FREDRICKSON: Good afternoon. Welcome to the Health and Human Services Committee. I am Senator John Fredrickson, representing Legislative District 20. And I serve as the vice chair of the committee. The committee will take up bill-- the bills in or-- in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table in the back of the room. Please be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify. When it is your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on 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, and spell your first and last name to ensure we get an accurate record. We will begin each hearing to-- 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 the 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 light on the table will be green. When the yellow light comes on, you have one minute remaining. And the red light indicates you will need to wrap up your final thought and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It is just part of the process, as senators may have bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outburst 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 committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission 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 committee members with us today introduce themselves, starting on my left.

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

MEYER: Glen Meyer, District 17: northeast Nebraska. I represent Dakota, Thurston, Wayne, and Dixon-- southern part of Dixon County.

QUICK: Dan Quick, District 35: Grand Island.

FREDRICKSON: Also assisting the committee today: to my left is our research analyst, Bryson Bartels; and to my far left is our committee clerk, Barb Dorn. Our pages for the committee are Sydney Cochran and Tate Smith, both students at UNL. Today's-- oh. I'm sorry.

MEYER: Ellie.

FREDRICKSON: What?

MEYER: Ellie.

FREDRICKSON: Ellie? Is it Ellie? Oh. Sorry, Ellie.

ELLIE LOCKE: You're OK.

FREDRICKSON: Ellie's our-- not Sydney. Ellie's our page. Student at UNL?

ELLIE LOCKE: Yes.

FREDRICKSON: Yes. OK. Today's agenda is posted outside the hearing room. With that, we will begin today's hearing with LB67. Senator Raybould.

RAYBOULD: Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Jane Raybould, J-a-n-e R-a-y-b-o-u-l-d. And I represent District 28. I am here today to introduce LB67. First, I want to thank the many comments of online support that we have received on this subject matter. This legislation deals with a difficult subject matter, and I hope that the testimony today is sensitive to all who have survived a sexual assault. LB67 would adopt the Sexual Assault Emergency Care Act. The bill directs a hospital which provides emergency medical care for a sexual assault to provide the survivor with medically and factually accurate and objective written and oral information about emergency contraception. Emergency contraception is a crucial part of a survivor's medical care. It is a safe, effective method of preventing pregnancy before it begins. The trauma of sexual assault should never be compounded by a

lack of access to essential medical options. The written and oral information about the option to receive emergency contraception at the hospital must be provided in a language the survivor understands. And unless declined by the survivor, the hospital shall dispense a complete course of emergency contraception in accordance with the currently accepted professional standards of care and establish protocols for sexual assault forensic medical examinations. The bill also requires that the hospitals which provide emergency care for a sexual assault survivor provide training for all personnel involved in such care regarding the provision of medically and factually accurate and objective information about emergency contraception. Additionally, the bill would direct these hospitals to develop policies and procedures if they had not done so already as necessary to ensure compliance with the act in the case of moral or religious objections by individual health care providers. Section 4 of the bill establishes the procedure for complaints regarding compliance with the Sexual Assault Emergency Care Act. The procedure ensures due process for all parties, including survivors, providers, and hospitals. Nat-- nationally, 1 out of 4 women will experience a rape or an attempted rape in their lifetime. The Sexual Assault Emergency Care Act furthers the Legislature's efforts to protect and support victims by ensuring that all survivors of sexual assault receive the comprehensive and compassionate care they need. As I know there are testifiers here who will share information with you regarding the importance of this legislation, I will save the remainder of my comments for my close. But I am happy to answer any questions you have. Thank you so much.

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

RIEPE: Thank you, Acting Chairman. I appreciate it. Thank you for being here. Did the hospital association have any-- provide any comments?

RAYBOULD: I did not see any online comments from them.

RIEPE: OK. I-- the other question that-- how does this vary from existing statute? Is it, is it, is it original or is it a replacement?

