HANSEN: All right. Good afternoon, 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 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 Ballard.

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

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

HANSEN: Also assisting the committee is our research analyst, Bryson Bartels; our community clerk, Christina Campbell; and our committee pages, Molly and Ella. A few notes about our policy and procedures: please turn off or silence your cell phones. We'll be hearing four bills and we'll be taking them sort of in the order listed on the agenda outside the room today. We'll actually be starting with LB1107 today and then following with LB1106. On each of the tablets near the doors to the hearing room, you'll find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Christina when you come up to testify. This will help, 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 a 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 Legislature's policy is that all comments for the record must be received by the committee by 8 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 a 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-- the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. 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 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 with LB1107. And welcome Senator Day to open.

DAY: Thank you. Good afternoon, Chairman Hansen and fellow members of the Health and Human Services Committee. My name is Jen Day. That's J-e-n D-a-y. And I represent LD 49 in Sarpy County. I'm here this afternoon to introduce LB1107, which provides coverage for electric breast pumps for every pregnant woman covered by Medicaid or a newborn child covered by Medicaid in the event the mother does not have insurance coverage. Under LB1107, the breast pump would be provided by 36 weeks or the child's date of birth, whichever comes first. The main goal of LB1107 is to close a gap in our coverage of breast pumps. Currently, most insurance-- including when the mother has Medicaid-- allows the mother to receive the breast pump before delivery. This is, this is very important timing because it allows the mother to establish milk suckly-- milk supply before the birth, which is critical for the newborn's nutritional needs and immune protection. Where we have a gap right now in Nebraska is for mothers who are not covered by insurance but whose child is on Medicaid. So right now, mothers in this situation can apply for a breast pump after the child is born and enrolled into Medicaid. LB1107's goal is to create the mechanism to move this timeline forward and make sure that all babies in Nebraska are getting this nutrition during these vitally important first hours after birth. The other piece of the bill creates a uniformity for the pump quality for mothers and children on Medicaid and specifies that the breast pump must be electronic. If you look at the fiscal note, DHHS has indicated that this will lead to a 10% increase in breast pumps given out under the Medicaid program but with the cost amount that they can absorb and will have no fiscal impact. Given that this bill carries no fiscal impact, while the scope will be larger than this, if we help even a few mothers and babies in this situation, passing LB1107 will be more than worth it. LB1107 is a simple technical change, yet its impact on the mothers and babies it affects will be substantial. I'd urge the committee's support for LB1107. And with that, I'm happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. We'll see you at close.

DAY: Yes.

HANSEN: All right. We'll take our first testifier in support of LB1107. Welcome.

ERIN FEICHTINGER: Happy to be back finally.

HANSEN: Yes. We missed you.

ERIN FEICHTINGER: Well, I appreciate that. Didn't fix my chair, though.

HANSEN: Yep.

ERIN FEICHTINGER: Chair Hansen, the one member here of the Health and Human Services Committee. My name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r. And I'm the policy director for the Women's Fund of Omaha. The Women's Fund believes that economic security is foundational to achieving gender equity and that lack of access to both reproductive and maternal health care is an impediment to that economic security. Increasing support for those who choose breastfeeding is not only critical for the health of mom and baby, but increases their economic security as well. So we offer our support for LB1107 and thank Senator Day for taking this on. There are a lot of reasons a person needs to access a quality breast pump if they are breastfeeding, not least of which is if they are returning to work shortly after giving birth. In Nebraska, women represent almost half of the full-time workers in the state, and the great majority of children in our state have working mothers. We have recognized as a nation the importance of supporting breastfeeding in the workplace through federal legislation. And this type of legislation recognizes that providing breastfeeding support is the right thing to do and it is an investment in our workforce and in our long-term stability as a state. But access to breastfeeding support is not universal and is, of course, limited based on a person's socioeconomic status and, in that case, whether or not they are receiving a breast pump through our state Medicaid program that adequately supports their breastfeeding needs. A 2019 study from the USDA found that if WIC participants were breastfeeding at the recommended levels, the reduction of incidences of various diseases among those participants would decrease the federal portion of Medicaid costs by at least $111.6 million and that total health-related costs would have been reduced by $9.1 billion, including savings to Medicaid, with over 3/4 of those savings resulting from reductions in early deaths. The rest would be due to

savings in medical costs and nonmedical costs. Now, that same USDA study found that if breastfeeding was not supported at recommended levels, that WIC participation would increase because of the reliance on formula through the program when that breast pump coverage ends or if they have to go back to work without a breast pump. LB1107 is a simple, cost-effective way to help moms and babies in Nebraska, to support breastfeeding Nebraskans, and to help them return to work without worrying about whether or not they can pump and feed their kids. So we would ask for your support of LB1107. And I'm happy to answer any questions to the best of my ability.

HANSEN: All right. Thank you. Are there any questions? Seeing none. Thank you. We'll take our next testifier in support of LB1107. Welcome.

JULIA KEOWN: Thank you. My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am a critical care and forensic nurse and former breastfeeding educator in Nebraska. I write to you on behalf of the Nebraska Nurses Association, the NNA, which represents the more than 30,000 nurses in Nebraska. Feeding a baby exclusively human breast milk for the first six months is recommended by the American Academy of Pediatrics. Breastfeeding is initiated in approximately 84% of postpartum people, but only approximately 25.8%-- so roughly 1/3-- achieve that benchmark of exclusively breastfeeding through six months, or breast milk feeding through six months as well. According to the American Academy of Pediatrics, infants fed human milk, quote, have better short- and long-term health outcomes, a decreased risk of late-onset sepsis and necrotizing enterocolitis, and protection from various infections. Human breast milk has also been positively correlated to, quote, better neurodevelopmental and cognitive outcomes, end quote. Put simply: human milk works on a supply and demand cycle. If there is not enough demand, there will not be enough supply. Breast pumps help mimic baby's demand to increase breast milk supply. Unfortunately, 19.4% of breastfed infants receive supplements of commercial infant formula in the first 48 hours after birth. Once formula is introduced, it can become quite difficult to reach the benchmark of exclusive human milk feeding. One effective way to prevent the use of formula and assist in achieving goals of exclusive breast milk feeding is to use a breast pump, often in addition to breastfeeding. The research has found that using a breast pump to express milk within one hour of birth-- so very, very shortly after birth-- versus within six hours of birth increases the amount of milk produced and stabilizes milk production sooner. And that-- we're talking, like, months and months down the, the line is what's affected, the supply that's affected.

This shows us that time is of the essence. If we advance LB1107, we will help postpartum people in Nebraska achieve an increased milk supply and quicker stabilization of milk supply. This can lead to higher breast milk feeding success rate and resultant better outcomes for infants in Nebraska. The Nebraska Nurses Association supports increasing timely access to quality breast pumps for Nebraskans. We respectfully ask the committee to advance this bill.

HANSEN: All right. Thank you.

JULIA KEOWN: Mm-hmm.

HANSEN: Are there any questions from the committee? All right. Seeing none. Thank you. Take our next testifier in support, please. Welcome.

TERESA PENA: Hi. How are you? My name is Teresa Pena. That's T-e-r-e-s-a P-e-n-a. Can I begin?

HANSEN: You can begin whenever you like.

