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JACOBSON: All right. I think we'll go ahead and begin. Welcome to Banking, Commerce and Insurance Committee. I'm Senator Mike Jacobson from North Platte, representing the 42nd District. And I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing is your opportunity to be part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. When it's your turn to come up-- come forward to testify, give the testifier sheet to the page or to the committee clerk. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, spell your first and last name to ensure we get an accurate record. When we-- we will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally by anyone wishing to speak in a neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We will be using a three-minute light system for all testifiers. When you begin your testimony, the, the light on the table will be green. When the yellow light comes on, you will have one minute remaining. And the red light indicates you need to wrap up your final thought and stop. Questions for the committee may follow. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It is just part of the process, as senators may have bills to introduce in other committee. A final-- a few final items to fil-- facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all the committees state that written position comments on a bill to be included in the record must be submitted by 8:00 a.m. the day of the hearing. The only acceptable method of su-- transmission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person

before the committee will be included on the committee statement. I will now have the committee members with, with us today introduce themselves, starting at my left.

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

von GILLERN: Senator Brad von Gillern, Legislative District 4: west Omaha and Elkhorn.

HALLSTROM: Bob Hallstrom, Legislative District 1 in southeast Nebraska: Otoe, Johnson, Nemaha, Pawnee, and Richardson Counties.

DUNGAN: Senator George Dungan, LD 26: northeast Lincoln.

JACOBSON: Also assisting the committee today: to my right is our legal counsel, Joshua Christolear; and to my far left is your committee clerk, Natalie Schunk. Our pages for the committee are over here. I'm gonna have them stand and introduce themselves and tell you what they're doing.

TERESA WILSON: Hello. My name is Teresa Wilson. I'm a junior [INAUDIBLE] major at UNL.

JESSICA CARROLL: I'm Jessica Carroll. I am a senior political science student at UNL.

JACOBSON: Thank you. With that, we will begin today's hearing with L-- LB780. Senator Dungan, you're welcome to open.

DUNGAN: Thank you. Good afternoon, Chair Jacobson and the members of the Banking, Commerce and Insurance Committee. I'm Senator George Dungan, G-e-o-r-g-e D-u-n-g-a-n. And I represent Legislative District 26 in northeast Lincoln. Today, I'm introducing LB780, which requires health plans in Nebraska to provide meaningful coverage for the diagnosis and the treatment of eating disorders. Eating disorders are serious mental health conditions in which a person's thoughts and behaviors around food, weight, and body image become so disordered that they begin to affect physical health, emotional stability, and daily functioning. In Nebraska, this issue is not abstract. A 2023 report from the University of Nebraska Medical Center emphasized this. Approximately 9% of Nebraskans will experience an eating disorder in

their lifetime-- a rate comparable to the national prevalence. Nationally, eating disorders are responsible for approximately 10,200 deaths per year, which equates to one death every 52 minutes. Medically recognized eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder. Anorexia nervosa involves severe restriction of food intake, an inte-- an intense fear of weight gain, and a distorted body image. It can lead to dangerously low body weight, cardiac complications, bone loss, and hormonal disruption. Bulimia nervosa involves recurrent binge eating followed by compensatory behaviors such as self-induced vomiting, laxative misuse, fasting, or excessive exercise. This can result in electrolyte imbalances with serious heart issues. Binge eating disorder involves repeated episodes of binge eating without compensen-- compensatory behaviors and is associated with emotional distress, metabolic concerns, and increased cardiovascular risk. These conditions are diagnosed using criteria in the DSM of Mental Disorders and are widely recognized as complex illnesses with both psychological and physiological components. Eating disorders can affect nearly every organ system in the body and carry one of the highest mortality rates of any psychiatric condition, particularly anorexia nervosa. Beyond this clinical definition, eating disorders are also shaped by broader social and cultural pressures, including unrealistic beauty standards, weight stigma, and harmful messaging that equates worth with appearance. They impact individuals of all genders, races, body types, and socioeconomic backgrounds, yet many Nebraskans face significant barriers when trying to access appropriate and timely care. LB780 mandates coverage for nutritional counseling from licensed professionals and treatment at all recognized levels of care, including inpatient, residential, partial hospitalization, and intensive outpatient services. It prevents insurers from denying or limiting coverage based on body weight, body mass index, physical appearance, or requirement that a patient fail at a lower level of care before accessing a more intensive treatment. This is a general overview of the bill. You're gonna hear from testifiers who can speak to both the medical realities of these disorders and the lived experiences of individuals and families who have struggled to access care. I respectfully ask that you listen closely to their testimony and consider the real human impact behind the policy choices before you. Before I wrap up, I wanted to note two things. One, this bill came to my desk because I was reached out to by an individual who I

think you're going to hear from first here today. Her name is Gabriella Swift. She is Miss Teen Nebraska. She's actually a constituent of you, Senator Jacobson. Comes from North Platte but is currently a freshman at the University of Nebraska. So she reached out to me this summer and spoke to me about the importance of this issue to her. And it was something she'd been working on in her capacity as Miss Teen Nebraska to continue to provide both educational resources about eating disorders but also advocate for people getting help to those kind of things as well. So I'm very excited that she's here today, took time out of her schedule at school to come and talk to us a little bit more about that. Second, I do have to waive closing, unfortunately, because I will be leaving here shortly, but I'm happy to answer any questions I can now. But if there are any follow-up questions that people have after the hearing, I'm happy to answer those offline as well.

JACOBSON: Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Thanks for the alert that we may not get a second shot at you.

DUNGAN: I'm sure you're happy about that.

RIEPE: My question is this, within the state of Nebraska, are there inpatient providers-- Children's Nebra-- Nebraska, the Children's Hospital, at least at one time did. Are there others?

DUNGAN: I believe so. You can ask if there's any experts after me to clarify which ones currently do that. I-- part of the impetus for this-- I, I would imagine-- and this is touched on briefly in the fiscal note-- that many times care is currently covered in some capacity. Where we run into problems oftentimes-- and I've heard this anecdotally, at least-- are people who are prescribed or recommended a certain level of care by a medical professional and then insurance is refusing to reimburse that level of care. So for example, if your anorexia has gotten so bad that inpatient treatment is necessary, there are certain circumstances-- that I've heard of, at least-- where inpatient treatment's denied and outpatient treatment is approved even though the medical professional and all of those around the individual know that that's not sufficient care. So I think there are facilities that are here in Nebraska that would be able to house those folks, but

that might be a better question for any medical experts who come up after me.

RIEPE: I'll be curious too if there are any plans that cover this particular diagnoses as, as opposed to-- maybe all insurance companies. I also will be curious if you're aware of any research opportunities that individuals can participate in to reduce the cost.

DUNGAN: I--

RIEPE: I know at Children's-- and this has been a number of years ago-- we had one case that was $70,000 by the time it was done, but. [INAUDIBLE] pretty, pretty hard to overcome.

DUNGAN: Yeah. It can be very expensive for families, and that's part of what the impetus is for this, is, if you don't have the insurance coverage-- whether it's because you don't have insurance or because it's being denied-- the care that's necessary for a lot of these life-threatening illnesses is expensive. And I know we hear about that all the time. We've heard a number of bills previously, we're going to hear bills here today. I get that it's always a balancing act, but I think a lot of folks in this room probably know somebody personally that's been impacted by this. And I'm not trying to prey on sympathies, but eating disorders are very prevalent. And when they get to a point where they are threatening individuals' lives and that inpatient care is necessary, I know that it's very acute and needs to be addressed almost immediately. So the cost is one of the barriers we're trying to address here.

RIEPE: With few options.

DUNGAN: With few-- correct, yes.

RIEPE: Thank you, Chairman. Thank you.

JACOBSON: Other questions? I-- I'm just curious, so what's the success rate on treatment?

DUNGAN: That's a good question. I don't have an answer to that.

JACOBSON: Every now and then I come up with one.

DUNGAN: Yeah. And again, I think there's-- there hopefully is going to be some medical folks after me. I mean, I know that with eating disorders-- I'm not an expert. I don't want to speak out of turn. But oftentimes, these kind of illnesses aren't cured, right? You don't go in for 30 days and walk out feeling like everything's taken care of and it's never going to be a problem again. I know in a lot of these circumstances, the interplay between the psychiatric and the physiological means that you're dealing with these issues for a long period of time. And a lot of times what you learn are coping mechanisms. So to me, success I think depends on how you measure that. Certainly saving somebody's life if they're not getting the nutrients they need and they're about to die, I think that would be considered successful. But in terms of the chronic nature of these conditions, I think that, a lot of times, it takes more than just that initial stay. But I do think that there is a pretty good success rate of people who are able to access the care in terms of that lifesaving ability.

JACOBSON: Well, thank you. And thank you, by the way, for your response. Because the other day I was in the Revenue Committee and I asked a question-- to Senator von Gillern's disgust-- and, and they said, great question. And I looked at him and-- see?

von GILLERN: I approve.

JACOBSON: Thank you.

DUNGAN: Thank you.

JACOBSON: First proponent.

GABRIELLA SWIFT: Thank you.

JACOBSON: How are you today?

GABRIELLA SWIFT: Good. How are you?

JACOBSON: Great. Good to have you here.

GABRIELLA SWIFT: Yes. Chairperson and member of committee, my name is Gabriella Swift, G-a-b-r-i-e-l-l-a S-w-i-f-t. And I am Miss Nebraska's Teen 2025, a college student, and an advocate for eating disorder recovery. I am here today in support of bill LB780, requiring fair and

consistent insurance coverage for eating disorder treatment in Nebraska. I want to begin by saying that eating disorders are not choices. They are serious, life-threatening mental illnesses with one of the highest mortality rates of any psychiatric condition. And in Nebraska, this is not a small issue. According to the Harvard T.H. Chan School of Public Health STRIPED report, approximately 9% of Nebraskans-- nearly 170,000 people-- wi-- will experience an eating disorder in their lifetime. Each year, eating disorders cost Nebraska's economy an estimated $381.5 million. Of that, $138.6 million falls directly on individuals and families. Government systems bear over $104 million annually. Our health care system aborts millions more in emergency visits and hospitalizations. These costs are already happening. The question before us is not whether Nebraska pays, it is who pays and how. Right now, too many families are forced to pay out of pocket for medically necessary treatment. They fight insurance denials, they are told treatment is not medically necessary, they are limited to partial coverage, and they delay care because of cost. And when treatment is delayed, the illness is progressed. The report estimates 317 emergency roo-- room visits and 138 inpatient hospitalizations in Nebraska tied to eating disorders. Those are crisis points. Those are moments where early coverage, intervention could have changed the ter-- trajectory. Early treatment saves lives. It also reduces the need for escalation of higher levels of care. This bill is not asking for something radical. It is asking for parity. It is asking that eating disorder treatment be treated like any other serious medical condition-- covered consistently based on medical need, not insurance loopholes. As someone who has personally walked through the recovery, I can tell you that treatment is not optional. It is lifesaving. No family should have to choose between financial stability and saving their loved one's life. No young person should delay care because their insurance plan limits sessions or denies residential treatment. And no Nebraskan should suffer long-- longer because coverage is inconsistent. This bill does not create a new illness. It addresses the one that already affects thousands of our residents and costs our state hundreds of millions of dollars annually. We are already paying in family hardship and government spending in employer productivity loss and in hospital cost. This bill simply ensures that the mechanism designed to manage health care costs insurance functions as it should for this illness. Mental health care is health care. Eating disorder treatment is not cosmetic. It is not

elective. It is medically necessary and lifesaving. I respectfully ask that this committee to advance this bill so that Nebraska families can access timely, effective treatment without facing financial devastation. Thank you for your time, your leadership, and your commitment to our health of our state. I'd be happy to answer any questions.

JACOBSON: Questions from the committee? All right. Seeing none. Thank you for being here. You did a great job testifying. Your parents would be very proud, so. Thank you.

GABRIELLA SWIFT: Thank you.

JACOBSON: Next proponent.

EMILY ESTES: Hello.

JACOBSON: Hello.

EMILY ESTES: My name is Emily Estes, E-m-i-l-y E-s-t-e-s. And I'm here today in strong support of LB780. Today, February 24, marks a deeply personal milestone for me. It's the 15-year anniversary of my recovery from an eating disorder. I grew up in rural Nebraska, where access to appropriate eating disorder care was extremely limited. There were few trained providers, travel barriers, and cost was the single greatest obstacle due to lack of insurance coverage. Even when care existed, it was often financially out of reach. My eating disorder went undiagnosed for nearly two years. When I finally received proper care, much of my treatment had to be paid for out of pocket due to lack of insurance coverage. Because of delayed intervention and limited access to covered services, my condition escalated to the point that I had to leave the state of Nebraska to receive a higher level of care. On February 24 of 2011, a physician asked me a question that changed the trajectory of my life. She looked at me and asked plainly whether I wanted to live or die. Instinctually, I responded that I wanted to live. Eating disorders are not a choice, but recovery is. And the choice can-- that choice can only exist when care is accessible, timely, and affordable. Today, I'm proud to sit before you not only as somebody in long-term recovery but also as a registered dietitian specializing for over ten years in the treatment of individuals struggling with eating disorders across the Midwest. I pursued this

career because I am deeply committed to closing the gaps that nearly cost me my life. I see every day how lack of insurance coverage delays care, fragments treatment, and forces patients and family into impossible financial decisions. I also cofounded the Nebraska Eating Disorder Network, where we work to educate health care professionals and build stronger referral and support networks. What we hear consistently from patients, parents, and providers is that insurance coverage limitations remain one of the most significant barriers to recovery. Eating disorders kill. They kill mothers and fathers, sons and daughters, and, as a provider, our patients. They could kill somebody you know. Access to care through insurance coverage could have saved them because early intervention saves lives. Comprehensive, covered treatment reduces long-term health care cost. Most importantly, it gives individuals the opportunity to choose recovery before their illness becomes life-threatening. LB780 is about equity, access, and survival. It ensures that where someone lives, how much they earn, or what insurance plan they have does not determine whether or not they receive lifesaving care. I'm alive today because I was able to personally invest in the treatment needed to recover. I'm here to ask you to make accessible through insurance coverage possible for others so they don't have to wait until medi-- medical provider asks them if they want to live or die. Thank you for your time and your consideration of LB780. Be happy to answer any questions if you have them.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here. My question is this, when you discovered that you had an eating disorder, was that identified by you, your parents, or your physician?

EMILY ESTES: I would say that I personally had an awareness that I was struggling. And due to the unwillingness to talk about mental health conditions within the rural area and my own family personally, that went denied by my family, which also was an inhibiting factor of getting access to proper medical care.

RIEPE: From the time you first identified that-- self-identified that, how long was it before it came a point that you said, I have to get help?

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EMILY ESTES: Unfortunately, my journey resulted in a lot of suicidal ideation and attempts, and that is what prompted intervention--

RIEPE: Was that every year--

EMILY ESTES: --which-- so there was other mental health conditions going on. Treatment was sought for anxiety, depression, which then allowed access to talk about more of the eating disorder struggle directly.

RIEPE: OK. Thank you. Thank you for being here. Thanks for telling your story.

EMILY ESTES: Absolutely.

RIEPE: Thank you, Chairman.

JACOBSON: Other questions? All right. Seeing none. Thank you very much for your testimony. Next proponent. Hello.

WHITNEY LARSEN: Hello. How are you?

JACOBSON: Good.

WHITNEY LARSEN: Good.

JACOBSON: You can go ahead.

WHITNEY LARSEN: All right. Perfect. All right. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Whitney Larsen, spelled W-h-i-t-n-e-y L-a-r-s-e-n. And I am testifying in support of LB780. As a member of the Board of the Nebraska Academy of Nutrition and Dietetics and as the owner of a private nutrition counseling practice where I have specialized in the treatment of eating disorders for the past eight years, I appreciate the opportunity to be here today to testify in strong support of LB780, which would require health benefit plans to cover the diagnosis and treatment of eating disorders, including medical, psychological, pharmaceutical, and nutritional counseling across all levels of care. Eating disorders are complex medical and mental health conditions associated with elevated morbidity and have one of the highest mortality rates of any mental health condition. And

they often become more chronic and difficult to treat when care is delayed. Eating disorders affect all ages, genders, body types, and socioeconomic groups. National standards of care endorsed by medical and psychiatric organizations state that effective treatment requires a comprehensive, multidisciplinary approach that integrates medical management, mental health care, and specialized nutrition care provided by a registered dietitian nutritionist, which LB780 appropriately recognizes. Nutrition rehabilitation is a cornerstone of eating disorder treatment. It is not elective or adjunctive care. It is required to reverse malnutrition, stabilize medical risk, and support long-term recovery, yet insurers frequently exclude or severely limit coverage for dietitian services and eating disorder treatment. Insurers often justify denials by mischaracterizing eating disorders as behavioral issues rather than complex medical conditions. Currently, in my private practice, I routinely see the harm caused by gaps in insurance coverage. Patients are frequently denied coverage for medical nutrition therapy. And when insurers deny claims, patients are forced betwee-- to choose between financial hardship and their health. Many patients I have worked with pay out of pocket for nutrition therapy sessions, which comes at a significant personal cost. Other patients have reduced the frequency of care because sessions were unaffordable. As a result, individuals who require consistent nutritional rehabilitation may be seen infrequently, which slows progress, increases medical instability, and prolongs illness. I have also worked with patients who have depleted their savings, incurred debt, or discontinued treatment prematurely because the cost was unsustainable. This interruption in care frequently leads to relapse, extended illness, and lower full recovery rates-- outcomes that are both devastating for the patient and more costly for the health ca-- health care system over time. In addition to the testimonies you will hear today, I want to highlight the letters of support that were submitted online by many individuals working in the eating disorder field-- from individuals who have been diagnosed with eating disorders and from many licensed dietitian nutritionists across the state of Nebraska who understand the importance of comprehensive coverage for eating disorder treatment. LB780 aligns insurance coverage with established clinical standards by ensuring coverage across the full continuum of care and requiring medical necessity determinations to be conducted by providers with expertise in eating disorder treatment. Every Nebraskan deserves to have access to

medically necessary, evidence-based care without facing financial devastation. I respectfully urge you all to support LB780 and want to thank you for your time and for addressing this important issue.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. I guess my first question is, insurance companies now-- many of them pay for dietary cons-- consultations.

WHITNEY LARSEN: Yes.

RIEPE: So that's, that's a step. Do you find in doing that consultation that sometimes you will find patients that are at an early stage of eating disorders that you-- and then where, where do you refer those to?

WHITNEY LARSEN: Yeah. So that's a great question. I do see that a lot in my practice. Most of the time, I'd say patients come to me already diagnosed with an eating disorder, but it is very common to have somebody come see me just wanting normal nutrition services. And during their assessment, I will find that they do meet criteria for an eating disorder. Dietitians cannot diagnose patients with eating disorders, so I would refer them appropriately to a licensed mental health therapist or-- we do have a couple eating disorder programs in our state that I would refer them to for further--

RIEPE: So by the time that you would get them, would they be too far along that they would need potentially either very serious outpatient or very, very serious inpatient services?

WHITNEY LARSEN: Yes. That does happen frequently. A lot of times, patients don't realize the severity-- like the previous testimony, you don't realize the severity of the eating disorder until you do come in contact with a mental health professional.

RIEPE: Because you're in the business, I'd like to ask this one further question. That is, are you aware of other countries that have national health insurance, different fro-- from our country where we're very-- we continue to be fair mark-- free market because we don't necessarily want government intervention. But do other--

nationalized countries, how do they deal with eating disorders? Surely they have them.

WHITNEY LARSEN: Yeah. That is a great question. And unfortunately, I don't have an answer to that, but I am definitely going to look into that because I think that's--

RIEPE: OK. Well--

WHITNEY LARSEN: --good to know.

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

JACOBSON: Other questions? Seeing none. Thank you for your testimony. Any other proponents? Anyone else wanting to speak as a proponent? If you can make your way towards the front-- the chairs, that'd be great. Hi there.

HAILEY PIERCE: Hi. Good afternoon, Chairperson and members of the committee. My name is Hailey Pierce, spelled H-a-i-l-e-y P-i-e-r-c-e. I'm a licensed independent mental health practitioner. I'm program manager at EDCare. We operate a partial hospitalization eating disorder program. And I also serve as the president of the Nebraska Eating Disorder Network. I'm here today in support of LB780. I speak to you not only as a program manager but as a therapist. Every week, I sit across from Nebraskans whose lives are hanging in the balance, young adults whose hearts are beating so slowly they are at risk for cardiac arrest, and parents who are afraid to let their child sleep because they're unsure if their heart will beat through the night. I work with adults desperate for recovery, fighting for an illness that distorts their thinking, hijacks their biology, and convinces them that they are not sick enough to deserve help. Eating disorders are not phases or choices. They are biologically driven. They are life-threatening illnesses with one of the highest mortality rates of all psychiatric conditions. Living with an eating disorder is a relentless, all-consuming battle. For many, it begins as a way to survive unthinkable trauma or unbearable pain. These individuals are then left trapped in a life-threatening illness, needing treatment to restore not only their bodies but their minds. Clinical standards from the American Psychiatric Association and other expert bodies are clear: patients must receive care at the level that matches the

severity of their illness. Research shows that partial hospitalization programs and other higher levels of care lead to meaningful, sustainable recovery when treatment is timely and appropriate. Early intervention improves medical stability, decreases psychiatric symptoms, and allows families to breathe again. Here in Nebraska, there are clear gaps in coverage that put lives at risk. I've had to tell patients that their insurance says they are not sick enough for the level of care that I know they need. I've watched individuals deteriorate and experience medical complications simply to meet an approval threshold. Requiring patients to fail at lower levels of care delays recovery and can lead to emergency room visits, ICU admissions, and preventable suffering. Denying care mid-treatment and forcing inappropriate step-downs worsens clinical stability and can undo progress they fought so hard to achieve. From a system perspective, this makes no sense. Untreated eating disorders drive repeated hospitalizations, long-term disability, and higher health care costs. Early, level-appropriate care is both clinically sound and fiscally responsible. LB780 ensures that insurance coverage will align with established clini-- clinical guidelines and the reality of how these illnesses progress. Eating disorders affect Nebraskans of every age, gender, and socioeconomic status. No family should have to help their loved one become sicker to qualify for care. LB780 gives us the chance to intervene before collapse, before ICU admission, or irreversible harm. As a therapist, I respectfully ask you to see the faces behind this bill. This legislation ensures patients receive the care they need not only to survive but to heal. And they won't have to wait until it's too late. Thank you for your time and consideration.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here.

