**ARCH:** [RECORDER MALFUNCTION] the 14th Legislative District in Sarpy County and I serve as Chair of the HHS committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Day.

**DAY:** Jen Day. I represent Legislative District 49, which is northwestern Sarpy County.

**MURMAN:** Hello, I'm Senator Dave Murman from District 38, and I represent seven counties to the south, west, and east of Kearney and Hastings.

**WALZ:** Hi, my name is Lynne Walz and I represent Legislative District 15, which is all of Dodge County.

**M. CAVANAUGH:** Machaela Cavanaugh, District 6, west-central Omaha, Douglas County.

**B. HANSEN:** Ben Hansen, District 16, Washington, Burt, and Cuming Counties.

**ARCH:** Also assisting the committee is one of our legal counsels, Paul Henderson; our committee clerk, Geri Williams; and our committee pages, Sophie and Jordon. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning, we will be hearing three bills, I believe, three bills, and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill and then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask

you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, please see the new public hearing protocols on the HHS Committee's Web page on NebraskaLegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and Transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. This committee has a strict no props policy. With that, we will begin today's hearing with LB485 and welcome, Senator DeBoer. Welcome.

**DeBOER:** Thank you. Good morning, Chairperson Arch and members of the HHS Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and I represent Legislative District 10, which includes Bennington and parts of northwest Omaha. Today, I'm introducing LB485, which would expand eligibility for the childcare subsidy program. But LB485 is not just a bill about childcare. It's a bill about workforce development. Investing in childcare is an investment in our workforce. When workers don't have access to quality, affordable childcare, they are often forced to take time off the job, scale back to part-time work, or drop out of the workforce altogether. If this last year has taught us anything, it's that childcare is a vital part of our economy. LB485 supports our workforce in two ways. First, it increases the eligibility level at which a family may qualify for childcare assistance from 130 percent of federal poverty level to 185 percent of federal poverty level. For a family of two, like a single parent and their child, 130 percent of federal poverty level is a yearly income of $22,412, or $18,068 per month. This change would extend initial eligibility for the program to a family of two, making $31,894 a year.

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

The current initial eligibility levels prevent many low-income families from accessing-- accessing much needed assistance that enables them to stay engaged in the workforce. LB485 returns initial eligibility for the childcare subsidy program to 185 percent of federal pov-- federal poverty level, the level at which our state provided childcare assistance to workers in the early 2000s. As a result of budget cuts, the state significantly reduced eligibility and still has not regained the ground from those cuts. All of our surrounding states have higher initial and eligi-- higher initial eligibility levels for assistance. Both Kansas and Colorado's initial eligibility is 185 FPL, as this proposes. And South Dakota and Wisconsin's initial eligibility levels are even higher. By increasing eligibility for this program, we can support families who are working their way toward greater financial security while also supporting employers by ensuring a more dependable workforce. The second change LB485 makes to the childcare subsidy program is to expand the income limit for transitional childcare support. Currently, if a worker meets the initial eligibility threshold for the program, they can increase their earnings slightly before they are no longer eligible for assistance. LB485 increases that top income threshold or the income at which a family would lose assistance from 185 of federal poverty level to 200 percent FPL or three-- or $34,480 per year for a family of two. This change will support workers as they advance in their career and lessen the cliff effect in the childcare assistance program. The cliff effect occurs when families lose assistance before they're able to bear the full cost of childcare on their own. This transitional assistance will allow workers the flexibility to accept promotions or transition into careers that provide more opportunity for growth without fear of losing their benefits instead of turning down raises or working fewer hours to keep their income below the threshold. By raising the income level at which families transition off the program, families will be better able to advance in their careers and afford childcare on their own. There will be a cost associated with these workforce investments, and LB485 prioritizes the use of existing federal funds in both the Child Care Development Block Grant and the Temporary Assistance for Needy Families, or TANF rainy day funds. The TANF rainy day funds have been provided by the federal government to help low-income families with children achieve economic self-sufficiency. For many years, the program has underspent the budgeted spending and spent below the annual federal block grant

amount, resulting in a carryover balance growing each year, also referred to as the TANF rainy day fund. In-- in June of 2014, the State Auditor, who I think is was then State Auditor Foley, now our Lieutenant Governor, cited $55.9 million in available reserves in this TANF rainy day fund. In September of 2019, that balance had grown to over $79 million. And in November of this year, DHHS provided a TANF funding update to my office that showed the rainy day fund has grown to over $90 million. LB485 provides an opportunity to invest these funds in the success of low-income families and our workforce. Childcare costs can easily outweigh the paychecks offered by low-wage work. No parent should have to choose between advancing in their career and caring for their children. Investing in our childcare system is a workforce investment strategy that supports Nebraska families as they work their way to financial stability. Therefore, I encourage you to support LB485 and I'm happy to answer any questions you may have.

**ARCH:** Are there any questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thanks for being here, Senator DeBoer. I'm just looking at the fiscal note and I'm sure the department will speak to this, but I was curious if they told you. It says that they have already committed all of the TANF funds available.

**DeBOER:** I don't know the answer to that exactly. I think that they have ideas for them, but I'm not sure. I think that was a couple of years they had said that-- ago they said that. And maybe now they're saying it again. But it seems like they keep saying that and the fund keeps growing. So I'm not entirely sure. And you'll probably have to ask those questions--

**M. CAVANAUGH:** Yeah.

**DeBOER:** --of them.

**M. CAVANAUGH:** Because $90 million to suddenly have a plan, I'll be interested to hear what it is.

**DeBOER:** Yeah. I mean, I'm not trying to-- I'm just curious myself.

**M. CAVANAUGH:** Thank you.

**ARCH:** Other questions? This-- I do have one question.

**DeBOER:** Yeah.

**ARCH:** And this may again not be for you, but somebody else may be able to answer the question. As I recall, a couple of years ago, we-- we did expand the, I say the transition, that transition. And I-- and I-- I don't recall the percentages of FPL that we're currently operating under today.

**DeBOER:** So we're currently at 130 percent is the initial eligibility. And 185, I believe is the--

**ARCH:** Is the transition.

**DeBOER:** --the transition out eligibility. And you did do something a couple of years ago. I think you may have--

**ARCH:** I introduced the bill.

**DeBOER:** --introduced the bill, but.

**ARCH:** I should remember the percentages.

**DeBOER:** But I can't remember all of the specifics of that. There was some other strange piece of that that had to happen that year that was--

**ARCH:** Yeah, it was to bring us in compliance with federal.

**DeBOER:** That's what I thought, yeah.

**ARCH:** Yeah. All right. Seeing no other questions, thank you very much. First proponent. Good morning.

**ADAM FESER:** Good morning. Chairman Arch, members of the Health and Human Services Committee, I'll actually start by addressing your question there. Just to clarify, while it's fresh in my mind, had it in testimony for LB677, I'm bring it up now. So in 2019, the Legislature took a step forward in addressing the cliff effect when LB341, which you originally introduced, was amended into LB460 and passed. So that bill removed the 24-month limit on transitional

childcare, and it bumped the income limit within an eligibility period to 85 percent, the state median income. So the eligibility period, like you couldn't be booted off for exceeding income within the eligibility period unless you're 85 percent SMI. So that brought us into compliance with a few things. The top end on this bill and LB677 addresses how long the eligibility limit for that transitional childcare by bumping it. So that did help the cliff effect. This is a different step that also would help it.

**ARCH:** Thank you.

**ADAM FESER:** My name is Adam Feser, A-d-a-m F-e-s-e-r. I'm policy advisor representing First Five Nebraska. We're an early childhood policy organization promoting quality care and learning experiences for Nebraska's youngest children. I am grateful for the opportunity to speak in support of LB485 and to thank Senator DeBoer for introducing this bill. Research suggests that access to childcare subsidy results in a range of long-term benefits for children and their families. We believe LB485 has the potential to benefit our state, communities, families, and children on multiple levels. The childcare subsidy allows more children to have access to safe, reliable, early learning environments they need for healthy cognitive, social, emotional, and physical development. It allows hardworking parents to earn more and create greater financial stability for their families by offsetting some of the heavy cost of childcare. Lastly, it enables more parents to participate fully and productively in the workforce so desperately needed by our state's employers, especially in the wake of COVID-19. Our ability to address these needs determines where our communities, families, and children can thrive. Leveraging our pool of unused TANF funds presents an opportunity for us to do just that. LB485 will allow more children to benefit from childcare through the subsidy. But we must also ensure that the subsidy makes it possible for early childhood professionals to cover the actual cost of delivering high quality care. We do want to applaud the Nebraska Department of Health and Human Services for their willingness to examine a hybrid approach for setting subsidy reimbursement rates to account for the costs of providing high-quality care for services beyond the standard market rate for childcare. Access to reliable quality care can improve the lives of children and families in need immediately and in the long term. It also points toward a more robust workforce and prosperous economy. Currently, Nebraska has some of the most restrictive

eligibility criteria for childcare assistance in the entire country, especially compared to our neighboring states. We have the opportunity to change that. We hope you advance LB485 to General File. With that, I will email out my testimony since we're not bringing in hard copies after the fact. And if anyone has any questions, I will do my best to answer them.

**ARCH:** Thank you. Are there any questions? Seeing none, thank you very much for your testimony. Next proponent for LB485. Welcome.

**JP LAUTERBACH:** Good morning. Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is JP Lauterbach, J-P L-a-u-t-e-r-b-a-c-h. I'm the COO of the YMCA here in Lincoln, Nebraska. And I'm speaking today on behalf of the Nebraska State Alliance of YMCAs in support of LB485. And we thank Senator DeBoer for introducing the bill and again want to register the strong support of the Ys in the state. LB485 would move initial eligibility from 130 percent of the federal poverty level to 185 FPL and eligibility for transitional childcare assistance from 185 to 200 FPL. The Y is a leading nonprofit committed to strengthening communities through youth development, healthy living, and social responsibility. We've been a presence in Nebraska for over 150 years. And through the work of the Ys in 14 YMCAs across the state, we provide programs and services in over 300 Nebraska communities. The Y has been a leader in the childcare field for over four decades and we are vested in the well-being of our state's children from their first steps as a toddler to them crossing the stage at graduation. Over 50 percent of our Y members and program participants are under the age of 18. They participate in youth sports, camping, childcare, before and after school programs, after school enrichment, teen outreach and leadership programs designed to help keep kids safe and engaged and encouraged to discover who they are. Both LB485 and LB68 are critical bills that will address the needs of hardworking, low-income families to access affordable childcare. Imagine, if you will, a single parent or even a couple working full time, making between $9 and $12 an hour, trying to afford quality childcare for their two children so they're safe and learning throughout the day while also trying to afford a safe place to take them home to at night. Thankfully, in 2018, Congress nearly doubled the funding every-- in every state to provide subsidized childcare through the Child Care and Development Block Grant. LB485 will help implement the significant federal investment by expanding

eligibility for families to access care and update reimbursement rates for childcare providers, which will provide much needed stability to ensure greater access. The bill is a solution for a tremendous unmet need. For every child receiving childcare subsidy, five more children have been on the waiting list. High-quality childcare programs can help lift that child out of poverty by providing early education at the most critical time in their development. The right start that includes early learning enrichment and fostering social and emotional well-being ensures their academic readiness for kindergarten and early investment that will fuel brighter futures. All parents, regardless of income, deserve to know with confidence that while they're at work each day, their children are safe and thriving in a quality childcare program. Subsidized childcare can also play a role in lifting a hardworking family out of poverty by helping them keep on working during the children's early years and provide the ability to make ends meet at the end of the month. The YMCAs in our state are committed to doing our part so that more children can reach their potential and more families can thrive. I thank you for your time and respectfully ask for your support of LB485. Thank you, Senator DeBoer, for introducing the bill and thank you to the committee for your time. And if you have any questions of the YMCA at this point, I'll do my best.

**ARCH:** Are there any questions from the committee? Seeing none, thank you very much. Thanks for your testimony. Next proponent for LB485. Welcome.

**LESLIE ANDERSEN:** Would you like me to take my mask off?

**ARCH:** Your choice, your choice.

**LESLIE ANDERSEN:** OK. Chairman Arch and members of the Health and Human Services Committee, my name is Leslie Andersen, L-e-s-l-i-e A-n-d-e-r-s-e-n. I'm CEO of the Bank of Bennington. And I'm here today on behalf of the Greater Omaha Chamber of Commerce and the Nebraska Chamber in support of LB485. LB485 presents an important policy change for Nebraska as it considers how it wants to invest in childcare and what impact that has on our workforce. The changes proposed in LB485 would increase the income levels eligible for initial childcare assistance. This change gives working families more financial breathing room to work, find a job, pursue education, and afford living expenses. It reduces the cliff effect at low-wage thresholds

and makes Nebraska's childcare assistance program more competitive with surrounding states. Childcare programs open opportunities for families to improve their financial situations with two incomes. Research also shows that the availability of childcare increases workplace productivity and local economic activity. Additionally, childcare options are among the top considerations for families looking to relocate to Nebraska communities. Greater financial stability among Nebraskans also increases economic activity and reduces the need for state assistance. That is why the Chambers of Commerce recognize this as a critical workforce need and are working to help unemployed or underemployed Nebraskans move into higher wage jobs and greater financial security. It's also why we're supporting LB485. Sometimes career advancement, getting that new job with the higher-- with higher pay puts family income above eligibility requirements for public benefit programs. As a result of losing that assistance, the family can actually become financially worse off, a benefits cliff, or no better off, a benefits plateau. Benefits cliffs and plateaus are financial barriers to economic mobility. While a new job could provide much greater long-term income, the immediate shortfall may make it too risky to pursue higher paying work. Losing access to public benefits that help with expenses such as medical insurance or childcare can become a financial disincentive to upward movement from lower wage jobs. The Greater Omaha Chamber of Commerce and the Nebraska Chamber of Commerce are proud to support LB485 and would encourage the committee to advance the bill from committee. I'd be happy to take any questions.

**ARCH:** Thank you. Are there questions?

**LESLIE ANDERSEN:** Thank you.

**ARCH:** Seeing none, thank you very much for your testimony. Next proponent for LB485.

**KEN SMITH:** Good morning, Chairperson Arch, members of the Health and Human Services Committee. My name is Ken Smith. That's spelled K-e-n S-m-i-t-h, and I'm the director of the economic justice program at Nebraska Appleseed. Nebraska Appleseed is a nonprofit organization that fights for justice and opportunity for all Nebraskans. I'm here today testifying in support of LB485. Simply put, LB485 would implement a policy change that is long overdue by increasing access to

childcare for thousands of Nebraskans experiencing poverty. In Nebraska, the childcare subsidy program is intended to provide temporary assistance to low-income families by helping to cover their costs of childcare on a sliding scale. The program helps parents have a safe place for their children while they find work, maintain employment, or gain the education and skills needed to get a job. For too long, Nebraska has taken an overly restrictive approach to eligibility for the childcare subsidy program. The current initial eligibility limit, as you've heard, is 130 percent of FPL, meaning that the childcare subsidy is not available to many low-income households that could benefit from it. As you have-- as you have also heard, in 2002, the eligibility for this program was cut from 185 percent FPL to 130 percent, or 120 percent FPL, and then later raised by 10 percent, back up to 130 percent. So in other words, more than 15 years later, we are still below 2002 program levels. And as you've heard, Nebraska lags behind many of our surrounding states in eligibility. I think, and Senator DeBoer touched on this in her opening, but to get a sense of how restrictive the current eligibility threshold is, it's helpful to consider the levels of income involved. We can hear things like 130 or 185 percent of federal poverty, but what-- what does that mean? The current eligibility limit of 130 percent FPL excludes families of three whose annual household income exceeds about $28,000. So currently, if you're a single parent with two kids and you make $29,000 per year, you're not eligible for childcare assistance. LB485 would change that so that families of three making up to approximately $40,000 per year can be eligible. Suppose there are two working parents with two young children. That family of four is currently ineligible for childcare assistance if the parents combined incomes exceed $34,000 per year. So again, we think LB485 is just a long overdue increase in access to childcare assistance for families who need it. You've also heard today about the cliff effect. The cliff effect is still prevalent in our childcare program, meaning that when a family's income increases modestly, it can push that household over eligibility limits for childcare assistance. By extending back end eligibility of up to 200 percent FPL when a family renews, this bill would help encourage work by allowing families to earn more income and retain their childcare support. As again, as I said, it's a slide-- kind of this program works on a sliding scale. So as a family's income increases, so does their share of costs for childcare. I think I also just want to touch on the

funding mechanism for this bill. The bill was written intentionally to first pull down, pull in our funds from our Child Care Development Block Grant and-- and then specifies that any remaining funds could be drawn from TANF with General Funds to take-- to take effect after that if needed. I think that was intentionally done because Child Care Development Block Grant funds, unlike TANF, do not roll over if the state doesn't use them. And so it is incumbent upon us to use all of those funds before turning to another source. TANF funds, if we don't use all of those funds, I think as we've heard today, we do, you know, those funds are placed in reserve, the so-called rainy day fund. And I think it's-- it's-- it's worth noting that we've heard for the past several years that Nebraska has a plan for those rainy day funds and that they're already-- they're already accounted for. You can't dip into them. We have a plan. But as far as we can tell, I've been at Appleseed since 2015, we've only had plans since 2015. And yet every time we look at that reserve fund, that rainy day fund, that pot of now $90 million in federal funds that are specifically intended to help children and families in poverty, the fund just grows. I think this Legislature has the ability, and this is reflected in the fiscal note, to direct the department to spend those funds in the best way for Nebraskans. And we would submit that this bill brought by Senator DeBoer is that-- is the way to do that for-- for all of the reasons that I've stated and the reasons previous test-- testifiers have-- have stated as well. In sum, we think LB485 would go far to ensure more families in Nebraska can find a job, keep their work, or take a pay raise. This is not only good policy for the welfare of our families, but also the health of Nebraska's economy. I'm out of time. Be happy to answer any questions.

**ARCH:** Thank you. Are there questions? Seeing none, thank you very much.

**KEN SMITH:** Thank you.

**ARCH:** Next proponent for LB485. Seeing none, oh, I'm sorry. Welcome.

**QUENTIN BROWN:** Well, thanks. Good morning, Chairman Arch and members of the committee. My name is Quentin Brown. I'm executive director of Eduare Lincoln, that's Q-u-i-t-i-n B-r-o-w-n. Educare Lincoln is a quality early childhood education program where we establish a high-quality, one stop community learning center for at-risk children

and families, implementing specialized learning environments which develop children academically and socially, empowering them to become productive members of society thrpigj research and evidence-based practices. Today, we serve all 165 children and families with high-quality supports and employ over 55 dedicated teachers and other professionals. In addition to providing academic, social, and emotional learning opportunities for children, part of our mandate is to ensure that we are working with our families to ensure they have the supports that they need to provide a healthy and safe home environment. A challenge that we face as we work with families through any number of crises and on the path to a better place financially is that we oftentimes arrive at a point where they no longer qualify for childcare subsidy but don't yet earn enough through employment to sustain what we might define as an adequate household. Extending childcare subsidy eligibility to families whose income is less than 185 percent, and in some cases we've heard 200 percent, of the federal poverty level will allow more families to remain on subsidy longer and avoiding or at least reducing the potential for childcare cliff effect. Our request of you today and look moving forward is to look favorably upon LB485, as it will create, extend, and sustain more opportunities for our families and our workforce. Thank you. And as everyone else, I'll be happy to answer any questions that you may have.

**ARCH:** Thank you. Any questions? Senator Walz.

**WALZ:** Thank you. Thanks for coming today.

**QUENTIN BROWN:** Thank you, ma'am.

**WALZ:** I'm just curious. I haven't had kids for a while. I'm just curious. Can you--

**QUENTIN BROWN:** We have a bunch of them.

**WALZ:** Can you just give me an average monthly cost of day care for one child?

**QUENTIN BROWN:** Oh, you're looking at approximately $1,500 to $2,000.

**WALZ:** OK.

**QUENTIN BROWN:** Yeah, right, yeah, I mean, and there are some statistics and some of my colleagues behind me may be better versen in this, but that will reference that childcare in some cases costs more than universities. And I think just hearing that, whether you even know what the numbers are, just understanding that, I mean, brings it into perspective.

**WALZ:** Um-hum.

**QUENTIN BROWN:** This is the most critical stage of development for our children and in a lot of cases, one of the greatest benefits that we can provide to our working families. So it's you know, [INAUDIBLE]

**WALZ:** So currently, and I'm just trying to get this straight, currently you're eligible if you don't make over the 130 percent, is that, or $28,000 for assistance.

**QUENTIN BROWN:** Yes.

**WALZ:** And $28,000 divided by 12 comes to about $2,333.

**QUENTIN BROWN:** You're doing the math, not me so I'm going--

**WALZ:** OK, well--

**QUENTIN BROWN:** --to say it's right. Yep. Yeah.

**WALZ:** So.

**QUENTIN BROWN:** Yeah.

**WALZ:** I mean I'm just--

**QUENTIN BROWN:** I know, I know. It's mind blowing, right?

**WALZ:** Leaves them about $33 of their childcare for rent and food and gas and-- am I doing that right?

**QUENTIN BROWN:** We are dealing with families that are in it and I can't speak for all centers and organizations and programs, but we are dealing with families that are in a very high risk and high poverty and they need every opportunity and support and benefit that they can receive to lift them out of that. And oftentimes we, from the outside

looking in, we think that the work that we're doing is only for the children because that's who we're spending most of our time with. But the work that I do and my colleagues do is not only for the child, but it's for the entire family. And it is a workforce issue. It is a childcare issue. It is a support issue. It's a-- it's an economic-- it's-- it's a responsibility that we all bear to get right, in my opinion.

**WALZ:** Thank you.

**QUENTIN BROWN:** You're welcome. Thank you.

**ARCH:** Other questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Do you know what the, well, you probably do know, what is the monthly reimbursement for a child that's on a childcare subsidy? How much does Educare receive in a reimbursement?

**QUENTIN BROWN:** I have people at my school that can answer that question, but I cannot.

**M. CAVANAUGH:** OK? Is it $1,500?

**QUENTIN BROWN:** I--

**M. CAVANAUGH:** [INAUDIBLE] do you think?

**QUENTIN BROWN:** I can follow up with you on that.

**M. CAVANAUGH:** OK.

**QUENTIN BROWN:** I can share with you and anyone else that wants to know, but I can't answer that right now--

**M. CAVANAUGH:** OK.

**QUENTIN BROWN:** --and feel confident in my response.

**M. CAVANAUGH:** That's fine. I was just curious if it was even-- you were even able to break even or do you have to have other funding?

**QUENTIN BROWN:** Oh, well, if that's your question.

**M. CAVANAUGH:** Yes.

**QUENTIN BROWN:** No, we're not breaking even from-- from that, no. I can definitely answer that.

**M. CAVANAUGH:** And so you have to seek other funding?

**QUENTIN BROWN:** Correct. We're-- we're a blended funding strategy, various funding streams to make up that difference. So.

**M. CAVANAUGH:** And most childcares are, even the ones that don't have subsidy children.

**QUENTIN BROWN:** Right.

**M. CAVANAUGH:** Yeah.

**QUENTIN BROWN:** Right.

**M. CAVANAUGH:** I am-- I do have children in childcare and it costs more than what I make here. So every day that I'm here is costing me more than what my pay is. So I appreciate the work that you're doing. Thank you.

**QUENTIN BROWN:** Thank you.

**ARCH:** Other questions? Senator Hansen.

**B. HANSEN:** All right. Since you''re answering questions, I feel remiss if I don't ask something.

**QUENTIN BROWN:** Oh, well, let's do it.

**B. HANSEN:** Why do you think childcare is so high?

**QUENTIN BROWN:** It's-- it is the most critical stage of development. I think, you know, I tell people oftentimes if a university or a high school rightfully builds a multimillion dollar facility, no one bats an eye. It's to be expected. But if someone says we're going to build a multimillion dollar facility for zero to five-year-olds say, wait a minute, they're only babies. Why do you spend that kind of money? But 85, at least 85 percent of brain development happens before the age of eight and the majority of it happens before the age of five. So it is

expensive because the people we are employing to do this work are people that not only want to hold and care for babies, we want people that-- that like playing with babies and holding them and smelling them, which they do. But these are people that care about the true development and future lives of these kids. Because if we don't get it right at zero to five, we're going to spend a lot more money on the back end trying to correct what we missed zero to five. So it is so expensive because this-- this is the most critical stage of development. This is the point where you have to get the work right. We don't get another chance. Their brains are sponges soaking up absolutely everything that you do. Everywhere that you look, they're watching where you look to understand what you're referring to and what you're calling that podium there and making connections. The neurons are always firing. And I won't get into all the science, but this is where it happens. This-- this is it.

**B. HANSEN:** In your opinion,--

**QUENTIN BROWN:** Um-hum.

**B. HANSEN:** --do you think government can sometimes be a hindrance or a cost because of excess rules and regulations in childcare, or is it pretty much null and void? You know, not so much--

**QUENTIN BROWN:** I think--

**B. HANSEN:** --an issue?

**QUENTIN BROWN:** In my opinion, I think in any instance, I think any authority or any external force can be a hindrance or not. It just depends on what the particular cases that we're referring to. So, I mean, in some cases, government can be a huge support and in some cases it could be a hindrance. It just all depends.

**B. HANSEN:** I've heard that from other childcare centers because I'm always curious about that because I don't know. I'm not familiar with, to some extent, I'm not familiar with the industry.

