HANSEN: Well, good afternoon, everybody. Thanks for coming. And welcome to the Health and Human Services Committee. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming, and parts of Stanton Counties. And I serve as the Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Day.

DAY: Good afternoon. I'm Senator Jen Day. I represent LD 49 in Sarpy County.

HARDIN: Senator Brian Hardin, District 48: Banner, Kimball, and Scotts Bluff Counties.

RIEPE: Merv Riepe, District 12, which is Omaha metro and the fine city of Ralston.

HANSEN: Also assisting the committee is our legal counsel, Benson Wallace; our committee clerk, Christina Campbell; and our committee pages are Maggie and Molly. A few notes about our policy and procedures: please turn off or silence your cell phones. We will be hearing five bills and will be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you'll find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are yellow sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note: if you are not testifying but have an online position comment to submit, the legislators' [SIC] policy is that all comments for the record must be received by the committee by 8:00 a.m. the day of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use the light system for testifying. Each testifier will have three to five minutes to testify depending on the number of testifiers per bill. 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 that you wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then spell both your first and last name. 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. On a side note, the reading of testimony that is not your-- that is not your own is not allowed unless previously approved. And we do have a strict no-prop policy in this committee. So with that, we will begin today's hearing with LB1381, which is my bill. And then I will hand it over to Senator Walz, if you could-- to be the Chair while I'm gone.

WALZ: Oh, OK. Oh, gosh. Wasn't ready for this.

HANSEN: [INAUDIBLE] stay there if you want. That's fine.

WALZ: OK. Here we are.

HANSEN: Letters for the record online--

CHRISTINA CAMPBELL: It's in [INAUDIBLE].

HANSEN: OK. Thanks. Thank you.

WALZ: Yeah. Welcome, Chairman Hansen.

HANSEN: Thank you. And good afternoon, members of the HHS Committee. My name is Ben Hansen. That's B-e-n H-a-n-s-e-n. I represent LD 16 and will be talking about LB1381 today. LB1381 is about helping able-bodied welfare recipients get back to work. Our economy, our budget and tax revenues, and, most importantly, those who find themselves in difficult situations will benefit from the changes my bill will make for those who receive SNAP. We can help those who are ages 16 to 59 that are able-bodied and capable of successfully holding employment attain the power of self-sufficiency. LB1381 alsh-- also ensures our welfare programs are thriving and effective. This is a commonsense bill with three parts, and none of, none of them are all that new. In fact, Idaho passed a bill almost identical to this one just last year because they're dealing with a lot of the same workforce issues that we are seeing here. The three parts makes sure Nebraska has a statewide work requirement for all able-bodied adults on food stamps who can and should be working. First, it codifies our state's across-the-board work requirements for able-bodied adults with dep-- without dependents. We already have a statewide work requirement for that group now, but this ensures that we keep one. Other agencies in other states have waived the work requirement without the legislature even ever knowing. We should prevent that in Nebraska, and this bill does just that. States like

Kansas, Missouri, Arkansas, and Florida have also codified this practice into law. Second, even if the department doesn't weigh the work requirement under federal law, they are allowed to use discretionary exemptions or no-good-cause exemptions that let able-bodied adults get out of work free. They don't qualify for an exemption. They don't have a good cause to not comply. That's its own exemption, but the department can exempt them anyway. The department has a stockpile of more than 85,000 such exemptions that could be used to exempt the entire population of able-bodied adults without dependents in Nebraska from the work requirement for months if it wants to. This bill closes that loophole. And again, not a new reform. Other states have done this, such as Arkansas, which passed a bill to this effect two years ago, and Kansas already has this provision in their statutes. Third, and most importantly, it expands Nebraska's work requirement inc-- to include more able-bodied adults. We already fund an employment and training program to get folks back to work, but we don't make it mandatory. Instead, participation is voluntary. And of 17,000 people who would be eligible, the department has 186 participants for the year. Let me repeat: 186 participants out of 17,000. This is important because that is the only way we can require able-bodied adults between 15 to 60 and able-bodied adults with school-aged kids to work, train, or volunteer part time. Otherwise, there is no work requirement for them even with the first two parts of the bill. This bill makes participation mandatory for all able-bodied adults on food stamps who don't have small kids. They either got to work or participate in this program. And by the way, participation will still be low because people will, will work instead. Texas already does this. And out of the folks required to participate or work, only some of them participate. The rest either work or end up leaving the program because their income goes up, which is a good thing. We need these reforms. Nebraska has a workforsh-- workforce shortage crisis. There are "help wanted" signs everywhere, there are 61,000 open jobs in Nebraska, and there are around 30,000 able-bodied adults without young dependents on food stamps. All of us are here because we worked. We know our communities are built around work. None of this, including spending on welfare programs, can happen without work. This legislation taps into Nebraska's natural work ethic and makes sure these programs prioti-- priori-- prioritize the truly needy. I am working with DHHS to come up with an amendment that makes sure the department can handle the demand and that exemptions comply with federal regulations. But let me remind you that the employment and training options provided by the collaboration between the Department of Labor and DHHS are proven to be helpful. Why wouldn't we want to help people? Of the last 1,082

individuals who received training, 86-- 86-- 46 have made visible advances in life. 227 of them were able to get off food-- SNAP entirely and get back to their feet, while 184 of them were able to lower their SNAP reliance. On average, they are able to increase their annual income by $15,000-- and that's a substantial amount. The training and employment options provided through LB1381 would help people with bus passes, background checks, car repairs, driver's license, uniforms, child care, skills trainings, tuition, books, and list continues. This is valuable for not only those who enroll but also an advantage to their families. To ignore this resource and to say that LB1381 is problematic is to say that you don't want actions to be taken that will promote growth, success, and productive options for those who can benefit from our help. Let's give Nebraskans this assis-- this assistance to advance and achieve the ability to, to succeed. Thank you for your time and thoughtful consideration. And I'm happy to answer any questions that you may have.

WALZ: Thank you. Questions from the committee? I don't see any.

HANSEN: And I'll stick around for closing.

WALZ: All right. Sounds good. I just want to give a reminder to testifiers that there's a three-minute time limit. So when you see the yellow light, it means you have one minute left. And then when you see the red light, it's time to make your closing remarks. So I'll call for any proponents to the bill. Hi.

ROY LENARDSON: Senator Walz, thank you very much. Members of the Health and Health-- Health and Human Services Committee. My name is Roy Lenardson, R-o-y L-e-n-a-r-d-s-o-n. And I'm a visiting fellow at the Opportunity Solutions Project. We're a nonprofit organization dedicated to helping folks get back to work, from welfare to work. I'm, I'm here today to support LB1381. It's a great piece of pro-work legislation that would help people on food stamps become self-sufficient and preserve benefits for those who truly need them. I, I thought Senator Hansen did a great job articulating all the details of the bill. I won't-- it's in my testimony, and the links and sources and some handouts are coming around now on that. I'll talk just more philosophically why we support this type of legislation. We very simply believe that work is a miracle, that the food on your table, the clothes on your back, and the roof over your head were bought and built by work. And then when folks go to work, it's more than just a paycheck. It's about dignity. And it's about a sense of purpose in your community. And so whenever we can be in a state and work with folks to make sure that people have the

opportunity to go back to work, we think that's a good thing. The other thing that we really like about this bill in particular is it says to your Department of Labor, your Department of Health and Human Services, we're not going to just ask you to replenish EBT cards. We're not going to ask you just to mail people EBT cards. We're going to engage with you one-on-one. We're going to be involved in your success. We're going to help you be successful. And we can do whatever we can to make sure that you're enjoying the life in, in Nebraska that you should. And so I think it's a very important distinction as departments change the way they do business where they become advocates for individuals as opposed to processors for government programs. It changes their outlook. And it's been a tremendous, tremendously effective program. It, it was mentioned-- the senator mentioned some of the states that do that: Texas, Idaho, Florida. I will just note that the results have been pretty amazing. And the first-year folks that are on these types of programs, their incomes double. In the third year, their incomes triple. Most of them move off of food stamps and engage and are back in society as folks who are members of your community. So it's not about just higher incomes. It's reengaging with your communities, getting skills and connections, and building a foundation for ch-- for the American Dream for years to come. It's-- America is a great country because it was built, and it was built by hard work, as folks in Nebraska well know. So we believe LB1381 will lift thousands of Nebraskans out of dependency and put them one step closer to experiencing the American Dream. Thank you for your time. I'm hanswer-- happy to answer any questions that I can.

WALZ: Thank you so much. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chair. Thank you for being here. One of the questions I have is, if a person is working in this particular area and happen to not be working at the time, are they required or expected then-- I guess required would be the an-- question here-- are they required to take any other piece of work or are they allowed to say no, not until I find something that's in my, quote unquote, whatever they consider their area of, of skill?

ROY LENARDSON: Yes. Madam Chairman, if I may. Senator, that's the great thing about this program, and what they found-- for example, I'll use Utah as a specific example. Lots of rural areas in Utah and in Texas as well. There are tremendous online virtual programs. I'm sure your Department of Labor runs those programs as health and human services. So for folks who want to change their skills if there's not employment immediately available, they have that option, and that

counts as well in the employment and training effort. In addition to that, they're working to help people develop skills and to train their skills so they can find work. So it's a very flexible program. Some of it even involves just the basics, which your Department of Labor does very well throughout the state, which is a new resume, skills, interviewing, job assessment, [INAUDIBLE] types of work. So it's really a hands-on process that would work much better. And it's, it's-- I wouldn't say it's disappointing. The problem with a voluntary program is if you only have 186 folks participating, there's lots of folks that are missing out on the opportunity, so.

WALZ: Yes, Senator Riepe.

RIEPE: I have a follow-up question, and that would be is, what makes this uniquely different than other programs we've had to try to help people find work in an environment that's-- there are a number of jobs? What makes your program di-- what makes this program different, unique?

ROY LENARDSON: Well, this is a program that has existed in Nebraska for 50 years. You guys have engaged in this specific program helping get folks back to work, and it's been very successful for the folks that take the program. So I think from our perspective, you have a program that works. We're hoping to codify it and encourage-- and make it not voluntary but mandatory to get those folks back to work. I will also say that your department has a thing called good cause exemptions. If it's a geographically isolated areas or rural areas without, without jobs, they are allowed to grant waivers for folks like that and exclude them from the program.

RIEPE: So are you telling me LB1318 is basically a change from voluntary to mandatory, boom?

ROY LENARDSON: Three things. Yeah-- Madam Chairman. Three, three thing-- one-- that's one of them. In addition to that, this program also looks at expanding the program to include folks whose kids are now in school. It does not do that now. And also expanding it from the ages-- I think now it starts at 52 you don't have to do it. I think this changes it from 53 to-- up to age 59. So it expands that pool, which is about-- I think that's the 17,000, 18,000 number make up a lot of population.

RIEPE: That's what I was looking for. Thank you, Chair.

WALZ: Mm-hmm. Other questions from the committee? I don't see any. Thank you so much for--

ROY LENARDSON: Thank you.

WALZ: --being here today. Next proponent. Any opponents?

KATIE NUNGESSER: Thank you, members of the Health and Human Services Committee. My name is Katie Nungesser, spelled K-a-t-i-e N-u-n-g-e-s-s-e-r. I'm here representing Voices for Children. We are opposed to LB1381 as a costly, ineffective, and harmful approach to addressing SNAP benefits and work requirements. It creates unnecessary barriers to food access without addressing the root causes of unemployment. There is no credible eviden-- evidence suggesting that receiving SNAP benefits is discouraging Nebraskans' unemployed adults from seeking employment. Instead, this bill is risk-- risking stripping essential SNAP benefits from some of the most vulnerable Nebraskans, including children. We are particularly concerned about the children residing in Thurston County on the Winnebago and Omaha Reservations. This bill does prevent Nebraska DHHS from utilizing any waivers for work requirements. Current law provides state agencies with discretionary exemptions, recognizing the unique challenges faced by individuals in specific regions such as Thurston County. Nebraska currently is using that in Thurston County for an-- and also for anyone in the Winnebago or Omaha Reservations due to a lack of sufficient jobs in the area. Native Americans living in Thurston County are facing higher than average unemployment rates that are attributed in part to the rural location and the economic disadvantages of the reservations. 2020 census data reveals that half of all residents in Macy are children, and Winnebago children make over-- make up over 60% of the population. The median income in these areas is under $21,000 per year, and almost 60% of all the kids living in those areas are under the poverty line. We are urging you to consider the devastating impact this bill could have on kids in Thurston County and other economically disadvantaged areas. Maintaining DHHS's ability to make informed decisions on waivers is imperative. Waivers have proven to be a vital tool for our state, ensuring Nebraskans have equitable access to SNAP. It's important to note that in every state in the U.S. except for one, utilize-- or, waivers have been utilized at some point, often for Native American reservations. States must provide a detailed evidence of high unemployment rates and adhere to rigorous standards set by the USDA. Waivers represent a proactive strategy for our state to address unique challenges and ensure that our citizens, regardless of their location, have the support they need to feed

their families. I spent over a decade as part of the on-the-ground SNAP outreach efforts across the state. In my experience, DHS [SIC] does tend to err on the side of all adults being able to maintain employment even if they truly can't. This leaves many Nebraskans incorrectly labeled and losing their food benefits. The process is hard to navigate, and many applicants don't know how to fight for their case to get corrected. A saving grace for these families had been the exemption in the current rules for families and children. This bill removes that and puts up more barriers and puts kids at risk of losing SNAP. Not a single Nebraska child should go to bed hungry or wake up uncertain where they will get their next meal. SNAP plays a vital role in addressing family food insecurity, and limiting access with additi-- additional work requirements for parents would lead to more hungry children, not fewer. For these reasons, we're strongly urging you not to move forward with LB1381. We ask you to trust the current work requirements that are in place and trust Nebraska DHHS to operate the exemption process as it exists. Thank you.

WALZ: Thank you. Questions from the committee? I don't see any. Thanks for being here today. Next opponent.

ALICIA CHRISTENSEN: Good afternoon, Chair Hansen. I just have that, like, programmed, I guess, so. Chair Walz and the members of the Health and Human Services Committee. My name is Alicia Christensen, A-l-i-c-i-a C-h-r-i-s-t-e-n-s-e-n. I'm director of policy and advocacy at Together, an Omaha organization serving our neighbors who face housing and food insecurity. I think we can all agree that with more than enough food to go around, none of our neighbors should live in hunger as they work to gain self-sufficiency. SNAP is an incredibly effective program that reduces participants' food insecurity by up to 30%. I found it hard to write my testimony because LB1381 runs counter to the reality that the statistics certainly show us-- only 8% of all Nebraskans are on SNAP. The work rates for households that are participating in SNAP is about the same as the rates of work in-- among households that don't participate in SNAP. It's 83% for SNAP participants and 87% for nonparticipating house-- households. And it also runs counter to an increasing body of strong evidence that indicates removing conditions on assistance is the most effective way to address poverty and food insecurity. Numerous pilot projects have provided participants cash payments, no strings attached, and reject the harmful and false assumption that people experiencing poverty don't want to work. Studies analyzing these outcomes-- the outcomes of these projects have found them to be successful and have documented improved economic security, nutrition,

school attendance, and child safety with positive spillover effects within the community. While I understand Nebraska may not be ready to implement a no-strings-attached cash assistance program, we can still draw on this growing evidence to see that the more requirements and less flexibility is moving us in the wrong direction. After all, most SNAP participants work. And there's little to no evidence that mandatory E&T programs prov-- improve employment options because this one-size-fits-all policy is not appropriate for the diverse array of individuals participating in SNAP, from teenagers to people approaching retirement. So we all want to live in a state where every family has enough food to eat, and SNAP is a key component in making this a reality. I ask this committee to oppose LB1381 because its proposed policies undermine Nebraska's SNAP program and take us further from the food security we envision. I can answer any questions if you have them.

WALZ: Thank you. Questions from the committee?

ALICIA CHRISTENSEN: Thank you.

WALZ: Thanks a lot. Any other opponents? Good afternoon.

RASNA SETHI: Good afternoon. Good afternoon, Senator Walz and members of the Health and Human Services Committee. As the health policy analyst at OpenSky Policy Institute, my name is Rasna Sethi. That's R-a-s-n-a S-e-t-h-i. And I'm here to testify in opposition of LB1381 because numerous studies have shown that work requirements on safety net programs are costly and highly ineffective. The structure of work requirement programs in and of themselves is temporary, as they prioritize securing an immediate, often low-wage job for participants. A 2015 pilot program in ten states, including Kansas and Illinois, implemented mandatory SNAP education and training. The results of this pilot showed that work-based learning programs did not lead to permanent employment. Rather, mandatory implementation led to challenges with service delivery that reduced participation engagement and-- increasing administrative burden relating to noncompliance and sanctioning participants. Additionally, economic evidence indicates that the majority of SNAP recipients who can already do work, although often in a low-wage position that may be seasonal, hourly, or have unpredictable schedules through which may result in the cycling in and out of SNAP eligibility. Many recipients, especially those in rural communities, face barriers to work such as reliable transportation. Ultimately, these requirements push individuals out of eligibility for SNAP rather than improving economic mobility and labor participation. Finally, a case study in

Virginia found that-- found a significant drop in SNAP enrollment with no real economic boost in job creation and retention following the implementation of work requirements. Work requirements there also failed to increase employment and-- or earnings 18 months after participation in the program. Working-aged adults without children were only earning about at most an additional $28 per month whether or not they lost their benefits with the resumption of work requirements in Virginia. If removed to SNAP, these people typically took a loss of $189 in benefits per month. Work requirements are ineffective and don't just-- don't justify the increased administrative burden that-- would place not only SNAP beneficiaries but also the Department of Health and Human Services. According to the fiscal note, if expanded, the SNAP E&T program would cost the department $1.9 million in fiscal year '25 and $2.7 million in fiscal year '26, significantly increasing the administrat-- the cost of administering the program in the state of Nebraska. For these reasons, OpenSky Policy Institute opposes LB1381. I'm happy to answer any questions you may have.

HARDIN: Thank you. Any questions? Seeing none. We appreciate it.

RASNA SETHI: All right. Have a good one.

HARDIN: Anyone else here in opposition to LB1381?

GRACE JACOBSON: Who am I supposed to give this to?

HARDIN: Welcome.

GRACE JACOBSON: Hi. My name is Grace Jacobson, spelled G-r-a-c-e J-a-c-o-b-s-o-n. And I'm here as a disabled member of the community to advocate on behalf of myself and friends who are also disabled in the community against this bill. Many of us who are disabled and can barely make ends meet don't even qualify for SNAP if we are able to work. I've gone weeks where I've only had rice and mayonnaise for all of my meals because I cannot afford food due to paying for medications, various expenses such as doctor's appointments, physical therapy, and other health care-related items. The fact that people think those on SNAP are not already working to the most, like-- to the greatest ability they have is very frustrating because everyone I know who is able-bodied and on SNAP is working. The only people I know who aren't working at least part time are disabled people or full-time caregivers to people such as children or other disabled individuals. I apologize. I'm kind of rambly. I didn't know if I could even make it to this hearing because I had to leave work during

my lunch break to come and speak to you. It's very frustrating just knowing that people want work requirements. The other issue with work requirements is, as a disabled person, there's a lot of jobs I cannot do. I appear able-bodied. I appear neurotypical. I seem to be put together, able to work, able to do everything. I can't. I cannot stand for long periods of time. I get flustered and become unable to articulate my speech due to cataplexy. And again, I am doing as much work as I possibly can, but finding employers that will accommodate my disabilities is nearly impossible. At this point, I am self-employed, which is an extreme privilege that most people cannot afford to do. So I ask that this body really take into consideration the fact that we are working. And even those of us who are working, we're not making do. We're not making ends meet. So taking away SNAP from those who make even less than I do, that's a-- that's just disaster. I don't want anyone else to have to survive off of rice and mayonnaise, if they even have that, for two weeks straight because they have to decide between their medication and their food. And that's all I have to say. If you have any questions, please feel free to ask. Thank you.

HARDIN: Thank you. Any questions from the committee? Seeing none. Thank you. Anyone else in opposition to LB1381? Welcome.

KEN SMITH: Thank you. Good afternoon, Interim Chair Hardin, members of the committee. My name is Ken Smith. I'm the director of the Economic Justice Program at Nebraska Appleseed. And we're strongly opposed to LB1381, which essentially I think does two things. One, it strips away our state agency's ability to claim certain valuable waivers that have been critical tools in fighting hunger across our state. It also makes our voluntary SNAP E&T program a mandatory SNAP E&T program. Both of these objectives are harmful. Stripping DHHS of the ability to use temporary and limited work requirement waivers removes an important tool that we have to fight hunger, particularly in times of high unemployment. The waiver option was designed to permit states to seek waivers in areas where jobs were not available. To qualify for a waiver, states have to provide detailed evidence of high unemployment in local areas that meets rigorous standards set forth by the USDA. In general, taking away flexibilities that we can use at our discretion to fight hunger during economic downturns is a bad policy idea. This becomes even more evident when you consider who specifically this bill would hurt. I think, as another testifier noted, since federal waivers were created by Congress in the late '90s, Nebraska has only utilized these waivers to help alleviate hunger in Thurston County and on the Omaha and Winnebago Reservations, which have experienced much higher unemployment rates

than in the rest of the state. The other major change proposed in this bill is to go to a mandatory SNAP E&T program. That's not only a misguided policy idea, it would be virtually impossible to administer without a significant appropriation of state funds. And to be clear, several states-- including Nebraska, as you heard-- implement voluntary E&T programs, which are very valuable. We actually worked alongside DHHS extensively to expand Nebraska's voluntary SNAP E&T programming between 2016 and 2019 through the use of third-party partners-- third-party partners being community based organizations that can contract with the state to provide employment and training programming. DHHS gravitated towards this third-party partnership model in large part because they just didn't have the capacity to offer meaningful statewide E&T prog-- programming on their own. It's our understanding that even with some expansions that may have happened since 2019 that capacity is still limited. A mandatory E&T program would immediately overwhelm our existing infrastructure. Participation would be very hard for people who do live within the limited service areas we have, and it would be impossible for those who don't. Even if imposing this was plausible, it would still be a bad idea. There is an unmistakable shift for states across the country that have tried this and are moving away from it in droves. At least 18 states have transitioned away from mandatory programs. 42 states have voluntary programs. The reason that they're moving away from it is because they cost a lot of money. States end up emptying their coffers on enforcement and oversight and federal compliance where they could just be spending that money on training and employment initiatives. The weight of the evidence from looking across the country shows that this is a bad idea. I see my light has turned on, so I will stop there. And I'm certainly willing to answer questions if you have them.

HARDIN: Thank you, Mr. Smith. Any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Would you want to finish what you were saying?

KEN SMITH: Yes, that'd be great. I was saying that mandatory E&T programs force states to spend resources on extensive monitoring and enforcement; those should be spent on education and training. We should learn from states who are jettisoning these mandatory programs and avoid dumping our own dollars into a similar failing program. And lastly, others have touched on this as well, but we don't need a mandatory SNAP E&T program because we already have and enforce work requirements for SNAP participants, with stricter rules that apply to able-bodied adults without dependents. So my-- in closing, we oppose

this because it would strip away our ability to use a critical anti-hunger tool when the need is highest. It would exacerbate food insecurity in communities across the state, with a particularly harsh impact on Native populations. It would derail our current productive, smaller scare-- scale, voluntary E&T program and replace it with a costly, ineffective, and impossible-to-administer mandatory one. And in general, it would just move us several steps backwards as we-- that other testifiers here and so many others across the state are trying to move us forwards in fighting food insecurity in Nebraska.

HARDIN: Thank you. Any additional questions?

M. CAVANAUGH: Yes. I do.

HARDIN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Mr. Smith, for finishing your thoughts. So you said that-- I think it was 42 states have voluntary-- this-- has a volunteer program, as does Nebraska currently.

KEN SMITH: That's right.

M. CAVANAUGH: And was it 18 states have transitioned away from mandatory? What states still have the mandatory? What are the eight states that still have the mandatory? If you know.

KEN SMITH: I know that Utah is one of them. I know that Kansas has a split voluntary and mandatory system. I think Utah might be the only one that has a purely mandatory E&T program. I couldn't off the top of my head to tell you those other ones. I do have that information. I could send it to you.