TERESA PENA: All right. So thank you for the opportunity to speak today. I want to thank Tiffany Uher and Senator Jen Day for working together to introduce this bill. So my name is Teresa Pena, and I am a WIC breastfeeding peer counselor and a member of the diverse community breastfeeding educators here in Lincoln-- Lincoln, Nebraska and a certified lactation counselor. Much of my work around lactation support and education is rooted in helping reduce breastfeeding disparities among women of color and their babies. I offer lactation support to families and help them meet their own desired feeding goals. The mothers that I support are often first-time mothers, are new to Nebraska, speak a language other than English, and are alone without a support system. Some are lifelong Nebraskans and have always called this state their home. In other cases, they are mothers who have had some experience with breastfeeding but have lacked the support to continue the process. However, they are almost always mothers who need to get right back to work after having their baby. The demands from other aspects of life create additional barriers to breastfeeding for them. Many of these mothers often will not initiate or continue breastfeeding because they believe that working and nourishing their baby with human milk is not possible given their circumstances. This bill is important because it will help create a stronger foundation for families bringing life into this world. It is crucial that all mothers in the state of Nebraska have access to sufficient quality pumps and are able to access them prior to the

delivery of their babies. In order to maintain a steady milk supply, a mother must stimulate and frequently remove milk from her breasts. A breast pump allows a person to remove milk from their breast when it is not possible to breastfeed, like, for example, when they are separated from their baby who is in the NICU or must return to work. A pump is also used to relieve engorged breasts, help increase milk supply, or assist in pulling out inverted nipples so that a baby can latch effectively and remove milk from the breast. A breast pump is essential during the first days postpartum. However, many mothers in this state who are not insured because they file under the Children's Health Insurance Program, or CHIP, are not able to access a pump until after their baby is born. This policy leaves mothers unprepared when feeding issues arise. It leaves parents scrambling in the days after the birth of a child looking to submit paperwork and travel to find and acquire a pump. Most insured mothers in this state are able to access pumps prior to the birth of their child. All mothers, regardless of race, socioeconomic status, class, and citizenship status deserve that dignity. Providing a pump prior to the birth of their baby is not only dignified, but it allows families to learn, prepare, and feel supported. The second, but very important, part of this bill is ensuring that managed care organizations are providing a sufficient quality pump to Medicaid mothers. Recently, because of new changes in Medicaid options for coverage in this state, mothers have switched over to new plans. Many of these mothers are being sent low-quality pumps that are not only ineffective at removing milk but are not compatible with all work environments and also create preventable feeding and breast issues. Some mothers that I have supported work in outdoor construction sites mostly alongside men. Access to an electrical outlet is almost impossible. Right now, Medicaid only covers pumps that need an electrical source. Having access to quality pumps that have the ability to run on battery would allow these mothers the opportunity to work and feed their babies their own milk. I recently supported a mother who was sent a pump through her insurance. She depended on a pump to help with her supply and feeding her baby while her baby gained strength to effectively latch. She used the pump a couple of times, and on the third day found that the tubing was damaged. When she tried to pump, little milk was extracted and came out in the form-- in the form of foam and bubbles. Frantically, she went to several stores looking for replacement pieces with no success. Pieces found online would take more than a week to arrive. Pieces sent directly from the manufacturer would take almost two weeks to arrive. She tried to have a new pump issued, but insurance only covers one pump during pregnancy. She was stuck and

unable to remove milk. Her supply dropped and, in the end, turned to formula to feed her baby. The subpar quality of the pump issue directly led to her inability to feed her baby and therefore removed any choice or agency she had in how she wanted to feed her baby. Another situation where changes in our system would have helped a mother was when the mother was issued a pump that came with only one flange size. A flange is a plastic or silicone shield that fits over the breast to create a seal and is important when removing milk using a pump. She was pumping every two hours to make sure she can maintain her, her supply to feed her baby. The flanges were too small and began to create such discomfort that she experienced cracked nipples, bleeding, and excruciating pain. She began to develop an infection that required antibiotics. She began to associate pain with feeding her baby. Again, new pieces were difficult to find for the pump. If this bill was passed, this mother would have access to the supply she needed to prevent infection, relieve her pain, and maintain her bil-- her milk supply, and successfully provide milk for her newborn baby. I want to thank the committee again for hearing these testimonies. And I urge you to support LB1107 and ensure that all mothers in the state of Nebraska have access to sufficient quality pumps and are able to access them prior to the delivery of their babies. Thank you.

HANSEN: All right. Thank you. Are there any questions from the committee? Oh, actually, there is one question for you.

TERESA PENA: Sorry. Is this you?

BALLARD: Yes.

TERESA PENA: Sorry.

BALLARD: Yes.

HANSEN: Senator Ballard.

BALLARD: Yes, it would be. It-- are private insurers covering breast pumps?

TERESA PENA: Most are.

BALLARD: Most are?

TERESA PENA: Mm-hmm.

BALLARD: It's just Medicaid that is not?

TERESA PENA: So we have-- no. There are some Medicaid options that do, that do cover breast pumps, but-- like, for example, you have the new Molina option in the state of Nebraska. That will cover it, but it will only cover it after the baby is born.

BALLARD: OK. Thank you. Yeah. Thank you.

HANSEN: All right. Seeing no other questions. Thank you. All right. We'll take our next testifier in support, please. Welcome.

TIFFANY UHER: Thank you. Good afternoon. My name's Tiffany Uher, T-i-f-f-a-n-y U-h-e-r. I'm the executive director of MilkWorks, and I'm here today to testify in support of LB1107. MilkWorks is a nonprofit community breastfeeding center that's-- has served families throughout the state of Nebraska for the last 23 years. The mission of our organization is to create a healthier community by empowering families to meet their breastfeeding goals. In addition to providing lactation support through a clinical setting, MilkWorks aims to increase the availability of personal use breast pumps for families and provide education regarding their proper use through locations in Lincoln, Omaha, as well as our ten Pump Access, Access Program partner sites throughout the rest of the state. It is very important for the ultimate success of breastfeeding mothers and babies that plentiful milk production is established by four to seven days post-birth. Difficulty in this stage is associated with a great-- the greatest risk of early, unplanned weaning. If a baby is not capable of initiating good milk production at this crucial time, mothers are dependent on breast pumps to promote adequate supply. Both timing as it relates to the need for the mother to begin using her pump and the quality of the device are significant in establishing optimal milk production. According to the CDC's most recent breastfeeding report card, although most babies born in the United States start out breastfeeding, only about half are still receiving breast milk at six months and less than 1/4 are being exclusively breastfed. This is despite the recommendation that all babies are explic-- exclusively breastfed for the first six months. Research shows that this drop-off is not a choice for most families or that-- one they're making willingly, but rather a default decision in the current social context where families are under supported. For many, rather than a matter of personal choice, infant feeding practice is determined by circumstance. I'm going to skip the next part about working and-- since some other people have already covered the need to pump while you're at work. But since the Affordable Care Act mandated that private health insurance plans provide coverage of breastfeeding

support services and supplies, many new pump companies have appeared to try and capture those dollars. At present, there's no evaluation of the safety or efficacy of breast pumps, and the performance does vary. Teresa did a nice job of describing that. LB1107 would ensure that mothers who qualify for Medicaid would receive a pump with sufficient power and durability to establish and maintain milk supply for the duration of br-- breastfeeding. I'd like to express my apprecianess-- appreciation to Senator Day for the introduction of this bill. And I'm happy to answer any questions.

HANSEN: All right. Thank you. Are there any questions from the committee? Yes, Senator Ballard.

BALLARD: Thank you, Chair Hansen. Each testifier keeps mentioning quality pumps.

TIFFANY UHER: Yeah.

BALLARD: Can you, can you describe what would be subpar quality?

TIFFANY UHER: Yeah. So as Teresa kind of alluded to, there are several companies, but the ACA covers a breast pump for-- all commercial insurance is required to, to provide a breast pump to a mother. Medicaid in Nebraska requires it currently, but there's variations within that. So you might find cost savings from different vendors that are trying to create a breast pump but haven't done that effectively. So there are some, some companies that have really perfected the design to make sure that they're really effective of removing milk. They've studied this for years. They've tweaked the design. We've got two or three models that we test at MilkWorks. We always check for the suction quality. We want to make sure that there's varying suction degrees so it kind of mimics the nur-- the suckling of a baby where they suck and then they stop and then they suck and then they stop. The other pieces Teresa was mentioning, like being able to be plugged in, electric, or battery powered. There's really a varying degree of quality. There are Bluetooth ones that you can wear that's really, like, extensive technology at this point, so.

BALLARD: And private insurers are covering quality--

TIFFANY UHER: They are required to through the ACA.