**QUENTIN BROWN:** Yeah, most people.

**B. HANSEN:** About the extra people they have to hire to figure out accounting, the extra people they have to hire to deal with rules

and-- and procedures that the government requires of facilities instead of letting them actually just do their job. And so sometimes that creates like an excess cost and then they have to push on to the parent for the-- for the cost of the childcare. So that's what I was wondering. I--

**QUENTIN BROWN:** It--

**B. HANSEN:** --was just trying to get your opinion because I appreciate you being here and talking with us, too, so.

**QUENTIN BROWN:** No, I appreciate being here. And again, it just-- it just depends. It all depends.

**B. HANSEN:** Makes sense, thank you.

**QUENTIN BROWN:** Yeah. Thank you.

**ARCH:** Other questions? Seeing none, thank you very much for your testimony.

**QUENTIN BROWN:** Thank you.

**ARCH:** Other proponents for LB485. Seeing none, are there any opponents for LB485? Good morning.

**STEPHANIE BEASLEY:** Good morning. Good morning, Chairerson Arch and members of the Health and Human Services Committee. My name is Stephanie Beasley S-t-e-p-h-a-n-i-e B-e-a-s-l-e-y, and I serve as the director of the Division of Children and Family Services within the Department of Health and Human Services. I'm here to testify in opposition of LB485, which would increase the income eligibility limit for childcare subsidy from 130 percent of the FPL, federal poverty limit, to 185 percent of the FPL and increase the eligibility limit childcare subsidy at redetermination from 180-- 185 percent to 200 percent FPL. LB485 would also authorize the use of funds from the Temporary Assistance for Needy Families, or TANF, program and state General Funds to offset expenses incurred with this change. Raising the income limit to qualify for childcare subsidy to 185 percent FPL and raising the income limit redetermination for childcare subsidy to 200 percent FPL would require significant state dollars to implement and sustain. TANF funny-- TANF funding referenced in this bill is

insufficient, leaving state dollars to cover the cost. DHHS has been responsive to the impact of COVID-19 on our childcare providers and working families who rely on childcare subsidy assistance. Diligently working through this pandemic with internal and external partners, DHHS strives to ensure childcare is available for families. It is imperative that parents can continue working. It is also imperative that childcare providers supported through funding opportunities-- are supported through funding opportunities to offset the cost of low attendance and increased operational expenses. The testimony and handout provided for LB677 summarizes actions DHHS took initially and supports created using CARES dollars. And I'm sorry when we flipped the order of the hearings, there's a handout that is coming with LB677 so. For example, Executive Order number 20-18 allowed childcare providers to bill unlimited absentee days for children and give parents flexibility to choose an in-home childcare provider. Additionally, stabilization funds and incentive to re-open funds were made available to childcare providers using Child Care and Development Fund CARES dollars. DHHS anticipates that increasing the income eligibility limit and redetermination income limit would increase the number of households eligible for childcare subsidy by approximately 5,400 and the number of children eligible for childcare subsidy by approximately 10,800. Please see Figure 1 at the end of this testimony for further details. Serving the proposed number of children eligible for subsidy at 185 percent FPL would require the addition of 19 new social service workers and 2 social service supervisors. The addition of approximately 10,800 eligible children would result in an estimated annual subsidy fiscal impact of nearly $30 million, $29,725,714 in fiscal year '21-22 and almost $40 million in fiscal-- fiscal year '22-23. Those already enrolled in the program would remain eligible unless they age out or have income that exceeds the allowable limits. DHHS currently obligates all CCDF and allowable TANF funding to maintain current childcare infrastructure. As our handout illustrates, all funding to support LB485 or any increases in the childcare subsidy program would come solely from state General Funds. There's also a technical issue regarding the language on page 2, line 18-26. There are several references to implementing this subsection. To the extent that it is a reference to 68-1206(1), that subsection encompasses all social services administered by the department, not just childcare. This language would mandate the use only of childcare and development funds, TANF funds, and General Funds for every program administered.

The Department of Health and Human Services adamantly believes that quality childcare plays a crucial role in children's development while providing vital assistance to support families. However, DHHS is unable to support legislation that will cost millions of state dollars for implementation. We respectfully request the committee not advance this legislation. Thank you for the opportunity to testify today and I'm happy to answer any questions you may have.

**ARCH:** Thank you. I'm sure we have questions. Senator Day.

**DAY:** Thank you, Chairman Arch. I just have a question about the fiscal note in reference to what Senator Cavanaugh had asked earlier. It says, Through years of underspending the allocation, the rainy day carryover funding, the balance on September 30, 2020, was over $92 million. And the department's fiscal note indicates that TANF funds are currently obligated for the future biennial. Can you help me understand--

**STEPHANIE BEASLEY:** Absolutely. Thank you, Senator.

**DAY:** --where that is going?

**STEPHANIE BEASLEY:** So we began programs in 2020 and we have begun new programs in 2021 too. And so the programs that were-- that we started where expenditures began in 2020 were supportive services and work supports for child welfare families, home visiting programs, SNAP employment and training, emergency assistance, NJAC [PHONETIC] program. In 2021, what is beginning is St.. Monica's Women are Sacred program and there's another program. These are-- these are residential treatment facilities for substance use disorders where the child can live with the parent, live with the mom. And then we have other initiatives starting like Fatherhood Initiative, pregnancy program and then a community response program, which is for at-- for families who are at risk to coming into the child welfare system. So while we have really focused on building some programs in 2020, obviously the pandemic, did-- those home visiting programs didn't get off the ground as well as we had hoped that, you know, people didn't want someone coming into their homes, etcetera. But those programs have been designed and we have the subawards that have been allocated and we really expect to see expenditures rise in this-- this coming year.

**DAY:** OK. And that would account for all of that $92 million.

**STEPHANIE BEASLEY:** No. So, no. What we have is we have a plan for the-- all the way through fiscal year '25, where we're adding programs each year. And the programs that have been added really are focused on crisis needs for families, ultimately focused on well-being for kids and families in the community to keep them out of the, deeper into the system and needing more formal interventions. And so we do have programs that are designed and ultimately that, in fact, if we-- if we would continue to-- if the amount that we're allocating would happen every year and those spends would happen, fiscal years '24 and '25 we actually would have to maybe pull back on the programs a little bit because it would spend down that rainy day fund.

**DAY:** OK. Thank you.

**ARCH:** Other questions? Senator Walz.

**WALZ:** Thank you. Thanks for being here today. I appreciate it. In your statement, you said that there could be an approximate 10,800 eligible children. How many eligible families don't apply?

**STEPHANIE BEASLEY:** You know, I don't know the answer. If you look at the grid at the bottom of my testimony, so I think I'm going to answer a different question. So this is who-- this is based on census data, the number of children who we believe at these various FPL levels would be eligible. We actually have families who are eligible, who have actually been authorized but don't actually bill. So they aren't utilizing that childcare assistance. And so I don't know that I would have the number for you to say how many would actually utilize the service, because we know it's a smaller portion. I think we were about 12,000 are authorized right now. Let me do this. I actually have it. Let me see. This last year, we had actually 20,000 children authorized, but only 12-- 12, 5, 12,500 children who actually billed. And so I don't know that I can determine for you the specific numbers.

**WALZ:** Yeah. So that's almost a little more than half that are actually taking it--

**STEPHANIE BEASLEY:** Who are--

**WALZ:** --using 20,000.

**STEPHANIE BEASLEY:** Yes.

**WALZ:** So would it be fair to say that, you know, you would see a similar case with the new 10,800 eligibility kids that are eligible? I mean, not all the kids are going to--

**STEPHANIE BEASLEY:** Not all of them will be billed time.

**WALZ:** --not all will take this, right. OK. All right. Thank you for clarifying that.

**ARCH:** Other questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Good morning. Since Senator Day asked about the TANF funds and the plan and I've heard a couple of things, but I didn't hear $90 million worth of a plan. And so this committee has asked previously of previous people in your position for the plan. And as we heard from Mr. Smith from Appleseed, we have been asking for what is the plan. So my first question to you is, can you please provide us with the detailed plan as follow-up to this hearing? I think we all would very much like to know how it is that $90 million are being spent without the Legislature's input. I think that's really critical because that is part of our job. My question about your testimony is you said DHHS is unable to support legislation that will cost millions of state dollars for implementation. So this is where we always come in this back and forth is that the department comes and testifies in opposition to something and it's because of the cost. But it is not actually your job to worry about the cost. It is our job to worry about the cost. It is our job to appropriate the funds for you to do your job. So if that is your opposition, then that shouldn't be your opposition. So are you opposed to more children having access to this program?

**STEPHANIE BEASLEY:** The way that this legislation is written--

**M. CAVANAUGH:** Are you opposed to more children having access to the program is my question, not anything about how this is written.

**STEPHANIE BEASLEY:** I think the program is a great program. I think childcare is in a very, very important thing for-- and one of the testifiers prior to me really talked about just the importance of that age in the development of children.

**M. CAVANAUGH:** So instead of coming in opposition because of the cost, why not come and work with us and work with Senator DeBoer on implementing this program as fully as we possibly can to impact the lives of as many children as possible?

**STEPHANIE BEASLEY:** So we are certainly happy to sit down with Senator DeBoer and talk through questions that we might have or what some of our concerns are.

**M. CAVANAUGH:** OK. I mean, the concern seems to be the cost. And-- and it also--

**STEPHANIE BEASLEY:** Absolutely.

**M. CAVANAUGH:** --my concern as a legislator is that the department has come in and told us that you are spending $90 million without our input. I see an RFP for this Fatherhood program for $2 million that seems to completely disregard all of the legislation that we as a body have been putting forward. It's talking about marriage, which I don't know what the state has a responsibility to get involved in people's marriages, financial stability while allowing parents to work and put their child in a safe and secure childcare. It seems like the path towards financial stability and you're doing these programs without any input from us. But then you're coming in, in opposition to childcare programs. You're coming in opposition to maternal health programs. You're coming in opposition to SNAP programs. I'm just really confused as to what the department is doing and why the department thinks that they have the authority to spend this money without our insights.

**STEPHANIE BEASLEY:** So our decisions to fund these programs have really been based on data and what we're seeing around kids coming into the deeper end of the system. So the Fatherhood program really is focused on, you know, really equipping fathers for-- for economic financial employment, really supporting that, their ability to parent and care for vulnerable kids. Ultimately, what we are hoping to do is to look at what are the issues that are facing families in Nebraska today.

**M. CAVANAUGH:** The first-- the first program goal is to sustain marriages.

**STEPHANIE BEASLEY:** Part of the Responsible Fatherhood and Healthy Marriage Initiative is definitely to build a family, healthy family structure, yes.

**M. CAVANAUGH:** That is, I mean, that is actually very galling that the state would put forward a program to sustain marriages in a Fatherhood program. Families look all shapes and sizes, and you've decided to dedicate resources to a specific type of family, a nuclear family, in a cisgender, traditional role and-- and at the expense of putting children into safe childcare. We could take that money and put it towards this instead.

**STEPHANIE BEASLEY:** So that.

**M. CAVANAUGH:** And the results would be much more tangible than sustaining marriages.

**STEPHANIE BEASLEY:** So, Senator, I have quite a bit of experience with Fatherhood Initiatives and really the design of a Fatherhood Initiative and the focus of a Fatherhood Initiative is really to support family. And family comes in all shapes and sizes.

**M. CAVANAUGH:** It does. And there are great fatherhood programs in this state run by nonprofits.

**STEPHANIE BEASLEY:** And there are-- and that's the solicitation for the services, the RFP. We did solicit bids and some of those very programs bid on that.

**M. CAVANAUGH:** And the pregnancy bids that you serviced, were those from healthcare organizations? Was there a healthcare requirement?

**STEPHANIE BEASLEY:** So those--

**M. CAVANAUGH:** Was there evidence-based practices?

**STEPHANIE BEASLEY:** So those bids are out right now.

**M. CAVANAUGH:** And-- but is there a requirement for them to be evidence-based and healthcare related?

**STEPHANIE BEASLEY:** I can look at the details of the RFA.

**M. CAVANAUGH:** I'm pretty certain that they are not. I'm just-- I'm really concerned. I'm concerned by your opposition. I'm concerned by $90 million being basically a slush fund for the Department of Health and Human Services. I'm concerned that you're starting programs without any input or insights from this committee or this legislative body. I'm concerned that you continue to come in opposition to programs that various senators have introduced to support families and children. And at the same time, you're making plans without discussing them with us. And this continues to put us in a really bad position as a state. The Department of Health and Human Services should not have this slush fund. You should not be working in isolation.

**STEPHANIE BEASLEY:** And I can say that I do not believe we are working in isolation. When we look at the data [INAUDIBLE]

**M. CAVANAUGH:** Does anyone on this committee know what your plan is for that $90 million?

**STEPHANIE BEASLEY:** I do not know that they do.

**M. CAVANAUGH:** Have you communicated it to any person on this committee?

**STEPHANIE BEASLEY:** I have not.

**M. CAVANAUGH:** Then I would say you are working in isolation. Thank you.

**ARCH:** Any other questions? I do have one. It was-- it was testified earlier that in 2018 Congress doubled the funding for childcare-- for the Child Care Block Grant. Is that-- did-- did Nebraska experience that, a doubling of funding?

**STEPHANIE BEASLEY:** No. In 2018, we did get, and this is a rough number, but approximately $12 million. Based on legislation and requirements that came in 2014, I think it was 2014, where they were, I referenced it as a mandate federally that we didn't have dollars that followed, those came in 2018 and we have had $12 million each year. But there's no guarantee that that $12 million will continue. But it was intended to support states in implementing what they had passed in '14 for us to do.

**ARCH:** Which is then what we implemented in LB677 I believe was what it was. No, I'm sorry, LB341, LB341. So at any rate, OK, so-- so I-- I have had the privilege of being in some of those discussions of the plan for the TANF rainy day fund. Why do they call it a rainy day fund?

**STEPHANIE BEASLEY:** I'm not sure why it's called the rainy day fund.

**ARCH:** It sounds like it's going to rain at some point. But-- but I-- I've been, with your predecessor, I was in some of those meetings and-- and it was confusing. It was confusing as to what the plan is for the expenditure of those dollars and-- and the best way to do that. So I think it would be beneficial to to have some input and some-- and some discussion on that-- on that plan for the rainy day fund. And-- and if-- and-- and for the maybe a little more clarity on the-- on the block grant as well, exactly how that's-- that's being expended as well. And that would help us in understanding LB485 as well so.

**STEPHANIE BEASLEY:** Wonderful. Thank you, Senator.

**ARCH:** Right. Well, seeing no other questions, thank you very much for your testimony.

**STEPHANIE BEASLEY:** Thank you.

**ARCH:** Are there other opponents for LB485? Seeing none, is there anyone that would like to testify in a neutral capacity? Seeing none, Senator DeBoer, you're welcome to close. And while you're coming up, I will-- I will say that we have received six letters as proponents and one letter as an opponent. And as far as written testimony received this morning, proponents, all proponents: Women's Fund of Omaha, ACLU of Nebraska, Lincoln Chamber of Commerce, Voices for Children, and Children and Family Coalition of Nebraska. And you're welcome to close.

**DeBOER:** Thank you very much, Senator Arch. So first, I'll say that the department did have a meeting with me yesterday, but unfortunately, I was in a bill that I was presenting that went over the lunch hour and I was unable to attend that meeting. So there was a little bit there where I apologize for that and I will meet with them in the future. I

just was introducing a bill and couldn't when we had our meeting set. The technical correction on page 2 I will-- I will certainly do something about that or I can help you with that. I intend to work with the department. I think we can-- can work on finding something because I think this is such an important issue in our state for our workforce, for our parents, for all of our families. But I-- I will say I do share a bit of a concern if we have $90 million that are going to be spent without going through the appropriations process. So, you know, I have a little bit of a concern there. So I'll look into that, you know, and see what's going on with that. So see what I can come up with, happy to work with the committee if they have concerns and just work forward on this bill.

**ARCH:** Thank you. Any final questions? Seeing none, thank you very much. This will close the hearing for LB485 and we will open the hearing for LB677, Senator Linehan. Welcome.

**LINEHAN:** Good morning, Chairman Arch and Health and Human Services Committee. I think you just had this hearing. There's-- I slipped up here with this bill. What I was trying to do is I am-- I understand. I got six grandchildren. I understand daycare is critically important. One of my concerns when we do these kinds of bills is it's based on your income and you have a lot of young families whose income looks significant, but their actual money that they have to spend because of high student loan costs is significantly less than what their income taxes say. So when I asked to look into this, what I had asked for is if we could take into consideration what student loan costs were when we figure out who should get subsidized, because you could have-- you could have a teacher who's married to a nurse who both of them have $100,000, well, maybe not 100, $50,000 apiece in student loans. And if you look at their salaries, they wouldn't qualify for anything. But if you took out their student loans, they would be well within qualifying. So that's one thing I would just ask the committee if you're going to do anything on this to look at. The other thing that has happened since I worked with this, and I I'm sure some of you have the same situation happening in your families, because of the CARES Act, I think the first CARES Act went to families, it was $1,200 per adult, $500 per child. So that was last fall, late fall. Then in 1st of January, at least in my family, everybody, and not all of them, some of them are above $75,000, but most of mine got $600 per person in a family. And now the way I understand by looking at the papers and

the Biden administration and the Congress are talking about $300 for each child, each family and a tax credit, and they're even talking about prorating it ahead of time starting in June. That seems to me like it's on its way. And I actually think that kind of help the families, a tax credit, refundable tax credit. So it's like the earned income tax credit. Even if you don't owe any income taxes, you're going to get $300 for every child in the household up to I think it starts tabling off at pretty significant income levels. And I think those programs are probably better than subsidies for daycare. You actually get the money in the parents' hands so the parents can make the decision so.

**ARCH:** OK. Are there questions? Seeing none, thank you very much.

**LINEHAN:** Thank you.

**ARCH:** Are you going to stay to close?

**LINEHAN:** We'll see.

**ARCH:** OK, OK.

**LINEHAN:** I'd like to.

**ARCH:** First proponent for LB677. Seeing none, are there any opponents?

**ADAM FESER:** I was a proponent. I thought someone else was going.

**ARCH:** I'm sorry.

**ADAM FESER:** I'm a proponent.

**ARCH:** A proponent.

**ADAM FESER:** I thought someone else was ahead of me. I apologize.

**ARCH:** OK, please.

**ADAM FESER:** Hi, my name is Adam Feser, A-d-a-m F-e-s-e-r, and I'm policy advisor representing First Five Nebraska. I feel like we went over a lot of what this bill would do with bumping from 185 to 200 percent federal poverty level. We just want to come in in support of it, because regardless of what happens LB485, this would still be a

good thing. We do support moving the upper level of subsidy eligibility to 200 percent federal poverty level. I feel like we went into cliff effect a good deal on the last-- the last hearing. This is still the cliff effect portion of that bill. We still support it. I don't want to spend time going over all the same things. So I was going to say I support it and see if you had any additional questions about LB677.

**ARCH:** Any questions? Seeing none, thank you very much. Other proponents for LB677? Seeing none, is there anyone that would like to testify in opposition to LB677?

**STEPHANIE BEASLEY:** Good morning, Chairperson Arch and members of the Health and Human Services Committee. My name is Stephanie Beasley, S-t-e-p-h-a-n-i-e B-e-a-s-l-e-y, and I serve as the director for the Division of Children and Family Services within the Department of Health and Human Services. I'm here to testify in opposition of-- to LB677, which would increase the eligibility limit for transitional childcare assistance care assistance from 185 percent of the federal poverty level to 200 percent FPL. Legislation passed in 2019 provided for expansion of transitional childcare through the Child Care Development Fund. The 2019 legislation removed the 24-month time limitation on transitional childcare assistance and presently allows families to gradually increase their income during their 12-month eligibility period as long as their income does not exceed 85 percent of the state median income. DHHS has worked through this pandemic internally and with external partners to be responsive to the impact of the pandemic on childcare providers and working families who rely on childcare subsidy agreement or assistance. The handout provided alongside this testimony also summarizes actions DHHS has taken to support working families. For example, as a growing number of schools decided to offer remote learning, DHHS allowed childcare providers to bill for the subsidy while assisting children with remote learning. This created the opportunity for children to be assisted in remote learning while parents were able to continue working. DHHS anticipates that increasing the redetermination income limit would increase the number of households remaining eligible for childcare subsidy by approximately 856, and the number of children eligible for childcare subsidy by approximately 1,703. The addition of 1,703 eligible children would result in an estimated subsidy cost impacts of an additional $3,967,560 in fiscal year '21-22 and $5,290,080 in fiscal

year '22-23. LB677 would increase income limits for families of eligibility redetermination, allowing families with higher income to remain eligible for childcare subsidy. However, in doing so, it would require Nebraska to invest additional state General Funds for the childcare subsidy program to implement and sustain this change. Due to the significant fiscal impact, DHHS opposes moving this legislation forward. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

**ARCH:** Thank you. Questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thanks for being here again. First, I'll just say same concerns as last time on the opposition, just for the record. We don't have to have that conversation twice. The CARES Act dollars, is that what this attachment is?

**STEPHANIE BEASLEY:** Yes.

**M. CAVANAUGH:** Could you maybe walk us through this a little bit more detail?

**STEPHANIE BEASLEY:** Certainly. And I think what-- so the very first thing, Senator, also I did confirm for the last question that you had, that the TANF plan has been provided to the Legislative Fiscal Office so-- but we will make sure that it finds its way to all of you. So-- so that if you-- if you look at this first grid right here, it sort of outlines in March of 2020 additional childcare hours and units were added. Then it goes into what was added in 2020 or in April of 2020 around in-home childcare was an alternative to transitional childcare; subsidy was able to claim up to the amount of hours authorized if the child was not in attendance. So again, you get into this, you know, absent days were not capped at that point. And so they were able to bill that. And then in July, CARES Act dollars were made available for childcare providers. And we were at about $20 million for the CARES Act dollars. And you'll see the grid on the top of the second page that really outlines how those were allocated and are being expended. And then again in August, several schools continued remote learning when they resumed. And so we notified providers that they could bill childcare subsidy during that time if they were assisting children with remote learning. So when you get into the CARES relief package, so those-- that early part, as soon as the pandemic hit, these were

early reliefs that we worked to provide. Governor gave executive order that allowed us to do some of these pieces and then we get into the CARES relief package. And so if you flip to the second half of the second page, there's a grid that tells you how those were obligated, how those have been expended, and what has-- what remains to date. And so there were some like stabilization grant funds. We had providers who had had difficulty. Obviously, they had lost revenue. They had difficulty keeping their doors open or even on the-- on number three, they had to close, but intended to reopen, but they needed some more support to do so. So these were ideas that were put together by a collaborative that said this is what we're hearing. This is what we see the biggest needs are. We partnered with NCFF and a couple others. And this-- this was really what was designed and proposed. And so these are the CARES dollars thus far that we were given in July.

**M. CAVANAUGH:** So the unspent dollars, some of these seem like they might not, just based on how long we've been in the pandemic, like the number three, we've spent $60,000, but we have $940,000. So if-- if those dollars continue to maintain at that-- at that rate, is there a plan to reabsorb them into one of these other categories?

**STEPHANIE BEASLEY:** To redistribute, we could do that, absolutely.

**M. CAVANAUGH:** So this $20 million will be spent in one of these categories.

**STEPHANIE BEASLEY:** Yes and we have a period of time to spend this. It's--

**M. CAVANAUGH:** And what-- how long-- forgive me, I know we had until December and then it was extended. So how long do we have to spend these dollars?

**STEPHANIE BEASLEY:** I can get the answer for you on that. I think it's three years, but I will-- I'll verify.

**M. CAVANAUGH:** OK, thank you.

**ARCH:** Other questions? Senator Murman.

**MURMAN:** Thank you, Senator Arch, and thank you, Ms. Beasley, for coming in and testifying. I think statistics show that overwhelmingly

children do better if they're at home with their father and mother, two parents, do better in school, do better in society, and do better, have less behavioral health problems. So I applaud you for your support of families. Do you agree with what I just said?

**STEPHANIE BEASLEY:** I think that data would show that-- that having too involved parents, right, is certainly a win for kids. Yes.

**MURMAN:** And on your previous-- the testimony on the previous bill, I think you testified that there was, I'm not sure if it's families or children, 20,000 eligible and I think 12,000 took the funding or received the funding.

**STEPHANIE BEASLEY:** Yes, to our-- yes. Yes, Senator.

**MURMAN:** Would it be more fair if the families or the children that didn't receive the funding also received funding because their one or two parents, probably most likely two parents, stay home and take care of their their own kids? Would that be more fair if they also received funding?

**STEPHANIE BEASLEY:** Yeah, so, Senator, thanks for that question. It's been a question that we've-- we've discussed at CFS. We really don't know. They're authorized, they're eligible to receive childcare subsidy. What we don't know is why they aren't doing it. And so is it that they're utilizing family, they have made arrangements within their family to, you know, one parent covers a different time, but but ultimately, we're not sure why they're not utilizing. The fiscal notes, etcetera, that we put together are based on those who are utilizing the childcare subsidy, not those who are authorized. And so but-- but certainly they're eligible, but we don't know why they are not using it.

**MURMAN:** OK, thank you very much.

**ARCH:** Thank you. Other questions? I have one. On the last page of your handout here, you talk about relief package II. It appears as though the state will receive another $60 million that can be used and it identifies the five bullets below, Funds may be used for these these various things. And you are-- you are to provide a plan.