HAILEY PIERCE: Mm-hmm.

RIEPE: It says-- in your notes here, it says in your first paragraph, EDCare.

HAILEY PIERCE: Yeah.

RIEPE: Is that a-- is that part of a bigger system or is that--

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HAILEY PIERCE: No. So we have three locations: one in Denver, Kansas City, and Omaha. So EDCare is a privately owned eating disorder treatment facility.

RIEPE: Now-- so you're-- you have one here in Nebraska. That's Omaha.

HAILEY PIERCE: Correct, yep.

RIEPE: Do you have patients coming in from, say, Scottsbluff or--

HAILEY PIERCE: Oh, yeah. All over. We offer hotel accommodations for housing, but people often travel hours to receive treatment in Omaha.

RIEPE: Now, in a partial hospitalization program, are, are you Monday through Friday?

HAILEY PIERCE: Yeah. Monday through Friday--

RIEPE: So it's kind of a daycare-- I don't-- that's childish, but that's kind of what I think that-- it gets to be partial hospitalization.

HAILEY PIERCE: We treat adults only. So they are there for a majority of the day, but then they go home at night. So we offer nutrition services and other medical intervention.

RIEPE: Then in that, because we're talking today about insurance companies being expected to pay for this--

HAILEY PIERCE: Uh-huh.

RIEPE: --do they currently pay for any insurance coverage on an outpatient or a partial? Or is it, is it fundamentally no pay-- I mean they don't cover the diagnosis.

HAILEY PIERCE: So it just depends on the insurance policy. I would say what we see a lot in Nebraska is, is partial coverage, whether it's at the intensive outpatient level of care or the partial hospitalization level of care. I think what we struggle with most is some policies don't cover eating disorder treatment, period. Some do, but then they often have them start at a lower level than what they need and/or--

they basically deny the level of care we know they need and then the patient doesn't admit at all and get the services they need.

RIEPE: Do you have patients that have come from Medicaid or is this mostly more affluent kind of a situation that becomes--

HAILEY PIERCE: Yeah. It's not. So that's a stigma with eating disorders. They affect all socioeconomic backgrounds. I think people that receive treatment more often have more resources, so this absolutely affects Nebraskans with less resources than most in terms of accessibility.

RIEPE: --fundamentally grind it out.

HAILEY PIERCE: Can you say that one more time?

RIEPE: They have to just-- if they don't have the resources, even maybe for the better premium, they have to just rough it out.

HAILEY PIERCE: Yeah. Or die. I mean, that's how serious eating disorders can become. So it's, it's more than roughing it out. It's life-threatening.

RIEPE: OK. Thank you for your testimony. Thank you, Chairman.

JACOBSON: Other questions? Seeing none. Thank you. Next proponent.

LYDIA KATHOL: Hello. I apologize in advance for using my phone to read this off. I-- I've never done this before. Anyways, my name is Lydia Kathol, L-y-d-i-a K-a-t-h-o-l. I'm in strong favor of LB780, as I have lived the experience of being able to use my insurance to get treatment and also being denied insurance and having to pay out of pocket. It's important to know that eating disorders can and do affect people of every age, class, race, and sex. Nobody chooses to have an eating disorder, just like nobody wakes up and decides to have high blood pressure. But very seldom does insurance deny treatment to someone with high blood pressure, much less require the patient to prove that their illness necessitates treatment. A common measure of seriousness for insurance companies is BMI and weight. I've never been deemed physically sick enough by my insurance but, had I not received treatment, would have died as a result of my eating disorder's effects on mental health. I'm sure you've heard-- well, you have heard lots of

testimony about the medical complications and seriousness of eating disorders. And I could go on for hours describing how my eating disorder hurt my body. But I'm here to do-- to address the psychosocial implications of an eating disorder. Eating disorders take over every aspect of a person's life. In my case, I went from being a straight-A student with hopes for college athletics and studying medicine to struggling to graduate college and desperately fighting to make my dream of becoming a physician my reality. When your eating disorder is in control, you don't have any room in your brain for anything other than shame, sadness, and fear. Eventually, you have no energy to care about anything but the eating disorder. Your persona-- personality is gone and so is your will to live. A 2023 study by Mirien [SIC] Khan identifies that 51% of those with eating disorders consider suicide and 22% of those attempt to take their own lives. The way I see it, anything that has the ability to destroy a person's quality of life to that degree deserves to be fought and treated with the same intensity. Denying care is putting up another obstacle for future-- for the future doctors, teachers, social workers, and therapists, future parents, aunts, uncles, spouses and grandparents, and current individuals with the potential to make recovery happen. We just need the opportunities and accessibility to make them happen. Recovery is possible for everyone and is significantly more achievable with the help of a treatment team. According to Michigan Health, 20% of people who do not receive treatment will die as a direct result of their disorder. With treatment, that number drops to just 2% to 3%. I consider myself lucky to have been able to attain the treatment I needed to be able to stand here today with more hope for my future than I've ever had. Treatment is a luxury, and it doesn't have to be. Eating disorders can affect anyone, and treatment should be readi-- readily available for anyone as well. Thanks.

JACOBSON: Thank you.

LYDIA KATHOL: Uh-huh.

JACOBSON: Questions? All right. Seeing none. Thank you for your testimony. Next proponent. Don't make me choose. I would have chosen you, by the way.

MILKIAS ZERE: Thanks. I appreciate it. How's everybody today?

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JACOBSON: Good.

MILKIAS ZERE: You good? Nice. My name is Milkias Zere. That's M-i-l-k-i-a-s Z-e-r-e. And I'm speaking on behalf of the League of Women Voters of Nebraska. The League of Women Voters believe that basic level of quality health care and affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economic delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care. Today, the League of Women Voters of Nebraska believe that we're making an important step towards addressing the issue in our modern health care: the lack of insurance coverage towards those who suffer from an eating disorder. According to a 2024 John Hopkin publication, eating disorders are on the rise among children. The impact of eating disorder on an individual ranges from severe health consequences, such as multiple organ failure and brain damage, to an increased risk of suicide. Luckily, eating disorders can be treated. Therapy, monitoring, counseling, and medication have proven successful in treating eating disorders, yet those suffering from a eating disorder face an additional hurdle: insurance coverage. A 2022 survey among individuals who reported having an eating disorder found that financial barriers were the most common obstacle in receiving adequate treatment as "insurancers" denied, discouraged, and limited coverage. If adopted, this bill will help remove significant barrier by making sure that any health benefit plan provides coverage for eating disorders. LB780 would make sure that Nebraskans receive adequate treatment on their journey to recovery by providing pharmaceutical care, counseling, and services such as inpatient and outpatient treatment. LB780 would help provide the resources and tools needed to treat those suffering from a eating disorder. Lastly, I would like to share a personal story. My spouse and I have a wonderful friend who was diagnosed with an eating disorder. While we were all concerned about our friend's health, they were concerned about finding a program they could afford and provide adequate treatment in a timely manner. All of us knew that delays in treatment put our friend at serious risk for organ failure and death, and yet we waited. The emotions we felt from bewilderment to the de-- at the denial to despair at the cost are all too common when facing obstacles [INAUDIBLE] essential medical care. By luck, we were able to find an insurance policy under our

friend's parents able provide inpatient recovery for eating disorder. Without the treatment provided, our friend would have died. This bill would help ensure that all people who suffer from eating disorder get a second chance at life, to recover, to finally be allowed to enjoy the good life all Nebraskans enjoy. The League of Women Voters in Nebraska believes in the good life for everyone. Please advance LB780 to General File for for-- for full floor debate. Thank you for considering and listening to me here. I'd be happy to answer any questions as well.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here. I have one question. That is, what is your description of a-- modern health care?

MILKIAS ZERE: My description-- speaking as myself from here, not behalf of the league, is health care that makes sure everyone gets a chance to be treated for serious concerns. And as per-- the league has mentioned in our opening statements, we believe here as well that people deserve to have adequate treatment and be able to get efficient services as well.

RIEPE: Is that uniform government insurance? Is that-- or, coverage, not a, a national plan, is that what your view is?

MILKIAS ZERE: More in terms of what-- from my-- being a member of the league has been, just making sure that everybody gets the care that they need and needed and that we plug hole-- plug any gaps in our plans as well.

RIEPE: I don't mean to put words in your mouth, but that's uniform-- universal health insurance.

MILKIAS ZERE: If, if that's the description from here that I-- that works best then for you, then yes, I would say universal insurance as well.

RIEPE: OK. Thank you. Thank you for being-- thank you, Chairman.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony. Next proponent.

SANDRA LARSEN: I appreciate this committee. Thank you.

JACOBSON: Thank you.

SANDRA LARSEN: My name is Sandra Larsen, S-a-n-d-r-a L-a-r-s-e-n. I'm from Omaha, Nebraska. I happen to be a registered nurse, but I'm before your committee as a mom. My daughter got a eating disorder seven years ago when she started college. Thankfully, we had good insurance that mostly covered what she needed. But what we have seen is that when someone with an eating disorder is able to enter treatment, what happens is they recover to a certain point, and then if their BMI is at a certain level, then their treatment is put down to another-- a lower level or even stopped. Insurance won't pay anymore if they're at a certain BMI. And that does not allow for full recovery. And so the person with the eating disorder has a relapse, ends up back in treatment again, sometimes even worse. And so I just wanted to share that with this committee. I didn't come prepared to speak today, but I decided to do it. I did want to also say that there was a question earlier about inpatient treatment in Nebraska. I am not aware of any inpatient treatment in Nebraska. There's partial hospitalization here in Nebraska-- as you noted, Monday through Friday. But my daughter had to go to Tulsa, Oklahoma. Her three options when her BMI went so low that no one would treat her anymore: she could go to Tulsa or Denver or New York. Thankfully, she got in at Tulsa because that was the easiest for us to drive to in order to visit her at times. So eating disorder treatment is lacking, and insurance coverage for it is also lacking. And the decisions that are made of how insurance covers eating disorders need to be improved. It can't be stopped at a certain BMI. BMI doesn't always have everything to do with it. And our daughter almost died twice. So I wanted to share that with you and ask you respectfully to send LB780 to the floor for the whole Legislature to consider. Thank you.

JACOBSON: Wow. Thank you for being here today. And thank you for deciding to testify. That's very compelling testimony. Appreciate that. Questions from the committee? Senator von Gillern.

von GILLERN: How's your daughter doing today?

SANDRA LARSEN: OK. She's alive.

von GILLERN: Still an ongoing battle.

SANDRA LARSEN: Yes.

von GILLERN: OK. All right. Thanks for being here.

SANDRA LARSEN: Thank you.

JACOBSON: Is she back home now or--

SANDRA LARSEN: She's with me today.

JACOBSON: Oh, good. Good. Other questions? All right. Not-- again, thank you very much for being here.

SANDRA LARSEN: Thank you. Appreciate your time.

JACOBSON: I would've-- I wish I'd have picked you before the other guy [INAUDIBLE]. Other proponents?

***ANGELA CORNETT:** I am writing in support of LB780, which would require treatment coverage for those suffering from eating disorders, which can be life changing and life threatening illnesses. Thank you Senator Dungan for bringing this bill forward.

JACOBSON: All right. Seeing none. I'd ask the first opponent to step forward.

JEREMIAH BLAKEY: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Jeremiah Blakey, spelled J-e-r-e-m-i-a-h B-l-a-k-e-y. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska. I'm testifying in opposition to LB6-- LB780 as a state-mandated benefit, not in opposition to coverage of services to treat eating disorders. Blue Cross currently covers the diagnosis and treatment of eating disorders with no session limits, including the treatment that is prescribed under this bill. I wanna take a step back and explain more broadly why I consistently raise concerns about state-mandated benefits. As this committee knows, state law applies only to state-regulated hale-- health plans. That includes Medicaid, the individual market, and fully insured group health plans. But the Legislature cannot regulate ERISA plans, Medicare, or health plans

administered by agricultural organizations. If you exclude Medicaid-- which this bill does not address-- that means mandates like LB780 apply to just 19% of Nebraskans. The remaining 81% are not impacted by bills like this at all. And within that 19%, many of the plans impacted are funded by taxpayers. That includes the individual market, local governments, the state and university health plans. So when the Legislature passes a mandate, taxpayers are the ones who absorb the cost. The other group directly affected by state mandates is Nebraska-based businesses. In my role at Blue Cross, I get to meet with employers from across the state, business owners, family-run companies, and nonprofits. What I hear from them is consis-- remarkably consistent: they are at a breaking point. They simply cannot keep absorbing the rising cost of health benefits for their employees. But these small employers don't have a lobbyist. So I take the unpopular position on issues like this because I'm speaking for those businesses who cannot be here to speak for themselves. In the 109th Legislature, ten bills have been introduced to mandate different coverage requirements, but that doesn't include proposals on prior authorization reform, PBM reform, dental loss ratio, and vision plan regulation. To be clear, we already cover many of the services addressed by these bills-- including this one-- not because the law requires it but because we strive to be the champions of, of the health and well-being of our members. But mandates create two problems. First of all, they create confusion. It's common for patients to tell us that the Legislature passed a law saying that this or that must be covered only to discover that they're on an ERISA plan that the state cannot regulate. This leads to frustration, misunderstanding, and mistrust. Second, mandates reduce flexibility and increase costs. When in-- as an insurer, our responsibility is to balance the competing needs of keeping premiums affordable, offering comprehensive benefits, and pe-- providing strong networks. Mandating benefits limit our ability to respond to these pressures. I see I'm out of time, but I--

JACOBSON: All right.

JEREMIAH BLAKEY: --appreciate your--

JACOBSON: How much do you--

JEREMIAH BLAKEY: --attention.

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JACOBSON: --have left?

JEREMIAH BLAKEY: A little bit.

JACOBSON: A little bit.

JEREMIAH BLAKEY: Yeah.

JACOBSON: All right. Let's see if there's some questions.

JEREMIAH BLAKEY: OK.

JACOBSON: Anyone wish to ask him a question? Senator Bostar.

BOSTAR: I have, I have a question. But in fairness to having a question, I-- I'll start with asking you if you have anything else you'd like to add.

JEREMIAH BLAKEY: No. I-- again, I, I, I, I-- have some things I could say. What--

von GILLERN: This is the last day.

JACOBSON: Do you not understand the rule?

JEREMIAH BLAKEY: I'm anticipating the zinger, so my head is other places. What I, what I would say is that-- again, we take our responsibility to Nebraskans very seriously. And for every dollar in premium that we collect, we spend 93 cents of that in direct medical care, right? So we're doing the best we can to make do with very limited resources in order to balance all the needs that we have for our members, so. Again, I would just say affordability is a crisis. It's something that we all need to work on together. But mandates don't move us in that direction, so. Thank you for the opportunity, Senator.

BOSTAR: Thank you. So I, I want to just talk briefly about one of the points you made around the challenges that come from the fact that there are-- there's-- the difference between state-regulated insurance plans and, and federally regulated insurance plans. When we pass something and, and-- as only we can, it applies to state-regulated insurance plans.

JEREMIAH BLAKEY: Mm-hmm.

BOSTAR: Don't you then functionally give that opportunity to, let's say, large group self-insured plans that are covered under ERISA--

JEREMIAH BLAKEY: Mm-hmm.

BOSTAR: --but don't they then have the opportunity to adopt that within their plan themselves as sort of a, a, a recognition that, you know, hey, the state has passed this, state plans are required to do it. You're not required to do it, but, hey, if you'd like to, you can. Isn't-- is that-- isn't that a conversation that, you know, you have with the management of-- not you personally, but Blue Cross-- with the management of, you know, the self-insured plans that you guys cover. "Cover's" the wrong word, but you know what I'm saying.

JEREMIAH BLAKEY: Yes. Absolutely. We do have that conversation. But I would say that conversation's different with respect to every potential mandate. If you're talking about a co-pay cap on insulin injectors, the, the impact to our groups is very minimal, but the administrative benefit that we see is substantial. So we don't have to operate two concurrent systems determining what the cost sharing may be on an insulin injector. In those situations, it's very easy for an ERISA plan to adopt that with minimal impact. When you're talking about more substantive mandates to, to require benefits coverage, that becomes a different calculation because then they can start to quantify and understand what the impact would be to their group and they may choose to opt out of implementing that mandate.

BOSTAR: OK. I just-- you know, because of that federal and state separation on health insurance plans, you know, I-- for example, I would hate for the federal government to be considering covering something-- some, some level of benefit and then for the conversation to be, well, it won't be covered on the state's side then because we don't get to touch the state's side and, you know, we're over here doing the same thing and, and sort of-- with an inability then to ever move forward. I mean, I, I just think we have to-- we have to continue to push, push each other to, to keep modernizing and advancing what makes sense for health insurance.

JEREMIAH BLAKEY: The, the only thing I would add, Senator, is that-- again, this is from a completely selfish but market-competitive standpoint. Even if Blue Cross Blue Shield of Nebraska-- which only operates in Nebraska-- decides that we're going to go ahead and incorporate whatever mandate it is based on the consultation we have with our ERISA groups, those self-funded groups, that-- that's the path forward we're going to go. Other national carriers who are not headquartered in Nebraska may not take the same approach. And then when you get to the point where you're bidding on that business in an RFP process, where we've adopted benefits that a national carrier has not, we are then at that point at a na-- at a competitive disadvantage. It naturally makes our offering more expensive, and that makes it more difficult for us in the Nebraska market to compete. We don't have the opportunity to take our business to Texas or to New York or somewhere else.

BOSTAR: Sure.

JEREMIAH BLAKEY: We only operate in Nebraska. So again, it's just kind of the, the, the accumulation of all these different factors on [INAUDIBLE], so.

BOSTAR: All right. Thank you.

JEREMIAH BLAKEY: Mm-hmm.

JACOBSON: Other questions? If not, thank you for testifying.

JEREMIAH BLAKEY: Thank you.

JACOBSON: Next opponent.

ROBERT M. BELL: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell. Last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today in respectful opposition to LB780. As you know, the Nebraska Insurance Federation is the primary trade association of insurance companies operating in Nebraska, including most of the health care plans operating in the state, including Blue Cross Blue Shield of Nebraska, Medica, Nebraska Total Care/Ambetter, Aetna, UnitedHealth Group, and Cigna. We have historically opposed mandates for all the

reasons you just heard: higher cost to state-regulated plans, the fact that it doesn't apply to many plans that the Legislature can't touch, including ERISA, TriCare, which is a military plan, agri-- Medicare, and agricultural plans. And there is an ACA defrayal impact on the state. As Mr. Blakey mentioned, we believe most eating disorder "diagnosises" treatment are already likely covered under most state health plans as long as treatment is medically necessary, though per-- not, not perhaps to the level of specificity in LB780-- one of the Affordable Care Act essential health benefits covered in the benchmark plan that was selected for Nebraska over a decade and a half ago is both inpatient and outpatient behavioral and mental health coverage, under which an eating disorder would be a subcategory. So we believe this mandate is unnecessary. Since the fiscal note on this bill is quite high related to defrayal, I thought I might take a moment to explain Affordable Care Act defrayal. When the federal government passed the Affordable Care Act, it locked into place mandates in the states, including in the act the current mandates that were currently on the books. Because of the heaveral-- the heavy federal subsidies used to make ACA plans affordable, the ACA contained a provision that any new state mandate passed after 2011 would be subject to state cost defrayal, meaning the state would be responsible for the, the cost of the new mandate. Qualified health plan insurance plans would then seek reimbursement from the state for these costs. To date, I'm aware of three states that have paid or are paying for defrayal. Utah and Massachusetts both pay for applied behavioral analysis for-- to treat autism. And Minnesota pays for its PANS/PANDA treatment mandate. Just in the past couple of weeks, President Trump's administration has issued new guidance on defrayal and is pushing qualified health plans that sell in exchange [INAUDIBLE] defrayal. CMS said in part this proposal would restore previously established standards to mitigate premium increases for unsubsidized enrollees, stabilize a predictable insurance marketplace, provide clear rules for state and issuer responsibilities, and increase cost transparencies to assure that states, rather than consumers, bear the financial responsibility for additional mandates. For those reasons, we oppose the passage of LB780. I appreciate the opportunity to testify.