M. CAVANAUGH: OK. I'm just curious because this-- a, a previous testifier had a list of states that have mandatory versus those that don't. And it says that states that have not implemented the pol-- work requirement are-- it lists only 3 states, but it sounds like 42 states have no mandatory work requirements.

KEN SMITH: As of the-- so the last USDA "State Options" report showed that [INAUDIBLE] 42 states that run a voluntary E&T program, only one state, Utah, that runs a fully mandatory program. And then-- I'm bad at math. What, 7, 8-- 42. Yeah. Seven states that have a sort of hybrid mandatory-voluntary.

M. CAVANAUGH: OK. I have--

HARDIN: Sure.

M. CAVANAUGH: I think Senator Day-- I'll let her jump in.

HARDIN: Well, go ahead and, and finish your reading. I insist. And then we'll come back to Senator Day in a moment. Go ahead.

M. CAVANAUGH: I, I, I will reserve my questions. They might get answered.

HARDIN: OK. Great. Senator Day.

DAY: Thank you, Chairman Hardin. And thank you for being here. So I just need to clarify. So I think-- and I certainly don't want to misspeak on behalf of Mr. Lenardson, who was a proponent of this bill. I thought I heard him say that in rural areas or-- we were-- you were referring to these Native areas, reservations where there's not as great of access to job opportunities, the waivers would still be available. But you're saying that this bill would eliminate the opportunity for DHHS to utilize those waivers?

KEN SMITH: One--

DAY: Is that correct?

KEN SMITH: 100% correct. This bill specifically cites the federal statute that gives states that ability and says that we are prohibited from, from making use of, of that. So--

DAY: So no waivers would be available for any of those areas, including the reservations, which have been, as I understand it, the ones that have utilized these waivers the most often?

KEN SMITH: Yeah. And to be-- I should be clear about sort of the, the purpose of the waivers. When, when SNAP was being designed, there was a discussion about-- so we have SNAP. In order to get SNAP, we, we, we are, we are mandating that states run these work requirements. But what do we do when work is not available, when there's some sort of economic crisis, when people can't get jobs, no matter how hard they, they look? And these-- and, and this was the answer. The answer was, well, if, if in a state there is some kind of economic crisis, there can be county-specific data the-- that states submit to the USDA to say, look, in this area of the state, the unemployment rate is X, the employment prospects are virtually zero, so we shouldn't be just kicking people off for, for not being able to, you know, temporarily not being able to meet those requirements. So Nebraska has on a few

occasions gone to the USDA, sought a waiver on behalf of Thurston County, because-- you know, for those reasons. And, and that waiver was granted. The last time that happened I think was in 2013. So-- but yeah. You know, that and these-- you heard a discussion about these other discretionary exemptions. But those-- all of the ability for the state-- for our state to exercise that flexibility would be eliminated by this bill.

DAY: OK. Thank you.

HARDIN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. So-- thank you for that answer because I, I was wondering why it was specific to the Winnebago Tribe in Thurston County. And so it is beca-- it's based on census data. And historically, there's no other instance of any other area in Nebraska receiving this waiver?

KEN SMITH: That's correct. So even though I think, you know, I think, you know, we, we would say that there were certainly other instances where, very likely, portions of our state were, you know, suffering from, you know, economic conditions that would merit the waiver that, that it had-- that the, the use of that waiver has been very, very limited. We're obviously very ha-- you know, pleased that, that, at least in the past, the state has extended those flexibilities to Thurston County. But, yes. To answer your question, that, that is the, the, the only area that has been the benefit of those waivers.

M. CAVANAUGH: Are we currently using that waiver for Thurston County?

KEN SMITH: No. So--

M. CAVANAUGH: So it's not, it's not being utilized at all currently?

KEN SMITH: The waivers that are being utilized are the discretionary ABAWD exemptions. So there's two, there's two different types of waivers. You can either-- you can go to the USDA and say, here's a portion of the state that's, that's having a hard time and so we want to temporarily exempt them. The USDA grants those I think on a 12-month basis. You can also use a, a small number of waivers. This was the, the stockpile that we heard about earlier of these ex-- of these discretionary exemptions. Our understanding is the state stopped asking the USDA for the Thurston County waivers I think ten years ago and has been using just a small handful of these discretionary exemptions in Thurston County to sort of take the place of, of what the USDA is doing. But to be very clear, both of those

tools under this bill as it's currently written would no longer be an option.

M. CAVANAUGH: That-- so the tool that they are, are currently using in place of the Thurston County waiver-- we'll call it the Thurston County waiver-- or I will-- would also be eliminated under this?

KEN SMITH: That's right.

M. CAVANAUGH: OK. And not for you to speak on behalf of the state, but you did work with the state on this.

KEN SMITH: Mm-hmm.

M. CAVANAUGH: Does the state use the current waiver that they do because-- is it, is it a more flexible waiver? Is it easier for the state to obtain? Why are we using that waiver versus the previous Thurston County waiver?

KEN SMITH: Again, without speaking for them, my guess would be that the-- a waiver to exempt a geographic area requires that sort of, you know, analysis of, like, county un-- unemployment rates and so on. The small collection of discretionary exemptions that the agency has I don't think, you know, goes through that same process.

M. CAVANAUGH: OK. Thank you.

HARDIN: Senator Walz.

WALZ: Thank you. So I-- you brought up the, the money piece. And I started to look at the fiscal note. Have you seen the fiscal note?

KEN SMITH: I have seen the fiscal note.

WALZ: OK. So who, who funds for the SNAP program? Where does the funding come from?

KEN SMITH: The federal government funds the SNAP program.

WALZ: 100%?

KEN SMITH: Excuse me. In general-- and this was-- part of the fun of working on the E&T program is unpacking all of the complexities of federal funding, which I'm-- I know you all also wrestle with, but. So in general, the, the federal government funds 100% of SNAP benefits. The state is on the hook for 50% of its administrative funds. E&T funding is sort of a microcosm of that. So they are what's

called 100% grant funding under E&T. And that's-- when I was working with the state, it is roughly, I think, like, $300,000 of just federal funds that would come to the state for E&T programming. If there were administrative costs that exceeded that, the state could pull down a 50% reimbursement for those costs. So E&T sort of functions in the same way that SNAP funding generally does, where there's a 100% federal funding and then there's a 50% match for administrative cost.

WALZ: OK. It-- I'm just-- it looks like if we were to expand this program that we would need an additional 16 workforce coordinators, 2 additional program coordinators. The fiscal note that I'm looking at, total cost-- and maybe I'm not correct here-- but total cost in 2024-2025 would be $1,964,000. And then in 2025-2026, the total cost to implement this new program would be $200,000-- or, $2,750,000. Am I on the right track there? If we were to implement this program, is that what we're looking at?

KEN SMITH: That-- so I have had time to read the fiscal note. I'm not sure I could-- so I, I think I have questions about whether, whether that's all we would, we would need. I think what you just described is definitely my reading of the fiscal note as it stands. But trying to project this means we're trying to figure out the cost of expanding services outside of existing service areas to different parts of the state to make services accessible to a, a portion of the population that's kind of hard to, like, specifically pin down. We know that there's 17,000 work registrants. We know how many people are currently on E-- E&T. But the number of people who under this would be required to then go find E&T programming could, you know, could and will change. And so this also-- and I was talking-- I did have a chance to catch up with the senator and his staff briefly before this hearing. And there was talk about sort of-- and I think there's mention about the SNAP Next Step program, which involves both E&T and some-- and a collaboration between the Department of Health and Human Services and the Department of Labor. So there was some question about how it-- this could also be the-- like, a two-agency supported endeavor. And my question is whether the fiscal note accounts for that if, if that's what they were thinking or not. But in any event, what you, what you said is I think my reading of the fiscal note. But I, I just have questions about how, how we can really kind of pin down at this point the, the full cost of a mandatory E&T program given all of those kind of complexities.

WALZ: Thank you.

HARDIN: I have a question. And I apologize. Before I ask my question, I was out presenting a bill to some terrible committee down the hall and-- anyway-- while I was gone. So forgive me if I'm asking about something that's already been discussed. Big picture-- so is the-- the Department of Labor that essentially passes this money through, and then our Department of Health and Human Services essentially creates a receiving mechanism? Is that kind of how it works?

KEN SMITH: So we're dealing with-- in this bill, it's dealing with SNAP employment and training. SNAP E&T resources are passed from the federal government to--

HARDIN: Through the DOL.

KEN SMITH: Nope.

HARDIN: No DOL?

KEN SMITH: No DOL. Just from the federal government to the state of Nebraska to the Department of Health and Human Services to administer E&T. The Department of Labor gets funding under WIOA to, to do all sorts of other wonderful things with workforce training and employment initiatives. And, and so that's what we're talking about-- two separate streams of federal funding going to two separate agencies that then collaborate because there is some overlap, certainly, between an interest in, in, in, in folks on SNAP accessing employment and training initiatives-- which we are all very interested in-- and the workforce work that, that DOL is doing. And so my point in the fiscal context was just that I wasn't sure whether or to what extent that type of, like, bi-agency collaboration was captured in the cost estimate.

HARDIN: That's helpful for me. Thank you. Did you say a moment ago there are 17,000 exempt workers?

KEN SMITH: No. There are 17,000-- roughly, 17,000 is the average number of participants mandatory for basic and ABAWD work requirements between July and December of last year. So basically, the number of folks on SNAP that are-- would, would be sort of subject to the requirements-- work requirements and mandatory E&T if they're not meeting those work requirements.

HARDIN: Is there such a thing as a nonexempt worker within this, this realm? I mean, how does that work?

KEN SMITH: I'm, I'm not sure I understand.

HARDIN: We've got the exempt workers. I'm wondering, is there a nonexempt category as well?

KEN SMITH: Yeah. So I think if you look at-- just everybody on SNAP falls into either exempt or nonexempt. So there are a number of things that could exempt you from work requirements. And, and, and so I think that number is sort of getting at the nonexempt population.

HARDIN: OK. The nonexempt.

KEN SMITH: Mm-hmm.

HARDIN: All right. Do we know approximately how much money is there for that nonexempt? And how, how big is that nonexempt population you just referenced? I'm just trying to get a, a sense of the scope of things.

KEN SMITH: And again, I think it, it can-- it changes over time, but the snapshot here referenced in the fiscal note is between July to December of 2023. The sort of nonexempt category would be about 17,000 people.

HARDIN: So the 17,000 is the nonexempt?

KEN SMITH: From-- of-- from-- of-- they're-- those are the folks that have to comply with work requirements.

HARDIN: OK. All right. I appreciate it. Thank you. Any other questions? Seeing none. Thank you.

KEN SMITH: All right. Thank you.

HARDIN: Anyone else in opposition to the LB1381? Come on down. Welcome.

JUDI GAIASHKIBOS: Good afternoon, Senator Hardin and Health and Human Services Committee. It's an honor to be here on behalf of the Nebraska Commission on Indian Affairs to oppose LB1381. My name is Judi gaiashkibos. I'm the executive director of the Nebraska Commission on Indian Affairs. My name is spelled J-u-d-i; gaiashkibos, g-a-i-a-s-h-k-i-b-o-s. I have been the director of the Commission on Indian Affairs for 27 years. My office is up on the sixth floor of the State Capitol. So I've had a lot of opportunity and experience working with our tribal nations. And I rise in opposition for-- to this bill based on the previous testifier. I was a little late getting here, so I don't know who testified prior to

that, but there are many reasons why I don't think this is a good bill to-- mainly for me, for the Indian Commission, it's the negative impact to our tribal nations, who are the most vulnerable. And they are the ones that you heard referenced that the waivers were used for, and it's been some time, but that would be eliminated through this bill. So based on that-- that's number one. Number two, I don't know how many of you senators have actually visited our tribal lands, which are somewhat remote and isolated. I do believe Senator Day visited this summer with the State-Tribal Committee Chair and Senator Raybould. And when you go to our tribal lands, the Omaha Nation, the Winnebago, and Santee Sioux, you see that there isn't available to them many places to work other than working for the tribe in government, like myself. I work for the state. And you have governments to keep your state functioning. So beyond that, there are no private business ventures. There isn't a McDonald's there. All the places where our young children go, students go to work, and where adults work, there aren't a lot of businesses, factories, et cetera. So many of the people don't have an option. They're limited by virtue of their tribal placement on these what we call grass prisons, where we were put intentionally to give us zero opportunities to-- kill the Indian, save the man, and make us be servant laborer, if at best. So that-- and also on the reservations, there aren't grocery stores. And if there are, most of it-- it's a food desert. There are frozen pizzas and all the things that contribute to underlying risk factors for people in poverty. Recently, the Omaha Tribe, through their Career Academy, has had this really awesome garden that is providing fruits and vegetables for their people. But most of the tribal members are limited to what they can buy. They mostly would have to drive to Walmart in Sioux City. And again, to get a job off reservation, you have to have a car and be able to have child care, et cetera, to go to those places. And much of the tribal diet is dependent upon USDA commodities. Those have improved over the years, but still it is somewhat limited to what our tribal people call eating too much of the box cheese like Velveeta, et cetera. You end up having a commod bod, which is not desirable. And I am so blessed and fortunate that I can go to a variety of grocery stores. And so for those reasons-- I see my red light is on. I just want to say that I think this is detrimental and it's shortsighted. And other states are, are gravitating away from this type of federal policy that is being brought down to our states. And I also have concerns about DHHS's willingness to execute under these conditions. So I would be happy to answer any questions. And I do hope that this doesn't move out of your committee to the floor.

HARDIN: Thank you.

JUDI GAIASHKIBOS: Mm-hmm. Thank you.

HARDIN: Questions, committee? Senator Cavanaugh.

M. CAVANAUGH: Well, I actually want to answer the question you put to us. I have not been to any of the reservations in Nebraska. I have visited every reservation in South Dakota, where my husband is from. But I have been remiss in visiting those tribal lands here in Nebraska, so I will have to make a point of it to see exactly what you are speaking about. Though, based on my experience in South Dakota, it sounds that it is not too much different from the resources that are available. And so I, I thank you for coming here and sharing with us the struggles of the Winnebago people specifically.

JUDI GAIASHKIBOS: Thank you. And I do hope you will visit because there are good things that are happening.

M. CAVANAUGH: There are, yes.

JUDI GAIASHKIBOS: There really are. And right now, you know, we have a bill before one of the committees requesting clean water for our tribal nations. And a lot of people don't know that, in Nebraska, our tribal citizens have to use bottled water. And they have to get, you know, big flats of that each week so that our-- the tribal members have clean water. And that's costly. I believe they said, like, $7,000 a week to buy all that water. So we hope that we can get some resolution on that as well this legislative session for our first peoples.

M. CAVANAUGH: Yes.

JUDI GAIASHKIBOS: You know, we're going to have a Standing Bear movie coming out in a couple years here to our state--

M. CAVANAUGH: I'm aware.

JUDI GAIASHKIBOS: --and it's going to shine the light. And we want to tell-- be truth-tellers and celebrate our first people. And that generates the sleeping giant ecotourism. And people will want to go to the homelands of the Ponca and the Santee. And when they go there, if they, they see this and learn this-- Friday, there are 18 countries coming to the building, per the State Department, that I'm going, going to speak to. And they are going to the Winnebago

Reservation on Saturday to see what Indigenous peoples are doing. And Ho-- and Ho-Chunk, Inc. has done amazing things over there, but they still have-- half of the people are unemployed and in poverty even with Lance Morgan's brilliance with Ho-Chunk, Inc. So I hope that we, Nebraska, can think about what message are we sending out to the international people about what we're doing here in our state with our first peoples.

M. CAVANAUGH: Thank you.

HARDIN: Thank you. Senator Riepe.

RIEPE: I will attest I have been on the Pine Ridge Indian Reservation. We were trying to do a-- with Children's Hospital, trying to do a pediatric program there with the hospital. And you're right: there aren't a lot of opportunities, at least that I saw on my visit. And it is concerning.

JUDI GAIASHKIBOS: Yes. They do have a Pizza Hut at Pine Ridge and a coffee shop. That's nice. But the grocery store is very much-- it's pretty much frozen things and not fresh vegetables and lean meats. And if there are, they're so expensive the tribal members can't afford it. And then to drive. Now that Whiteclay is closed down there, there is a grocery store there and there's a dollar store. And many communities now are really depending on dollar stores. And they provide more affordable things, but a lot of that is processed. Not so good.

RIEPE: I think they're now $1.25.

JUDI GAIASHKIBOS: Yes, they have, they have risen to that, so.

RIEPE: Thank you for being here.

JUDI GAIASHKIBOS: Thank you so much.

HARDIN: Thank you. Any other questions? Seeing none. We appreciate it.

JUDI GAIASHKIBOS: Mm-hmm.

HARDIN: Anyone else in opposition to LB1381? Welcome.

RANDI SCOTT: Hello. Good afternoon, Vice Chair Hardin and members of the Health and Human Services Committee. My name is Randi Scott. I'm a registered lobbyist appearing today on behalf of the Winnebago

Tribe of Nebraska in opposition to LB1381 with a letter I'd like to read, if I may. The letter is being passed out now. And as you will see, it does have contact information for our human services department, a tribal member who will be able to answer many, many questions. There's been a lot of good discussion already to our concerns. But the Winnebago Tribe is opposed to the provisions of LB1381. It would eliminate SNAP waiver options and mandate SNAP employment and training, which are bad policies for Nebraska SNAP. And in Winnebago, we have some of the highest rates of unemployment. Many families struggle to find employment due to the community being in a rural area. As we've discussed, there's limited jobs locally as well as a lack of access to reliable transportation and affordable child care. The Winnebago Tribe of Nebraska is working to alleviate these problems and build a local economy, but these changes to the SNAP program will have a negative impact on our families. This legislation would have a detrimental impact on the health and well-being of families and children in our community. Thank you for your time and attention. I can attempt to answer questions.

HARDIN: Thank you. Questions from the committee? I'm not seeing any.

RANDI SCOTT: All right. Well, thank you very much.

HARDIN: Thank you. We appreciate it. The next person in opposition to LB1381. Hi.

MAGHIE MILLER-JENKINS: Hi. My name is Maghie Miller-Jenkins, M-a-g-h-i-e M-i-l-l-e-r-J-e-n-k-i-n-s. Long name. I'm here representing myself in opposition to LB1381. First of all, happy Black History Month. Second of all, shame on all the senators briding-- bringing such hate-filled doctrine to the table during Black History, Black Heritage Month. I'm in direct opposition of this because it is a continuation of colonization. I'm in direct opposition to this because my family has already paid blood, bones, and tears for this state, and we haven't received much back. I'm in opposition to this because we have already stolen land, stolen food, stolen heritage and language, and now we're trying to continue stealing more from our most disadvantaged human beings. My son came here last night and asked a really important question: why are we devoting time and attention to a bill like this? Why is this hitting the floor? Why is a ten-year-old being able to notice how hateful some of y'all choose to be? Why do you not notice? Why do you guys not engage each other in a way that makes y'all more human? I don't understand. It's extremely frustrating and disheartening to walk in these halls and see each of you walking through the halls and have

decent conversations with so many of you and then turn around and watch your reaction to some of these bills. This is hate-fueled doctrine. This is something that is an attempt for colonization to finish the job that it started and eliminating those that they don't want to hear from. What's the best way to kill a people? Starve them out. What's the best way to kill a society? Kill the educational system. Deny the children the right to have real education about how we got here. We stole this land. We genocided the people on it. We are trying to continue that process with bills like LB1381. And shame on all of the proponents for this bill and shame on each and every senator that signs on to something like this and that brings forth hate-fueled doctrine for us to have to be pain-filled and continue to come here and speak to you every single day and keep you accountable. Thank you for your time.

HARDIN: Thank you. Questions? Seeing none. Thank you. Anyone else in opposition to LB1381? Welcome.

HOLLY SMITH: Hello. So I'm Holly Smith, and that's H-o-l-l-y S-m-i-t-h. And I just-- I guess I wanted to tell you guys a little bit about me, I guess. I started working when I was 15. And it was a family-run business. I won't name the business because they are very well-known here. But the family there was interesting, to say the least. And I got sexually harassed there. And when I brought it up to the family, the father said, boys will be boys. And the mom tried to punish the son, but that same son held a knife to my throat in the kitchen where there were no cameras. And again, I was 15, so I thought no one would believe me. It's hard for me to work because of that. I've been sexually harassed at almost every job I've worked at and I've been threatened to be raped at multiple jobs. So forcing somebody to work when they have problems working is so, so disrespectful. And that's all I got to say. So thank you.

HARDIN: Thank you. Any questions?

HOLLY SMITH: Yeah. I always forget about the questions. Second time testifying, by the way.

HARDIN: I'm not seeing any questions, but thank you for being here. Anyone else in opposition to LB1381? Anyone else? LB1381. Anyone in the neutral for LB1381? Seeing none. Senator Hansen, will you close? We have 5 proponent letters, 56 opponent letters, 2 neutral letters for LB1381.

HANSEN: All right. Thank you, Vice Chair. I just want to clear up a few things and some questions that were maybe asked in some of the testimony. Currently, Florida, Texas, Idaho, Maryland, North Dakota, Ohio, Oregon, Utah, Virginia, and Kansas all have mandatory E&T programs. And I believe there's four more in the process of legislation of them doing the same. I believe it-- Kentucky, Tennessee, New Hampshire, and Arizona all have current bills that are going through the process of also introducing similar, similar legislation such as this. One other thing is this does not affect work requirements, really, because they're already in place. There are already work requirements in place. This does not affect those at all. The only thing this does is if you are, if you are able-- an able-bodied person able to work, this would require you to just take the training portion of it, education and training portion, which is varied. The DHHS and the Department of Labor both have multiple avenues for you to fulfill-- for-- to fulfill the education and training proportion of it. And they're kind of throughout the entire state to-- there as well. And for my understanding, the Department of Labor and DHHS both have the resources avail-- available to accomplish this. And some people mentioned that this was expensive. For instance-- and I'm still trying to understand this number here. Texas, for instance, spends $29 million for 440,000 people, nonexempt work registrants. Florida spends $12 million for 133,000. We spent $2 million on 186 people. So I'm trying to-- so the fund-- funding is there for this program. It's-- maybe it not being used in the right way, I think, right now because I'm still trying to figure out how we spend $2 million on 186 people. Exemptions. So some of the people that testified mentioned that they would not be eligible for SNAP anymore if this bill passes, but we are actually keeping all of the federal exemptions in place. And, and actually, there are more here. And we're including the federal regulations under CFR 273.7, which would include if you're in Social Security, if you're taking care of young children who are not school-aged, six years and younger, or an inc-- incapacitated person, if you're a-- and student enrolled half time, if you're participating in rehabilitation program, or if you are physically or mentally unfit to work, you got an exemption, you're employed 30 hours a week. So there are, there are multiple-- there's pages of exemptions people can have for this program. So out of 157,000 people in Nebraska who are currently on SNAP, this would affect 17,000 of them. The rest are not eligible for the-- they do not fit under this bill. We're talking about 17,000 out of 157,000 people in Nebraska. Currently, DHHS and Department of Labor work with multiple entities, including Metro, throughout the state to help with the education portion of this. Those who are unable to work, you can

actually still do volunteer work that would fit the criteria as the E&T. So this bill does not take anything away. It does not stop people's SNAP benefits. It's just telling us the 17,000 people who are able to work, excluding all the exemptions, we're giving you now the opportunities and the resources available to improve the outcomes of work. A few notes too I had here. After work requirements are implemented in many of these other states I mentioned before, enrollees saw their incomes more than double. I think the department told us the average-- like I mentioned in my opening, the average income increased by $15,000 when people enrolled in the E&T program, which is pretty significant. Even if Nebraska can't find one of the 61,000 open jobs, they can comply by volunteering locally, which increases their skills, connections, and job opportunities. And for some who say this doesn't work, this bill, I'm just going to list off a few states that have implemented this. Arkansas within two years of implementing work requirements, able-bodied, childless adult enrollment dropped by 70%. Within two years of leaving welfare, Arkansas-- Arkansans saw their incomes triple. Taxpayers saved $28 million annually. Florida two years after implementing requirements, the number of able-bodied adults on food stamps dropped by 94%. Mississippi fell by 72%. Missouri dropped by 85%. And all of them have increased their annual income and saved the taxpayers exponentially. So it has been shown to work in, in other states that have implemented this. So I, I was just hoping to respond to a, a few of the test-- testimony and some of the questions and maybe hopefully clear some things up. And I'll do my best to answer any questions if people have them.

