to file for a waiver to the federal government asking for these changes to be waived and for these communities to maintain the assistance they have been able to access for decades. Food is not an option. Everyone in our state must eat, and there is not nearly enough support in our communities to meet that need. I think it is a misstep to make families choose between rent or groceries as our economy continues to grow worse and worse for working-class people. I appreciate your attention to this bill and to the needs of Nebraskans. There are some amazing testifiers who have braved this weather behind me who can answer some of the more technical questions you may have. But with that, I am happy to answer any questions.

HARDIN: Thank you. Questions? Will you stick around?

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ROUNTREE: I will be around. I plan to remain in Lincoln tonight, but I know some have to travel.

HARDIN: Very good. Proponents, LB843. Welcome.

JOANNA LINDBERG: Thank you. My name is Joanna, J-o-a-n-n-a; Lindberg, L-i-n-d-b-e-r-g. And I am a refugee sponsor and have worked with Afghan refugees. Senator Hardin and members of the Health and Human Services Committee, I appreciate you hearing this bill. Our Catholic Church in Omaha, St. Wenceslaus, has successfully sponsored refugee families in the community for the past ten years. Currently, we are working with three Afghan families who worked for the U.S. military and settled here in October 2024. The family I am most concerned about is six children-- six young children ages one, three, five, and six. And-- mom and dad. And their three-year-old son is severely disabled and bedridden. The father was a cook for the U.S. military and has legal permanent residence status, with green cards, Social Security numbers. This a-- this father works at Airlite Plastics overnight, making \$18 an hour. This overnight job works well for the families. He can attend to his son's weekly physical therapy and, and many medical appointments while his wife attends to the complex skill needs of their son, who receives tube feedings, asthma treatment, suctioning, and just a highly medically needy child. With SNAP benefits, they pretty well function. They could pay their monthly expenses of rent, utilities, auto, diapers for two. And their-- one of which has diapers because of his disability. So the loss of food stamps and the new requirement that he's gonna have to pay \$105 a month for Medicaid benefits means they have a monthly deficit of \$400. I'm deeply worried and don't know how they're gonna-- how they are gonna have enough to feed their kids. And I just wonder, how can this H.R. 1, this Big Beautiful Bill, take food away from a family of six whose parent worked for the U.S. military in Afghanistan? And they came here to escape the persecution of the Taliban government because they worked for the military.

HARDIN: Thank you.

JOANNA LINDBERG: Thanks to Senator Rountree for, for submitting this bill.

HARDIN: Questions? Senator Quick.

QUICK: Not necessarily a question, but thank you for the service that you do to help with these families.

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JOANNA LINDBERG: They're such good people.

QUICK: Thank you.

JOANNA LINDBERG: Yeah. You're welcome.

HARDIN: Senator Riepe.

RIEPE: Thank you. I'm curious because I don't know a-- what other agencies with-- even within the Omaha community-- I'm an Omaha senator--

JOANNA LINDBERG: Yeah.

RIEPE: --that-- have they been rejected by or-- and I'm talking beyond SNAP here. I'm talking about-- you know, some agencies might. I don't know--

JOANNA LINDBERG: Yeah.

RIEPE: I don't know. You have to teach me. Did anybody make a cash payment to, to help them narrow this \$400 gap?

JOANNA LINDBERG: Yeah, we--

RIEPE: We're very fortunate in Omaha. We have a lot of very generous but very wealthy people as well. Not, not all of us, but some of them. But I've heard they're out there.

JOANNA LINDBERG: Well, Heart Ministry Center on, on 24th and Binney is an amazing place. And you can get food there. And they have somebody to help with your taxes and they have an attorney. And that is the best service we've found. You know, we've-- I don't know people-- you know, other programming that--

RIEPE: Can't, can't you use some good Catholic guilt on them?

JOANNA LINDBERG: I do that a lot. Yeah. We raise money. Our, our church is very generous financially. And I'm-- you know, that's a lot, though, to ask--

RIEPE: You have a great benefactor in your church too.

JOANNA LINDBERG: Yeah.

RIEPE: But God bless you for it. Thank you.

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JOANNA LINDBERG: Yeah,

RIEPE: I don't have any more questions [INAUDIBLE]. Thank you, sir.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So my question is, I know-- so this is just one family. How many families-- and maybe it's in here. Maybe you already said that, but how many families are you serving right now?

JOANNA LINDBERG: We're working with three families--

QUICK: Three families.

JOANNA LINDBERG: --in the community. Right.

QUICK: OK. But you're not the only--

JOANNA LINDBERG: Volunteer?

QUICK: --volunteer or people for-- I mean, there's other people who are helping refugees within Omaha, right? So--

JOANNA LINDBERG: Yeah. I mean, they're-- the, the-- you know, Lutheran Refugee Services gets enough to serve three months for refugees. So then anybody else that's volunteers then comes in. But in this case, this very ill child does have Omaha Public Schools coming in and looking at him, helping with braces-- wonderful medical care through Children's Hospital. But I, I don't know if-- it-- maybe Salvation Army comes in and helps. All of that-- it-- wouldn't be cash payments.

QUICK: Yeah. Yeah. I know there's other, like, Heart-- well, we have Heartland United Way in Grand Island. So there's, like, United Way and some other food banks that maybe would help in some situations too. But, but I didn't know how many actually refugee families in Omaha, because it's not just three. It's not just-- it's, it's probably a lot more than-- and other-- there's other services that are providing for them too, right?

JOANNA LINDBERG: Yeah. I thought I heard Senator Rountree say 3-- 10,000 maybe--

QUICK: OK.

JOANNA LINDBERG: --are affected.

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

JOANNA LINDBERG: Yes.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. I was just kind of looking at the dates here. And so-- are, are they currently-- have they lost those benefits currently right now?

JOANNA LINDBERG: You know, it'll be June 1 for this family. Another family I'm working with--

G. MEYER: June, June 1 of this year?

JOANNA LINDBERG: Yeah. So they've got a little, you know-- or, they got a little mental preparation.

G. MEYER: Yeah.

JOANNA LINDBERG: Another family I'm working with, they lost them in February.

G. MEYER: OK.

JOANNA LINDBERG: And another family will be actually next month, March.

G. MEYER: OK. And, and with the-- it appears that the disabled three-year-old needs 24-hour attention? Are, are they receiving any benefits through the disabled program?

JOANNA LINDBERG: He gets disability.

G. MEYER: He gets disability.

JOANNA LINDBERG: Yeah. \$90 a month. Wa-- I'm sorry. \$900--

G. MEYER: Yeah.

JOANNA LINDBERG: --a month. Yeah. So that helps pay--

G. MEYER: --\$90, \$90 would be a little short, but, we-- you know, that's--

JOANNA LINDBERG: That helps pay for diapers and--

G. MEYER: Certainly.

JOANNA LINDBERG: Yeah.

G. MEYER: Certainly.

JOANNA LINDBERG: Yeah. Tha-- on [INAUDIBLE].

G. MEYER: Thank you.

JOANNA LINDBERG: Yeah.

HARDIN: Thank you.

JOANNA LINDBERG: Appreciate your questions. I'm going to go back to Omaha.

HARDIN: OK. Be safe. LB843 proponents.

ERIC SAVAIANO: Hello, Senator.

HARDIN: [INAUDIBLE] find out what people's auctioneering skills are really like today, I think, but. Thanks for being here.

ERIC SAVAIANO: No problem. Thanks, Senator Hardin and members of the Health and Human Services Committee. My name is Eric Savaiano, E-r-i-c S-a-v-a-i-a-n-o. And I am the Economic Justice Program Manager for Food and Nutrition Access at Nebraska Appleseed. I think you know us. I'll just use my time to reiterate some of the stu-- the things that Senator Rountree spoke about and the mechanism by which this would occur. I'll leave it to others behind me to talk more about Omaha's situation and the general refugee population impacts in the state. H.R. 1, or the Federal Reconciliation Bill, or the One Big Beautiful Bill, changed eligibility for SNAP participation nationwide in July. The law removes SNAP eligibility for refugees, asylees, and certain visa holders, which is causing major hardships for these lawfully present, productive, and particularly vulnerable Nebraskans. LB843 would require the Department of Health and Human Services to apply for a federal SNAP waiver to return Nebraska's SNAP immigrant eligibility to pre-H.R. 1 rules. Now, the USDA is empowered to waive statutory requirements to test program changes to increase the efficiency of SNAP and improve the delivery of benefits to households. Essentially, they are empowered to change rules to conduct pilot projects that may make SNAP participants more self-sufficient. Importantly, the USDA has broadly interpreted its SNAP waiver authority, especially recently.