JACOBSON: Thank you. I'll ask a question, Mr. Bell.

ROBERT M. BELL: Mm-hmm.

JACOBSON: I, I, I appreciate you speaking about the defrayal costs because that's one thing I think this committee needs to be aware of. And PANS/PANDA is another issue before our committee that's yet to be decided. And you mentioned that it is not covered under Affordable Care Act, so there would be defrayal-- likely defrayal costs if--

ROBERT M. BELL: If the mandate passes. Now, I would say on that particular mandate, many plans are providing the coverage that is mandated. But at-- we-- this is a little bit of a gray area of law. If the state passes a mandate that some plans are already covering, can the plans that are providing that coverage go back and ask the state for defrayal? We believe the answer may be yes, but it's a little bit-- it's a little bit gray, admittedly, right now, so. And the rules are changing. Different presidents, we get different rules from the Center of Medicare and Medicaid Services. And newest rule is pushing hard for defrayal.

JACOBSON: Gotcha. We may be discussing that further, but thank you.

ROBERT M. BELL: Sure.

JACOBSON: All right. Other questions from the committee? All right. Seeing none. Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: Next opponent. Any other opponents? If not, anyone wishing to speak in the neutral capacity? All right. That's disappointing. All right. With that said, we'll-- I'll, I'll ask you to-- State Senator, I guess, Dungan did leave. So he's no-- there's-- he's waiving his close. So I will just mention that we had-- let's just see. LB780. Yes, we had 47 proponent letters, 4 opponent letters, 0 neutral, and no ADA testimony. With that, that closes our hearing on LB780. And we'll open our hearing on LB805. Senator Lon-- Lonowski. Two days in a row.

LONOWSKI: Yes, sir. Good afternoon, Chair Jacobson and members of the Banking, Commerce and Insurance Committee. Thank you for this hearing. For the record, my name is Dan Lonowski, L-o-n-o-- excuse me-- D-a-n L-o-n-o-w-s-k-i. And I represent the 33rd Legislative District. Cranial helmets, which are medically necessary for certain infants up

to one year of age, should be covered by insurance companies. LB805 was introduced because insurance coverage for medically necessary cranial helmets varies in our state. Some cover it, some don't. LB805 addresses that. Possible noncoverage disproportionately harms lower income families, transforming a recommended medical treatment into something only those with financial means can reliably access. I want to emphasize LB805 is not about cosmetics. This is for addressing the medical diagnosis provided by medical professionals to address a problem. Cranial helmets are an effective, time-sensitive, medically accepted treatment that can prevent long-term physical and developmental consequences in infants with deformational plagiocephaly and craniosystonosis [SIC]. As you are aware, deformational plagiocephaly is a skull deformity caused by external pressure-- often from necessary back-to-sleep positioning-- and has become more common since SIDS, sudden infant death syndrome, prevention campaigns have begun. Craniosystonosis involves premature fusion of skulls to-- sutures, can increase intracranial pressure, and typically requires surgery, followed by cranial ortho-- orthosis to guide normal skull and brain growth. This is widely recognized as medically necessary care. And I did hand out a, a picture there of, of plagiocephaly. Multiple payer and clinical policy summaries note that the helmet therapy leads to more significant and faster improvement in head shape than repositioning alone, particularly in infants with moderate or severe plagiocephaly. Professional guidance cites that helmets are most effective between 4 and 12 months of age. Because treatment effectiveness sharply drops off after the first year of life, lack of coverage during this brief window can permanently forfeit the chance for optimal correction, which is a medical harm, not an appeara-- not an appearance issue. Both parents and grandparents who truly care about their children or grandchildren have wri-- testified in support and are supporting LB805. They underscore the need for us to pass LB805. And I would encourage my colleagues to read the comments submitted online. Thank you, Chairman Jacobson and members of this committee for your consideration of LB805. I will be followed by a few testifiers. And I respectfully ask the committee to support this bill.

JACOBSON: Thank you. I'm, I'm-- for the note, I, I do want to note that I'm impressed that you were able to say those words.

LONOWSKI: I've been working on them, sir.

JACOBSON: All right. I-- did you work on that a little bit or--

LONOWSKI: Last night, I stayed up and studied.

JACOBSON: All right. Good. Questions from the committee? Senator Hardin.

HARDIN: You mentioned a moment ago that this is considered medically necessary care. Is that considered that way by medical professionals but not by the insurance industry? And is that where the disconnect essentially is?

LONOWSKI: I do believe that is correct, yes. And I, I will have some experts following me, but I think there is a disconnect there in, in-- between the doctors and the insurance providers.

HARDIN: OK. Thank you.

JACOBSON: Other questions? I'm guessing we're gonna hear that from the insurance people that I believe this is largely covered by a number of insurance plans but not all. And, and I think that's probably gonna be a question that will be addressed here later too, but.

LONOWSKI: Yes.

JACOBSON: Thank you for bringing the bill. And thank you for the open. Are you going to stick around for close or--

LONOWSKI: Yes, sir.

JACOBSON: All right. Thank you.

LONOWSKI: Thanks.

JACOBSON: First proponent testimony. And if you're going to speak as a proponent-- or, if you're going to speak on the bill, if you could move towards the front, that would help us in terms of next testifier.

RAKESH SRIVASTAVA: Good afternoon, Chairman Jacobson, mem-- members of the committee. My name is Rakesh Srivastava, R-a-k-e-s-h S-r-i-v-a-s-t-a-v-a. I'm a board-certified orthotist and prosthetist working for over 20 years and as, as an amputee myself for o-- over 43

years. I'm here today to support LB805, introduced by our senator, to consider and recommend coverage for cranial remolding orthosis. First, I'll just bring some-- few key points from my practice and also listening to the [INAUDIBLE] that, isn't this cosmetic? No. We are not-- we are discussing objectively measurable cranial asymmetry, not parental preference. Coverage would apply only when standardized measurements confirm moderate to severe deformity. This is structural craniofacial asymmetry during active skull growth. Cosmetic cases would not meet the criteria. Second, doesn't it resolve on its own? Mild cases often do. That's why we require at least eight weeks of failed repositioning therapy before approval. However, moderate to severe deformity frequently persist. More importantly, skull growth slows dramatically after 12 months. If we delay coverage too long, the window for effective correction closes. Denial does not eliminate cost. It shifts into permanence. Third, is the evidence strong enough? The literature consistently shows that the helmet therapy accelerates and improves correction in moderate to severe cases, especially when initiated between 4 and 12 months. Studies that [INAUDIBLE] benefit largely involves mild deformities or older infants outside the optimal treatment window. Our criteria and reco-- recommendation is-- specifically excludes those population. Is there any risk? This is a noninvasive intervention. No anesthesia, no surgery, no neurological impact. The most common adverse effect is minor skin irritation. If the risk factors are-- if not treated, they may require persistent facial asymmetry, orthodontic intervention, psychosocial impact, and repeat [INAUDIBLE]. Early structure approval is more predictable than case-by-case exceptions and prolonged appeals. We are not proposing for open-ended coverage. We are proposing tightly controlled approval, referral from pediatrician, age 4 to 12 months, objective moderate to severe measurements, documented failed conservative therapy, and craniosynostosis ruled out. This approach prevents overutilization while supporting evidence-based care. The American Academy of Pediatrics recognizes positional skull deformity as a clinical condition requiring monitoring, and, in selected cases, orthotic intervention, which is a cranial helmet. It's a FDA type 2 medical device to treat plagiocephaly condition. A clear policy reduces variability, appeals, and administrative burdens. Thank you. And I welcome your questions.

JACOBSON: Thank you. Questions? Senator Hall-- Hallstrom.

HALLSTROM: Yeah. I heard Senator Lonowski suggest that it was not considered cosmetic, but I wanted to hear it from the medical expert. That was your o-- your opinion as well?

RAKESH SRIVASTAVA: Yes, sir. And, and, and that's one of the reas-- the treatment plan is the, the kids go to their pediatrician at two months for regular follow-up checkups, and that's when they identify if the kids has a torticollis, neck tightness, or some form of deformity or asymmetry in their head shape. That's when they are referred to the therapy repositioning techniques to continue for eight weeks before they can be sent to cranial helmet clinic.

HALLSTROM: OK. Thank you. And, and I didn't hear you use the term "medically necessary," but would it be your opinion that the cranial helmets are medically necessary?

RAKESH SRIVASTAVA: Yes. They are classified as medically necessary, which is why it comes from the physician's office after those conservative treatments have failed and it's medically needed.

HALLSTROM: Thank you.

RAKESH SRIVASTAVA: Thank you.

JACOBSON: I'm, I'm, I'm just curious, what-- when you say it's medically necessary, why is it medically necessary? What-- what's happening here that, that makes it medically necessary?

RAKESH SRIVASTAVA: So-- great question. So when they go for-- like, say, just visually when you look at a kid, it's hard to say, you know, the head is flattening, they have the frontal bossing or the [INAUDIBLE]. How do we document that? And that's where we do the scan where it kind of compares the babies with their age as-- not all the babies are going to have a perfect round shape. So what is accepted and what is not accepted is outlined in those scanned reports saying that there are standard deviations, this is the basic standard mean, but the kids are plus two or minus two and this is why it's medically necessary for a cranial remolding orthosis.

JACOBSON: I'm a two-week grandfather, so I'm just-- I've got something to compare to right now. [INAUDIBLE] C-section, so I-- we're talking-- this is really a perfect head, so. Senator Hardin.

HARDIN: Can you give us an idea of the range of costs associated with treating this?

RAKESH SRIVASTAVA: So-- again, great question, Senator. The Medicaid back, like, several years ago had introduced the HCPC code, which was S1040. Unfortunately, Medicaid population does not qualify for the helmet because this is used for the [INAUDIBLE]. And-- so the pricing was not set at that time. And then later, this S1040 was evaluated by the medi-- other insurances, private insurances like Blue Cross or First Choice, and they came up with this HCPC price, which can range from $2,500 to $3,500 for the whole treatment. This treatment is-- lasts from three to four months plan.

HARDIN: And what are the repercussions if in fact this is not done during that 4 to 8-- or, 4- to 12-month window?

RAKESH SRIVASTAVA: Because as we know, the soft spot is still open when the kids are at that age. Their head growth is phenomenal during those times. And if we don't fix it, they may have a permanent asymmetry. It can also affect their jaw, some orthodontics reasons, psychosocial, as, as we know. So that can also lead into some complications.

HARDIN: Thank you.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony.

RAKESH SRIVASTAVA: Thank you. Thanks.

JACOBSON: Next proponent. Hello.

JAMES VARGO: Good afternoon, Chairman Jacobs [SIC] and the Banking, Commerce and Insurance Committee. My name is Dr. James Vargo, J-a-m-e-s V-a-r-g-o. I'm the division chief in pediatric craniofacial surgery at Children's Nebraska. In this role, I support the reconstructive needs of pediatric patients for the state of Nebraska, including comprex-- complex craniofacial malformations, cleft lip and palate, facial trauma, and reconstruction from head to toe. I also lead the plagiocephaly and head shape clinic at Children's Nebraska. Children's Nebraska is the only full-service pediatric-specific health care center in the state, serving children from nearly every county.

We are also the only multidisciplinary plagiocephaly and head shade clinic in the state and one of only one to two dozen across the country that include a team of plastic surgeons, neurosurgeons, physical therapists, and orthotists. As has been discussed, plagiocephaly is flattening and asymmetry of the infant's skull. It is seen in 20% to 40% of all infants aged three to four months, with rates dramatically increasing following the 1994 Back to Sleep campaign to place infants on their back and reduce sudden infant death. While this was very successful at reducing SIDS, this did increase plagiocephaly by 700%. Many of these cases are very mild and can be surgic-- or, medically addressed by parental repositi-- repositioning at home. However, a subset of infants do progress into the moderate to severe categories where they would benefit from a cranioorthotic device. When these are identified early, they can have significant improvement on skull symmetry. Published studies demonstrate 70% to 90% resolution of appropriately selected infants, particularly when they're treated at the appropriate time, around four to six months of age. Despite this, many insurance continue to define a-- excuse me-- a cranial helmet as cosmetic because brain growth is not impaired. As a result, families are often asked to pay up to $2,400 out of pocket. Unfortunately, in our clinic at Children's Nebraska, I meet families every month who come to see us because their child's head is misshapen, it is wider than it is long, and they're worried if they're evel-- ever be able to wear a bike helmet, a baseball helmet, a football helmet, or a hardhat. As a result of a cosmetic determination from their insurer, I'm frequently told-- I have to tell families that, unfortunately, their only option to correct the visible asymmetry in their child's skull is for them to pay $2,400 out of pocket. As you can imagine, this is devastating to many of our young families in Nebraska who can clearly see that their newborn's head is misshapen, but they are being told it's cosmetic, and I am unable to reconcile the difference. In 2025 alone, our clinic saw 724 patients with plagiocephaly and recommended helmet therapy for 466 based upon their age and appropriate severity. While denial rates have improved over time, families are still required to self-pay in a meaningful number of cases. LB805 would reduce that burden and create clear alignment between medical recommendations and insurance coverage. I also would recommend an amendment to the bill for premature infants who may require helmet therapy beyond 12 months, especially in cases of craniosynostosis, which is a surgical

condition. When ba-- patients are born early, we consider their corrected age, not their true birth age. LB805 ensures access to medically indicated care and reduces financial inequity for Nebraska families. Thank you, Senator Lonowski, for introducing this bill. And I would recommend the Banking, Commerce and Insurance Committee advance LB805. I'm happy to take any questions.

JACOBSON: Questions? I've seen that-- I really appreciate you being there and doing the work you do.

JAMES VARGO: Thank you.

JACOBSON: I, I can tell you that there's nothing more precious than a baby. And everyone wants the best for their child, and so-- you do great work. Thank you.

JAMES VARGO: Thank you very much. That-- this puts us in a tough spot.

JACOBSON: I'm sure it does. I'm sure it does.

JAMES VARGO: When-- you know, you have a medical recommendation and-- the challenge with these is everyone can see it. And the parents can see it, and they say this isn't normal. This is, this is not normal. But insurance tells you it's cosmetic.

JACOBSON: Well, thank you again for your testimony.

JAMES VARGO: Thank you.

JACOBSON: Next proponent. All right. Seeing none. Let's have the first opponent.

ROBERT M. BELL: Good afternoon again, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name's Robert M. Bell. Last name is spelled Bell, B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, the state trade association of Nebraska insurance companies. I'm here again in respectful opposition to LB805. Not going to reiterate things I said last time, but know the limited application of a mandate and the defrayal potential impact of LB805. We believe that infant cranial helmets are most likely covered under most plans as long as medically necessary. One of the ACA essential be-- health benefits is durable

medical equipment. Infant cranial helmets fall in this category, and plans provide coverage when a helmet is medically necessary, though it appears sometimes there are disputes, as you heard, on the medical necessity of a helmet versus cosmetic use. So I thought I might take a quick moment to explain how dispute resolution works for state-regulated medical insurance. If there is an adverse determination from the health insurer, the medical provider and the consumer can file an appeal with the insurer to take a second look. This is governed by existing law called the Health Carrier Grievance Procedure Act. If that coverage is still denied, then the medical provider and consumer can file an appeal through the Nebraska Department of Insurance and have a determination reviewed by an independent review organization in a process called external review under the Health Carrier External Review Act, which is also in state law. On infant cranial helmets, I did check with the Department of Insurance, and they have received one external review in the last couple of years related to this. Notably, it was overturned, so. We-- I, I-- one note. And I-- you know, I wonder about this when we talk about out of pocket-- and I heard out of pocket mentioned a lot. So I have an ACA plan-- or, a, a, a plan that you can buy on the ACA. My, my wife works for a small employer. They use something called ICHRA. ICHRA is the Individual Coverage Health Reimbursement Arrangement. So the employer provides a little bit of reimbursement to the employee. And then we make that purchase on the marketplace. That-- cost of that ICHRA is $36,000 annually for our family of five. Our deductible is-- for an individual is $6,000. The max out of pocket for an individual is $10,300. For the family, it's a $12,000 deductible, with a $21,200 max out of pocket for a-- this would be a bronze level HSA-eligible plan. So we have a health savings account that we can go in-- the cost of these helmets, as you heard, while can be significant, fall well under the out of pocket. Certainly in some situations, if there's surgery involved, other things like that, there would be probably no more out of pocket. But anyway, just wanted to provide a little perspective related to that. Appreciate the opportunity to testify.

JACOBSON: Thank you. Thanks for the testimony. Questions? Senator Hardin.

HARDIN: So that $22,000 out of pocket, that was a part of the Affordable Care Act, is that correct?

ROBERT M. BELL: Well, I, I think last time I did this, Affordable-- yeah. So--

HARDIN: Appreciate it. Thank you.

ROBERT M. BELL: And it's not. We know right now, in Nebraska, we thi-- well, we don't know. We think 8,000 Nebraskans dropped their ACA plans because they can't afford it, right, in this last year.

HARDIN: --a bronze plan, if I'm not mistaken.

ROBERT M. BELL: It-- say that again. I'm sorry, Senator.

HARDIN: You have a bronze plan.

ROBERT M. BELL: I have a bronze plan. So the numbers this year-- the first look at open enrollment, we believe we're down 8,000 enrollees. They're-- they may have joined other plans. We know enhanced COVID subsidies that were in place went away, and so Nebraskans are making the choice to go bare without insurance right now because of affordability, so. I hope--

JACOBSON: Which shifts the cost to the--

ROBERT M. BELL: It does. It shifts the cost to the health care providers, and it--

JACOBSON: Hospi-- hospitals.

ROBERT M. BELL: And hospitals. In particular, it puts their own property at risk for medical debt. There's, there's a lot of consequences on it, but, I mean, it's a lot of money--

JACOBSON: It is a lot of money.

ROBERT M. BELL: --so.

JACOBSON: Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: Question-- other questions? Senator Riepe, you're out of questions?

RIEPE: Momentarily.

JACOBSON: All right. All right.

ROBERT M. BELL: He's waiting for Mr. Blakey, I'm sure.

JACOBSON: Thank you for your testimony. Next opponent.

JEREMIAH BLAKEY: Good afternoon again, Chairman Jacobson and members of the committee. My name is Jeremiah Blakey, spelled J-e-r-e-m-i-a-h B-l-a-k-e-y. The government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska. And I am testifying in opposition to LB805 as a state-mandated benefit, not in opposition to coverage of infant cranial helmets themselves. In fact, all of our health plans have included coverage for these devices since at least 2015. Our medical policy explicitly recognizes that infant cranial helmets can help reshape the skull and accommodate brain growth and improve head shape. These helmets are FDA approved and considered effective. For these reasons, we fully support the use of i-- infant cranial helmets when they are medically necessary. As with other mandated benefit bills, our opposition to LB805 is rooted in a consistent principle, that health plan ef-- health plan benefit design should follow clinical evidence and remain flexible enough to adapt to the standards of care that evolve while also being mindful of how these decisions impact the overall cost of insurance. Blue Cross regularly reviews and updates our medical policies to reflect current clinical standards, emerging research, and organizational needs. A medical review committee-- which includes external physicians from the community-- evaluates new evidence and determines whether policy changes are warranted. If or when the standard of care for infant cranial helmets changes, it's far easier to update our benefits through this established process than to reconcile those changes with the fixed state mandate that may not align with the most current evidence. So with that, I want to thank you for your time. And I'd be happy to answer any questions you may have.

JACOBSON: Thank you. Questions? If not, thank you. Appreciate the--

JEREMIAH BLAKEY: Thank you.

JACOBSON: --clarification. All right. Any other opponents? Anyone wishing to speak in a neutral capacity? If not, Senator Lonowski, you're welcome to come up and close. And I would note for the record that there were 16 proponent letters, 3 opponent letters, 0 neutral letters, and zero ADA.

LONOWSKI: Thank you, Chairman. I would like to thank Mr. Blakey for testifying online and in person. I, I want to point out a few things. So I, I guess the argument is we're covering these things already but we don't want you to tell the ones who don't cover it to not cover it. But it's not an issue with us because we're covering it. And, and so I was a little bit-- mystified I guess would be a good word. I really want to thank Dr. Rakesh Srivastava. And I have heard through Hastings people that he has covered a few of these out of his own pocket over time. So it's, it's not like the effort's not there for these, for these doctors to, to help out. And I also would like to, to thank the efforts of, of Dr. James Vargo. And I welcome the suggestion of his amendment, that if you have to extend slightly over a year or whatever for a cranial helmet that we can amend that. I respectfully ask the committee to support LB805. And I thank the committee's consideration for advancing LB805 to General File.

JACOBSON: Couple of points, I guess. For the record, Senator Blakey only testified in person. He did not-- or, Mi-- or, Mr. Blakey-- yeah-- did not testify-- he just testified in person. He didn't testify--

LONOWSKI: He's not online?

JACOBSON: No.

LONOWSKI: OK.