HARDIN: Thank you. Any questions for Senator Hansen? Senator Day.

DAY: OK. So you said that it-- waivers are still allowed. But on line-- or, on page 6, line 30, there's underlying text that says: Unless required by federal law, the department shall not seek, apply for, accept, or renew any waiver of work requirements established by the federal SNAP program. So we're-- I mean--

HANSEN: Yeah. Yeah. And so that has to do with the-- and this is some of the stuff that we're including in our amendment that we-- that we're clearing up with the department about following federal regulations. So as they change, like work requirements with federal regulations and exemptions and waivers, we're following whatever the federal government does. So we're not going to be out of compliance. And some of this is what we're, we're going to be addressing in our amendment. It says 7 U.S.C 205 on the top of page 7. We're actually-- we're going with the CFR because they said it was easier to do that,

[INAUDIBLE] those exemptions that I listed earlier. So some of that will change.

DAY: So then how would that affect the issues that were brought up by a few testifiers in terms of the tribal reservations?

HANSEN: From my understanding, I think they haven't had waivers in the last ten years.

DAY: They haven't, but at some point they may need them. And so the state would need the flexibility to be able to apply for those waivers for those locations. And I think the, the major issue is that this would remove the ability to do so.

HANSEN: OK. I think it still allows it, but I don't--

DAY: OK.

HANSEN: I, I-- this is, this is a question I can get back to you on. I want to make sure I follow up, but I don't want to give you the wrong answer or anything.

DAY: That's fine. OK.

HANSEN: Because that's a good question.

DAY: Yeah. Thank you.

HARDIN: Any other questions? Oh, Senator Cavanaugh.

M. CAVANAUGH: Thank you. I had similar questions, but we had the testifier, Mr. Smith from Appleseed, who said in, in my reading-- I am not an attorney-- but my reading of lines 30 through 31 on page 6 over to lines 1 through 3 on page 7, you are striking the waiver, the waiver that was specific to the census data that had been-- hasn't been used since 2013, but also the other waiver that is being utilized by the Winnebago Tribe is being struck here. And so it sou-- my understanding from the opposition testimony specifically, your bill is eliminating the ability of the tribal people to have this-- any waiver from the work requirement. Do you want to speak to that?

HANSEN: Yeah. I would rather clarify with DHHS to make sure. And-- if, if that's-- and-- if that is what's happening to the bill or, or not before I answer that.

M. CAVANAUGH: Is it your intention to have that be part of the bill?

HANSEN: I don't believe so.

M. CAVANAUGH: You don't--

HANSEN: I'm going to have to get back to you because I don't-- I want to know the answer before I give you any other answers. You know, I want to know what I'm talking about. And I don't want to give you the wrong answer and misspeak.

M. CAVANAUGH: Well, I-- my, my question to you is, what is the intention? Because it is clear from the testimony that at least the people who have reviewed this believe that this very much targets the Winnebago people.

HANSEN: Yeah.

M. CAVANAUGH: What is your intention?

HANSEN: My intention, from what I mentioned-- also just right now-- is to get able-bodied people the resources and opportunities to get back to work with the E&T program by the Department of Labor and DHHS, not to, not to affect, really, certain waivers or anything else. So if that's what this is doing, that's something I'm going to have to look at.

M. CAVANAUGH: So are you willing to then work with the tribal people in ensuring that they can have the waivers that they need in order to utilize the waivers?

HANSEN: I'm willing to work with anybody to, to, to address any concerns or questions that they might have.

M. CAVANAUGH: I would say that the, the greatest concern here is requiring people who have no access to jobs whatsoever to have a job to have SNAP--

HANSEN: Which can be difficult. And then I didn't-- I don't, I don't--

M. CAVANAUGH: --even if they are able-bodied because of where they live on the reservation--

HANSEN: Yep.

M. CAVANAUGH: --and cannot.

HANSEN: And there are other ways too that they can fulfill some of these requirements that don't include work, such as volunteer work, training online. You know what I mean?

M. CAVANAUGH: I--

HANSEN: I'm saying there's, there's other options. It's not just like you have to work and you're getting rid of benefits. There's a, there's a, there's a [INAUDIBLE].

M. CAVANAUGH: Options that involve technology are most likely going to be problematic for some of our tribal people. As I said, I haven't visited the tribes here in Nebraska, but I also am on the Transportation and Telecommunications Committee, so I do know that they have a lack of access to that technology, so. I just want to make sure that we're being mindful of that. And I, I, I also just want to make it, it clear for us as a committee and for the people who have come here today what your intentions are. It sounds like your intentions are to ensure that the tribal people are not targeted in this, that we can work with them to--

HANSEN: No. No. Don't target one group of people because of that. That's--

M. CAVANAUGH: I didn't think--

HANSEN: --definitely not my intent.

M. CAVANAUGH: I certainly didn't think it was, but I think that that was the perception of, of the bill. So I want to--

HANSEN: No.

M. CAVANAUGH: Yeah.

HANSEN: No.

M. CAVANAUGH: I know. So--

HANSEN: Yep. I'm just making sure. OK.

M. CAVANAUGH: Yes. So thank you.

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

HANSEN: Thank you.

HARDIN: This concludes the hearing for LB1381. We will be moving on to LB1278 and Senator McKinney. Well, we'll wait just a moment, Senator, for people to kind of clear out. Welcome, Senator McKinney.

McKINNEY: Thank you. Good afternoon, Vice Chair Hardin and members of the Health and Human Services Committee. My name is Terrell McKinney, T-e-r-r-e-l-l M-c-K-i-n-n-e-y. And I represent District 11 in the Legislature, which is in north Omaha. We're here today to discuss LB1278, which provides reimbursement of doula and full-spectrum doula services under the Medical Assistance Act. Doula care is one of the most effective interventions to help improvement and, and-- to help improve health outcomes and reduce racial disparities among pregnant and postpartum people. Over the last several years, there has been a largely successful grassroot movement to improve access to doula care throughout the United States. As of November 23, 11 states and Washington, D.C. have opted to provide Medicaid coverage for doula services. And nine additional states are in the process of implement-- implementing coverage. LB1278 intends to provide for Medicaid reimbursement to a doula for providing doula or full-spectrum doula services to an individual covered under the Medical Assistance Program in Nebraska by January 2026. Doulas provide nonmedical and nonclinical physical, emotional, and informational support during pregnancy, labor, birth, and postpartum period. Doulas are selected by the birthing, birthing person and, and undertake a range of supportive activities. Most commonly, full-spectrum doulas engage pregnant people and their families in birth planning and preparation, provide a network of resources related to birth and postpartum per-- and, and the post-- postpartum period, and attend the actual labor and birth, acting as physical and emotional support and, and helping families navigate decision-making as a member of the care team. Doulas also typically provide informational and emotional support during the postpartum period, including postpartum doulas, who may work directly in the family's home to assist with feeding, light chores, and provide overnight sleep assistance for the family and newborn. Studies have shown that doula support during pregnancy, birth, and postpartum is linked to improved maternal and inf-- infant health outcomes. For example, doula-assisted mothers were four times likely to have a baby with low birth weight, two times less likely to experience a birth-- to experience a birth complication for the mother or baby, and significantly more likely to initi-- to initiate breastfeeding. Receiving care from a doula is also associated with reports of a positive birth experience. Additionally, doul-- doulas can help the health-rela-- can help the health-related social needs of mothers,

including assisting beneficiaries with referrals to community-based social services such as housing, food assistance, transportation services, and linkages to community health workers. One studily-- study modeling the cost-effectiveness of doulas concluded that payment for doula services would likely be cost savings for the state Medicaid program by offsetting costs associated with preterm birth and cesarean deliveries. We have brought this bill to several community partners, and it has been received with overwhelming support. I'd like to bring a few things to your attention: a language amendment and certification requirements and costs serv-- cost savings. Amendment language is the first one. Currently as written, LB1278 reads that the Department of Health and Human Services shall reimburse the recipient of medi-- medical assistance for doula services for its full-spectrum doula services, line 15. It has been pointing out-- pointed out to us that this could be interpreted as the person on Medicaid will receive the reimbursement themselves. This is not our intent and may more accurately be phrased as: the Department of Health and Human Services shall reimburse as-- reimburse a service provider for, for doula or full-spectrum doula services. We are working on the amendment currently, and we want to be clear that the intention of LB1278 is to reimburse doulas as a provider type. Next is certification re-- requirements. Although there are no mandatory licensure, certification, or conditional-- credentialing requirements for doulas to practice in the United States currently, many doulas seek certification from private entities. Doulas in, in states that have implemented Medicaid coverage for doula care have had to meet specific requirements laid out by each state to be eligible for reimbursement by state Medicaid programs. Training and certification requirements under Medicaid vary by state, with most states maintaining a list of approved doula training or cert-- certification programs. For example, Minnesota requires doulas to be certified by one of ten approved doula certification organizations. On the other hand, Rhode Island opted for even more flexible approach that does not limit training to state-approved programs. LB1278 would require HHS to work with stakeholders and a work group to develop an implemation-- imp-- implementation plan, including a reimbursement rate and specific competencies needed for doulas by October 2025. This gives the state flexibility to customize doula services to benefit, benefit details in a way that works for Nebraska, and this model has also been tested with the Doula Passage Program managed by I Be Black Girl in conjunction with partners like Charles Drew Health Center, Nebraska Per-- Perinatal Quality Improvement Collaborative, Nebraska Medicine, CHI, and more. Next is cost savings. Maternal and infant mortality

and, and, and morbidity have significant cost to health systems, health insurers, states, and communities. The, the main cause of pregnancy-related deaths, including hemorrhage, infections, cardiovascular conditions, blood pressure disorders like preeclampsia, eclampsia, heart disease, problems with anesthesia, and noncardiovascular conditions like diabetes and, and breathing problems. It has been determined that over 80% of these pregnancies-related deaths are preventable. Maternal and infant mortality and morbidity disproportionately affect marginalized communities. Despite improvements in per-- prenatal care, pregnancy-related mortality rates among black and Indigenous pregnant people are two to three times higher compared to white pregnant people. Black and Indigenous pregnant people also have higher shares of preterm birth, low birth weight births, and reduced or no prenatal care compared to white pregnant people. Rates of infant mortality are also significantly higher aclo-- across black and Indigenous communities compared to white communities. Doula support is also well-researched and evidence-based pathway to improve pregnancy outcomes and experiences and reduce medical interventions related to birth. Rigorous studies show that doula care results in substantial cost savings by reducing the need for medical interventions, including cesarean, instrument-assisted births, and pain medication, while also providing a more positive birth experience. Considering that ces-- cesarean births cost 50% more than vaginal delivery and about 1/3 of all births in the U.S. occur via cesarean, the, the potential cost savings is dramatic. In addition to cesarean births, NICU admissions are dri-- are a driving factor of high health care costs. The Institute of Medicine estimates that the annual health care costs in the United States associated with preterm delivery is $26.2 billion, or $51,600 per infant. One study found that when looking at the beneficial impact of doulas on cesarean and preterm births among Medicaid beneficiaries regionally, doula care was associated with a cost savings of $58.4 million and, and 3,288 fewer pre-- preterm births annually. Increasing use of doula services is, is an important strategy to improve equity in maternal health care outcomes. The benefit of doula care coverage under, under Medicaid extend beyond improved health, health care outcomes and racial equity. Coverage can reduce health care costs by shifting care away from high-cost specialists, reducing cesarean deliveries, limiting the use of instruments [INAUDIBLE] assisted births, and increase in breastfeeding. Medicaid coverage of doula services would also drastically reduce out-of-pocket cost barriers to use for low-income mothers. Together with I Be Black Girl, we worked to bring together community members who could speak to this further and look forward to

this bill advancing to address the maternal health care crisis in Nebraska. Before I close, I would like to mention that there is an amendment underway that clarifies language regarding the recipient of the reimbursement. LB1278 currently reads as the Department of Health and Human Services shall reimburse a recipient of medical assistance for doula or full-spectrum doula services. We've wrote-- we've realized that this could be interpreted as a person on Medicaid, as I said earlier, earlier, will receive the reimbursement themselves. And since, and since that, that is not the intention, we are amending this to state the Department of Health and Human Services shall reimburse a service provider for doula or full-spectrum doula services. And with that, I will answer any questions. Thank you.

HARDIN: Thank you. Any questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator McKinney. I have two questions. One of them is on the fiscal note, talks about the bill. It basically talks about appropriate training and certification. So immediately in, in my head, it's-- it goes to them but does that require 407 review for a scope of practice? It seems to me that-- and, and the second one I'll give you at the same time here is of-- you talked about-- in the next paragraph, it talks about-- attending a labor and delivery and being a hospital administrator for a lot of years, we're real touchy about who goes into delivery rooms and, and have-- being-- having them be credentialed and-- so that's, that's a hurdle that would have to be overcome as well in any hospital that delivers. And I assume we're not talking home deliveries here.

McKINNEY: As far as 407, I'm not completely sure on that. And hopefully one of the testifiers can answer that question. But as far as I know, doulas are already-- have been allowed in delivery rooms, and it has not been a problem. So I don't, I don't think that's a issue.

RIEPE: Well, that would be an issue with the individual hospital because they're not state hospitals. No one can come into a private hospital and just say, we want to come in. That doesn't work that way. I assure you.

McKINNEY: I don't, I don't believe it works like that currently as, as, as, as much as I know. I think the testifiers who are, who are going to come up behind me can answer that question and kind of clarify that, so.

RIEPE: OK.

McKINNEY: Yep.

RIEPE: Well, thank you for being here.

McKINNEY: No problem.

HARDIN: OK. Any other questions? Seeing none. Thank you. Will you stay for close?

McKINNEY: Yes.

HARDIN: OK.

McKINNEY: All right. Thank you.

HARDIN: All right. The first proponent for LB1278. Welcome.

BRYONNA WARD: Good afternoon, members of the Health and Human Service Committee. My name is Bryonna Ward, B-r-y-o-n-n-a W-a-r-d. And I am representing myself. And I'm here in support of LB1278. When I found out I was pregnant with my first child in November of 2020, I was filled with a whirlwind of emotions: excitement, fear, happiness, uncertainty. I knew my life was about to change forever. And with so much uncertainty, there was one thing that I was certain about: I needed a doula. With so many responsibilities brewing as a young pregnant couple, figuring out how to pay for this doula became a source of stress. My husband and I had several conversations on the necessity of having a doula. And after deep consideration, we decided that having a doula was worth the investment. Luckily, my doula allowed us to pay for her services over several months with a payment plan-- otherwise, we would not have been able to afford her services. Studies have shown that having a doula can lower cesarean rates, have fewer interventions, and fewer complications. As a black woman with a deep understanding of the gap in hea-- maternal health care and disparities that occur for black women specifically, I knew that having a doula was deeper than having a birth companion. It was about choosing life for me and my unborn child. At 36 weeks pregnant, I was diagnosed with mild preeclampsia, a high blood pressure disorder that occurs in pregnancy. This unexpected twist in my pregnancy caused strain on my mental health. As I was pushed by health care staff to participate in medical interventions that I was not comfortable with, my doula served as a buffer. She helped me ask important questions, pushed for me to know the alternatives to the things that I was being presented, and gave me permission to take the time I needed to make

the best decision for me and my unborn child. She helped me find my power, something that is often taken away from birthing people. After a strenuous, long, three-day-long induction and labor process, I gave birth to a beautiful baby boy. He is now two and a half years old, and he is here with me today. Having a doula saved my life. Without her prenatal care, I would not have had the knowledge needed to navigate my unique labor and birth. Without her at my labor and delivery, I would not have had the time and space to make critical life-or-death decisions for me and my son. Without her postpartum care, I would not have had the knowledge to determine the best options for me as a new mother. So many birthing people experience less than desirable situations when it comes to their pregnancy and birth simply because they do not have access to a doula. Doulas should be an essential part of pregnancy, and LB1278 would allow for Medicaid reimbursement for doulas so that more Nebraskans have access to that kind of care because it can make a difference in a multitude of ways. I would like to thank Senator McKinney for his commitment to maternal health. And I urge the committee to support and advance LB1278. Thank you. And I am happy to answer any questions you have for me.

HARDIN: Thanks for being here. Any questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here.

BRYONNA WARD: Yeah.

RIEPE: I'd like to ask a question: did your doula work in concert with your prenatal physician or was this a home delivery?

BRYONNA WARD: So I was actually at Immanuel in Omaha, Nebraska. So I was in a hospital setting. And I had had discussions with my health care providers about having a doula, and it was understood and accepted by the hospital that I was at that she could be in the delivery room. And this was in 2021 during COVID times, so there were certain restrictions. So I was allowed to have two personal people. So my mother and my husband were in the room with me, and then my doula also served as an additional, like, support person that was separate outside of those two people that were allowed since she was my doula.

RIEPE: So she had gotten permission from the hospital or somebody. She'd have to get it from the hospital, not the doctor.

BRYONNA WARD: Yeah. There--

RIEPE: She must have done that. So--

BRYONNA WARD: There wasn't any issues. We were able to-- it was known from the beginning of my pregnancy that I had a doula. She wasn't at any of my appointments or anything, but I made sure that it was understood that I needed her as my birth companion and that-- and it was no problem that I faced.

RIEPE: Have you also had friends that have used doulas? Based on your experience, it sounds very positive to you.

BRYONNA WARD: I, I hadn't had any friends or anyone that I knew who had, had doulas. I had just done my research and knew that there were a lot of things that could occur without having a doula and just not having your voice in a very vulnerable state.

RIEPE: Are there a lot of doulas in town in Omaha? Did you say Omaha?

BRYONNA WARD: Yeah. There were definitely a lot of doulas that I was able to find. And I went through the process of interviewing them, finding the ones that I wanted, and then selecting them from that way.

RIEPE: OK. Well, you got a great little boy out of the whole thing, so good for you.

BRYONNA WARD: Yes.

RIEPE: Thank you, Vice Chairman.

BRYONNA WARD: Bless him. Thank you.

HARDIN: Can I ask a question?

BRYONNA WARD: Of course.

HARDIN: When you were doing those interviews, what kind of questions did you ask? I mean, how, how did you pick the winner?

BRYONNA WARD: That's a great question. I, I was just-- one of the main things that I wanted was them to have experience with give-- with, with births. And that was just kind of one of the basic things that I needed.

HARDIN: You didn't want a rookie.

BRYONNA WARD: No, not really. I wanted someone who kind of understood the hospital setting, would be able to give me accurate resources, and just to be able to provide adequate resources that I needed that-- to just help me answer questions. Like, they referred me to different birthing classes that I could take. I was having pain. She referred me to a chiropractor. Just, like, knowledge that she had that was medical in a sense, but she obviously wasn't my medical professional. So it just provided knowledge, access, and just a partnership that was someone on my team outside of my health care team at the hospital who was really advocating for me. So that was just-- the main thing was just someone who knew their stuff and had experience navigating the health care system.

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

BRYONNA WARD: Thank you.

HARDIN: Any other proponents for LB1278? Welcome.

ASHLEI SPIVEY: Well, hello. How are you?

HARDIN: Dandy, thanks.

ASHLEI SPIVEY: Well, hello. Good afternoon, members of the Health and Human Services Committee. And thank you, Senator McKinney. I am Ashlei Spivey, A-s-h-l-e-i S-p-i-v-e-y. And I'm the executive director of I Be Black Girl. I Be Black Girl serves as a collective for black women, femmes, and girls to actualize their full potential to authentically be through autonomy, abundance, and liberation. We are the first and only reproductive justice organization in Nebraska, and we are here today in support of LB1278. Anarcha Westcott, Betsey Harris, Lucy Zimmerman. These are the founding mothers of gynecology. Each of these women, including 17-year-old Anarcha Wescott, endured torturous, experimental gynecological procedures without the use of anesthesia in the name of medical advancement, which we still feel the ripples of today. We will never be able to forget the horror black women experience in the obstetrics sector, and are looking to the future to regain power and control over our bodies and birth experiences. At I Be Black Girl, one of our strategic goals is to expand access to quality and culturally relevant maternal health services. We know that when you center those most impacted, especially when curating policy solutions, all communities will benefit. There are inequities across the health care spectrum around accessibility and quality of care for black women, and maternal and infant health care outcomes present some of the starkest disparities.

Among developed nations, the United States is the least safe country in which to have a baby. Nebraska has the 11th highest rate of maternal mortality or death at 28%, scoring a D-minus from the March of Dimes' latest report card. We know that black women die from pregnancy-related causes more than three times the rate of white women, and the rate of death-- near-death experiences is even higher. The black infant death rate is at an all-time high, over 12%, and across the state we are seeing maternal care access gone. Time and time again, the voices of black women and birthing people have been ignored within the health care system and continue to be dismissed as an afterthought. The lack of access to equitable, culturally relevant care compounded by the stress of racism and implicit bias continue to kill us or create near-death experiences on a daily during birth and the postpartum period that seem to be normalized. And there is a path forward. There are accessible interventions that allow for people, especially black people, to not only live through their birthing experiences but thrive. Doulas-- specifically, full-spectrum doulas-- can disrupt families' experiences of harm, mistreatment, and adverse health impacts by acting as an advocate while enhancing feelings of agency, security, and respect. At I Be-- at I Be Black Girl, we have spent the last two years explicitly working to understand the doula reimbursement models through Medicaid across 11 states that are reimbursing doula services, not only from the provider side but the impacts of community. We have also developed a doula passage program, a culturally relevant, full-spectrum doula training program in partnership with community-based organizations as well as institutional partners. We also lead two pilots around doula reimbursement with two managed care organizations. To date, we have trained 37 full-spectrum doulas and just launched another cohort earlier this year. Doula reimbursement is also a viable career path, and it's a workforce opportunity in our community.

HARDIN: Ms. Spivey, if I could have you kind of wrap the thoughts up in a little bit. Go ahead and finish your, your last paragraph--

ASHLEI SPIVEY: Yeah. Absolutely. Thank you. We support this bill because it gives intentional time for implementation, it's not overly prescriptive and allows the folks on the front lines to participate in crafting the actual system for reimbursement, and is based on the experiences of leadership of those most impacted. So we would like to thank Senator McKinney for his commitment to maternal health. And we urge this committee to advance LB1278. And I welcome any questions.

HARDIN: Thank you.

HANSEN: OK. I'm back. Sorry.

ASHLEI SPIVEY: Welcome.

HANSEN: Sorry about going--

ASHLEI SPIVEY: So you have a whole bunch of questions for me now that you're back, right?

HANSEN: I was actually outside writing a whole bunch down just for you, so. Sorry. I'm in and out-- there's hearings and other things going on, so I apologize.

ASHLEI SPIVEY: It's totally OK.

HANSEN: Are there any questions from the committee? Senator Hardin.

HARDIN: Evidently, we're pretty bad at birthing people in Nebraska.

ASHLEI SPIVEY: Yeah.

HARDIN: Did you say we're the worst?

ASHLEI SPIVEY: We're the 11th.

HARDIN: The 11th.

ASHLEI SPIVEY: So there's a report card that's put out by March of Dimes every year. They look at data across our country, and Nebraska's scoring pretty low in maternal-related outcomes. So we have high maternity care deserts-- which Senator Day, I know you did a lot of work in education around that-- high preterm birth rates, NICU stays, cesareans. And so there's really an opportunity to rethink what care looks like. And doula reimbursement and support of doulas and the access to doulas really allows for one intervention. It's not the silver bullet. It's not going to solve the crisis, but it's definitely an accessible intervention to start to change some of those outcomes that we're seeing.

HARDIN: May I ask a follow-up? Can you kind of give us an idea of what may be-- is there a consensus of what these other states are doing by way of training or certification? Is there a norm?

ASHLEI SPIVEY: Yeah. So there is an ecosystem of the states that are looking at doula reimbursement. And so you have actually a packet of information that kind of outlines some of the models. That's from that ecosystem that we're a part of. And so the consensus at-- one,

we want to make it flexible for states. There's not a one-shoe-fits-all solution for this. We do know that harm can happen by anyone in the medical field, right? And medical practitioners, we're all working within the same system. So the goal with creating a standard of care around competency says, here are the eight competencies that we know are needed in order for a doula to perform effective doula care in the full-spectrum area in our state. And so say you have a training that only touches on six. Well, here's two additional models that you'll need to be trained on in order to be reimbursed. And so doula care and doula work is really ancestral to communities of color. We've been doing birth work for centuries, right? Like, if you look at the history of granny midwives and the role that they played in the United States around birthing people and literally birthing America, there's an opportunity to really give that back to community in a way that honors those ancestral ties while making sure we change the outcomes, and we need a revenue stream for that. Within the Doula Passage Program, we have a fund that we created that pays for doula services. And it's grant-funded. We received ARPA dollars through Douglas County for that, and those are running out. And so when we think about how can we make sure folks have this viable job, it has impact on community, it's saving the state money, right, there's all these outcomes for better community, we need a source that allows for people to be able to be paid for the work that they're doing, and this is one of the solutions that we've seen across those 11 states that have started to already have outsized impact.