BALLARD: Through the ACA. Perfect. Thank you.

TIFFANY UHER: Yup.

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

TIFFANY UHER: Yep. Thank you.

HANSEN: Anybody else wishing to testify in support of LB1107? Welcome.

KELSEY ARENDS: Thank you. Good afternoon, Chair Hansen and member of the committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s. And I'm the Health Care Access Program staff attorney at Nebraska Appleseed. Testifying in support of LB1107 today on behalf of Nebraska Appleseed. One of our core priorities is working to ensure that all Nebraskans have equitable access to quality, affordable health care. And because this bill improves access to breast pumps for Nebraskans with Medicaid so that newborns and their families have the resources that they, that they need, Nebraska Appleseed supports this bill. Despite its importance, as you've heard, breastfeeding can be incredibly difficult. And Nebraskans face barriers to breastfeeding, including a lack of support and access to resources. Breastfeeding is strongly recommended by the American Academy of Pediatrics because of breast milk's strong nutrient content and numerous health benefits. Breastfeeding improves health outcomes for newborns and their families. Infants who are breastfed have reduced risks of both short- and long-term illnesses and diseases. And breastfeeding also improves health outcomes for moms. Further, low breastfeeding rates are associated with increased medical costs of more than $3 billion a year for the mother and the child in just the United States alone. Breast pumps are essential to allow new moms to spend time away from their baby for things like school, work, or time in their community. Many lactating parents will need to pump in order to maintain breastfeeding long term, especially once any parental leave expires. And some lactating parents will need pumps to start as soon as their baby's date of birth to successfully initiate breastfeeding. Pumps play a critical role, role in ensuring new moms are able to manage their milk supply and ensuring that babies have the milk they need. LB1107 makes needed improvements by ensuring new parents with Medicaid will have coverage for an electric personal use breast pump beginning at 36 weeks gestation or the date of birth, whichever is earlier. Because of this, families will be able to get more support to improve their breastfeeding success. For these reasons, we respectfully request that this committee advance LB1107.

HANSEN: All right. Thank you. Any questions? Seeing none. Thank you.

KELSEY ARENDS: Thanks.

HANSEN: Take our next testifier in support of LB1107. Anybody else wishing to testify in support? OK. Is there anybody wishing to testify in opposition to LB1107? All right. Is there anybody wishing to testify in a neutral capacity to LB1107? Seeing none. We'll welcome Senator Day back up. And for the record, we did have 26 letters in support of LB1107 and 1 in opposition.

DAY: OK. So again, this is a pretty straightforward and simple change that we're making here that we think can go a really long ways for zero cost and supporting new parents and babies in getting appropriate nutrition and allowing them to get some more preparation. I think-- there may be some people on the committee who haven't had children yet, but I know that the, the days and the weeks after labor and delivery are some of the most chaotic weeks of your life, really, and trying to figure out how to use a pump in that frame of time just adds to the chaos. And so I think this is a great way to help alleviate some of that for moms and babies. So thank you.

HANSEN: All right.

DAY: Hopefully we can get it on consent calendar, maybe. Would be great.

HANSEN: You mentioned no cost because-- and I saw it in the fiscal note too. But they have a line in here that says the total increase is estimated to be $279,000 in fiscal year '25. Is that federal dollars? [INAUDIBLE]-- I-- when I read it, I was a little confused because they say-- they're talking about the MCOs paying for stuff. But then also we're going to save money by doing this or actually--

DAY: Well--

HANSEN: --because [INAUDIBLE] not renting the equipment anymore.

DAY: And I think that--

HANSEN: Do you know?

DAY: I'm not sure exactly how it all interacts with each other, but I know that there is a somewhat decreased cost for coverage of formula through WIC.

HANSEN: Yes. OK.

DAY: And so they basically said, whatever the costs are, they, they will be able to absorb it.

HANSEN: [INAUDIBLE] what it looks like. OK.

DAY: Yeah.

HANSEN: Cool.

DAY: Yeah.

HANSEN: All right. Any questions? All right. Seeing none. That will conclude our hearing on LB1107. And then we will now open on LB1106. And welcome Senator Day to open.

DAY: Thank you. Good afternoon, Chairman Hansen again and member of the Health and Human Services Committee. My name is Jen Day. That's J-e-n D-a-y. And I represent LD 49 in Sarpy County. LB1106 and LB1107 are complementary bills. While LB1107 addresses the equipment side, LB1106 ensures that our state's provider infrastructure remain sustainable so that we support mothers and their babies. Lactation consultants are trained professionals with specialized knowledge in breastfeeding and lactation. They understand the complexities of breastfeeding and can provide evidence-based guidance tailored to the individual needs of each mother. When beginning breastfeeding, a number of potential issues and challenges can arise, such as latch issues, low milk supply, and pain. By working to solve these issues early on, lactation consultants can prevu-- prevent complications and help mothers achieve successful breastfeeding outcomes. As I mentioned in LB1106, these early days-- excuse me-- LB1107, these early days in a newborn's life are critically important for the baby's health and well-being as well as the well-being and health of the mother. Currently, the state provides coverage for five visits. And in the fiscal note, the Department of Health and Human Siv-- Services reports that 91% of mothers enrolled in Medicaid that utilized a lactation consultant visit only used one or two of these appointments. So LB1106 is meant to improve the outcomes for those that may need a higher continuity of care to sustain healthy breastfeeding. DHHS projects that they can-- excuse me-- absorb any increase in visits from LB1106 within their current appropriation. So in a similar manner to LB1107, while this change will not affect the vast majority of mothers on Medicaid, for the ones that it does affect it has the potential to make a world of difference. The second half of LB1106 ensures that our state's lactation consultants can provide this care at a sustainable

provider rate. The department has projected that they will be able to absorb these costs as well. Increasing the rate of reimbursement so that consultants are offering this at market rate improves access to care for both Medicaid and private side mothers and will keep our skilled lactation consultants in the profession and practicing in Nebraska. LB1106 is a crucial step toward bolstering lactation support for mothers, ensuring healthier outcomes for both moms and babies. Tiffany from MilkWorks will be testifying behind me, and she will probably be better able to answer any of the questions you have, but I'm happy to try to answer any now.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. See you at close. We'll take our first testifier in opposition. I'm just joking. In support. Welcome back.

TIFFANY UHER: Yeah. Thank you. Again, my name's Tiffany Uher, T-i-f-f-a-n-y U-h-e-r. I'm the executive director of MilkWorks. We're a nonprofit community breastfeeding center. And I'm here to testify in support of LB1106 and to share why breastfeeding dyads receive-- receiving medical assistance would benefit from improved access to professional breastfeeding support. The health beati-- health benefits of breastfeeding for mothers and babies have been well-documented for decades, and the list of proven benefits continues to grow. I've actually provided you with a list of all the health benefits today so I don't have to read through all of them. But most significantly perhaps is a study that was done by the CDC and published last year. It looked at 9.7 million births in the U.S. from 2016 to 2018 and showed that any breastfeeding in the hospital-- and this is the only data point that the CDC has for all babies-- but any breastfeeding in the hospital is associated with a 33% decrease in infant death between ages 7 and 364 days of age. Over the last decade, breastfeeding rates have improved in the United States. However, this achievement has not been equitable for all families. Breastfeeding disparities exist based on race, ethnicity, and socioeconomic status. According to the most recent CDC National Immunization Survey, 25.4% of the general population are able to meet the American Academy of Pediatrics' recommendation to exclusively breastfeed for the first six months, while only 19.7% of those among low-income households are able to meet this milestone. Barriers to success, success in breastfeeding abound in our society. Improved access to instruction on lactation from breastfeeding experts during the postpartum period is critical to overcoming these barriers. Some studies have found that approximately six in ten families do not meet their breastfeeding goals. The most common reasons are low milk production and significant pain while

feeding. At MilkWorks, a clinical lactation consultation involves assessment of both the mother and baby, including a physical exam, assessing how effectively the baby is latching on, how much milk the baby removes at the breast, and, if indicated, how mu-- how to use their breast pump. Many dyads only require two to three visits before they can breastfeed successfully on their own. However, there are situations where babies need to grow and mature, and some of these families require extended support. The United States Breastfeeding Committee currently recommends coverage for 9 to 12 visits. Current Medicaid reimbursement for a visit with an internationally board-certified lactation consultant, or an IBCLC, is $20.62 for every 30 minutes spent with the family. Given the current cost to staff a clinic, it is not feasible to provide care at this rate. Because of this, many independently practicing lactation couns-- consultants cannot afford to see Medicaid patients at all. In addition, there is currently no Medicaid reimbursement for the many lactation consultants in our state who are not registered nurses, further limiting their access to care. LB1106 would ensure that lactation support is more financially viable for providers and available regardless of complexity of the mother and baby's needs. Thank you again to Senator Day for bringing forth the bill. I'm happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. Thank you very much.