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USDA has allowed states, including Nebraska, to waive statutory language to fit their needs, including allowing states to change their congressionally established definition of food. The bill seeks to utilize that flexibility to improve Nebraska's SNAP program. Implementation of H.R. 1 eligibility changes-- this is an answer to your question, Senator Meyer-- they started-- October 20 in Nebraska they started being implemented. Since then, the applicants are screened for those eligibility changes immediately. Those are new applicants. Existing enrollees are screened on their recertification date, which in Nebraska takes place every six months. So se-- so participants will get screened between now and April-- between October 20 and April 20 for these specific changes. I'll also mention the chart at the bottom of this testimony shows the initial drop in Nebraska's SNAP participation from H.R. 1 changes. And other events, like the government shutdown, also likely contributed. 14,000 Nebraska SNAP participants, or 11% of those on SNAP, have lost or dropped SNAP between January and December 2025. More are expected, obviously, between now and April. These new restrictive SNAP policies leave people more hungry, less healthy, and less able to buy food for their often U.S. citizen children and less able to contribute to their communities. We urge the committee to advance LB843. Thank you very much.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here on a snowy day.

ERIC SAVAIANO: Sure.

RIEPE: My question is, on your chart-- because I'm an Omaha senator. I mean, I-- Iowa's, like, 15 minutes away. What, what a-- comparable-- that's the only one I'd be interested in-- is, what's Iowa done? Have they followed this H.R.-- at-- I mean, is there an incentive for people to move across the river to get better benefits?

ERIC SAVAIANO: At this point, every state in the nation is under the H.R. 1 rules.

RIEPE: So it's not totally determined by-- the state may cut it down; the state will cut it down.

ERIC SAVAIANO: Correct.

RIEPE: OK.

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ERIC SAVAIANO: Yep.

RIEPE: Because that-- OK. Thank you. That's what I wanted. Thank you, Chairman.

ERIC SAVAIANO: Yeah. And related to the chart. I, I haven't seen Nebra-- Iowa's data about their loss of SNAP participants. I think that--

RIEPE: It's probably very similar if it's mandatory.

ERIC SAVAIANO: --expected to be that.

RIEPE: Yeah. OK. Thank you.

HARDIN: Seeing no other questions. Thank you.

ERIC SAVAIANO: Thank you.

HARDIN: Proponents, LB843. Welcome.

KRISTIE PFABE: Thank you. Good afternoon. My name's Kristie Pfabe, K-r-i-s-t-i-e P-f-a-b-he-- P-f-a-b-e. I'm here in support of LB843. I'm first inviting each one of you to the best dinner you've ever had. I've been helping Afghan refugees in Lincoln since the Taliban took over Afghanistan in 2021. A year ago, I started helping a family of ten who arrived summer of 2024. The father has a degree in computer science from Shaikh Zayed University in Khost, Afghanistan. He worked as a journalist and editor at Radio Mili, the government radio and TV station. He was paid by the U.S. military. He edited video taken by journalists after recording the aftermath of such things as bombings. In addition, he accompanied Apache Company 1-501st into the field to help them conduct interviews. After the Taliban took over, his family was in great peril due to his work. His family was finally able to find safety when they came to the U.S. as Priority II refugees, which is a status that's provided to specific groups of special humanitarian concern, including Afghans who worked in media. His family applied for green cards in June of 2025, and we were expecting them to arrive right around now, but the shooting of National Guard's persons in November. Since that happened, all immigration proceedings for Afghans have halted. The actions of one were used to punish a large group of people seeking safety. The consequences for this family are that, in addition to the five-year waiting period mandated by H.R. 1 for SNAP benefits with green cardholders, they have an even longer waiting period. The father says to me, what will my family do? What can we do?

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I have a big family. What can we do? The father has Type I diabetes. And when they went off SNAP, he got a 25-hour-a-week part-time job in addition to his full-time job. His doctor told him he had to stop working more than 40 hours a week or he would die. His oldest son is senior in high school, works about 35 hours a week at a grocery store. They're doing what they can, but it is not enough. They feel betrayed and they are betrayed. When refugees start new lives, they're incredibly vulnerable, and they deserve our support. But they don't need help forever. It's temporary. And it's no secret that refugees and immigrants add more to our economy than they take. I spoke to the family about my test-- testimony, and they want to prepare a wonderful meal for you to experience Afghan hospitality and generosity. And so that there is no conflict of interest, I will wait until the fate of this bill has been determined to email you invitations. And I will pay them to buy the food. The family is now celebrating Ramadan, which is an important Islamic month that fosters empathy for the less fortunate. In the spirit of Ramadan, please advance this bill. I want my taxes to help others. I love this family. Dera manana. Thank you very much. And thank you, Senator Rountree.

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

KRISTIE PFABE: Thank you.

HARDIN: Proponents, LB843.

HANNAH VLACH: Hello.

HARDIN: Welcome.

HANNAH VLACH: Included in the handouts is my speech and the speech of a refugee woman who couldn't make it today because of the weather. So I wanted to hand out her speech. Good afternoon. My name is Hannah Vlach, H-a-n-n-a-h V-l-a-c-h. And I am the founder and executive director of Restoring Dignity. We are a nonprofit in Omaha that serves the over 60,000 legally present refugees in our city. I recently went into the home of a refugee family of seven in Omaha. Mom had just given birth, and she had two toddlers that were adorably waddling around inside. They were brought here by the United States government about a year and a half ago and survived in one of the most difficult refugee camps in the world for almost two decades. The government and their country is committing genocide against the Rohingya people because of their religious beliefs, and so they are here. Because if they weren't here and they were back in their home country, they would

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be killed. So there is no option. They're either here or they go back home and they die. Right now, this family is currently living in the basement of a house of another Rohingya family. And so there are 15 total people living in a four-bedroom home. And the reason that they have had to do this is because they both recently lost SNAP, and their only option is that they had to move in together because they couldn't survive without SNAP. Just so you guys are aware, the U.S. government has stopped the processing of all green cards for refugees, which is preventing families from getting their green cards. So this family has applied for their green cards, but they can't get SNAP because they don't have green cards. But the government won't process their applications, so they can't get SNAP. So it's just this terrible, like, I don't know, hamster wheel that they're on that they can't get off. When I was visiting them, the mom showed me her empty cabinets and her empty fridge, and I can verify that they had no food in this house. I asked the dad, well, are you going to food pantries? And he said they have no car because they haven't been able to save up enough money to buy a car. And in Omaha, you can't really get around really without a car. And then he said when he can get a ride to the pantries, they're closed. He's working full-time graveyard shift at a meatpacking plant, upholding our Nebraska agriculture economy, and he's bringing in about \$2,000 a month for a family of seven. His wife can't work because she just gave birth. She has two toddlers at home. The cost of sending kids to day care is more than she could make it a job. And normally, it takes a few years for refugees to get on their feet, to save enough to get a car and so on. And the thing that broke my heart is that, when I was talking to the family, the toddler was drinking diluted milk in her bottle because they didn't have any milk, and so they had to put water in the milk to stretch it. So DHHS has reported that there's going to be about 7,000 legal refugees in Nebraska losing SNAP as a result of H.R. 1 passing. And these are all families that are here legally. Our government brought them here. And I just want to end by saying that there is no benefit to our state to have children starving. There is no benefit if families become homeless because they have to use their rent money for food. There's no benefit for any of us. And so I am asking you to please support this bill.

HARDIN: Thank you.

HANNAH VLACH: Thank you.

HARDIN: Questions? Seeing none. Thank you.

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HANNAH VLACH: Thank you.

HARDIN: Our staff attorney, John, is finally putting that law degree to work. And he will be our new page. Welcome.