**STEPHANIE BEASLEY:** Yes.

**ARCH:** Of how these funds will be spent within 60 days of enactment. So is that 60 days from December 27 when the bill was passed? What-- but you didn't receive notice, official notice until February 3 so you didn't know the amount of money. Do you-- do you have a 60-day clock running right now from December 27?

**STEPHANIE BEASLEY:** I'm not sure what the due date is, but I can confirm that. But I know the team is working on a plan. We had estimates that we believed we might receive, and so they have been working on how that-- how that could be expended. But we don't-- we didn't have guidance.

**ARCH:** We didn't have the exact number.

**STEPHANIE BEASLEY:** And we didn't have federal guidance on exactly what could be expended upon.

**ARCH:** But this-- but this is a one-time-- this-- this is a one-time grant.

**STEPHANIE BEASLEY:** Yes.

**ARCH:** That-- and it says here the funds must be obligated by 9-30 of 2023. So you've got a couple of years. You've got a couple of years to spend the dollars, but there'll be $60 million there to spend in some type of childcare support.

**STEPHANIE BEASLEY:** Yes.

**ARCH:** Correct?

**STEPHANIE BEASLEY:** Yes, Senator.

**ARCH:** Well, I would-- I would say that when you, when you finalize that spending plan, that would be-- that would be another plan that we would-- we really appreciate seeing so we-- so we know what the-- what the department intends to do with that $60 million. And-- and if, yeah. That-- that would be-- that would be helpful.

**STEPHANIE BEASLEY:** Certainly, Senator. Thank you.

**ARCH:** Other questions? Seeing none, thank you very much for your testimony.

**STEPHANIE BEASLEY:** Thank you, Senator.

**ARCH:** Any other opponents for LB677? Seeing none, are there-- is there anyone that would like testifiy in a neutral capacity? Seeing none, written testimony received this morning from-- as proponents: Women's Fund of Omaha, Lincoln Chamber of Commerce, and Voices for Children. And-- if I can find my piece of paper. OK, I just had it. Lost my piece of paper. Geri, do you have another-- do you have-- you have another one on letters in support/opposition for LB677? Did we receive anything? Sorry, I misplaced that piece of paper. Find it after the hearing. Thank you. Yes, four proponents for LB677 letters of support, no opponents, and no neutral. Senator Linehan has waived-- has waived close on LB677. So this will close the hearing for this bill. We will now open the hearing for LB68. And Senator Day, you are welcome to open.

**DAY:** Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Jen Day, that's J-e-n D-a-y, and I represent Legislative District 49, which covers northwestern Sarpy County, including the areas of Gretna, southern Millard, and western Papillion and La Vista. I'm excited to be back in person today and here this morning to introduce LB68. This legislation makes permanent an executive order made by Governor Ricketts that changed the state's childcare subsidy program from one based on the attendance of the-- of the child to one based on the enrollment of the child in the program. This was done to stabilize Nebraska's childcare system in the un-- during the unprecedented uncertainty that providers were facing, with some losing as many as 40 percent of their enrollees overnight. In April when the executive order was implemented, Governor Ricketts stated that these changes would help ensure continued access to high-quality childcare, provide new job opportunities, and support local communities by making sure Nebraska has a strong childcare network throughout the state. He's been proven correct. It's important to note that this policy has been successful and served its intended purpose, with 59 percent of Nebraska childcare providers reporting that they had used this temporary rule change. Simply put, this policy is strengthening our childcare system by stabilizing payments to providers and providing access to care for working parents. I have a

fact sheet here if I could get a page. Thank you. This change was seamlessly implemented in part because it mirrors common billing practice in nonsubsidized childcare. The majority of childcare businesses bill families based on enrollment rather than by the days that their child attends. Our state childcare regulations make it difficult for providers to hold spots open for children that may only be in attendance 16 of the 22 business days a month, while-- while all of the providers' fixed costs, such as staffing and facility expenses, remain the same, whether the child is in attendance that day or not. Some providers do attempt to navigate this. However, many providers operate within tight margins and cannot balance this patchwork of reimbursement against their limited attendance slots and fixed costs. This issue resulted in many of our state's childcare providers declining to serve families participating in the childcare subsidy program. Having our state childcare subsidy structured in a way that disincentives participation of providers undermines the main objective of the program, which is to make it easier for parents to find and maintain childcare so that they can continue employment. In addition to the benefits for parents and children, this change is important for providers as well, and would come at a critical time in the health of Nebraska's childcare system. In the Buffet Early ChildhoodIinstitute's 2020 Early Care and Education Provider Survey conducted in August, nearly half of all respondents reported that they were at serious risk of permanent closure due to the pandemic. Our childcare system has been hit especially hard by COVID, and this kind of economic fallout will take time to repair. Our providers will need stability while the workforce economy recovers after the COVID-19 emergency. I recognize that the fiscal note on this bill-- on this bill may cause initial concerns for some of you. But I would ask you to consider the strong likelihood of more available federal funds to support the increase in LB68. In the current version of the next round of COVID relief legislation that just passed the first round vote in the Senate, there's a $15 billion increase in the Child Care and Development Block Grant. Additionally, the Republican stimulus proposal contains an even larger increase in the Child Care Development Block Grant at$20 billion. Federal aid for the childcare industry has strong bipartisan support and is likely to be implemented in the upcoming relief legislation, regardless of compromise on part of Democrats or Republicans. To put the aforementioned 15 and 20 billion in perspective, the first round of CARES Act funding only included $3.5

billion in Child Care Development Block Grant increases. So it's reasonable to-- reasonable to expect that our state will be looking at significant flexibility in funding in this area, and it's likely we won't have to dip into General Funds for this bill. It's also worth mentioning that since September 2019, the state Department of Health and Human Services has allowed a child in the program to miss up to five days a month while still being reimbursed. We think this is a good regulatory step and applaud this move. But this also gives us reason to believe that looking at the full 12-month cycle in the fiscal note that covers the period before and after this change might have led to a higher cost projection. That being said, we as a Legislature have had long stretches where we've underfunded our childcare system in the past and there were already strains in the system before COVID. Lastly, it would also serve us well to think about these funds in the broader context of economic concerns. In August, the University of Nebraska Bureau of Business Research found that a lack of affordable childcare for parents had significant effects on productivity, resulting in losses and increased costs for businesses that stem from parents having to call in sick, reduce hours, or quit jobs. Statewide, this reduced income by $639 million, which resulted in a direct net decrease in state taxes of $21.1. This program could be compounded as we-- as we reopen, as according to the U.S. Chamber of Commerce, 32 percent of employers have seen employees leave the workforce because of childcare and health concerns. In this context of a potential statewide crisis, in the event that we let childcare providers fail, I consider a $26 million fiscal note much easier to digest. The best part of LB68 is we already have evidence that it's working well and providing an essential lifeline to providers and parents. Let's take this opportunity to solidify this new stability in our state's childcare system and move LB68 forward. And with that, I will answer any questions.

**ARCH:** Thank you. Are there questions for Senator Day? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you, Senator Day. I have to admit that even though I've worked in childcare and I have children in childcare, it took this pandemic for me to know that we weren't doing the reimbursement based on registration, but based on attendance, which how do you run a business like that? You-- you own a gym.

**DAY:** Right, right.

**M. CAVANAUGH:** You have monthly fees, right?

**DAY:** Right.

**M. CAVANAUGH:** So if somebody comes once or comes 30 times.

**DAY:** Would they still pay the same amount?

**M. CAVANAUGH:** Yeah.

**DAY:** Yes.

**M. CAVANAUGH:** That's how you--

**DAY:** It would be impossible to.

**M. CAVANAUGH:** Run a business.

**DAY:** --have any kind of projections for income when it's based on-- if it were to be based on a daily payment versus a monthly type payment. And I don't know how some childcare providers do that. Again, I didn't know this until the pandemic either. And I also used to work in childcare. So I see it as very problematic--

**M. CAVANAUGH:** So--

**DAY:** --that this is how we pay providers.

**M. CAVANAUGH:** --some of the numbers that you talked about. You said that this results in $639 million annually in wages that we're missing or could you--

**DAY:** Correct.

**M. CAVANAUGH:** OK.

**DAY:** Yeah.

**M. CAVANAUGH:** And so that's $21.1 million annually--

**DAY:** In--

**M. CAVANAUGH:** --Income tax.

**DAY:** Correct. Lost.

**M. CAVANAUGH:** Lost for the state.

**DAY:** Correct.

**M. CAVANAUGH:** And so assumedly that also would include sales tax, because if $639 million are not being made in income,--

**DAY:** Then they're not spending--

**M. CAVANAUGH:** --you're not spending.

**DAY:** --the money.

**M. CAVANAUGH:** And then additionally,--

**DAY:** Right.

**M. CAVANAUGH:** --if you're not making that income, you're likely receiving other social benefits, such as SNAP.

**DAY:** Right.

**M. CAVANAUGH:** OK. So just interesting. Just the $21 million alone is almost the same as the fiscal note.

**DAY:** It would pay essentially.

**M. CAVANAUGH:** Yeah.

**DAY:** Yes.

**M. CAVANAUGH:** OK, thank you.

**DAY:** Yeah. Thank you.

**ARCH:** Other questions? Seeing none, thank you very much. First proponent for LB68.

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

**ADAM FESER:** Chairman Arch and members of the Health and Human Services Committee, my name is Adam Feser, A-d-a-m F-e-s-e-r, policy adviser representing First Five Nebraska. I'm grateful to have the opportunity to speak in support of LB68 and to thank Senator Jen Day for introducing this bill. We believe LB68 would be a positive development for childcare providers and children at risk in Nebraska. As you know, childcare marketplace offers relatively little financial security for early childhood professionals who own and operate their own programs. For these businesses to thrive, they need reliable sources of revenue. Typically, providers bill families for enrollment rather than attendance. As a father of three little guys, I can tell you that's definitely a fact. So you pay for the slot regardless of whether or not your child's there. You go on a trip or whatever it may be, maybe a child is sick, you're still paying for your slot. So this creates a consistent revenue stream that enables childcare owners to pay staff, rent, mortgage, utilities and then any other business expenses they have. However, for providers who care for children through the childcare subsidy, those children that are most at risk of falling behind before kindergarten, they're only able to bill subsidy for the hours the children are in attendance. And I should also mention that, I think Senator Day mentioned it. But the new regs will allow for billing for-- for up to five absence days after this executive order expires after the emergency declaration, definitely a step in the right direction. But that means providers who accept the subsidy can experience considerable uncertainty in their cash flow when subsidy-eligible-- eligible children are absent or family schedules change. As a result, many providers are disinclined to accept subsidy or they may limit the number of slots that they have for subsidy children. That creates a greater burden for the families to try to find it, but also reduces the amount of quality providers willing to accept it. If you have the ability to have a waitlist with all private pay families, what's your incentive to accept subsidy when it's greater administrative burden and also more uncertain? So we did have some letters that were submitted. I wanted to highlight some of the language from one from Adrianne Agulla, who owns Hamilton Heights Child Development Centers. She wasn't able to testify today, but I thought she did a really nice job of laying some of this out. So our centers are for profit and operate at extremely thin profit margins, under 10 percent, even the best of times. Our break even point is roughly 80 percent utilization. So that means there is the percentage

of capacity before they get full payment. So if they have-- if you have 80 percent of your capacity at full-time slot payment, then you're-- they're breaking even. Because utilization is so critical, private pay families must commit to pay their weekly tuition regardless of attendance. The current model of only reimbursing subsidy providers for attendance makes it risky for providers to enroll children who use it. Their enrollment occupies a full spot of capacity, while often not returning a full slot of tuition. This presents variability in the business model that is unsustainable at thin profit margins. So that was from a letter. You have the letters that I just really wanted to highlight that because I thought she did a really nice job of provider's perspective how it matters. So LB68 would address this concern and make it financially safer for childcare businesses to accept childcare subsidy. I also wanted to thank Governor Pete Ricketts and Child Development Fund team for their various efforts to minimize childcare closures in the pandemic. And you've heard about a lot of these things today, particularly Executive Order number 20-18, which enacted this very policy we're talking about. There's also provider grant support for PPE, things like that. LB68 offers the opportunity to continue this insightful policy and enhance our early childhood infrastructure overall. Access to quality care in the early years has positive lasting impacts, particularly for children at risk. LB68 removes a barrier to quality providers accepting the subsidy and supports those who already do. We hope you will advance LB68 to General File. With that, I'll open myself up to any questions.

**ARCH:** Thank you. Are there questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. I have a really important question. Did your new colleague inform you that you were testifying in front of the best committee in the Legislature?

**ADAM FESER:** I, I think not not to be a kiss up or anything, but I already agreed. I already knew all that with all my experience in here. But, yeah, we were extremely pleased to have former Chairwoman Howard on our staff. And she brings a ton of experience and knowledge that-- more than I'll be able to accumulate in decades I'm sure, so we are pleased with that. Thank you.

**M. CAVANAUGH:** Thank you for your testimony.

**ARCH:** I do have a question.

**ADAM FESER:** Sure.

**ARCH:** You mentioned that the new regs will pay for five absent days. These are regs. These are proposed regs that are [INAUDIBLE].

**ADAM FESER:** They have been approved, I believe. But they-- they've been approved. But that won't go into effect until after the executive order is no longer operative, which would be 30 days after the emergency declaration is lifted.

**ARCH:** So then roughly 23 days of day care in a month. I mean, assuming a five-day, a five-day schedule could vary. But a five-day schedule, roughly 23 days. So 5 out of 23 days could be absent. And so then-- then it would be paid then at that.

**ADAM FESER:** And I think so one-- one other-- one difference in here would be say the amount of hours you're in childcare for a day might be not absent, but it might not be the full amount you were hoping for. So that would be one difference. Another difference would be there's an administrative burden to having to track hours. And so for some providers that have a lot of subsidy children, that means trying to have a staff person to do it because it's a lot to track. But I also-- I think that might be a worthwhile question to ask. If they're already planning to allow for billing up to five absences, that seems like the note might be larger than it would have to be if they're already planning on that. But that-- you could-- that would be something, I guess, for the department.

**ARCH:** OK. All right. Thank you. Next proponent, please. Welcome.

**NICK BROTZEL:** Thanks. Chairman Arch and members of the Health and Human Services Committee, my name is Nick Brotzel, that's N-i-c-k

**ARCH:** I'm sorry, I can't hear you.

**NICK BROTZEL:** Sorry, we'll try this.

**ARCH:** OK.

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

**NICK BROTZEL:** My name is Nick Brotzel, that's N-i-c-k B-r-o-t-z-e-l. And I'm here on behalf of the Children's Respite Care Center, or CRCC, here to testify in support of LB 68. And I want to thank Senator Day for offering this bill and for her strong leadership and advocacy on behalf of Nebraska children and early childhood educators. A bit just briefly about CRCC. We provide comprehensive educational, nursing, and therapeutic care for children with special needs through behavioral health day and weekend programs. The children we serve have among the most medically complex care needs in the region, needs which cannot be met in traditional care settings. We are in many cases the only option for many of the families we serve. Upwards of 30 percent of our daily day program census, or approximately 200 children, is comprised of clients served by the Nebraska childcare subsidy program. Now, as you can imagine, the COVID-19 pandemic has had an outsized impact on the families we serve, given the medical fragility of the children in our care. Now, by way of reference, our census in May 2019, this is a daily census, number 196 clients. Our census in May 2020 numbered 96. While our census has stabilized since the early days of the pandemic, our monthly enrollment numbers remain down by over 20 percent when compared to the previous year, and we are not alone. As the members of this committee are all too well aware, the early childhood care industry in Nebraska is in crisis. According to numbers released in June of last year, the state of Nebraska has realized a 24 percent decrease in the number of children being served by childcare subsidies. As we've heard from Senator Day and the testifier before me, the economic impact of these childcare closures cannot be overstated. A lack of affordable childcare options means that Nebraska wage earners are leaving the workforce. And keep in mind, as I know you all do, Nebraska is home to among the highest percentage of dual wage earners in the nation. And even those families who have up to now successfully juggled full time employment, in-home learning, and childcare will be forced to make difficult decisions as they are asked to return to traditional work settings in the coming days and months. Make no mistake, our state cannot effectively reopen and our state's economy will not fully recover without the help of a robust childcare system. LB68 more closely aligns Nebraska to childcare subsidy billing practices in states across our region especially, and we think this is really critical, as it relates to children with chronic health conditions. I ask that you please vote to move LB68 out of committee

and on to the full body for debate. Thank you for the opportunity to be here today, and I'm happy to try to address any questions.

**ARCH:** Thank you. Are there questions? Senator Cavanaugh.

**M. CAVANAUGH:** I just feel like I have to ask this testifier some questions. First of all, how was drop-off this morning?

**NICK BROTZEL:** It was good. Yeah, thanks.

**M. CAVANAUGH:** Any fits?

**NICK BROTZEL:** No. Everyone was great. They knew we both had to be here today.

**M. CAVANAUGH:** That's good. I'm glad. I know so much about this because of most of what you said today and because I've heard from your work and I've seen firsthand how this has impacted the population that you serve. So thanks for being here.

**NICK BROTZEL:** Thank you.

**ARCH:** Other questions? Seeingy none, thank you very much for your testimony. Next proponent for LB68. Welcome back.

**QUENTIN BROWN:** Hi. Thanks for having me back. Quentin Brown, Q-u-e-n-t-i-n B-r-o-w-n, still with Educare Lincoln. And as I shared earlier, Educare is a quality early childcare. Oh, actually, thank you again for having me back and Chairperson and committee. But as I said earlier, Educare Lincoln is a quality early childcare education program, serving over 165 children and their families with high-quality supports. And we employ over 55 dedicated teachers and other professionals. We are able to sustain our work thanks to generous funders, supporters, partners, and various funding streams like childcare subsidy, all of which depend on organizations like ours to enroll as many children and families as we can and support them on the way to lifelong success. And I am more than confident saying that despite a challenging year, we have all demonstrated our ability to step up to that challenge. What we cannot afford is for funding sources to unintentionally burden us financially for children who are physically absent due to any number of credible short-term factors. And I certainly get it. For some, the argument may be if customers and

clients aren't there, why are they paying? And I can hear that question in the atmosphere, so to speak. But the fact is, for our team of professionals, they are not just doing this work because they have to. It's because they care. So whether it's reaching out to understand why a child is absent for a day or a few days, sending home a care package or learning activity or a number of other contacts that we routinely make, our team is still working on behalf of that child or children, even when they are not physically present. I appreciate the executive order by Governor Ricketts in April of 2020, which allowed for enrollment-based reimbursement on a temporary basis. It without question sustained a number of organizations like ours during the critical work of supporting our local workforce. As similar to my prior testimony, I ask that you look favorably-- favorably upon LB68, as it will extend the benefits of the recent executive order allowing Educare and many other organizations to continue doing the work that we all now realize we depend so heavily on. Thank you.

**ARCH:** Thank you. Are there questions? Seeong none, thank you very much--

**QUENTIN BROWN:** Thank you all.

**ARCH:** --for your testimony. Next proponent for LB68. Welcome.

**AMARA MADSEN:** Thank you. Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Amara Madsen, that's A-m-a-r-a M-a-d-s-e-n, and I'm a service director at CEDARS Youth Services, a child welfare organization that works to ensure that all kids have a safe environment where they can grow and thrive. CEDARS is in strong support of LB68, and we'd like to thank Senator Day for introducing this legislation. Within our vast array of services for children and families. CEDARS operates three programs here in Lincoln that are eligible to receive payment through the childcare subsidy program. These include our early childhood development center on North 27th Street and the Community Learning Centers at both Clinton and Hartley elementary schools. All three of these programs are state licensed and nationally accredited programs that provide early and ongoing developmental opportunities in an inclusive environment to help provide a foundation for lifelong learning and success. Last year, CEDARS served 139 children in these three early childhood and school-age childcare programs; 63 percent or

a total of 87 children served in the last year received childcare subsidy. As such, our agency is impacted by the changes proposed in LB68 and believes that they are a positive and important step toward improving access to quality care and education for children in low-income families. As you've heard, the proposal in LB68 would make permanent a change that has been in place during the current COVID emergency. And our center and the families we've been able to continue serving have experienced the benefits of this change firsthand. Whether or not a child is attending our childcare center that day, we have held a spot for that child and have invested in the infrastructure to provide that child a first-class education and quality care. If a child comes to our facility through a private pay family, we rely on that family paying per day their child is enrolled, not per day their child attends. And that same policy only makes sense for kids receiving childcare assistance. A model in which providers are only reimbursed when a child attends care creates a significant disincentive for providers to serve families receiving state subsidy due to the financial loss sustained when a child is absent. We see a correlation between children from low-income families and increased absenteeism. Many of our childcare assistance families work in jobs that do not have a set or consistent schedule and can result in irregular childcare needs. Prior to the COVID pandemic, there was an average absentee rate of 14 percent for children receiving state subsidy who were served in our early childhood development center. That was a net loss of $35,000 per year for this one program. The absentee rate in our community learning centers, school-age childcare programs is even greater. This financial impact has resulted in CEDARS needing to downsize and even close childcare programs in recent years. For many providers, it often means limiting the number of slots available to low-income families on childcare subsidy. By permanently moving to a pay per enrollment rather than a pay per attendance model, CEDARS would be able to continue our participation in this important program. In short, LB68 alleviates a primary barrier to providing high-quality childcare for low-income families. Thank you for your consideration of this bill.

**ARCH:** Thank you. Are there any questions? Seeing none, thank you very much for your testimony. Next proponent for LB68.

**JP LAUTERBACH:** Take this off this time. I struggled with it a little bit last time so. Well, good morning again, Senator Arch and members

of the Health and Human Services Committee. Again, I'm JP Lauterbach, and that's J-P L-a-u-t-e-r-b-a-c-h. And once again, I'm the COO of the YMCA here in Lincoln, Nebraska. On behalf today of the state of Nebraska Alliance YMCAs, I'm here to speak to you about the importance of LB68. And we also thank Senator Day for introducing the bill, and we are here to register our support. LB68 would allow childcare providers who accept the subsidy to account for student enrollment rather than attendance, which helps with staffing stability and would solidify our childcare infrastructure across-- across crosswise all over the state. I'll repeat quickly some earlier testimony given for LB485 about the Y. We are a leading nonprofit committed to strengthening communities through youth development, healthy living, and social responsibility. We have been a presence in Nebraska for over 150 years; and through the work of 14 Y systems across the state, we provide programs and services in over 300 Nebraska communities. The Y has been a leader in the childcare field for over four decades. And we are vested in the well-being of our state's children, from their first steps as a toddler to crossing the stage of graduation. Over 50 percent of our members and program participants are under the age of 18. They participate in youth sports, camping, childcare, before- and after-school programs, after-school enrichment, teen outreach, and teen leadership programs designed to keep kids safe and-- keep kids and children safe, engaged and encouraged to discover who they are. LB68 is incredibly helpful as we staff our childcare areas and plan for the needs of our children and families. As has been mentioned, during the pandemic we have been able to utilize the provisions that LB68 is now seeking to make permanent. The ability for childcare providers to account for child enrollment rather than actual attendance will help stabilize our childcare infrastructure throughout the state. And the small change has helped with employment in the childcare field and to keep many providers afloat through the pandemic. This change will also help working families and youth in the sense that our facilities will be fully staffed and stable with consistent employee expertise in the childcare field. Without this change, there is just more day-to-day uncertainty on attendance and how to staff appropriately for that. The Y is committed to doing our part so more children can reach their potential and more families can thrive. Once again, thank you for your time and ask for your support of LB68. Thanks again, Senator Day, and to the committee for your time. And I'll try to do my best to answer any questions.

**ARCH:** Thank you. Are there any questions? Seeing none, thank you for your testimony. Next proponent for LB68. Seeing none, are there any opponents of LB68?

**STEPHANIE BEASLEY:** Good morning again,--

**ARCH:** Welcome back.

**STEPHANIE BEASLEY:** Chairperson Arch and members of the Health and Human-- do you want me to wait until she--

**ARCH:** No, please.

**STEPHANIE BEASLEY:** OK. Good morning, Chairperson Arch and members of the Health and Human Services Committee. My name is Stephanie Beasley, S-t-e-p-h-a-n-i-e B-e-a-s-l-e-y, and I serve as the director for the Division of Children and Family Services within Department of Health and Human Services. I'm here to testify in opposition to LB68, which would require the department to amend the state plan for services to pay childcare providers based on a child's enrollment rather than on a child's actual attendance. It is anticipated that changing attendance to enrollment, as proposed in LB68, would result in an estimated annual state-funded fiscal impact of over $26 million in fiscal year 2021 to '22 and each year forward. At the start of the pandemic, DHHS began seeing the impact of COVID-19 on childcare providers. In March and April of 2020, at peak closures, approximately 18 percent of licensed childcare providers reported temporary closure during the pandemic. As a result, DHHS has worked internally and with external partners to be responsive to the impacts the pandemic has had on childcare providers and working families who rely on childcare subsidy assistance. The handouts provided summarize both actions DHHS took at the start of the pandemic, as well as additional supports created using CARES Act dollars. For example, Executive Order number 20-18 was issued on April 15, 2020, allowing licensed childcare providers to bill DHHS for unlimited absences related to the pandemic. This allowance is still in effect and will end 30 days after the Gov-- after Governor Rick-- Ricketts lifts Nebraska's COVID-19 state of emergency. In September of 2020 new regulations were promulgated in Title 392 of the Nebraska Administrative Code regarding the childcare subsidy program. These regulations allow childcare providers, both licensed and license exempt, to bill up to five absentee days per

child per month, not to exceed the weekly authorized amount. Currently, DHHS determines the number-- determines the hours per week a child is eligible for childcare and creates an authorization that reflects that determination. DHHS believes that supporting childcare providers is vitally important. The handouts provided demonstrate DHHS's response and commitment to support providers and families with our CARES Act funding and newly available Coronavirus Response and Relief Supplemental Appropriation-- Appropriations Act funding. Given the $26 million of state dollars needed for implementation, DHHS opposes LB68. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

**ARCH:** Thank you. Are there any questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So the $26 million is for FY '21-22. We're currently in the state of emergency. Are you anticipating that that is going to end soon?