HARDIN: Thank you.

HANSEN: Any other questions? Senator Riepe.

RIEPE: Thank you, Chairman. This is the fiscal conservative in me coming out. Is there any way to have the cost of the doulas offset by some other expense? I'm, I'm assuming the maternal, infant, the OB-GYN isn't discounting his or her fee by the cost of the doula. So it, it's an add-on. It's a new cost is what it--

ASHLEI SPIVEY: Right. So ideally, it would be a new provider type. So it would be a different cost. What we've seen-- federally, there's some funds and a new model that was just released by the federal government that would allow for higher reimbursement rates for doulas that the state could access. So we have sent that information to HHS, and they are looking at if they're going to apply for that. And then they are looking at the reimbursement rate. So the, the nice part about this bill is that we know that doulas need to be rebur--

reimbursed at a living wage, right? And so the working group would put together those recommendations. We do have some in your folders around what that could look like. And for us, the floor is $2,000. You'll hear from some doulas and the work that they're doing. They spent a lot of time with that pregnant person. Like, they are a part in, in this really intimate, important way. And so they are very accessible, and they should be compensated for that time. And so most states have started to outline for prenatal services, a 90-minute visit is this much reimbursed. Labor and delivery up to ten hours is this amount. If it's a cesarean or a vaginal delivery, they'll have different amounts. Eight postpartum visits, 90 minutes are this. And so it really does outline-- but it is a different service and provider type. And then-- are you OK, Senator Riepe, if I answer your earlier question about the hospitals and how that works?

RIEPE: Sure. Please answer my [INAUDIBLE] question.

ASHLEI SPIVEY: OK.

RIEPE: See, you can't ask the questions, but I can ans-- so, yes. Please-- would you ask-- would you answer my question then?

ASHLEI SPIVEY: I would love to. Thank you, Senator Riepe. So our partners at the Nebraska Perinatal Quality Improvement Collaborative have really been working with us to think about, across the state, how do we create douly-friendly-- friendly hospitals? Because each hospital institution is so different, right? And so we have spent time going to do visits with those hospitals. We do meet and greets. We talk about what does it look like for doulas to be incorporated in that care team, really in that labor and delivery space. And so we have, have seen success in that. There's always some bumps in the road, right? It's a new model. What does that look like for folks that need to be educated on the roles? But because they're so different-- this is not a clinical position-- it serves a different purpose in advocacy and support of that pregnant person. Doctors and OBs and folks alike want that pregnant person to be successful and have that support. So they're open to thinking about how do, how do they-- how are they incorporated in that care team. And so we have seen success in that.

RIEPE: Are commercial-- because you, you hit a bone there-- are commercial-end carriers recognizing and paying for doulas?

ASHLEI SPIVEY: So we are--

RIEPE: Blue Cross, Blue Shield, UnitedHealthcare, all those?

ASHLEI SPIVEY: So we are in the process of working with private pay insurers to look at this. We have seen Blue Cross in two other states adopt this for their members. And we have been in conversation with a couple of private payers here around what does that look like. It's currently going through their legal department. So, yes. We hope to-- this is the first step. Majority of births are taking place on Medicaid. So this is an important step. And I think it'll role-model for those private payers what could be, and we are absolutely in conversation with them.

RIEPE: Can you cut down the length of stay or--

ASHLEI SPIVEY: For-- like, in the hospital?

RIEPE: Well, in the fiscal note, it talks here, it says it, it costs-- the range would be $350 to $1,500. And I'm just saying that's a day in the hospital, the $1,500. You know, can you cut off-- if you could cut off one day a length of stay, then you've, you've justified the added cost is where I'm coming from.

ASHLEI SPIVEY: Yeah. So how we've been looking at cost savings is more long term. And so there will be some immediate up-front costs of that doula, what does that look like. We're seeing the cost savings around some of those specialized services or more expensive interventions like cesareans--

RIEPE: Yeah.

ASHLEI SPIVEY: --and NICU stays. And so I think it just depends, right? Every person's birthing experience is really intimate, important to them. And we want to honor that. We don't want to just kick folks out of the hospital if they need to be there. But we're seeing because they have that advocate, because they're able to make better decisions and have those conversations with care team, they're able to adjust things a little bit differently.

RIEPE: See, I have to confess: I'm interested in the short-term savings and, and not the, the long term because it's-- Keynesian said-- economics said, long run, we're all dead [INAUDIBLE]. Trying to recover those costs, so.

ASHLEI SPIVEY: Yeah.

RIEPE: But thank you.

ASHLEI SPIVEY: You're welcome.

RIEPE: That's very informative. I, I have a lot to learn, I think, about it.

ASHLEI SPIVEY: Yeah. And there's-- is a cost savings benefit analysis in that packet too. So because you're interested in that, we've-- we have a table with some of that information in there for your review.

RIEPE: So you've given me some weekend work, huh?

ASHLEI SPIVEY: Absolutely.

RIEPE: OK. Thank you, Mr. Chairman.

HARDIN: Yes. Senator Ballard.

BALLARD: Thank you, Chairman. Thank you for being here. Is, is cost the primary factor in individuals not seeking out a doula? [INAUDIBLE]. Or is there a education component as well about the benefits of a doula?

ASHLEI SPIVEY: Yeah. So I think the word doula, right, has different ties when you look at the origin. But people doing birth work, supporting people through this birth journey, is not new. And so now we've kind of put this term to, this is what this type of doula means. We're specifically talking about full-spectrum doulas. But there's lots of different types of doulas. You can have a ferturli-- a fertility doula, a death doula, someone that's helping you transition, right? And so for us, we want to make sure that folks know that this is a, a source in support for you as in-- in your birth journey. We have found that people that are pregnant are really receptive to that because it is a complicated time. You're really vulnerable. There's a lot of things to take in, especially navigating complex health care systems. And so we put together a tool kit that allows you to understand what a doula is, the right questions to ask, how do you source out, what does that look like, and what does it mean for them to integrate into the care team. And then the cost does make it prohibitive. Most folks are operating private doula practices. There's not a reimbursement-- like, for sure reimbursement thread. There's lots of organizations that may have funds or grant opportunities that reimburse, but sometimes there's income limits to that. And so folks that can afford this luxury of a doula are not the folks that always need it the most. And so there is an accel-- accessibility opportunity here to make sure that folks who need

doulas and want doulas to be a part of their care team can actually access them because there is that revenue source.

BALLARD: OK. Thank you.

HANSEN: I have a couple questions, I think.

ASHLEI SPIVEY: Yeah. Absolutely.

HANSEN: And I just want to make sure I'm, I'm ans-- I'm asking the right questions. So are doulas certified and registered in the state of Nebraska right now?

ASHLEI SPIVEY: No. So there's not a licensure.

HANSEN: OK.

ASHLEI SPIVEY: And this bill does not go after licensure.

HANSEN: Yes. OK. Is there a concern? Because this-- sometimes what we hear from other people maybe asking about reimbursement-- whether it's Medicaid or similar kind of government program or-- about getting government involved in doulas and maybe a concern then that might lead to more rules and regulations, certifications, registrations, which then-- you know, it, it becomes kind of a--

ASHLEI SPIVEY: Right. Absolutely.

HANSEN: It's a revolving wheel and sometimes-- once you start it, sometimes it kind of keeps going and then it, you know, makes it more difficult. Because I appreciate what doulas and full-spectrum doulas-- I wish many more people would use them. I think they're awesome. I'm just concerned that-- I just don't want the government then all of a sudden put a lot more restrictions on what they can and can't do because now they're starting to reimburse them.

ASHLEI SPIVEY: Yeah. Absolutely. I think that's definitely a concern, and that's why we didn't, when working with Senator McKinney and HHS around this, look at licensure. And so I think in general, right, when you think about health care and who is activating in health care, you want to make sure that there's a standard of care for anyone that's participating. And that's why the core competency model is the opportunity there versus licensure. So making sure folks have the understanding and the knowledge around these core competencies keeps it standardized so that we know that folks have it, allows for different training programs to meet those competencies, and then

there's some sort of management because CMS will need that, right? We know for a fact that when you go through the Center for Medicaid Services there has to be some sort of standard in, in measurement. And so the competencies model versus licensure allows for government to be able to reimburse without a heavy hand in what does that experience look like.

HANSEN: OK. Hopefully. That's what I'm concerned about, is that they don't all of a sudden become a heavy hand in saying, well-- this is what we see a lot of times whenever we start stuff like this. And all of a sudden now they're saying, well, only full-spectrum doulas now can do this and only certified people with X, Y, and Z. And then reimbursement rate's becoming kind of weird too. And so that's the only concern I'd, I'd, I'd have, but--

ASHLEI SPIVEY: Yeah. Absolutely. We haven't seen it in other states yet. There's been conversations in looking at doula work and community health workers. So that's kind of an adjacent type of community-based health worker that is doing some of this. And HHS has been very engaged with us over the last two years to ensure that. So we've had conversations through leadership changes around, like, what does this look like for you? What are your concerns? How do we bring that back to community, act as a liaison? And so I feel confident that with the work plan and what's in the bill of spending time on the implementation we can really work to ensure that there is not that over-- heavy hand in oversight and that we create an implementation plan that works for both those doulas that have been doing this work as well as what's needed to get them paid.

HANSEN: OK. Good. If this leads to more people using doulas, I think it's awesome. I just-- then-- on the flip side--

ASHLEI SPIVEY: Absolutely. That's a great question.

HANSEN: --[INAUDIBLE] all of a sudden-- now we-- it's more difficult to become a doula and stuff like that, right? And one more quick question, if I could. Sorry. What about home births? Like, do doulas help with home births at all?

ASHLEI SPIVEY: So they can. So pregnant people can make the decision of where they want to give birth. That is not up to the doula. And so doulas help that birthing person based on their experiences. Majority of births are still happening in, happening in hospital settings. But if you think about in rural communities where labor and delivery centers are closing, folks are being forced to have home births

because they are 50 minutes away from the next hospital, right? And so, again, the role of that doula is not to decide where that pregnant person is giving birth, not to decide their treatment of care. They're an advocate for them based on what they want to have in their birthing experience.

HANSEN: So you wouldn't expect-- if it was a home birth that wouldn't affect reimbursement or any of that kind of stuff?

ASHLEI SPIVEY: Mm-hmm.

HANSEN: OK. Good. All right. OK. Yes, Senator Riepe.

RIEPE: Chairman, thank you. A quick question.

ASHLEI SPIVEY: Yes.

RIEPE: Do doulas have professional liability insurance?

ASHLEI SPIVEY: Yes. So they're-- we practice-- and what we've said at I Be Black Girl is, yes, they should. We help to provide that insurance for the doulas. And there's also a brief that was put out, an analysis done by some attorneys that have doulas reimbursed around the limits around liability because they're not a clinical practitioner. So the, the liabil-- liability is really low for doulas based on that. And we do encourage folks to have li-- liability insurance.

RIEPE: So the doula doesn't have hands-on with the baby?

ASHLEI SPIVEY: No. They are not the person that is delivering.

RIEPE: They're the coach.

ASHLEI SPIVEY: So they are an advocate. So imagine, so imagine you are-- and as Bryonna before the story, she was having complications. The information was a lot. She was having a hard time processing. That doula's a person that says, OK. This is what they're saying. Do you understand? Do you want-- do you need to ask more questions? Let's take a pause there. They'll advocate for that birthing person. So they're not in charge of managing any of the clinical care within the hospital setting. They're, they're another advocate in the room.

RIEPE: It's kind of what mother-in-laws used to do.

ASHLEI SPIVEY: Is it? I don't know. Some people might disagree.

RIEPE: OK. Thank you. Thank you, Chair.

ASHLEI SPIVEY: You're welcome.

HANSEN: I think that's in our policy and procedures: we don't mention mother-in-laws.

RIEPE: That's not a prop, is it?

HANSEN: Any other questions? Thank you for answering all our questions. I appreciate it.

ASHLEI SPIVEY: Yeah. Thank you. I appreciate the intentionality with the questions.

HANSEN: Thank you. We'll take our next testifier in support, please. Welcome.

MICHAEL GREENE: Hello. Welcome-- or, thank-- I can't welcome you guys, I guess. I'm used to saying that. But thank you to the members of the Health and Human Services Committee for allowing me to speak. My name is Dr. Michael Greene. That's spelled M-i-c-h-a-e-l G-r-e-e-n-e. I am here today representing both CHI Health-- because I'm a family medicine physician. I practice at the Cuming street clinic, which is in north Omaha-- and I'm also the director of Creighton Family Medicine Residency program-- so I'm also representing Creighton-- both in support of this bill. To comprehensively address structural barriers to optimal health birth outcomes, our health system-- CHI Health-- is partnering with and investing in community-based doulas to help patients navigate health care systems that have historically caused harm instead of healing. Doulas bridge the health and social systems to improve patient health literacy and advocacy in their care, build trusting relationships, and identify and address health-related social needs. They are trusted members of a birthing person's maternity care team. And over the coming years, we plan to provide training for clinical providers and doulas on effective collaboration to study their integration. Doulas support birthing people throughout their perinatal journey, which may include attending prenatal visits-- which is where I'm seeing them-- assessing patients' health-related social needs and securing community-based resources, creating a birth plan, delivering breastfeeding education and lactation support, providing labor and delivery support, and postpartum home and virtual visits. Doula care is associated with, as we've mentioned, lower rates of cesarean delivery-- that alone is worth way more than one hospital day stay

because of the cost-- lower birth weight, and lower preterm births. And I can't emphasize how important that is enough because a NICU day stay is not a 1,500-day stay on a [INAUDIBLE]. So that would save tremendous amount of money. As well as improved Apgar scores, which is measurements of how healthy babies are when they're born, and breastfeeding initiation. Our doula pri-- pilot that we have prioritizes serving pregnant patients at risk for poor birth outcomes due to barriers in access to resources. In Omaha, as an example, one in five black births are preterm compared to 12% of white births. Over that same time period, an average of 15% of black infants were born at low birth weight compared to 7% of Caucasian infants. An average of 15% of black births included a neonatal intensive care unit stay compared to 11% of white births. Black residents also report diff-- higher difficulties in accessing health care, higher concerns with food security, and higher challenges with understanding health information. Even on, on this committee, health literacy is a challenge all around, and it's very helpful to have partners to bridge that gap. I've got a quote that I've-- all of you I think have seen from one of our patients. And you've heard from a patient at the Immanuel Hospital, where currently we're, we're delivering babies. One major impediment to the "proliferally" to having doulas-- sorry-- is reimbursement, as we've been talking about. Doulas are not currently a designated medical provider type eligible for reimbursement through Nebraska Medicaid and Long-Term Care despite their established benefits. Currently, our doula program is entirely grant-funded, which is not a sustainable funding mechanism for community-based doulas. I implore the committee to advance this bill and create a mechanism such as a state plan amendment for reimbursement of doula services. I'd like to thank the Health and Human Services Committee for your interest, and to thank Senator McKinney for intro-- introducing this bill. I'm happy to answer any questions that you have.

HANSEN: All right.

MICHAEL GREENE: Thanks.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. I'm trying to get this [INAUDIBLE] the doula.

MICHAEL GREENE: Yep.

RIEPE: Do they-- they're predelivery.

MICHAEL GREENE: Yep.

RIEPE: Is that correct?

MICHAEL GREENE: Yep.

RIEPE: Because last session and this morning, we were talking about postborn care. So do they partici-- I'm trying to make sure--

MICHAEL GREENE: All of the above.

RIEPE: --needless duplication over here.

MICHAEL GREENE: Yeah.

RIEPE: So is this a handoff then or-- how does this work?

MICHAEL GREENE: No. Nope. Not-- so I'm a-- as a family medicine physician-- so I don't hand off to anybody, typically. [INAUDIBLE] take care of somebody. Yeah. And the doula is not, not a handoff in that case either. So this is-- you were kind of right in, in the model.

RIEPE: That's all I ever am: kind of.

MICHAEL GREENE: Yeah. This is-- doulas are, are not a medical person. They're not there to assess a prenatal strip to see who might need to have an intervention such as a C-section. They're there as an advocate for the patient. So the-- my-- the patients can have whoever they want in the, in the delivery room with some, you know-- not-- you know, obviously, the whole community can't come in, but, but there's some guidelines around that. But doulas are a trusted member of that-- that's somebody who's been with a pregnant patient, like an extended family member, but has special knowledge about birthing and has special knowledge about the health system that, that we operate in. So that-- and it's very important, I would say, for them to be community-based doulas. What we're talking about is doulas that are in the community that I'm attempting to serve. So I practice, as I said, on 2412 Cuming Street, north Omaha, across from Creighton University because we're a Creighton University's clinic. So I have a number of populations of patients that I see there. They're different in their needs, the various different communities. We have the refugee contract with the state of Nebraska. So I see lots of, of refugees coming in, all with their own community's health needs. So a

doula would be somebody in that. So they wouldn't pass off to anybody else. They'd just be themselves [INAUDIBLE].

RIEPE: I'm a big fan of continuity of care.

MICHAEL GREENE: Yes.

RIEPE: So-- OK. Thank you. Thank you, Mr. Chairman.

HANSEN: Any other questions? Senator Ballard.

BALLARD: Thank you, Chairman. Thank you for being here, Doctor. What if there's a disagreement between a physician and a doula? How do, how do you work through that?

MICHAEL GREENE: So the doula is an advocate for the patient, so. Can-- so I guess philosophically your question is, could there be a disagreement between a physician and a patient? Not really, because my job is to do what the patients say-- I advise and recommend, right? So I'm advising and recommending all of my patients. Can we disagree? Kind of no is the way I teach medicine. Because suppose you have high cholesterol and I recommend you take a statin and you don't want to take a statin medicine. Does that mean we're in disagreement? No. I agree that you don't want to take a statin medicine, and you can agree that I'd say, I have some evidence that it's good, but I don't want to do that because of X, Y, Z. That's OK. So it's not-- there's not really a mechanism for a disagreement. And if-- where your question is coming through, if you were wondering about something like a concern in the birthing room-- like, I might make a recommendation to do X, Y, Z and maybe the doula would say no. Ultimately, I'm going to do whatever the patient says, same thing doula's going to do.

BALLARD: OK. Because I'm--

MICHAEL GREENE: Does that make sense?

BALLARD: Yeah. It does make sense. But I'm assuming a, an individual hires a doula because they, they have trust in that doula. So I'm just curious on that interaction between-- OK. I appreciate it.

MICHAEL GREENE: Yeah. The doulas-- I don't think any of the doulas are here today that, that I see. Some-- yes. OK. There they are. OK. None of the doulas I've worked with are here today, so. But they-- the-- they're working with me in addition to working with the patients too. I see them in the office in between times. And so we

have a good relationship-- like, a good professional relationship, which is going to help with the continuity of care with the patient.

BALLARD: OK. Thank you.

MICHAEL GREENE: Yeah.

RIEPE: I have one more question.

HANSEN: Senator Riepe.

RIEPE: Thank you, Mr. Chairman. I, I, I, I don't want to be insensitive here, but I want-- I just received this-- a Blue Shield-- Blue Cross, Blue Shield Association, and it, it talks about national health equity strategy. And the title on this thing says, "How Do-- Doulas Can Improve the Safety of Childbirth for Women of Color" And so my question is, is this sort of an exclusive thing? I, I wouldn't think it would be. I mean, a birth's a birth, but. I see heads shaking, so.

MICHAEL GREENE: Yeah. A bir-- a birth's a birth. Our particular pilot, the one at that Immanuel Hospital, is looking at specifically a low-income African-American women with that. But that's-- as I said, there's multiple different communities. Each should have a doula that understands the community.

RIEPE: I was just--

MICHAEL GREENE: Yeah.

RIEPE: I'm not sure why they put that-- even added those words into that, that line. So-- OK. Thank you very much. Thank you, Mr. Chairman.

HANSEN: All right. Seeing no other questions. Thank you very much.

MICHAEL GREENE: Thank you.

HANSEN: Take our next testifier in support, please.

SHANIKA KING: Good afternoon, members of Health and Human Services Committee. My name is Shanika King, S-h-a-n-i-k-a K-i-n-g. I am the cofounder and executive director at A Mother's Love, Incorporated in Omaha, Nebraska. We are a community-based organization that provides pregnancy support, doulas, community health workers, baby supplies, and different classes for moms. Have you ever had a hard time or a

hard task by yourself and didn't know where to start or the guidance or the knowledge that you needed to complete that task? If the answer is yes, then we all know that, in life, there are things that are hard and we need help and encouragement to get through those moments at hand. Birth is one of the hardest, most rewarding moments in families' lives. Changes that begin when parents find out that they are expecting are immediate. And with, with families in that change, a doula is there to help them navigate those changes. We encourage Nebraska's health system and legislators to collaborate and get to know some of our community-based maternal support services around in Nebraska and, and our rural areas of Nebraska. Like doulas, they can assist parents in navigating health systems that have historically harmed and-- rather than healed, what we've been doing in our structural barriers for birth. Nebraska requires doulas to support and bring about change between the community and the hill-- health systems. But due to the lack of resources and awareness about maternal health in our communities, mothers and babies are dying. We have a lot of clients that come in just with different things that they need to share or different things that they need but don't feel comfortable with letting everyone know those things. So we serve as just that liaison to help them be able to get those needs that they need. By assisting birthing individuals in our communities with doulas that are culturally specific to the work and their culture, it helps tremendously. The assistance that doulas in the communities provides to families is throughout. It lessens the impact of systematic racism, which in-- which contributes to health disparities and lessens the impact and bring forth change in maternal health. There are, like they stated, 11 states that are participating in reimbursement for doulas. And with that, they are already building the workforce in the communities. They have built those relationships. And they've had sus-- sustainable decrease in maternal health because of those relationships that they have created in the community. If we focus on our community and what they need in order to heal and change instead of telling them what they need, they may be more open to be-- open to change and share those true needs, needs that they have without judgment. The impact of doulas had opened up in the community culturally specific workforce that supports and encourage healthy living amongst each other and amongst the clients that we serve. Let's see. Doulas would be able to live a, a fulfilling and purposefis-- purpe-- purposeful life while bringing change to Nebraska's maternal health crisis. March of Dimes' grade was a-- in Nebraska was a D, and I know we are better than that. We are the heart of the United States. How can we conduct-- I'm sorry. How we conduct and treat our workforce and our families is important.

If we can push change in the middle, it will overflow into other parts of our country and create change in our maternal health system. Doulas are one piece of the puzzle to change maternal health. And doula reimbursement is not only important to maternal health, but it's also important to our communities and the people that are serving and receiving these services. Nebraska, we do need to change in our maternal health for generations to come to have better outcomes for our moms and babies. I would like to thank Senator McKinney for committed to maternal health and urge to commit-- the committee to advance this LB1278 bill.

HANSEN: All right.

SHANIKA KING: Any questions?

HANSEN: Thank you.

SHANIKA KING: Yes.

HANSEN: Are there any questions? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Sort of a follow-up on Senator Riepe's previous questions. So-- bear with me for a moment. So doulas oftentimes offer a cultural sort of competency in the delivery, birthing process. And so the idea of targeting black mothers is to increase outcomes for black mothers. And it's probably a well-known statistic that we have very adverse health outcomes for black mothers of any socioeconomic and educational background. So I just wanted to give you an opportunity to maybe address that is why the proposals might say specifically.

SHANIKA KING: Yes, definitely.

RIEPE: [INAUDIBLE] educate Senator Riepe?