MOHAMMAD SAHIL: Thank you so much, Senator Hardin, and the committee for allowing us to speak. My name is Mohammad Sahil. I'm the current chair of Omaha [INAUDIBLE]. And I'm executive director of Nebraska Afghan Community Center. The reason I'm here today-- I'm sure my colleagues talked about this H.R., H.R. 1 bill, which was the Big Beautiful Bill as well, and effect of that bill as well on families. But I want to talk about that because most of our families, the Afghan families have impacted by this. In Afghanistan, I worked as an interpreter with the U.S. troops for almost 11 years. And we were working with the U.S. troops. The Talibans, who were the bad guys, were calling us that we were the traitor or we were the spies for the U.S. government because we were helping the U.S. mission in Afghanistan. A lot of these Afghans that they're here now, they did the similar job like I did in Afghanistan. When they were brought in 2021 to U.S. bases to be red-- to be resettled in the U.S., the Talibans were calling them that, whoa, the U.S. took their own spies and traitors with them and now they are happy in the U.S. So now that these Afghans are actually labeled as traitors back in their home country. But when they come to the U.S., now they're-- actually try to-- struggle to find food for their kids and for themselves. I think this is a big shame for us because a country and the people that [INAUDIBLE] given their time, their lives, for the people of this country, and now they're struggling to get food at the table for their kids. I think it's a shame for our country that [INAUDIBLE] this because our families now-- we have big families. Like, Afghan families, they are big families. But they're also working really hard to contribute, contribute back to the city and to our community and the state as well. But it's the life that's actually making it harder for them because, right now, we see there is a lot of stuff that's going on with, like for example, immigration hurdles, that-- the U.S. government is actually making the process kind of very difficult for them to get green cards. But i-- in the meantime, they're telling us, like, if you want to apply for these benefits, you have to have these documents. So I think the problem is coming not only from the people, but it's also coming from the government. Like, if they make the documents more easy for people to get, they will be able to be eligible for these benefits as well. So the reason I'm here and I share the story-- it's not because I'm asking for myself, because I've been here in the U.S. for almost 11 years, but I'm asking for these

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families because they deserve to get the benefit they receive because they have given up their lives and they also sacrificed their lives in Afghanistan for the U.S. government and the U.S. mission in Afghanistan as well. So I don't have any other things to add to this because most of my colleagues talked about it. If you guys have any questions for me, I would be happy to answer. And thank you so much again for your time and listening to me.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. Now, do you, do you currently live in Nebraska?

MOHAMMAD SAHIL: Yes.

RIEPE: What-- did you choose Nebraska or did you get assigned to Nebraska?

MOHAMMAD SAHIL: So I was actually-- resettled in New York. And then after one year, some of my friends told me that Nebraska is a nice city, it's a beautiful place. So then I chose to come to Nebraska. And I think I'm happy from Nebraska because I've been treated so well. So I've been here for almost ten years now.

RIEPE: OK. Yeah. Just curious. Thank you. Thank you again.

HARDIN: Thank you. We appreciate it.

MOHAMMAD SAHIL: Thank you so much. Thank you for your time.

HARDIN: Proponents, LB843. Welcome.

PAW BWAY: Hello. My name is Paw Bway, spelled P-a-w B-w-a-y. I stand before you as someone who will be grateful to the United States of America. This country gave me safety when I had none. It's give me freedom when the future was uncertain. I do not take the blessing lightly. I love this country and respect the responsibility that come with it. America is known around the world a, a place of opportunity, faith, family val-- value, and hard work. Refugee like me come here because we believe in those value. We do not look for handouts. We are looking for a chance-- a chance to rebuild, to work, to contribute, and to become self-sufficient. When we come here, we do not come with wealth. We do not come with connection. We come with hope and very little else. We come with zero-- we started from zero-- no saving, no established job, no family support system. Just hope and willingness

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to work hard. I remember those early day. Everything was new. The language, the system, the paperwork. We were learning how to survive in completely different world. And in that season, the most basic question was the most important: how will we put food on the table? As a parent, there's nothing more painful than worrying about whether your child will have enough to eat. Food is not a luxury. It's a survivor. A child cannot focus in school when they are hungry. A parent cannot build a stable future if they are-- constantly have to worry about the next meal. The SNAP is not about dependence. For a family like mine, it's about stability during transition. It is a-- it is a temporary support when we learn English, search for work, and building a foundation. It gives us breathing room so we have-- move-- so we can move forward. If America bring family here for safety and new beginning, it will not be fair to welcome them into freedom but leave them struggle to feed their children. No parent should have to choose between paying a rent and buy a grocery. I want to be clear: refugee want to work. I want to work. We want to contribute, to pay taxes, to give back to the country that give a second chance. SNAP is not the goal. Dependent is. SNAP simply help family get-- SNAP simply help family get there without children going hungry. I stand before you as someone who love this country, respect conservative value, and believe in hard work and personal responsibility. Strong family are the foundation of strong nation. Ensuring that children have food while their parent work toward a self-sufficient strengthen those family. I'm here today not asking for special treatment but fairness and opportunity. Refugee were brought here to survive and to rebuild. Access to food during those transitions are essential. Please vote in favor of allowing refugee to receive SNAP benefit. Give family the stabili-- the stability they need in the first step so they can stand strong, work hard, and fully contribute to the country we are proud to call home. Thank you for all your listening. And thank you for your service.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here. I'm very impressed with your command of the English language.

PAW BWAY: Thank you.

RIEPE: That is a, a real asset and a blessing for you. Were you required to have a sponsor when you came here?

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PAW BWAY: So we-- I came here as a refugee status, so the U.S. government bought us-- brought us here, so we don't need a sponsorship.

RIEPE: Yeah. OK. I just didn't know.

PAW BWAY: Yes. No sponsorship for this [INAUDIBLE].

RIEPE: OK. Well, we're glad, we're glad to have you here.

PAW BWAY: I'm very blessed to be here.

RIEPE: Thank you. Thank you, Chairman.

HARDIN: Thank you. We appreciate it.

PAW BWAY: Thank you.

HARDIN: LB843 proponents. Welcome.

TOBY REES: Hello. My name is Toby Rees, T-o-b-y R-e-e-s. And I'm the executive director of Kountze Commons Community Outreach Center in downtown Omaha. We have a-- we-- has a food pantry, a free clin-- medical clinic and pharmacy. We have behavioral health services. So we have a lot of services to help those in need. Thank you for allowing me to speak this afternoon. Thank you to Senator Rountree for bringing this before each of us today. Did each of you have a nice lunch today? Looks like maybe you did. And I'm glad to hear and see that you did. However, not everyone in this room or in the great state of Nebraska have had that opportunity today. Food insecurity is present throughout Nebraska at alarming rates right now. This is certainly the case for, for those who have patiently waited their turn to come to our great nation and state. The people we are here to talk about today have come to our country legally and contribute to all the things that make Nebraska the place we all chose to live in and call home. The passing of this bill, as you're aware, would allow immigrants and refugees the self-dignity and preservation to afford food for themselves and their families. These are people who have followed all the rules and the expectations we have previously put before them. Cutting off SNAP benefits to those who previously qualified will be no different than changing where the three-point line is during the middle of a basketball game. Kountze Memorial Lutheran Church is one of the many organizations in the state of Nebraska that support refugee families. The family that Kountze Memorial Lutheran church is currently supporting is here on an SIV status. The father was an Afghani

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soldier, just like many you've heard of already. As a mother of two active-duty military members, I'm pretty proud of his service and thankful for that service. Our country was built on the greatness of its people. Unless you are a Native American or your family-- your family or you were an immigrant to this country, we are no different than those we have taken the SNAP benefits from. As someone who oversees a pantry and a free health clinic and pharmacy, I see daily those who are in need. They are not numbers but people who wish they didn't have to need our help, and yet they are incredibly grateful for the help that we give them. Just like you've heard in the cases, they are thankful for SNAP benefits as well. On May 28, 1788, just a few years ago, George Washington wrote a letter to Francis Adrian Vanderkemp, who was a Dutch revolutionary. President Washington in this letter was welcoming and providing asylum to the Dutch refugees. We need to do the same here: continue to welcome and support refugees and immigrants in our state and in our country. George Washington in his letter to the Dutch refugee said, I have always hoped that this land might become a safe and agreeable asylum to the virtuous and persecuted part of mankind to whatever nation they might belong. Let Nebraska be like George Washington, where we help those in need. Please pass LB843.

HARDIN: Thank you. Questions? Seeing none. Thank you. Proponents, LB843. Welcome.