TIFFANY UHER: Appreciate it.

HANSEN: Take our next testifier in support, please. Welcome back.

ERIN FEICHTINGER: Twice in one day. Chair Hansen, member of the Health and Human Services Committee. Once again, my name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r. I'm the policy director for the Women's Fund of Omaha, and we offer our support for LB1106. You've heard from actual experts, so I'm not going to repeat them. And I'll keep this brief. It is, of course, up to every individual to decide whether or not to breastfeed, but that freedom of choice, as we've heard, about how to best care for a baby is currently limited by whether or not a person can access the necessary support for breastfeeding, including lactation support. While the national rate for breastfeeding initiation is at 84.1%, that percentage drops according to race, income level, and participation in federal assistance programs like SNAP and WIC, indicating that even if a parent wants to breastfeed, some parents are not given the adequate resources to pursue that choice. Best practice recommends lactation support both in the

hospital and after the parent goes home. But again, as you've heard, the out-of-pocket costs of accessing those adequate lactation services are cost prohibitive for those parents whose insurance does not cover those services. By providing increased coverage for lactation support, LB1106 will reduce reliance on the formula provided through WIC, reduce long-term health care costs for the state, and support the individual choices of those parents who want to breastfeed. We ask for your support of LB1106 and so for the choices of Nebraska families and how best to care for their babies, regardless of their income. And I'm happy to answer any questions to the best of my ability.

HANSEN: Thank you. Are there any questions? There are no questions. Thank you. Anybody else wishing to testify in support? Welcome back.

JULIA KEOWN: Thank you. My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am a registered nurse, as I said before, a native Nebraska. And I am here testifying as a private citizen for LB1106. I'm a mother of twins. It was a hard-won three-year battle with infertility on my part. We did six IUIs and one round of IVF. I'll spare you the gory details of that. But suffice to say, it was just so stressful. I swore that I would never do another cycle of IVF again even if it was successful. Fortunately, our first go-around was. And we ended up with twins. So at 35 weeks and three days, which is before the 36 weeks-- so glad that we got that in. That's awesome. Thank you, Senator Day-- I went into labor. Neither twin was breathing well when they came out after their C-section, so they both went to the NICU. I didn't, I didn't get to hold my babies until they were 11 days old, so well past the sense of-- period for establishing proper breastfeeding, really, without an LC. So I had been pumping with little success, but I knew it would get better after we could get them to latch, or at least I thought I did. It was very, very, very wrong. It took months of working with LCs, lactation consultants, both in the hospital while we were in the NICU and then at MilkWorks. I worked with lactation consultants who were medical doctors by training, and then they were IBCLC certified. I worked with registered nurses who were IBCLC certified. And then I worked with-- also with the bachelor prepared-- So there's three different pathways to get to certification for LCs. So I worked with two of those pathways. One was, like, the medical and then the other that I worked with was-- they were bachelor prepared, but they were, they were also-- they took health courses and also were certified. So everyone was certified and had that appropriate level of care. And everyone was wonderful. I didn't-- I wasn't able to find a difference in knowledge and care. And obviously, that's just anecdotal. That's just me, right? But-- so, yeah. The care I received

from all of them was incredible. We were actually able to stop formula feeding after the second month of seeing the LCs, and it was definitely one of the more extended ones. I think we ended up going into three months of seeing them over and over. They probably get sick of seeing me, but it was worth it for me. Our struggle never ended until our breast meat-- milk feeding journey ended, but it was certainly worth it. I think I made it to 18 months with Evie and 12 months with Gavan. So we got so fortunate. Thank you for your consideration of this bill to increase access to valuable LC care for all postpartum people.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. Thank you. All right. We'll take our next testifier in support, please. Welcome.

KARINA RUIZ-VARGAS: Hi. My name is Karina Ruiz-Vargas, K-a-r-i-n-a; last name, R-u-i-z-V-a-r-g-a-s. And I'm here today as the chair of the Nebraska Breastfeeding Coalition. And thank you so much for being here. I'm here in support of LB1106. I wanted to talk today about something that may not always be the top of mind but is absolutely crucial, which is getting paid fairly in the field of lactation, as you've heard. So let's acknowledge the incredible importance of lactation consultants and professionals in our communities. These individuals provide vital support to new mothers and families during one of the most crucial periods of time: the journey of nurturing a newborn. Their, their expertise, compassion, and guidance are invaluable as they help mothers navigate the complexities of breastfeeding and ensure the health and well-being of both baby and mother. However, despite the significant impact they have, it's disheartening to note that many lactation consultants struggle to receive fair compensation for their services. This is not just a matter of monetary value. It's about recognizing the immense skill, knowledge, and dedication required to excel in this field. And-- moreover, we just recognize the emotional labor involved in the work of lactation consultants. They often serve as pillars of support for mothers who may be facing challenges, doubts, and anxieties about breastfeeding. They listen, they empathize, and they provide encouragement when it's needed most. This aspect of their work is invaluable and cannot be overlooked. This does not mean that medical providers or nurses who are IBCLCs would do a poor job in-- you know, in retrospect, but they get pulled in other directions, which defeats sometimes the purpose of having someone focus on lactation. So sometimes when you have someone that is an IBCLC, there's not compenta-- compensation if they are not an RN or above in the medical

field that they are still skilled enough to provide the same services. So fair compensation's not just about recognizing the individual efforts of lactation consultants; it's about ensuring equitable access to their services for all mothers, regardless of their socionomic status-- soci-- socioeconomic status. When lactation consultants are not adequately compensated, it limits access to crucial support for those who need it most, perpetuating disparities in health care and exacerbating existing inequities. So as a newly certified IBCLC, I am not an RN, but now I'm thinking that I have to pursue an RN, you know, degree in order to be able to serve the communities that I want to serve, which are already communities that are underrepresented. So what can we do to address this issue? It starts with advocacy and awareness. We must advocate for policies and practices that ensure fair compensation for lactation consultants, whether through insurance coverage, government funding, or employer support. We must also raise awareness about the importance of their work and the value they bring to our communities. Additionally, we can all play a role in supporting lactation consultants by acknowledging and appreciating their contributions, advocating for fair compensation in our workplaces and communities, and ensuring that all mothers have access to the support they need to succeed in their breastfeeding journey. And so again, this is not a matter of financial reward. It's a matter of recognition, respect, and equity. By valuing their expertise, dedication, and emotional labor of lactation consultants, we can create a more supportive and equitable environment for breastfeeding mothers and their families. And like I mentioned, I would love to help everyone in my community, but that makes it really difficult. And I wouldn't be able to work at a hospital because in order to work at a hospital, you have to be an RN if you want to do lactation. I provide bilingual skills, so I would be able to help a set of mothers that usually will not be able to get that-- those services all at once. I've worked at Bluestem for eight years now, Bluestem Health. And I have done lactation work, but that has been all volunteer based because it is something that I feel a lot of people don't have access to. It took me five years of getting lactation hours, certification hours, commu-- education hours in order to get my IBC cert-- IBCLC certification. So thank you all for listening to this. Appreciate it.