M. CAVANAUGH: I am very, I am very nicely saying to frame the conversation for Senator Riepe in a way that explains the significance of who you are as a black woman, doula in this space. You could educate both of us. You can use education--

SHANIKA KING: Yes, definitely. Being a black woman or any as far as woman in a culture, you're able to relate to that person that is being-- that you are helping. You're able to know the things that they are going through, and they're able to feel just able to share those things with you and not feel any judgment. You're able to close those gaps. So if a mom is not feeling the best and she doesn't feel

like she's going to be heard when she goes to the doctor or she feels like it's too much to even call and say-- or it might take too long, she has a doula that she can reach out to right away either by text, phone call, and say, hey, I'm feeling this way. What do you think I should do? And then as far as us being able to encourage her, yes, you do need to go to the hospital and, yes, you do need to do these things. And if those resources aren't there, if you don't have transportation, if you don't have a way-- then we are able to assist in those and get you resources or even take you sometimes to those appointments when you need it. Because in our community, a lot-- in north Omaha-- we don't have a lot of the same things that maybe out in west Omaha might have and be able to call and make those same requests that others might need to.

M. CAVANAUGH: And is it fair to say that a contributing factor to some of the adverse ou-- health outcomes for black mothers is that they aren't believed in the doctor's office? And what role would the doula play in helping?

SHANIKA KING: Yeah. And it is-- and it's-- sometimes, the role of the doula plays-- as far as advocating for the mom, if they feel like they're not being heard, just maybe giving ways-- different ways that they can be heard. So giving them different tips on how they can talk to the doctor or really advocate for their self if they do feel like they aren't being heard because you don't have to go as far as to a certain-- there's other places that you might be able to go to to be heard in regards to what you and your baby are going through. Because it does make change when someone is listening to you and you feel more comfortable to be able to come and share. Maybe that might not be the issue, but maybe later on in your pregnancy you might have a different issue. But you felt comfortable enough to come share that.

M. CAVANAUGH: But doulas are not just for black mothers.

SHANIKA KING: No. They are-- there's all types of doulas. You know, different culture-- I, I believe that every culture should have a doula to be able to help navigate because everyone has different cultural beliefs and different things that they do during birth and different things that they don't do throughout birth. So when you have that knowledge, you know, and then it makes it a better birthing experience for that person.

RIEPE: Well, it's not something you do every day.

M. CAVANAUGH: Not you.

SHANIKA KING: Not you. I'm not saying every day I do, but--

M. CAVANAUGH: Thank you so much.

SHANIKA KING: Yes. No problem. Any other questions?

HARDIN: Thank you.

SHANIKA KING: Thank you.

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

SHANIKA KING: Thank you.

HARDIN: Next testifier. Welcome.

SYDNIE CARRAHER: Hello. Good afternoon. Senator Hardin is going to be leading us. And members of the Health and Human Services Committee. I'm Dr. Sydnie Carraher. For the record, S-y-d-n-i-e C-a-r-r-a-h-e-r. I am a UNMC staff member and the program administrator of the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC. However, I am not speaking as a representative of the University of Nebraska System today. I'm here testifying regarding LB1278 on behalf of NPQIC and in my role as a private citizen. The Nebraska Perinatal Quality Improvement Collaborative is a network of key stakeholders committed to improving health care and outcomes for all Nebraska mothers and babies. In the United States, roughly 1,200 women die annually as a result of pregnancy or delivery complications, and as many as 60,000 women experience life-threatening pregnancy-related morbidities every year. Disparities in maternal and infant health outcomes disproportionately affect individuals of color, those with socioeconomic disadvantage, and those living in communities where systemic inequality is prevalent. Black and Native American women are at the highest risk for pregnancy-related death, enduring rates nearly two to three times higher than their white peers. Black mothers also suffer from higher rates of labor intervention, cesarean delivery, and preterm birth. Maternity care is failing many pregnant mothers, newborns, families, and communities in our country and right here in Nebraska. As you can see in appendix A, relative to other states in the Midwest and nationally, Nebraska has high overall maternal mortality rates, maternity care deserts, and disparities for black and Native American infants. Nebraska ranks in the top five in the U.S. for the highest rates of maternity care deserts and black infant mortality rates. These inequities are not driven by race but by social determinants of health, including access to care, quality of delivered care, communication with the health care team, food and

housing security, as well as multigenerational exposure to racism and a lack of culturally appropriate care. Integration of doula support for high-risk birthing people has the potential to reduce health disparities and improve outcomes. As you've heard, doulas are trained professionals who provide nonmedical, physical, emotional, and informational support to clients and their families before, during, and after birth. Consistent evidence shows that doula support is associated with improved birth outcomes that can have a positive impact on reducing racial disparities in maternal and infant health outcomes. The presence of a doula supports enhanced communication between clinicians, birthing people and their families, improved quality of maternal care services, use of fewer obstetric interventions, including cesarean delivery, less use of pain medications, reduced rates of preterm birth and perinatal mental health conditions, and increased patient satisfaction and the potential to reduce health care costs. Despite the benefits of doula support, barriers exist to exact-- accessing doula care, including a lack of knowledge of their role, cost, availability of services across race and socioeconomic levels, and a lack of access to culturally congruent care. Consequently, birthing people with the highest risk for adverse outcomes are less likely to utilize doula services. Doulas also face challenges navigating the health care system, including misconceptions of their roles, certification and training requirements, lack of service reimbursement, and resistance from health care team members. Doulas are an integral role of the health care team and have a proven potential to improve birth outcomes. Implementing a pathway for those at highest risk of poor pregnancy outcomes to access doula services would help to ensure a higher quality of care for low-income women, provide culturally appropriate and patient-centered care, and reduce unacceptable racial disparities in maternal and infant health outcomes in Nebraska. Thank you for your time. I'm happy to answer any questions.

HARDIN: Thank you. Any questions? I'm not seeing any.

SYDNIE CARRAHER: OK. Thank you.

HARDIN: Thank you. Appreciate it. The next testifier for LB1278. Welcome.

MAGHIE MILLER-JENKINS: Hello again. My name is Maghie Miller-Jenkins, M-a-g-h-i-e M-i-l-l-e-r-J-e-n-k-i-n-s. Happy Black History Month again. A lot of people are going to come up behind me and a lot of people have come up ahead of me to tell you about the disparities that black birthing people face. And I just want to read a quote.

This is from Lies My Teacher Told Me. I just think that education is a really important part of how we move forward and how we make our decisions. It says: On Haiti, the colonists made Arawak mine for gold, raise Spanish food, and even carry them everywhere they went. They couldn't stand it. Pedro de Cordoba wrote a letter to King Ferdinand in 1517: As a result of suffering and hard labor they endured, the Indians chose and have chosen-- sorry. The Indians have chose and are choosing to commit suicide. Occasionally, a hundred have committed mass suicide. The women, exhausted by labor, have shunned conception and childbirth. Many, when pregnant, have taken something to abort and have aborted. Others after delivery have killed their children with their own hands so as not to leave them in such oppressive slavery. This is from 1517. I gave birth to my son in 2013. I had a student perform my epidural. And I didn't get told that a student was performing my epidural before it happened. I don't know what it feels like to be set on fire, but I'm pretty sure that that experience was the closest I've ever been. It felt like the entire left side of my body had been dipped in lava. It felt like my bones should have been melting. When I told them how bad it was, I had two nurses look at me and tell me that I was a complainer. After I got my epidural and I was taken to the interim-- I was in labor for about 16 hours-- and I had a nurse come in. And her-- I will never forget her words and I will never forget her face. She walked into my delivery room and said, are you ready to have a baby in an hour? And I said, how is that going to happen? Her exact words are, oh, we're just going to cut him out. It's a really awful way to tell a first-time mother that she's about to have a C-section. So I had a lot of complications. My son ended up in the NICU. My second birth, I demanded to have the head of anesthesiology be in there so that I wasn't traumatized again. And it didn't matter because it was still a traumatic experience. It would have been so much different if I would have had access to a doula who could have helped me advocate for myself. I didn't know what I was doing in that sphere. I deserved to have somebody there to help me want to have more children, help me want to look at birth and birthing as a great experience. So if you guys are going to use this month to do something, support Senator McKinney in LB1278 and help us make Nebraska somewhere that I want to encourage my children to have children because I could tell them with an honest heart that the people in charge of our laws are doing what they're supposed to be doing to help fix the continued history of the devastation that we still feel from colonization. Thank you for your time.

HARDIN: Thank you. Any questions? Seeing none. Thank you. Next testifier. Welcome.

CHARMAINE BOX: Good afternoon, members of the Health and Human Services Committee. My name is Charmaine Box. That's spelled C-h-a-r-m-a-i-n-e. Last name spelled as B-o-x. I am a full-spectrum doula, prenatal and postpartum doula. I'm here in support today of LB1278. I've been a doula for three years, and I've been able to work with birthing women and their families throughout the years. I have worked with families that are on Medicaid. I will lower my price to help those women to be able to afford a doula, or I will have to put them in programs for those families to receive a doula. My experience as a doula, I've been able to emo-- be an emotional support and a companion for my doula families. I can go on prenatal visits with my doula families to help them remember the questions that they want to ask their midwife or doctor. I can help the birthing people with postpartum support. With my support, I can advise the birthing families to take walks outside to help with depression, provide resources to seek mental health support. Having a baby can be stressful, but a doula is there to help alleviate some of that stress. We provide the emotional support to our birthing families. Having a doula-- having Medicaid doula reimbursement would help a lot of families in my-- in the community I live in and support. Most families do not like to be part-- take part of programs that offer sup-- that offer to supply a doula for them, as they must give up too much information to be part of those programs that make that-- that makes them take mandatory classes. Most families do not have the means of transportation to attend those classes. Birthing families just want to have one person to help support them and listen to them. Also, some of these pro-- other programs, doulas must have to wait four to six months to be paid for their services, and that can-- they-- that they provide for those families. With doula reimbursement through the state, doulas would be able-- wouldn't have-- need to have-- go through a third-party to reimburse. I would like to thank Senator McKinney for the commitment to medi-- maternal health and urge the committee to advance LB1220-- LB1278.

HARDIN: Thank you.

CHARMAINE BOX: You're welcome.

HARDIN: Any questions? Senator Riepe.

RIEPE: I have a question. Yes. Thank you. Would you help me with the journey on-- you said you've been a, a doula for three years. What

was your-- did you work under an apprenticeship or did you go to a formal training or-- help me with that. How'd you--

CHARMAINE BOX: So--

RIEPE: How do you become a--

CHARMAINE BOX: I found out about who I can go through. I went through a program here in Lincoln, Nebraska.

RIEPE: A program here in Nebraska?

CHARMAINE BOX: Yes. A wonderful program. I was able to get a scholarship to pay for myself to become a doula. This program has helped me grow and be able to be successful. From there, I was able to go with a agency that was out of state, out of New York. I did 40 hours of training. So I spent two weekends at my house virtually because they didn't, they didn't have in person here in Omaha or Lincoln yet. And I was able to take those classes on there to become a prenatal and postpartum doula. I have just recently last year became a full-spectrum doula through the D-- Doula Passage Program with I Be Black Girl.

RIEPE: Is that a certificate or an accreditation or--

CHARMAINE BOX: It's a certificate that you receive--

RIEPE: Was it a specific institution--

CHARMAINE BOX: ProDoula.

RIEPE: Oh, OK. OK.

CHARMAINE BOX: And they're out of-- so they have stations in New York, and then they have some that are in the South.

RIEPE: OK. So it's totally independent from--

CHARMAINE BOX: But they're nationally credentialed.

RIEPE: --just totally independent from the med schools or any of those.

CHARMAINE BOX: So I can take that certification from ProDoula, and I can go to any other state that I would like-- want to be able to be a doula at. So--

RIEPE: Is there any process-- any peer review or anything?

CHARMAINE BOX: You do have to take a test to get certified, but they don't do, like, a review to see. But the agencies that you do work with, they do have to go through a background check to make sure you're--

RIEPE: You don't have to register with the state?

CHARMAINE BOX: No, you do not. Not like if you are a midwife.

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

HARDIN: Thank you. Any others? Seeing none. We appreciate it.

CHARMAINE BOX: Thanks.

HARDIN: Next testifier for LB1278. Welcome.

MARCIA ANDERSON: Hi. Thank you. Good afternoon. My name is Marcia Anderson. That's M-a-r-c-i-a A-n-d-e-r-s-o-n. I am also a full-spectrum doula. I've been a doula for three years as well. I first took my training with the National Black Doula Association. That was also a two-week course. And then I too last year took the training with I Be Black Girl. I can say I have serviced both African-American families and Caucasian families, families of different socio-- socioeconomic class. And what I've noticed is my Caucasian families that I serve, they've been able to pay out of their pocket. Whatever my price is, they're able to pay. With my African-American families, I have to put them through the programs like I Be Black Girl and different pilots that we have because they're not able to afford it. Most of the women who I serve, these are young women, teenagers. I've had 16-year-olds, 17-year-olds. And it's no way they're going to be able to afford a doula out of pocket. Even if I lower my prices, they just can't. These young women are not working. So programs like I Be Black Girl that they provide for the grants is very beneficial. But these grants aren't always going to be around. Most of my community that I serve, they are on-- they receive Medicaid. Another benefit of having a doula-- again, most of my community-- I serve our African-American-- within our community, it has always been taboo to breastfeed. I'd say out of most of my families that I've served, they've all been able to breastfeed. I've been able to help them latch. When they feel like they want to give up and not breastfeed, I've been able to encourage them. And they're like, oh, my mother or somebody is telling me I shouldn't and they think it's weird. But because of my help, I'm able to help them

successfully do it. I'm also-- I'm there for the duration of your pregnancy. Some women come to me early on. Some come to the end. I'm there for your pregnancy, your labor, and delivery. I'm not leaving that hospital until a good two hours after your baby is born. Watching your blood pressures, making sure your bleeding is under control. Just making sure Mom is safe. And then postpartum journey-- like I said, breastfeeding, nutrition. And I follow them up to at least four months. But there's some families who I've served as long as two years ago, and I'm still serving them and making sure that they're still doing good mentally. Postpartum depression is something that's so serious, and black women are more susceptible to that. So I'm always watching them, making sure you're not having postpartum depression, letting them know it's normal. Talk to your physician. I love the programs we have with the hospitals because a lot of them are very open with us. They want us there. I've had doctors tell us that you're needed. You've helped us. And I do see the light is red, so I'm going to end for any questions.

HARDIN: Thank you. Appreciate it. Any questions? Senator Walz.

WALZ: Thanks for being here. You answered the question about postdelivery, the time that you spend. So that's good to hear. I'm just curious, how many women do you help in a year? Like, an average.

MARCIA ANDERSON: So like I said, I did my training in 2021. I really started 2022. Last year, I think I served about maybe, oh, goodness, 20 families. I try not to do more than four in one month because I want to make sure I'm giving you your full attention. I never want to risk someone going into labor at the same time. So if I do that, I make sure they're spread out so everybody can have the devoted attention that they need. So if I take four, that's pushing it. But I tend not to do four in one month, so.

WALZ: That's more than I thought.

CHARMAINE BOX: Yeah. Well, February has been pretty busy for me, but I normally don't do that.

HARDIN: Have you ever had two that were happening at the same time?

CHARMAINE BOX: Yes and no. And I say yes and no because one of them-- I was a backup doula for someone, and her client went into labor that day. So as I was at the hospital with her client, my client went into labor. So her actual-- I was there until her actual doula was able to

come. And then I was able to go to the hospital and deal with my client. I have had births within, like, two days apart, though, so.

HARDIN: Well, thank you. Any other questions? Seeing none. Thank you.

CHARMAINE BOX: Thank you so much. You all have a good rest of your day.

HARDIN: Next testifier for LB1278. Welcome.

SAMANTHA WALL: Thank you. Good afternoon, members of the committee. My name is Samantha Wall, spelled S-a-m-a-n-t-h-a W-a-l-l. I'm the executive director at Omaha Better Birth Project. Omaha Better Birth Project stands in strong support of LB1278, a bill to provide reimbursement for doula services for Medicaid recipients. I have my master's in public health and have been working in the maternal health field for over eight years. As a public health practitioner, I've witnessed the positive impacts that doula support can have on maternal and infant health outcomes. LB1270-- excuse me-- LB1278 is a crucial step towards addressing health disparities, promoti-- promoting positive birth experiences, and ultimately improving the well-being of birthing people and their newborns. Omaha Better Birth Project was founded to decrease inequities in childbirth, particularly for low-income families. Since the launch of our birth doula grant services in 2021, providing families with funds to pay for birth doulas, we've seen a cesarean rate of 12% compared to the state cesarean rate of 29%. Our families experienced zero NICU admissions and had a 0% preterm birth rate compared to the state rate of nearly 11%. Doulas are essential allies for low-income parents, offering support, education, and advocacy to enhance their birthing experiences and improve maternal and infant health outcomes. It's well-documented that there are significant racial and socioeconomic disparities in maternal and infant mortality rates. Medicaid recipients, often from marginalized communities, face unique challenges in accessing adequate health care services. Doulas are a critical part of the birth team for parents, but access to birth doulas is financially out of reach for many. By extending reimbursement for doula services to Medicaid recipients, LB1278 addresses these disparities directly and promotes a more equitable health care system. Low-income families often experience unique challenges during their pregnancy, birth, and postpartum, making them at higher risk for poor birth outcomes. Transportation barriers, limited access to healthy food, lack of social support, and other issues experienced by Medicaid recipients can be greatly alleviated by doula services. When the risk factors are mitigated, maternal

stress is reduced, thereby reducing risk of preterm birth and low birth weight. By addressing the unique challenges faced by low-income families, doulas contribute significantly to cr-- to creating a more equitable and compassionate health care system. It's crucial to highlight the cost-effectiveness of doula care. While the initial investment in doula services may seem significant, the long-term benefits far outweigh the costs. Su-- studies consistently show that births attended by doulas result in fewer complications, decreased rates of preterm birth, and lower health care expenses in the postpartum period. Investing in doula support aligns with a preventative health care approach, ultimately saving resources in the long run. LB1278 is a vital piece of legislation that has the potential to enhance maternal and infant health outcomes, reduce health care disparities, and promote the well-being of Medicaid recipients. By providing reimbursement for doula services, we're investing in a healthier community, fostering positive birth experiences, and creating a more equitable health care system. Thank you, Senator McKinney, for your commitment to maternal health. And I urge the committee to advance LB1278. Happy to take any questions.

HARDIN: Thank you. Any questions? Seeing none.

SAMANTHA WALL: Thank you.

HARDIN: Thank you. Next testifier for LB1278. Welcome.

ALEX DWORAK: Good afternoon, Vice Chair Hardin, Senators of the Health and Human Services Committee. My name is Alex Dworak, A-l-e-x D-w-o-r-a-k. I delivered babies for eight years early in my career as a family doctor-- I was actually a coresident of my friend, Dr. Greene-- primarily to low-income, Medicaid, and, for a time, LB599 Medicaid-excluded women. I strongly support this bill as an evidence-based practice for effectiveness, cost reduction, and taking action on racial disparities in maternal and child health. The American College of Obstetrics and Gynecology as well as the High Risk Specialty Society for Maternal-Fetal Medicine and the American College of Nurse Midwives have recognized the effectiveness of doulas in improving the health outcomes of birthing people. Particularly at a time when enormous and, frankly, unacceptably worse outcomes are widely documented for minority patients, especially black patients, I feel it is a social and ethical imperative to do everything possible to correct this. Failure to do so will send a clear message that our state quite literally does not value the health and well-being of young pregnant people in poverty who, while having an overrepresentation of minorities, also include-- a majority are white

folks and rural people too. I'll close by noting that, late last night in this room, I heard Dr. Martin Luther King Junior quoted, and a quote of his came to my mind as I was thinking about this. It's simple and direct: The time is always right to do what is right. And I will mention that I've already sent a couple things to Senator Riepe from the best district in Nebraska, the 12th District, where I live. I'd be happy to try to connect you with people at Nebraska Medicine who are linked in one of the articles I mentioned. And I'm happy to discuss some of the outcome-- the evidence that I've seen as well. Better birth outcomes, four times reduced risk of having a low birth weight baby, half the risk of experiencing a birth complication, significantly more likely to be able to start and successfully breastfeed, as was mentioned by a prior testifier. And again, doulas are cost-effective with minimal training. They also reduce epidurals and need for pain medication, which is making for a less invasive birth, less risk to Mom and baby of having very potent anesthesia meds such as fentanyl or other meds in a medical setting, which leads to less risk and less likelihood of NICU stays, so. As a physician, this just seems like an all-around win. I'll highlight that, besides black women, I delivered a lot of Spanish-speaking women and also some Guatemalan women. I can walk in and speak to somebody in Spanish, but to have a towering white doctor come in when your first language isn't even Spanish but a Mayan language-- like Chuj, Q'anjob'al, or Mam-- I can't imagine what that's like. I bet it's scary. I bet it would be a better experience for them and also it will be more effective and safer to have a doula in those situations as well. I appreciate Doc-- or, Senator McKinney for bringing this. I appreciate the honor of being able to speak. And I'm happy to take any questions.

HARDIN: Thank you. Any questions? Senator Riepe.

RIEPE: Thank you. Thank you, Doctor, for being here. A good citizen of the 12th District, I might add. My question gets to be, as we've heard from a number of doulas, that-- are, are, are black by ethnicity. And you talked a little bit-- I, I picked up on that one-- you talked about Hispanics. Are there doulas out there that work with Spanish speaking-- well, I see some heads nodding back there, so.

ALEX DWORAK: Yep. I would be almost certain. Again, I haven't delivered babies in a few years because of other changes in my practice, but, yes, I, I would-- the evidence would generalize to them. And particularly with a lot of physicians, especially, but medical practitioners in general being overrepresented as white men like me as opposed to being more representative of the patients that

they're taking care of, I think that's-- it's particularly important when there's language barriers, not just for Spanish speakers, also for our refugees, such as Karen speakers from Burma or Myanmar, from areas in Africa. And again, it's just-- it's-- as good as the physician or the obstetrician or the midwives' decision-making can be, having that additional emotional support, another set of eyes helping to advocate, that's going to be whatever the clinician's brain is plus a bonus. And so I think it's just always going to be a good thing.

RIEPE: OK. Thank you. Thank you for being here. Thanks for taking your time.

ALEX DWORAK: Absolutely.

HARDIN: Any other questions? Seeing none. Thank you. Next testifier for LB1278. Hi there.

KELSEY ARENDS: Hi. Good afternoon. Members of the Health and Human Services Committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s. And I am the Health Care Access Program staff attorney at Nebraska Appleseed, testifying in support of LB1278 on behalf of Nebraska Appleseed. As you have heard, LB1270-- LB1278 ensures that Nebraskans with Medicaid can access doula services. Medicaid plays a crucial role in ensuring that Nebraskans can access health care, currently providing coverage to over 345,000 Nebraskans, covering approximately 35% of all births in Nebraska and nearly half of all births in maternity care deserts. Low-income individuals covered by Medicaid tend to face more chronic conditions and risk factors that can negatively impact maternal health and birth outcomes. By providing health coverage to Nebraskans who have limited resources and limited options for coverage, Medicaid can be a critical tool in addressing health disparities. Including doula care in comprehensive health coverage can improve health outcomes and result in cost savings. Evidence indicates that doula care can improve health outcomes and birthing experiences for both moms and babies. As you've heard, evidence has shown that doulas reduce the need for medical inter-- interventions like cesarean delivery, which can be riskier for pregnant people and babies. Doula support during pregnancy, birth, and postpartum further reduces rates of prematurity and illness in newborns and the likelihood of postpartum depression. Additionally, doula care has-- also has the potential to reduce health care spending overall. Doula care's reduction in cesarean births alone can reduce costs, but doula care may also reduce costs by preventing birth complications. As you have heard, for many years,

the maternal mortality rate in the U.S. has consistently worsened and exceeded that of our other high-- of other high-income countries, and long-time systemic inequities in the U.S. have contributed to particularly high maternal mortality rates for black people and people of color. Additionally, disparities in maternal mortality exist among geographic regions, with most-- with the most rural counties seeing significantly more maternal deaths as compared to metropolitan counties. Doula care can help address racial disparities and other inequities in maternal health and improve maternal and birth outcomes. Because of the potential benefits of providing full-spectrum doula coverage and because of the many different approaches available to implement col-- coverage of doula services, the federal Centers for Medicare and Medicaid Services, or CMS, is providing technical assistance to states on the ways in which data services can re-- be reimbursed under Medicaid. Appleseed supports LB1278's proposal to have Nebraska join the growing number of states ensuring coverage of doula services. We also support the small change in bill language to clarify that Medicaid reimbursement would be paid directly to doula service providers. Because this bill will increase access to health care and address long-standing disparities and inequities while promoting cost savings, we respectfully urge this committee's support of LB1278.