SARAH ALHEAHOM: Hi. Hello. My name is Sarah Alheahom, S-a-r-a-h A-l-h-e-a-h-o-m. I'm here for interpreter for my client, Kathouma Ali. She unfortunately cannot be here because of the storm warning and her kids' cancellation of school, so she have been-- stay with the kids. So she said, hello. My name is Kalthouma Ali, K-a-l-t-h-o-u-m-a A-l-i. I am thankful for the United States government for bringing me here with my kids and my mom. I'm thankful for bringing-- being proud here as, as a legal refugee. And I ask you to support LB843. I came here with my five kids and my old mom. I am a single mom, and I am the only one who is working in the house. And I have to feed seven people. I am working as a full-time job right now, and I make \$2,600 each month. And I spend \$1,800 for rent and bills. And I spent \$150 for laundry, shampoo, soap, menstrual products for my daughter. So I get left with \$600 for all the month to buy food after cutting SNAP. And that cannot be enough for the kids. So when my kids get home from school and they open the fridge, there is no food in the fridge and they start crying. They need food to survive. I thank you for hearing my-- me today, to hearing my story. And I ask you to support bill LB843 to return the

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SNAP back so we can survive, me and my kids and my old mom. Thank you so much.

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

CONNOR HERBERT: Hello. Good afternoon-- or, I guess good evening. And thank you, Chair Hardin, members of the Health and Human Services Committee, for the opportunity to speak today. My name is Connor Herbert, C-o-n-n-o-r H-e-r-b-e-r-t. And I serve as a staffer with the Nebraska Commission on African American Affairs. The Nebraska Commission on African American was established to advise the Legislature and the Governor on propose-- proposals that may or-- positively or negatively affect our constituency and the overall stability of Nebraska communities. In that capacity, we come here today to support LB843 because it serves as a vehicle to protect the various, in our view-- well, for our focus, African diasporic refugee and asylee communities, alongside obviously many other groups that exist within our state. As has been mentioned already, Nebraska is home to a large population of refugee groups. Am-- chief among them, I think-- maybe chief is the wrong word, but a very large portion of them come from places like Sudan and other pla-- other countries within Africa. And many of them have had to flee their homes for a variety of reasons involving war, conflict, and other things. Our state has played a significant role in welcoming these individuals here on refugee and asylee status, going back to the, the '90s. Of course, like, a-- there's a-- most prominent story about a-- what are known as the Lost Boys of Sudan. And of course, the other, the other element to refugee stories is that conflicts happen at different times and in different places and lead to people coming from different parts of the world to our great state. This change made to the pra-- to the president's One Big Beautiful Bill, passed this last summer, threatens nutri-- Supplemental Nutrition Assistance Program access to these already marginalized and income-reduced populations by restricting, quote, alien eligibility in a manner that excludes refugees and asylees. Reflecting back on, like, the, the USDA's questionnaire on who is now eligible for SNAP, there's a very clear statement at the end about refugees. And of course, as be-- as ha-- has a-- as has already been mentioned, green cards following a shooting outside of the White House last December have been restricted to a great degree. As a consequence, by restricting access in this matter, proposed here in the One Big Beautiful Bill, and then also compounded by the reduction of access to legal permanent residency status, you know, given through gre-- green cards, families that have relo-- re--

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relocated to Nebraska and throughout the country are in a situation, you know, where, as has already been testified to, they're struggling to find access to food. And their finances are being strained. And of course, you know, America is a nation that's designed to ru-- not designed, but, you know, prides itself on accepting and welcoming communities from across the world. And we find that even though-- as you've already seen today, waivers may not always lead to the outcomes that you're looking for when given to DHHS or other organizations within our state. This would be one step that we think would be a, a good solution or at least an attempt. And so for that reason, we urge you to consider moving LB843 out of your committee. Thank you.

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

CONNOR HERBERT: Thank you.

HARDIN: Proponents, LB843. Come on down. Welcome.

POE DEE: Thank you. Good afternoon, Chairman and members of the committee. My name is Poe Dee, P-o-e D-e-e. I'm the director of Refugee and Immigrant Services at Catholic Social Services of Southern Nebraska, or CSS. CSS is a nonprofit organization that provides a wide range of services to people in need across southern Nebraska regardless of faith, including refugee resettlement and immigration legal services. Since World War II, CSS has welcomed thousands of refugees and other authorized immi-- immigrant population escaping war, violence, and persecution in their home countries. I'm here, I'm here to express my strong support for the proposed bill, LB843, regarding SNAP eligibility for immigrants. Since recent restriction on SNAP eligibility for lawfully present refugees, asylees, and humanitarian parolees, vulnerable population have faced significant hardship. These individual arrive with trau-- trauma and face substantial barriers to integration. Food insecurity should not be an, an addition obstacle as they strive for self-sufficiency. They have been through enough. And we must ensure they have access to the basic nece-- necessity required to rebuild their lives. For many arrivals, SNAP is essential for establishing reliable access to healthy food, especially for children. For example, in 2024, we welcomed a Sudanese family of eight. Father could not find a job in Lincoln. Now he's working in Omaha. He's making \$3,000 monthly. Barely covers their \$1,795 rent and utility. DHHS has terminated their SNAP benefits on November 25, 2025. They have struggled to afford, afford food. And they did not have a car. Transportation barriers further prevent them from accessing local food pantries. This is critical situation. During

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a recent visit, a mother shared with me that her children rely on school meals because there is not enough food at home. Sadly, there are many immigrants like this-- families in our community who are struggling with us now. They are trying their best, but they still need a little support from us because they can be-- before they can become self-sufficient. CSS and other nonprofits are doing our best to assist these families, but we need the cooperation of our state government to help us-- help them. As a country, we welcome these population through a thorough legal process. We have an obligation to provide basic support reflected off human dignity. These individual-- these individuals are our neighbors, taxpayers who deserve the good life Nebraska offers. On behalf of CSS and Nebraska Catholic Conference, I urge you to support LB843 and help provide the sta-- sta-- stability necessary for our immigrants' families to rebuild their lives. Thank you for your time. And I'm happy to answer any question you may have.

HARDIN: Thank you. Questions? Seeing none. Thank you. Proponents, LB843. Welcome.

ABBY CAWLEY: Good evening. Thank you for staying in the cold weather. I appreciate it. My name's Abby Cawley, A-b-b-y C-a-w-l-e-y. And I'm here to speak in support of LB8-- LB843. I'm an employee of Lincoln Literacy, a local nonprofit that helps immigrants and refugees. But to be clear, today I'm representing myself as an individual just wanting to support immigrants and refugees in our community. My daily work includes not only teaching but providing professional support for immigrants and refugees and asylees in addition to monitoring our student list for SNAP participants in E&T eligibility. This gives me a unique in-- window into how the federal changes to SNAP eligibility pushed through in H.R. 1 negatively impacts real families in my community. In the classroom, I have watched broken hearted as students who are refugees and asylees keep working hard to learn English, take computer class, get their GED, get career navigation assistance. They're doing everything right to try and integrate into Nebraska, but they've still been cut from SNAP benefits due to unnecessary changes in immigration status requirements. They're working just as hard, they're paying taxes, and they're facing the same employment and stability barriers as students who are citizens or permanent residents at Lincoln Literacy. While citizens and permanent residents can continue to receive SNAP benefits, others are being punished and being cut just because they're at an earlier step in their citizenship process. Preventing this access to SNAP for refugees and asylees is a distinction that does nothing more but hurt community members. Outside

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of the classroom, I review our enrollment lists for SNAP eligibility in the efforts to get them into E&T so that they can continue to get support and get on their feet. In doing so, I've become acquainted to the able-a-- or, able-bodied requirements and work requirements. And many of our immigrants who will be removed with LB80-- LB843 do not-- does not pass our non-ABOD student language requirements. We've seen it. It's a le-- significant, legitimate barrier here. On top of not knowing English, many face employment barriers such as access to cars or educational opportunities. We have immigrants and refugees in our communities with advanced medical degrees who would love to return to their fields, who want to give back to Nebraska in this way-- many working in our hospitals. But they did-- don't have the time or support if they get cut from a-- SNAP to get recertified to take those classes, and especially gain those language skills that-- it-- just a requirement. I want to be clear to anyone who feels skeptical, that, like, this is a, a handout for immigrants. It's not. The work requirement remains the same. You need that 20 hours a week working or being in class, and I think that's more likely to happen if it's mandated as part of your retention requirements for staying on SNAP, not as a result from being isolated from social services. LB843, by requiring the state to seek a federal waiver, ensures that Nebraskans aren't punished for how they arrived in the country and how long they've been there through legal means already. By returning to-- wi-- the pre-Big Beautiful Bill eligibility rules, we aren't providing charity. We are providing support that allows ELL students to stay in class and eventually reenter Nebraska's workforce as self-sufficient professionals. When a family loses SNAP eligibility, it's not just food support. They lose a part of their stability, and their stability is-- I think the goal of this Legislature is to increase the stability and vibrancy of Nebraskans' lives. And they're a part of that. They live here. They want to be a part of our community. So I urge you to please advance LB843 onto the floor. And thank you for your time.