RAYBOULD: Well, you know, we did receive one on-- online comment from DHHS, and they did say that some of the language in the compliance part, as well as the complaint part, was "duplicatous" of other standard policies that DHHS has in place.

RIEPE: OK.

RAYBOULD: But I think, in my opinion, there's no harm in being a little bit repetitive in the language in this bill outlining very clearly the policies that are-- some hospitals have adopted. And certainly DHHS is saying that some of these are standard procedures.

RIEPE: Do you have the advantage of having the bill in front of you?

RAYBOULD: Yes, I do.

RIEPE: I, I'm just-- I'm trying to-- Section 2(4). And it reads, and quote, emergency contraception means a federal Food and Drug Administration-approved drug administered after sexual intercourse that prevents pregnancy which was-- not disrupt an existing pregnancy. I'm kind of like--

RAYBOULD: So it prevents a pre--

RIEPE: I don't know that you can get pregnant when you're already pregnant. Or, or can you? I'm not a physician, obviously.

RAYBOULD: Well, let me-- I'm not a medical expert, I will admit, but the emergency contraception prevents a pregnancy after a, a sexual assault because it prevents ovulation. And therefore no pregnancy has taken place at that time. And the medication that is considered the, the normal standard protocols for emergency contraception does not impact an existing pregnancy. Because ovulation has already occurr--

RIEPE: I still have a hard time figuring out how one could-- if you're already pregnant how you can get pregnant a second time. That-- medically, I don't think that that would fit.

RAYBOULD: I think-- I, I don't read the language the way that you are. It defines what emergency contraception is and--

RIEPE: What's that line 12?

RAYBOULD: That prevents pregnancy.

RIEPE: But--

RAYBOULD: It--

RIEPE: --which does not disrupt an existing pregnancy. I don't think that's possible.

RAYBOULD: I, I, I think it is. And I'm, I'm pretty sure there's some medical experts that can validate the language that is being used.

RIEPE: Because the ovulation would have been the cycle-- that would have been concluded with the-- with getting pregnancy-- pregnant.

RAYBOULD: Emergency contraception would prevent ovulation from occurring. I'm pretty sure if you're pregnant you don't ovulate anymore. You're already pregnant, so.

RIEPE: I may bring this back up as we-- I-- because I'm sure there's someone out there that's-- maybe even a woman that knows more-- a lot about-- lot about this than I do. But thank you very much. Thank you.

RAYBOULD: Well, hopefully we'll have some experts validate the language that was chosen.

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

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

MEYER: Thank you, Vice Chair Fredrickson. I noticed there's a reference to staff training. Or, or-- is this over and above training that the staff receives now-- hospital staff? Or do you know if hospital staff are getting trained now in dealing with this?

RAYBOULD: It is-- thank you, Senator. It is my understanding that the hospitals do have team members that are trained to assist a victim after a sexual ha-- assault and work with that victim on a number of issues, including walking through the process and procedures of, you know, what they call a rape specimen kit. This, however, is additional language on top to make sure that that sexual assault victim survivor understands all the medical options that are available to them. So this would be an additional amount of conversation, either written and oral and, and/or both, so that that individual understands all their medical options at this point in time. And I think emergency contraception is certainly one of the most critical methods of emergency medical care that a sexual assault victim should have access to.

MEYER: OK. Thank you, Senator Raybould.

FREDRICKSON: Are there questions? Seeing none. Thank you, Senator Raybould.

RAYBOULD: You bet.

FREDRICKSON: We will now take proponents for-- can you turn that sign a little bit? Hey, Tate, can you turn that sign a little bit, the number? Thanks. Perfect. And I'll take proponents for LB67. Welcome.