HARDIN: Thank you. Any questions? Seeing none. We appreciate it. Thanks.

KELSEY ARENDS: Thank you.

HARDIN: The next testifier for LB1278. Welcome.

AMBER BROWN KEEBLER: Hi. Thank you, Health and Human Services Committee. My name is Dr. Amber Brown Keebler. A-m-b-e-r B-r-o-w-n K-e-e-b-l-e-r. I was not originally prepared to testify on this bill today, but I felt compelled to speak because of my personal experience as a birthing person and now mother. For my second pregnancy, I was in a rural town in Missouri practicing there, and I was going to have to consider undergoing a vaginal birth after C-section. Back then-- that's now been seven years ago. The evidence was pretty clear that doulas were resulting in improved health outcomes. And so I looked into that service for myself. Now, I realize that I'm coming from a place of privilege and that we were able to afford these services out of pocket. It was not covered by our insurance at the time either. And we had an incredible experience in a small hospital in St. Joan, Missouri with a doula. So knowing that this is successful in these smaller hospitals I think is

important. The entire birthing team, my OB/gynecologist, our nursing staff-- it was an incredibly positive experience. And I was very successful at being able to achieve a vaginal birth after C-section. I'm incredibly indebted to my doula who was with us through that experience. After that, I was also able to successfully breastfeed after I had not been able to for my first child, and that was incredibly important to me. And I know that it's very, very challenging for other mothers. I cannot imagine how much more difficult it would be for mothers who do not come from my place of education and experience in the health care system. Not only am I a physician [INAUDIBLE] medicine in pediatrics, my husband is an ER doctor. And even we felt the benefit and the support of having that person there to help us get through the process. And I can't imagine it being any different for anyone else. And so I just wanted to thank Senator McKinney for introducing the bill and to just provide my support. Thank you.

HARDIN: Thank you. Any questions? Seeing none. The next testifier for LB1278. Proponents. Hello.

SCOUT RICHTERS: Hello. Good afternoon. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s. Here on behalf of the ACLU of Nebraska in support of LB1278. We would first like to thank Senator McKinney for bringing this bill. The ACLU of Nebraska works to ensure that Nebraskans can make reproductive ce-- decisions with autonomy and dignity. This work includes ensuring Nebraskans have access to birth control and abortion care, prenatal and maternal health care, and that the rights of pregnant and parenting students and workers are protected. Expanding funding under the Medical Assistance Act to fund doula services will ensure that more patients are supported in making decisions about their reproductive health care. As you've heard from other testifiers, increased access to patient supporters and advocates such as doulas can also help Nebraska address the persistent racial disparities in reproductive health. So for those reasons and the reasons stated by other testifiers, we urge your support of this bill. Thank you.

HARDIN: Thank you. Any questions? Seeing none. Thank you. Appreciate it. Next testifier in support of LB1278. Welcome.

PAUL FEILMANN: Hey. Good afternoon. My name is Paul Feilmann, F-e-i-l-m-a-n-n. 317 Clear Creek Drive, Yutan, Nebraska. And I won't take too much time. I wanted to bring up-- I talked to Phil Hughes [PHONETIC], who is at Douglas County Health Department, over the lunch hour, and he sent me the current data on infant mortality for

Douglas County. That is-- he said this, this was in last year's State of Public Health report. Black infant mortality was 14.1 per 1,000 births; and whites was 3.9%-- 3.9 per 1,000 births; and Hispanic was 1.7. So that's a real clear racial disparity. The information that I gave out just really talks about-- there's probably some other things. It's in your email that I sent today. It just talks about the value of the, the doula. And what I really wanted to say today is I testified-- and I think some of you guys were in the Urban Affairs Committee. The bill was introduced to develop poverty reduction plans in every city in the si-- in the state. And this is a great template for how to do that. It's-- it, it's where you intervene. My undergrad degree is in child development. It's not rocket science to understand the earlier you intervene-- and the issue about the doula things, it takes you through the birth, but then what? You've got-- the number of kids in poverty in some districts in this state are just, you know, just hor-- I mean, 75%. And if you intervene early-- there's right now a study through-- the Weitz Foundation is-- got a unique spot in a national study where they're intervening with mothers as soon as the baby is born, providing resources, and then monitoring their growth, their brain development. And they're into the fourth year now. And that data's going to be available and shows a lot of the interventions that they're doing. But it would be kind of what the-- what I've heard today talking about the doul-- doula interventions. But then you got a pregnant mother who you've got her all the way through the birth, and then it's like, see you. You know, this-- you got to continue those services all the way up because those first five years is where the damage of poverty is most severe, and that's where the interventions could be. So hopefully that can be passed onto the antipoverty game plan as far as some of the things that Senator McKinney's other bill was looking at. Thank you.

HARDIN: Thank you.

PAUL FEILMANN: Yep.

HARDIN: Any questions? Seeing none. The next testifier in support of LB1278. Any more proponents? Any opponents to LB1278? Welcome.

ALLIE FRENCH: Thank you. My name is Allie French, A-l-l-i-e F-r-e-n-c-h. I first want to begin by saying that everybody who spoke before me is absolutely right. Our only reason for being here today is to express the concern that going under-- allowing medical-- Medicaid reimbursements would actually tie the hands of doulas. Many speak about wanting to be able to help low-income families or those in poverty. And I can tell you from actually a recent conversation

with the dentist, who's-- obviously has Medicaid reimbursement-- that that's actually become nearly impossible for them. Those rates are determined often by zip code. And if you happen to be in the wrong zip code, you can't lower your prices to help individuals that you want to. So just because you provide the services that they want, they feel that you're the best characterized to help their needs and desires, doesn't mean that you're going to be able to then help those if you happen to serve from the wrong zip code. And so I think these are real concerns that need to be taken into consideration that, you know, tying yourself closer to the government and putting those reimbursements in place don't always help. I think that the grants that-- you know, many that are available out there are great. I think we should be looking at ensuring that those continue to be fulfilled and available to doulas so that they can help those who can't afford their services. When I was pregnant, that was not a service I could afford. I was on Medicaid. It wasn't really in the cards. I also had a family who didn't see the benefit of it. But I think that comes down to the education side of things. And for so very long, we've been pushed and told that the medical professionals in the hospitals know best. And I can tell you from personal experience and having children then later on that those who are here to help moms have their babies are in the best position to help them. Those advocates are absolutely necessary. We want people to have access to those, but I think the education side of things is where we need to focus, making sure that people know that they're an option. And again, through our communities, providing assistance so that they can have those tools. But to go in and take the reimbursement, I think that they're going to find that their hands are actually more tied from helping the individuals that they'd like to help out, so. That was our main concern. I don't really have anything else to add. Thank you, guys.

HARDIN: Thank you. Any questions? Seeing none.

ALLIE FRENCH: Thanks, guys.

HARDIN: Thank you. Anyone else in opposition to LB1278? Welcome.

JOYCE DYKEMA: Hello. My name is Joyce Dykema. J-o-y-c-e D-y-k-e-m-a. I have been a birth doula in Lincoln since 2009. I'm certified with DONA International and Hypnobabies. I'm an evidence-based birth instructor. I'm a partnering birth doula, childbirth educator, and the doula mentor with the Malone Center's Maternal Wellness Program, and I sit on the board of directors for DONA International as director of communications. I am testifying today on behalf of the

DONA Board of Directors. DONA International's the only nonprofit member-owned doula organization delivering evidence-based training, education, and certification worldwide. Founded in 1992, our organization and its network of doulas first professionalized the doula role. We have certified over 16,000 doulas and support over 5,000 members in over 54 countries. DONA opposes LB1278, surmising that it will result in unintended harm to doulas, childbearing families, Medicaid providers, and Medicaid recipients in Nebraska. The likelihood of exploitation due to the ambiguous, misleading, and incorrect definitions of doulas is high, putting extra strain on Medicaid dollars when the goal is improving perinatal outcomes and reducing costs through implementation of doula care. The definitions of a doula and full-spectrum doula LB1278 do not reflect widely recognized definitions. DONA recognizes that the doula role precedes the modern profession and is widely accepted today by multiple doula organizations, the medical community, and the general public to mean a trained individual who provides nonmedical, physical, emotional, and informational support and advocacy before, during, and after childbirth while a full-spectrum doula provides similar support from preconception through postpartum. The inaccurate definition of doulas in LB1278 is so broad it could include minimally trained support for any number of health-related experiences outside of pregnancy, birth, and postpartum. DONA supports the expansion of Medicaid to cover doula services for pregnancy, birth, and postpartum. However, we strongly oppose any legislation that does not center a diverse group of doulas from across the state of Nebraska, representing a wide variety of training organizations with all levels of experience in the development of Medicaid expansion. Outlining this process and the members developing this expansion is vital to include in the bill itself to ensure oversight and long-term sustainability of doula engagement, increasing the likelihood that doulas across the state will enroll. I'm proud to have served Nebraska families for the last 14 years. I believe Nebraska has the opportunity to come together to build a Medicaid benefit that will make a difference for our citizens. On behalf of DONA, I thank Senator McKenney and his colleagues for valuing doula support as one way to address the perinatal health crisis. While DONA opposes LB1278 in its current form, I hope that you and your colleagues make the necessary changes to ensure success, and I look forward to collaborating as part of that process. Thank you.

HARDIN: Thank you.

JOYCE DYKEMA: Thank you.

HARDIN: Any questions? Seeing none. We appreciate it. Thanks. Next testifier in opposition to LB1278. Welcome.

MARSHA DVORAK: Thank you. I appreciate you're hearing all of us this afternoon. And thank you for listening to me. I've evolved here listening to all of this. And I need to keep things short, obviously. So due to the time constraints, I must condense the last 36 years. OK. I've been for 36 years teaching a comprehensive pregnancy, childbirth, postpartum, lactation, and early parenting class that's over 12 weeks long. I was also a labor assistant. This was prior to our being called doulas by Penny Simkin in 1992. We had a labor assistant with our second child and had a vaginal birth after cesarean. So that was at the beginning of the V-BAC revolution. And I was working at St. Elizabeth's at the time and started this class. And they decided to send me to get trained by Penny Simpkin. And she's the one who called us doulas. So their intent, St. Elizabeth's was, to have me trained not only to become a certified doula but a birth doula trainer. And they implemented a volunteer doula program. So in exchange for sending me to be trained by Penny, I and one other person professionally-- you probably would know her name. I'm not going to share it-- taught four pro bono classes to train this-- the new doulas. So because I earned great respect, that was-- I ended up being part of the vanguard of doulas that had the experience as labor assistants being trained by the experts. So by the time I had my training, we were doulas. And-- oops. So DONA International is the premier organization. They're the ones that, that started it all. And that included Marshall Klaus, Phyllis Klaus, John-- and John Kennell. They're the bonding physicians. They were my teachers, mentors, and friends. I went to multiple conferences through the years-- and I'm getting goosebumps and could get teary. I miss them all. Phyllis is still living, and she's near and dear to me. But I learned by the best. And consequently, you continue learning. And so 36 years, I've done about 2,000 births. And from that standpoint, I definitely see and feel the connection to LB1278. I will say, however, there's some wording that needs to be different. But at the same time, I've learned so much and I'm very pleased to hear about-- sorry. I'm on the red, aren't I? I apologize.

HARDIN: If we could, if we could ask you to wrap up as soon as you can. We, we appreciate--

MARSHA DVORAK: Yes. I'm wrapping.

HARDIN: --your experience--

MARSHA DVORAK: I'm wrapping.

HARDIN: --and are looking forward to it.

MARSHA DVORAK: You bet. I've supported women from all cultures, including Tanzania. And the bill needs to be readdressed a little bit, attending to provide the education that is critical to produce the statistics that you seem to wish to benefit from. So the big-- general full spectrum may not be, you know-- I'm, I'm-- certainly, there's going to be some changes in regards to that. But to really get the benefits of doula care lessening and decreasing costs and so on and increasing the value of life and so on-- definitely. It just needs to be rewritten a little bit.

HARDIN: OK. Thank you.

MARSHA DVORAK: OK.

HARDIN: We appreciate that.

MARSHA DVORAK: Thank you. Thank you so much.

HARDIN: Any questions? Seeing none.

MARSHA DVORAK: OK.

HARDIN: Thanks for being here.

MARSHA DVORAK: You got it.

HARDIN: Next testifier in opposition to LB1278. Going once. Going twice. Well, two is all we're going to do here. Neutral. Anybody in the neutral? Welcome.

BECKY SHERMAN: Hello. My name is Becky Sherman, B-e-c-k-y S-h-e-r-m-a-n. Good afternoon, evening, Senators. My name is Becky Sherman. And I am a certified doula serving in the Lincoln and surrounding areas. I have been a birth doula for almost 17 years, and I've attended 300 births spanning from Omaha to Red Cloud, Nebraska, including home, hospital, and cesarean births, with the occasional accidental side of the road car birth. I have served birthing persons between the ages of 16 and 48 with many diverse religious backgrounds, socioeconomical, racial, and ethnic backgrounds. I have also been a part of legislative acti-- activity through my advocacy and lobbying efforts with grassroots organizations, centering around birth and birthing family rights since 2008. I believe in the idea

that all families deserve to have a birth doula throughout their birthing process, including prenatal, labor, and postpartum times. I am testifying in a neutral position today, as I am in favor of all families having access to doula care without the barrier of finances, and I'm excited that other states have figured this out as well. I am concerned about the bill, however. Concern number one is the definition of birth doula inside this bill. The definition of a birth doula is and has been mentioned many times: A trained professional labor assistant that provides physical, educational, and emotional support to pregnant individuals, and that is simply not what's listed in this bill. The definition of full-spectrum doula as written in this bill also fails to include the complete definition of a full-spectrum doula. A full-spectrum doula would also include a doula for infertility, adoption, menstrual pain, abortions, and end-of-life care in hospice situations without any bias towards gender, family status, sexual orientation, religion, race, or any other qualities that would make it difficult for a person to find or hire a doula. I encourage a full and complete definition. My second concern has been addressed. My third concern would be the participants of the work group. I would like the bill to state from the beginning the importance and the state's intention for doulas from across the state as well as across levels of experience to be the center of this work group to determine compensation. Listing experts is not specific enough. I have been made aware that the team, that the team of experts would be medical experts and community, family advocates. It has been my experience that many medical providers and other community leaders in the medical field highly undervalue, disrespect, and often are ignorant of my profession. Based on the language in this bill, the stakeholders mentioned here are also lacking information needed to fully understand what a doula is and what we do, let alone how to value our services in a comprehensive way. To address the 407 review--

HARDIN: Can I ask you to wrap your thoughts up since you're--

BECKY SHERMAN: Of course. All wrapped up.

HARDIN: --we're into the red. OK. Thanks so much. Any questions? Seeing none. We appreciate it.

BECKY SHERMAN: Thank you.

HARDIN: Anyone else in the neutral for LB1278? Very good. Senator McKinney, would you come back for close? And we have 26 proponents, 14 opponents-- and letters, 3 in the neutral.

McKINNEY: Thank you. And thank you for everyone that came to testify in support. Thank you for those who came in opposed and neutral to offer your suggestions and feedback. One thing I will say, and I say this for any of my bills-- and I was looking at the date of introduction of LB1278 and the time of this hearing-- I would have loved it if any of those in opposition or neutral would have reached out to my office and offered those suggestions a lot earlier. We would have tried to address those concerns a lot earlier and not the week of or the day off. So for future references, if you oppose a bill, reach out a lot sooner so we could try to clear up those concerns and maybe we can address those prior to a hearing. But I will say, I, I would hope that this committee would vote LB1278 out. If we need to make some changes with an amendment to address some of the concerns that were stated by some of the individuals today, I'm open to it. I'm willing to work with any of the partners that came before us today as proponents and try to get this passed. I think it's important. I wish the hearing was a lot sooner because we're-- you know, priority deadlines are, you know, today and tomorrow, so. I know-- I'm not sure if you guys have a committee package or anything put together yet, so I'll try to talk to Chair Hansen. But I'm hopeful that we can get this out because I-- I just think is very important, especially-- last year, you know, this Legis-- Legislature passed a bill that is very restrictive on women and, you know, women that are going to deal with births and, you know, in my opinion, kind of forcing women to have births. So if we're going to do that as a state, I think we should be doing all we can to make sure we're taking care of women during their births and making sure that they get the proper care that they need as they go through that process. I think that's the least we can do, especially for black women who deal with the worse outcomes during birth. So I'll, I'll open myself up to questions if you have any.

HARDIN: Thank you. Any questions? Seeing none. We appreciate it.

McKINNEY: No problem. Thank you.

HARDIN: This concludes our hearing of LB1278. And we will be moving on to LB1111. We'll wait just a moment, Senator Clements, as we wait for the folks to find their way out who want to leave this place. Granted, the popcorn is gone, but all of the activity and fun is still going on, so. It looks like we're settled, finally. Senator Clements, we're ready when you're ready.

CLEMENTS: Thank you, Vice Chair Hardin, members of the Health and Human Services Committee. I am Senator Rob Clements, R-o-b

C-l-e-m-e-n-t-s. I represent Legislative District 2. I am here to introduce LB1111. LB1111 would require a local public health department organized as a city/county health department located in a county with a population greater than 200,000 to obtain approval from the De-- Nebraska Department of Health and Human Services before implementing directed health measures, DHMs, pertaining only to a national or multistate pandemic. Doing this would bring more continuity of DHMs across the state for the citizens of Nebraska during larger pandemic situations. Currently, only a local health department organized under Section 71-1630(4) has a city/county health department located in a county with a population greater than 200,000 people can implement DHMs without the approval of DHHS. The Lincoln-Lancaster carve-out was created by the Legislature with the passage of LB185 in 1997. To date, only the city of Lincoln and Lancaster County have established a public health department under this subsection. The three changes made in this bill apply to (1) communicable disease investigation, immu-- immunization, vaccination, testing, and prevention measures, including measures to arrest the progress of communicable diseases; (2) environmental health related to prevention measures; (3) duties of the health director with regard to investigation of the existence of any contagious or infectious disease and adoption of measures to arre-- arrest the progress of the disease. These three instances would only be subject to approval by the Department of Health and Human Services when a national or multistate pandemic has been declared by the CDC. In all other circumstances, the local health department would direct localized issues. The bill also requires the board of health of such district to have a public hearing after a ten-day notice before enacting rules and regulations. This language also occurs in Section 71-1631, which applies to all other health departments in Nebraska. It is my belief that no strong evidence or data supports allowing Lincoln and Lancaster County to create their own DHMs apart from the rest of the state in multistate or national pandemic situations. There is no apparent unique health risk in Lancaster County that would demand different treatment than the rest of the state in that situation. This exception caused divisions among local communities located in this jurisdiction and caused inconsistency in the DHMs implemented to address the COVID-19 pandemic across Nebraska. Many constituents who contract-- contacted my office believe that this unique power allowed overreaching local DHMs to encroach upon their personal liberty when residents in the rest of the state were free to make their own decisions regarding exposure to health risks. Many Lincoln businesses were forced against their will to enforce a mask mandate on their premises. Some Lancaster County school districts outside of Lincoln

were also forced to follow a DHM that may not have fit their individual needs. The Lincoln mask mandate was particularly restrictive, landing-- lasting on and off more than 600 days. Industrial hygienist Dr. Stephen Petty questions the effectiveness of simple nonrespirator face masks in the prevention of microscopic airborne disease. He argues that there is little potential health benefit to wearing a mask, and this is greatly outweighed-- weighed by the health risk of prolonged ma-- mask use. In addition, Lincoln made no distinction between the quality of the mask: paper, cloth, N95, or something else in its DHM. Mask mandates in Lancaster County occurred over three separate time periods: ten months from July 2020 to May of 2021. Then there was a break in the mask mandate. Then it began again for four months from August 2021 through December 2021. Then there was a 22 break-- 22-day break. Then it continued about one month from January 2022 to February 2022. When Lincoln's mask mandate expired on December 23, 2021, national coronavirus cases were trending downward. However, in response to a national trend, Lincoln brought back the mask mandate three weeks later on January 15, 2022, to many Lincolnites' disdain. It was dropped about a month later. Local officials may believe the status of their mask mandate was the reason case numbers trended higher and lower, but that conclusion is suspect in light of more meaningful national trends. On-again, off-again local responses such as this are a clear example of why, in these widespread pandemic situations, local power to impose separate health mandates should be limited. Usually, I prefer keeping local decisions pertaining to local regulations as close as possible to those affected by them. This bill still does this. In the event of a local measles, chicken pox, or other localized outbreak, Lincoln and Lancaster Health Department would have every power to take measures they deem appropriate. It has become clear to me that a statewide pandemic of an airborne virus would be best dealt with on a statewide level when considering DHMs. Having consistent DHMs throughout the state benefits our citizens by leveling the economic playing field for businesses, treating our residents as equally and fairly as possible, and eliminating citizen confusion. I should mention that Section 71-1612-- included at the beginning of this bill-- applies to a health district, which is a concept never used in our state, and this does not apply to Lancaster County. It is my understanding that this section will be removed in a revised or cleanup bill. As always, I'm willing to work with the committee to improve the bill in any way. Thank you for your consideration of LB1111. I'll answer any questions at this time.

HARDIN: Thank you. Any questions? Senator Riepe.

RIEPE: Thank you. Thank you, Senator Clements. Good to see you again. My question would be is, were you asked to bring this from a particular group or is this your own reflection?

CLEMENTS: This is my own. I brought a bill similar to this a couple years ago.

RIEPE: OK.

CLEMENTS: And I've brought it again.

RIEPE: OK. I was just curious if it was a county government or somebody trying to-- somebody that-- or-- any-- I thought maybe you'd have special meetings with DHHS.

CLEMENTS: No. Nobody has prompted me to do this. This is my opinion as to what I think is best for the state.

RIEPE: All right. Well, thank you. Thank you for being here.

HARDIN: Any other questions? Will you be with us to close?

CLEMENTS: Yes. I did leave you a handout showing the mask mandate dates in an-- a article from 2022 of someone being frustrated with the mandates.

HARDIN: OK. It looks like we have a late arriver on the question front.

WALZ: I'm just trying to, you know, stay awake here so I thought I'd ask a question. Had a late night last night. I do have a question. It just kind of perked up my ears when you said you're bringing this just because of your own opinion. So I'm wondering about any data, research, statistics that you might have that go along with the opinion that you have.

CLEMENTS: Well, it's my opinion also influenced by constituents who complained and made comments of concern regarding this. I shouldn't just say it was my opinion. I received other concerns from constituents. But no, I, I wouldn't say I have data, but I have also not had any other county, including Douglas County, come forward and have a carve-out for themselves. All the other counties in the state are required to be under approval of DHHS. This is more for uniformity. In my previous bill, it put Lancaster under a requirement for approval on anything they wanted to do, which all the other counties have that requirement. This-- I, I thought that was probably

overreaching in my case. And this one is-- a national or multistate pandemic is the only thing you'll find in here as triggering this bill.

HARDIN: Very good. Senator Riepe.

RIEPE: I had a little follow-up question as I was looking over some notes. I can tell you how it-- I think it works in Omaha. And we may have some other people that can clarify this too. But I know having sert-- served on the school board too is they immediately went to the University of Nebraska Med Center with a specialist. And they relied on that individual. And it was very spontaneous in terms of getting quick turnarounds to answers. I get real nervous when I think about the D-- Department of Health and Human Services at the capital about how fast they can or will turn around a response. I mean, this is, this is something that maybe has to happen in hours, not in days, not in weeks but, like, lickety-split I guess would be, be the word. That's, that's my major concern.

CLEMENTS: And--

RIEPE: And you can respond to that. I'm, I'm-- I didn't mean to lecture. I'm just kind of--

CLEMENTS: All right. Yeah, I would respond that the state does have a state medical director, as you folks know. And back then, I believe, he was very responsive quickly on what action needed to be taken. And we have a medical director that would take responsibility, I believe, quickly.

RIEPE: But I would kind of respond by saying Omaha has an Ebola center. So they're very, at the national level, very high on the knowledge list. And so, quite frankly-- and I, I, I love the medical director. He's great guy. But I would trust the Ebola staff down there in, in the Omaha market.

CLEMENTS: I would agree. Yes. The UNMC is cutting edge in that regard.

RIEPE: Yes. Thank you.