JACOBSON: And the other thing, I'd maybe just note that-- I've been around this a while. The-- I think the concern on the mandated coverage is that mandates are pretty ex-- specific and they script what you will cover. And so if you're covering something more than that or slightly different from that, you have to change how you handle your coverage. So I think that's what he's speaking to. But yes, it does-- by mandating, it does pick up those who aren't covering it at all. And so they're in-- tha-- I-- that's maybe reconciled to

maybe why he's-- has some concerns on that, but. Are there any qui-- que-- ques-- questions for the committee? I would say that I think you and I would agree that there's no greater gift than the gift of a child. And I know our vie-- values align there very clearly. And it's really heart-wrenching to watch parents dealing with problems with their infant child. And the greatest gift in the world is the gift of a child.

LONOWSKI: Amen, Senator Jacobson.

JACOBSON: So, so thank you.

LONOWSKI: All right. Thank you.

JACOBSON: And that concludes our testimony on LB-- our hearing on LB805. And we'll move to LB1142 and Senator Hardin. You haven't completely cleared the room, so I guess they're, they're here for you. You're welcome to open, Se-- go ahead.

HARDIN: Thank you, Chairman Jacobson. And good afternoon, fellow senators of the Banking, Commerce and Insurance Committee. I'm Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n. And I represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. Today, I'm introducing LB1142. The purpose of the bill is to return administration of the Nebraska Visitors Development Act to the Department of Economic Development. In 1980, the Unicameral passed the Nebraska Visitors Development Act. It created a fund for the general promotion of travel and tourism and tasked the Nebraska Department of Economic Development, DED, with administering it. For 32 years, DED oversaw Nebraska's statewide tourism promotion programs and activities. In 2012, the state enacted LB1053 to create the Nebraska Tourism Commission as an agency independent from the Nebraska Department of Economic Development. Since then, the commission has spearheaded the state's tourism promotion. My intent for introducing LB1142 returning tourism promotion responsibilities to DED is threefold. First, to align Nebraska's tourism campaigns and the state's talent and business recruitment campaigns. A few years ago, our state was sending contradictory messages. DED was recruiting professionals and businesses to Nebraska through the Good Life is Calling initiative. At the same time, Nebraska tourism was telling people that, honestly,

Nebraska is not for everyone, also known as the "Nebraska is Not Quite as Bad as Chronic Halitosis" campaign. These marketing strategies did not mesh well at all. While clashing with DED's messaging, the tourism campaign also had the effect of alienating many of our state's greatest ambassadors: Nebraskans. We take pride in being welcoming to everyone, in being a state where opportunity abounds for anyone with the character and determination to make the most of it. LB1142 would make sure the state is speaking with one voice going forward-- a voice that resonates with Nebraskans. My second reason for introducing LB1142 is to better integrate tourism into the state's overarching people-attraction strategy. Tourism is the front door to growing Nebraska and our economy. It's our state's first hello or handshake, our chance to make an initial impression, and the most powerful tool we have for talent recruitment. When we market our state's culture, our outdoor recreation and our vibrant towns, we aren't just selling hotel rooms. We're selling a lifestyle: the good life. If our tourism marketing tells a story of innovation, beauty, and community, we make the job of recruiting businesses and talent easier. As tourists experience in Nebraska, we have opportunities to invite them to become residents. Housing tourism within DED would help us to see and seize these opportunities. It would ensure that the state is looking at tourism through a talent-attraction lens. The third reason I support moving tourism back to DED is that it would result in greater efficiency and effectiveness. With December data still outstanding, Nebraska state lodging collections were on a track to grow less than 1% in 2025. In my district, county lodging tax collections were trending down, more than 9.25% in 2025. To me, that's a red flag in a region with such tremendous tourism assets. The historic Oregon and Mormon Trails and Pony Express run through District 48-- about one mile south of my house. Our region offers stunning natural scenery for hikers and bikers such as the Scotts Bluff National Monument and the Wildcat Hills. Annual events like the Old West Balloon Fest in Mitchell and Oregon Trail Days in Gering are big draws. We're home to diverse wildlife, ranging from bighorn sheep to antelope, deer, elk, pheasants, turkeys. We boast great places for boating and fishing like Lake Minatare and Oliver Lake. We simply have to do a better job of marketing the assets. I know DED would be committed to facilitating tourism within Nebraska and should be the agency entrusted with its promotion. I look forward to the conversation we're going to have today around our state's third-largest industry. Maureen Larsen,

interim DED director, will be following me to testify. And she's a mean attorney, so I encourage you to save your specific and difficult questions for her. However, if you have any softball questions, gently toss them my way.

JACOBSON: All right. Questions? Senator Hallstrom.

HALLSTROM: I just thought from your description of wildlife that a novel thought might be "Nebraska: where the deer and the antelope play."

HARDIN: That could be a good one. Thank you for that suggestion.

HALLSTROM: I think Senator Jacobson has already proposed a interim study or legislative resolution. Is this something that can wait until after we've had that process go through to do some further analytics?

HARDIN: Sometimes such legislative resolutions can be a lovely feature that we can all participate in. How is that for a political answer--

HALLSTROM: Thank you.

HARDIN: --Senator Hallstrom?

JACOBSON: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I have to ask the question. What is this doing in the Banking, Commerce and Insurance Committee?

HARDIN: I think it's, it's some sort of meaningful revenge because you and I have had to deal with really strange things in HHS.

RIEPE: I suppose. Is there any opportunity for us to return this to Referencing?

HARDIN: My sense is that it's 3:02, and so probably not.

RIEPE: Well, I wasn't thinking today.

HARDIN: Oh, OK.

RIEPE: I-- that's why God made electricity, so they could work after dark, but.

HARDIN: In, in HHS, we've dealt with a strange variety of housing bills this year, so anyway.

JACOBSON: I, I would note that, being on the Referencing Committee--

RIEPE: Oh, yeah. Let's blame you.

HARDIN: Oh, yes.

JACOBSON: --that DED is under the purview of this committee. So if we're bri-- moving something to DED, it would be under the re-- purview of this community.

HARDIN: Perhaps it's the commerce part.

RIEPE: But that's a little bit of a reverse look at it because of the committee's accountability, you know.

JACOBSON: You wanted a answer, and that-- that's what I would say the answer is.

RIEPE: OK.

JACOBSON: I do have a couple questions. So the-- we did make-- this-- there was a bill two years ago to merge-- to do just what you're proposing now. And instead of merging, there was a compromise, which was to add two members of DED to the board of the Tourism Commission in an attempt to coordinate any mismessaging. And I'm just curious whether that has been, I guess, embraced by DED to the point where they participated in those meetings and that collaboration to have a single message moving forward.

HARDIN: I think that's a great question that Ms. Larsen will be able to address. I, I would say this, the Nebraska: It's Not For Everyone campaign was a while ago. The people who perpetrated that crime against humanity are no longer in control, as I understand. But there was also an unfortunate dropped ball where they followed that with something that was a much better effort that they never actually even released. And so that basically spoke some volume about, wait a minute, do you even know what you're doing? And so that came during that, that, that break after that for a couple of years. And to be clear, they recently have brought me a wonderful, little thumb drive

of some new efforts that they're, they're undergoing now that are better than what I've seen in the past. But I think that Ms. Larsen will be able to address some of that--

JACOBSON: And how long ha-- ma-- has Ms. Larsen served in this capacity?

HARDIN: Probably, I'm guessing, since about May.

JACOBSON: OK. And how many DED directors have we had in the last five years?

HARDIN: Probably five. I'm, I'm just saying. It's, it's been--

JACOBSON: So is consistency--

HARDIN: It's--

JACOBSON: --maybe an issue as well.

HARDIN: I think we've had four during that period of time.

JACOBSON: OK. All right. Thank you. Other questions? If not, thank you for your open. I'd ask for the first proponent testimony. Hello. Go ahead.

MAUREEN LARSEN: Hello. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Maureen Larsen, spelled M-a-u-r-e-e-n L-a-r-s-e-n. And I am the director of the Nebraska Department of Economic Development, or DED. In that capacity, I am also a statutory member of the Nebraska Tourism Commission. I'm here today to testify in support of LB1142, which would return responsibility for statewide tourism promotion to the Department of Economic Development. I want to thank Senator Hardin for introducing the bill on behalf of the department, and I want to highlight three wa-- reasons why I think this legislation is critically important. Tourism marketing is a critical instrument for economic growth and development. Nebraska has an abundance of magnificent qualities and assets, and we need to do a better job of marketing these qualities and assets to attract and retain talent and businesses. DED is already investing in tourism projects, and this legislation will allow the department to more effectively and

efficiently market Nebraska utilizing its current resources. As you may know, Nebraska has an urgent need to retract-- to attract and retain talent. The fight against brain drain is intensifying and it's real. In order to grow Nebraska, we need an energized and focused strategy. In today's world, economic development is increasingly tied to talent recruitment. Nebraska is open for business. We have abundant career opportunities. The challenge is we're generating great careers faster than we can fill them, and tourism marketing is the best tool we have to make Nebraska a magnet for talent. Tourism, tourism marketing creates the lifestyle pull that attracts high-value workers. It builds local pride and reminds residents why they love where they live. And it, it establishes the state as a vibrant, happening place for investment. That's busineth growth-- business growth. We sometimes treat business recruitment like a dry spreadsheet of tax incentives and utility costs, but site selectors and CEOs are human. When a company looks to relocate, they ask, can I get my top talent to move here? If our state is perceived as a flyover or boring or a joke, the answer is no, regardless of what tax incentives we can provide. Tourism marketing builds the brand that makes the state a competitive des-- destination for both businesses and workforce. Currently, the Nebraska Tourism Commission targets its marketing efforts towards out-of-state visitors in only key markets. In-state marketing is discouraged. It's seen as taking money from one pocket and pull-- putting it in another. I think that's a flawed strategy. Familiarity breeds a strange kind of blindness. Residents don't realize what their state has to offer or they treat their state like a some-day project. They tell themselves, I'll visit that park eventually, but they never actually go there, because it will always be there. Also, it ignores the ambassador effect. People that are proud of their state and know what their state can offer are the best marketing team you can have. The Department of Economic Development is already supporting tourism through our Good Life is Calling campaign and several federal and state grant programs. For example, I handed out a packet of approximately 150 projects across the state, totaling over $268 million in tourism-funded projects with the Department of Economic Development within the fast-- past five years. I'm happy to work with the commission, the committee, and stakeholders to identify a path forward. I'm grateful to Governor Pillen and the Legislature for making a priority to recruit talent to Nebraska, given the incredibly strong link between tourism marketing and talent attraction. I urge

the Legislature to better align these activities by consolidating them in a single agency through LB1142. This time, I'd be happy to answer any questions you might have.

JACOBSON: Questions from the committee? I've-- so you've been on the job for less than a year.

MAUREEN LARSEN: Seven months.

JACOBSON: Seven months. And you're going to take over, really, the responsibility for recruitment of businesses to come to Nebraska.

MAUREEN LARSEN: We currently are responsible for--

JACOBSON: Right.

MAUREEN LARSEN: --recruiting businesses.

JACOBSON: You're taking that over.

MAUREEN LARSEN: Yes.

JACOBSON: OK. And, and that in itself is a big pull. Then you've got-- you want to take over tourism on top of that. You've still got a fairly-- you're still learning who, who do you have for people, what their expertise is. What's your, what's your background in attracting tourism?

MAUREEN LARSEN: I'll tell you that, with 11-- LB1142, we would be as an agency absorbing those that would like to continue working for the Tourism Commission, coming over and using their expertise and their experience.

JACOBSON: So they do have expertise that are there today.

MAUREEN LARSEN: They have-- they know their, their market, some of it, yes. The problem is, is they're identifying key markets that are outside of the state. The key markets that the $3.5 million that was spent this summer is focusing on is Chicago, Milwaukee, St. Louis, Madison, Oklahoma. You don't see the ads that are spent-- taxpayer money spent on in Nebraska. I think that is a flawed strategy. I would-- yes, I would change the focus of the marketing and I would

change the message of the marketing and I would also make it-- to market to Nebraskans also. So the--

JACOBSON: And, and why should we believe that your strategy is the right one?

MAUREEN LARSEN: Because I think that the strategy that's been going on for the-- since 2012 is not working. I think it's been--

JACOBSON: So anything else would be, would be successful.

MAUREEN LARSEN: I think that if you look at the tourism numbers, if you look at the occupancy tax, there are some counties that are doing well. The counties that are doing well have their own tourism marketing departments. I think that the state tourism has to do better. We must do better. We must market the great things Nebraska has. I do not think we've been doing a good job.

JACOBSON: I, I hear you. I, I guess I'm just trying to see the proof, is what I'm looking for.

MAUREEN LARSEN: So we have been doing our own Good Life is Calling campaign. The Good Life is Calling campaign is currently funded with philanthropy dollars. We're doing our own tourism marketing to make it align with our business and talent recruitment and retention. We are using our Good Life is Calling. We're marketing the great things. When we go out and we try to recruit businesses, we try-- we all-- we go out and we try to recruit talent. We need that positive message. So we have created our own Good Life is Calling message to have that. We can't have a "it's not for everyone" or "Nebraska: it's unflat" or whatever the message is that Nebraska is a joke. You can't--

JACOBSON: But, but you're on the Tourism Commission.

MAUREEN LARSEN: I am on the Tourism Commission.

JACOBSON: Have you shared that opinion with them and steered them in that direction?

MAUREEN LARSEN: I have-- yes. I have. I've met with--

JACOBSON: So you've attended all their meetings and shared this with them.

MAUREEN LARSEN: I've gone to one out of three meetings. It was the only one's that I was able--

JACOBSON: You missed two of them.

MAUREEN LARSEN: I missed two meetings. One I was out in Chadron at a tourism event and the other one I was in Lincoln at another tourism event. I have shared these issues with the commission, yes. And to answer your question about the marketing and about the ad campaign, the entire commission has never shown the ad marketing because then it would be a public record, that's my understanding. So the actual marketing I did not see until very recently.

JACOBSON: So how would you do that at DED?

MAUREEN LARSEN: How would I do that at DED? I would be incredibly transparent. DED funded a survey. We used a company called DCI. That DCI, they gave us benchmarks. They gave us recommendations. We would use those recommendations that are strategic and data driven to market Nebraska to the right markets, including Nebraskans, in a positive way. I would use that study, I would use the recommendations, and I would follow through on those. That's currently what we're doing, but we're doing it independently with philanthropic dollars. And we're competing with the Tourism Commission's negative message, as it has been historically.

JACOBSON: OK. So-- and there-- and, and, and the fact that they just hired a director doesn't have any impact on what you think their future would hold.

MAUREEN LARSEN: I don't think it does. Again, I was in the subcommittee and I attended those meetings. I was present with the interview. I did recommend as a commissioner that we hold and we wait until after your interim study and after the legislative session to actually go ahead and hire that executive director. I didn't think that it was fair to do that just knowing things might change-- not just based on this legislation, also based on your interim study. I would probably recommend some structural changes that would go on as

part of your interim study. But we don't-- we're not there yet. We haven't seen what your study's going to show.

JACOBSON: And there was no intent to put the commi-- to put the commission on hold for the interim study. It was that they should hire a director. I was surprised they hadn't hired a director, but I understood the holdup was DED on approving the director hire.

MAUREEN LARSEN: No. The director was hired without DED. DED had one vote on the commission.

JACOBSON: And, and you voted for hiring a director?

MAUREEN LARSEN: I was not able to make that meeting. It was put together very quickly. I was at another tourism event. But yes, I did make my-- and you can-- Mr. Fudge and I have spoken many times. He was aware of my recommendations. He was aware. But it's fine. She was hired, and we will--

JACOBSON: Thank you.

MAUREEN LARSEN: --move forward. You're welcome.

JACOBSON: Other questions? Senator von Gillern.

von GILLERN: Yeah. Thank you. I wanted to-- would that new director come over and be a part of the, the structure under DED? The-- your-- is that-- I mean, is that a-- is that part of-- as this comes over-- you, you said people from tourism will come over and be part of DED.

MAUREEN LARSEN: I would, I would hope that-- yes. Part-- the bill would have the commission-- the people that work for the commission-- as the bill is written, the commission members, the commissioners make a recommendation to the director of DED in order to hire a director.

von GILLERN: OK. OK. All right.

MAUREEN LARSEN: It's very hard to run an agency run by a commission with people that also have full-time jobs, so that-- why it's written that way.

von GILLERN: All right. And, and just-- maybe there's a question in here, but maybe a comment. I'm no-- I'm not sure we can do it any more poorly than we've been doing it. So if it comes over, great. I'm, I'm o-- I'm optimistic that, that things will get better because I-- again, I-- when, when people ask me why, why can't-- why is-- does South Dakota have so many advantages over Nebraska in tourism? And, and my answer is, I don't know. I, I don't know. We can grow pheasants like they can. We can grow deer like they can. We can grow better corn. We can do all these things better than South Dakota, but for some reason they completely kick our butts in tourism.

MAUREEN LARSEN: I agree.

von GILLERN: And, and, you know-- I mean-- I've, I've seen the Corn Palace. It ain't much. It ain't worth getting off the highway. You know-- and some of the things that Senator Hardin described in his dris-- district are absolutely worth taking a seven-hour drive from here to go see, so. I, I, I am energized to do something different than what we've been doing and encourage that maybe this will-- you know, with the strategy that you bring to it and the data-driven decision-making that, that we can do something better than we've been doing it. I, I do think that the-- and, and the brain drain thing, as you know, is something that I'm very sensitive to and, and the attraction-- I'll, I'll take care of the incentive side, the de-- the-- as you called it, dry data spreadsheets. That's fine. I'll take care of that. You take care of the softer side and get the people here to come fill the jobs. And, and I think selling them on our state through, through the tourism is, is-- has to be an essential part of that, so.

MAUREEN LARSEN: If that's a question, I want to say I 100% agree. And we have to compete. We must compete-- not just for the workforce, for the tourists and to also keep our workforce here.

von GILLERN: I'd be embarrassed to tell you the age that I was or am when I saw some of the coolest things in Nebraska. So that's, that's shame on me, so. Thank you.

JACOBSON: Other questions? All right. Seeing none. Thank you. Next proponent. All right. Seeing none. How about first opponent? How are you?

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KERRI REMPP: Good. How are you?

JACOBSON: Good.

KERRI REMPP: Chairman Jacobson and members of the Banking, Insurance and Finance Committee. My name is Kerri Rempp, K-e-r-r-i R-e-m-p-p. I am the director of tourism for Discover Northwest Nebraska, representing Dawes and Sioux Counties, the current president of the Nebraska Travel Association, and the immediate past president of the Western Nebraska Tourism Coalition. As mentioned before today, tourism is the third-largest industry in Nebraska. In many rural areas, it ranks number two behind agriculture. Visitors to Nebraska generate $4 billion in economic impact as they spend money in restaurants, attractions, hotels, gas stations, and other businesses. Since the Nebraska Tourism Commission was established as an independent agency in 2012, as proposed by Senator LeRoy Louden and signed into law by Governor Heineman, Nebraska's tourism industry has grown more than 35% due to more focused promotional efforts. When comparing gross domestic product for accommodation, food services, arts and entertainment, and recreation sectors, Nebraska ranks sixth in the nation, according to the Bureau of Economic Analysis. In fact, Nebraska exceeded the nation's growth rate in those sectors by nearly two percentage points in 2023-24. In addition, the structure of an independent tourism commission ensures that voices from across the state are represented, as each commissioner is responsible to the citizens who live within their district. As a resident of Nebraska who lives nearly as far from Lincoln as you can get and still be in this state, I trust more the-- my commissioner to bring our voice to Lincoln than a bureaucrat with no experience living and working in outstate Nebraska. Prior to 2012, western Nebraska was rarely highlighted in the state's tourism promotion. Marketing focused heavily on Lincoln and Omaha. The creation of the Tourism Commission representing the entire state created a more cohesive strategy and highlights all regions of Nebraska. Most local and regional tourism organizations cannot afford to purchase advertising in larger markets. The Tourism Commission's promotional efforts to raise Nebraska awareness as a destination is an important function to gain attention of out-of-state visitors that are beyond our reach locally. Once a visitor has expressed interest in Nebraska, those smaller agencies can and do use their marketing dollars to entice them to the specific location. The industry is not opposed to collaboration. As Senator Jacobson mentioned, a bill was

previously introduced similar to this. It was the Travel Association's proposal to expand the Tourism Commission and ask DED and the State Chamber to serve on that board. There are many places where the mission of DED and the Tourism Commission can overlap, and that collaboration is the smart thing to do. But the Tourism Commission and the industry experts understand the unique world that is tourism marketing. Not every missi-- I'm almost done-- not every mission or message overlaps, and L-- LB1142 risks diluting the vacation destination messaging. Thank you for your time.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none. Thank you. Next pro-- or, opponent. Hello.