HANSEN: All right. Thank you. Are there any questions? I have a question. Is it per the hospital rules and regulations that they only allow RNs to be LCs? Or is that, is that pretty much what the hospital tells you?

KARINA RUIZ-VARGAS: Yeah. Usually when they hire RNs, the RNs can become IBCLCs. They don't normally do it backwards where they say we'll hire an IBCLC who will then one day maybe become an RN or things like that. You get the RNs that are IBCLCs to help, but then if they get pulled in other directions, then they're not focused on the lactation piece, where then they get referred to MilkWorks. And MilkWorks is the one that has the lactation consultants that also don't get compensated fairly. So then it, it's a cycle.

HANSEN: OK.

KARINA RUIZ-VARGAS: Mm-hmm.

HANSEN: OK. All right. Seeing no other questions. Thank you.

KARINA RUIZ-VARGAS: Thank you.

HANSEN: Anybody else wishing to testify in support of LB1106? Welcome back.

KELSEY ARENDS: Thank you. Chair Hansen and 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'm the Health Care Access Program staff attorney at Nebraska Appleseed. We're testifying in support of LB1106 today on behalf of Nebraska Appleseed. Because this bill improves access to lactation consulting services for Nebraskans with Medicaid so that newborns and their families have the resources that they need, Nebraska Appleseed supports this bill. I'll be very brief and tell you just that LB1106 makes needed improvements by increasing the number of lactation consulting visits and increasing provider rates to support the workforce. Currently, our understanding is that Nebraska Medicaid guidance provides that there are only five lactation consulting visits available per child, which can only be exceeded if medically ne-- if medical necessity is demonstrated. This bill increases that minimum amount to at least ten visits. Under LB1106, families will be able to get more support to improve their breastfeeding success. Additionally, increasing provider rates also makes needed investments in supporting the provider infrastructure for babies and moms to ensure they are off to a healthy start. For these reasons, we respectfully request that the committee advance LB1106.

HANSEN: Thank you. Are there any questions from the committee? Seeing none. Appreciate it.

KELSEY ARENDS: Thanks.

HANSEN: Anybody else wishing to testify in support? OK. Seeing none. Is there anybody who wishes to testify in opposition to LB1106? Is there anybody who wishes to testify in a neutral capacity? Seeing none. We'll welcome Senator Day back up. And we did have some letters-- if I can find it. We had 24 letters in support of LB1106 and 1 in opposition.

DAY: Thank you. Again, both of these bills, they kind of-- they work together. Originally, we had them in one bill. We split them into two just to make it more clearer. But they both work to provide better outcomes for moms and babies. Related to LB1106, I can tell you I was-- felt very strongly. I've nursed both of my babies for a year each. I felt very strongly about nursing when I had my first 15 years ago. But I can tell you: although breastfeeding is one of the most natural things you can do, it can be very complicated and can be really difficult for both mom and baby. So having support can, can drastically increase positive outcomes for both mom and baby. So that's why we feel like we need both of these bills sort of working together to improve that. Simple, straightforward. Again, ideal bills for consent calendar. No fiscal note. No opposition.

HANSEN: Looks like it.

DAY: Yeah.

HANSEN: All right. Any questions from the committee? There are none. Thank you very much.

DAY: Thank you.

HANSEN: All right. And that'll wrap up our hearing for LB1106. And next, we will have LB1373. The floor is yours.

ALEX MAYCHER: Thank you. Good afternoon, Chair Hansen and members of the Health and Human Services Committee. My name is Alex Maycher, spelled A-l-e-x M-a-y-c-h-e-r. And I am the legislative aide for Senator Carol Blood, who represents District 3, which is the western half of Bellevue and eastern Papillion, Nebraska. She does apologize. She cannot be here to introduce LB1373. This compact was created as other interstate compacts, with stakeholders within the industry and with their input. The Council of State Governments, Department of Defense, and Academy of Nutrition and Dietitians worked on this compact to facilitate the mobility of licensed dietitians and reduce licensure barriers to portability. This compact does take effect once

seven states pass the legislation. This is a fairly new compact, so no state has passed legislation yet, but it is currently pending in nine states, including ours. This compact, like all the compacts, is a constitutionally authorized, legally binding, legislatively enacted contract among states. With approximately 111,000 registered dietitians in the U.S., they are currently limited, limited to practicing in their home states only. LB1373 would provide multistate licenses for licensed dietitians wishing to practice in any member compact state. This is especially helpful for licensed dietitians that are relocating, such as a military spouse moving to another state, as it is-- allows them to obtain a multistate license and enter the workforce in Nebraska sooner. It is important to note that the scope of practice in Nebraska will not change with the passing of the compact. In order to obtain a multistate license, a registered dietitian would need to complete a programmatically accredited education program, completion of an accredited, planned, and documented, supervised experience in diet and nutrition, and a successful completion of the RDN examination. Licensing authorities will benefit from LB1373 with the reduction of administrative burdens. A compact information system will be created supporting the facilitation of licensure and discipline information for dietitians. Cooperation among member states is expanded with a shared database for investigators-- or, investigations and disputes. And maybe most importantly, regulators retain jurisdictions within their own states. Nebraska will reap benefits from LB1373 with yet another industry where we can address our workforce needs, getting qualified people into the workforce faster. Patient access is expanded with more qualified dietitians available to Nebraskans, and the shared interstate data system between member states improves consumer safety with better verification of licensure status. State sovereignty is preserved, as with other compacts, and the scope of practice is not altered. Again, active duty military spouses that are registered dietitians coming to Nebraska will have a major financial hurdle removed. They will not have to spend the time, money, and effort to get relicensed and instead will be able to enter the workforce and earn income for their families. The compacts and all the relevant industries also help spouses and military families that often struggle to regain income when they move. So just to point to the amendment that was handed out, this was suggested language by DHHS to comply with just the State Patrol and FBI background check process. It does not alter the compact in any way, the intention of it. In every industry, these interstate compacts have improved labor markets, enhanced public safety, and helped military families, all while

preserving state sovereignty. The proponents online are registered dietitians that see the benefits for their industry if LB1373 is passed. I thank the committee for their time today.

HANSEN: All right. Thank you. Are there any technical questions? All right. Seeing none.

ALEX MAYCHER: Thank you.

HANSEN: Thank you. We'll take our first testifier in support of LB1373, please. Welcome.

SHANNON MUHS: Thanks. My name is Shannon Muhs. It's S-h-a-n-n-o-n; last name is M-u-h-s. And I'm here representing Nebraska Academy of Nutrition and Dietetics. I'm here today in support of LB1373, the Dietitian Licensure Compact bill. I'm a dedicated clinical dietitian with 29 years of experience, currently working at Boys Town National Research Hospital in Omaha, Nebraska, specializing in the pediatric gastroenterology department. I hold licenses in seven states, a pursuit initiated in 2020 during COVID-19 pandemic when telehealth emerged as the primary means to connect with patients. As a registered dietitian nutritionist, I have undergone rigorous training and certification through the National Credit-- Credentialing Program of the Commission on Dietetic Registration, also known as CDR. CDR sets the standards for our profession, governing our scope of practice, continuing education requirements, and facilitating programs for professional advancement. While maintaining that national credential is essential, obtaining individual state licenses proved to be a time-consuming task, especially given the unique details and variations in requirements across states. The Dietitian Licensure Compact would significantly alleviate the burdensome process of obtaining multiple licenses. This legislation is a vital step toward streamlining the licensure process, enabling dietitians like myself to practice seamlessly across state borders, particularly in an era where telehealth is paramount. The compact not only benefits dietitians but also supports the relocation needs of military spouses and families, contributing to overall workforce mobility. Moreover, the compact offers advantages to state licensing authorities by reducing administrative burdens and establishing a comprehensive information system. This system facilitates the efficient exchange of licensure and disciplinary information amongst states, ensuring a more coordinated and effective regulatory framework. In conclusion, I strongly urge the committee to support and advance the Dietitian Licensure Compact. This legislation is a win-win for dietitians and

our state. It promotes workforce development, strengthens labor markets, expands patient access to highly qualified practitioners, and enhances public safety through improved interstate cooperation and information sharing. Thank you very much for your time for this critical matter. I'm available for any clarification or questions if you have them.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Hardin.