HARDIN: Any other questions? Seeing none. We'll see you at the end. Proponents for LB1111. Any proponents? Any opponents for LB1111? Welcome back.

AMBER BROWN KEEBLER: Hello again. I'm back again. This is Amber Brown Keebler. And now I'm testifying on behalf of the League of Women Voters Nebraska. I'll spell my name: A-m-b-e-r B-r-o-w-n K-e-e-b-l-e-r. We are testifying today in opposition of LB1111. Since its founding in 1920 as a nonpartisan organization, the League of Women Voters has worked diligently for equal rights of all Americans. One of the first issues the League of Women Voters of Nebraska focused on was protecting and promoting public health-- specifically efforts in the 1930s to establish a city health department in Omaha. Recognizing the wide-reaching impact of coordinated, government-led, expert-informed health initiatives, the league has continued to advocate for strong public health policy free from political pressure. LB1111 states it will require city/county health departments to obtain the approval of the Department of Health and Human Services in issuing these directed health measures in the case of a national multistate pandemic. This bill clearly limits the abilities of local health departments to act expeditiously in the event of health emergencies and would delay necessary preventative steps leading to negative health outcomes for citizens. It is in this tradition of civic engagement and equity that the League of Women Voters of Nebraska strongly opposes LB1111. A 2021 study by the Network for Public Health Law shows that other states that have enacted such laws have experienced delays in public health measures like mask-wearing, social distancing, and quarantine, and this poses an immediate threat to life and health. Legislation to stop expert public health agencies from leading the response to health emergencies creates unforeseen, serious risks to life and health, and these legislation, legislations also strips authority from public health agencies and the executive branch, infringes on the constitutional separations of powers, and undermines effective government response. These laws will make it harder to advance health equity during a pandemic that has disproportionately sickened and killed black, Hispanic, and Latino, Indigenous Americans. After summarizing similar legislative efforts in several other states, the Network for Public Health Law report concludes: Reforms to emergency authority should be carefully crafted to ensure that public health officials retain the authority to act quickly to address future public health emergencies. Current legislation under consideration, however, does not meet this standard. These proposed enacted laws would add a level of bureaucracy and politics that undercut the flexibility and timeliness of local public health orders, making it harder for public health experts on the front lines to protect and respond to local communities. In this light, we as the League of

Women voters strongly oppose LB1111 and ask that you do not advance the proposed legislation.

HARDIN: Thank you. Any questions? Seeing none.

AMBER BROWN KEEBLER: Thank you.

HARDIN: Thanks. Next person in opposition to LB1111. Welcome.

JON CANNON: Thank you. Good afternoon, Vice Chair Hardin and members of the Health and Human Services Committee. My name is Jon Cannon, J-o-n C-a-n-n-o-n. I'm the executive director of the Nebraska Association of County Officials, also known as NACO. Here to testify today in respectful opposition to LB1111. I certainly want to thank Senator Clements for bringing this bill. I think these are always good times for us to have a good conversation about what local control is and, and what that means. And so, you know, the fact that it's Valentine's Day, I, I think I'll just mention that we love local control at the county level. And we want to preserve the balance between state and local control. Not exactly related to this particular issue, but regarding the Governor's tax plan, we recently commissioned a poll. We-- one of the first questions we asked in that poll was, what do you think about state versus local control and, and who should be in charge of the effort at the local level? And overwhelmingly, Nebraskans think that they pre-- they trust their county leaders and their local leaders. And so from a community standpoint, we think that's, that's wise advice to, to heed. In speaking about striking that balance, last year, this committee heard LB421. It was from Senator Kauth. We have worked with-- fairly diligently with Senator Kauth, put a lot of months of negotiation into making that bill better to a place that we can, we can reasonably say that we're, we're supportive of the efforts that she wants to make. And that really does strike that balance between state and local control. And we certainly don't want those months of negotiation to really go to waste. We think that we're in a good place with that. We'd really be starting over if we, if we advance this bill. The-- one of the other things I want to mention is the subject of interlocal agreements. You know, to the extent that you have that sort of cooperation between a city and a county, I think that's a model to be emulated. That's struck down. And I've, I've heard it said it-- said that, you know, why should Lancaster be different? Well, they, they don't have to be different, frankly. This is a model that can be emulated elsewhere in the state. You know, it's not like you're putting a screen around Lancaster County. By that logic, you know, we're not exactly putting a screen around the

state of Nebraska if we have every decision coming from, from a central location. Want to wish you all a happy Valentine's Day. And I'm happy to take any questions you may have.

HARDIN: Thank you. Any questions? We're letting you off easy.

JON CANNON: All right. Have a great evening, everyone.

HARDIN: Thank you.

JON CANNON: Thank you.

HARDIN: Anyone else in opposition to LB1111? Welcome.

KEVIN REICHMUTH: Thank you. Thank you, committee members. I'm Dr. Kevin Reichmuth, R-e-i-c-h-m-u-t-h. I'm a pulmonary critical care physician here in Lincoln, Nebraska. I'm representing myself, also my practice at Nebraska pulmonary specialties here in Lincoln and the Lancaster County Medical Society. I'm speaking in opposition to LB1111. I am sure you have heard the term "all disasters are local." This is an important operational framework for disaster response, of which I think COVID-19 pandemic is a good example of a sustained sisaster-- disaster that required sustained response. Local authorities understand their communities and situation on the ground. They tend to make decisions that are best for their community in a collaborative way. We experienced this firsthand in Lancaster County. As it related to the COVID disaster, we were dealing with an ever-changing, highly infectious respiratory virus. Multiple surges resulted in increased infections, hospitalizations, and deaths. As you know, our health care system over the entire state was under a tremendous strain. Being in a tertiary center was even more challenging since we needed to do our best to get patients transferred from smaller outstate locations to hospital systems here that had higher levels of respiratory support, including advanced intensive care unit management and respiratory support capabilities. As difficult as this was, the saving grace was the collaboration of our local stakeholders. This included the Mayor's Office, Lincoln-Lancaster County Health Department, the health care systems, and frontline medical professionals, of which I worked with. We appreciated the Nebraska Department of Health and Human Services' support, and we were grateful that our current framework did not bureaucratize or politicize public health decisions such as directed health measures. I felt blessed. And I certainly heard and saw from other communities the challenges they faced because of those barriers. It's important to be able to use the tools as directed

health measures in a timely manner to protect individuals and sometimes health care resources and capacity. Of course, there's competing interests as it relates to restrictions of individual freedoms, and I respect these concerns. I felt that the Lincoln-Lancaster County response took these into account. Decisions were made based on epidemiologic and medical information in a timely manner and were rescinded when necessary. I see the red-- or, I guess I got yellow. That's my warning. I would point out that if you look at Lancaster County's death rate, it was 42% lower than the rest of the state. I believe-- we believe that a large part of that was the ability to respond without the bureaucratization and politicization that often occurs as we saw nationwide. I would also point out that I'm certainly happy to provide the committee with a publication that would support this as well. This is published in the Int-- International Journal of Health Planning and Management--

HARDIN: If you could wrap your thoughts up soon--

KEVIN REICHMUTH: Sure.

HARDIN: --that would be great.

KEVIN REICHMUTH: --in September of 2023, which further supported that, higher level control on public health authority impacted response and increased death rates. And I'd be happy to provide that study if necessary. And I'm happy to answer any questions.

HARDIN: Thank you. We appreciate that. Questions? Senator Riepe.

RIEPE: Thank you for being here. Are you aware that, in the process, there's a, a piece of legislation that comes through that would require any of these actions taken by health directors to have a vote of elected officials, whether that's at the county level or the city council or something like that? And I don't know how that bill's going to go. How, how did you-- here in Lancaster County-- or, Lincoln-- who made the call?

KEVIN REICHMUTH: Well, I would say it was a collaboration, as I mentioned, with--

RIEPE: I don't like group decisions, but go ahead.

KEVIN REICHMUTH: Yeah. Well, I think the ultimate decision-maker was the, the Lancaster County Health Department health director but in collaboration with, with the rest of us.

RIEPE: In collaboration with who?

KEVIN REICHMUTH: With health care professionals, health care systems.

RIEPE: OK. Was there a vote on it by the elected offi-- officials?

KEVIN REICHMUTH: No.

RIEPE: OK. That's what's-- I'm just giving you a heads-up on it. That's, that's what's rolling down the track.

KEVIN REICHMUTH: Sure. And to your point earlier, my concern with that is when you're dealing with a public health emergency, time can be of the essence. And any, you know, responses that happen now won't have an impact as it relates to that surge until much later, so. You're already behind the eight ball when you're trying to deal with these things.

RIEPE: And I think they're respond-- [INAUDIBLE]. Their responses-- fundamentally, they respond to a lot of floods and everything else in a matter of telephone calls and those kinds of things. They think they're fairly responsive. I've talked to some county commissioners and stuff like that in Douglas County, but. Thank you. I appreciate you being here. I appreciate your opinion. Thank you.

HARDIN: Senator Cavanaugh.

RIEPE: Oops.

KEVIN REICHMUTH: Oh, I'm sorry.

M. CAVANAUGH: No. I just-- so you're a pulmonologist--

KEVIN REICHMUTH: Yes, ma'am.

M. CAVANAUGH: Well, I just wanted to say thank you because we would not have fared as well as we did, whatever that is, without people like you in the medical profession and putting your own health and safety and your families on the line. So thank you for that. And thank you for testifying today.

KEVIN REICHMUTH: Thank you. I appreciate that.

HARDIN: Any other questions? Senator Ballard.

BALLARD: Thank you, Vice Chair. And thank you for being, Doc. In your testimony, you say, you say, we, we've learned some lessons from the

COVID-19 pandemic to help respond better to possibly the next one. Can you outline those? We had a-- we had a hearing [INAUDIBLE] that.

KEVIN REICHMUTH: Sure. Well, I think what we learned is that-- I, I'll, I'll be honest-- that we were handcuffed many times in things that I think would have helped save lives and reduce spread. And, and again, I feel fortunate in Lancaster County. But some of the things that could have been enacted-- and, and I know this gets centered largely on masking, but that's only one, you know, one modality that's used in directed health measures. So I think what we learned is that-- and, and everything, you know, leading up is to, you know, preparedness for whatever, you know, pandemic is next. And so I think what we've learned is that we definitely need to improve our public health capability and response. And to me, LB1111 goes the opposite direction and-- as I stated. And I think the comment made earlier, what I would encourage is improving the-- you know, again, all disasters are local-- allowing the local response amongst the public health authorities.

BALLARD: OK. Thank you.

KEVIN REICHMUTH: Yes.

HARDIN: Any other questions? Thank you. The next opponent. Welcome.

ANNE O'KEEFE: Hi. Good afternoon, Senators. My name is Dr. Anne O'Keefe, A-n-n-e O'K-e-e-f-e. I'm a board-certified public health and preventive medicine physician. I've had 25 years of experience working in the United States public health system at the federal, state, and local level. This includes 15 years as a senior epidemiologist at the Douglas County Health Department. I also have experience working for Nebraska DHHS and the U.S. Centers for Disease Control and Prevention. In these roles, I have participated in responding to small and large outbreaks, single cases of diseases that constituted public health emergencies, seasonal influenza epidemics, and an influenza pandemic, and a-- the 2001 anthrax ber-- bioterrorism attack, and COVID-19. Today, I'm speaking on my own behalf and as a private citizen and a public health expert. I'd like to make four main points about the bill that concern me. The first is that Nebraska has worked very hard to develop a strong local public health system and has been acclaimed for this. This bill erodes that. In 2001, the Nebraska Legislature made a groundbreaking decision to ensure that every Nebraskan would have a local health department that can provide core public health functions. These local health departments are in the best position to know their communities and

quickly detect public health threats that affect them. They have been empowered to respond quickly to public health threats and to make rules and regulations to safeguard the health of their communities. I'd like to read you a small part of the legislative intent of the, of the bill that created them. The Legislature declares that each local health department should be able to carry out fore-- core public health functions, including assessment and policy, prevention of illness, illness and disease, assurance of support services including public health nursing, health education, and environmental health services. In addition to the language in this bill that refers to a specific local health department, there's also language that adds, subject to approval from the DHHS, to a sentence that describes health districts and their core functions. This bill will, will create unnecessary obstructions and delays that will chip away at the ability of-- the ability of Nebraska's local public health system to provide effective public health services. Oh, I'm already on yellow. My second point I'm not going to talk about because the previous testifier talked about local emergencies. But I do want to mention the terminology about pandemic situations and, and-- the, the-- there is no such thing as a national or multistate pandemic. Pandemics are global issues, and CDC does not declare them. Practical definitions of pandemic or epidemic or outbreak involve understanding the biology of disease and having the public health and epidemiologic expertise to deter-- to determine if the disease is causing more illness than is expected and having expertise to apply this knowledge to new or emergent-- emerging diseases. Each public health threat is unique and each response is unique. In conclusion, I believe it's a mistake to legislative-- legislatively impair the practice of public health and erode the local public health system we have worked so hard to create because of one specific situation. Thank you. And I will answer any questions.

HARDIN: Any questions? Seeing none. Thank you. Anyone else in opposition to LB1111? Welcome back.

ALEX DWORAK: Thank you, Vice Chair Hardin, Senators of the HHS Committee, and Senator Clements. My name is Alex Dworak, A-l-e-x D-w-o-r-a-k, MD. It is my honor to once again testify before you today on LB1111. This is a complex topic, and I will do my utmost to address it in three minutes in my capacity as a Nebraska primary care physician with particular and relevant expertise in infectious disease and care of the underserved as well as a proven track record of commitment to public health-- notably, the 2023 UNMC College of Public Health Defender of Public Health Award, one of the proudest achievements of my career. I interpret this bill as a means of

blocking local jurisdictions from instituting mask mandates during the pandemic, full stop. The text of the bill subjects local control of such measures to approval by Nebraska DHHS, which logically follows that the decision will not be made by local polities who know their own circumstances on the ground but rather political appointees of the Governor of Nebraska. Based on these statements, records, and appointments of former Governor Ricketts and Governor Pillen about masks, that will clearly mean a partisan animus against such directed health measures and the professionals who supported them, including public rhetorical attacks and lawsuits. This is about saving lives or preventing human suffering, pure and simple. Mask mandates were professionally estimated to have saved 87,000 lives before the end of 2020, which was when I spurred Ralston to enact a mask mandate with an assist from Senator Wayne and a vote from the local city councilmen, including Mayor Groesser in Ralston. I did that to try to keep my hospital and ICU colleagues from being broken in an already incredible-- incredibly stressful situation so they could remain able to save the lives of people who needed critical care. Three examples of this. One: a fit, healthy ICU nurse from Utah named Jill Holker who got COVID in the line of duty. She needed a double lung transplant, having her chest cracked open and spread apart so-- and she will be on immunosuppressive meds and carrying those scars for the rest of her life. Example two: a Guatemalan immigrant patient of mine who lived with painful chronic disease but still always had a smile when talking about her family, who she worked to support. I saw her in the parking lot outside my health center in 2020 in the summer of a COVID. She looked terrible and staggered into the ambulance, struggling to breathe. Senator Clements, if I close my eyes, I can still see her face as clear as I can see yours. She quickly died despite world-class medical care at UNMC. Example three: Dr. Lorna Breen, B-r-e-e-n, a renowned teaching physician, dual-boarded in internal med and emergency medicine, who was on the front lines in New York during the worst of COVID in 2020. She was broken by being overwhelmed with COVID and losing so many patients, and that moral injury was directly responsible for her death by suicide. Health professionals are not disposable. We can break. If a-- anyone advances this bill because some of your constituents were annoyed or inconvenienced about wearing a mask that transplant surgeons routinely wear for 12 to 14 hours as they save somebody's life, that is callously straining and disregarding the professionalism of every health care worker who answers the call and runs toward danger in the name of duty and humanity when the next pandemic hits. We've had 7 million hospitalizations and over 1 million deaths from COVID in the United States so far. I'll close by saying that, to Senator Clements,

it would bring me great joy to provide you with extensive evidence of the effectiveness of mask mandates and masks themselves from the medical and public health literature from professionals with much more relevant expertise than industrial hygienists. I appreciate you allowing me to speak on this very personal and emotional topic. And I would be very happy to take any questions that you might have.

HARDIN: Thanks. Questions? Seeing none. Thank you. Anyone else in opposition to LB1111? Welcome.

PATRICIA LOPEZ: I think maybe I should say good evening now. I appreciate being able to speak to the community. I'm Patricia Lopez, P-a-t-r-i-c-i-a L-o-p-e-z. I'm the director of the Lincoln-Lancaster County Health Department, and I'm here today to speak in opposition to LB1111. It's critical that, as you've been hearing, that local public health officials have the ability to take rapid action to reduce the impact of infectious diseases, authority that our department has used very judiciously for over 100 years. During my 40-year career, our department has faced many infectious disease health threats-- not just from COVID-19. And you can look at the list there. I want to be respectful of the time. But these are many things that you don't hear about because we are able to respond rapidly and quickly and control the spread of the disease. That's what we're focused on in public health. And I want to say that all of our consultation occurs with our local medical community to guide decisions and assess the local situation, consider relevant factors, and take action. And our focus is always making the public's health the top priority. With COVID-19, we had a small amount of time before it arrived in Lincoln. Our depar-- health department team with expertise in epidemiology, infectious disease, public health, nursing, and environmental health continuously assessed the spread of COVID-19 virus. We activated our pa-- pandemic response plan. Partners, including local medical providers, education systems, business, and industry were brought together, and a multiagency, unified command system was activated to constantly monitor and to respond to the emergency. We established ongoing two-way communication with our partners and communities throughout the pandemic. We relied on evidence-based practices ad-- advocated by CDC, the American Medical Association, American Apa-- Academy of Pediatrics. Our goals were not to just save the hospital system but also reduce illness and death and lessen the impact on our schools, colleges, health care system, businesses, and government operations. We even provide information to the Unicameral on how to operate safely. Our actions were informed by consultation with our departments' infectious disease, medical consultants, local medical

providers, business-elected officials, state epidemiologists, and experts at UNMC Global Center for Health Security and the Johns Hopkins Bloomberg School of Public Health. I wanted to get to the point here. Our local directed health measures had a clear and measurable impact of slowing the spread of the virus, resulting in fewer people becoming ill and fewer people dying. Sadly, by February 22, there were 424 deaths in our community due to COVID-19.

HARDIN: If I could encourage you to wrap up quickly.

PATRICIA LOPEZ: I will. These were our friends, neighbors, grandparents, parents, and siblings. If we have the same death rate as Nebraska, 230 more people would have died. Johns Hopkins analyzed over 700 counties with similar demographics and found that Lancaster County was in the lowest 10% for death rates in the nation. This is strong data to ev-- for evidence at the local directed health measures.

HARDIN: Thank you. Senator Riepe.

RIEPE: I have what I think's one question because I don't believe any of us serves or exists as an island. And I-- you mentioned the CDC, Johns Hopkins, UN Med Center. Do you use-- do you have one source that you go into in a crisis that you-- this is your lifeline?

PATRICIA LOPEZ: We have to monitor what's happening around and what measures have--

RIEPE: I'm talking outside of Lancaster, Lincoln, or Nebraska. I'm talking on a-- trying to get a national perspective.

PATRICIA LOPEZ: You know, primarily, we focus a lot on CDC. But in public health, you can't just look at one side. You also have to look at the medical-- it's an art and a science, Senator Riepe.

RIEPE: But one of them has to be your first call.

PATRICIA LOPEZ: Yeah. And so that's why we have to focus on both those areas. We take that information. But we worked really closely-- if you want to talk about, like, in state-- with the Global Center, Dr. Lawler personally, who couldn't be here today and submitted a letter.

RIEPE: OK. And he's with the Omaha Med Center.

PATRICIA LOPEZ: Yeah-- with the Global Center for Health Security.

RIEPE: And that is who [INAUDIBLE] from the hospitals.

PATRICIA LOPEZ: Yes.

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

HARDIN: Thanks. Any other questions? Seeing none.

PATRICIA LOPEZ: Thank you.

HARDIN: Thank you. Anyone else in opposition to LB1111? Hello.

JULIA KEOWN: Hello. [INAUDIBLE] bumping into all sorts of stuff. OK. Good afternoon, committee. My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I'm a registered nurse of almost 7 years, and I have over 18 years of direct care experience with underserved Nebraskans. I am here on behalf of the, the Nebraska Nurses Association, the NNA, speaking in opposition to LB1111. The following statements represent the NNA's position. There are actually-- looks like six statements. I'm going to cut a few for clarity, but you guys have a copy. We are proud and fortunate in the great state of Nebraska to have nurses leading our most populous public health departments: Douglas and Lancaster Counties. They are highly educated in population health and epidemiology and are experts in public health practice. Health directors and local health boards are uniquely qualified to follow the public health ethical standards that guide evidence-based public health practice, including the balance of optimal targets for health and well-being and in cases balancing the autonomy, freedom, privacy, and other legal interests of individuals and populations for common good. Requiring approval of the Nebraska Department of Health and Human Services-- specifically, I'm just going to mention our last chief medical officer was a bariatric surgeon, and our current one is an ear, nose, and throat specialist. So neither of these people have any expertise whatsoever in public health implementation. So just as an aside. Requiring approval of the Nebraska Department of Health and Human Services to issue directed health measures, DHMs, during a pandemic creates bureaucratic red tape that will delay implementation of emergency public health services. Further, the legislative intent behind this law undermines the education, experience, and skill set of the public health director, who is uniquely qualified to implement evidence-based practice. I am going to say-- just kind of editorialize this by saying, on the last page, it does mention something about having a ten-day-- having a ten-day notice in general circulation prior to a hearing in order to implement these DHMs. Clearly, this was written by someone who does not understand public

health. Just a crash course in public health, you often have diseases where you have one person who is infected, right? So-- and then you have this thing called R0. That one person who is infected by a disease will-- say you have an R0 of 4, right? That one person who is infected by the disease will infect four people. Omicron, the COVID variant, had an R0 of approximately 4 or 5. OK? So I calculated it out--

HARDIN: If I could have your wrap your thoughts.

JULIA KEOWN: I will, thank you. I calculated it out. So in approximately 10 to 11 days, you go from one person infected with COVID using that R0 to-- let's see. What did I get? 11,718,750. So that completely undercuts any point to using-- to having public health and DHMs. So we need to be able to have this on a local level.

HARDIN: Thank you. Questions? Seeing none.

JULIA KEOWN: OK.

HARDIN: Thank you. We appreciate it. Next person in opposition to LB1111. Welcome.

THOMAS SAFRANEK: Senators, my name is Thomas Safranek, S-a-f-r-a-n-e-k. I'm a physician, board-certified internal medicine and infectious disease. I had the honor and privilege of serving the people of Nebraska for 31 years on the inside at the Nebraska Department of Health and Human Services. The early part of my career was the Nebraska Department of Public Health. And then in the late '90s, we converted to this umbrella agency with the Division of Public Health that's subsumed under a, a, an umbrella agency. I would like to say, during my time, I have been impressed at the quality and skill of our local health departments. They have matured since the early 2000s when they were first established. We've developed very cohesive working relationships with them. I did and, and the rest of the agency, the, the staff that coordinated public health throughout the state. Douglas County and Lincoln-Lancaster had extraordinary local health departments. We had very positive working relationships, collegial relationships. We learn from them. They learn from us-- they learn from us. One item that-- well, I guess it did get mentioned. So much of what I had to say-- when you, when you come at the end has already been covered. But the leadership at the Div-- Department of Health and Human Services, and particularly the Division of Public Health, has not been focused on and scrutinized by the Governor, who perhaps doesn't have any knowledge of what public

health is all about and who should be appointed to that position and, very respectfully, the-- this committee. And I encourage this committee to ask the question of individuals appointed to the executive leadership positions. What qualifies you to oversee the Division of Public Health? What skill sets do you have that you will bring to leadership in the service of public health in Nebraska? And what, what are your goals and expectations for the Division of Public Health in Nebraska? My perspective from the years in my position as I look at who has come into leadership roles through these appointments is a very discouraging report back in terms of, are these folks qualified with subject matter expertise? I will say they are good people. They are honorable people. They are decent people. I would in no way detract from their human-- their virtue and their, their goodness as human beings. And so I really am almost reluctant to bring the issue up. But in terms of professional skill sets, why we would say we're going to take this responsibility away from dedicated career professionals in the local health departments who've built coalitions and have engaged the stakeholders within their jurisdictions and move that up to a government-- gover-- Governor appointees who have been in their position for a very brief period of time--

HARDIN: If I can encourage you to wrap your thoughts.