CHRISTON MacTAGGART: Thank you. Good afternoon, members of the Health and Human Services Committee. My name is Christon MacTaggart, C-h-r-i-s-t-o-n M-a-c-T-a-g-g-a-r-t. I am the Executive Director of the Nebraska Coalition to End Sexual and Domestic Violence. Testifying in support of our member programs who provide crisis intervention services to survivors of domestic violence, sexual violence, and human trafficking in all 93 Nebraska counties. We know from our work that survivors of sexual violence experience a wide range of mental and physical health consequences, including unintended pregnancy, as a result of sexual assault. The 2020 Nebraska Statewide Intimate Partner and Sexual Violence Survey found that more than 50,000 Nebraskans have experienced unintended pregnancy due to rape or sexual assault. Provision of emergency contraception is well-established as a best practice in post-sexual assault care. The World Health Organization, the International Association of Forensic Nurses both recommend survivors of sexual assault be offered it as part of that care. And it's been found to be both safe and effective in, in preventing unintended pregnancy immediately afterwards. It is considered by those of us who work with survivors a basic tenet of trauma-informed sexual assault care. The passage of this bill would increase survivors' access across Nebraska, which currently varies widely by community and is particularly challenging in rural areas. When hospitals don't offer this, it's the on-- it's often the only way-- the on-- sorry. Often the only way for survivors to then access it is to travel to a pharmacy in another town. In rural Nebraska, that can be two hours away. Even more populated areas, they may have to drive to multiple pharmacies to find one that is open since it's sometimes sold behind the counter. Because emergency contraception has a short window of effectiveness to prevent pregnancy, this must happen quickly after a sexual assault. And-- sometimes after they've sat through what's typically a multiple, multiple hour-long exam. Because of this, it is true that right now in Nebraska-- depending on where you live and what hospital you go to-- a sexual assault survivor may or may not get fully trauma-informed health care for that sexual assault. When you couple this with survivors attempting to uphold regular responsibilities such as caring for children and working, we are forcing victims of sexual assault into pregnancies with a rapist. This brings its own host of excruciating decisions, financial challenges, and trauma on top of trauma. I don't think this is really the basic trauma-informed care that we want to provide survivors or the message that we want to send them in Nebraska.

Access is imperative. This bill would increase that access, and it would create consistency across the state, which is equally as important. So we support this bill, and we hope that you will too and will vote it out of committee. I am happy to answer any questions if you have any.

FREDRICKSON: All right. Thank you for your testimony. Any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. In our urban markets-- I'd say Omaha, Lincoln-- do we have designated hospitals that are rape centers? I came from a market--

CHRISTON MacTAGGART: Sure.

RIEPE: --sometime back-- Columbus, Ohio. They had a designated hospital within the Columbus, Ohio area. Do we have that?

CHRISTON MacTAGGART: We have, I would say, hospitals in our urban areas that have possibly more robust sexual assault forensic exam programs than others, but all hospitals provide sexual assault forensic exams in those areas.

RIEPE: If I may, Chair. The other question-- it talks in here is-- Section 2(4) talks about an FDA-approved drug. Is that is two pill morning-after-- I mean, I don't know of other pills that end up of terminating a pregnancy.

CHRISTON MacTAGGART: Sure.

RIEPE: Is that it? It's the same--

CHRISTON MacTAGGART: Well, it's, it's not terminating a pregnancy. It's, it's preventing conception. And it's my under--

RIEPE: It's the morning-after pill kind of deal then.

CHRISTON MacTAGGART: Right. It's my understanding that there's, there's more than one FDA-approved morning-after pill. There is a sexual assault nurse examiner that's going to testify after me that I know can speak to the different types of FDA-approved morning-after pills.

RIEPE: OK. I might save that question then because--

CHRISTON MacTAGGART: OK.

RIEPE: --if it is, it's probably the same compound. It's just a matter of maybe it's a generic. OK. Thank you. Thank you, Chairman.

FREDRICKSON: Thank you. Are there questions? Seeing none. Thank you for being here. Next proponent for LB67. Welcome.