**STEPHANIE BEASLEY:** The state of emergency?

**M. CAVANAUGH:** Yeah, the declaration that allows us to be under the executive order.

**STEPHANIE BEASLEY:** So it will end 30 days after the executive order ends.

**M. CAVANAUGH:** Right, but the-- your fiscal notice for the-- the biennium, and so that would assume that the state, we're no longer in the state of emergency with the executive order.

**STEPHANIE BEASLEY:** I believe that is with-- with-- with that assumption removed, yes.

**M. CAVANAUGH:** OK, so I guess I'm-- I'm asking, are we anticipating that the Governor is going to end this state of emergency?

**STEPHANIE BEASLEY:** I do not know that.

**M. CAVANAUGH:** OK, so there's a potential that there would be no fiscal note for this biennium if the state of emergency continues.

**STEPHANIE BEASLEY:** So ask the question, so if--

**M. CAVANAUGH:** So if the state of emergency and the executive order continue for the biennium, then this fiscal note won't exist. This is for--

**STEPHANIE BEASLEY:** The ex-- the expense still exists for the-- for the billing, the enrollment days. Billing the expense still exists. Now we do have a lower number of kids utilizing childcare right now, so we're covering that expense.

**M. CAVANAUGH:** So the issue is--

**STEPHANIE BEASLEY:** I'm not sure. I'm sorry, Senator. I'm not sure.

**M. CAVANAUGH:** Sorry. I guess we get back to the same issue again, that we're-- we just don't want to pay for more kids in childcare?

**STEPHANIE BEASLEY:** It's the fiscal impact that is the issue.

**M. CAVANAUGH:** But not putting more children in childcare because the bill--

**STEPHANIE BEASLEY:** Childcare is--

**M. CAVANAUGH:** --the bill seeks to put more children in childcare and to basically stabilize childcares that provide services to low-income families.

**STEPHANIE BEASLEY:** The bill seeks to allow billing for enrollment versus absent days and right now we have, based on our regulations last fall-- or I guess two-- a fall ago, we implemented regulations that said that you can bill for five absent days.

**M. CAVANAUGH:** Right.

**STEPHANIE BEASLEY:** So this--

**M. CAVANAUGH:** So I guess why are we doing that if we oppose-- if you oppose this bill? Because this bill is just continuing to do what you're already doing.

**STEPHANIE BEASLEY:** Well, it opens the door further.

**M. CAVANAUGH:** Right. But--

**STEPHANIE BEASLEY:** Right.

**M. CAVANAUGH:** --what you're doing right now is working, right?

**STEPHANIE BEASLEY:** During the pandemic?

**M. CAVANAUGH:** Yeah.

**STEPHANIE BEASLEY:** Yes.

**M. CAVANAUGH:** I mean, we just heard a bunch of testimony it's working.

**STEPHANIE BEASLEY:** Yes. Yes. At the peak of the pandemic, about 18 percent of providers were closing, and so this was a way for us to really sustain their income so that they were able to pay their staff and do all the things that they needed to do.

**M. CAVANAUGH:** So we've seen a few bills this session. Chairman Arch brought a bill on telehealth that has sought to codify into statute changes that we made as a result of the pandemic because we recognize that they were filling a need. And it sounds like this is filling a need and it's successful, so I-- I-- and it's something that DHHS did on their own. So I'm very-- I-- I'm confused why the DHHS wouldn't support this moving forward, because it's filling a need and it's working, so it's purely cost.

**STEPHANIE BEASLEY:** One of these issues is significant cost, yes. During the pan--

**M. CAVANAUGH:** What is the other issue?

**STEPHANIE BEASLEY:** Well, during the pandemic, we really lifted that because we wanted to ensure-- kids were being kept home for three weeks, four weeks, etcetera-- that they were able to bill. So ultimately, with the five days for-- I-- I understand what you're saying is that it is a solution that has worked during the pandemic. I think the five days was an addition that we added on in the fall, just recognizing that this was a need for people to be able to sustain so that people weren't taking their kids to the provider who were sick because they were worried about, you know, losing their slot, etcetera.

**M. CAVANAUGH:** Yeah.

**STEPHANIE BEASLEY:** But it is a significant impact fiscally.

**M. CAVANAUGH:** So just, I'm sorry, one more question. The fiscal note says due to system limitations DHHS is unable to identify if the provider is billing based on enrollment rather than attendance. So that to me says that you would actually have to create more infrastructure to go back to the way you were before, because if you can't tell-- so this seems like less of an administrative burden, in addition to serving more families and stabilizing childcare.

**STEPHANIE BEASLEY:** I can find out what the system limitations are. I think it's-- it's how that they're billing that we have-- we're unable to go and-- and right now look and see is this a-- that you have billing for absentee or you're billing for those who are--

**M. CAVANAUGH:** OK.

**STEPHANIE BEASLEY:** --attending.

**M. CAVANAUGH:** Thank you.

**ARCH:** Other questions? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch, and thank you, Director Beasley, for being here. I want to be sure that I'm-- I'm trying to understand this-- this difference with the five days that came into play this fall that does seem to me to be a step in the right direction that helps with that. Is-- is that change taken into consideration in the creation of the fiscal note that's in front of us?

**STEPHANIE BEASLEY:** I can verify for you, Senator.

**WILLIAMS:** Yeah, I-- I'm wondering if we're missing something in that; to look at that total cost, that would be helpful for me. Thank you.

**STEPHANIE BEASLEY:** Our costs have varied throughout this, and I can have that broken down. So implementation, so from April of '19 to March of 2020-- these are the 12 months prior to COVID-- our cost per child was 5-- about $513, then during COVID it jumped quite a bit. And then it-- it has come back down. We're-- we're having a hard time

really pinpointing why it's coming back down, because there are so many funds available right now. But I can find out very specifically for you, does this fiscal note include-- does it separate out the five days?

**WILLIAMS:** Yeah. Thank you.

**ARCH:** I would like to have a follow-up question. I was thinking along the same lines as Senator Williams here because as-- as I just ran a quick-- and just help me if I'm thinking correctly on this. If I just ran a quick calculation that if-- there's a weekly authorized amount per child per family. I don't know exactly how it's done, but DHHS is-- according to your testimony, determines the hours per week a child is eligible. So just for sake of-- of illustration, if a child is eligible for full-time care 5 days a week, full-- full-time, eligible for that, and assuming 4 days, 4.3 weeks, approximately 23 days, and 5 days then a child doesn't have to be present for the-- for the provider to be paid. Eighteen out of 23, I ran a calculation. It's about 78 percent. So a provider-- or I should say the child only needs to be present 78 percent of that-- of those days for the provider to be paid full-- in full. If-- if-- if I'm understanding this new regulation, and-- and I think that's what we-- you know, that-- that's really what we're struggling with here is that-- is there-- is there-- is the state responding to the issue of absent versus-- versus the bill that that specifies you're going to be paid on enrollment. This-- this seems to be a pretty significant step towards that-- that payment. So am I understanding that? Am I understanding that correctly in this new regulation?

**STEPHANIE BEASLEY:** For the 78 percent, yes.

**ARCH:** Well, 18 out of 23 days, if they're able to be absent 5 days, assuming s full time, and if they're even-- and if they are eligible for less days than-- than full-time, still 5 days, so it actually-- the percentage would even-- you know, it-- it would even be more significant. So at any rate, I'll-- I'll look into the regulation itself and-- and try to better understand that. But I guess along with Senator Williams' question that it is-- it is-- is that-- is-- is that really taking care of a lot of this issue? That's-- that's really my question, so--

**STEPHANIE BEASLEY:** Yeah. And I can make sure that we get the regulations to you and--

**ARCH:** Yeah, well, I'd appreciate that.

**STEPHANIE BEASLEY:** [INAUDIBLE] the program description.

**ARCH:** Thank you. Any other questions? Seeing none, thank you very much for your testimony today.

**STEPHANIE BEASLEY:** Thank you, Senator.

**ARCH:** Is there anyone else that would like to testify in opposition to LB68? Is there anyone that would like to testify in a neutral capacity to LB68? Seeing none, Senator Day, you're welcome to close. And as you come up, we had letters of support from nine individuals, associations and we had one in opposition. And written testimony received this morning on LB68 we had three proponents from Nebraska Children's Home Society, the Children and Family Coalition of Nebraska, and Voices for Children. Senator Day, you're welcome to close.

**DAY:** Thank you, Chairman Arch. So I think we obviously have several questions about the fiscal note, specifically as it relates to the five-day allowance. LB68 can't be both unnecessary because the extra five days are already being paid for and also extremely costly. So I think we need to get answers on that. And so I come at this obviously from a parent's perspective, but also as a business owner perspective. This bill is just about stability for providers and for what are a lot of small businesses in Nebraska that are childcare providers. We as a state already have a shortage of providers that will serve families who use the childcare subsidy. And the main reason for that shortage is because of the instability in the payments that they receive. It's-- it's virtually impossible to run a small business and maintain staff and facility when you are not sure how much you're going to be bringing in every month. So that's mainly what this bill is about. And then also, I just wanted to mention to Senator Murman's question earlier about families. And, you know, is it-- is it better for children to be at home with two parents? And I think that we all know that, yes, that's the ideal situation. But, you know, we don't live in Utopia and there's various different types of families that exist. Mine in particular, I-- I-- I was a single mom at one time and the

childcare subsidy was very important to me. And I think the decision to be a single mom is one of the reasons that I'm sitting here in front of you today with the ability to introduce this bill. So I think we have to make sure that we're supporting all different types of families in Nebraska and all different types of parents in-- in success in their lives. And also it's always about the kids and making sure that they have the care that they deserve at home and otherwise. So I'm happy to answer any other questions you have.

**ARCH:** Any further questions for Senator Day? Seeing none, thank you very much.

**DAY:** Thank you.

**ARCH:** This will close the hearing on LB68 and the hearings for the morning. And we will be back at 1:30 to hear bills this afternoon. Thank you.

**ARCH:** Good afternoon. Welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Day.

**DAY:** Jen Day. I represent Legislative District 49, which is northwestern Sarpy County.

**WILLIAMS:** Matt Williams from Gothenburg, Legislative District 36, Dawson, Custer, and the north portion of Buffalo Counties.

**ARCH:** I'm sure we'll have other members joining us shortly. Also, assist-- assisting the committee is one of our legal counsels, T.J. O'Neil; our committee clerk, Geri Williams; and our committee pages, Kate and Rebecca. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we will be hearing four bills and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make

closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill-- fill one out, hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, please see the new public hearing protocols on the HHS Committee's website at NebraskaLegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is correct-- is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and Transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table, chair-- and chair between testifiers. This committee has a strict no props policy. And with that, we will begin today's-- this afternoon's hearing with LB86 and welcome, Senator Bostelman.

**BOSTELMAN:** Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Bruce Bostelman. I spell that B-r-u-c-e B-o-s-t-e-l-m-a-n, and I represent Legislative District 23. I'm here today to introduce LB86, which requires the registration of each credential holder who is a prescriber or dispenser of prescription drugs, with some exemptions, into the prescription drug monitoring program by October 1, 2021. The exemptions include credential holders who do not prescribe or dispense drugs: veterinarians, active-duty members of the armed forces who do not

prescribe in Nebraska, retired credential holders, credential holders who are researchers and do not treat patients, credential holders who are faculty members of a college or university who do not treat patients, and finally, any other credential holders who do not treat patients. The purpose of this bill is to prepare Nebraska's prescribers and dispensers or federal law set to take effect on October 1, 2021. In 2018, H.R. 6, or the SUPPORT Act, was passed into law; and Section 1944 of that act requires each covered provider to check the prescription history of a covered individual being treated in a qualified prescription drug monitoring program. Section 3990 of the SUPPORT Act provide perpetual federal funding for states to upgrade and continue to operate their PDMPs as long as two conditions were met: (1) the state has implemented a PDMP; (2) a state has implemented penalties for the unauthorized use and disclosure found in the PDMP. With these two conditions met, should this bill pass, Nebraska could expect funding in perpetuity for our PDMP program. Finally, I would like to thank former Senator Howard for assisting me with this bill. She had carried this bill in 2019 with no opponents. I also would like to thank the Pharmacists Association and CyncHealth for their help with the language of the bill. With that, I ask for the advancement of LB, LB86 to General File. And I'll be happy to answer any questions that you may have.

**ARCH:** Thank you. Are there any questions? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. And thank you, Senator Bostelman. Can you help me a little bit with the the fiscal note on this or somebody behind you--

**BOSTELMAN:** Sure.

**WILLIAMS:** --if that works better? Because what I'm understanding you saying if we qualify, that fiscal note--

**BOSTELMAN:** Goes away.

**WILLIAMS:** --goes away. Right?

**BOSTELMAN:** I think majority of it. Maybe someone behind me will say maybe there's a small portion, but I believe the entire thing goes away. Yes.

**WILLIAMS:** That's what I wanted. Thank you.

**BOSTELMAN:** Yes.

**ARCH:** Any other questions? Seeing none, are you going to stay to close?

**BOSTELMAN:** Yes.

**ARCH:** OK, thank you. First proponent for LB86. Is there anyone wishes to testify as a proponent? Seeing none, any opponents for LB86? Welcome.

**FELICIA QUINTANA-ZINN:** Hello. Good afternoon, again, afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Felicia Quintana-Zinn, F-e-l-i-c-i-a Q-u-i-n-t-a-n-a-Z-i-n-n, and I am the deputy director of the Division of Public Health within Department of Health and Human Services. And I'm here to testify in opposition of LB86 and would-- which would, with limited exceptions, require prescribers and dispensers to register for the PDMP or the prescription drug monitoring program, PDMP, as a condition of a new application and renewal of credential. One reason that the agency opposes this bill is that it would mandate all prescribers and dispensers to register with the PDMP by October 1, 2021. The department opposes additional mandates on providers as DHHS already mandates the dispense prescriptions-- that dispense prescriptions be reported daily to the PDMP. Therefore, additional requirement is not necessary. If enacted, LB86 would require registration beginning October 2021 and this is a very short time frame given the large number of persons who would need to be registered. Currently, approximately 4,500 out of 18,000 licensed prescribers, or about 25 percent, have completed the registration process. The percentage of licensed pharmacists or dispensers is similar. Approximately nineteen-- or 1,920 out of 5,200, or approximately 37 percent, have completed the registration process. This leaves nearly 16,800 persons to be registered within a few months. The licensure unit is currently modernizing the credentialing software and would need to adjust current customizations and timelines already underway in order to meet the requirements set out in this bill. Both the PDMP registration and the updates needed to current-- to the current modernization projects will be time and resource

intensive to accomplish by the current implementation date. However, a schedule that resembles the current biennial licensing renewal process would be less burdensome. For example, physicians are required to renew on October 1 in even years; dentists on March 1 in odd years; pharmacists on January 1 in even years, etcetera. Extending the registration time frame would give DHHS staff more time to set up appropriate processes, procedures, and technology requirements to register prescribers and dispensers and develop capacity to appropriately share registration information within DHHS to meet LB86 requirements. The additional time could also be used to educate licensees about the new requirements and provide a user-friendly way to register and renew their licenses. DHHS also has concerns with LB86 requirement on new applicants and renewals. By statute, in order to register for the PDMP, the registrant must have a current and active license. However, as noted in this bill, in order for the registrant to be credentialed, they must first be registered to the PDMP. This presents a paradox and in order to meet both requirements, credentialing would need to have a window, for example, of 30 days for registration to be completed so professionals can maintain their licenses. Currently, if you register for the PDMP, you do not need to renew your PDMP registration, unlike prescribers' and dispensers' licenses which need to be renewed biennially and do not currently require PDMP registration. However, LB86 would require PDMP registration renewal as a condition for maintaining the professional credential. And this would require the creation of additional processes and technology changes to adequately document and monitor PDMP renewals, plus additional staff time and resources. In summary, LB86 would require more staff resources than DHHS is able to provide due to the bill's short time frame for registering all prescribers and dispensers in the state. We respectfully request that the committee not advance this legislation and thank you for the opportunity to testify today. And I'd be happy to answer any questions.

**ARCH:** Questions? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. And thank you, deputy director, for being here. In Senator Bostelman's opening presentation, he talked about qualifying by October 1, 2021, to receive federal funding. Do you agree that that would be in the best interest of Nebraska to meet that deadline?

**FELICIA QUINTANA-ZINN:** So I think you can register for the PDMP, which we currently have, without needing to require a mandate. And that's-- that's the biggest piece here is-- is the mandate piece.

**WILLIAMS:** So you-- it seems to me that you have a question about the mandate, but then also the, the timeline of--

**FELICIA QUINTANA-ZINN:** Yes.

**WILLIAMS:** --of the registration and getting that done.

**FELICIA QUINTANA-ZINN:** With regards to adding it to renewal credentialing requirements,

**WILLIAMS:** Assuming work that detail out, but then finding a way to do that.

**FELICIA QUINTANA-ZINN:** Um-hum.

**WILLIAMS:** If that timeline was given more time to implement on a, would that reduce what you believe would be your cost at HHS to do this implementation?

**FELICIA QUINTANA-ZINN:** No. The-- the-- the cost that's associated with this is primarily staff time, and that's still going to be needed with regards to making sure that people have the questions that they have that they ask us answered and appropriate time frames and then making updates to our systems that we would need to update.

**WILLIAMS:** But you certainly see the value of the PDMP.

**FELICIA QUINTANA-ZINN:** Yes.

**WILLIAMS:** Thank you.

**ARCH:** Thank you. Other questions? I have one and you may not be able to answer this question, but--

**FELICIA QUINTANA-ZINN:** OK.

**ARCH:** --one of the things that Senator Bostelman said was that there is a federal requirement that-- that prescribers be able to, and I'm

going to paraphrase here, be able to look up other meds that the patient is receiving.

**FELICIA QUINTANA-ZINN:** Um-hum.

**ARCH:** If-- if not in the PDMP, if not-- if not enrolled through that, do you have any idea how a provider would be able to do that with-- with the systems not necessarily talking to each other all the time?

**FELICIA QUINTANA-ZINN:** So they can still enroll and register for the PDMP. It's just that they wouldn't be mandated. So if-- if the mandate isn't there, like they can still currently register for the PDMP and they--

**ARCH:** I see. It's the mandate.

**FELICIA QUINTANA-ZINN:** --would still be able to make up that information.

**ARCH:** It's the mandate.

**FELICIA QUINTANA-ZINN:** Yep. Um-hum.

**ARCH:** So right now you're receiving information from the pharmacy, not from the prescriber.

**FELICIA QUINTANA-ZINN:** Correct. So PDMPs receive the dispensed prescriptions from the pharmacies daily.

**ARCH:** Thank you.

**FELICIA QUINTANA-ZINN:** Um-hum.

**ARCH:** Other questions? Senator Walz.

**WALZ:** Yeah, I'm-- I'm still going to follow up on your question regarding the communication and their ability. Did that answer? Did I miss that?

**ARCH:** It ans-- it did for me, yes.

**WALZ:** OK.

**ARCH:** Yeah.

**WALZ:** So if it's not mandated, even if it's not mandated they'd still have the ability to have that communication and--

**FELICIA QUINTANA-ZINN:** Um-hum.

**WALZ:** OK. All right. Thank you. Sorry.

**ARCH:** Any other questions? Seeing none, thank you for your testimony.

**FELICIA QUINTANA-ZINN:** Thank you very much.

**ARCH:** Any other testifiers in opposition to LB86? Seeing none, anyone want to testify in a neutral capacity?

**KEVIN BORCHER:** Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Kevin Borcher, K-e-v-i-n B-o-r-c-h-e-r, and I'm testifying in a supportively neutral capacity to LB86. I'm testifying here today as a prescription drug monitoring program director at the Nebraska Health Information Initiative, or NeHII, now doing business as CyncHealth. The value of PDMPs across the country is recognized on both federal and state levels. Several federal agencies recommend and support the use of the PDMP. As was mentioned through the CMS quality payment program Merit-based Incentive Payment System, a big word, the MIPS program, a measure for performance requires the prescriber to check the PDMP for Medicare recipients beginning in 2022. Currently eligible hospitals, eligible providers receive bonus points for these, and it will be required in 2022. In the SUPPORT for Patients and Communities Act signed into law October 2018, prescribers will be required to check the PDMP for Medicaid beneficiaries prior to prescribing an opioid or other controlled substances beginning October of this year based on state requirements. Registration is the first step in ensuring providers' success in this process. Pharmacists understand the benefits of reviewing not only the patient's opioid and other controlled substance prescriptions, but in Nebraska, having the access to view all dispensed prescriptions for a more thorough and comprehensive picture of the patient's medication history. This is important for medication reconciliation systems that clinicians use and contributes to safe clinical care everyday through avoidance of medication errors. In

addition, a comprehensive medication history improves outcomes by preventing medication errors that lead to extended hospitalizations. As of January, there were 46 states which require prescribers or pharmacists to either register with or queried their state PDMPs. In Nebraska, there are approximately 4,800, I'm sorry, 4,500 of over 18,000 or about 25 percent of the allowed prescribers and around 2,400 of 5,072 or 47 percent of pharmacists who have voluntarily registered to use the PDMP. While these healthcare providers are seeing the value of the PDMP, there are others that, as one physician told me, don't know what they're missing. By offering clinicians access to this valuable tool, we're enabling providers to have ready access, which will soon be a required process for full reimbursement. LB86 helps align the Nebraska PDMP with federal policy and regulations by supporting access to check the PDMP. I thank you for allowing me to speak today. I'm honored and fortunate to be Nebraska's PDMP director in keeping Nebraska's successful implementation of the PDMP noticed across the country. With your help, we can continue to build on the strong foundation that the Nebraska Legislature, that it's created for the PDMP. With that, I would be willing to answer any questions you may have. I'd be glad to expound upon Senator Williams' question earlier. There was one piece of the fiscal note you had mentioned, and I-- I can't really speak to the DHHS FTEs, but they do mention that the PDMP contractor, which is CyncHealth, would take approximately 4,100 hours. If we had an amendment to this bill to require prescribers to include their NPI and DEA numbers, that could automate that process and cut down the number of hours significantly, which is currently manually. And our estimate is going from that 4,100 hours to less than 1,000 hours.

**ARCH:** Thank you. Are there questions? I do have a question, just a second here. So is there-- is there any other way for the prescriber to meet the requirements, you said now in 2022 for everything, to meet the requirements in 2022 other than through the PDMP? Is there another way that prescribers could meet that requirement?

**KEVIN BORCHER:** The federal requirements mandate that they check the PDMP. Now sometimes that could mean that the PDMP is integrated into the HIE or the EHR and that would allow for that instead of having to go to a separate system.

**ARCH:** But it's still the PDMP.

**KEVIN BORCHER:** It would still have to be the PDMP through that integration.

**ARCH:** Oh, I see. So if it is integrated into the EMR, then they wouldn't necessarily have to enroll in the PDMP at that point?

**KEVIN BORCHER:** They would still-- my understanding is they would still need to enroll as a prescriber or dispenser to access the PDMP and then that would help to meet the requirement.

**ARCH:** Even if it's integrated into the EMR.

**KEVIN BORCHER:** That would be my interpretation.

**ARCH:** OK. So I guess what I'm hearing is they're going to do this by 2022. Whether we mandate it, don't mandate it, they're going to have to-- they're going to have to get into the PDMP to meet the requirements, the federal requirements that will take effect.

**KEVIN BORCHER:** I believe so.

**ARCH:** OK. So cost, the cost to the prescriber. There's only 25 percent right now. You're getting information from the pharmacies. The cost to the prescriber for enrolling in the PDMP and staying, maintaining that, what would that be?

**KEVIN BORCHER:** There is no cost for prescribers or dispensers, i.e. pharmacists to register to the PDMP. That is currently in 71-2454.

**ARCH:** They may have technology costs in order to-- in order to look at the PDMP, in order to, whether it be interconnectivity to their-- to their EMR or looking it up separately, they would have technology costs. But that's-- that's, there's no cost that the prescriber does not need to pay CyncHealth money to participate.

**KEVIN BORCHER:** That's correct.

**ARCH:** OK. Thank you. Other questions? Seeing none, thank you very much.

**KEVIN BORCHER:** Thank you.

**ARCH:** That was supportively neutral. Is that how you described that?

**KEVIN BORCHER:** That's correct.

**ARCH:** OK, I thought I caught that. Anyone else wish to testify in a neutral capacity? Seeing none, Senator Bostelman, while you're coming up, I would note that there were no letters in support or opposition. We did, however, receive two written testimonies this morning: Dexter Schrodt from Nebraska Medical Association and Bob Hallstrom from the Nebraska Pharmacists Association, both proponents.