THOMAS SAFRANEK: Yeah.

HARDIN: Thank you.

THOMAS SAFRANEK: I'm good, except to say I look forward to further testimony on LB1086 where we do professionalize the-- what I hope to be the Department of Public Health. Thank you, Senator Walz.

HARDIN: Thank you. Any questions? I don't see any.

THOMAS SAFRANEK: Thank you.

HARDIN: Thank you. Anyone else in opposition to LB1111? Anyone in the neutral for LB1111? Seeing none. Senator Clements, if you would not mind coming back to close. In the meantime, I'm looking for the letters. Do we have any letters? There are letters. There were 15 proponents, 13 opponents, and 1 in the neutral.

CLEMENTS: Thank you, Vice Chair Hardin. And thank you for hearing my bill. The reply would have some of these-- the bill is not affecting localized health dangers or decisions. It was intended to be when it's widespread. The word "pandemic" may, may have been incorrectly

used. I meant widespread-- statewide at least. But no other county has requested a carve-out like Lancaster that I know of. And so I'm, I'm inferring-- apparently, DHHS worked with the other health departments during the COVID situation. None of the opponents have requested that all counties be exempt from DHHS possible approval. I would admit that the ten-day notice should have an emergency exception. And that is not in the bill. And it would, it would be advisable, I agree, with-- a quickly spreading disease should have an exception of that sort. That was all I had.

HARDIN: OK. Any questions? I was impressed, Mr. Chairman of Appropriations, that you brought us a fiscal note with a zero on it. So thank you for that.

CLEMENTS: That's my goal. Thank you.

HARDIN: Seeing no other questions. We appreciate it. Thanks. This closes our hearing on LB1111. We're moving on to LB1007. And Senator Walz. I believe we are ready. Thank you, Senator Walz.

WALZ: Thank you, Vice Chair Hardin and members of the Ed-- oh. This is Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z. And I represent LD 15. I am introducing LB1007, which was a concept which was initially brought to me by a constituent. And these are my favorite bills, when they're brought to me from one of my constituents. Currently, an individual has two-- has to file two separate applications for Supplemental Security Income and Medicaid. These applications are often duplicat-- duplicative and burdensome for individuals that are typically going through large life changes or experiencing medical difficulties. Nebraska is currently one of only seven states to require the state Medicaid agency to determine eligibility for Medicaid instead of allowing the Social Security Administration to determine eligibility while they are approving SSI. This forces individuals to apply separately to the state Medicaid agency and to the Social Security Administration. Most states have a very different approach. 33 states are entered into what is known as a 1634 agreement. Under a 1634 agreement, individuals who are approved for Supplemental Security Income by the Social Security Administration would automatically be approved for Medicaid. This streamsli-- this streamlines the application process for families that would otherwise be filling out additional paperwork and waiting additional time for extremely important services. LB1007 would have the Department of Health and Ser-- Human Services submit a state plan amendment to the federal centers for Medicare and Medicaid to authorize Medicaid eligibility

for individuals that are already eligible for the federal Social Supplemental Security Income program. I would also like to add that the LB376 report that came out at the end of last year recommended that the state review entering into a 1634 agreement and the impact it may have. LB1007 is a commonsense step to reducing red tape fa-- red tape for families in need and I think also reducing additional work and red tape for the people who work in our government. With that, I'd like to-- I'd be happy to answer any questions.

HARDIN: Any questions? Senator Riepe.

RIEPE: Thank you for being here. My question would be this: is the states that automatically do that, can you give me two or three of those states that do that?

WALZ: Can I give it to you on my closing?

RIEPE: You could do that.

WALZ: All right.

RIEPE: I just want to find out whether they're very progressive or very-- a very conservative state. That's where I'm going. Just to give you a tip.

WALZ: Oh, OK.

RIEPE: So if it's New York and California [INAUDIBLE]. OK. Thank you.

WALZ: Yes.

RIEPE: Thank you, Chairman.

HARDIN: Can you unpack the 1634 a little bit more for us newbies?

WALZ: Yeah. At closing? At closing. How's that?

HARDIN: Thank you.

WALZ: Sorry. Thanks.

HARDIN: Any other questions? If not, I'll turn it back over to Chairman Hansen.

WALZ: You know what? And if I can't, there may be somebody else coming up who probably can.

HARDIN: Thank you.

WALZ: Thanks.

HANSEN: All right. Well, we'll take our first testifier in support to LB1007.

EDISON McDONALD: Hello. My name is-- my name is Edison McDonald. I'm the executive director for the Arc of Nebraska. I'm sorry. E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director of the Arc of Nebraska here advocating for people with intellectual and developmental disabilities. I know it's been a long day for y'all and this is a really complex bill, but I think we can simplify it a whole bunch. I want to start off with, over the last few years, this committee has worked with us in the disability community to find pathways towards ensuring we have a better developmental disability system. Speaker Arch in particular really pointed out how it just seems like it's kind of layered all over the place; it's not clear, there's not a plan. So we got the 376 study, which-- the recommendations were amazing. So the first handout that y'all have is the 376 study that walks through those recommendations. And I hope that that's something y'all are going to watch and, in the next year, introduce legislation reflecting some of those recommendations. One of those, however, is up, and that would be to shift to become a 1634 state as proposed in LB1007. So then shifting to the other handout that I gave you, this is direct from the CMS Program Operations Manual System that really walks through the different types of states. So you've got first what are called 209(b) states. And they have additional criteria on top of what the federal government has. And I've spent a lot of time talking to other states trying to figure out how does this work. What I've found is that all 209(b) states really hate it. SSI criteria states, if they know about it, aren't very emphatic about it or they very much dislike it. And 1634 states, it works so well and easy they don't even realize. So the second category is SSI criteria states-- that's what Nebraska is currently-- states that use SSI criteria. Basically, what we're doing is we're double-guessing Social Security. We're going back and making the same basic assessment and then saying, this is our determination. Now, the problem comes when we're wrong, which happens, unfortunately, more than we'd like to see. And so what we deal with then are a lot of cases that get bounced back, families who are eligible but then get bounced back improperly, lawsuits, and a lot of back and forth between us and DHHS on these types of cases. Whereas with a 1634 state, we would just get the data exchange from Social Security. It would give it to us nice, clean, and concise and makes sure that we

had the answer, makes sure that we weren't dealing with those cases that were improperly denied or those cases where we end up in litigation. So I think this is a tremendous place to shift to. Senator Riepe, to your question, I do have the states listed in that secondary handout.

RIEPE: [INAUDIBLE]. Thank you.

EDISON McDONALD: And so that breaks down where those states are. And with that, I'll take any questions. Or, Mr. Gray behind me is an excellent expert in this subject.

HANSEN: Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Senator Hansen. You've had some time to observe this. My-- one of my question gets to be is, should we go this way? It looks like it's rather a automated way to go. So my question would be is, how many employees in DHHS can we expect to be downsized given this efficiency?

EDISON McDONALD: And--

RIEPE: Five? Ten?

EDISON McDONALD: Yeah, I, I don't have an exact answer to that. And--

RIEPE: I'm sure we'd--

EDISON McDONALD: I, I know-- the interim director's back there, and so I think he'll, he'll talk with you a little bit more about that. I do expect some significant efficiencies, though. And out of the report recommendations-- just because this is one that does create significant efficiencies both in terms of staff time and in terms of decreased litigation and confusing cases-- I think there's some tremendous benefits on, on the other side that could be seen.

RIEPE: I don't think I will ever live to see when DHHS downsizes. [INAUDIBLE]. Thank you, Mr. Chairman.

HANSEN: Yep. Any other questions from the committee? Seeing none. Thank you. Take our next testifier in support.

PHILIP GRAY: Good afternoon.

HANSEN: Welcome.

PHILIP GRAY: I have to tell you: I appreciate your stamina. You guys are amazing. The time you spend and what you do here. I hope all Nebraskans get a chance to see the effort that you put in. My name is Phil Gray, P-h-i-l-i-p G-r-a-y. I'm from Omaha. I had been a parent for-- a parent advocate for more than 40 years. I've worked in this agency and this area for more than that time. I worked for the Department of Public Welfare for the state of Nebraska as a supervisor of quality control. And I spent roughly 40 years working for the Social Security Administration and had a lot of in-- a lot of in-- touching with this bills and the implementation of these bills. If Senator Riepe would like to request-- rephrase his questions when I'm done, I think I have some of that information for you, sir. Supplemental Security Income and categorical Medicaid were developed to help provide a support for disabled individuals living in their local communities as an alternative to what was then traditional institutional care. These community-based programs are a federal-state cooperative partnership with the state given flexibility to manage the programs within the parameters of the federal funding legislation and the federal government providing matching funds. Eligibility for SSI, Supplemental Security Income. It confers automatic entitlement to categorical Medicaid, and categorical Medicaid is the basic criteria for community-based services. To assist the states in making eligibility decisions, SSA provides a number of data programs with various eligibility information. The majority of states have elected to accept this information and not require a separate application for categorical Medicaid. This clearly reduces the administrative costs of requiring a duplicate Medicaid decision, which SSA is already responsible to make. These states are designated as 1634 states. Seven states have elected to require a separate application for categorical Medicaid to determine if the individual is a qualified Medicaid-eligible individual. These seven states are designated as SSI criteria states. Nebraska's one of these states. This places an unnecessary and avoidable cost on the state and, and requires extra unnecessary work for eligibility workers. It's especially difficult in these situations when the individual is entitled to SSI but not currently receiving SSI cash payments under eli-- the eligibility umbrella of the Pickle Amendment, the Disabled Adult Child Amendment, referred to as the DAC Amendment, and Section 1619(a) and (b), the Return to Work Amendment. Attached is a copy of the written testimony submitted by a parent explaining what happened to her daughter in trying to correct an error by the department. From her story, it is clear the process is not well-understood by the state. She was not able to find out from the state why they had initially terminated her daughter's

Medicaid nor why they decided she was eligible but with a large share of cost. She reached out to me and we were able to obtain the correct information for the state to correct their decision. I know another parent facing the same situation for her son. She also does not know why the state terminated her son's categorical Medicaid. The lack of information from the state is a barrier to taking corrective action and potentially harms individuals in the IDD community. The Optimus Meyers study that the committee requested also recommended transferring to a 1634 state. And I would strongly encourage you to support LB1007. Thank you. Sorry I went over.

HANSEN: Oh, that's all right. Thank you for your testimony. Are there any questions from the committee? Don't see any. Thank you very much. Is there anybody else wishing to testify in support of LB1007? Is there anybody who wishes to testify in opposition to LB1007? Anybody wishing to testify in a neutral capacity? Welcome.

MATTHEW AHERN: All right. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Matthew Ahern, M-a-t-t-h-e-w A-h-e-r-n. And I'm the interim director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in a neutral capacity regarding LB1007, which will require the division to enter into a 1634 agreement, an agreement pursuant to Section 1634 of the Social Security Act, 42 U.S.C. 1383(c), under which the Social Security Administration would have-- or SSA-- would have the authority to make Medicaid eligibility determinations for those receiving Supplemental Security Income, or SSI. The population of individuals receiving SSI is a small subset of the overall Medicaid population: under 27,000, or approximately 7% of the total enrollees. Per the agreement, the SSA will not determine Medicaid eligibility for SSI individuals who refuse the assignment of rights to medical support and third-party liability payments for medical care, refuse to provide third-party liability information, or have or appear to have a Medicaid trust. Additionally, the Social Security Administration will not provide notice of eligibility determinations and would require the state to provide those notices. There is a fiscal impact, as the state is required to pay the Social Security Administration when half of the-- 1/2 of the costs incurred in addition to other costs incurred by the SSA. If the, if the state would like the SSA to ask an applicant about retroactive eligibility, there is an additional fee for this question. If the state were to request statistics or data from the SSA, the state would be required to pay the full cost of the request. The department reached out to the SSA prior to the hearing to inquire about the current cost structure and did not receive any response.

The SSA can have a lengthy application approval process when determining eligibility for SSI. If the applicant must wait for the SSA to make their-- make an SSI eligibility determination, there could be delays in the applicant's access to care during the pendency. The department processes applications for SSI eligibility individuals for Medicaid quickly in comparison to the SSA's SSI process. Additionally, if the individual is not categorically eligible, DHHS will determine if the individual is eligible under any other categories and will determine eligibility for all family members with a single application. In contrast, the SSA will only determine eligibility for the person who is requesting or receiving SSI. Dependents would have an-- have to apply separately from the SSA process to determine eligibility. There will be a technic-- there will be technical changes required with associated costs that cannot be predicted or estimated based on the information currently available. Several other states have entered into these agreements, and it has the potential to be beneficial to Nebraska. However, at this time, the department lacks sufficient information to provide an estimate of potential savings. Thank you for the opportunity to testify today. I'd be happy to answer any questions you may have pertaining to the bill.

HANSEN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Do you have-- I know that you-- I looked at the fiscal as well; blank page. Do you have kind of a general thought about what the new cost would be for this alleged cost-efficiency? It seems rather contradictory.

MATTHEW AHERN: You know, we, we don't have the information. You know, there, there are set expectations in terms of what we would have to pay the SSA to do the services. We know that it, it flags at around 50% of their cost, but we don't know what their cost is.

RIEPE: But it will be a cost increase.

MATTHEW AHERN: Well, it may or may not be. It kind of depends on, on what it replaces for us, right? If we're able to get that at a price that's better than we can, we can do the, the applications for, then it has a potential to be a savings. But we would-- we just don't know because we don't have the information to--

RIEPE: Well, I thought I heard earlier it wasn't [INAUDIBLE] put the burden of doing the application on the Medicaid recipient.

MATTHEW AHERN: So--

RIEPE: So it shouldn't be a cost to the state.

MATTHEW AHERN: So I'll, I'll clarify there, right? So for the, for the population that is receiving the SSI determination from, from SSA, that comes over, then we'd be able to process that. And, and, and it-- basically just take that in without having to do an additional check, right? So there is potentially some savings there. Right now, our process for that is a pretty streamlined process compared to everything else that we do because we take the information from the Social Security Administration pretty directly. Then we just do a few, a few basic checks, and then we're good. Additionally, any renewal for this population is already handled by, by [INAUDIBLE]. So nobody's actually doing the renewal for them currently. So, so it, it's still potential that there would be some savings, but this is, all things considered, a fairly streamlined process for us. So our expense to do this population is relatively minimal as is. So we would just have to make sure we have the information from the SSA to really evaluate the cost-effectiveness based on the cost that they get to provide us.

RIEPE: I'm a doubting Thomas any time DHHS comes forward with some savings. Never works out that way. There's always an added cost. That's my experience over the years, so. Thank you very much. Thank you, Chairman.

MATTHEW AHERN: Thank you for the question.

HANSEN: Any other questions? Seeing none. Thank you very much.

MATTHEW AHERN: All right. Thank you very much.

HANSEN: Anybody else wishing to testify in neutral capacity? All right. Seeing none. We'll welcome back up Senator Walz to close. And for the record-- where's all my stuff at?

WALZ: Senator Riepe, you have your question answered on the states.

RIEPE: I did. It's five to two; five progressives to two conservatives. I got my number. Thank you.

WALZ: You're welcome. You know, I do want to just go back to the reason why-- or, one of the reasons why I brought this bill, and it was due to a story-- or, the story that Mr. Gray told about a child falling through the cracks and was denied because the two-approval

process that was in place. And I am happy to work with the division on streamlining the Medicare or Medicaid eligibility process. Maybe looking into how other states have done it. I know that-- you know, the fiscal note does say zero. It does mention that there will not be any, any additional staff needed. There may be some additional staff time needed, but no additional staff. And it looks to me like the fiscal note also talks about these changes being due to the implementation and initiation of the, the program, so. But again, happy to work with the committee. Happy to work with DHHS on this.

HANSEN: Any questions from the committee? OK. Seeing none. Thank you.

WALZ: Thank you.

HANSEN: And for the record, there were 6 letters in support of LB1007. With that, that'll close our hearing on LB1007. And that will end our hearings for today. Oh, never mind. I got one more.

WALZ: Oh. Wendy, you should have seen your face.

HANSEN: Sorry.

RIEPE: I second the motion.

DeBOER: I'm going go super quick.

HANSEN: That's what I get for being out.

DeBOER: Super quick. Super quick [INAUDIBLE].

RIEPE: Yeah. Those are her famous last words.

HANSEN: Here you are, right down here. OK. You are--

DeBOER: Good--

HANSEN: --ready, ready to begin whenever you are.

DeBOER: Good evening, afternoon, evening, Chair Hansen and members of the Health and Human Services Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r. I represent LD 10 in northwest Omaha. I'm here today to introduce LB904. LB904 actually is a simple bill. Statute currently authorizes the Department of Health and Human Services to use just one method to determine the child care subsidy reimbursement rate. That's the market rate survey. You can see on the chart that I passed out the result of the last survey. There are two markets in Nebraska. One market is Dakota, Douglas, Lancaster, and Sarpy--

Dakota, Douglas, Lancaster, Sarpy-- and the other market is all the other counties. The market rate survey simply may not have the flexibility to consid-- take into consideration all the various situations across the state. LB904 allows the department to use a different model if they want to. If they want to. Permissive authority. Does not require anything. There are at least two federally approved methodologies, but DHHS could make another one all of their own. If they did that, then they would have to get federal approval for it. The bill cites the federal code to give the flexibility to DHHS to do that if they would like to, if they'd like to make up their own model. So currently, the department has no ability to use any other model but the market rate, and LB904 gives them the discretion. The second change-- so that's the first change-- the second change is that LB904 just codifies what we included in our budget to provide reimbursement for providers in the 75th percentile of the market rate as determined by the department if they stay with that model. So I will note for you that the Planning Committee has prioritized this bill. This is going to be the stem bill. And then there are other bills that potentially will be used with this bill that we'll put on on the floor because the Planning Committee is one of those weird committees that doesn't have subject matter jurisdiction, and therefore we'll take the bill out of a different committee. So if you have any questions, I'm happy to answer them. But if you think of other questions tonight, tomorrow, whenever, I'm happy to answer them then as well because, since I've already prioritized this, I have a pretty vested interest in it, so.

HANSEN: So you're saying we should take our time execing on it?

DeBOER: All the time in the world, Senator Hansen. No, please.

HANSEN: [INAUDIBLE] bringing that up. All right. Any questions from the committee? Yes, Senator Riepe.

RIEPE: I do. I'm looking at the fiscal note, and it says the-- where is it? I had it here. It says the state would not be required-- the department would not be required to use the alter-- would not be required to go to this methodology. What do you think the probability is that they would switch to it?

DeBOER: I know for a fact from the department's letter that they won't be going to it right away because they've already started the process for the next use-- the next market rate survey. So since they've already started that, they're going to use it. So at least in the short term, they certainly will not. But we want to give them the

flexibility to either use this or create their own model in the future. And--

RIEPE: So will this information then be dated by the time they might get to it?

DeBOER: Will what information be dated?

RIEPE: That-- this-- the survey.

DeBOER: So the survey that you have in front of-- is an old one. I'm not sure which one--

RIEPE: '23?

DeBOER: '23. So they're working on the next one right now.

RIEPE: I thought they just did this every two years.

DeBOER: So '23. So they'd do it on '25, but they have to probably work for a while to do it ahead of time.

RIEPE: Oh, OK. OK.

DeBOER: So--

RIEPE: Thank you.

DeBOER: Yep.

RIEPE: Thank you. Appreciate you being here.

DeBOER: Yep.

RIEPE: Thank you.

HANSEN: Any other questions? Seeing none. Thank you. We'll take our first testifier in support of LB904. Welcome.

KATIE BASS: Thank you. Good evening, Chairperson Hansen and members of the Health and Human Services Committee. My name is Dr. Katie Bass, spelled K-a-t-i-e B-a-s-s. And I'm the policy and research advisor representing First Five Nebraska. We are a statewide public policy organization focused on supporting policies that promote quality early care and learning experiences for young children. I want to thank Senator DeBoer for introducing LB904, which, as she said, allows flexibility in-- for the state in choosing a methodology

for setting subsidy reimbursement rates. So you all have my formal testimony here. I'm just going to hit on a couple of high points. Right now in statute, it explicitly says we must do a market rate survey every two years. A market rate survey is one of the options that are approved federally, and all states are required to do a market rate survey or an alternative methodology or seek out approval for a different methodology. They are also all required to do a narrow cost analysis, to do an examination of what it costs to provide care because we are getting more information about how the child care market works, right? And research has shown that not all markets can allow providers to charge what it actually costs to provide that care. And those markets where we see those biggest gaps tend to be in our more rural areas, right? They tend to be around family child care and they tend to be around providing care for infants, right? So this year, the department is going to do that market-- or, that-- excuse me-- that narrow cost analysis. But what's really important is that they can't use any of that information when they think about our-- their subsidy rates, right? They would not be allowed to based on the way the statute is written. So what LB904 does is it opens it up. It says that we would analyze the market and we would analyze costs, things that the department will have to do, right, and that they can but do not have to use that information then to set subsidy reimbursement rates, right? So really, as Senator DeBoer said, this is a pretty simple bill that allows us to stay in line with what the federal regulations allow and require and then gives the department the flexibility to choose how they would proceed from there. And with that, I'm happy to answer any questions you may have.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you. In the fiscal note, it says there is no federal requirement to use the findings, number one. Number two, this appears to be a rerun. You were in here a month ago with your consultant that went through the market-based-- wanting a--

KATIE BASS: Yes.

RIEPE: --cost-plus kind of a program, as I called it. This looks like a second run at that same objective. Is that true?

KATIE BASS: So this is that foundational. So that was not a bill a month ago. That was actually an interim study to talk about what those other models are.

RIEPE: But it appears it was the foundation for this.

KATIE BASS: Yes. In fact, the department is using the cost estimation model, right, which is not quite a cost-plus model because it's not about profits; it's about what it costs to run a business. And that is the tool they're using for their narrow cost analysis. But we were very clear with this bill that that is not required, right? We did not set forth a tool that they have to use.

RIEPE: It's just that anything it does with Medicaid, the idea of-- that you're going to recover your cost is sort of a nebulous position for anybody, whether it's nursing homes or anybody else. If they don't get their cost, they're not likely to get their cost in the near future. So I don't know-- OK. No more-- no further questions. Thank you, Chairman.

HANSEN: Yep. Any other questions? Seeing none. Thank you very much.

KATIE BASS: Thank you.

HANSEN: Anyone else wishing to testify in support of LB904? Seeing none. Does anybody wish to testify in opposition to LB904? Seeing none. Anybody wishing to testify in a neutral capacity? All right. You were right.

DeBOER: I promised.

HANSEN: All right. And then for the record, you did have 8 letters in support of LB904 and 1 in the neutral capacity.

DeBOER: All right. Thank you, Senator Hansen. So I had promised Senator Hansen that I would only have one testifier so that he would schedule me for this point in the session. So I had only one. Senator Riepe, I will want to respond to some of the questioning I heard from you, and that is that what we had come this summer in our interim study was specifically that cost model. What we have done in this bill is allow the department to use the market, the cost model, or also to make up its own, which was not the subject that we talked about this summer. My concern-- the thing that I'm trying to solve with this bill is that, over time, I would hope we would be more responsive to the local situations throughout the state than just Dakota, Sarpy, Dag-- Douglas, and Lancaster are all one, and then we have all the others. Because regardless of whether you're going to get your cost back or not-- remember, I called it a cost-minus because what I would like is to see that if you have super, super high costs in Gage County and you have super, super low costs in

Dawson County that there's a model that accounts for the fact that the people in Dawson under the market rate would be getting really, really well-reimbursed and the people in Gage would be really, really poorly reimbursed. So providing flexibility throughout the state to have it be more responsive to the individual needs throughout the state than just you're either in category A or you're in category B. And that's one of the things that either the cost model or some other model that would be a kind of a hybrid or whatever it would would allow the state to be more responsive to the various localities to make sure that we are not just trying to do a one-size-fits-all throughout the whole state.

RIEPE: That makes sense. Thank you. Thank you, Chairman.

HANSEN: Any other questions? I don't see any.

DeBOER: Thank you very much.

HANSEN: Thank you. That'll conclude our hearing for LB904 and all of our hearings for today. Thank you.