JULIE TYLER: Thank you. Good afternoon, chairman person and members of the Health and Human Services Committee. My name is Julie Tyler, J-u-l-i-e T-y-l-e-r. I am a forensic nurse examiner at Methodist Hospital in Omaha, Nebraska, though I am testifying in my own personal capacity today. My goal this afternoon is for you to gain a clear understanding of what occurs when women who have been sexually assaulted present to our hospital seeking professional help. When women arrive to the hospital-- women arrive at-- to the hospital in, in a number of ways, which may be independently, brought by law enforcement, by the encouragement of loved ones, after confiding to a mandated reporter, an advocacy group, or by a concerned guardian. The path to starting the sexual assault forensic exam is often complex, messy, and emotional. As a forensic nurse examiner, consent from the victim is essential before I be-- begin my exam. Consent involves an explanation of the examination process, options of how her sexual assault can be reported to law enforcement, and assurance that she is always in control of her body throughout the exam. After consent has been given by sexual assault victims, I am then able to start the forensic exam, which includes a head-to-toe physical assessment, noting miscellaneous findis-- findings such as ripped clothing that could be used as evidence, strangulation assessment, suicidal risk questionnaire, and finally taking photos of injuries-- which often include genitalia-- with a forensic camera. In addition, I collect evidence from her body using the Nebraska sexual assault evidence kit. Victims have already had their consent and their choices taken away as a result of sexual assault. Best practices for this entire process is to ensure that victims are given back the choice and are treated with trauma-informed care throughout the process. It is really hard for a victim to come and seek care because they have been so vulnerable throughout this process. While my goal is to provide comfort and support throughout the evidence collection process, a recently sexually assaulted woman-- or, asking a se-- recently sexually assaulted woman to spread her legs is less than ideal. Sexual assault victims are brave to ensure their story is told, and they deserve full-- access to full care that they need throughout this process, ic-- including emergency contraception. Please allow the-- all girls and women of childbearing age to feel in control of their sexual assault by giving them the option to prevent pregnancy from taking place. Emergency contraception is vital to the healing process for women who are sexually assaulted. Thank you for your time.

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

RIEPE: Thank you, Chairman. Thank you for being here. My question would be-- I have a couple here. One of them, it sounds like you have an existing protocol. I'm sure Methodist does.

JULIE TYLER: Yes, we do.

RIEPE: How does this vary-- what would, what would this piece of legislation do that-- why do you need it if you already have the protocol?

JULIE TYLER: Sure. The hospital-- Methodist hospital that I work at currently, that is best practice overall. So they have adopted that.

RIEPE: Sure.

JULIE TYLER: It is not necessarily a law that has to be in place, but.

RIEPE: Has it failed you?

JULIE TYLER: No.

RIEPE: OK.

JULIE TYLER: Women that come want to prevent pregnancy. It's a very traumatizing experience. And after the harsh, ugly conversations, it's one of the first questions women often ask, is, am I going to be pregnant?

RIEPE: But-- you know, I'm somewhat familiar with Methodist. You know, you-- I'm sure, from a quality institution, which you are, you have a certain protocol that when they come in the first thing you do is this, this, this, and this. I don't know exactly what that would be, but you've been in business long enough, and particularly in the women's business. The other question that I would have is, what's the frequency of sexual assaults on a typical month, say, or maybe a typical year?

JULIE TYLER: Methodist Hospital has over 400 forensic exams a year. That could include domestic violence. They're not necessarily all sexual assault. Could be human trafficking. I have been on call--

RIEPE: 400 a year?

JULIE TYLER: Yes.

RIEPE: Of sexual assaults?

JULIE TYLER: Not necessarily just sexual assaults. It could have been-- included human trafficking or domestic violence.

RIEPE: OK. Does this--

JULIE TYLER: So I don't-- I can't--

RIEPE: --policy cover human, human trafficking?

JULIE TYLER: If there was a sexual--

RIEPE: It's only sexual assault, isn't it?

JULIE TYLER: Some, some people that are human trafficked are sexually assaulted.

RIEPE: Yeah. OK. I understand that.