**BOSTELMAN:** Thank you, Mr. Chairman. This bill was brought before this committee last session. There was no opposition to it. There was opposition on the original bill, and that was the exemptions. That was worked with DHHS and all the parties involved to clear up those objections. There was no opposition to-- from DHHS over a year ago. We provided this bill to DHHS in advance and we heard no objection until yesterday. I can tell you and you have heard from Senator Howard the need for this to be in place. My brother died four years ago. And he was given medications, as my sister-in-law would say, by the bagful, opioids, others. He died of cancer. If we don't have a mechanism to help prescribers, help pharmacists be able to identify the overprescribing or if someone is, I'll say shopping, we heard the person goes to this doctor and goes maybe across into another town to get another one. You know, I think we need to take it serious. We know what the opioid problem is in this country. We know what distributing medications are in this country. If we don't do this, and I do think there will be a significant cost, fiscal cost to DHHS because they're going to have to do it one way or the other. So if not now, when? If we don't get on board and get the federal funding behind us to provide that support, then we're going to have to come up with General Funds. So this gives us an opportunity to meet the requirements of federal law, of H.R.6. And my understanding is-- is-- is the providers and the pharmacists out there want to do this. They're not-- they don't object to it. We're just providing that vehicle for that to happen. And DHHS hopefully will get on board and we'll be able to work something out. So I'll take any other questions you may have.

**ARCH:** Any questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thanks for bringing the bill again, Senator Bostelman. You talked about last year when you brought the bill and you worked with them. And I apologize. I was a little bit late this afternoon, so I'm not fully caught up on what the opposition is from the department. Is it different from what it was last year?

**BOSTELMAN:** The bill, no.

**M. CAVANAUGH:** No, I mean the opposition.

**BOSTELMAN:** Opposition? Yeah, well, yes. The-- my understanding there was DHHS did not oppose the bill. There-- the only objections to the bill, if you were, was the exemptions and those exemptions were-- have been included. There was actually an amendment done, I think I brought to the committee. The memo was it was approved. I think it got kicked out onto the floor, but we ran out of time.

**M. CAVANAUGH:** Right.

**BOSTELMAN:** This would have been done last year, but we just ran out of time.

**M. CAVANAUGH:** And this version now includes the amendment that we kicked out to the floor.

**BOSTELMAN:** Yes. Yes, it does.

**M. CAVANAUGH:** Thank you.

**BOSTELMAN:** Yes.

**ARCH:** Any other questions for Senator Bostelman? Seeing none, thank you very much.

**BOSTELMAN:** Thank you.

**ARCH:** This will close the bill, the bill LB86and we will now open the hearing on LB411. Welcome to HHS, Senator Lathrop.

**LATHROP:** It's a pleasure to be here, Mr. Chairman, members of the Health Committee. My name is Steve Lathrop. I'm the state senator from District 12, which includes Ralston and parts of southwest Omaha. It

is a pleasure to be here to introduce LB411. I'm passing around an amendment for your consideration as you consider this bill today, LB411 seeks to improve healthcare across the state by making it easier for providers to access a complete history of a patient's past care. It does this by requiring healthcare providers and medical insurers to provide clinical information to the state's designated health information exchange, a system that facilitates the sharing of medical record. It achieves this at no cost to providers. For decades, the U.S. healthcare system has been building towards the capacity for digital medical records to follow patients wherever they are receiving care. President George W. Bush created the Office of National Health Information Coordinator in 2004 and doubled funding for these efforts. Every administration since then has sought to increase the capacity, capability, and integration of healthcare information systems. In 2009, Governor Heineman designated NeHII, now known as CyncHealth, to operate a statewide health information exchange. Thousands of providers and insurers across the state, including most of our hospitals, are already participating in this system. We now have an opportunity to increase the value of this system for everyone by making it inclusive of all relevant health records. The reason this is a good time to do this is that there are currently federal grants to reimburse the cost of building software systems, to translate providers' electronic records into a form that can be incorporated or imported into the statewide system. This bill takes advantage of that funding, which is why there is a deadline found in the bill. All this asks providers to do is authorize CyncHealth to access their existing electronic records by July 1, 2021, and CyncHealth does the rest. My interest in this matter is simply to benefit consumers of healthcare, which is all of us, by making sure medical practitioners have ready access to a complete medical history when making important decisions about our care. Currently, if I get into a car accident and I'm taken to the emergency room somewhere in the state that hasn't treated me before, they don't-- and they don't participate in the health information exchange or my providers back in Omaha don't participate, then the doctors treating me may not have access to important parts of my medical history. If I'm unconscious and can't tell them about ongoing health problems I-- that I experience, that could impact my-- the best course of treatment. They have no way of knowing that. This bill would change that. We've already built the infrastructure we need to do this. Everyone is in agreement that this is in the best

interests of patients. This bill won't cost providers anything and doesn't require them to do anything they aren't already doing. To ensure that's the case, I'm bringing an amendment, AM122. This does two things. First, it simply provides for a process administered by the Health Information Technology Board, whereby healthcare providers included in the definition of this bill that do not have electronic medical records can self-identify and be exempt from participation. It is not the intent of this bill to force providers to create electronic records they don't already have or to change their existing recordkeeping or reporting practices. Second, there's language that ensures that the bill affects only those insurers whose information is relevant to the health information exchange. Improving the quality of electronic medical records is clearly in the best interest of everyone receiving healthcare. This is the direction the country is moving and there is currently federal funding available. I think it makes sense to take this opportunity to make our patient health records complete and to do so at no cost to our providers. Those testifiers who follow me today will be able to discuss the technical issues involved and talk about the many benefits and potential cost savings of doing this for our patients, providers, and insurers. Thank you for your consideration.

**ARCH:** Thank you, Senator Lathrop. Any questions?

**LATHROP:** And this is usually where the introducer says I'd be happy to take questions. Mostly, I'm hoping you'll ask the people that come up [INAUDIBLE].

**ARCH:** Do we have any hard questions for Senator Lathrop? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. And thank you, Senator-- Senator Lathrop. I do have a question either for you or for somebody following. And it's-- and it's digging into the weeds a little bit on the fiscal note, when it says in the fiscal note: The expected cost for data sharing could range from $56,000 for a simple transaction to as much as $859,000 for a more complex one. And of course, fiscal note used the high number on that.

**LATHROP:** Sure.

**WILLIAMS:** Do you have any comment about that at this point?

**LATHROP:** No. I think I'll let the people behind me--

**WILLIAMS:** OK.

**LATHROP:** --answer whether they-- they anticipate there is something to the fiscal note or whether the people that prepared the fiscal note just didn't understand something that's going to take place.

**WILLIAMS:** It's my understanding, at least, that the exchange is already there and the process for doing that and this is more flipping a switch.

**LATHROP:** That's my understanding as well. And I know that there are federal grants available and that's why there's a deadline in the bill and why it makes sense to mandate it now is we're asking people to do it now while they can get their hands on these federal grants or the federal dollars to-- to take care of the cost of doing that rather than miss the deadline for the federal dollars and then be told to do it, and find out they've got to pay for it out of their own pocket.

**WILLIAMS:** Thank you.

**LATHROP:** Sure.

**ARCH:** Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So in the work with the YRTC Oversight Committee, it came to my attention that the healthcare records at those facilities and within Corrections are not digital and not shared with the NeHII system. So would your bill without-- without the amendment, would it include state-run healthcare facilities?

**LATHROP:** To be honest with you, I'm not sure the answer to that. But I know it's an issue. At the Department of Corrections, they're trying to develop their own program for electronic medical records and that's still underway. Because they're-- they don't have it done, they can self-identify and be exempt from the mandate, at least at this point in time. I know it's an issue. And in the time that I investigated or worked on the issues at the Beatrice State Developmental Center, it was a very significant issue because they would take one of the

residents from BSDC to the local hospital and then they'd have to dig in and try to access medical information about a patient that may not be able to communicate accurately their health history.

**M. CAVANAUGH:** And that's the problem we saw with the youth when they were discharged, that their medical records didn't necessarily follow them and were lost. So I just was curious if this was maybe an opportunity to do something there. Thank you.

**LATHROP:** OK.

**ARCH:** Other questions? Seeing none, will you be staying to close?

**LATHROP:** Yes.

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

**LATHROP:** I will.

**ARCH:** All right. First supporter, proponent.

**JAIME BLAND:** Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am president and chief executive officer for CyncHealth, also known as NeHII. I'm testifying today in support of LB411. This legislation creates universal participation for healthcare facilities and payors within the state-designated Health Information Exchange. The secure movement of health data across the state and beyond profoundly impacts the health of individuals and communities in Nebraska and other regions. Since its inception as a statewide HIE in 2008, until-- until its codification as the-- as the statewide designated entity in the Nebraska statutes with the passage of LB1183 last year, CyncHealth has worked to create a comprehensive longitudinal healthcare record for Nebraskans receiving healthcare. The benefit of the Health Information Exchange is that comprehensive information is shared where it's needed when care is delivered and the information is easily accessible to providers. By securely sharing a patient's health information among healthcare providers, pharmacists, emergency rooms, and urgent care facilities, we enable a healthier community in Nebraska and across the region through the availability of health information. Information sharing is an important part for patient safety, for providing the right information to clinicians at

the right time. Through utilization of the HIE, a provider has access to their patients' health-- health records at one point of access when receiving care and it's easily accessible. I want to make clear that this legislation is not intended to create any additional burden on utilization of resources for facilities who participate. There's no manual entry. There's no additional burden beyond the connection of the-- to the EHR that they currently use. CyncHealth technology does carry this burden and works directly with the EHR companies and provides for an offset of funding for those-- those facilities and any time that they dedicate. Facilities are tasked with giving access to their EHR and allowing us to work with their vendor to create seamless data sharing through the transitions. Our organization is vendor agnostic and we will work with any organization within their means to create a connection. The importance of including payors has many benefits for care management and other member management for quality members-- measures. Using patient data, assist with performance improvement projects and even member migrations to a new plan. By using HIE data to update contact information to aid managed care organizations, we can improve-- improve member attribution upon enrollment. In 2020, health data became a key instrument in the fight against COVID-19. CyncHealth assisted state efforts by serving as a conduit for testing data to populate Nebraska-- Nebraska's COVID dashboard. And within two weeks we created a comprehensive COVID-19 dashboard that provides critical information for decision makers in the state related to the availability of beds, PPE, ventilators, and more. And I think we're still the only state in the country that actually provides the COVID-19 test results to providers directly. Our organization shows a commitment to seeing Nebraska through this period by assisting with efforts to carry out contact tracing and, furthermore, believe that having a longitudinal health record for patients will be an effective tool as we confront the long-term effects of COVID. At the federal level, the Department of Health and Human Services is committed to developing a nationwide infrastructure of interoperability across the healthcare continuum. The large scale federal interoperability regulations released in 2020 by the Office of the National Coordinator in which I've included in your packets, now require healthcare providers to share information with any and all providers that treat a patient, sharing not only in near real-time manner, but also providing complete and usable information in electronic format. LB411 will help Nebraska's providers meet the

requirement and stay at the forefront of these federal guidelines. States that will thrive in the fast-paced interoperability development at the national level will be the ones where providers are actively participating in establishing the Health Information Exchange, which does most, if not all, of the heavy lifting of compliance for interoperability. Please note, I have also passed out a letter from Dr. Don Rucker, who is the former head of the Office of the National Coordinator for Health Information Technology, on the benefits of the health information exchanges and how their expansion in the marketplace has a benefit on a national level. We also worked directly with Dr. Rucker during his time at ONC in a number of national COVID efforts. In closing, we believe that this work can be better accomplished when all facilities share data and facilities align with one another in the best interest of the patient and patient safety. I thank you for your time and attention to this important matter, and I would be happy to answer any questions. Thank you.

**ARCH:** Questions? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. And thank you, Ms. Bland, for being here. Would you agree that CyndHealth is the envy of most other states?

**JAIME BLAND:** Yes, sir. Yes, Senator.

**WILLIAMS:** I just wanted you to have to say that. We're very proud of that, by the way.

**JAIME BLAND:** Thank you.

**WILLIAMS:** You heard my question to Senator Lathrop concerning the-- the what I call a discrepancy in the fiscal note.

**JAIME BLAND:** Yeah. So

**WILLIAMS:** Are you the one that could address that? I know you talked about technology--

**JAIME BLAND:** I can.

**WILLIAMS:** --and the ease of that in your opening comments.

**JAIME BLAND:** I just want to pull up the notes so I can look at it. Yes. So in the fiscal note, there's a-- the cost-- the cost, I think is believed related to these in the interoperability rule, which is this fact sheet that I provided. There's some peer-to-peer data exchange and some APIs that are required of Medicaid that I believe is part of this cost and fiscal note. And we have scoped some of that data sharing with the department historically, and it will be integrated into their-- into their platform and the sharing of that information. Now, we don't intend to, through this legislation, require the department to do anything that's not within the Medicaid regulation of what data that could be shared. We are just asking to, one, not only share data, but also provide data back to providers that can be helpful in care coordination, patient safety, the use of the right medication, you know, understanding the comprehensive patient history.

**WILLIAMS:** And they're sharing a lot of that data now--

**JAIME BLAND:** Yes, correct.

**WILLIAMS:** --correctly with the system.

**JAIME BLAND:** That's correct.

**WILLIAMS:** And that-- that interface is working for them at this point.

**JAIME BLAND:** Correct.

**WILLIAMS:** Thank you.

**JAIME BLAND:** At the department, we do not have the interface ready at this time. I think there's still development within their systems that need to take place. And I think some of that's addressed in this fiscal note that the-- and I believe that there's somebody here from the department to answer more specifically, but. So there's the $85,900 of the General Funds and then there's the 90 percent match, which would be the eight-- that $859,000 of what is what they are indicating here.

**WILLIAMS:** Yeah.

**JAIME BLAND:** And then to share clinical information from some of their systems, I believe.

**WILLIAMS:** Thank you.

**JAIME BLAND:** Yeah.

**ARCH:** Other questions? Senator Day.

**DAY:** Thank you, Chairman Arch, and thank you for being here today. I think you answered some of this with Senator Williams, but I just want to clarify. So you do currently work with the department when it comes to data sharing--

**JAIME BLAND:** Yes, we do.

**DAY:** --as would be required. OK. And then in terms of the current contracts that you have with the department, do you feel like they would support the onboarding that would be required in LB411?

**JAIME BLAND:** So I will say this. I have very good working relationships with the department. We work very well together. We're collaborative. And I understand that there's costs that may be incurred should there be a requirement for certain integrations. I think some of that can be overcome with resources, but it's-- it's not-- there may be some changes within their claims system that they would have to do. I don't know what the scope of that would be, but I don't think that's the intent of the bill. I think the intent of the bill is to encourage data sharing across providers and healthcare systems and payors so that we are consistent in our information that's available and then ultimately for consumers to have access to that information, a longitudinal health record to-- to meet the portability components underneath it. But we haven't achieved that as a country yet today.

**DAY:** OK.

**JAIME BLAND:** So-- but I would let the department speak to their specific system requirements--

**DAY:** OK.

**JAIME BLAND:** --and any changes that may need to take place.

**DAY:** Thank you.

**ARCH:** Other questions? I have a couple.

**JAIME BLAND:** Sure.

**ARCH:** So the interoperability rule, effective this year?

**JAIME BLAND:** Correct.

**ARCH:** What-- do you know the date?

**JAIME BLAND:** There's several dates of compliance. One of the first ones is April 20, April 20 where [INAUDIBLE] notifications would be required of eligible hospitals to provide to the community.

**ARCH:** So admission, discharge, transfer,--

**JAIME BLAND:** Correct.

**ARCH:** --ADT. OK. And-- and there was also in the opening, I think there was illusion, an illusion, that's not the word. Anyway--

**JAIME BLAND:** Reference to.

**ARCH:** Reference, referencing funding.

**JAIME BLAND:** Yes.

**ARCH:** And the possibility that funding will run out at some point--

**JAIME BLAND:** Yep.

**ARCH:** --to help providers be compliant.

**JAIME BLAND:** So right now there's what's called HITECH, which is some of the legislation that Senator Lathrop introduced with HITECH that started under Bush and continued through the other administrations that actually that piece of legislation sunsets on September 30 of 2020. They've chosen, they being HHS, chosen to integrate much of the EHR funding for the nation within Medicaid regulations. So that does

sunset September 30, 2020, but there are other funding mechanisms through the Medicaid Enterprise Services that will continue on. It is a different structure than the HITECH 90-10. But there is still components that would allow for providers to be on boarded to different data sharing mechanisms that would be supported past that date.

**ARCH:** Would you go so far as to say that their costs would be covered?

**JAIME BLAND:** Right now the costs are covered.

**ARCH:** OK.

**JAIME BLAND:** Yeah.

**ARCH:** OK.

**JAIME BLAND:** Yeah. And we have worked with the department historically to ensure that that's the case and that we do provide the option for the-- for that for providers.

**ARCH:** OK. Thank you. Any other questions? Seeing none, thank you very much.

**JAIME BLAND:** Yes.

**ARCH:** Other proponents for LB411.

**JEANETTE WOJTALEWICZ:** Good afternoon, Chairman Arch and members of the HHS Committee. My name is Jeanette Wojtalewicz, J-e-a-n-e-t-t-e W-o-j-t-a-l-e-w-i-c-z. I'm the senior vice president of finance and chief financial officer for CHI Health, and I'm here today speaking in support of LB411. SyncHealth's Health Information Exchange, the HIE, has been a critical resource for our hospitals and providers. When a patient comes to one of our facilities for the first time or in conjunction with care received outside of our CHI health network, that information from participating facilities in the HIE is available to our providers; and we are able to deliver more informed care by having the full context of that patient's record. Having this information available takes the burden off patients trying to remember complicated medical terminology of past diagnosis or procedures, lists of the names and dates and results of lab tests that they've had, names and

dosages of medications prescribed, and other details that may be relevant or necessary for the treating provider to be aware of. Additionally, the added value of CyncHealth's event notification system provides that there isn't the financial or system burden of having an outside vendor to run this program for CHI Health. Similarly, this also removes the burden on the provider to try to piece together an unclear or incomplete medical history and still, despite gaps in information, offer an accurate diagnosis or treatment plan. In emergent situations where patients may not be able to recount specifics of their medical history due to the urgency of the situation or the patient's state of consciousness or ability to communicate, the immediate availability of this important data through the HIE can be lifesaving. As the current national health emergency with COVID-19 has demonstrated, information about underlying and chronic conditions can be vital to a provider's ability to assess if a patient is at greater risk of complication and needs additional monitoring or preventative measures. With universal participation in the Health Information Exchange, both patient and provider can be confident that most, if not all, of the patients longitudinal health record from all care received at Nebraska healthcare facilities is conveniently and immediately available to the provider at the point of care. This ensures patients are at the center of their own care and providers are as informed as possible. Additionally, recent federal regulations released from the Centers of Medicare and Medicaid require hospitals to send event notifications when a patient is admitted, transferred, or discharged from an emergency department or inpatient stay. These electronic notifications must be sent to a patient's treating provider, any postacute care providers, and any other providers that the patient designates. CyncHealth's event notification system helps hospitals meet this new condition to participation. And while the requirement does not currently apply to nonhospital healthcare facilities, those facilities need to be able to receive the event notification alerts for the coordination of care to take place as designed. Universal participation in the Health Information Exchange would ensure that all alerts sent by hospitals are able to received by all Nebraska providers. Lastly, while LB411 provides for the universal participation of the Nebraska healthcare facilities in Nebraska statewide designated Health Information Exchange, it is extremely important to note that CyncHealth's network extends beyond our state borders to several partnering neighboring states. For Nebraska

patients who live or work near or outside of our state borders, especially in rural areas, and who may occasionally see out of health-- out-of-state healthcare providers, the value of that extended exchange network is immense. When they return to their routine Nebraska provider, the provider can easily and quickly get caught up on any out-of-state care encounters. And for facilities where-- where-- who serve out-of-state patients come to Nebraska to work or vacation or seek specialized treatment, providers can still demonstrate quality, well-informed care by incorporating medical records from any participating out-of-state facilities. In closing, I would ask that you support LB411, and I thank you for your time and attention to this important matter. I would be happy to answer any questions you may have. Thank you.

**ARCH:** Thank you for your testimony. Any questions? Seeing none, thank you very much.

**JEANETTE WOJTALEWICZ:** Thank you.

**ARCH:** Next proponent for LB411.

**JUSTIN BIRGE:** Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Dr. Justin Birge, J-u-s-t-i-n B-i-r-g-e. I'm an internal medicine physician and informatician at Nebraska Medicine UNMC. I also serve on the board of directors at CyncHealth. I'm here today in support of LB411. State Health Information Exchanges like CyncHealth are important. Accessible, complete, and accurate health information is an asset to both the clinicians and patients of Nebraska. To achieve maximum impact, this asset should be recognized and utilized to its full potential. Physicians and healthcare providers are often overloaded with burdensome data review and administrative tasks. This can compromise or erode the time and attention devoted to patient care and clinical activities during a patient visit. Evaluating historical patient information through faxed, printed, mailed, hand-carried paperwork is one such burden. Having patient medical history accessible, complete, and organized, especially information from healthcare encounters outside the network the physician or provider has access to, having that information integrated into the natural workflow in the health information system they are using to care for patients in their own practice allows the physician or provider to efficiently gain valuable

context and insight without additional administrative effort or relying on the patient to recollect and restate their complete medical history in detail. Additionally, Health Information Exchanges are important when caring for patients without the ability to provide medical record or medical history, and who may be without a patient advocate. An unresponsive or ill patient may be unable to provide important information about their medical history. Health information technology is a critical tool for data review in these time-sensitive scenarios. A complete and integrated Health Information Exchange improves clinical decision making and patient safety through communication of allergies, medication reactions, crucial regional health events, and other vital information. I know this committee is aware that patient access to their own medical information has many benefits. This information belongs with the patient readily available to any healthcare provider or facility they may see without the burden to collect, update, organize, archive, retrieve, and manage accessibility on their own. It is also important to acknowledge the current and future benefits to our healthcare infrastructure. The administrative burden of sharing medical records is greatly reduced when all facilities and providers can access complete health information directly and simply through the Health Information Exchange. The Health Information Exchange also operates independent of any one specific system. And should local health information systems become unavailable, patient medical records remain accessible through the Health Information Exchange. With universal participation in our Health Information Exchange, all patients, healthcare workers, and systems in Nebraska will benefit from a stronger and more sophisticated data infrastructure. This foundational concept will empower Nebraska to continue advancement as a national leader on technical interoperability, patient choice, patient data ownership, and patient-centered care. I urge the committee to support LB411. I'll be happy to answer any questions. Thank you.

**ARCH:** Thank you. Are there any questions? Seeing none, thank you very much for your testimony.

**JUSTIN BIRGE:** Thank you.

**ARCH:** Next proponent for LB411. Seeing none, is there anyone that would like to speak in opposition to LB411?

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

**KEVIN BAGLEY:** Good afternoon.

**ARCH:** Good afternoon.

**KEVIN BAGLEY:** Good afternoon, Chairman Arch, members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. And I'm here to testify in opposition to LB 411 which, as one of its provisions, delegates decision-making authority for Medicaid data to the Health Information Technology Board for the purpose of exchanging clinical information within the state's Health Information Exchange. The department's primary concern with the bill is the delegation of authority to the HIT Board for the use and sharing of Medicaid data, which is inconsistent with federal and state requirements mandating Medicaid program data be administered by a single state agency. LB411 would allow the state's HIT Board to define which clinical information the Medicaid program would share within the HIE. As the committee may be aware, Medicaid information is highly protected by a variety of state and federal statutes. Violating such statutes would come with considerable risk, including the loss of federal financial participation in the Medicaid program. DHHS solely retains the obligation to make determinations that any information shared in the furtherance of the administration of the Medicaid program be appropriate. Additionally, any entity that receives Medicaid information must maintain a duty to similarly safeguard the information and cannot use it for any purpose other than those predetermined by DHHS. LB411 would also impact state-run facilities managed by DHHS in its current form. Our current record system, while serving our needs, isn't capable of the interoperability that is typical in most healthcare electronic medical records. If enacted, we would likely need to procure and implement a new technology system to support that requirement. From an MLTC perspective, we would also note, and this is where I'll speak to some of the potential costs outlined in the fiscal note that Senator Williams asked about earlier, that making changes to our data warehouse to facilitate the exchange of that information, the creation of some of those APIs that would be required will come at cost to the agency. As well as the deadline meeting those-- those requirements by September 30, 2021, would likely be a challenge depending on the nature, structure, and complexity of the data being shared. Now, in summary, I'd like to emphasize that we

at the department fully support the state HIE, the value it has brought and will continue to bring as it evolves in Nebraska. We also support data interoperability, the democratization of data for consumers in order to help support population health initiatives. However, our opposition lies in both requiring state-run facilities to participate in the delegation of authority outside of the Medicaid single-- single state agency for the sharing and use of data as proposed. For this reason, we respectfully request that the committee oppose the legislation. I'll note here that the amendment discussed by Senator Lathrop, we have not had a chance to review yet and that may change some of the items I've mentioned here. But not having had the chance to review that, we present that testimony. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

**ARCH:** Are there any questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So I'm just going to start with a statement. I'm confused. I don't-- I don't quite understand what your opposition is. Do you not currently share data with NeHII?

**KEVIN BAGLEY:** We do. I think to-- to clarify that a little bit, some of the language in the bill allows for that Health Information Technology Board to make decisions around how the data is shared. And that is not a-- an authority that we're in a position to delegate as a department.