SHANNON MUHS: Yes?

HARDIN: Practically speaking right now, how long would it take even someone like you to go somewhere else and just-- kind of compare it for me. How hard is it to get into Nebraska?

SHANNON MUHS: That's a good question. It kind of varies on, I would say, the amount of administration staff to handle the paperwork, basically. For me to get my seven licenses, I would say it took about three months of-- because you have to submit and then wait and submit and then wait. And they all have kind of varying--

HARDIN: They're sequential?

SHANNON MUHS: What?

HARDIN: Well, do you have to-- if you're applying for different licenses and so forth, do you have to get this one before you get that one, and so on and so forth?

SHANNON MUHS: No, not so much that. So all of them require that if you're previously licensed, they want to see where and show proof. So you have to submit to that state where you're previously licensed and then have them send, like, a sealed, stamped envelope with all the-- so when I wanted to obtain multiple, I decided to do it all at once so that I only had to prove two because I started with Nebraska and Iowa.

HARDIN: OK.

SHANNON MUHS: So Iowa was simple to get a license there. But, like, oh, Wisconsin and Missouri were a nightmare. Nebraska is, like, mediocre. I don't know. I did it so long I don't remember.

HARDIN: Were you tasking satellites, that kind of thing?

SHANNON MUHS: Yeah.

HARDIN: OK.

SHANNON MUHS: One of them was even talking to my former internship director, you know. Thankfully, she's still around.

HARDIN: The whole thing-- even though-- if-- it-- let's say a person was only licensed in one state.

SHANNON MUHS: Mm-hmm.

HARDIN: What does that look like before they can practice here? I mean, what's-- what is it on our end--

SHANNON MUHS: Of how long it takes?

HARDIN: Yeah.

SHANNON MUHS: Oh, I don't know that I know. I would say two, three months.

HARDIN: Two, three months. OK. And then it's just a question of, are we-- since there's no compact, are we, are we in any way reciprocal, so on and so forth, that-- to would to allow them to go to work? And this is not the first time we've heard this. And thanks to Senator Blood, we're used to hearing about compacts and how they smooth the way, right?

SHANNON MUHS: Yeah. Yeah. I see what you're saying, like if they're licensed somewhere else. I think the timeline varies dependent upon, again, the administrative staff to shuffle papers.

HARDIN: Supply it.

SHANNON MUHS: Yeah.

HARDIN: Gotcha. OK. It's not easy.

SHANNON MUHS: Correct. It definitely puts a-- yeah. It's harder. Way harder.

HANSEN: I have a couple questions. So right now, what they're saying-- a, a dietitian, in order to be eligible to, to participate in this compact, it's not more restrictive than what you currently have to do?

SHANNON MUHS: No.

HANSEN: OK.

SHANNON MUHS: No. It would all around be easier.

HANSEN: OK. Why do you have to do a background check, do you think? Do you think you have to? Do you think you, you should?

SHANNON MUHS: I think it's a good idea just in today's world. Not all of them do require background checks, but a couple of them did.

HANSEN: I always have a, a concern about the idea of overburdensome rules and regulations that get put on, you know, you know, dietitians-- every, every-- in-- every aspect, even health care-- everything, right?

SHANNON MUHS: Right.

HANSEN: So it seems like it always kind of adds up. And so [INAUDIBLE] start to see background checks being put on people all the time. Maybe in some aspects I could see perhaps, like, a, a, a-- someone who's in child care who's alone with a child, right--

SHANNON MUHS: Right.

HANSEN: --[INAUDIBLE] reason for background check there. But we're starting to-- do-- seems like we're doing background checks on everybody just to make sure somebody feels better about something.

SHANNON MUHS: Yeah.

HANSEN: And so I don't know why-- I was, was-- I was curious to get your kind of just your, your personal opinion.

SHANNON MUHS: Well, I don't-- I would say-- you know, in dealing with patients and populations, it's important that you have a person with integrity, for sure. I would say maybe-- you know, a DUI or something like that might be a good thing to know or someone-- but again, [INAUDIBLE] going to be driving, but still. If there's a substance abuse issue or-- they ask you to disclose that, you know, in the, the application form, but--

HANSEN: Sure. OK. I was just kind of curious.

SHANNON MUHS: It's just an extra measure. I don't know. Yeah. That's a good question.

HANSEN: Because I-- we've, we've had some problems, I think, with background checks for people who are trying to get into, like-- whether dietitian or, or, you know, I think maybe even-- I can't remember for sure-- nursing? I don't think that's it. But-- where it takes sometimes months to get, you know, a background check back from the State Patrol, which then delays their ability to kind of get into the profession, which then causes a whole host of problems, so.

SHANNON MUHS: Yeah. Yeah.

HANSEN: So I was just kind of-- that's why I was asking that. Just kind of curious about that.

SHANNON MUHS: Yeah. I could see that. But I did it during COVID, so it's hard to tell because I think everything took longer then.

HANSEN: Yeah.

SHANNON MUHS: Yeah.

HANSEN: And more of a clarifying question: are you here on behalf of Boys Town National Research Hospital?

SHANNON MUHS: No, I'm here on behalf of Nebraska Academy of Nutrition and Dietetics.

HANSEN: OK. Just wanted to make-- clarify that with your testimony to make sure, so.

SHANNON MUHS: OK.

HANSEN: OK.

SHANNON MUHS: Thank you.

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

SHANNON MUHS: Thanks.

HANSEN: Anybody else wishing to testify in support of LB1373? Anybody wishing to testify in opposition to LB1373? Anybody wishing to testify

in opposition to LB1373? All right. I'm assuming you're waiving closing.

ALEX MAYCHER: Yes.

HANSEN: All right. And he'll waive closing. And that will actually wrap up our hearing for LB1373. And then we'll open it up to LB823. And you are welcome to open again.

ALEX MAYCHER: Good afternoon again, Chair Hansen, members of the Health and Human Services Committee. My name is Alex Maycher, spelled A-l-e-x M-a-y-c-h-e-r. And I am the legislative aide for Senator Carol Blood, who represents District 3, which is the western half of Bellevue and eastern Papillion, Nebraska. The Senator does apologize again for not being in-- here to introduce LB823, the Physician's Assistant Interstate Compact. The PA Compact has a set of baseline requirements. Oh. Excuse me. Backtrack. As with other compacts she has introduced, the goal of the Physician Assistants Compact is to ease the licensure burden for physician assistants moving to Nebraska. The PA Compact specifically began as an initiative in 2019 with the Council of State Governments, Federation of State Medical Boards, American Academy of Physician Associates, and the National Commission on Certification of Physician Assistants. The goal of this compact is to facilitate licensed PAs to practice in multiple states that have joined the compact without having to obtain an individual license in each of these states. States automatically join the compact by passing the compact legislation. The privilege to practice model does apply to this compact, where a licensee seeks compact privilege to practice in any state within the compact. The process is expedited, as with other contacts, with the shared database system between states confirming if an individual is qualified to practice within a member compact state. The PA Compact has a set of baseline requirements a state must meet before being eligible to become a member. This should help concerns that qualifications for being a PA would be diluted within the state with Nebraska joining the compact. These requirements include a national exam and continuing education for licensed PAs. Also, licensed individuals within any compact state must meet baseline requirements themselves agreed upon by the member compact states. This includes obtaining a NCCPA certification and graduating from a nationally accredited PA program. So basically, the bottom line is the PA Compact does not change scope of practice for Nebraska. And as always, we maintain our sovereignty. Health care industry stakeholders had a major say in the formation of this compact to protect industry standards in participating states. A major reason our office wanted to