HARDIN: Thank you.

ABBY CAWLEY: Yeah.

HARDIN: Questions?

ABBY CAWLEY: Any questions?

HARDIN: Seeing none. Thank you.

ABBY CAWLEY: Thank you.

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HARDIN: Proponents, LB843. Welcome.

ABDULRAZZAK ALKOUTAINI: Good afternoon, Chairman and members of the committee. My name is Abdulrazak Alkoutaini. Abdulrazak is A-b-d-u-l-r-a-z-z-a-k; Alkoutaini is A-l-k-o-u-t-a-i-n-i. I'm a Syrian refugee. I have proudly called Lincoln, Nebraska my home since September 2021. I stand here today representing the Syrian community in our city, a group of resilient individuals who have been welcomed by this state and are eager to give back. I'm a living proof that this program is an investment, not a cost. When I arrived in September 2021, the food assistance I received was the foundation of my success. It allowed me to focus on learning English, finding a stable job without the constant fear of hunger. Without that-- without the early support, I wouldn't have reached the self-sufficiency I have today. Our goal as refugees is not to, to be a liability or burden on the state. On the contrary, we want to be part of the support system. We want to be a taxpayers, workers, business owners who will strengthen Nebraska's economy. But to become an asset, one must first have their basic needs met during transition. The humane cost of removing this bridge is best seen in the story of one of the families of, of our community. This family is a widow and her three young children. She lost her husband in the war in Syria. The three children still carry the heavy, heavy weight of trauma from the war-- the trauma that manifests as severe behavioral and mental challenges. Because of their needs, this mother is in impossible position. She can't leave, leave them to work and she can't afford child care. If this assistance is cut, we're essentially abandoning her. We can't expect her to, to heal herself, heal her children, and build a life if she can't even have food for the kids. I'm asking this committee to see us as your future neighbor and fellow contributors. I'm asking you to, to maintain, maintain this vital lifeline so others can follow the path from arrival to self-sufficiency. Thank you.

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

ABDULRAZZAK ALKOUTAINI: Thank you.

HARDIN: Proponents, LB843. Welcome.

TOM VENZOR: Good afternoon, Chairman Hardin and members of the HHS Committee. My name's Tom Venzor, T-o-m V-e-n-z-o-r. I'm the executive director of the Nebraska Catholic Conference. Here in support of LB843. And I want to thank Senator Rountree for bringing this forward. I'll try not to be, you know, too repetitive of what's been said

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already, but kind of lay out some of the few, I think, kind of moral, basic principles that we think are at play in this. As I've testified in the past on many occasions in this committee when it comes to SNAP bills, that the Catholic Church is doing all sorts of work both, you know, individual Catholics, but also just local parishes. But as well at our social service agencies-- whether that's places like Catholic Social Services-- that you just heard from-- or Catholic Charities providing food assistance work throughout the state. And we're doing everything we possibly can both as private actors and coming together as a community. But the fundamental fact is that there's still a need beyond that. OK? And when there's a need beyond that, that means that, as we grow larger out into the community, that means we have larger circles of the community that have a role in meeting that food assistance need. And we believe that, on this issue, this is a place where the state has a role an addition in-- to what's already being done more at the individual and more at that communal, the local level, the broader community level, the broader sort of philanthropic level. So I think this is a place that's really important that the state step up and ensure that we're meeting the needs of those who have food assistance needs. Because we certainly are doing everything we can do, but there's still a need out there. As well, I think-- and that's sort of an expression of our solidarity, right, with one another. And-- so in particular, I think, as you've heard already-- just sort of also our fundamental obligation too to welcome the stranger that we have is just-- you know, good people, good, moral, upstanding people, as well as Christian people to welcome those strangers who come among us and meet their needs. As you've already heard from the testifiers before, you've got people fleeing all sorts of very difficult situations, whether it's human trafficking, whether it's religious persecution, you name it. So these are people who have gone through the processes to be here, to be-- you know, whether they're refugees or have some other status. They-- they've gone through processes to be here. And so I think we have an obligation to ensure that we can meet their needs so that they can get what they want. In, in, in addition too-- just rem-- remembering just the fundamental fact that access to food is just a really basic need and it's a basic right that people have. This isn't merely sort of a political question. It's, it's also sort of fundamentally a moral question about how we're gonna take care of those who have a fundamental, basic need. So again, we're going to continue to do our part as a Catholic church to do everything we can, but we're asking here in this situation that we also have the state play a role in ensuring that those migrant communities can also just continue to have

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access to SNAP benefits. So I thank you very much for your testimony. And happy to take any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: I have a question. And thank you for being here. My question is this, the, the Catholic Church and the Metho-- or, Lutherans' churches-- I don't know which denomination, branch in the-- have been very in front of this issue and taken on a big challenge. Was the number of refugees overwhelming? I mean in terms of-- and that's-- I'm-- I assume it was with planning that SNAP would be there for, for the refugees. Was, was that a-- it-- did we get overwhelmed by refugees or--

TOM VENZOR: You know-- so from the refugee resettlement work, I'm-- I'd have to ask behind me the folks that-- Catholic Social Services whether they were overwhelmed. I-- and maybe they're nodding their head one way or the other, but I don't generally think that's the case. You know, they were staffed to be able to help provide those services. And as you heard from a, a testifier much earlier on, there was some level of support that was also given by the federal government for a period of time. But af-- I think it's 60 or 90 days-- I, I forget exactly. But after that ends-- and of course, you know, it, it comes back to what can the community do for this person or what other benefits might they be able to access, again, to help provide them that temporary assistance so they can get on their feet basically in a new country and a whole new community. And then hopefully once they're on their feet, you know, self-sustained, self-sufficient, you know, that, that would help. But, but yeah, I mean, those social service agencies, you know, recognize that they have a need. They're helping them-- you know, Catholic Social Services or Catholic Charities, they're gonna be helping people with food assistance, maybe housing assistance. Maybe there might be mental health needs, et cetera. So there's any number of things they're trying to do to help provide those services. But again, they can't meet the full needs, and that's where programs like SNAP can come in and provide some backfill to ensure that many other needs that are there can be met through social assistance.

RIEPE: Did you say that the federal government provided for 60 days?

TOM VENZOR: Yeah. I forget if it's--

RIEPE: That's pretty short.

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TOM VENZOR: Yeah. It's a short period of time to help provide kind of those services at the beginning when, like, a new refugee comes.

RIEPE: OK. Thank you.

TOM VENZOR: You're welcome.

RIEPE: I appreciate the--

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chairman. Thank you for, for being here and for your, for your testimony. This could be a question-- I think, I think you're an attorney-- but this might be a good question for a-- for another testifier, but, I mean-- so with-- so H.R. 1 obviously chan-- kind of changing this from what we historically did as a country, are, are states allowed to go in a different direction than H.R. 1? I, I just don't even know what's the legality there. Do you-- I-- if-- and, and I can ask another testifier if that's better, but.

TOM VENZOR: Yeah. Sure. Eric at Appleseed might have even a better answer than me, but obviously, you know, through this bill, what we're trying to do with LB843 is to, to provide a waiver to say, hey, here's-- are the general rules of how SNAP runs at the federal government. But within these programs--

FREDRICKSON: So like any other waiver--

TOM VENZOR: --with any-- yeah. With-- yeah. With any o-- with any other number of programs, you know, there's an opportunity for the state to come in and say, hey, we want to access a waiver on this so we can provide for a particular need that we see in our community, that one being here, you know, refugees and, and other immigrants that we can assist. So essentially it's engaging in the waiver process--

FREDRICKSON: Understood. Yes. Thank you.