**M. CAVANAUGH:** So currently, how-- how are the decisions made at NeHII around the data that they have? How is it--

**KEVIN BAGLEY:** So we have-- we have contracts with NeHII that-- with CyncHealth that we'll continue to monitor and discuss with them. We have a very close working relationship with them as-- as has been discussed in other testimony.

**M. CAVANAUGH:** So I would, and maybe this is a wrong assumption, but in those contracts, do you outline how the data shall be used and shared?

**KEVIN BAGLEY:** Typically, that would be the case, yes.

**M. CAVANAUGH:** So-- and then there is a board already with NeHII that makes decisions for the organization. So they take those decisions and-- and incorporate them into their policies. Correct?

**KEVIN BAGLEY:** I can't speak for how the board functions. But in terms of the sharing of Medicaid data, we're happy to share what data we're able to in the ways that are appropriate under federal and state statute.

**M. CAVANAUGH:** And you--

**KEVIN BAGLEY:** I think our concern really lies in the delegation of the authority to make decisions on what data is shared and how.

**M. CAVANAUGH:** But you haven't to date had an issue with what data is shared and how.

**KEVIN BAGLEY:** Well, not that I'm aware of. That being said, I think we still have retained the ability through that contracting process to make those determinations.

**M. CAVANAUGH:** So--

**KEVIN BAGLEY:** Delegating that authority to a separate board that was independent of the department would present risk.

**M. CAVANAUGH:** OK, thank you.

**ARCH:** Any other questions? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. I'd like to just follow up on Senator Cavanaugh's question there. Have you thought about a solution to that issue, knowing that the sharing of information is vitally important to Medicaid people and all the people of the state?

**KEVIN BAGLEY:** Well, I think as I-- as I've sat back and listened to the proponents of the legislation, I think I'm certainly in a position to sympathize with a lot of the discussion of the need to have the data be available and readily so. I think our opposition really lies in the delegation of that decision making. We would be happy to sit down with-- with any stakeholders that we would need to in order to help facilitate better data sharing. I don't think our opposition is to the sharing of data, but rather to how the decision to share [INAUDIBLE]

**WILLIAMS:** I understand that and I would suspect that that could be taken care of contractually in this arrangement somehow so that your opposition on that delegation would-- would diminish or go away. The timetable that you talked about, it would be burdensome by the September 30, 2021. Is there a date that you think would be suitable for HHS to make that work?

**KEVIN BAGLEY:** So that's a great question. I think the struggle we've had as a department as we look at the legislation is just that it's not clear to us what those interfaces would need to be. And I'm-- I'm certainly not suggesting that that be included in the language of the bill. But really, I think there's just uncertainty on our part as to what the level of effort would be required from a technical standpoint. So I-- it may be truthfully that the September 30 date is feasible. It may be that that date would need to be pushed out substantially. I can't speak to what the date would be unless I'm sure what the level of effort would be.

**WILLIAMS:** Thank you, Mr. Bagley.

**ARCH:** Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So just-- I just want to be clear. The concern is over being compliant with state and federal law and losing-- losing funding. But this doesn't preempt this. It actually says to the extent not preempted by federal law. So is there a concern that NeHII would not be in compliance with state and federal law?

**KEVIN BAGLEY:** Well, again, I don't want to speak to NeHII's operations. That-- that's not something I can do. But my-- my concern is really just the delegation of the authority to make the decision. So to the extent that federal law preempts state law, certainly that would be part of the discussion. And I think as long as there were still a provision whereby the Medicaid agency could retain the ability to frankly make different decisions about sharing its data based on how we see our risk associated with-- with federal statute, that would be something that would be critical [INAUDIBLE] as an agency.

**M. CAVANAUGH:** So are there-- so as long as they are federally and state compliant, what additional restrictions would you want the authority to put on the use of data?

**KEVIN BAGLEY:** Well, I think that's a difficult question to answer as well, just because I'm not sure exactly what APIs and sharing would look like. That being said, I think when we talk about Medicaid data, that's a very sensitive area. We want to make sure that we balance the need to share the information to provide quality care and timely care, but also the need to manage privacy and the security of that information on those participants' behalf.

**M. CAVANAUGH:** OK. Well, I-- I know Senator Lathrop well, and he is a judicious lawyer and would never, I think, bring anything to this committee that would jeopardize our federal funding or the fidelity of data. So I would encourage you and the department to work with him on coming to a solution for this. Thank you.

**KEVIN BAGLEY:** Thank you. We'd welcome that.

**ARCH:** Any other questions? Seeing none, thank you very much.

**KEVIN BAGLEY:** Thank you.

**ARCH:** Next opponent for LB411. Welcome.

**HEATH BODDY:** Good afternoon, Chairman Arch, members of the committee. My name is Heath Boddy, H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association. And on behalf of 423 of our not-for-profit and proprietary skilled nursing facilities and assisted living communities, I'm here today to testify in opposition to LB411. This bill would require facilities to share clinical information with the state-designated Health Information Exchange, as we've discussed today, known as CYNCHealth or NEHII by September 30. I want to first note that our members support data transparency and prioritization of population health. Nursing facilities already share extensive resident and facility data with various federal and state agencies. Copies of residents' clinical records are made available to them within 24 hours. Our members' concerns with this bill are really in two different buckets and I'd like to address them separately and then just talk about a few potential solutions that we would see. I plan to highlight and reference the handout that you got, but not going to read through it today. So let me first talk about assisted living. Assisted living in Nebraska is designed to be a social model. It is not a medical operation. Providers offer a range of nonmedical

services for individuals wanting assistance with meals, housekeeping, and activities of daily living. They do offer limited medical services for those requesting them. The majority of assisted living facilities do not have a nurse on staff. They have a nurse consultant who visits regularly to oversee medication provisions. Because assisted living is not a medical model, providers are not required to maintain clinical records. If you look at page 4 of your handout, you'll see a handout that lists the only information required in the assisted living's resident record; and you can see it's not clinical. Second, let's talk about nursing facilities. Our association worked collaboratively with NeHII for over a year, offering ideas on how to make their database more attractive to nursing facility providers. You can imagine we were surprised to discover this bill was introduced as we had no advance notice. As I understand it, NeHII was really designed as an acute care tool and we have been encouraging them to make modifications that would provide nursing facilities with information that would be helpful to their operations. We feel making these changes would increase voluntary participation and not require this mandate. According to NeHII, 39 of Nebraska's 206 nursing facilities currently participate in their program. As referenced before, Nebraska nursing facilities already submit extensive resident and facility data to various state and federal agencies, including Nebraska DHHS. As an example, every three months or upon a change in a resident's condition, the facility must complete a 45-page multidisciplinary assessment of each resident. This data is submitted to the Centers for Medicare and Medicaid Services and to Nebraska DHHS. And if you want to see examples of some of those, pages 8-12 in your handout would give you some good examples. The majority of this data is deidentified and publicly available. Resident identifiable data would be available from DHHS or from CMS. During the public health emergency, nursing facilities had additional reporting requirements. This initially revolve-- involved reporting the same data to both federal and state agencies. And we were pleased that DHHS worked really hard to eliminate the duplicative efforts. They recognized that the additional requirements take staff time away from care at the bedside and making sure those residents were cared for as they deserved to be. Our members are concerned that there are no limitations on what data will be required to be shared with the NeHII board. Any additional information would need to be manually entered into the resident records so it could be extracted by NeHII. In addition to this

administrative burden, our members are also concerned about the additional cost that would be involved after July 1. In discussions with NeHII, they've indicated they would not rule out additional costs in the future associated with this participation. So let's talk about offering some solutions. Our association and our members believe strongly in not just saying no, but trying to identify solutions where we can work together. If you look at pages 16-18 in your handout, you'll see some of those alternatives. First, let's talk about Nebraska DHHS already shares information with NeHII. We've heard some about that today. NeHII could extract the resident clinical data from nursing facilities that was already submitted to DHHS. And rather than requiring each nursing facility to share that, then becoming redundant sharing, we could encourage NeHII to continue to work with providers and provider associations to enhance the resources offered to nursing facilities. This would encourage voluntary participation, again not requiring a mandate. And third, exempt assisted livings from sharing clinical data with NeHII as they do not collect this information. Resident clinical data would be available from each of those Nebraskans' physicians already. I want to emphasize one last time our members agree with data transparency. They understand the overall goal of NeHII, but feel like this is not the approach. Thank you for your time and your consideration today, and I'd be happy to try to answer any questions.

**ARCH:** Any questions from the senators? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. Excuse me. Thank you. Thank you, Mr. Boddy, for-- for not only coming, but coming with some solutions. Appreciate that. My question is pretty simple. On the last one with assisted living facilities, I think we're aware that there are some facilities that combine assisted living with a graduated move into skilled nursing. Would you see an exemption there as a problem or are those two, even those-- those facilities can be in the same physical building, are they licensed separately so that that would not be a problem?

**HEATH BODDY:** They are indeed licensed separately, Senator. So there should be a wall, if you will.

**WILLIAMS:** So you could still work with an exemption like that?

**HEATH BODDY:** It would seem so.

**WILLIAMS:** OK, thank you.

**ARCH:** Other questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you for being here, Mr. Boddy. The amendment, have you seen the amendment?

**HEATH BODDY:** I don't believe I've seen the amendment.

**M. CAVANAUGH:** It's-- there's an exemption for if this were a technological burden. Does that address the concern for assisted living that wouldn't have the technology?

**HEATH BODDY:** Thanks, Senator. Perhaps it would. My question would be sorry, not up to speed on the amendment, would that be something they'd have-- they would apply for once? Who would they apply to that for or would that be something they'd have to do over and over, whether it be quarterly, annually? I'm not-- I'm not really sure.

**M. CAVANAUGH:** It says annually.

**HEATH BODDY:** I'm sorry, Senator.

**M. CAVANAUGH:** Annually.

**HEATH BODDY:** So perhaps it would help. Would there be an opportunity to have it-- have an amendment like that be a longer term thing, but maybe annually is the right number.

**M. CAVANAUGH:** OK, thank you.

**ARCH:** Other questions? Seeing none, thank you very much. Next opponent for LB411. Seeing none, is there anyone that would like to testify in a neutral capacity?

**ROBERT M. BELL:** Good afternoon. Chairman Arch and members of the Health and Human Services Committee, my name is Robert M. Bell, spelled R-o-b-e-r-t, middle initial M., and last name spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today to testify in a neutral position

on LB411. And I should say, with apologies to Senator Williams because he hears this all the time, but since it's the first time I've been before HHS Committee this year, I just want to tell you a little bit about the federation. We are the primary trade association of insurance companies domiciled in or with a significant economic presence in Nebraska. Currently, the federation consists of 29 member companies and 8 associate members. The members write all lines of insurance. One of the goals of the federation is to promote the concepts and importance of insurance products to the public. Nebraska insurers provide high-value, quality insurance products to Nebraskans that help Nebraskans during difficult times. Not only do Nebraska insurers provide financial protections to Nebraskans, but insurers also provide high-paying jobs. Members of the Nebraska Insurance Federation alone provide well over 14,000 jobs to the Nebraska economy. And according to a recent economic survey back in 2015, the insurance industry had a $14.24 billion impact on the Nebraska economy. And so get into the meat of my testimony. First, let me express my gratitude to Senator Lathrop and his staff and CyncHealth for agreeing to narrowing the definition of healthcare payor that was found in the green copy to the language that is now found in AM179, which limits the scope of the bill to health insurance plans. Many types of insurance companies make a variety of medical payments, but typically those are just financial transactions and not necessarily related to patient management, like they would be in a health insurance plan. It'd have that clinical data that CyncHealth seeks. So we very much appreciate everybody listening to the concerns of the insurance industry as a whole. There's this one minor thing I just wanted to bring up with the committee. I have health insurance plans or the federation has health insurance plans that do participate already and are big supporters of CyncHealth. I have some health insurance plans that do not participate currently, although they are all supportive of the ideals of having a statewide health information system and do see the benefits from a payor perspective. However, there have been some data privacy concerns that a couple of my or at least one of my member companies has, and they would like to sit down with CyncHealth and talk about those particular issues. So their concern would be, you know, having a hammer and legislation that they have to participate by a certain amount of data. When you sit down at the negotiation table and try to work out two things, when you have a law bearing down on you, it makes it pretty tough to negotiate. So I

just-- I put that before the committee, just a consideration to think about. And data privacy, when you think of it from an insurance standpoint, it's interesting. The doctor from Nebraska, Medicine kind of caught my attention. I got a letter yesterday from Nebraska Medicine saying my health information had been compromised and I was not alone. Right? There's 200,000 people that-- that had their health personal information compromised. When you're an insurance company and that happens, you also have to provide notification. But there's also some-- there are also other steps within the insurance code that you may have to do. And depending on what state you may be domiciled in, there may be additional requirements that your state of domiciliary puts on you. So these are, I mean, for data privacy is very important. I'm sure it's very important for CyncHealth. I know it is. But it's also important to insurance companies that they protect their consumer data. And thus, you know, they would like to sit down and discuss those with, you know, the attorneys, the smart people on both sides. Well, the attorneys on both sides. How about that? So speaking as an attorney myself. So anyway, thank you for the opportunity to testify.

**ARCH:** Any questions? Seeing none, thank you very much.

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

**ARCH:** Anyone else wish to testify in a neutral capacity? Seeing none, Senator Lathrop, you're welcome to close. While you're coming up, I will mention that we did receive three letters, proponents for LB411. We also received three written testimonies this morning: Nebraska Insurance Information Service, Nebraska Hospital Association, Blue Cross Blue Shield, all proponents; and LeadingAge Nebraska, an opponent in written testimony.

**LATHROP:** OK, well, that was helpful. You know, sometimes you introduce a bill and people will come and try to work through the bugs before you get to the hearing. And sometimes you need a hearing to smoke out the people that won't come forward in a timely manner and talk to you about the concerns that they have. I am hopeful that we can and we will try to address the concerns to the extent they can and consistent with the mission of Health Information Exchange, try to address the concerns that we heard. And then what I'll do is come back to you as a committee and say I've worked through them or we worked through all of them and here are the ones that just can't be worked through and

whether they're reasonable concerns or just sort of a pretext for not wanting to-- this is all scary. And so we don't want to do it because it's scary, which I think is a little bit of some of the opposition. But this is important. It's really important and it's the future of healthcare. And this whole process has been a build. And we're now at the place where it's time to get everybody on board because the infrastructure's there and patients will benefit from it. At the end of the day, the details can-- can get worked out. But at the end of the day, it's about the patients getting the best quality of care and all those people that roll in to an ER and can't speak for themselves or maybe they're accompanied by a child or a family member that doesn't know about their-- the particulars of their medical history that'd be important to a physician. So my office will continue to work through some of the concerns that you heard. You're welcome to contact me, but I'll be in touch after we've kind of tried to check all the boxes. And-- and if we can't get them all checked, I'll tell you why.

**ARCH:** Very good. Thank you.

**LATHROP:** OK, perfect, thanks.

**ARCH:** Any questions? Any final questions? Senator Day.

**DAY:** I do just want to ask while you're here in front of us, what you-- how you felt about do you have concerns being as though NeHII or CyncHealth is the state-designated information exchange, do you-- how-- do you have concerns about the data sharing? Or I don't know if this is something that you're going to come back--

**LATHROP:** You mean the security?

**DAY:** Correct. Correct.

**LATHROP:** So I would have to defer on that because I'm--

**DAY:** OK.

**LATHROP:** --believe me, some of you have heard me say this. In the morning, I have to have Isela in my office that get me on a Zoom call. So I'm not a technical person and I'm just not--

**DAY:** OK.

**LATHROP:** --I'm not equipped to really address the-- what-- what are the measures taken to make sure this doesn't turn into a leak where people's--

**DAY:** Sure.

**LATHROP:** --private information gets out? I'm sure they have that base covered, but that would be a question for their technical people.

**DAY:** Thank you.

**ARCH:** Any other questions? Seeing none, thank you very much.

**LATHROP:** OK. Thanks. I appreciate it.

**ARCH:** This will close the hearing for LB411. And the committee is going to take a ten-minute break and we'll start a little bit after 3:00. This will now open the hearing for LB238, and Senator McDonnell, you may proceed.

**McDONNELL:** Thank you, Chairman Arch and all members of the human relations committee, Health and Human Services Committee. I will start by providing some history behind this legislation. In 2017, I introduced LB578 with the simple goal of providing additional funding to first responders in our state. The bill called for the implementation of what is referred to as the Ground Emergency Medical Transportation, or GEMT program, which allowed for a supplement payment structure for emergency transports through state Medicaid programs. LB578 was adopted on Final Reading with a vote of 41-0 and signed into law by the Governor on May 22, 2017. To comply with enacted provisions of LB578, DHHS submitted a State Plan Amendment, SPA, to the Centers for Medicare and Medicaid Services that it knew was not likely to be approved. This may have been done to meet the letter of the law basically as set forth by LB578, but it did not meet the overarching intent of LB578 as approved by the full Legislature. The Centers for Medicaid and Medicare Services gave DHHS the opportunity to modify the 2017 State Plan Amendment and its proposed methodology to align with the programs approved in other states. DHHS declined to accept the recommendations from CMS, which would have met the legislative intent of LB578. When a 911 call is received, our state's first responders are not able to decide if they want to

respond based on the patient's ability to pay or what insurance they have, and rightfully so. The first responders react immediately and provide the necessary assistance. This means that there are many times when there is no reimbursement for the services provided. Even when the emergency care and transfers are for patients with Medicare and Medicaid coverage, the reimbursement rate falls well below the actual cost of providing the services, thereby creating a gap in funding. The Ground Emergency Medical Transportation program required by LB578 when it was passed in 2017 was a means to address this gap in recognition of the underpayment by federal and state payors. Ground Emergency Medical Transport programs are intended to be cost neutral to the state Medicaid agencies, and the state's reasonable costs directly associated with the program are intended to be reimbursed through the process. This is reflected in the May 4, 2017, fiscal note for LB578, which reflected no fiscal impact to the state General Fund. Most of our fire and rescue departments across the state are financially strapped and critically in need of additional funding to help protect our Nebraska communities, in part because the cost of providing emergency response services is exceeding the level of reimbursement that providers are receiving. I recognize the fiscal restraints we face as a state, especially as local entities try to recover from the ongoing devastation we have seen this past year. Once this program is up and running, it will help local departments fill a funding gap without dipping into the state's General Fund, just as it is doing in 14 other states that currently have a Ground Emergency Medical Transportation program. LB238 proposes to implement this supplemental payment program as continued effort for Ground Emergency Medical Transportation through the state Medicaid agency for public ambulance providers. Nebraska has participated in Medicaid for over 30 years. However, the state plan does not recognize first responder ambulance services as part of the higher reimbursement allowable under the regulations administered by the Centers for Medicare and Medicaid Services. A minor change to the language in the state plan will allow the Centers for Medicare and Medicaid Services to reimburse at a higher rate, which is imperative to the state of Nebraska. The testifiers who will follow me today will provide additional perspective relating to the need for this legislation. You will be hearing from Fire Chief David Engler, Lincoln Fire and Rescue; Darren Garrean, president of the Nebraska Association of Professional Firefighters; and Jack Cheloha, representing the city of Omaha.

Additionally, you also have received written testimony from Omaha Fire Chief Dan Olsen and Omaha Fire Assistant Chief Cathy Bossman. I'm here to try to answer any of your questions and I will also be here to close.

**ARCH:** I have a-- any other questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. Thank you for being here, Senator McDonnell. Remind me and I'm sorry I missed the beginning of your opening, so maybe you already said this. But you brought this bill two years ago.

**McDONNELL:** So originally, as I mentioned in my opening remarks, this bill was passed, LB578, and signed by the Governor in 2017. I brought a bill a year ago based on the idea that I thought if I introduced new legislation, it would hopefully bring all parties together and they would figure out a way to do this since 14 other states have been doing this for a number of years and we already know that 7 are pending right now and the need we have for the-- the state of Nebraska. Between 15 to 30 million dollars this could bring in for needed equipment and training for firefighters that are paid and volunteer across our state. That did not work. That fell on deaf ears. I'm back with a new bill. I mean, yes, it does feel like Groundhog Day. We're repeating the same bill, trying to improve in any way. But there's also got to be a will. There's got to be a will to actually follow the direction of the Legislature. If there's no will, I don't-- I don't know where to go basically, when you have a bill that was approved and signed by the Governor and there-- there was no, I don't think, the will to-- to actually implement it. And that's sad based on the number of people that those monies could have went to the departments to help people when they call [INAUDIBLE].

**M. CAVANAUGH:** And I apologize. I forgot that you have passed a bill in 2017. That was before my time. And then you brought, in 2019 you brought a bill because they hadn't enacted it. And--

**McDONNELL:** That's correct.

**M. CAVANAUGH:** And it seemed that the department at that time had taken your law as a suggestion.

**McDONNELL:** I felt that way. I felt like they were-- the Department of Health and Human Services were basically the fourth branch of government and had decided to veto my bill.

**M. CAVANAUGH:** And so this bill seeks to do what hasn't happened yet.

**McDONNELL:** Correct.

**M. CAVANAUGH:** OK, thank you.

**ARCH:** Thank you. Any other questions?

**McDONNELL:** And I'll be here for closing.

**ARCH:** Thank you. First proponent.

**DAVE ENGLER:** Good afternoon, Senator Arch and members of the Health and Human Services Committee. For the record, my name is Dave Engler. That's D-a-v-e E-n-g-l-e-r. I'm the acting fire chief for the city of Lincoln. And today, I'm speaking in support of LB238 on behalf of both the city of Lincoln and other fire agencies throughout the state. For review and for the new committee members, I will try to provide some insight into the crisis growing within the emergency medical field and how LB238 would provide some relief to first responders, local taxpayers, and Nebraskans statewide. The average cost of running an ambulance call for my department is over $500 per transport. Medicaid pays around $180 for this service. The underpayment means that we must charge other non-Medicaid patients who receive the same service over $1,200 to make up the budget deficit the underpayment creates. Accordingly, CMS has approved GEMT programs in 14 states. At least eight other states are currently pursuing GEMT programs. The Medicaid programs in nearly all of these states have managed care components and yet still realize the advantages of a GEMT program as a complement to the managed care delivery model. These states, the medical industry, and CMS recognize the value initial EMS treatment and transport has on definitive care. Definitive care is a term used to describe medical care that makes a difference in patient outcomes. Patient outcomes are the same focus for managed care delivery models. Outcomes are measured in percentage of patients that survive a medical emergency, the level of care provided in the hospital, the length of the hospital stay, how treatment was needed after discharge and

etcetera. Proper EMS deployment improves a patient's chance of surviving a sudden medical emergency. It decreases the amount of medical intervention needed in the hospital, and it lessens the need for subsequent care. Conversely, improper EMS deployment, typically due to funding shortages, means a lower chance of survival and more expensive medical interventions afterwards. Lincoln begin pursuing a GEMT program for the state in cooperation with a group of stakeholder agencies in 2017. The group, supported by Senator McDonnell, succeeded in passing the bill that required Medicare-- Medicaid to implement the GEMT. DHHS interpreted the bill as requiring a methodology it knew CMS would not allow. CMS denied the SPA submitted and the program was never implemented. In 2019, Senator McDonnell introduced a follow-up bill and DHHS assigned a large fiscal note to it. The bill ultimately did not advance from committee. It's notable that the Fiscal Office wrote that the costs are significant and more information is needed to evaluate the potential costs for LB238. I have-- I have just a few comments on the fiscal note, otherwise, from a general perspective as the fire chief and not as the Medicaid director. First, the program involves a very small number of claims, an estimated 11,000 per year compared to the millions of claims the Medicaid program processes annually. It appears that there will always be claims that do not fit into the managed care box and will need to be processed by a claims broker or the MMIS until the claims broker is in place. Given the small volume for these GEMT claims in comparison to those other nonmanaged care claims, it seems unfair to attribute the entire cost of this alternative method for processing claims solely to GEMT. Second, DHHS is asking for a lot of FTEs, especially when it only called for one in the original bill that required implementation of the GEMT program in 2017. As an example, Indiana runs this program with a half FTE and the entire state of California has 1.5 FTEs to run its more complex version. Third, GEMT programs require keeping the state Medicaid programs whole. This means that the cost DHHS is-- has directly associated with the implementation of the program will be reimbursed once the program is up and running. It also means that any cost that DHHS has for the program would need to be directly associated with the GEMT program and eventually justified to CMS. So while it may take some time before the costs are fully reimbursed and the local agencies begin to receive any supplemental payments, the supplemental payments will eventually start being disseminated to the local agencies, with DHHS costs continuing to be covered. In summary,

requiring DHHS to complete the implementation of the GEMT program the Legislature has already supported and authorized in 2017 will mean the difference between service levels deteriorating and maintaining high service levels across the state. It will also help provide some relief to the other patients and minimize the need for subsidization of the services from local taxpayers. Along with the other stakeholder agencies across the state, we ask for your support on LB238 to finally implement this GEMT program. Thank you.

**ARCH:** Thank you. Are there any questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you for being here. I'm looking at the-- the staffing that you mentioned. And what was-- do you recall what the staff, the one FTE was from 2017, what the position was?

**DAVE ENGLER:** I do not.

**M. CAVANAUGH:** OK, I can look that up. I just was curious because this is a lot of--

**DAVE ENGLER:** The-- the number of people proposed in the fiscal note is highly inconsistent with any other state that actually handles more claims.