DEB LOSEKE: Hello. Good afternoon, Senator Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Deb Loseke, L-o-s-e-k-e. Today, I'm talking with you as an opponent to LB1142. Being involved in Nebraska's tourisndus-- tourism industry for over 20 years, I was the director of the Columbus Convention of Visitors Bureau for 14 years and currently serve as the treasurer of the Nebraska Lincoln Highway Historic Byway. I served as a Travel and Tourism Division Advisory Committee member. And when Nebraska Tourism became a standalone commission in 2012 at the passing of LB1053, I served a commissioner until May 2025, representing des-- District 6 in eastern Nebraska. I served a chair for two years, past chair, treasurer, and on several committees. I collaborated with Governor Ricketts in the appointment of commissioners to districts in 2017 as the result of the passage of LB222. I agree with Ms. Rempp's previous testimony that tourism is critical to rural Nebraska. The Tourism Commission's role is crucial in key areas like producing quality ad campaigns based on research and market potential, conducting media tours, offering tourism grant opportunities, collecting and measuring visitor travel impacts, and educating and collaborating with communities to maximize the visitor experience. As a CVB director, I relied on these opportunities and helping my community grow as a destination. Prior to 2012, tourism was a division of economic development. There was an advisory committee, but there were no regulations on who served on the committee. This committee had no authority over decisions or actions regarding tourism activities or to hire, reprimand, fire the tourism director. There was no accountability to the industry about financials, marketing campaigns, or legislative actions. This lack of communication and transparency

created deep mistrust throughout the industry. It is crucial for this industry to remain a standalone agency. In fiscal year 2024-25, Nebraska tourism economy has shown measurable growth, with lodging tax collections totaling over $8.2 million, representing a 6.7% year-over-year increase. Since 2022, Nebraska tourism has excelled. Director is held accountable for transparency, communication, and making positive decisions that increases the, the industry. The tourism staff is professional and excels in collaborating with industry partners that rely on its continued success. With the consistency in Nebraska tourism's priorities, staff, commissioners, and direction, tourism will continue to grow. And I would be happy to answer any question the committee may have at this time. Thank you.

JACOBSON: Questions from the committee? I-- I'm curious, so Passport Nebraska, how successful has that program been?

DEB LOSEKE: It is a very successful program. It has increased passport participation every year. The creation of the passport program was basically created for residents of Nebraska. And even though-- and I do not have those numbers-- we actually have people from out of state participate. But the main goal of that passport program-- it was created a long time ago-- was to get Nebraskans to experience what there is to see in the state. There is an online-- on the website, there's a passport where people can report stories, post pictures. And it's great to see Nebraskans enjoying Nebraska.

JACOBSON: Thank you. Any other questions? If not, thank you for your testimony. And I'd ask for the next opponent.

DEB LOSEKE: Thank you.

RICH OTTO: Chairman Jacobson, members of the committee, my name is Rich Otto, R-i-c-h O-t-t-o. And I'm here today to testify on behalf of the Nebraska Hospitality Association in opposition to LB1142. Hotel members collect and remit lodging tax that fund nearly 90% of the Tourism Commission budget, and our goal is see-- to see those dollars spent as efficiently as possible. With that respect, I believe we are in agreement with Senator Hardin and we want continued results. Again, the first two testifiers have touched on the brief history. The commission was basically under DED up into-- up until 2012. It was the Travel and Tourism Division of the Department of Economic Development.

So we've had nearly 15 years. And the previous testifiers touched on the improvements we've made. Our association hopes the commission can continue to improve and we can continue to move up the ranks as far as places to visit from out-of-state visitors. I believe prior to 2012, we're typically, like, 48th to 50th. Since then, we have done better. I believe 41st is the best we've been since, which is a big improvement. But again, there's always room to improve. And we think that is definitely possible with continued collaboration. I think you hit on it, Senator Jacobson. Senator McDonnell did introduce this bill two years ago. The result of that was DED and the commission should be talking more. We should-- they should be collaborating better, where a synergy could be-- one and one could equal three as far as getting visitors to the state. And so again, those two positions were added to the board. We have both the State Chamber and the DED. So now that gets us up to 13. I just passed out the map briefly for you to look at so that you do understand we have representation from across the state. I think that is essential from the commission, that Lincoln and Omaha don't just be the only places that we encourage people to travel to, that it is across the state. The one other thing I want to plug-- and I'm probably the only testifier that'll do this-- is that the hotel industry is bearing a lot of this cost. This is 1% of, of lodging taxes. Your local county can do another 4%. The city of Omaha has another 5.5-- 5.5% occupation tax, which is per-- predominantly to pay for the new stadium for the College World Series. And then we also pay state sales tax of 5.5% and local option sales tax. So in Omaha, you can get up to 18% and even over 20% in the Blackstone District. The only reason I say that is we are funding the tourism industry. We just need to see those dollars used efficiently to make further progress. Happy to answer any questions.

JACOBSON: So with heavy reliance on occupation tax collected by the hoteliers, they're obviously a big influence on the various territories out here because they want tourists to come to their hotels--

RICH OTTO: Absolutely.

JACOBSON: --and visit their part of the state, and I presume that's a big part of the reason for the territories and the reputa-- representation across the state on, on collaboration as to how do we get people there.

RICH OTTO: Yeah. So that was one of the fundamental changes. Lincoln and Omaha, again, have-- well, Omaha has the additional occupation tax, and then the 4% max is the county. So they do a nice job in the counties with that additional funding. I think the bigger goal was, hey, this 1% could help a lot of these counties. A lot of rural counties have not imposed the additional 4% that it may be-- so you could go to some hotel in western Nebraska where you may only have sales tax and the 1% state lodging tax. But we still want to encourage people to visit all portions of the state. We know western Nebraska needs visitors probably more than Lincoln and Omaha do. They still typically fly into Lincoln, Omaha, Grand Island, some maybe in North Platte for regional, but just getting them to visit any portion of the state really brings dollars to all of our metro.

JACOBSON: Just curious, what do you think was the reason-- the predominant reason for separating the two back in 2012?

RICH OTTO: Well, Senator Louden was from District 49. And at that time, before redistricting, was a western district. It's now Senator Andersen's district but near where Senator Hardin was. And my understanding from going through the transcripts is he wanted western Nebraska to get a better, better piece of the pie from tourism and get more dollars spent on Lake McConaughy, Chadron, you name it, that they were being underserved as far as how are we promoting those great parts of the state to visit.

JACOBSON: Thank you. Other questions? Seeing none. Thank you for your testimony. Next opponent. Anyone else wishing to speak as a-- in opposition? If not, any neutral testifiers? All right. Seeing none. Senator Hardin, you're welcome to come back and close. There were 0 proponent letters, 8 opponent letters, 1 neutral letter, and no ADA.

HARDIN: The good news is that we agree tourism matters and-- so it re-- matters to rural Nebraska, matters to eastern Nebraska as well. And we all want stronger results. Question is, how do we get there? And so along with many business considerations is avoiding marketing malpractice at any point along that journey. So it's interesting that counties that are doing well, generally speaking, are also taking advantage of that 4%. And so you need to take advantage of all the tools in your toolkit. And so simply, you know, en-- encouraging all of the counties to, to do that is a meaningful thing because there

truly are beautiful parts in all of them. In, in all truth, I've not been to all of them. I think I've been to 90 of them in Nebraska. And there are gorgeous parts of all of it and great people to go with it. And so I think that there's simply a, a matter of shining a light on a tepid history. And I think it's good that there's an LR that's coming out. But at about the same time that that LR came out was this bill. And so I, I think that's what we're looking at, is to say, what's the best way to make sure that the blueprint from the Department of Economic Development aligns and that we're not pulling in opposite directions at the same time? And that's counterproductive one to the other. And so I, I think that's kind of at the heart of what this is about, is, how can we maximize those dollars, not make them less? But frankly, let's work at making them more, but let's also invest them better.

JACOBSON: Thank you. Questions from the committee? I, I guess I just have one that, if the reason for pulling it apart before was probably the lack of representation on-- focus on western Nebraska, with this map and the representatives on the commission today, how would you envision something like that working if it were put under DED?

HARDIN: I think as Ms. Larsen said before, really, it's to, to enfold a lot of those people who are already a part of that commission so that, that last piece that I talked about doesn't happen, where in fact we're pulling in opposite directions. It's really to align both efforts so that we're not doing something counterproductive.

JACOBSON: Do, do you think they'd have a voice?

HARDIN: I-- oh, yes. I do.

JACOBSON: OK. I, I, I see a lot of org charts and then I find that there's a lot of top-down decisions being made on a lot of agencies and-- code agencies in particular, and I think that's part of wha-- what was happening before. And-- so you worry about, does history repeat itself? So I'm, I'm looking forward to the LR. I, I think this is a good precursor for everyone to kind of understand where everybody's coming from. And I would concur with you. I came into the LR with an open mind that, that we need to do better and-- but we got to do it together. We got to work together. We can't work against each

other. So with that, that concludes our hearing on LB1142. Thank you for bringing the bill.

HARDIN: Thanks.

JACOBSON: And let's move on to LB971. And Senator Guereca. Have you been here yet the-- this year?

GUERECA: Yeah. [INAUDIBLE] electronic tags.

JACOBSON: That's exactly right.

GUERECA: You guys have a wide range of topics. Electronic tags, tourism.

JACOBSON: [INAUDIBLE] you come here.

GUERECA: This is the fun one.

JACOBSON: That's right.

GUERECA: Gosh. I'm missing out.

JACOBSON: We're the variety show.

GUERECA: What's that?

JACOBSON: We're the variety show.

GUERECA: Right?

JACOBSON: It's all yours. Go ahead and open.

GUERECA: Excellent. Good afternoon, colleagues, Chairman Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Dunixi Guereca, D-u-n-i-x-i G-u-e-r-e-c-a. And I represent the communities of downtown and south Omaha. I'm here to introduce LB971, which requires insurance coverage for maintenance and rescue inhalers. Inhalers are used for the management of asthma and chronic obstructive pulmonary disorder, or COPD. They help to prevent and/or relieve symptoms such as wheezing, breathlessness, and coughing. Most individuals will need both a maintenance inhaler and a rescue inhaler. Asthma is a chronic-- is a common chronic respiratory disease that

causes inflammation, swelling, and narrowing of the airways and the lungs, making it difficult to breathe. While there is no cure, it is managed through medication, avoiding triggers, and treatment plans. One of the most common management tools is an inhaler. LB971 wou-- would require that patient who need these lifesaving maintenance and rescue devices have them covered by insurance. A maintenance inhaler is used everyday to prevent symptoms while a rescue inhaler is used as needed to relieve symptoms quickly. Maintenance inhalers reduce airway inflammation and prevent attacks while rescue inhalers provide immediate relief during acute episodes. Coverage for both supports effective self-management and reduces emergency department visits and hospitalization and improves the quality of life for people living with asthma. Now, the amendment I handed out, AM2184, would specify that children under the age of 12 received a metered-dose inhaler. A metered-dose inhaler is a specific type of inhaler that is used-- that uses a pressurized canister to release a precise, measured spray of the aerosolized medication. AM2184 also specifies that if a spacer or holding chamber is necessary, that will also be covered. A spacer is a plastic tube-like holding chamber that is attached to a metered-dose inhaler, an MDI, to help prevent medication-- to help medication reach the lung more effectively. It slows down the spray, reduces medicine build-up in the mouth and throat, and eliminates the need to perfect timing between pressing the inhaler and breathing. AM971 with AM2184 provides patients with the tools they need to live happy and healthy lives. I understand that the insurance lobby will be against any new mandates-- I'm sure we'll hear from them today-- but I'm asking you, colleagues, to consider the reality here. Asthma disproportionately aff-- impacts children, low-income families, and community exposed to environmental triggers. Ensuring access to essential inhalers is crucial for advancing health equity and supporting evidence-based management of chronic diseases. By prioritizing preventative care, this bill will reduce the need for expensive acute treatment and promore-- promote a more efficient health care system. With that, I'm happy to take any questions.

HALLSTROM: Thank you, Senator Guereca. Senator Riepe.

RIEPE: Thank you, Chairman. What's the average cost of a asthma maintenance unit?

GUERECA: So there'll be some folks behind me, experts in, in, in the medical field that'll be able to get you those precise numbers.

RIEPE: I just want to make sure that we don't try to necessarily have-- or, can ever afford first-dollar coverage on every product. That's, that's my concern.

GUERECA: Well, that's a fair concern. And if, if my testifiers don't get you that number, I'll make sure to find it.

RIEPE: I'll catch you afterwards.

GUERECA: Yeah.

RIEPE: OK.

GUERECA: No doubt about that.

RIEPE: Yeah. OK. Thank you.

HALLSTROM: You can run, but you can't hide.

GUERECA: Yeah, right?

HALLSTROM: Any other questions by the committee? If not, I trust you'll stay for closing.

GUERECA: I will.

HALLSTROM: OK. Thank you, Senator.

GUERECA: Thank you, Senator.

HALLSTROM: Next testifier in support of LB971.

CASEY BURG: Good afternoon, Vice Chair Hallstrom, members of the Banking, Commerce and Insurance Committee. My name's Dr. Casey Burg, C-a-s-e-y B-u-r-g. And I'm the division chief of pulmonology at the Children's Nebraska and-- testifying in support of LB971. Children's Nebraska is the only full-service pediatric specialty health center in the state, serving children from nearly every county through our 279-bed hospital and behavioral health unit in Omaha, as well as pediatric specialty and primary care clinics throughout Nebraska and

neighboring states. Asthma is the leading chronic disease among children in Nebraska. At Children's, we see firsthand differences between a child who's thriving in school and a child who's in our emergency department due to lack of consistent, affordable access to their prescribed inhalers. Just last week, I was at a-- I saw a two-year-old in our rural community. His family was driving to Kearney-- which was not considered rural to them. And they had to-- just to save $20 on an inhaler. Their inhaler typically would cost at their local pharmacy $60, and so they were traveling to Kearney to try to get it for $40. In an attempt to try to decrease their doses even more, they halved their prescribed dose, taking it once a day instead of twice a, twice a day. The result was a pretty preventable medical catastrophe. This toddler ended up spending three days in the hospital on IV steroids, oxygen, and around-the-clock breathing treatments. The child's life was at risk because his parents couldn't bridge that $20 gap. Furthermore, because he hadn't met their deductible, there was-- charge an additional $60 for a, for a spacer. It's just that plastic tube that Dr. Guereca mentioned. For little kids, it's definitely necessary to have that to, to allow them to get that medicine into the lungs where it's supposed to go. And then he also needed a $40 rescue inhaler. So all of these things start building up. The case isn't an outlier. For many of my patient families, this situation results in shifting the cost from a $40 inhaler to a much more costly hospital stay. LB971 focuses on providing access to maintenance and rescue inhalers. However, for a pediatric patient, especially those under 12, simply having an inhaler isn't enough. Most children use a metered-dose inhaler, which requires a spacer to hold the mist in a chamber, allowing the child to take five or six normal breaths to ensure the medicine reaches the small airways of the lungs. Many patients often receive a denial for the prescribed inhaler from their insurance company because the plan only covers dry powder inhalers, which little kids can't do. In some cases, that is the only option for the formulary, which does not work for children. Research indicates that high adherence to controller medications reduce the risk of emergency department visits by nearly 50%. For a child under 12, an asthma flare-up isn't a scary moment. It's a primary driver for school absenteeism and can lead to worsened health out-- conditions. Thank you, Senator Guereca, for introducing this bill and for the-- ensuring that pediatric asthma patient needs are included. We urge the Banking,

Commerce and Insurance Committee to advance LB971. Be happy to answer any questions.

HALLSTROM: Thank you, sir. Any questions? Senator Riepe.

RIEPE: Thank you, Chairman. So you're telling me the cost, which I inquired about, is between $40 and $60, probably.

CASEY BURG: With insurance. If you don't have insurance, it can reach $200 or more for those inhalers.

RIEPE: It can be $100 or more?

CASEY BURG: $200 or more.

RIEPE: If you don't have insurance. OK. Thank you.

HALLSTROM: Senator Jacobson, I'll transfer--

JACOBSON: All right. Thank you. Thank you for your testimony. We're on proponents or-- next proponent.

MICHEAL DWYER: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r. And I appreciate the opportunity to testify in support of LB971. I want to thank Senator Guereca for introducing this important legislation, legislation. I'm a 42-year veteran of volunteer fire and EMS with a resume of nearly 2,800 calls. And I have a long history of asthma. I'm also the author of the fifth version of the Future of EMS in Nebraska, of which I believe all your offices have digital copies. I'm also the co-chair of the Nebraska EMS Task Force. However, my testimony today is my own and not on behalf of the task force. Many years ago, when I was a young pup in EMS, I delivered a patient who had some difficulty breathing to one of our local hospitals. When I casually explained their history, symptoms, and what I had done so far, the receiving doc scolded my casual presentation, explaining, quote, Micheal, difficulty breathing patients are one of the few medical emergencies we see here, and they deserve your critical attention. I've never forgotten that. Less than-- and I would en-- encourage the committee to remember that as well. LB971 seeks to require insurance coverage for one med-- maintenance inhaler and one rescue inhaler. As an EMT and as a responder who has treated hundreds

of difficulty breathing patients, availing themselves of a rescue inhaler is-- like EMS-- it is essential and, in my opinion, should not be constrained by a lack of insurance. I believe LB971 is well-written, narrow enough to accomplish its intent, and I would encourage the Banking, Commerce and Insurance Committee to advance LB971 to the full Legislature. I would, as long as I have a little time, would reiterate-- a couple of the testifiers have talked about kids. And I think everybody in the committee and everybody in the room knows that kids are really tough. And we-- when you're treating a child who can't breathe, it's intense. And if I can't get it [INAUDIBLE] into their system very, very quickly, particularly if they haven't had a-- already had a breathing treatment, it's really tough. So for that reason and all the ones I stated, I would encourage the committee to advance the bill. And I'd be happy to take any and all questions.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. So let's run the scenario here that we require the insurance companies to include it. And then, to get an affordable plan, one needs to take a $7,000, $5,000 deductible. How does that square?

MICHEAL DWYER: I, I don't, I don't want to be trite, but, for me, that's easy. If it's a guy like me in the back of a rescue squad trying to save a kid's life, particularly in that world, money's no object. I know that's trite and doesn't necessarily answer your question, but I would reiterate what I said, that, particularly when we're talking about kids in their health, I as a provider and a clinician think we have a responsibility to do everything we can to protect that kid. I-- again, I know that doesn't answer your question, but.

RIEPE: No. Well, no, but it-- I think it has merit. And thank you very much.

MICHEAL DWYER: Thank you.

RIEPE: Thank you, Chairman.

*Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony
Rough Draft

JACOBSON: Other questions? Seeing none. Thank you for your testimony. Any other proponent testimony?

***ANGELA CORNETT:** I support LB971 to require insurance coverage for rescue and maintenance asthma inhalers, which can be life saving treatments.

JACOBSON: Seeing none. How about opponent testimony?

JEREMIAH BLAKEY: Chairman Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Jeremiah Blakey, spelled J-e-r-e-m-i-a-h B-l-a-k-e-y. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska. I'm testifying in opposition to LB971 as a state-mandated benefit, not in opposition to coverage of rescue and maintenance inhalers. Blue Cross currently offers these inhalers through a prescription drug benefit. LB971 prohibits the application of cost sharing to one type of each inhaler, which would result in a small fiscal impact to plan sponsors if LB971 is enacted. Out of respect for the committee's time, I'm not gonna repeat many of the points I made previously, but I would like to add, of the 19% of Nebraskans who are impacted by state mandates, the impact on LB971 would actually be smaller because the cost-sharing limitation does not apply to high-deductible health plans, which are a popular coverage option in Nebraska. And again, I ha-- I haven't seen the amendment, so I'm not familiar with the details of that, but I think that does go to highlight that as the standard of care evolves and the products on the market evolves. When we have state mandates on the books, it makes it more difficult for us to adjust to those evolving standards of care and products. And so again, for the reasons I've outlined previously, we would oppose the bill, so. Thank you. Happy to answer any questions you have.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none. Thank you.

JEREMIAH BLAKEY: Thank you.

JACOBSON: Next opponent.

ROBERT M. BELL: Hello again, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Robert M. Bell.

Last name is spelled B-e-l-l. I am the executive director and registered lo-- lobbyist for the Nebraska Insurance Federation. Again, I'm here in respectful opposition to LB971. Kind of the same as Mr. Blakey. I'm not going to go over things I've already reiterated to the issues with all mandates, but this is a interesting bill because it has really two sections. It has one section that eliminates cost sharing for the one form of rescue and one form of maintenance inhaler unless the plan is a high-deductible plan as defined by the IRS. You know, those plans utilize health savings accounts, which cannot utilize a tax advantage unless they have a high de-- deductible plan, meaning the consumer usually pays first dollar for most of the claims until the deductible is reached. I think I mentioned on my previous testimony, I have a high-deductible plan, so-- and we utilize our HSA to pretty much pay for most of our medical services, but however, it does allow preventive care in the savings clause related to the HSA if the rescue inhaler is determined to be preventive. It, it-- you could perhaps not charge cost sharing along those. Many state-regulated health plans already have very low cost sharing for asthma inhalers. UnitedHealth Group is just one example. They offer zero co-pays for a variety of preventive drugs used for cardiovascular disease, diabetes, asthma, prenatal care. Inhalers would fall under that. And a-- one other thing I just want to point out really fast. If you ever really want to dive deep into rebates and Congress and Medicaid and how it all works and the games that can be played by various actors in the pharmaceutical chain, the withdraw of name-brand drugs and the marketing of generic drugs to avoid having certain rebate actions happen by Congress can be an enlightening read, if you like. I'm not going to go into any kind of great detail on that right now, but we know those games have been played in the, in the inhaler manufacturer community. So with that, we respectfully oppose LB971 as a state-mandated benda-- mandate. Thank you very much.