TOM VENZOR: --for the SNAP program. Yep.

HARDIN: Mr. Venzor is an attorney, but do not hold that against him.

TOM VENZOR: Please don't.

QUICK: Thank you, Chairman. So I-- you know, I, I know we-- the-- there's all, all the refugee issues and, and, and immigration status,

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but there's also-- like, you provide services for people who, who are here now. And we've seen food banks. And this is not just from the refugees, but even people from Nebraska who are-- who live in poverty who's-- also struggle with, with food assistance and those. So I know the food banks have been-- especially probably since COVID-- have been, have been struggling to meet the needs of just even regular citizens. And now we have what-- now we're losing the-- some of the food assistance for the refugees and immigrant status. And so that's just compounding it. Don't-- I mean, that's how I feel. I don't--

TOM VENZOR: Yeah. That's our-- yeah, that's been our observation as well too, that you've seen increasing numbers for food assistance need. Again, doing everything we can to meet those needs, but, again, the private community can't meet those needs. Just like with any other number of things I think within the state-- you know, we're asking our private community-- individuals, the private community, the nonprofit community, the, the-- even the business community, whoever can come in to step in to help with these problems can and should. But at some point, you know, when, when those people can't take care of the need, that's a place where government can come in and say, hey, let's additionally-- let's help supplement with what can't be totally taken care of by other individuals. So yeah, our experience is that there's been an increased need. We're doing everything to meet it, but there's still nee-- help that's needed.

QUICK: Yeah. Thank you for your-- thank you for your work.

HARDIN: Senator Meyer.

TOM VENZOR: Yep. Thank you.

G. MEYER: Thank you, Chair Hardin. You may not be able to answer this-- and, and maybe I should reserve this for Senator Rountree, but, Mr. Venzor, are there any other states considering waivers? Are you aware?

TOM VENZOR: You know, I, I haven't been able to look. That might be a better-- senator-- question for Senator Rountree. I-- I'm not a-- I haven't looked to see what other states are entertaining a similar waiver to this.

G. MEYER: And then the quality control-- control payment error rate, you don't have any idea where we're at with that with regard-- because looking at the fiscal, if we're under 6%, you know, Health and Human

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Services can absorb the, the administrative costs. If we're under 6%, then it's 100% federally funded. If-- and it's graduated if we are outside of the 6%. So we-- so the state has to pick up part of the burden. Right now, if we're under 6% and HHS absorbs all administrative-- what's required of the state, it doesn't appear that if we would be granted the waiver we would have necessarily any financial exposure, if I read the fiscal right. So I was just curious whether any other states are looking into getting a waiver and-- you know, we're, we're obviously fiscally con-- very conscious right now, and yet we certainly need to be taking care of the citizens of the state of Nebraska, so. Just, just curious. And maybe that-- I, I-- maybe I-- we fed that to Senator Rountree and he's furiously looking that up on his iPad or whatever, but, but it was just a curiosity.

TOM VENZOR: Yeah. So I don't have a, you know, full history of what the error rate has been over time or over the years. Again, I think, you know, part of what this bill is doing is sort of retaining or renewing the eligibility of people who've been on it. Obviously, you know, we have to be cognizant of the, of the error rate to ensure that we're under that 6%. I think that's something that historically has not been a problem here. And of course, you know, that's always just a constant mandate of, of HHS to do no matter what, whether you adopt this or you don't adopt this.

G. MEYER: Sure.

TOM VENZOR: So, so I think that's always something that we have to be conscious of and be stewards of at all times. But, you know, happy to-- if we can't get that question answered right now about the error rate, happy to follow up with more information about that so we kind of know specifically where it's been and how close we are. But yeah, I did see that in the fiscal note, sort of the tiers of what that would look like. Mm-hmm.

G. MEYER: I think we gave Senator Rountree enough of a heads-up, so he's not--

TOM VENZOR: I think so. Yeah.

G. MEYER: Thank, thank you, Senator.

HARDIN: Other questions? Seeing none. Thank you.

TOM VENZOR: All right. Thank you for your time.

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HARDIN: Proponents, LB843. Opponents, LB843. Those in the neutral, LB843. Oh, Senator Rountree, are you around?

ROUNTREE: I am around without the D-- R-o-u-n-t.

HARDIN: And online, we had 306 proponents, 62 opponents, 2 in the neutral.

ROUNTREE: All right. Thank you so much, Chair Hardin and members of our HHS Committee. Thank you for taking the opportunity to listen today, to listen with open heart. And I especially want to thank all of our testifiers who have come and testified today. Some of the closing's already been done. It's been great testimony or input today. And I would just say, in 2001, September 23 of 2001, I re-- I responded with our nation's call after the 9/11 attacks. September the 23rd, a Sunday night, we arrived in theater. I won't name where it was, but we arrived and went right to work to prosecute this war against an enemy that had attacked our nation. October the 7th, we were in place and we launched an air campaign. You can look that up and see. We were ready to do what our nation had asked of us. November, December, we made great strides that the Taliban fell. And we thought it was going to be a little bit quick that we'd get Bin Laden, but you see how long that took. So throughout the course of those years, this 20-year war that we prosecuted, executed, we had many people that came to our side and worked with us. That was in 2001. Back in 2007, I went back out again and spent time in some of the areas that these members are affected by, sent our people out to other places to do things that our nation asked us to do. And our companions marched beside us. So with refugees coming into our country, as the testifiers' testimo-- testified that some were de-- deemed to be traitors, spies, and everything else, in danger, but yet they put their necks on the line and their lives on the line to walk beside us so that we could get our war needs accomplished in that. So as they have come here to our nation, our country-- it's one of the things I was writing down and just looking at. So many different words and so many different thoughts expressed today. I wrote down food insecurity. That's what we're dealing with not only with our refugees and immigrant community but with our citizens as well. Food insecurity. It was asked, why-- can't we just use our food banks? The food banks have been stretched thin. Stretched so thin. And we're doing the best we can. Even to the point that in this great fiscal environment I'm in now I even asked our Appropriations Committee for \$100,000 for the expansion in our Bellevue food pantry that would serve a greater need and a greater portion of the area. We talked

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about stability, self-dignity, love, opportunity, wanting to become a real asset to our nation. Our support activities talked about really how much they reach out and the services provided so that our members can participate in the good life. In 1975, our Vietnam War ended. From 1975 to 1999, we had over 590,000 Vietnamese refugees that settled-- not in Nebraska, but here in our United States. So we've always received refugees into our nation. And they've become viable citizens that, as our testimony said today, don't want a handout-- just an opportunity to be able to transition and help us get up and so we can be taxpayers, leaders in our communities, and helping others as they come. And so I would like for us to be able to advance this bill out of the committee. And I think Senator Meyer asked a question, how many states have already put in this waiver? Well, this is relatively new. So checking with Mr. Savaiano, we haven't had any that we can put on record. But it doesn't take away that opportunity to be able to be the first. One of the things that I've noticed that Nebraska has done: wanting to be first in many things-- first to deal with sugars and candies, dealing with the Agriculture Committee. So we've stepped out first on a number of things. So let us be the first one to seek this waiver so we can protect then our communities. And they won't be on this forever. As with my LB319 SNAP bill last year, I said SNAP is just-- it's a transition. But as a lot of our testifiers that testified today and our organizations that provide that support, they're not just supporting the refugees. They're supporting native-born Nebraskans. They're supporting anyone who has a need. Resources are stretched thin, but we want to be able to get the assistance that we need so we can elevate the life of our refugees, our communities, and ensure everybody can participate in the good life. So with that, I'll yield to any other questions.

HARDIN: Questions? Senator Hansen.

HANSEN: Thank you. And I'm sorry if I missed this earlier on your opening or if somebody a-- asked this earlier. This is-- is this primarily-- we're talking about legal immigrants that are here, on visa, or refugees on le-- like, a legal status?

ROUNTREE: Yeah. H.R. 1 eliminated all categories of refugees, asylees, and UNT visa hols-- holders, which are victims of trafficking and domestic violence.