**M. CAVANAUGH:** It's-- it is robust.

**DAVE ENGLER:** It is.

**M. CAVANAUGH:** Thank you.

**ARCH:** Other questions? Seeing none, thank you very much.

**DAVE ENGLER:** Thank you.

**ARCH:** Next proponent for LB238. Welcome.

**DARREN GARREAN:** Good afternoon, Chairman Arch, members of the Health and Human Services Committee. My name is Darren Garrean, D-a-r-r-e-n, last name is G-a-r-r-e-a-n. I am president of the Nebraska Professional Firefighters Association, representing approximately 1,400 firefighters, EMTs, and paramedics across the state of Nebraska. This is theoretically Groundhog Day. We've been here before. As you

heard both from Senator McDonnell and Chief Engler, that this was passed not only unanimously by the body, but signed into law by the Governor. And-- and here we are years later with-- with something that has not been enacted. I want to read something just as a context of how this plays out. On March 23, 2020, your Scottsbluff firefighters are asking for your help. We're dangerously low on the PPE needed to protect us in firefighting and fighting COVID-19. If you or your business can donate unopened boxes of N-95 masks, surgical masks, please reach out to us immediately. Your Scottsbluff firefighters are on the front lines of treating this virus and are unable to obtain the needed resources to protect ourselves. If you are willing-- if you are willing and able to donate, contact-- contact us via and has a telephone number. And I say this in a context where in 2017 this was enacted and signed and you've heard some numbers of upwards of $30 million that could come back to Nebraska and the fire departments. I'm not saying that that wouldn't have solved a problem for Scottsbluff, but a reasonable person would deduct that the money coming back to the fire departments may have had an impact as it could have related to the global pandemic. That being said, you know, I don't know why we're here again. This should have been done a long time ago. We support this and ask that you do the same. Are there any questions?

**ARCH:** Thank you. Are there any questions? Seeing none, thank you very much.

**DARREN GARREAN:** Thanks.

**ARCH:** Next proponent for LB238. Please.

**JACK CHELOHA:** Good afternoon, Senator Arch and members of the committee. My name is Jack Cheloha. That's spelled J-a-c-k; last name is spelled C-h-e-l-o-h-a. And I'm the lobbyist for the city of Omaha. I want to testify in favor of LB238 this afternoon. First of all, I'd like to thank Senator McDonnell for his stick-to-it-iveness, if that's a word, on this issue. You heard from two previous witnesses the frustration that has already overtaken some of us regarding this issue. And so if I could, I want to implore this committee to-- to help us this year. It's very important. Our fire chief did submit a letter of support to this committee. Just to reiterate some of the major points in there, Omaha Fire and Rescue makes roughly 51,000 transports a year. And of that amount, 81, I'm sorry, 85 percent of

them are Medicare and Medicaid participants. So with that, if we're only being reimbursed $180 for these calls, it's dramatically below what the actual cost is for the city of Omaha. And so we question why would the taxpayers of Omaha have to subsidize the U.S. government relative to these transports? And if-- if indeed there is a policy and a program in place to get us a higher rate of return, then we should pursue it. We've actively pursued it since 2017 and we think we found a way to-- to get it done. Before I finish what I handed out, I'd like to read into the record relative to the fiscal note, because as we read it, we're as frustrated as anybody else. The city of Omaha has reviewed the fiscal note to LB238 provided by the Department of Health and Human Services. The city believes the department has greatly exaggerated the cost to implement this piece of legislation, primarily with regard to the issue of fee for service claims processing. The department has had for several years the objective of placing as many Medicaid-eligible persons under managed care contracts as possible. The city acknowledges their goal, but takes no position as to whether this goal is in the best interest of all persons eligible for Medicaid services. The city does acknowledge from discussions with the department staff and the current fee-for-service payment system known as MMIS is outdated and that alternative mechanisms to pay claims outside of managed care must be developed. As you know, this legislation does require that GEMT service claims submitted by the city fire and rescue departments be paid via a fee for service in order to obtain the additional federal funds. The payment of GEMT claims under fee for service is really an issue within an issue. Unless the department is able to successfully put every service and every claim under managed care, the central issue of an alternative means of paying a valid Medicaid claim must be addressed. It seems reasonable to the city of Omaha that there will always be situations where claims will need to be paid outside of managed care. It is hard for the city to believe that the managed care entity has the experience and expertise that the cities have in providing emergency transport services. And then on summary, we basically say we're willing to work with not only the department, but this committee to come up with the proper way to-- to word this and to get it done. In closing, I think why we feel frustrated is it's turned into a, you know, the statewide fire and rescue services have ended up being at odds with the Department of Health and Human Services in order to obtain the federal funding. It seems like we, the state people, should

all be working together to get this higher rate of return. And it would be beneficial not only from Omaha, which submitted a fiscal note of this could help us roughly $4 million a year to departments as were mentioned in Scottsbluff-Gering area. So with that, we support LB238. We thank Senator McDonnell. We thank this committee and hopefully we can advance this bill to General File. It seems like it's very similar to LB101 this committee has already looked at and addressed and advanced 7-0 where you've extended the ability to do these types of payments. So we'd appreciate your help. Thank you.

**ARCH:** Thank you. Any questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So it looks like we're losing out around $5.3 million in federal funds every year from the fiscal note. You said around $4 million for Omaha.

**JACK CHELOHA:** That was our estimate, Senator. Yes.

**M. CAVANAUGH:** Or maybe it's more than that. I'm--

**JACK CHELOHA:** And that's a-- it'd be a voluntary program for each department. So depending if you signed up and we get it up and moving, that number could grow. I think some other witnesses said as high as maybe 15 to 30 million.

**M. CAVANAUGH:** And I did look up the fiscal note from 2017 and there was one employee. It was a DHS program specialist at $46,376 a year and operating of $20,964. I mentioned that to give those that are coming after you the opportunity to address how all of a sudden we need so many more people to do this. So thank you.

**JACK CHELOHA:** Thank you.

**ARCH:** Any other questions? Thank you for your testimony.

**JACK CHELOHA:** Thank you.

**ARCH:** Next proponent for LB238. Seeing none, is there anybody that would like to testify in opposition on LB238?

**KEVIN BAGLEY:** It would appear I'm back in the hot seat.

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

**ARCH:** Good afternoon.

**KEVIN BAGLEY:** Good afternoon, Chairman Arch, members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director in the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB238. As currently written, LB238 would require the division to create a supplemental reimbursement program effective July 1, 2021, for ground emergency medical transportation services and further require that those services be paid on a fee-for-service basis. I would note before I continue, as has been brought up already, that the agency opposed similar legislation, LB645, during the 2019 session. GEMT services are currently paid by the Heritage Health managed care plans. As part of an episode of care, this bill would remove an important piece of management of care for individuals for whom the rest of their healthcare services are managed by our managed care organizations. Requiring fee for service payment for GEMT services is in dissonance with the division's long-term strategy and approach with respect to managing health outcomes for Medicaid beneficiaries. Furthermore, requiring fee-for-service claims processing contradicts the Medicaid Information Technology Architecture modernization strategy and would complicate DHHS's ability to move forward with our progress toward sunsetting pieces of our 40-year old functionality, such as the claims processing module in the legacy Medicaid Management Information System or MMIS. If claims processing continues under a fee-for-service basis, we estimate a significant cost to implement a more modernized system. In 2016, the department received a cost proposal in excess of $24 million to implement a more modern claims broker service for fee-for-service claims processing. This bill would not allow the department to incur any unreimbursable costs to implement the supplemental payment, adding that as a condition of receiving supplemental payment providers shall agree to reimburse the department for any costs of implementing and administering the program. In addition to creating agreements with each provider to make supplemental payments, the department would need to establish separate payment arrangements with each participating provider to receive any administration reimbursement and determine an allocation methodology to distribute costs fairly for each provider. The supplemental arrangements and administrative operationalization would lead to the

necessity for additional staff, as reflected in the fiscal note. And I'm happy to answer any questions along those lines as well. The department has concerns about the ability to implement the program as required by July 1, 2021. In addition to the State Plan Amendment necessary to perform a supplemental payment, the department would also need to remove GEMT services from capitation rates with our managed care plans, execute contract amendments, amend the federal 1915(b) waiver, update the MMIS and provider enrollment systems and processes, as well as hire and train additional staff and possibly acquire consulting services to implement the requirements and subsequently support it in operations. The department would also note that this bill only appears to apply to ambulance ground emergency medical transports, leaving air emergency medical transport and nonemergency medical transportation within the managed care delivery system. Finally, I'd like to speak to an initial rate evaluation that the division completed in 2017. This evaluation determined that the rate Nebraska Medicaid was paying for GEM service-- GEMT services was on average above what other states in the region were paying for similar services. Furthermore, we discovered that one state that implemented a supplemental payment for GEMT services appeared to do so to address an even lower rate than is currently paid in the state. In this case, their fee-for-service schedule rate plus the supplemental payment is roughly in alignment with the Nebraska Medicaid fee schedule right now. It's for the state of California. In summary, the department opposes LB238 because it does not align with our long-term strategic vision to manage patient care. The bill introduces complexities in the delivery system in order to enhance payments for services that appear to be in alignment with other Medicaid programs. We respectfully request that the committee not advance the legislation. I thank you for the opportunity to testify today and I'd be happy to answer any questions.

**ARCH:** Thank you. Are there questions? Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. OK. Yeah, let's hear about the staff.

**KEVIN BAGLEY:** Sure.

**M. CAVANAUGH:** What can you tell me? That's a lot of staff.

**KEVIN BAGLEY:** So to-- to address it at a little bit of a high level without going into too many details, one of the complexities that comes out of this is the need to really contract with each of those entities to manage the certified public expenditure as outlined in the bill. So that requires substantive contracting and accounting staff, as well as some additional staff to perform the oversight needed from an auditing perspective to make sure that none of the additional funds going out are going to be subject to recoupment from a federal audit. So that's substantive, really. That's probably the bulk of those individual employee costs.

**M. CAVANAUGH:** And then the information system would be $28 million.

**KEVIN BAGLEY:** That's correct. So as I mentioned in my testimony, in 2016 the department received a bid.

**M. CAVANAUGH:** Oh, I'm at-- this whole committee is very familiar.

**KEVIN BAGLEY:** Sure. So we, we took that $24 million and really just inflated it to be more reflective of the current time period.

**M. CAVANAUGH:** So--

**KEVIN BAGLEY:** That being said, I think it's-- that is a piece that would be necessary if we were to perpetuate fee-for-service payments into the future.

**M. CAVANAUGH:** So I don't know if anyone within the department agency informed you, but that that information system has been attached to many, many bills over the last couple of years. And it seems like something that the department should be asking for in their budget--

**KEVIN BAGLEY:** So--

**M. CAVANAUGH:** --instead of attaching to senators' bills.

**KEVIN BAGLEY:** Rather than try to address that, I'd like to to speak to it a little bit differently.

**M. CAVANAUGH:** OK.

**KEVIN BAGLEY:** Our long-term vision as a department within Medicaid is really to move toward managed care payments. What that does is it provides a more stable budget outlay. It provides for more integrated care and really provides for a higher quality of service for members.

**M. CAVANAUGH:** So but do you need this information system to do that to [INAUDIBLE]?

**KEVIN BAGLEY:** We would not.

**M. CAVANAUGH:** OK.

**KEVIN BAGLEY:** If-- if we moved to a spot where all of our services were provided through a managed care service delivery system, we would not need this additional claims brokering system.

**M. CAVANAUGH:** So the current system that we have that we've needed to replace for over 20 years would be just fine if we didn't pass this bill.

**KEVIN BAGLEY:** That system would be sunset as we move toward putting all of our services into a managed care framework. There's still a lot of work to be done on that. As is noted, this would not be the only fee-for-service service as-- as currently outlined in our-- our service delivery system.

**M. CAVANAUGH:** And what's the target for having everything within managed care?

**KEVIN BAGLEY:** Well, I can't give a good date for that right now. That's something that I've been evaluating as I've come into this role.

**M. CAVANAUGH:** Are we talking years or decades or?

**KEVIN BAGLEY:** We would be talking years.

**M. CAVANAUGH:** And would there need to be legislative authority, action taken to make that happen?

**KEVIN BAGLEY:** I don't believe that there would need to be current legislative action taken. That being said, there have been other bills

that have been mentioned here, LB101, for example, that pushes out the date at which the state would be able to implement a managed long-term services and support system.

**M. CAVANAUGH:** OK.

**KEVIN BAGLEY:** That would be a substantive undertaking on our part, but one that we've really been pushing for for several years. It would take a lot to do correctly, but that is something we believe would be beneficial to members.

**M. CAVANAUGH:** I have more questions, but I assume others might want to jump in.

**ARCH:** Other questions? Senator Walz.

**WALZ:** Thank you, Senator Arch. I'm just curious, do you guys have information on how many departments are-- are really struggling to keep their heads above water and be able to provide ground [INAUDIBLE]?

**KEVIN BAGLEY:** You know, that's not information I've seen. Having-- I know the department has had a lot of conversations with the Lincoln and Omaha department, fire departments around this in the past. And I can obviously say that has been before my time here.

**WALZ:** Um-hum.

**KEVIN BAGLEY:** I haven't had the chance to sit down and have that discussion with those entities yet. I'd welcome it. Being able to go through and look at the cost-base reimbursement that may be associated with taking that approach is something we could look at. That would be a departure from how we've set rates in the past for this service. But it's an approach to rate setting that could be looked at.

**WALZ:** Yeah, I think that's really an important piece to investigate, especially if, you know, you talk about the long-term strategy and approach with respect to managing health outcomes for Medicaid beneficiaries. And I think just making sure that people who pay taxes can continue to receive the services that they deserve is-- is important. And obviously, I mean, I think it's imperative that you

talk to fire stations across the state and find out who's struggling. That's got to be part of your strategy.

**KEVIN BAGLEY:** Yeah. And like I said, we would very much welcome those discussions. I'd-- I'd be happy to talk with folks as we adjourn here, and I'd be happy to set up some time.

**WALZ:** OK.

**ARCH:** I have a couple of questions. One is you said you're currently processing other fee-for-service claims now.

**KEVIN BAGLEY:** We are.

**ARCH:** It's not all you're migrating to a managed care platform where you really get out of the business of claims processing, correct?

**KEVIN BAGLEY:** That's correct.

**ARCH:** So is it possible, one of the suggestions in earlier testimony was the possibility of outsourcing claims processing for this particular, for this 11,000 claims or whatever the number, whatever the number might be? Is it possible to outsource?

**KEVIN BAGLEY:** I-- it is. I would say that that's typically where that $24 million price tag comes in. And I can't speak to-- I don't have a current bid, I guess would be the way to say that.

**ARCH:** Because the $24 million is-- is really replacing the MMIS system.

**KEVIN BAGLEY:** That's my understanding.

**ARCH:** Which would then, that would be investment to keep going into fee-for-service processing, which probably will decline over time in fee for service. But it was just whether or not-- whether or not you'd be able to take those 11,000 or probably the bigger question, which is a really big question, is take all the fee-for-service out and sunset the MMIS system now and just move to-- move to claims processing with a third source. But that's a bigger question.

**KEVIN BAGLEY:** Sure.

**ARCH:** But at any rate, it sounds like it would be possible to do out-- outsourcing of claims processing. Do other-- other-- other states do that? Do you happen to know?

**KEVIN BAGLEY:** It varies between states as to kind of what level of control they exercise over that. There are some states where that is largely outsourced, including some of the-- the policy and review of those claims. And there are other states that have that all done in-house. So I can't speak specifically to this scenario--

**ARCH:** OK.

**KEVIN BAGLEY:** --or to what the cost could potentially be, but they could be substantive.

**ARCH:** Well, for that, for that matter, the utilization of MCOs is outsourcing.

**KEVIN BAGLEY:** It is.

**ARCH:** They become a claims processor as well that you're--

**KEVIN BAGLEY:** That's correct.

**ARCH:** --that you're outsourcing so.

**KEVIN BAGLEY:** Yeah.

**ARCH:** OK, thank you. Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So looking over the numbers here, it looks like in failing to enact the-- this program in 2017 after it was passed into law and signed by the Governor, the department is now increasing the staffing budget by 90 percent. And we would experience, if we were to move forward with this system, whether or not that is actually what we would do, it's an additional 14 percent or $4 million. And so we talked about the timeline here. And I-- I still-- I know you weren't-- you weren't here when we-- when we enacted this. You weren't here when we had another hearing about this. But I still don't understand what the department's problem is with doing this. They-- they-- we shouldn't be here today. This should have already happened. We passed a law. And if the department needed the millions

of dollars to enact this, they should have put it in their budget in 2018. So why does the department not want to do this? I mean, we could all get up right now, walk out that door and you could still do this because the law has passed. It hasn't been unpassed. You haven't been compliant with the law since 2017. Maybe speak to that.

**KEVIN BAGLEY:** Sure. So, Senator, as the saying goes, the devil's in the details. And I think really in this case, it comes down to the-- the method of implementation that's outlined in the bill would incur additional staff costs, would incur--

**M. CAVANAUGH:** Would incur more staff costs than the bill that's already law.

**KEVIN BAGLEY:** Yes.

**M. CAVANAUGH:** OK, so then let's just do what's already law.

**KEVIN BAGLEY:** Well, and that's something that the department did. The department submitted that State Plan Amendment.

**M. CAVANAUGH:** The department submitted a State Plan Amendment that they knew would be rejected. It was purposely drafted to-- to be rejected.

**KEVIN BAGLEY:** Well, I don't want to speak to the motivation of the staff that would have participated in the submission of that. But I can say it-- it's difficult sometimes to implement, as outlined, when there's an awareness that CMS may not be willing to accept the terms that come with the legislation that's passed. And in this case, that was something that was the case. We did not see a way that we could implement as outlined in the bill--

**M. CAVANAUGH:** I guess--

**KEVIN BAGLEY:** --while making the changes to that State Plan Amendment.

**M. CAVANAUGH:** It's intriguing to me that you say that because the department seems to be able to find ways to get done what they want to do with CMS contrary to what, say, the voters might vote on requiring and compelling you to do or what the Legislature might pass and requiring you and compelling you to do. When the will is there, the

department seems to be very creative in executing these things. And I guess why is there no will to pay our first responders?

**KEVIN BAGLEY:** I think I'll go back and say I would welcome additional conversation with stakeholders on this, on how we could make this a better outcome for everyone.

**M. CAVANAUGH:** Well, I think four years is a long time for there not to be a resolution to a law that was passed. But I appreciate you being here. I'll stop asking you questions.

**ARCH:** Any other questions? Seeing none, thank you for your testimony.

**KEVIN BAGLEY:** Thank you.

**ARCH:** Any other opponents to LB238? Seeing none, is there anyone that would like to testify in a neutral capacity to LB238? Seeing none, Senator McDonnell, you may close. And while you're coming up, I would say we had two written testimonies provided this morning, one from the League of Municipalities, Nebraska Municipalities; the Nebraska Association of Medicaid Health Plans, excuse me, the League of Nebraska Municipalities was a proponent in written testimony. The Nebraska Association of Medicaid Health Plans was an opponent in written testimony. We also received three letters for the record that were all proponents of LB238, no opponents, and no neutral. You may close.

**McDONNELL:** Thank you, committee members. The problem that was brought to me by departments east, west, north, south, paid and volunteer in the state of Nebraska in 2017 hasn't gone away. People call 911 every day and they have an emergency and they expect people to show up that are well trained and equipped and make a difference in their lives. When they came, they said, we're always going to answer the bell. When that bell goes off, we're going to go and we're going to do the best we can. We need your help. And this isn't, you know, brain surgery here. We've got an idea based on the, that 14 other states have put this program in place. And today's dollars, it could be anywhere between 15 to 30 million dollars going to fire and rescue across our state. So we have a situation where maybe LB578 wasn't the best bill. Maybe there was all these problems. OK, what-- what do you want us to do to change it? We'll introduce another bill. But also we had a

situation to where you basically you're a kid and you're in school and the dog ate my homework. And there's a test today. And I didn't study. And the teacher said, you know what? Go ahead and move two seats to the right. You'll get an A. Copy off that person. That's what happened with this plan. Basically, they said, here, redo your plan and do it this way and it'll be right because you're not plowing new ground. They've done it in 14 other states. No effort, zero effort, nothing. I don't care how we get from A to Z because this isn't about me and it's not about my bill. It's about the people out there that are responding every day to those emergencies and they're asking for help. And it is impacting because the idea of that next dollar and a bill to invest that dollar that could be coming back into those departments and not everyone has to participate in this if the department doesn't want to. But we have to have a statewide plan. But that next dollar that comes back and says, oh, we can buy that piece of equipment, we can do more training, it is going to make a difference in someone's life. That's the goal. And that's what I need help with. I am open to suggestions, ideas, amendments. Let's just not be too proud to borrow a good idea from other states and follow through with it. Please, I'm asking you for help.

**ARCH:** Thank you. Senator Cavanaugh.

**M. CAVANAUGH:** Thank you. So if we did a new State Plan Amendment taking the advice of CMS, we could implement this program, is that correct, in your assumption?

**McDONNELL:** Yes.

**M. CAVANAUGH:** You're on the Appropriations Committee.

**McDONNELL:** I am.

**M. CAVANAUGH:** Have you been-- had-- since 2017, has there been a request to fund this [INAUDIBLE]?

**McDONNELL:** No. You know, and also, I think there's an attempt here by its death by fiscal note.

**M. CAVANAUGH:** Well--

**McDONNELL:** We've got an idea. We're-- we're going to kill your bill and based on the fiscal note. I just-- I just-- you can see it. You asked the question earlier, Senator Cavanaugh. You looked at that fiscal note and what it was in 2017 compared to today. It's embarrassing. I mean, it's flying in the face of logic and they really don't care. I don't know how anybody could sign that. I don't know how anybody could send that over. And we are going to discuss some things in Appropriations.

**M. CAVANAUGH:** Thank you.

**ARCH:** Senator Walz.

**WALZ:** Thank you, Chairman Arch. I was just curious, Senator McDonnell, over the last four years, has there been any communication from the department regarding this?

**McDONNELL:** I can't tell you the effort that's been made by the fire departments, the-- the city of Lincoln, the city of Omaha, the east, west, north, south, I mean, people trying to say, OK, how can we do this? How about this idea? How about this idea? Would this work? And I really, I was naive because I thought when I brought back the next bill, I thought, oh, there'll be time. And really this, the second bill wasn't-- because LB578 was signed by the Governor and put in place, it was really to say, OK, well, it forces everyone to sit at the table, work together, because who wouldn't want to get potentially 15 to 30 million dollars into the state at no cost to the General Fund, no cost to the taxpayers of the state of Nebraska through the General Fund, and help these departments and help people that are calling in emergency situations. So I was naive because I really thought we'll work this out. We'll figure it out. I mean, 14 other states have done it. Some other states are in play. We'll get this done.

**WALZ:** I guess what I'm asking is, has there been conversations from the Department of Health and Human Services to, you over the last [INAUDIBLE]

**McDONNELL:** That's who they were-- they were reaching out to--

**WALZ:** OK.

**McDONNELL:** --as the stakeholders, and that was part of LB578.

**WALZ:** OK.

**McDONNELL:** Hey, we're going to work together. The stakeholders are going to work with-- with the department, yes, definitely.

**WALZ:** OK.

**ARCH:** Any other questions? Seeing none, thank you very much.

**McDONNELL:** Thanks for the opportunity.

**ARCH:** This will close the hearing on LB238 and we will now open the hearing on LB418.

**MURMAN:** Good afternoon, Chairman Arch and members of the Health and Human Services Committee. For the record, my name is Dave Murman, Senator Dave Murman, spelled D-a-v-e M-u-r-m-a-n. I represent District 38, which includes the counties of Clay, Nuckolls, Webster, Franklin, Kearney, Phelps and southwest Buffalo County. I am pleased to come before you today to introduce LB418 for your consideration. It was-- I was contacted last year by Ohio Representative Jim Butler, who has sponsored similar legislation in the state of Ohio. HB345 was recently passed by the Ohio Legislature and offers an innovative approach to finding cures for deadly diseases like cancer, Alzheimer's, Parkinson's, HIV and diabetes. LB418 intends to adopt the Solemn Covenant of States to Award Prizes for Curing Diseases compact. The bill provides that upon enactment, enactment by six states, the governing Solemn Covenant of States Commission is established and the compact becomes binding and effective as to any other state that enacts it into law. The commission is granted the power to review treatments for the cure of diseases specified by the commission, to award prizes for successful cures and to make treatments widely available for use. The commission establish its criteria for defining and classifying diseases for which prizes will be awarded, which must include at least 10 major diseases determined by their severity, survival rate and public health and treatment expenses. The commission also adopts criteria for a successful cure. The prize amount for each cure shall be equal to the most recent estimated total five-year savings in public health expenses for the disease in all compacting

states. And number two, money donated by other, others intended for the prize. And number three, any other factors the commission finds appropriate. The bill requires a two-thirds favorable vote for all members for a cure approval to be effective and requires the prize winner to transfer the patent and all related intellectual property for a treatment to the commission in exchange for the prize. I have a flowchart that explains more clearly how this bill will work better than I can describe it to you in this testimony, testimony. I offer it now as a handout. After the introduction of this bill, I was contacted by the representative for the Nebraska Association of Trial Attorneys who proposed an amendment to the immunity section of the bill to match the level of liability any state employee would have under the same or similar circumstances. Since this change would not be a substantive change, I will offer an amendment to address their concern. Earlier this week, I received a written statement from Lewis Lainhart, who works for the Ohio House of Representatives and specifically worked on the cure bill in Ohio. He offers a unique perspective that I would like to share with you. So I've got another handout from him. Thank you for your consideration of LB418. At this time, I would be open to questions, but I am very pleased to have Jim Butler, the former speaker pro tem of the Ohio House of Representatives, with us today to testify in support of LB418 and explain, explain the rationale behind the bill and answer your questions. Do you have any questions for me?