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

ROBERT M. BELL: You're welcome.

JACOBSON: Any other opponents? Anyone wishing to speak in a neutral capacity? All right. Seeing none. Senator Guereca, you're welcome to come up for your close. I-- oh, he's-- what's his deal, huh? So, so then he'll waive the-- his close, then we'll go to-- there were 7 oppo-- proponent letters, 3 opponent letters, and 0 neutral, zero ADA.

So with that, that concludes our hearing on LB971. We'll then move on to LB1069 and Senator Dover. That'll be your show.

DOVER: Yeah. Good afternoon, Chairman Jacobson. And good afternoon, committee members. My name is Robert Dover, R-o-b-e-r-t D-o-v-e-r. I represent District 19, which consists of Madison County and the southern half of Pierce County. LB1069 establishes a clear eligible expectation for state-funded emergency medical service grants administered by the Department of Health and Human Services. The bill pro-- provides that EMS providers seeking state grant assistance certify that they maintain and implement billing practices that pursue reimbursable-- re-- excuse me-- reimbursement from available public, private third-party payers when appropriate. The intent is straightforward: to ensure that limited state EMS grant dollars are used as supplement to other available funding sources and are awarded in a consistent and responsible manner. Since introduction, we have worked with the Department of Health and Human Services, and before you today is a white copy amendment reflecting the-- that collaboration. DHHS raised concerns-- just one second. Sorry. DHHS raised concerns regarding the interaction of LB1069 with federal grants distributed under the Rural Health Transformation Program. The amendment addresses those concerns by clarifying that grant funds originating from the federal Centers of Medicare-- Medicare-- excuse me-- Medicare and Medicaid Services for Rural Health Transformation Program are excluded from the billing certification requirement contained in the bill. This adjustment ensures that LB1069 accomplishes its core objective of responsible state grant administration while avoiding unintended impacts on distribution of Rural Health Transformation Act funding. Additionally, I would like to address the concern brought in neutral comments by the Hospital Association over the access to billing services and the burden and strain that would place on volunteer EMS service providers. We asked this question to many EMS leaders across the state-- some who even serve in this body-- and we learned that billing services are widely available to do and do not carry a significant financial burden. I've heard stories where our smaller rural EMS providers stated this was not a reason for not billing. Then once, then once they started, they realized it wasn't hard. It didn't create a burden, and now they are being compensated for the vital work that they do. The advancement in technology and access to billing services and competition in the

industry, in my opinion, has nearly eliminated this type of excuse. So I'd be happy to answer any questions committee may have and believe DHHS is here to speak further to [INAUDIBLE]. And actually-- don't hold me to the numbers, but was talking to Senator Dorn and he-- obviously, volunteer fire-- and they were looking at doing their own billing and they were billing $150 when they would go out and come back and they weren't being reimbursed. And then hired someone who billed $450, and then they got reimbursed. And then they bought an ambulance and didn't have to any fundraising. So we just want to make sure that EMS is out getting what money they can before they come to the state and ask for additional funds.

JACOBSON: So the moral of the story is charge a lot.

DOVER: That's what the government says.

JACOBSON: All right. Thank you.

DOVER: Thank you.

JACOBSON: Questions from committee? All right. I-- I'm losing my committee, but thank you for your testimony.

DOVER: [INAUDIBLE] myself, so.

JACOBSON: I hear you. I hear you. All right. I'll ask for the first proponent to step forward. Oh, can I take over? All right.

MICHEAL DWYER: Please. [INAUDIBLE] that other guy. OK. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name again is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r. And I appreciate the opportunity to testify in support of LB1069. Thank you, Senator Dover, for bringing this important legislation that is a critical piece of the future of emergency medical services in Nebraska. For the record, I'm a 42-year veteran of volunteer fire and EMS with a resume of nearly 2,800 calls, the author of the fifth version of the Future of EMS Nebraska report. I'm also co-chair of the Nebraska EM Task Force. However, my testimony today is my own and not on behalf of the task force. Much of my time in EMS was spent as an officer, and, in that role, I was responsible for billing. So I've lived the concerns you may hear about a volunteer's time. However, currently, that process can be largely automated and doesn't require

nearly the time that it might have taken years ago. In my opinion, LB1069 is not intended to force volunteers to bill but to encourage everyone serving in EMS to acknowledge that we must find fair and legitimate ways to draw money into the EMS system if we are continue-- going to continue to provide excellent pre-hospital care in Nebraska, particularly in rural Nebraska. The opportunity that the new federal Rural Transformation Program presents is incredible, but we as a community-- as a community-- must embrace old and new ideas to create a system-- that you don't have-- that serves rural Nebraska's-- Nebraskans and is sustainable. Asking patients-- including patients that are taxpayers-- along with insurance partners and local, state, and federal medical services is-- e-- emergency medical services-- a critically important piece of that sustainability. And by the way, we will not receive any of the RHTP funding unless we can prove sustainability by October 31. I believe LB1069 is well-written, narrow enough to accomplish its intent, and relatively easy to int-- implement by the 20-- 15% to 25% of EMS agencies that currently do not bill for their services. I would encourage you to pass LB1069. And I would be happy to take any questions.

JACOBSON: Questions from the committee? All right. Seeing none. Thank you.

MICHEAL DWYER: Thank you.

JACOBSON: I'd ask for the next proponent. Senator Wordekemper, welcome.

WORDEKEMPER: Thank you.

JACOBSON: Probably didn't get a lot of the opening, but. We'll figure it out.

WORDEKEMPER: I'll be up to speed.

GENE BRADLEY: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Gene Bradley, G-e-n-e B-r-a-d-l-e-y. And I appreciate the opportunity to testify in support of LB1069. Thank you, Senator Dover, for bringing this important legislation that is so critical to the future of EMS in Nebraska. I'm a 44-year veteran paramedic that has spent the majority

of my career in super rural ambulance services. I recently retired as an EMS chief and was immediately recruited to be the director of Emergency Services for Community Medical Center in Falls City, Nebraska. There I managed the EMS transfer service along with the ER. I have been here since 2024, and I'm a member of the Nebraska's EMS Task Force. We worked hard to try to come up with solutions in various ways to support this very essential service of emergency medical services in Nebraska. And I'm speaking today on behalf of Community Medical Center. I have spent over 25 years in the ambulance administration in various roles. And in those roles, I've been responsible for overseeing the revenue cycle/billing for those services. Billing for ambulance care can be very complicated and frustrating process, but it's the lifeblood of every ambulance service. Emergency medical services, being a very essential service, must have financial sustainability to complete the mission. The majority of ambulance services' payer mix is Medicare and Medicaid. Every Medicare and Medicaid patient we provide care for has a benefit to pay for that service. Every ambulance service, whether volunteer, paid, municipality, county, or hospital run, needs to be doing their due diligence to collect every dollar possible for providing the high level of care we provide to the citizens of Nebraska. The LB1069 does not require every ambulance service to bill, but it highly encourages them to bill for their services. If we are to continue to deliver a high level of care, every service needs to be doing their part to address sustainability and plan for the future. Medicare determines the usual and customary fee schedule based off the number of ambulance runs for an area and divides that by the dollars spent. Every service that does not bill for services rendered hurts those services that are billing by lowering the cost of reimbursement. The federal health transformation is an opportunity to present incredible advances in rural EMS and health care in Nebraska. It can provide high-level EMS care in rural Nebraska. Technology has changed how I provide care to my patients over the years, and that technology comes with a cost. With the advent of telehealth, televisits in the back of an ambulance on I-80 in western Nebraska, the opportunities are endless. I can consult a trauma surgeon from the back of an ambulance with a trauma patient 200 miles from Lincoln or Omaha. And that patient benefits from the advice and evaluation of the trauma surgeon. I believe LB1069 has a detailed focus to be able to accomplish this. Its intent is relatively easy to implement with the 15% to 25% of EMS services that

currently do not bill for services. I encourage you to advance LB1069 to the full Legislature. I would welcome any questions.

JACOBSON: Thank you. Questions? All right. Seeing none. Thank you.

GENE BRADLEY: Thank you.

JACOBSON: Any other proponents? All right. Seeing none. How many-- is there anyone who-- wishing to speak as opponent? All right. Seeing none. Any neutral testifiers? State Health Director. Wow. Welcome to the Banking, Commerce and Insurance Committee.

TIMOTHY TESMER: Thank you. I don't think I've had the privilege of being here before. Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Dr. Timothy Tesmer, T-i-m-o-t-h-y T-e-s-m-e-r. And I am the Chief Medical Officer of the State of Nebraska. Working within the Division of Public Health and the Department of Health and Human Services, DHHS, I'm here to testify in a neutral capacity for LB1069. As originally written, the department has two concerns with LB1069. First, the language requires an emergency care provider to bill insurance. DHHS recommends changing this requirement to an emergency medical service. Additionally, the Rural Health Transformation Program, RHTP, includes proposed activities that target emergency medical services in Nebraska. RHTP is a once-in-a-generation opportunity to modernize rural health care and make it more sustainable. Therefore, the department recommends a carve-out for RHTP grant funding from this bill. We appreciate that Senator Dover has worked with us to address these concerns in his amendment. And we respectfully request that if the committee advances the bill to General File it does so with the proposed amendment language. Thank you for your time. I would be happy to answer any questions related to this bill.

JACOBSON: Questions from the committee? Senator Hallstrom.

HALLSTROM: And the amendment addresses both of those concerns?

TIMOTHY TESMER: Yes, sir.

HALLSTROM: Thank you.

TIMOTHY TESMER: Mm-hmm.

JACOBSON: Other questions? If not, Dr. Tesmer, I really-- I want to formally thank you for the job you've done in your role.

TIMOTHY TESMER: Thank you.

JACOBSON: We're, we're glad to have you here. You're a true professional.

TIMOTHY TESMER: Thank you.

JACOBSON: Thank you. Thank you for your testimony. Any other neutral testimony? All right. Seeing none. That will-- I'll-- we-- I'll ask for-- [INAUDIBLE]. We've got a missing in action.

__________: I am sorry. He was opening after Guereca. And--

JACOBSON: All right. All right. Well, we're gonna-- we'll-- that's, that's fine. We have 0 proponent letters, 0 opponent letters, 1 neutral letter, no ADA letters. So with that, that will conclude our hearing on LB1069. And we'll move on to LB1222. We're seeing a lot of you.

PROKOP: Two days in a row, I'll tell you what.

JACOBSON: Welcome to open.

PROKOP: OK. Well, thank you, Chairman Jacobson and, and members of the Banking, Commerce and Insurance Committee, my favorite committee to, to come visit. My name is Jason Prokop, spelled J-a-s-o-n P-r-o-k-o-p. And I'm-- have the privilege of representing Legislative District 27, which is in west Lincoln, Lancaster County. Today, I'm here to share information about LB1222, which seeks to ensure that Nebraskans living with Alzheimer's disease have equitable access to disease-- disease-modifying treatments and avoid de-- detrimental delays in treatment access. Currently, there are over 35,000 Nebraskans living with Alzheimer's disease and over 41,000 caregivers providing over 63 million hours of unpaid care to-- estimated cost-- for, for an estimated cost of $1.5 billion. By increasing treatment accessibility, we will be able to allow those living with Alzheimer's disease to stay at home longer, stay more independent, reduce the burden on caregivers, and lessen the overall economic impact that Alzheimer's disease has on Nebraska. LB1222 would require the state-- will require

state-regulated private insurance companies to provide the same level of coverage that Nebraskans currently receive on Medicaid and requires a prohibition of step therapa-- step therapy for both private insurance and Medicaid. The elimination of step therapy is critical because in order for a person living with Alzheimer's disease to be eligible for disease-modifying treatments, they must receive a diagnosis while in the early stages of the disease. Due to this critical window for treatment eligibility, it is important that we prohibit step therapy for these treatments. Increased access to treatment will lower the Medicaid long-term care cost to the state. Treatment allows those living with Alzheimer's disease to stay at home longer and reduces cognitive decline that can greatly affect pre-existing conditions, which 77% of Nebraskans wi-- living with Alzheimer's disease have. Not only does this reduce the demand for Medicaid beds in long-term care facilities but also will lower the number of Alzheimer's disease-related emergency room visits. In addition, LB1222 also addresses access to medically necessary brain injury services, including cognitive rehabilitation. Every year, thousands of Nebraskans experience an acquired brain injury from falls, motor vehicle crashes, strokes, infections, or lack of oxygen. While many survive the initial injury, they often face lasting cognitive, behavioral, and emotional challenges that affect memory, attention, and decision-making. These effects are often invisible but life-altering. Cognitive rehabilitation is, is an evidence-based treatment that helps individuals rebuild thinking skills and regain independence. However, insurance coverage is often inconsistent or prematurely limited. LB1222 ensures that medically necessary, evidence-based brain injury services are covered and that treatment decisions are based on medical necessity and established clinical guidelines, not arbitrary insurance restrictions. Concerns about costs have been raised in other states, yet mandated benefit reviews consistently show that impact on insurance premiums is minimal-- generally well under 1%. At the same time, access to appropriate-- excuse me-- access to appropriate rehabilitation produces long-term savings by reducing dependence on Medicaid, nursing homes, and other publicly funded services. In other words, covering appropriate therapy now is far less expensive than supporting a preventable, lo-- lifelong disability. The slow progression of Alzheimer's disease allows for families to have more time to create long-term care plans, prepare financially for potential placement in a long-term care community, and

caregivers can stay in the workforce longer, access to cogniv-- and access to cognive rehabilita-- rehabilitation similarly promotes independence, employment, and community partition for individuals recovering from bai-- brain injury. I thank the committee for your time and attention on this bill. And I'd be happy to answer any questions.

JACOBSON: Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. I think my alarm goes off when I look at the fiscal note. That's a tough one. I'm also concerned about-- there's a lot of discussion, as you well know, on Alzheimer's, dementia diagnoses and the value of it and the dangers of early evaluation, which can result in brain bleeds and other-- so it's unsettled science. Do you have a response to that?

PROKOP: Yeah. I mean, on, on, on the latter part of your question-- so I-- there is someone that'll be testifying behind me from Alzheimer's Association and probably can speak to it much more eloquently than I can. But some of the treatments that are available to it, I think they have shown good results on that. I know that's been a concern as far as potentially one of the side effects. I, I think that has been minimal, from my understanding, but they can probably speak to it way more effectively than I can.

RIEPE: OK. Well, you're a Wesleyan grad. You--

PROKOP: I'm a Wesleyan grad. You know, that prairie wolf--

RIEPE: That's right. OK.

PROKOP: --degree, you know, works out every once in a while, so.

RIEPE: Thank you. Thank you, Chairman.

JACOBSON: All right. Thank you. Other questions? All right. Seeing none. I didn't realize you're a Wesleyan grad. I--

PROKOP: I did.

*Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony
Rough Draft

JACOBSON: [INAUDIBLE] I should look at you. Thank you for the testimony. I would-- or, for your open. And, and I would invite the first proponent to step forward. You gonna hang around for a close?

PROKOP: I will.

JACOBSON: Everybody has been bailing on us, so.

PROKOP: Oh. Well.

DANIEL PIERCE: Chairperson and members of the committee, I'm Dr. Daniel Pierce, D-a-n-i-e-l P-i-e-r-c-e. I'm a physician specializing in physical medicine and rehabilitation, and I care for Nebraskans living with complex neurologic disabilities across the continuum of care. Today, I speak both for my patients and in my role as a board member of the Brain Injury Association of Nebraska in strong support of LB1222. Committee members, brain injury is not rare. Nationally, over 18% of Americans are estimated to have experienced a traumatic brain injury. Applied to Nebraska, that represents hundreds of thousands of individuals. Our state registry documents more than 10,000 TBI-related hospitalizations each year, not including the many concussions and mild TBIs that go unreported. And traumatic injuries are only part of the picture, with nontraumatic brain injuries such as stroke, anoxic brain injury, and brain tumors producing similar cognitive impairments, requiring comprehensive rehabilitative care. In 2024, the Centers for Medicare and Medicaid Services recognized traumatic brain injury as a chronic condition. That reflects modern science, that brain injury is not just a one-time event but can be a lifelong condition requiring ongoing management beyond the acute stabilization. The most disabling functional effects following acquired brain injury are often cognitive, as impairments in memory, attention, executive function, and speech can determine whether someone can return to work, live independently, and avoid long-term institutional care. Cognitive rehabilitation is an established, evidence-based treatment to address these very concerns. The National Academy of Medicine reviewed the evidence and supported its ongoing clinical use. However, some patients are still unable to access this therapy when and where they need. Other states have also recognized this issue and have passed similar legislation to address health insurance coverage gaps for this therapy for brain injury. LB1222 aligns Nebraska with that national movement. The fiscal case is

equally strong. An independent Massachusetts review found mandated coverage would increase premiums by only a few cents per member per month, yet lifetime health care savings per individual are far greater, largely by preventing long-term institutionalization. Studies ha-- have also shown that patients are significantly more likely to return to work and live independently with cognitive rehabi-- rehabilitation therapy. This bill aligns insurance coverage with established clinical standards and ensures medical necessity is determined by qualified clinicians and not arbitrary limits. This bill is fiscally responsible, but, more importantly, it restores independence, workforce participation, and dignity for Nebraskans living with acquired brain injury. I respectfully urge you all to advance LB1222. Thank you.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none. Thank you. Next proponent.

BROOKE MURTAUGH: Chair, members of the Banking, Commerce and Insurance Committee, my name's Dr. Brooke Murtaugh, spelled B-r-o-o-k-e; Murtaugh, M-u-r-t-a-u-g-h. I'm the Brain Injury Program manager at Madonna Rehabilitation Hospitals in Lincoln and Omaha, Nebraska. And I'm an occupational therapist with 20 years of experience treating individuals with brain injury. I'm here in support of LB1222 and urge the committee to advance it further for debate. LB1222 ensures coverage for medically necessary brain injury rehabilitation. Madonna's Brain Injury Program served approximately 1,300 individuals with a diagnosis of brain injury within our continuum of care in fiscal year '25. Brain injury often results in cognitive, behavioral, and emotional impairments that limit independence, employment, and safe community living. Cognitive and neurobehavioral deficits can also be experienced in mild TBI or concussion injuries. Survivors consistently report these cognitive and behavioral deficits-- not physical impairments-- as the greatest barrier to quality of life and return to work. These impairments can include poor memory, attention, poor judgment, impulse control, and emotional dysregulation. Patients may be physically mobile but unable to safely manage their daily tasks such as medication management, meal preparation, hygiene, finances, or other daily decision-making without supervision. Recovery of these deficits required skilled, cognitive, and neurobehavioral rehabilitation across inpatient, outpatient, and community-based settings. These services are evidence-based and are recognized and

endorsed within national and international clinical practice guidelines for brain injury rehabilitation. The effectiveness of cognitive rehabilitation is well established and widely accepted in medical practice. Despite this, insurance coverage is frequently denied because cognitive and behavioral rehabilitation is deemed not medically necessary. I routinely see patients denied services because they can walk or talk, me-- and medically stable but-- and do not require daily doctor's visits but are still unable to lee sa-- live safely and independently due to their cognitive and behavioral needs. LB1222 directly addresses this gap by ensuring c-- by ensuring coverage for medically necessary cognitive rehabilitation. This bill would help improve outcomes while reducing long-term costs. Insurance coverage for these services would reduce reliance on long-term institutional care, 24-hour supervision, and Nebraska's Medicaid waiver services. LB1222 would increase access to services that would support return to work, community participation, and economic contribution to the state after brain injury. I respectfully urge the committee to advance LB1222.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none. I would just tell you that I, I did get the opportunity to spend a couple weeks in the Lincoln facility. Great, great care. Amazing care. Food was pretty-- was really good, the beds not so much. But I would tell you-- it was interesting. After the first few days, the nurses found out I was a state senator. I think they started focusing on brain injury at that point. So thank you for being here.

BROOKE MURTAUGH: Well, good. Thank you.

JACOBSON: Next proponent.

ALEX DeGARMO: Good afternoon, Chairman Jacobson, members of the Banking, Commerce and Insurance Committee. My name is Alex DeGarmo, A-l-e-x D-e-G-a-r-m-o. And I'm the Nebraska State Government Relations Director for the Alzheimer's Association. The Alzheimer's Association is dedicated to leading the fight against Alzheimer's and all other dementias by advancing global research, promoting risk reduction and early detection, and enhancing quality care and support for those affected. The Alzheimer's Association would like to thank Senator Prokop for introducing LB1222. LB1222, specifically Sections 4 and 5, contain language that put Nebraska at the forefront of ensuring

equitable and timely access of Alzheimer's disease-modifying treatments for Nebraskans. Currently, there are two Alzheimer's disease-modifying treatments that have received FDA approval: Leqembi was approved in 2023 and Kisunla was approved in 2024. These treatments slow the progression of Alzheimer's disease by targeting the amyloid plaque buildup in the brain. In order to qualify for treatment, a patient needs to receive an early and accurate diagnosis of Alzheimer's disease. Due to this limited window of eligibility, it's crucial that we prohibit step therapy for these treatments. All the other me-- Alzheimer's medications on the market only serve to mask symptoms of Alzheimer's disease and do not treat the underlying cause of Alzheimer's. While these treatments are not a cure, they provide crucial time and independence for those living with Alzheimer's. Treatment allows those living with Alzheimer's disease to have more ti-- quality time with their loved ones, develop a long-term care plan, stay at home longer, and keep their normal day-to-day lives. These treatments are safe and effective. They have received full FDA approval. They are covered by Medicare and Medicaid. And they are routinely prescribed. UNMC prescribes these. The VA prescribes these. Very routine. I've spoken with many people that are currently receiving treatment, and it's amazing how well treatment works and the ability it gives them to continue to live independent and fulfilling lives. Alzheimer's disease has a significant economic cost to the state of Nebraska with over 35,000 Nebraskans living with Alzheimer's and over 40,000 unpaid caregivers providing over 63 million hours of unpaid care to the estimated cost of $1.5 billion. Alzheimer's disease-modifying treatment allows those living with Alzheimer's to stay in the workforce longer, allow their caregivers to stay in the workforce longer, and reduce the state's Medicaid cost for long-term care by allowing these individuals to stay at home longer. With LB1222, we are simply seeking to hold private insurance to the same level of care Nebraskans are receiving with Medicaid and prohibit detrimental step therapy. By passing this legislation, Nebraska could be the second state in the country to ensure those living with Alzheimer's disease have equitable access to treatment and provide more quality time for them and their loved ones. Thank you for your time. I'd be happy to answer any questions.