HANSEN: OK. Only because I know I'm going to get this question asked later, we, we-- is there the potential that people who are here illegally, illegally would be able to get these benefits?

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ROUNTREE: People that are here--

HANSEN: Illegally.

ROUNTREE: --illegally. That's another process. We're just looking at this particular--

HANSEN: Yeah. They, they, they would not have access to these benefits.

ROUNTREE: They would not.

HANSEN: OK. Just clearing that up because I'll get a text or something later about this, so.

ROUNTREE: You will. I've gotten a lot from my own community.

HANSEN: Yep. And, and I'm gonna-- I'm just gonna tell you a concern of mine-- doesn't mean we pass this bill or not-- is, I don't trust the federal government. And I don't trust what they say. And so I don't-- they both know they need to cut some form of Medicaid and Medicare or Social Security in order to make our country solvent, eventually. I don't think they will ever do that. So wha-- and this is something I've mentioned on the floor multiple times whenever a bill like this comes up. And so what they're going to end up doing-- which we've kind of already seen-- is that they're just going to say, well, what-- we used to pay 100% of this, and now we're going to start paying 90% and just push the onus onto the states. So that's the concern that I have with a bill like this when we say, well, they're paying 100% now. And then next year, they say they're going to pay 90%. And so-- and we are-- we're ill-afford to have that happen here. And so-- just-- is that a concern of yours? Or do you have any issues with the federal government continuing to pay this 100%? I know this is new, and so it's-- I mean, we have-- haven't had a lot of historical context with this, but.

ROUNTREE: And we don't have a lot of historical-- I-- each person has to feel about the federal government the way they feel about it. And you can look at historical data. Some of the testifiers and others and other side of our-- in the Judiciary Committee, some of the bills I heard over there, people had concerns about what the government may do or they may not do. Yesterday, we testified about having a joint hearing with HHS and with our Urban Affairs Committee so we can get that out and get it started and make adjustments as we go. So I, I

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cannot prognosticate. I don't know what's down range, but I work with what I have now. And it-- that could be exactly as you're saying.

HANSEN: Yeah. Well, I appreciate it. Thank you for answering the question. Thank you.

ROUNTREE: Thank you. Mm-hmm.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Senator Rountree.

ROUNTREE: Yes, sir.

G. MEYER: My understanding in hearing the testimony is we've got immigrants that have aided the United States. They are trying to establish lives here. They are trying to advance themselves socioeconomically, and so the anticipation is that they will not be on these benefits forever. They are trying to advance themselves, get stable, stand on their own two feet. And so the anticipation of, of this being a forever plan for, for these folks i-- is, is not their plan, and so they're trying to advance themselves. So I, I applaud them for that. I was just--

ROUNTREE: Yes, sir.

G. MEYER: You know, Senator Hansen-- and, and, and I, and I think where he was going-- I'm not-- I don't speak for Senator Hansen, and I'm-- I think he's glad of that. You know, we have an assumption sometimes that once we have a program, we're going to be hooked into it forever. But what I take from the testimony today is, is the folks here are trying to advance themselves, get better jobs, advance their families, and get off of any SNAP benefits, any other, any other government programs. They want to stand on their own two feet and, and, and, and move forward. So that-- that's what I take from the testimony today, so.

ROUNTREE: Thank you so much, Senator Meyer. And I, I appreciate your heart. That's what I took for it. And any time I testify or bring a bill that deals with any of our services, whether it be SNAP, Medicaid-- many times, people don't want-- they want a transition. And we heard one testifier that came and testified earlier today thankful for the SNAP that was able to help him get through and, you know, move beyond that. So it became a foundational-type thing for him. So most of the time when I testified to anyone that are on the benefits, I

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don't think anyone wants to stay on it forever. And if they can transition-- a hand up, not a handout. Thank you.

HARDIN: Other questions? If not, this will conclude LB843.

ROUNTREE: Thank you so much, sir. And again, I thank all the testifiers. And have a safe journey home.

FREDRICKSON: All right, folks. We're going to move on to the next bill, so if folks can transition. OK. I think we're ready for the grand finale today. Senator Hardin, you're welcome to open on LB1217.

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 Scotts Bluff Counties of the 48th Legislative District in western Nebraska. This is likely one of the simplest bills this committee will consider this year. Aren't you glad? LB1217 would allow schools-- allow schools-- to store epinephrine in any form approved by the FDA for use as an emergency stock medication. Currently, students may carry any prescribed form of epinephrine on their person, but schools must follow Rule 59 of the Nebraska Department of Education. Rule 59 permits emergency stock only in the form of an epinephrine auto-injector-- needles-- and does not account for other FDA-approved delivery methods like the new ones. You might reasonably ask, if this limitation comes from the rules and regs of the Department of Education, why can't they simply fix it? In my experience, the only process that moves slower than the Legislature is changing rules and regs within an agency. So that's what makes this bill necessary. That limitation makes sense historically because, until 2024, the only FDA-approved epinephrine option for emergency anaphylaxis treatment was injectable. With the a-- recent FDA approval of nasal epinephrine spray, our regulations have not yet caught up with the medical practice. LB1217 simply updates the law to reflect that reality. It gives schools flexibility to stock FDA-approved epinephrine products, including nasal spray, which has been shown to be an effective alternative and offers a slightly longer shelf life than injectable forms. It's a great value. Following me today will be medical professionals who can address detailed clinical questions regarding epinephrine delivery methods. I'm happy to answer any general questions the committee may have at this time. Let me also just say I, I sicced my staff on this to do a little pharmacy shopping today. And guess what? I'll just say that, believe it or not, you can actually get the nasal spray cheaper than you can get the injectables.

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And 12 to 18 months is the shelf life of the auto-injector. The nasal spray's 24 months. So I just thought I would share that information.

FREDRICKSON: Thank you, Senator Hardin. Are there questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. I'd ask you to respond to this because, last year, we passed legislation-- I believe it was signed by the Governor-- requiring insurance companies to pay for EpiPens.

HARDIN: EpiPens.

RIEPE: Not nasal, just EpiPens.

HARDIN: Didn't know what we were doing, clearly. Yes. I was right here.

RIEPE: Well, yeah--

HARDIN: I didn't know that option exist--

RIEPE: You were on the committee--

HARDIN: I was on the committee. Yeah. I didn't know this option was available. But being as cheap as we all are, had we known there was an option that lasted longer and would cost less money still approved--

RIEPE: But it shows when we get so specific in our written statutes--

HARDIN: Yeah.

RIEPE: --then we, we lose the flexibility. So then we, what, come back next year and, and take it-- you know, it's, it's not good governance.

HARDIN: We don't do great things around here all the time. Sometimes.

RIEPE: We don't have time to stay here and list all of them.

HARDIN: Dang it. I agree. Yes.

RIEPE: My question originally was, is, if it's allowed-- if it's allowed, why are we putting it into law? Just let them do it.

HARDIN: Well, I guess that's the challenge, right, is-- it's already been a couple years and the world of the agency still hasn't changed it.

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RIEPE: Well-- and I think everyone knows I'm not a fan of the State Board of Education. They're ineffective. They're not-- you know, I, I could go on for an hour. But I'll spare you. But where are they on this and a number of other issues? Absolute-- they're out eating donuts and cutting ribbons. And you can put that on the record.

FREDRICKSON: Thank you, Senator Riepe. Further questions from the committee?

RIEPE: Oh, yes. Thank you, Chairman.

FREDRICKSON: Oh, yes. You're-- all right. All right. Are you sticking around to close?

HARDIN: There are much smarter people behind me to answer questions, so.

FREDRICKSON: Thank you, Senator Hardin. We will take our first proponent for LB1217. Welcome.