**ARCH:** Are there any questions for Senator Murman? Senator Williams.

**WILLIAMS:** Thank you, Chairman Arch. And thank you, Senator Murman. I understand what this does. What I am missing is why would we want to do this? You've not told me anything about the purpose for this.

**MURMAN:** Well, the purpose of the bill is to cure these devastating diseases, and our present health care system does not offer adequate incentive to find cures. It, the present health care system incentivize basic research, and we need the final research that's needed to find the actual cure. The basic research is just designed to find treatments, not cures. But Senator Butler could explain that further.

**WILLIAMS:** OK, I just want to be sure that-- are you aware of the programs through the University of Nebraska, NUtech Ventures, the different programs through Innovation Campus that are highly incenting

people to to find cures, then working with patents, holding those patents, which then become the intellectual property of people in Nebraska to, to handle those? I just want to be sure that you're aware that we have many things like that going in our state.

**MURMAN:** I'm somewhat aware of those, but this incentive would be much bigger than the incentives you're talking about. And also, you know, it's not limited, I mean, the cure could come from Nebraska, but wherever it comes from, it wouldn't cost the taxpayers of Nebraska any more than what they're, they would be paying for the care of the person with that disease right now. So the cure would be a great thing, and it's at no cost. It's a win-win situation if we're in the compact.

**ARCH:** Other questions? Senator Hansen.

**B. HANSEN:** So it sounds like kind of the return on investment is the cure, right?

**MURMAN:** Yes, and there's no investment until a cure is found.

**B. HANSEN:** Sure. And so, and the cure then you discern, OK, whatever disease it is, however much the state is going to save by not having that disease anymore is what they then distribute?

**MURMAN:** Yes.

**B. HANSEN:** An the incentive? OK.

**MURMAN:** Yes.

**B. HANSEN:** For one year, whatever that is?

**MURMAN:** It's for five years.

**B. HANSEN:** OK.

**MURMAN:** But actually, if you're in the compact, the royalties from selling-- or not selling the patent, but other states that aren't in the compact or other countries that aren't in the compact, those royalties would probably pay for what it would cost us to treat that

disease for five years. So actually, we'd probably gain on it. We wouldn't-- we're guaranteed not to lose and most likely would gain.

**B. HANSEN:** But we would split up between all those states, right?

**MURMAN:** Yes.

**B. HANSEN:** Just curious. Thanks.

**ARCH:** Any other questions? Seeing none, thank you.

**MURMAN:** Thank you.

**ARCH:** I'd like to call the first proponent or LB418. Welcome to the Health and Human Services Committee in Nebraska, a fellow traveler from Ohio to the Unicameral, the only unicameral in the nation.

**JIM BUTLER:** I love it.

**ARCH:** No comment. Welcome.

**JIM BUTLER:** We need that in Ohio. So thank you, thank you, Chair Arch, members of the Health and Human Services Committee. Good afternoon. My name is Jim Butler, J-i-m B-u-t-l-e-r, and I am a former member of the Ohio House for the past 10 years. So I'm just recently back to the private sector. And I know from 10 years of being in the legislature what it's like to be on a committee and be the last bill for a committee and seeing, you know, four pages of written testimony in front of you. So I'm not going to read my testimony. You have it there to, to review. I'm going to-- hopefully I'll be a lot shorter than that, but happy to answer any questions that you might have. And so I want to just at first start, Senator Williams, what you had asked Senator Murman about, and that's why, where did this bill come from? Why do we need it? And the overriding reason is the system as a whole, actually the global system as a whole, is not designed and incentivized at all to find cures for diseases. It's heavily incentivized to find treatments for diseases. And the reason-- I didn't know this at all until, until a personal-- I'll tell you my personal story here in a minute. But now, after a lot of research, all the money that NIH spends, which is a third of all of research and development that happens in the United States annually, it's $34 billion a year, and all of the money that charities spend-- almost

all, never-- it's not completely absolute, but $ or $7 billion a year, all of that money will never cure anything. It will do great basic science research for a new product. We're talking new products now. It will, you know, it will make amazing discoveries from, you know, starting in test tubes, identifying, you know, potential great cures and treatments for that matter. That might happen. It goes all the way through animal studies, which is why we see in the media and everyone gets so excited that, you know, multiple sclerosis or Alzheimer's or cancer or, you know, it was cured in a mouse or another animal. And that's a big story and people have a lot of hope about it. Which is, it's good. And that's great research that a lot of research universities do, and very necessary. But the problem is the human clinical trials almost always are done by the private sector. They're the ones that put, that go through human clinical trials for a new drug, for a new potential product that needs to be tested. And the problem is there's no money in finding a cure. And we have private businesses, their job is, their number one thing is to make money. There's just not money in finding a cure, so the incentive isn't there for them. They really, I'm sure, would love to find a cure. But the incentive is all around treatments instead of cures. And actually they're even punished if they find a cure instead of a treatment financially. And really for that's for three reasons. First, when you, when you have a-- when you're looking at all the great research that's done by the research universities, and a lot of times they partner. So they do, they are in this. Once they make an amazing discovery, they can partner with a private sector company, and under a 1980 amendment that the U.S. Congress passed, they can take a commercial stake in that and it can benefit people in Nebraska if it's, if it's here or in Ohio. Which is absolutely great, I'm all for that. But they still need that private sector partner. And the private sector, when they're looking at all the great research out there that they want to invest in and invest billions of dollars sometimes in trying to find their next product that they're going to, they're going to launch, then they're going to, obviously they're going to pick something that's going to have the greatest likelihood of success. And more likely than not, that's going to be a change in an existing treatment that's still going to get them a new patent and, you know, six or seven years of sales. And it's great. I love treatments, I'm sure we all do. Better treatments, that's a great thing. But it's much more likely to happen because if you just change a small piece of, of an existing treatment

that you already know works and it has a better side effect profile, better efficacy, just it's better business. It's a better business move to do that. And then you also a lot of times if it's a treatment, then you're going to have repeat customers. There are a lot of treatments that we take, if you're on blood pressure medication, cholesterol, you know, heart, the heart medications, blood thinners, it's something that you have to take for a long period of time instead of a cure that you might have to take once or a short period of time. So pricing becomes a big issue, trying to get that covered by insurance companies. It's more difficult if it's something that's a short period of time versus a long period of time. And so for those reasons, I just-- it's unfortunate that that's our system, but that will tend to have the private sector when they're choosing what they want to invest in, to invest in a treatment instead of a cure. And what can actually punish companies for developing a cure instead of a treatment is all the existing treatments that are out there. Because if you cure disease, then the disease is gone. Then any existing treatments that you already have a patent still, more patent life on, you're still selling it or you have stuff in the pipeline, because it takes a long time to develop a new drug, and you have these drugs in the pipeline as an industry, then those drugs are going to be not needed. And so you actually can get in this perverse situation where it can, it can, it can be a perverse incentive for looking for a cure. And all of this I found out from, from talking to people in pharmaceutical and biotech, from talking to researchers at universities. And, and that's, that's just unfortunate the way the system is. And maybe it's because before 1980 than, you know, private-- or public universities or public entities couldn't take an ownership stake in any intellectual property. And that's the way the system developed. I'm not sure how we got here, but that's where we are right now in terms of how the system works. And it's not necessarily bad, it's just that there needs to be more of an incentive for cures for the private sector in addition to the incentive that they already have, the financial incentive for treatments. And that's why this multistate compact will pool the potential savings that states will see. And it's dynamically scored on a budget, so it's not, it's not just what the disease itself cost, but actually how much money states truly save and then pool that as a potential-- as a reward for somebody who comes along and cures the disease and, and causes that savings to happen to the states. It doesn't happen unless

the cure happens. So there is no, as Senator Murman mentioned, there's no upfront appropriation, there's no cost. And the only thing that can ever be spent by the states that are in the compact is simply what you actually save down the road after a cure already happened. So there's no risk in doing that.

**ARCH:** Could I stop you for just a second?

**JIM BUTLER:** Sure.

**ARCH:** We have a light system and you see it's kind of like a Christmas tree right now. The red light is on. That means your time is up. But I'd like to give you more time so you--

**JIM BUTLER:** Thanks.

**ARCH:** So, so please, please, please continue.

**JIM BUTLER:** OK, thank you.

**ARCH:** I just want to be consistent with our light system. So please.

**JIM BUTLER:** If it's OK, then I'll just-- I just wanted to tell you kind of how this came about for me and how-- I've talked to so many people who have gone through this themselves for various diseases. But almost exactly 20 years ago, last month, my mother passed away of breast cancer. And before she passed away, her cancer spread. And again, this is an all-too-common story. Then I thought there's got to be something that's currently in clinical trials because we exhausted the chemo and everything. So there's got to be something that you can try it, even if it has a 0.5 percent chance of success, at least it's a hope that you will be cured. And I looked at every-- spent months, looked at every clinical trial, called the researchers, looked-- read every book I could, found everything-- because I thought I for sure I could do that for my mother. And I couldn't because every single human clinical trial that was listed, and there were hundreds, was for a treatment that could extend her life for two weeks or two months, but it wouldn't actually save her. That's, that's not what the product was going to do. So then we were, and this happened so much we were then saying, well, let's-- maybe it's something we can find. We'll get you into a clinical trial so that you'll live two more months and then somebody will put in a clinical trial that might cure you. We'll just

buy, get you-- buy some more time so that somebody might come along and find and propose a clinical trial. But no clinical trial was ever going to be proposed because of the way the system worked. And sure enough, that was the case because seven years later, my father was diagnosed with pancreatic cancer and I went through the exact same thing with him and he passed away. But at the time, I had no idea why it was that there was actually zero cure, you know, you know, potential cures and human clinical trials. And subsequently to that, it's that way not just for cancer, but for, for every major chronic disease. So that's what this bill does, is it, it does-- it's all the private sector. So the compact just operates as a conductor. Just between-- you have the flowchart in front of you, and I'm happy to answer any questions, between the bank, the banks that will underwrite the essentially loan that's based on future savings and the risks, all with the private sector, which they're good at, and monetizing risks. We want the private sector to, to take that risk. It has the contract manufacturer. They're the ones that will manufacture and distribute and get all the license and do all the liability for the cure itself. And then, of course, any inventor for a cure, and it's totally permissive. So there's this-- if nobody comes forward or if somebody develops a cure and wants to sell it themselves, they don't have to claim the reward, obviously. It's entirely permissive and it doesn't cost anything and there's no risk to the taxpayer. So, Mr. Chairman, thank you for the extra time. I really appreciate it.

**ARCH:** Sure. With that, questions. Senator Hansen.

**B. HANSEN:** All right, thanks for traveling and coming here and testifying. So you had mentioned a little bit about the liability. Would it be on the person inventing the product or finding the cure? The state will not have any kind of liability in case the cure comes out and two years later, finds out it does something that it wasn't intended to?

**JIM BUTLER:** OK, so that the liability for that type would go to the contract manufacturer. So when they bid on, hey, we want to mass-produce the cure, that's part of what the price will be that, for the, for the cure and will encompass taking on that risk. So that risk is offloaded onto the contract manufacturer. The states would never have any liability for anything like that.

**B. HANSEN:** OK. And so then when it is mass-produced-- I'm looking at the flowchart, there's that-- those, they, they'll break your mass-produced cure at cost. And so then those who are in the compact get it at a different price compared to those who weren't?

**JIM BUTLER:** Correct. So they, if you're in the comp-- there's every advantage to being in the compact, because besides being part of the potentially great thing of curing diseases, you get it at the manufacturing cost and license your distribution, just the cost. Everybody else, as Senator Murman mentioned, they have to pay a royalty on top of the cost. It's still going to be way less than virtually every other drug out there, less than a generic. But they have to pay a royalty that's equal to their projected five-year savings so that everyone pays their five-year savings. So and that's added per cure dose. So however many doses are projected, five-year savings, say Ohio wasn't a member compact, in the compact and Ohio wanted to buy the cure after it's invented. Then Ohio would pay the cost plus a royalty equal to the number of projected cure doses or the five-year, projected five-year savings divided by the number of cure doses. That royalty money, that's extra money. It's not part of the reward that goes to pay the bank interest, day-to-day operations of the compact. And then it goes to pay the compacting states and offsets any required savings payments that they would have. So being in the compact, not only do you get the cure at cost, the compacting states will likely never have to share in the four-- to five-year savings. They'll be able to get the savings right away because there will be more people outside of the compact, the whole rest of the world, compared to those that are in the compact.

**B. HANSEN:** OK, and who verifies the cure?

**JIM BUTLER:** So the cure when it's presented has to be-- of course it's in the bill, it has to be approved by the FDA. So the FDA has already approved it as a product that's, you know, it's safe and effective for humans. So that's part of this process. But even after that, the bank that is-- different banks can underwrite different diseases that are posted by the, by the compact. But jointly with the compact, the bank will come up with cure criteria. So in addition to being approved by the FDA, it has to have this level of efficacy, this level of side effects or less, you know, maybe this manufacturing cost. [INAUDIBLE] I'm an attorney, you know, all the legal requirements. And that's,

that verification will happen jointly between the bank and the compact because the bank is the one taking the risk and it has to meet that legal requirement. That was essentially an open offer by the bank, that if your, if your product meets these requirements and you, and you want to, you don't have to give up, trade us your intellectual property and your patent for the reward, then that's a, it's a legal transaction.

**B. HANSEN:** OK, the FDA wouldn't verify the cure.

**JIM BUTLER:** They have, they have to verify and approve that product as a product.

**B. HANSEN:** Yes.

**JIM BUTLER:** But it doesn't necessarily meet the cure criteria.

**B. HANSEN:** Yeah, and that's what I was wondering, because when you get the FDA involved, now you're getting government involved and trying to find a cure and trying to get the private sector involved. And that just muddies the whole waters, especially when the FDA is mainly made up of pharmaceutical companies.

**JIM BUTLER:** You're exactly right.

**B. HANSEN:** It's a--

**JIM BUTLER:** Totally, totally.

**B. HANSEN:** I've been in the national health care field for a long time. For decades, we've been talking about how nobody really wants to find a cure in pharmaceutical because then you won't make any money off of it. At least that's the old adage anyway, not saying that they don't. But when, when somebody does develop a cure, is there a difference between a medical versus a natural cure?

**JIM BUTLER:** No, there is not. It could be a natural cure. It doesn't necessarily have to go through the FDA if it does-- if it normally would have to go to the FDA. So if you find out that, you know, feeding you know, putting extra pepper in your soup--

**B. HANSEN:** Yeah.

**JIM BUTLER:** -- cures cancer and you prove it and it saves money, has to result in savings. And it was, it was listed as a, an open offer for a reward if you meet these requirements, then it can be a natural cure.

**B. HANSEN:** I know natural is kind of a--

**JIM BUTLER:** Could be anything.

**B. HANSEN:** -- bastardized term, but it kind of is now. You know what I mean? It's been, been used for all of these different kind of purposes. And so--

**JIM BUTLER:** That's right.

**B. HANSEN:** -- I appreciate the innovative approach to this, because I think that's usually how you get stuff done. That's kind of what America was kind of founded on, you know, [INAUDIBLE] private sector and trying to find, you know, supply and demand-type free market kind of policies, so I appreciate that. Thank you.

**JIM BUTLER:** Thank you.

**ARCH:** I have a question. Who pays for the research?

**JIM BUTLER:** So, Chairman, the research is all private sector. So the compact sent with the banks, they put out that open offer, which is cure criteria, plus projected five-year savings for what the reward will be, and then they're done. And if somebody, if the private sector sees $20 billion if you cure Alzheimer's, which is roughly what it would be if about 10 states were part of the compact project-- state savings for Alzheimer's. And then all of a sudden, you know, not just biotech and pharma, but I would foresee startup companies saying, hey, I'll raise $500 million and I'll do all this research in the private sector at different research universities and find and meet the criteria. All that's done in the private sector. And if they want to meet that criteria, if that's what they're aiming to do. Of course, they can just sell it if they, if they would rather, and then they come forward. So it's all in the private sector that's doing the research on their own. So that's, the government is not involved in that at all other than if they want to come and claim the reward, it has to be ethically done research. So that's one thing that's very

clear in this, in this bill, is the ethical standards for the research have to be the highest common denominator of all 50 states, whether they're in the compact or not. So it's the highest of ethical standards.

**ARCH:** So I'm sure you're familiar with the process generally that happens. NIH funds research, there's a, there is a scientist that discovers a cell-signaling process, discovers the-- discovers how, how to block the signaling and stop the progression of the disease. But in that process, the scientist has discovered something--

**JIM BUTLER:** Absolutely.

**ARCH:** -- that is patentable.

**JIM BUTLER:** Yes.

**ARCH:** And they go out and get it patented and then they go and present it at, at the conferences and tell people what, what they have discovered. But it's already, it's already, it's already protected by the scientist.

**JIM BUTLER:** Yes.

**ARCH:** I guess I'm stumbling on how then does that-- first of all, why would the scientist give up the patent? Why would, why would the scientist turn a patent over to the, to the compact, to the commission? And then, of course, what generally happens is more money comes from the manu-- the pharmaceutical company, if it's, if it happens to be a drug process. But the pharmaceutical company that provides the dollars to the scientists to go into phase one, phase two, phase three.

**JIM BUTLER:** Sir.

**ARCH:** And more dollars are coming and but, but the scientist still controls the patent.

**JIM BUTLER:** Yes.

**ARCH:** So this is a very different model. And, and of course, while, while I understand your, your, your concept that we seek treatment,

not cures, the finding of a cure would not be a short-term process with no guarantees of outcome, long-term, large dollars on the hope that a cure would result with no real payoff in between until the cure is found, correct?

**JIM BUTLER:** Well, so I guess I'll, Chairman, I'll start with that because--

**ARCH:** [INAUDIBLE] questions in there.

**JIM BUTLER:** -- because you absolutely described it perfectly. Typically, the scientist that has the patent, just like they would now as they partner, they maintain those rights. You know, that's obviously worth a lot to them, worth a lot of money. They might, and they, if it was sold in the open market, they'd share in the revenue and they'd be able to make a lot of money with that. Because they have the right to the patent and the intellectual property, it would be up to them. They wouldn't have to. But if they wanted to get $20 billion upfront in exchange for their work, they would be able to say they have a 50 percent deal with the pharmaceutical company for future revenues. And then they, they have to agree because they have the intellectual property to do it. So they say, yeah, we want 20, $20 billion, we'll take 10, you take 10. That's their choice, completely up to now if they want to do that. And then in terms of the delay, that's currently what happens. There's a lot of money invested. You don't make anything until it's approved by the FDA and launched, and then you make money. This actually is better because if you do want to claim the reward, the bank gives you a check up front. So you, it's even better from a, from a private sector perspective, because that's a sure thing for you. You've met the criteria. You come forward, you're essentially selling your intellectual property, your patent in exchange for the reward, and then you get a check and you're done. Unlike now where you go through that years and years and years and lots of money and investment, and then you still have to hope that something doesn't happen down the road, you know, and somebody comes up with a better, better cure or better treatment in this case in the current model. And then you don't make as much money as you thought. This way you just get it up front. So it's, according to talking to lots of different researchers and biotech and pharmaceutical companies, that would be even more attractive, but it's still completely up to them if they want to do it or not. So there's--

**ARCH:** All right, thank you. Senator Day.

**DAY:** Thank you, Chairman Walz [SIC], and thank you for being here today. I think this is a really fascinating and interesting concept, and I appreciate you traveling all the way to talk to us today and including the state of Nebraska in the conversation. It says that it would take six states to pass the cure bill before the compact is formed. Are you currently working with any other states on this?

**JIM BUTLER:** Yes, there, there are-- we, I started this after July of 2019 when we passed it in Ohio. And then I started talking to other states. We had 14 states introduce it, about 6 others were about to introduce it before COVID hit. And so then we took, there was, obviously everybody had a little bump in the road there. And now we have 31 states, I think, or maybe a couple more that have either already introduced it this session, which I think we're at 12 or 13. And then, and in fact, I just testified in Utah virtually--

**DAY:** OK.

**JIM BUTLER:** -- I think last week. But then so it's moving through the process just like it was. So it's really a new--

**DAY:** OK.

**JIM BUTLER:** -- a new process. But a lot of it's, and it's bipartisan in every state and there's a lot of enthusiasm. So we're very hopeful that it will get to that six states.

**DAY:** OK, great. Thank you.

**ARCH:** Other questions? Senator Hansen.

**B. HANSEN:** It sounds like the general philosophy is to get government out of it. I mean, as Senator Arch was talking [INAUDIBLE] the NIH typically involved, you have data to some extent, pharmaceutical companies, but actually making this more of a private sector-driven enterprise. I mean, instead of the typical way we've been doing it for, I don't know, 40 years? I mean, and about controlling symptoms and not finding a cure. I mean, because that's really, really, really only gonna get compensated, when they actually find a bona fide cure. And I think that's kind of the keystone to your whole flowchart.

**JIM BUTLER:** It is.

**B. HANSEN:** Is that finding the cure, because if you're wrong and it's not a cure and you just paid somebody a bunch of money, then that's on the states. I mean.

**JIM BUTLER:** It's, it's on the bank.

**B. HANSEN:** It's on the bank. OK, not the states?

**JIM BUTLER:** Just like an investment bank.

**B. HANSEN:** OK.

**JIM BUTLER:** Like they bet on companies all the time.

**B. HANSEN:** OK.

**JIM BUTLER:** And I've talked to banks. They're very enthusiastic about this because they can decide by the cure criteria.

**B. HANSEN:** They'll have a say in it.

**JIM BUTLER:** Yeah, a big say.

**B. HANSEN:** OK.

**JIM BUTLER:** So that's a good bet for them. And then, like as I mentioned earlier, they can charge interest for the risk. So they can monetize the risk, which is what the private sector is very good at. But if it falls short, and they calculated wrong, you know, and the cure criteria didn't pan out the way they thought, the states never pay anything unless they save money.

**B. HANSEN:** So the states would almost be like the equity that the banks then would rely on if they actually, if they were right.

**JIM BUTLER:** Correct. For future savings.

**B. HANSEN:** Yeah, OK. That's what I'm trying to wrap my head around.

**JIM BUTLER:** Yeah.

**B. HANSEN:** So.

**JIM BUTLER:** So they're betting on future savings.

**B. HANSEN:** OK, all right. Good, I like it.

**ARCH:** Other questions? Senator Walz.

**WALZ:** I just, I have a quick question. Is there a lot of opposition from the inventors. I don't know what other word to use, inventors, on this bill?

**JIM BUTLER:** So pharma in some states, either sometimes they're neutral and they're behind the scenes, not working against it or they're outright opposed to it. So kind of big pharma, just for the same reasons I just mentioned at the beginning of my testimony, because they stand-- if there is a cure, they stand to lose a lot of money. It's not their fault, but that's the way the system is. So in states that it's pharma who has shown to be in opposition or behind the scenes, you know, opposition to this bill. But the inventors, the research scientists, they love it. So Emory University, for example, in Georgia, they testified as a proponent when I was in Georgia, because they get it, that this is a big problem. And they're going to, they're likely going to get even more research that will come in. And a lot of those researchers, they get into the, they become researchers because they want to, you know, either personally they were affected or they just, they want to do something great for society and cure one of these diseases. And they go through the process and get this money from NIH and from the charities and they know they can cure these diseases. And I've heard it so many times. And then they can't get funding for human clinical trials. It's, and it's, and they get-- and they're very frustrated about it. So this gives them the potential, the extra incentive for whether it's pharma, biotech or brand new companies that are just saying, hey, we're going for the cure and we're going to invest in all these human clinical trials, we're going to partner with research universities and do that. That gives them the opportunity to see their dreams fulfilled and have these diseases get cured.

**WALZ:** OK, thank you.

**ARCH:** Other questions? Seeing none, thank you for your testimony.

**JIM BUTLER:** Thank you, Mr. Chair. Appreciate it.

**ARCH:** Other proponents. Yes?

**JIM BUTLER:** I also wanted to thank Senator Murman for all of his leadership on this.

**ARCH:** Certainly. Other proponents? Seeing none, any opponents? Seeing none, anyone wish to testify in a neutral capacity? Seeing none, Senator Murman, you're welcome to close. And we had no letters and no written testimony.

**MURMAN:** Thank you, Chairman Arch and fellow committee members. With LB418, I believe that Nebraska has a great opportunity to be a founding member of the cure act compact and join this cause to fund cures for diseases that afflict us today. If no cure is found, as we talked about, no prize is awarded. I see tremendous upside potential for this bill and virtually no downside. I wish to personally thank Mr. Butler for traveling from Ohio to join us today. If you have any questions.

**ARCH:** Any questions for Senator Murman? I'm sure we'll think of others later. This is just kind of starting to, to percolate, right? All right. Thank you.

**MURMAN:** Mr. Butler has given me a lot of answers for probably about anything you can shoot at me, as you've seen, seen already.

**ARCH:** OK.

**MURMAN:** Thank you.

**ARCH:** All right, thank you very much. This will close the hearing for LB418 and the hearings for the day.