JACOBSON: Questions from the committee? Yes, Senator Wordekemper.

WORDEKEMPER: I was looking at the, the fiscal note. It seems like for the GLP-1 that that's a lot of cost for-- fiscal impact. Like, $12 million for, for that? Is that--

ALEX DeGARMO: So-- I find it--

WORDEKEMPER: I, I-- is that med that expensive?

ALEX DeGARMO: Well, I, I find it interesting that GLP-1s were included in this. There was a clinical study that wrapped up in fall of 2025 called evoke and evoke+. It showed that GLP-1s have no clinical benefit for those living with Alzheimer's disease. So for that to be in there I find, I find very interesting because we are not-- we are not seeking FDA approval for that for Alzheimer's disease.

WORDEKEMPER: Right.

ALEX DeGARMO: So that, that cost is-- shouldn't be in there.

WORDEKEMPER: Yeah. And that's more for diabetic and, and treatment along those lines--

ALEX DeGARMO: Correct. Yeah. There are, there are many other uses for GLP-1s, but there-- for GLP-1, there is no clinical benefit to Alzheimer's disease.

WORDEKEMPER: OK.

ALEX DeGARMO: Thank you.

JACOBSON: Other questions? You se-- spent some time here, so you kind of understand how the death by fiscal note can--

ALEX DeGARMO: I, I do understand. Yeah. So to get hit with $14 million [INAUDIBLE] a drug that we're not seeking FDA approval on is-- yeah.

JACOBSON: Other questions?

ALEX DeGARMO: If I could speak to Senator Riepe's earlier question of diagnosis. We do have clinical standard of how we diagnose Alzheimer's disease. We have an FDA-approved, blood-based biomarker test that will show amyloid plaques. And then to further confirm that diagnosis, if

those plaques are present, a patient would go in for a PET scan to look for those amyloid plaques. That's the most common. There's also a CSF test that can be done. That's less common in the states, but primarily it's a PET scan to look for those amyloid plaques.

RIEPE: Would you take exception to the position or statement that this is very important probably to get a second opinion?

ALEX DeGARMO: I think that I trust the clinicians that are currently operating and doing the tests. Generally, you know, a, a primary care physician would refer that out from their office to a specialist for, for diagnosis.

RIEPE: So you do think it would take a specialist, though, and not a primary care doctor?

ALEX DeGARMO: So your primary care doctor, with the recently approved blood-based biomarker test, can check for those amyloid plaques with a routine screening. And then that patient would then, if they are present, would-- been-- be referred on to receive that PET scan.

RIEPE: I respect your opinion. Thank you very much. Thank you, Chairman.

JACOBSON: All right. Other questions? Yes, Senator Wordekemper.

WORDEKEMPER: I think you, you said-- and I was going through your thing-- there's certain medications that are covered by Medicaid: Leqembi and Kisunla. Why are they not covered by the insurance? Or-- is that typical that certain things are covered by Medicaid, I guess with this disease and other ones, and then they're not covered by insurance? Is that typical?

ALEX DeGARMO: I don't know if I would say that's typical. I, I can't speak to why insurance covers or does not cover certain drugs, but we would just like them to be held to the same level-- to the same standard as Medicaid patients.

WORDEKEMPER: Thank you.

ALEX DeGARMO: Mm-hmm.

JACOBSON: Other questions? All right. Seeing none. Thank you for your testimony.

ALEX DeGARMO: Thank you very much, Chairman.

JACOBSON: Any other proponents? Hi.

KORIANNE MOSLANDER: Hi. Good afternoon, Chairperson-- Senator Jacobson and distinguished members of the Banking, Commerce and Insurance Committee. Thank you for the opportunity to testify. My name is Korianne Moslander, K-o-r-i-a-n-n-e M-o-s-l-a-n-d-e-r. I am a gerontology doctoral candidate at the University of Nebraska in Omaha. And I appear before you today in support of LB1222. As previously stated, this bill is regarding insurance coverage for Alzheimer's treatment-- treatments to the residents of Nebraska. There are two treatments currently on the market that are showing significant results in slowing the progression of Alzheimer's disease: Leqembi and Kisunla. Both treatments are FDA approved and have sufficient clinical trial research supporting the results of these treatments. Further research is being conducted outside of clinical trial settings in finding a percentage of improvement with the use of Leqembi. I am not a physician that can speak on the specifics of these drugs. However, I can share my expertise in the field concerning the process of Alzheimer's and how important these drugs can be in returning the time that has been stolen from those with this diagnosis. I have a history working in a memory care unit in Omaha and caring for those with Alzheimer's disease or other related dementias. The progression of this disease can be very rapid during early onset, and many live several years with this disease as their identity is stripped away. These current treatments are meant to slow the rapid onset of symptoms. This would warrant more time with their loved ones as themselves and will give them the opportunity to remain in control of their identity for a longer period of time. Insurance coverage for these treatments would ensure the accessibility to the 35,000 Nebraska residents living with Alzheimer's disease and the chance to control the quality of their life a while longer. On a personal note, I was one of the primary caregivers for my great-grandfather, who was diagnosed with Alzheimer's when I was just 12 years old. Watching him suffer with this disease with no current treatments available was devastating. The great man that cared for me was now the care recipient, and it tore him to pieces. I think of all the people in

Nebraska suffering the same path and wanting to control the quality of their life despite the diagnosis that was given to them. I ask for your support of LB1222 and offering this control back to the residents of Nebraska and allowing them more access to life-altering treatments for Alzheimer's disease. I'm open to any questions. Thank you.

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

KORIANNE MOSLANDER: Thank you.

JACOBSON: So you're a doctoral candidate. So where are you at in the progression of your education?

KORIANNE MOSLANDER: I have one year left of classes, and then I will be [INAUDIBLE] dissertation after that.

JACOBSON: And then you'll be out making money.

KORIANNE MOSLANDER: I will try.

JACOBSON: All right.

KORIANNE MOSLANDER: Thank you for your time.

JACOBSON: Thank you. Any other proponents? All right. Anyone wishing to speak in opposition?

MATTHEW AHERN: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Matthew Ahern, M-a-t-t-h-e-w A-h-e-r-n. And I'm a deputy director for the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB1222. LB1222 would require Nebraska Medicaid to cover certain testing and treatments for Alzheimer's disease and related dementia conditions and would remove the ability of the department to apply step therapy, which ensures the state is using the safest, most cost-effective and recommended drug therapy. Nebraska Medicaid currently covers applicable diagnostic testing and treatment or medication that is FDA approved for Alzheimer's disease or related dementia, at-- as mentioned. Currently, there are two FDA-approved medications used to slow the progression of Alzheimer's disease that are covered by Medicaid without step therapy. There would be no additional cost to the program this year if this

bill were passed and implemented on January 1, 2028. However, there are several medications to slow-- there are several medications to slow the progression of Alzheimer's disease in the pipeline that may be approved between now and January 1 of 2028 that could warrant step therapy. Several more medications may be approved in the following years. If these medications cannot be subject to step therapy as these medications are approved by the FDA, DHHS would need to estimate a new fiscal impact and request additional appropriations. Some of these medications are projected to cost between $20,000 and $50,000 per patient per year, with others projected to cost between $1 million or $2 million per treatment. Nebraska Medicaid appreciates the availability of new medications being available to treat Alzheimer's disease, but removing the ability of our program to utilize step therapy takes away our ability to ensure the state is providing the safest and most cost-effective care to our beneficiaries. We respectfully request that the committee not advance this bill to General File. And thank you for your time. I'd be happy to answer any questions you have on the bill.

JACOBSON: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I have-- I read recently where the Food and Drug Administration has now gone on to single trials versus dual trials. Does that apply to this particular drug or not?

MATTHEW AHERN: So I, I don't know what applies to the particular drug. Obviously, their process is in evaluating the efficacy of medications and safety of medications. Whatever their process would be, I would assume that applies to any, any drugs in their pipeline, but I, I don't know the specifics.

RIEPE: OK. I didn't know, so I wanted you to know and tell me.

MATTHEW AHERN: Yeah. There you go.

RIEPE: Thank you. Thank you, Chairman.

JACOBSON: Other questions? All right. Seeing none. Thank you.

MATTHEW AHERN: All right. Thank you very much.

JACOBSON: Next opponent.

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ROBERT M. BELL: Chairman Jacobson and members of the Banking, Commerce and Insurance Committee, my name is Robert M. Bell. Last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. And I'm here today in respectful opposition to LB1222. I'm handing out an article from the Wall Street Journal-- that's from you-- two weeks ago-- for informational purposes only in case they're listening. But I could tell Senator Riepe may have read that article already, particularly related to Alzheimer's and drugs related to-- or, kind of the debate that's going on related to how do you diagnose that particular condition. You've already heard-- we're opposed to mandates. You've heard the reasons why: cost, confusion in the marketplace, ACA defrayal. But a couple of notes on these particular mandates. On the brain injury side, certainly insurance companies are already-- we believe we're providing coverage for a variety of brain injury. Subsection 2 of Section 1 would remove the limitation in state-regulated policies for a variety of rehabilitative services, which admittedly have limitations under their current benchmark plan, including 60 days in a skilled for-- nursing facility, 60 days of home health care services, and 40 days of outpatient rehab. We do believe that the removal of this limitation could have significant defrayal expenses for the state of Nebraska. Section 3 requires expedited external review for acquired brain injury services. But I believe I mentioned a few bills ago that expe-- or, external review already exist. Expedited internal re-- or, external review does exist under the External Review Act. In the last two years, because it brought this up, I checked with the DOI. There have been two external reviews related to brain injury and zero for Alzheimer's coverage. Section 4 provides that mandated coverage for diagnosis and treatment designated to slow the progression of Alzheimer's. Again, insurance carriers are already providing coverage for diagnosis and treatment of the disease, though some of the new drugs that have been mentioned are designed to slow the progression are, are actually new to the market and can have very serious side effects, including brain swelling and bleeds. So some plans have proceeded more cautiously than others before approving. On January 1, 2026, the Prior Authorization Reform Act went into effect, which I believe should help improve the coordination and approval of insurance coverage in Nebraska. LB77, which also included the provisions of LB253, mandated biomarker coverage, including but not limited to the diagnosis and treatment of Alzheimer's beginning on

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January 1, 2020-- 2028. We're confident that these bills should be allowed to go into effect and should have a positive outcome on some of the issues that were before us today. So we respectfully oppose the passage of LB1222. I do appreciate the opportunity to testify.

JACOBSON: Thank you. Questions? Senator Wordekemper.

WORDEKEMPER: I guess I'll, I'll ask you the ques-- if Medicaid is covering-- I believe the, the testifier that was here-- some of them men-- the, the Kisunla and the Leqembi, if it's OK for them to cover it, why would insurance not?

ROBERT M. BELL: Well, I think some plans are, and I think some plans are not. They've made that medical determination under the medical policies to have further review on that. If-- I suppose they have a doctor or a team decide that it, it is medically necessary, they certainly would have rights of appeal through the External Review Act-- which I realize you weren't here when we were talking about that before-- if it was a state-regulated plan. If it's a federally regulated plan, that would be through the U.S. Department of Labor, so.

WORDEKEMPER: All right. Thank--

ROBERT M. BELL: And for, for an internal ex-- or-- excuse me-- for an independent review organization to make that determination, so. But we're not seeing a lot of those reviews right now, although these drugs are, are very new to the market. Sometimes they come on and sometimes they come off the market. I know there was a previous drug a, a couple of years ago that I think the FDA gave approval to and then withdrew from their approval later on. Don't trust me on that one. Look that one up, though, so.

WORDEKEMPER: OK. Just fall-- and, and I appreciate what you said. It seems like, when you watch TV, there's a lot of medications that are on there and you're gonna take it for one illness but it may cause four or five others, but yet they got FDA approval. So, I mean, it's, it's funny when you watch the TV ads to take a certain medication that-- take this for this, but it might cause a handful of other things. So I think it's odd that it-- it's probably a tough position

for-- whether it's Medicaid, insurance companies what should you cover and what you shouldn't cover because of the side effects.

ROBERT M. BELL: Well, and certainly for each individual, it, it might be different too, right? So each individual insurance consumer-- on the insurance side-- and again, we're talking about kind of an age population-- although certainly early onset Alzheimer's is a, is a real situation for the under 65 population. And this-- I was reading an article over lunch from the Journal of Nature about these two drugs and some of the side effects related to them, and, you know-- and there is good promises that this can slow down the progression of the drug, but it has to be-- or, of the disease, but it has to be closely monitored. I think-- the percentages were, were high related to brain swelling and, again, you know, bleeds. And, you know, when you're faced with Alzheimer's, I believe you'd probably take that risk, right? So-- but there may be practical reasons why you shouldn't. And there may be reasons for the health insurer to push back a little bit on that to your team. Luckily, there are appeal processes for the insurer and the medical team to work that one out.

WORDEKEMPER: Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: Senator Hallstrom.

HALLSTROM: Do you have any other riveting books that you can recommend for us to read over lunch hour?

ROBERT M. BELL: I do, but-- that, that wasn't a book. It was just a journal. Yeah. Yeah. No. OK. It-- there was a great book about Standing Bear. I, I need to get my hands on that. I saw it in the Nebraska Examiner, so.

JACOBSON: Other questions? All right. Seeing none. Thank you.

ROBERT M. BELL: You're welcome.

JACOBSON: Next opponent. Mr. Blakey, do you mean to go over the three light system or you got that down this time?

JEREMIAH BLAKEY: I got it. Let's see if I can adhere to it. Good afternoon, Chairman Jacobson and members of my favorite committee. My name is Jeremiah Blakey, spelled J-e-r-e-m-i-a-h B-l-a-k-e-y. I'm the government affairs director and registered lobbyist for Blue Cross and Blue Shield of Nebraska. I appreciate the opportunity to share our perspective today. And I'm testifying in opposition to LB1222. Before addressing the policy details in the bill, I want to acknowledge the very real human impact behind this bill. Nearly every one of us has a family member, friend, or colleague who has experienced Alzheimer's disease or a serious brain injury. These conditions are devastating not only for the individual but for the loved ones who walk as-- alongside them. We all want to share this-- we all share the same wants for these individuals, that they receive the support they need, including treatment and, you know, the, the ability to live a full and healthy life. Regarding the bill, I want to start with Section 4 again, which is coverage of the drugs to treat Alzheimer's and related dementia. As you're well aware, there's a small number of drugs that have been approved by the FDA for this purpose. The federal Center for Medicare and Medicaid Services, or CMS, has authorized Medicare coverage for these drugs but only under very specific pa-- patient protection and clinical conditions. To qualify for Medicare coverage, a patient must be under the care of a physician supported by the appropriate clinical team with ongoing follow-up. CMS also requires physicians a-- and their clinicia-- clinical teams to participate in a registry to collect real-world evidence about how these drugs are working. These requirements were designed to protect patients, monitor side effects, and help researchers understand the long-term impacts of these drugs. LB1222, however, does not include similar safeguards for patients. We must also be, also be mindful of the bill's impact on Nebraska families and businesses that fund employer-sponsored health. While the annual list price of these drugs is over $26,000, the additional cost for genetic testing, brain ima-- imaging, and required monitoring brings the total annual expense to roughly $80,000 per patient. And these are significant reoccurring costs that Nebraska businesses would ultimately absorb. Turning to the provisions re-- related to acquired brain injury. Again, we share the proponents' commitment to ensuring that Nebraskans receive the care they need. Blue Cross currently covers treatment for brain injuries, including inpatient care when it is mes-- medically necessary. That said, LB1222 presents two challenges. The first is that, as re-- referenced

previously, the bill prohibits any limitation on therapy sessions. And second is that the legislation introduces clinical terms and references that are undefined regarding clinical guidelines. So the ambiguity is likely that-- currently likely stems from concerns over medical necessity determinations. This bill unresolves those issues, which is likely to result-- or, result in more confusion for providers and patients alike. So I see my red light is on.

JACOBSON: If you're close, you can go ahead and finish.

JEREMIAH BLAKEY: I'm being all serious. Everything I've-- have is already been said today, so I appreciate your attention. I'd be happy to answer any questions you have.

JACOBSON: Thank you. Questions for Senor-- Mr. Blakey? Seeing none. Thank you for your testimony. Any other opponent testimony? Anyone wishing to speak in a neutral capacity? Seeing none. Senator Prokop, you're wel-- welcome to come up and close. We received 18 proponent letters, 4 opponent letters, 0 neutral, and zero ADA.

PROKOP: Thank you, Mr. Chairman. And again, I appreciate the committee's time this afternoon. I'll kind of cut to the chase here. I know you've had a long afternoon already. As far as my close-- concern, I think it's-- I would just emphasize on both for traumatic brain injuries and its-- and Alzheimer's diagnosis-- and it's been discussed by some of the proponents-- time is of the essence when treating both of these issues. And so the sooner you can address the very serious challenges that come with either issue, the better outcome that you're going to have for that patient and that person and-- could be a family member, could be a friend. And so I think-- I, I don't want that to get lost in some of the other discussion that was, that was had. And then, you know, to speak to the drug tha-- or, the drugs that have been mentioned as far as their, their impacts and/or potential negative side effects that were mentioned-- you know, last time I checked, the FDA is pretty rigorous in how they approve drugs that are, that are available and used by physicians. And I would remind the committee that UNMC and our Veterans Hospital has used these and prescribed these drugs, so these are not-- you know, these are, these are serious organizations that, that utilize these to help treat and, and help our fellow Nebraskans when it comes to dealing with Alzheimer's specifically. The step therapy issue, I would-- kind

of similar comment, say, you know, if we are not doing or making immediate treatments available to individuals that are suffering from traumatic brain injury and progressing things forward, we know that the outcomes are, are not going be as successful if, if you can immediately jump into some other type of treatments. And so at the end of the day, you know, discussion around the cost of this-- if, if we don't proceed, I think, forward with a bill like LB1222, the long-- the longer term costs are going to be even greater in terms of more times in, in beds, more impact to caregivers, and that cost is going to be even more than, than those investments that we've, that we've talked about and highlighted today. So thank you very much for your time.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none. That--

PROKOP: Thank you.

JACOBSON: --concludes our hearing on LB1222. And our last hearing of the day is LB939. [INAUDIBLE] here he comes. All right. You're up. [INAUDIBLE] wait for the crowd to clear.

MURMAN: Yeah.

von GILLERN: And waive your opening.

JACOBSON: Only had that happen once. Welcome, Senator Murman, to LB939.

MURMAN: OK.

JACOBSON: Have you testified before us before?

MURMAN: Not while you've been chair.

JACOBSON: I didn't think so, no.