HOLLY DINGMAN: Thank you. Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Holly Dingman, H-o-l-l-y D-i-n-g-m-a-n. And I'm the director of Community Health and Advocacy at Children's Nebraska. And I'm testifying in support of LB1217. Children's Nebraska's the only full service pediatrics specialty health center in the state serving children from their-- nearly every county. We provide a comprehensive continuum of care for children through our 279-bed hospital and behavioral health and wellness center in Omaha, as well as pediatric specialty and primary care clinics throughout Nebra-- throughout Nebraska and neighboring states. Children's Nebraska has a strong commitment to community health and advocacy, focused on positively impacting children where they live, learn, and play. One of the community health initiatives in our partnershi-- is our partnership with the Nebraska Department of Education for School Health Services. Through this partnership, Children's Nebraska supports school health staff and-- with best practices, mentorship, and resources. Children's Nebraska has partnered with NDE for several years to oversee education and resources developed for Rule 59, the regulations around management of severe asthma and life-threatening anaphylaxis. When revisions to the regulations are required, Children's school health liaison and our pulmonology team have been involved with reviewing materials, providing guidance to school nurses and ensuring best practices are met. Children's Nebraska sor-- supports LB1217, which will-- would

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allow schools to have epinephrine in any form approved by the federal Food and Drug Administration for the purposes of emergency aid to students. This is particularly helpful for schools, as the nasal form provides needle-free administration, rapid absorption, and has a longer shelf life than the injectable epinephrine. The nasal form also allows students to self-administer the medication more easily in an emergency. A life-threatening allergic reaction, called anaphylaxis, can be caused by food, medication, insect bites, latex. With food allergies posing the greatest risk in a school environment, it is estimated that 1 in 3-- or, 1 in 13, 8% of children in the United States, are affected by food allergies, with 40% needing to be treated in an emergency department for an allergic reaction. 1 in 5 students with food allergies have a reaction while at school, and 25% of severe allergic reactions occur in a school without prior diagnosis. So ensuring school health offices have access to all forms of epinephrine allows for our school emergency response teams to have-- to be better prepared to quickly respond to a student experiencing anaphylaxis. Thank you, Senator Hardin, for introducing this bill and the Health and Human Ser-- Services Committee for your consideration.

FREDRICKSON: Thank you for your testimony. Any questions? Senator Riepe.

RIEPE: I'll be-- I'll have one question. Where's parental responsibility?

HOLLY DINGMAN: Parental responsibility ensures that the student is--

RIEPE: If I had a child with a, a, a peanut allergy, I would duct tape an EpiPen on their left arm. I, I-- you know.

HOLLY DINGMAN: And students are--

RIEPE: We seem to want to take over all responsibility. It's a-- yeah, the-- maybe that's a statement. Maybe it was a, a question, because I don't know that you have an answer on it in terms of that [INAUDIBLE].

HOLLY DINGMAN: We want to reduce the risk for students, and so self-caring is important, and also being prepared. There are 25% of those requiring the Rule 59 response that didn't even have a diagnosis. So there are kids in schools that don't know they have or could potentially react to a food.

RIEPE: OK. Thank you.

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HOLLY DINGMAN: Mm-hmm.

RIEPE: Thank you. No more.

FREDRICKSON: Thank you, Senator Riepe. Senator, Senator Hansen.

HANSEN: Sorry. The weather gets to us here when it snows.

HOLLY DINGMAN: Right.

HANSEN: We all get excited. [INAUDIBLE]. Will this require any-- if, like-- if we pass this and you start carrying EpiPens or nasal sprays, will that require any informed consent with parents in ca-- like, new informed consent rules at all by, by schools? Do you know-- would-- would you expect-- and maybe somebody with the schools can answer behind you-- so in case they don't know their kid has one and you have to administer this?

HOLLY DINGMAN: No, this just requires the schools to have a additional form in their emergency stock.

RIEPE: Requires? It says allows.

HANSEN: Yeah. Yeah. You mean--

HOLLY DINGMAN: Yeah, allows.

HANSEN: Yeah. Yeah.

HOLLY DINGMAN: Mm-hmm.

HANSEN: OK. I, I, I just didn't know for sure, like, if-- like--

HOLLY DINGMAN: Not that I'm aware of.

HANSEN: --emergency situation you find your kid all of a sudden aller-- they didn't know they were allergic to something-- like, like you mentioned in your opening-- and then they have to administer this medication to a child. I think in an emergency situ-- situation, there's not, like-- informed consent sometimes kind of goes off to the side a little bit, so. But you would-- the school wouldn't be responsible for any kind of informed consent laws or rules in order to administer this, I wouldn't think, right?

HOLLY DINGMAN: I would have to double-check, but I don't think so.

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HANSEN: It's not a big deal. Somebody behind you maybe could answer.
I-- or--

HOLLY DINGMAN: Yeah.

HANSEN: Senator Hardin could, so. Thanks.

HOLLY DINGMAN: Mm-hmm.

FREDRICKSON: All right. Thank you, Senator Hansen. Other questions?
Seeing none. Thank you for being here.

HOLLY DINGMAN: Perfect. Thank you.

FREDRICKSON: Next proponent for LB1217. Welcome.

LINA BOSTWICK: Thank you. Hello, Vice Chair Fredrickson and committee. Thanks for your time here. My name is Lina Bostwick, L-i-n-a B-o-s-t-w-i-c-k. And I'm here representing the Nebraska Nurses Association. We are 30,000 strong and lurk-- looking for more recruits, but NNA strongly urges the committee to support this LB1217, which authorizes and encourages schools to maintain-- so it's encouraging schools to maintain-- a supply of epinephrine for emergency first aid. Anaphylaxis is a rapidly progressing emergency. I was a, a critical care practitioner for, gosh, 17 years. I've been around for a long time. And witnessing anyone struggling for air as their airway narrows is a harrowing experience. I've been there. I've been in the ICU where I have a environment conducive to helping those individuals and-- you know, for a different situation. Those that have respiratory distress or cannot breathe, we have respiratory therapists. We have anesthesia to immediately secure an airway for those individuals that can't breathe. Well, this is really no different. And actually, with an anaphylaxis reaction, it occurs very quickly. And-- so it is important. I can't imagine-- honestly myself-- personally cannot imagine the experience for the person that's down, the kid that's down, with no one being able to intervene while they are suffocating. And I have personally witnessed that in people's eyes when they cannot breathe. And this to me is something that would be good, good Samaritan-- I'm not completely sure-- but, you know, in good faith of trying to take care of a situation. I don't know if you can remember your first bee sting. That is something that kids are-- react to too. A bee sting taking a kid down; they're having an anaphylactic reaction. So-- and groups like the Asthma and Allergy Foundation of America emphasize that 25% of the anaphylaxis cases is

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something that happens that we don't know what's precipitating it because the kid hasn't been diagnosed yet. They don't have that EpiPen. So we do encourage you to pass or move forward LB1217. Thank you for your thoughtful consideration of this vital protection for our children.

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

QUICK: Yeah. Thank you, Vice Chairman. So-- like, on the nasal-- so if someone's not breathing-- I mean-- so the nasal-- they don't have to breathe it in. It just-- if it, if it goes up, then it's absorbed through the nasal passage somehow.

LINA BOSTWICK: Right. And it's absorbed by the blood system.

QUICK: OK.

LINA BOSTWICK: Mm-hmm. Yeah.

QUICK: So it's not like they have to breathe it back into their--

LINA BOSTWICK: No. Uh-uh.

QUICK: OK.

LINA BOSTWICK: You know, and the other thing too is that even if it would be-- even if it is an injection, the box-- there's two steps. You can read it like-- it's simpler than A-- AI-- help me.

HANSEN: AID.

LINA BOSTWICK: AID. Thank you. Yeah. It's, it's much more-- fewer steps than that.

QUICK: OK.

LINA BOSTWICK: Mm-hmm.

QUICK: All right. All right. Thank you.

LINA BOSTWICK: Yeah.

FREDRICKSON: Other questions? Senator Ballard, is that-- no. Oh. All right. Thank you for being here. Appreciate you.

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LINA BOSTWICK: You're welcome.

FREDRICKSON: Yep. Other proponents for LB1217? Seeing none. Are there any opponents for LB1217? Seeing none. Neutral capacity, LB1217. Seeing none. We had some online comments. We had 16 proponents, 0 opponents, and 0 in the neutral capacity. Senator Hardin, you are welcome to close.

HARDIN: Technology changes. Sorry, Senator Riepe. And so-- and it will probably change again. And so it didn't have my permission last time when it changed, and it probably won't seek my permission the next time it changes. So. Any questions?

FREDRICKSON: Questions of committee? Seeing none. Thank you, Senator Hardin.

HARDIN: Drive safely, everyone.

FREDRICKSON: That will close our hearing for LB1217 and the hearings for the day for the HHS Committee.