introduce this compact is due to the major success of other health care compacts previously introduced, including the Nurse Licensure Compact and Interstate Medical Licensure Compact for physicians. These compacts have been enacted in over 40 states and have been extremely popular in the health care industry. There isn't a reason Nebraska shouldn't be one of the initial states to join the PA Compact before you today. So the PA Compact can become one of the multiple solutions we have for Nebraska's lack of health care access. Rural areas have become particularly more vulnerable, with 13 physicians for every 10,000 residents, as compared to 31 physicians for every 10,000 residents in urban areas. This coverage gap is growing for rural communities with doctors in these areas retiring and not being replaced. A bright spot that emerged from this troubling data during the pandemic was the emergence of telemedicine, and a PA Compact can help maximize those benefits. The health care gaps Nebraska is experiencing as well can be filled with telemedic-- telemedicine facilitated by the PA Compact. This compact will allow care providers an ease of practice in multiple states and, with telemedicine, can provide the care needed in areas like rural Nebraska without having to always be physically present. Streamlining the licensure process for PAs will allow more health care options for Nebraskans, especially with the expansion of telemedicine. So as many of you in the committee already know, these compacts greatly benefit active military spouses-- again, many of whom hail from the Senator's district. Military spouses experience substantial income loss when they have to transfer to a new location, with one of the common reasons being new licensing requirements for their occupation. When arriving in a new state, a military spouse often has to acquire a new license for that specific state, which becomes time-consuming and costly. For the PAs, specifically for those military spouses, we can ease the licensure burden and hurdles to make their transition to Nebraska easier. So after seven states have enacted the compact model legislation, the compact will be activated and begin the process to operationalize the compact and be able to give out privileges to practice. Eligible PAs can then complete a single application to receive a compact privilege-- which is equivalent to a license-- from each compact state in which they intend to practice. And as an FYI, the compact has passed in 3 states and is currently pending in 17 states. And just to make note of the amendments as well-- there's two. AM2073 was suggested for cleanup language and, again, does not alter the compact's legislation's intent. AM2289 was suggested again by the DHHS for compliance with the State Patrol and the FBI relating to criminal background checks. With LB823, we can add to the success of other

health care compacts we have introduced in Nebraska. We can kill two birds with one stone, so to speak, by helping to address our lack of health care access in rural areas of the state and ease the transition of military families and their spouses, further reducing licensure burdens. The Senator asked the committee to continue to help my office pass these compacts have been so successful from Nebraska. And I want to thank the committee for their time today.

HANSEN: All right. Thank you. Any technical questions? Seeing none. Thank you.

ALEX MAYCHER: Thank you.

HANSEN: All right. We'll take our first testifier in support of LB823. Welcome.

NICOLE SCHWENSOW: Hi. Thank you. Chairman Hansen and members of the Health and Human Services Committee. My name is Nicole Schwensow, N-i-c-o-l-e S-c-h-w-e-n-s-o-w. And I'm appearing on behalf of the Nebraska Academy of PAs. I'm a physician assistant. I work in Grand Island in hospitalist medicine. I also work part time at a critical access hospital in emergency medicine and-- also in Grand Island. Outside of my Nebraska PA license, I'm licensed in Colorado, Wisconsin, and Kansas. And then outside of my clinical work, I serve on the Department of Health and Human Services' PA Licensure Committee. I thank you for the opportunity to testify in support of LB823 and the Physician Assistant Licensure Compact. For nearly 50 years, NAPA has represented the interests of more than 1,700 practicing PAs in Nebraska, including advocating for quality, cost-effective, and accessible health care for Nebraskans throughout the state. It is our pleasure to provide this committee information on the PA Licensure Compact and its anticipated impacts to patients, PAs, and state administrators. Like many states, Nebraska is competing to recruit and retain qualified health care providers to meet the needs of patients. The roles that PAs play in meeting these health care needs in Nebraska and across the country is critically important. 1/4 of PAs in Nebraska serve in rural areas, and approximately 30% work in primary care. So it's important that the state look for ways to fully leverage the PA workforce to meet the needs of Nebraskans, and the PA Compact can be a useful tool in this effort. If enacted, we hope the compact will strengthen access to medical services provided by the PAs via the mutual recognition of PAs' qualifying license by other compact-participating states. Should Nebraska join the PA Compact, the compact would be administered by a compact commission, an interstate

government agency comprised of delegates from compact member states. This would also allow for the creation of a licensure data system to improve information sharing between compact member states, which also includes disciplinary information. States joining the compact would agree to recognize a valid, unencumbered license issued by another compact state member via the compact privilege. Licensed PAs utilizing the compact can obtain a privilege in each compact member state where they want to practice. Importantly, PAs using a compact privilege to practice in another state must adhere to laws and regulations of that state under the jurisdiction of the state's regulatory board in which they are practicing. The PA Compact also adopts the prevailing standard for PA licensure and affirms that the practice and delivery of medical services by the PA occurs where the patient is located at the time of the patient encounter, and therefore requires the PA to be under the jurisdiction of the state licensing board where the patient is located. So by preserving the sovereignty of state rules and regulations, the compact safeguards Nebraska's ability to regulate the profession, charging licensing fees, and preserve the structure of the state-based licensing system. If enacted, we pri-- we anticipate that the compact will provide several benefits to PAs, patients, and state regulators. First, the compact will facilitate license portability, making it easier for PAs to practice without lic-- lengthy licensing delays or administrative burdens. Rather than obtaining an invid-- individual license they want-- for the state that they want to practice, the PA can utilize the PA Compact for applying for compact privileges for-- through a more streamlined process. This can make Nebraska more competitive in attracting high-quality practitioners. Licensure portability is especially important for military families. The compact will more easily allow active duty military personnel and their PA spouse to obtain a compact privilege in Nebraska if they're licensed in another compact state. For patients, this could mean expanded access to highly qualified practitioners and would also help the state facilitate practitioner mobility during public health emergencies. But beyond the benefits to the patients, the state could benefit from improved cross-state collaboration, enhanced public safety through data sharing, and strengthened health care labor market. Nebraska PAs stand ready to be a resource to you as you consider the PA Compact. And NAPA thanks to you for your opportunity to provide input on this important discussion. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Drove all the way from Grand Island and we don't have any questions for you? You did-- you're just that good, so. All right. Thank you very much.

NICOLE SCHWENSOW: Thank you.

HANSEN: All right. Anybody else wishing to testify in support of LB823? Welcome.

JOYCE BECK: Welcome. Thank you. Chair Hansen and members of the Health and Human Services Committee. My name is Joyce Beck, J-o-y-c-e B-e-c-k. And I'm here today as a volunteer on behalf of AARP Nebraska in support of LB823. According to the U.S. census, there are more than 1/3 of-- Nebraska's population in 2023 were 50 years or older. When asked, AARP members make it clear that their highest choice-- their highest priority when they get old is to age in place. In fact, 90% of them re-- responded that they wanted to live in their homes as long as they could. In a 2020 MM-- UNMC report, 13 of the 93 counties have no active primary care physicians. The state itself has designated all counties except for Douglas and Lancaster County as shortage areas for at least one type of primary care specialty. 58 of the 93 counties are designated shortage areas for family physicians. As a nursing home and hospital CEO for 28 years in Nebraska and in Colorado, I saw firsthand the PAs' essential role in health care delivery system. It often makes sense for a PA to take care of less complicated patients who still need constant care and ongoing monitoring and let the physicians concentrate on those with most intense needs and complications. Access barriers such as-- delay patient care, especially in rural communities and other underserved areas. Delays in that care also attribute to delays in diagnosis and treatment, which has-- leads to poor patient outcomes. In Montrose, Colorado, for example, we established that there are over 1,000 cardiac clinic appointments and follow-up appointments that were necessary to meet the needs of the area. Recruiting a PA was paramount to meeting those needs. The PA addressed the clinic needs of many patients, freeing the cardiologists up for surgical interventions. While this example comes from my experience in Colorado, similar examples could be found in Nebraska. Developing interstate compacts for health care professionals is essential to meeting Nebraska needs. At Thayer County Health Services in Hebron, Nebraska, where I was as CEO, interstate compacts are particularly important to the triage nurses providing services to patients in Nebraska as well as Kansas. This drives home the point that facilities on border towns would find the compact advantageous. Enactment of the Physician Assistant Licensure Compact would provide critical to enhancing and improving health care access to rural Nebraska and throughout the state. PAs are clinically versatile and cost-effective clinicians, extending the services of physicians' practices and improving the care delivery to underserved populations. They are an

essential component of the health care workforce. Consumers in our state need better access to high-quality primary care and preventive care. The physicians' assistants have the training and the skills necessary to provide this care, especially for older people who need to receive care in their own community. Enforcement of the physician-- or, enactment of the Physician Assistant Licensure Compact is an additional step forward to ensure Nebraskans receive the care they deserve. Thank you to Senator Blood for introducing this important legislation and for her ongoing dedication to enacting licensure compacts that assist approving access and care to all Nebraskans in their community and in locations close to home. Thank you for the opportunity to comment. And I ask that we support-- that you support and advance the bill to the floor.