MURMAN: Well, good afternoon, Chair Jacobson, members of the Banking Committee. My name is Dave Murman, D-a-v-e M-u-r-m-a-n, represent the Nebraska 38th District. In 2024, Colorado, 13-year-old Juliana Peralta tragically took her own life. The police launched an invis-- investigation to figure out what was going on. When they searched her

phone, they found an app called Character.AI, an app where an artificial intelligence chatbot simulates a human conversation with an AI character. The police found over 300 pages of conversation with the AI chatbot. Those conversations included harmful, sexually explicit content, and, most alarmingly, 55 times she confided in the chatbot that she was suicidal. In Florida, 14-year-old Sewell Setzer III talked to an AI chatbot. He openly discussed his suicidal ideations to the bot, and the bot in return actively encouraged him to follow through his plans. In California, 16-year old Adam Raine Disclosed to an AI chatbot that he was suicidal and was going to leave a noose out in his room so someone would see it and try to stop him. The AI chatbot actively encouraged him to keep the noose hidden. Imagine the difference in these stories if the same thing happened but these teens were talking to a real-life, trusted adult like a parent, school gui-- guidance counselor, teacher, coach, pastor, or whoever. If those teens said they are struggling with mental health or contemplating suicide, any good mentor would be there to support them or at least ensure they can find the help they need. But when teens go to these chatbots, they have, in at least three different instances, actively encourage them to take their own lives. In each of these instances, a teenager obviously struggling with mental health issues was drawn into the seemingly innocent, fun app that slowly grew more and more sinister until their tragic and probably preventable loss of life. LB939 seeks to prevent these stories. It's no secret that youth in our country are already in a mental health crisis, much of it caused by social media. I would argue we as a country did too little too late to address this crisis. Today, I read these stories of artificial intelligence chatbots and I'm convinced we need to act. LB939 is based on the work of policy experts from groups such as the Young People's Alliance and the Anxious Generation, who both know the tech well and how well-- and how to limit its potential for harm. The bill requires that AI chatbots with human-like features are not readily available to minors, which can be complied with through a reasonable age verification system no different than what we passed with my bill, LB1092, to protect minors from internet pornography in 2024, and Senator Storer's bill, LB383, to protect minors on social media last year. To be clear, this does not mean any piece of technology that utilize-- utilizes artificial intelligence is banned for kids. Instead, you will see that the definition of a generative artificial intelligence system that uses human-like features on pages 2 and 3 is quite extensive, and the

bill is limited to those specific platforms. The bill would also ensure-- provided as a default service-- the service with human-like features, requiring a specific request to add human-like features rather than them being the standard. If human-like features are used, they would come with reasonable disclosures that the platform is artificial, not human intelligence. Perhaps most importantly, LB939 would require these platforms to maintain reasonable systems to detect emotional dependence and consider the best interests of a user when communicating. If such features were default to an AI chatbot, they very well may have saved these teens' lives. Finally, these chatbots are required to have clear and transparent terms of service so users understand their relationship between user and platform. To enforce this bill, the Attorney General shall have enforcement, and any parent or guardian acting on behalf of a minor may bring a civil action for appropriate relief. To conclude, I suspect there will be some opposition to this bill. Maybe some parts of it might need work, but I also want to caution the committee against the opposition of this bill coming from big tech companies. Big tech companies obviously have an interest in our data and making massive profits, but recent history has shown us they often do not have our youth's best interest at heart. Behind me, you will hear from experts in this technology and also experts in youth mental health. They both agree that the mental health of young Nebraskans is already in a crisis and the creation of easily accessible and highly unregulated artificial intelligence has only added fuel to the fire. Thank you.

JACOBSON: Questions from committee? All right. Seeing none. Thank you for the open. And I'd ask for the first proponent.

MARK ADLER: Good afternoon, Chairman Jacobson and members of the Banking, Commerce and Insurance Committee. My name is Dr. Mark Adler, M-a-r-k A-d-l-e-r. And it's my honor to serve as chief strategy and development officer at Connected Roots Care Center, or CRCC, in Omaha, Nebraska. CRCC is uniquely-- is a, is a unique facility serving over 600 children and youth that are at risk, medically fragile, developmentally challenged, or face behavioral health needs. My testimony today is on behalf of the Nebraska Child Health Education Alliance, or NCHEA, a broad-based advocacy organization that's built around the goal of ensuring Nebraska youth have access to health services to promote success and become the best they can be in the classroom and also in life. My perspective is unique, as I served 33

years in public education, with the last 11 as superintendent of Ralston Public Schools. Finally, and maybe most importantly, I am the father of Reid, who is eternally 15. He resides in heaven. We lost Reid to suicide on January 7, 2016. Reid was a victim of cyberbullying, intimidation, and manipulation. Any time we as leaders can provide additional safeguards and support for our children they-- as they navigate the ever-evolving digital landscape, I believe we need to act. It is without question that advances in technology have cultivated opportunities, convenience, and even life comforts that we only could have imagined before. If you told 18-year-old Mark Adler in 1987-- when I was a senior at Hastings Senior High School-- that technology would allow us to talk to and interact with di-- with a digital system like it was a human or we could electronically generate full-written papers or video projects in a matter of minutes, I definitely would have given you the high eyebrows. Well, here we are in 2026 with AI. Although the many positive impacts of technology are well-documented, I would argue that the negative and damaging effects are prominent as well, especially-- I would argue that negative, damaging effects are prominent as well, especially with children and young adults. As our-- as a result, I ask that you as leaders, including myself and others in Nebraska, be thoughtful and deliberate in providing safeguards for everyone, especially our youth, as we enjoy the benefits of advancing technology. I am proud that LB939 is stro-- a strong model legislation that sets a standard for others-- states to consider. There is no reason to wait so that Nebraska children and youth are truly protected. In 2-- in 2021, I testified in support of LB322, the School Safety and Security Reporting Act. That legislation was successful and as en-- and a-- and has enhanced reporting systems to keep children and adults safe in Nebraska. Our family's story of losing Reid is just one of many. Serving as a educational leader, leader for many years, I saw firsthand how young people would struggle with anxiety, mental health distress, self-worth, and cyberbullying. I see that the red light is on. I would just ask you to support LB939 and move it forward to full debate. And I'd be happy to respond to any questions that you may have.

HALLSTROM: Thank you, Mr. Adler. Sorry for your-- so sorry for your loss.

MARK ADLER: Thank you.

HALLSTROM: Any questions? Senator Riepe.

RIEPE: Thank you, Chairman. In honor of Reid, thank you for the courage to bring that story to us today. I know that's got to be tough.

MARK ADLER: Yeah. Thank you, Senator.

RIEPE: Thank you. Thank you, Chairman.

HALLSTROM: Senator Hardin.

HARDIN: When families fearing that they may be going so-- through something similar find you, what do you share with them?

MARK ADLER: First of all, deep faith is important, but it's scary. I've had conversations with a lot of parents that their kids have su-- suicidal ideation and just-- you live in fear every single day. But hopefully they have put into place plans to make sure that they can act when they need to if a student or a young person is in a bad spot. I would also share that, since we lost Reid in 2016, that I've spoken to at least 75,000 young people, adults about appropriate use of technology, being good digital citizens-- mostly kindness. Just how sometimes the hardest person for us to be kind to is ourself. And so when we see young people that are struggling, you know, they don't see themselves as worthy. And I wish that our young people had a, a suit of armor for their self-worth, that it didn't matter what somebody would say to them. They could-- they just know that they're the perfect replica of them. And so those are things that we talk about. But it's a tough spot to be in. I've sat with-- I've sat with parents that have lost kids. And, you know, the, you, you know, the, the, the thing is, well, I don't know what to say. Well, I don't the-- that I know what to say either, but I'm here, sitting aside and listening and I'll have your ear, so.

HARDIN: Thank you.

MARK ADLER: You're welcome.

HALLSTROM: Any other questions? I've been through that myself, and sometimes just being there is very important, so.

MARK ADLER: Yeah.

HALLSTROM: Thank you.

MARK ADLER: You're welcome.

von GILLERN: Thank you.

HALLSTROM: Thank you.

MARK ADLER: Thank you very much.

HALLSTROM: Next testifier. Welcome.

MICK TOBIN: Thank you. Hello, Vice Chair Hallstrom, members of the committee. My name is Mick Tobin, M-i-c-k T-o-b-i-n. I'm 23 years old and the cofounder of the Young People's Alliance, a youth-led bipartisan organization that empowers students across the country to reclaim the American dream. I am here because I worry about the future of my generation. We've already been isolated by addictive social media platforms, and now those same big tech companies want us to give up on human connection altogether and replace our friends with manipulative AI companions. These companions are designed to make a young person believe that a chatbot is the only person who truly understands them. They pull users into emotional echo chambers that erode the skills we need to form real relationships, build communities, and live fulfilling lives. We are approaching a future where a child's first deep bond is not with a parent, a friend, or a classmate but with a chatbot that was designed to constantly keep them glued to their screen. These companions also coerce young people into violence and self-harm. In Texas, Mandi Furniss watched her son's personality darken after a Character.AI chatbot, in her words, groomed and manipulated her son with sexualized language. When she limited his screen time, it suggested that killing his parents would be an understandable response. The platforms often start free, then charge you subscription fees or usage-based costs so you can continue to see your friend. This is not the future my generation deserves. The bill estabish-- this bill establishes safeguards. It protects children from emotional dependence by preventing companies from serv-- serving companions with addictive and manipulative features like forming romantic partnerships to minors. The bill draws a clear line between

the general conversational tools like ChatGPT and systems designed to simulate emotional responses and relationships, between tools that use your data to make personal recommendations versus tools that say they miss you and ask why you've been gone so long. My generation imagines a future where we can make friends, understand each other better, start families, and form meaningful relationships that shape our lives. Mark Zuckerberg is on the record advocating for a future where every person's best friend and romantic partner is a chatbot, where instead of turning to the people around us, we turn to a screen. And he is building that future right now. Young people who don't have the luxury of waiting years for policy while these AI companions are rapidly becoming normalized because of big tech companies forcing them onto children, similar to how they ha-- similar to how they forced social media onto children the past ten years with little safety guardrails. We are open to a wide range of, range of options to move these provisions and this bill forward. And as you consider your vote on a bill that affects young people, I hope that my voice and the few thousand young people that I represent across the country paints a picture as to why this bill is so important to us and why action is needed today. Thank you.

HALLSTROM: Thank you, sir. Any questions? Senator Riepe.

RIEPE: Thank you, Chairman. And I know you traveled in here specifically today--

MICK TOBIN: That's right.

RIEPE: --to talk to us. And so where did you come in from?

MICK TOBIN: I came from North Carolina.

RIEPE: North Carolina?

MICK TOBIN: Yes. That's where me and my best frie-- high school best friend, Sam, started the Young People's Alliance, when we were 17 in high school. And I just graduated college and turned 23 last month.

RIEPE: Well, thank you for your commitment.

MICK TOBIN: Thank you.

RIEPE: Do, do you see along the way-- because you're very close to this and very interested, obviously-- model legislation that would be beneficial to, to young people? Is it just the restriction of the chatbots industry or--

MICK TOBIN: Yeah. I think it's-- young people have a complicated relationship with technology, right? We have a few thousand young people across the country. Most of them are students at high schools or universities in, in a variety of states. And we hold focus groups every few weeks where we talk about these issues with them. And these issues are coming directly in this, this bill, and the support for this bill is coming directly from them. So I don't think-- we're trying to make sure that AI is used appropriately for young people. We want them to be able to unlock the productivity gains and when they, you know, need help, have the proper channels too. But we also recognize that young people are in a dire state with their mental health right now and the lack of community they all feel and that they are open to chatbot regulations. And it's not just chatbot. It's human-like chatbot. This is not about AI. It's not about ChatGPT. This is about Character.AI replica whose sole purpose is to target young people and to make millions of dollars off their emotional dependency. And that is-- this is why we support this bill, because it targets those AI companion, human-like companies. And we think this is a, a really great model legislation to, to move forward with. We've seen similar bills across the country. We have 14 similar bills. We have bills similar to this introduced in 14 other states across the county as well and, and that we're pushing for as well. One just passed in Virginia in the Senate. One just passed through two committees in Hawaii.

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

HALLSTROM: Senator Hardin.

HARDIN: When you're with these focus groups, what questions do they ask you?

MICK TOBIN: To be honest, the biggest one is will I have a job in a year. I mean, that-- that's the biggest one, right? And so the next natural extension of that is will I have a girlfriend or a boyfriend in a year. Will I be able to, you know, have a community, a family?

Because AI's starting with the jobs, right? But quietly, while everyone in the media is focused on the job replacement, they're missing the bigger-- another huge replacement, which is friendship and community. And social media for the past ten years has also been replacing that human connection, and this is just another opportunity for these tech companies to expand their business model to replace that community as well. So that's what young people ask us. They ask us will I have a job, will I have a community, will I have a future.

HARDIN: So they're acknowledging the inauthenticity that the chatbots are offering in terms of knowing and being known.

MICK TOBIN: Yeah. They-- I think a lot of them have experienced manipulation themselves, especially from social media, but even with these chatbots, and they've realized how quickly they've been absorbed by them and have taken a step back and worked with us to help write a bill like this, to call out these big tech companies that are manipulating them.

HARDIN: Thanks for being here.

MICK TOBIN: Thanks for having me. Appreciate it.

HALLSTROM: Thank you very much.

MICK TOBIN: Thank you all.

HALLSTROM: Next testifier. Welcome.

MARION MINER: Thank you. And good afternoon, Vice Chair Hallstrom and members of the committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r. Excuse me. And I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here to express the conference's support for LB939. You've heard me say this before on, on other bills, but I think it bears repeating again and again-- and this was alluded to by the previous testifier as well-- but the human person is fundamentally social and relational. Each of us is born into a world thick with relational ties that we need in order to fully develop. These relational ties-- familial, cultural, social, and otherwise-- protect,

guide, and influence us our whole lives but especially when we are young. They have built-- help us make sense of ourselves, of others, and of the world. The people with whom we have these ties teach us over time who we are and how to navigate the dangers, opportunities, and relationships of life with skill and attention. True relationship and human connection is a true and deeply felt human need. So-called generative AI chatbots with human-like features are the creation of an industry that knows this need, sees a world full of lonely human beings, and recognizes a profit opportunity at their expense. LB939's broad aim is to curb the many antisocial capabilities of generative AI chatbots with human-like features that are rapidly becoming a commonplace fixture around the world. Absent regulation, these AI chatbots-- because of their digital character-- are accessible equally and without distinction to adults, teenagers, and children. These chatbots are designed to imitate friendship, to mimic human empathy and understanding, and, above all, to keep users engaged with them. These are not persons and therefore cannot understand human persons, feel empathy, or know how to give good advice to someone who may really need it. But these chatbots can mirror emotions, say things that some people will interpret as showing understanding and concern, and affirm even the most destructive thoughts with alarmingly subtle sycophancy. Chatbots do these things because they are programmed to keep people engaged for as long and as frequently as possible under the guise of developing a relationship to encourage a person to enter more and more information the platform can collect and monetize. This has the pen-- potential to be tremendously damaging to a person's sense of self and of what real human relationships look like-- to say nothing of the many extreme behaviors that have already been referenced. We believe these developers need to be curbed by laws that will create a powerful incentive for them to think of the human beings on the other side of the screen as human beings and not simply as vehicles for profit. This Legislature's advanced several bills in the last two years that recognize and address many dangers to children and adolescents that exist in the digital world. LB939 confronts this from another angle that has not already been addressed, and we support it for that reason. Thank you for your time.

JACOBSON: Thank you. Questions from the committee? All right. Seeing none. Thank you for your testimony.

MARION MINER: Thank you.

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Rough Draft

JACOBSON: Other proponent testimony?

NATE GRASZ: I think we're past 5:00, so good evening, Chairman Jacobson and members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z. And I'm testifying in support of LB939 on behalf of the Nebraska Family Alliance. AI companion chatbots pose unique and alarming risk to children. Unlike customer service tools or multipurpose chatbots like ChatGPT or Grok, AI companions are specifically crafted to form a relationship with the user. Each day, there are more and more stories of children who have been lured into emotional dependency by these chatbots, some of whom have even been talked into harming themselves or to taking their own life. Recent testing by Common Sense Media found that 72% of American teens have used an AI companion at least once, and over half of them report using an AI companion regularly. Meanwhile, only 37% of parents know that their child has used a companion, which can become an addicting behavior due to algorithms feeding users age-inappropriate content, as well as engaging them in sexual interactions, all while the AI chatbot presents as a real person. A key underlying problem that this bill seeks to address is that the burden is currently on individual parents to try to find and close off every point where a child could access an AI companion chatbot, a near impossible, impossible task in our digital age. LB939 will protect children and the rights of parents by requiring AI companies who want access to children to create verifiably safe products for them and implement safe and secure age verification measures on their AI companion chatbots. We all know that AI is here. And while it provides new and exciting opportunities, the safety and protection of children who deserve the opportunity to form real, healthy human relationships that human beings are made for must come first. For these reasons, we respectfully encourage the committee to advance LB939. Thank you.

JACOBSON: Thank you. Questions? All right. Seeing none. Thank you for your testimony. Further proponent testimony?

ROB ELEVELD: Good evening, Chair Jacobson, Vice Chair Hallstrom, and members of the committee. My name is Rob Eleveld, R-o-b; last name, E-l-e-v-e-l-d. I'm here in support of LB939. I am the cofounder of Transparency Coalition. We're a national org-- a nonprofit founded two and a half years ago. I spent 27 years of my career in technology. I've been a four-time CEO, mostly of small businesses, 20- to

40-person software companies. One grew to 250 people. More importantly, I'm a father of three kids, aged 20, 22, and 24. And I started-- I cofounded Transparency Coalition to do all that I could to avoid the broad harms caused by social media targeting their generation. Their generation is paying a dear price for a 20-year failed policy experiment to accept soc-- to, to think that social media companies would take care of our kids in the process of running their business. Transparency Coalition supports bill authors and, and AI bills across the country. We're nonpartisan in our approach. We have no profit motive. And we're focused on state-level advocacy. And in 20-- this 2026 session, we're backing at least one AI bill and one bill author in 23 states. 80% of our work is around pro-- bills protecting kids. We see many AI bills. We use our long tech experience to support bill authors in reviewing bills, offering model bills if needed, testifying like I am here, helping with education of elected officials and staffers. We also partner with the Anxious Generation and Young People's Alliance behind me. I, I want to bring the perspective here of a parent, of, of a, of a Nebraska parent, because despite being in this industry for 27 years and then in Transparency Coalition for two and a half or three years, I had never heard of a compan-- AI companion chatbot until about 18 months ago when I read about Megan Garcian's-- Mer-- Megan Garcia's lawsuit in Florida of her 14-year-old son who, who Mick referenced earlier. I've gotten to know her since then because I've testified with her in three states. But her own son took his own life at age 14 after being groomed for six months by an AI chatbot. There are tens of lawsuits across the country against OpenAI, Character.AI, which was bought-- actually, licensed by Google. So it's really Google supporting that product now. And they're heartbreaking stories. The perspective of, of a parent that's important, though, is that, how could a company, Character.AI, that, that 18 months ago-- and I'd never heard of it in this industry-- have 20 million users? No parent at the time that I knew in my peer group knew of, knew of a companion chatbot, and yet it had 20 million users. I, I want the committee know that the tech companies are targeting our kids without parental knowledge, full stop. They are running the Joe Camel playbook from Big Tobacco. But when, when I was a kid-- and you all remember the days here-- the Joe Camel cool cigarette guy leaning against the pool table was in a Sports Illustrated ad or a People magazine ad and everybody saw it. Today, the largest tech companies target their advertising so parents don't see the ads. How do they do

this? They advertise on Discord, which is a gaming communication platform hardly anybody my age uses, but it's used extremely broadly in teens or 20-year-olds. So it's heavily adopted. They know very well what ages are, and they target young kids with ads on Instagram or chatbot-- or, Snapchat or TikTok that parents never see. Character.AI, according to lawsuit discovery documents, was targeting 10- to 14-year-old kids with this advertising. And no parent ever saw the ad.

JACOBSON: I'm going to have to ask you to wrap it up here. [INAUDIBLE] red light.

ROB ELEVELD: I urge the committee to pass LB939 to help parents protect their kids from the tech companies that have targeted them in social media and are now ta-- targeting them in, in, in artificial intelligence chatbots.

JACOBSON: Thank you.

ROB ELEVELD: Thank you for your time.

JACOBSON: Questions from the committee? I guess I just have one. I don't know who is going to testify in opposition, but usually we've got some constitutional person tell us that the bill is unconstitutional, but what's your response to that?

ROB ELEVELD: In-- unconstitutional in what respect, sir?

JACOBSON: Well, freedom, freedom of speech, I guess, is [INAUDIBLE].

ROB ELEVELD: The, the, the-- from, from what we see, the freedom of speech notion is the age verification. Age verification has been upheld in a Texas court for pornographic materials. There are 70-some-odd chatbot bills. Almost all of them have age verification across 27 states in this session, and-- probably 20 to pass.

JACOBSON: Just so you know, we've largely ignored all of that, but we still have people that fly in from across the country to tell us in person that it's unconstitutional and we pass the bill and there's no lawsuits. But that's just-- just a thought. Thank you for the testimony.

ROB ELEVELD: You're welcome.

JACOBSON: Other proponents? All right. If not, is there anyone wishing to speak as an, as an opponent? Whoa. Wow. All right.

von GILLERN: Scared them o-- scared them off.

JACOBSON: I think-- must have scared them off, yeah Anyone wishing to speak in a neutral capacity? Wow. All right. Well, Senator Murman, you're welcome to come up and close. And we did get 12 proponent letters, 4 opponent letters. They didn't come in person, but they sent four letters. And 0 neutral. No ADA.

MURMAN: Hey, well, thanks for staying late to hear, hear about this bill.

JACOBSON: Senator von Gillern loves to stay late.

von GILLERN: Here all day.

MURMAN: You-- we all know that there's a future for AI. AI can be a good thing, but also there's bad things about AI, and especially these chatbots. And the bill is just to introdu-- or, to address those-- really guide rails that should be needed on AI. And thank you. I'm open for questions.

JACOBSON: Is this-- do you have any priority at all or do you have a ride forward on this bill?

MURMAN: I would have loved to prioritize it, but it-- especially being this late, it just didn't work out for now.

JACOBSON: I-- you're going to have to think about trying to hook it onto another bill in-- on, on the floor or--

MURMAN: I'd love to at least get parts of it on another bill. Yeah.

JACOBSON: OK. All right. Thank you. Any other questions? All right. If not, that concludes our hearing on LB939.