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

JOYCE BECK: Thank you.

HANSEN: Seeing none. Thank you. Anybody else wishing to testify in support of LB823? All right. Seeing none. Is there anybody wishing to testify in opposition? And is there anyone wishing to testify in a neutral capacity? Welcome.

DANIEL ROSENQUIST: Thank you. Hi. Good afternoon, Chair Hansen and ment-- members of the Health and Human Services Committee. My name's Dr. Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a family medicine physician in Columbus and the immediate past president of the Nebraska Medical Association, which represents approximately 3,000 physicians, residents, and medical students across the state. The NMA appreciates Senator Blood for her work on LB823 and her efforts to reduce barriers to licensure and increase the health care workforce in Nebraska. Many of my colleagues at NMA, myself included, work closely with PAs. We value those partnerships and the role PAs play on the health care team. In Nebraska, PAs are authorized to perform medical services that are delegated by and provided under the supervision of a physician licensed in Nebraska whose own practice includes such components. Supervising physicians are responsible for ensuring that the PA's scope of practice is identified and appropriate to the PA's level of education, experience, and training. Nebraska law requires that a physician supervise no more than four physician assistants at any one time, although it does not require the physical preven-- presence of the supervising physician. The relationship between a supervising physician and a PA is documented in a collaborative agreement. One of the questions our members have raised as it relates

to the PA Compact is whether PAs who receive a privilege to practice in Nebraska via the compact will be required to maintain a collaborative agreement with a physician who is licensed in Nebraska. The NMA believes this is important not just for PAs who physically practice in Nebraska but also for those who may use the compact to provide remote telehealth services in Nebraska. While the NMA strongly supports telehealth, we have reservations about out-of-state telehealth-only providers using streamlined licensure proc-- processes to provide remote services to Nebraska patients without established patient relationships and with limited accountability. While current Nebraska law requires a supervising physician to be licensed in Nebraska, it is not clear whether rules established by the PA Licensure Compact Commission could alter that requirement for PAs who receive a privilege to practice in Nebraska through the compact. The second question that has been raised in our conversations with the Board of Medicine and Surgery is whether collaborative agreements between physicians and PAs, including those authorized to practice via the compact, should be filed with DHHS. Under current law, those must be supplied to the licensing board and DHHS upon request. But often, that is not until there's a disciplinary matter under investigation. With the PA Compact potentially bringing additional PAs into the state, physically or virtually, now seems like an appropriate time to require all supervising physicians and all PAs to submit those collaborative agreements and keep them current. This would promote accountability for physicians and for PAs and ensure that both practitioners are respons-- practicing responsibly. The NMA believes that both of these questions raised can be, can be addressed. And we appreciate Senator Blood for her willingness to entertain those discussions. Thank you for your time. I'm willing to answer any questions.

HANSEN: Thank you. Isn't it already current state law that the PA has to have a relationship with the medical doctor, right?

DANIEL ROSENQUIST: A collaborative agreement, yes.

HANSEN: A collaborative-- so I don't think the contract would change that, would it?

DANIEL ROSENQUIST: The question is, is whether that collaborative agreement within a state would be-- it-- I don't-- would it be with a physician in Nebraska who is also licensed in Nebraska? And would that phys-- what-- would we have to have the-- of accessibility, could we

access a collaborative agreement from somebody-- from a physician or PA who is practicing in another state coming into it, like telehealth?

HANSEN: --maybe it's not spelled out in--

DANIEL ROSENQUIST: Right. Just-- and we'd just like to, to have that defined.

HANSEN: OK. Because I thought-- I think the compact states that you still have to follow state rules and regulations, right? So the-- so if they come from, like, Iowa to Nebraska they-- maybe not. I don't know. I, I did-- that-- Senator Blood, I'm sure, would answer that, you know, to all of us here in an email or something, but-- about how that-- I thought they still have to follow state law. So if they came to Nebraska, they would have to have a collaborative degree with a, with a MD.

DANIEL ROSENQUIST: That was our-- that was our request for clar-- for clarification.

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

DANIEL ROSENQUIST: Thank You.

HANSEN: Anybody else wishing to testify in a neutral capacity? Welcome.

ISABEL ELIASSEN: Thank you. Chair Hansen and members of the committee. My name is Isabel Eliassen, I-s-a-b-e-l E-l-i-a-s-s-e-n. And I am here-- appearing on behalf of the Council of State Governments. Thank you for the opportunity to provide input on LB823, the Physician Assistant Licensure Compact. The Council of State Governments is a nonpartisan membership organization that serves the three branches of state government. We also provide technical assistance for states on interstate compacts, including the PA Compact. The PA Compact is an interstate compact, or contract among states, which allows PAs licensed in a compact member state to practice in other compact member states without the need for multiple licenses. Like other interstate licensure compacts, the PA Compact is designed to pr-- improve access to services, enhance mobility for practitioners, support relocating military spouses, improve continuity of care, and ensure cooperation among compact member states. The PA Compact reflects how states currently license PAs. For example, to participate in the compact, PAs must hold an unrestricted license, have no felony or misdemeanor

convict-- convictions, have graduated from an accredited PA program, and hold current certification from the Commission on Certification of Physician Assistants. PAs who meet these uniform requirements are enabled to quickly obtain a privilege. Compact member states retain control over their own scope of practice and licensure requirements. For example, any collaboration, supervision, or controlled substance prescription authority requirements that Nebraska has in place would have to be met by the PA before they can obtain a compact privilege. So to answer the question from the NMA, if there is a collaboration agreement required, that agreement would still stand. And then the additional question about, if there's an agreement-- if the agreement with-- would need to be with a Nebraska physician-- so I am not aware of the current law. But if the current law says that agreement has to be with a Nebraska phydi-- physician, then the, the PA would need to find a Nebraska physician to, you know, set up a collaborative agreement with. The compact creates a shared interstate licensure data system, allowing for near instant verification of licensure status. Through the data system, a privilege to practice can be obtained in a matter of minutes. The data, data system will also enhance public protection by ensuring that member states share investigative and disciplinary information with one another. In 2023, three states-- Delaware, Utah, and Wisconsin-- joined the compact. This year, the legislation is being considered in an additional 17 states. And just to give you guys an idea, this is pretty standard tradect-- trajectory for a compact within its first couple of years of being written. Nebraska is currently a member of nine other occupational licensure compacts. Thank you for the opportunity to deliver this informational testimony. CSG is available to assist with any questions regarding the PA Compact or compact law.

HANSEN: All right. Thank you. Are there any questions from the committee? There are none.

ISABEL ELIASSEN: OK. Thank you.

HANSEN: Thank you very much. Anybody else wishing to testify in a neutral capacity? All right. Seeing none. We-- that will end our hearing on LB823. And before we end for the day, I just want to mention that we did have some letters for the record for LB823, and that was 4 in support. And we also had some letters for the record on LB1373, the previous bill from Senator Blood: 20 in support, 12 in opposition, and 1 in the neutral capacity. So with that, that will end our hearings for today. Thank you.