JULIE TYLER: So if they're-- if it-- if they're sexually assaulted during domestic violence-- often, they're-- they go together. Sometimes they're separate. But our, our standard is to provide a lot of education and resources, such as STI prevention. We give them prophylactic antibiotics. There's three different types that we offer them. We also do offer support and education, providing, if they were exposed to HIV or AIDS, the medication process, which is over about 28 days. We offer that education and support and how to follow up with that.

RIEPE: What I'm trying to understand is-- and maybe we'll do-- learn more, is, how does this contribute to what we already-- the protocols that we already do? Or what, what-- is it some piece-- because it seem-- appears to me it's an unfunded mandate. What are we-- what are we helping with and not just being more of a burden? And the other question-- I'll give, give you two here at once.

JULIE TYLER: OK.

RIEPE: Is on the victims that come in, what's the level of law enforce-- law-- the-- engagement of the law-- police, if you will-- to report it? Is that, is that an institutional requirement or is that strictly up to the victim?

JULIE TYLER: The victim has the option to report a number of ways. They can do a full report, which means that their name is attached to the

sexual assault kit and a number and it has gone to law enforcement. It's public knowledge their name, the kit number, the sexual assault kit number. They could do a partial report where they just want to collect the evidence but they don't want to necessarily call the police at that time. They want to think about it. Or they could do an anonymous report, and that's when we collect the evidence but their name is attached to the kit number. So it's not public. I would like to say that the law enforcement that I've worked with has been phenomenal. I know that's not always the case, but the detectives take their time researching it, speaking with the victims. We see a lot of minorities. Mi-- not-- excuse me-- not minority, but children under the age of 18, so obviously parents and guardian consent is involved. But they have a special room, special detectives that are trained to collect evidence, to talk about sensitive matters with people.

RIEPE: I notice you've use the terminology they. Because I think with HIPAA, you are somewhat restricted. You cannot just turn it over without the permission of the victim, the woman.

JULIE TYLER: Oh, absolutely. And--

RIEPE: Absolutely or absolutely not be able to?

JULIE TYLER: Well, I can't give any personal information.

RIEPE: Yes.

JULIE TYLER: Yeah. And safety is always a concern with sexual assaults and domestic violence. We want to make sure their identity is protected or their choices are protected in terms of how they want to report and pursue the sexual assault.

RIEPE: OK. Thank you, Chairman.

FREDRICKSON: Other questions? Senator Meyer.

MEYER: Thank you, Vice Chair. I want to follow up a little bit with what Senator Riepe was, was inquiring about. You just gave us a very detailed-- number one, thank you very much for what you do. This is an extremely difficult job, and I appreciate very much what you do. You just gave us a very detailed-- per-- perhaps not totally comprehensive-- rendition of, of what your responsibilities are in, in a forensic exam and, and the aftermath of that. And, and so I, I believe Senator Riepe asked this-- and, and perhaps I didn't understand it or hear it properly, but what, what-- in addition to what you're already doing, what does this bill do? Is it the training aspect? Is

it, is it just expanding, expanding the, the training and discussing with the, the victim on additional options or-- just, just what more are we doing? Because it sounds like you have a very comprehensive protocol right now, and, and-- which, which I appreciate. So just what, what are we doing differently? Or, or what are we adding in?

JULIE TYLER: Sure. Methodist is very advanced. They very much want to do best practice. I think there's a lot of misconceptions about what emergency contraceptive care is. A lot of people think it would be ending a pregnancy. It is not. It's preventing ovulation and implantation of the egg in the uterine wall. So I think to make it accessible to rural communities in Nebraska, making it-- well, Methodist Hospital, I can only speak to that. It sounds like it's not necessarily the case at other hospitals, or there's misconceptions amongst the public about what emergency contraceptive care is. And so I think this bill would protect that and expand it.

MEYER: Thank you. Just one more briefly. You mentioned medications that would prevent ovulation. And so the, the-- I'm assuming a layperson not, not with a medical background, these would be medications different than, than something we would use for a chemical abortion.

JULIE TYLER: Yes. This is completely--

MEYER: Totally different--

JULIE TYLER: Yeah. I can-- there's three approved by the FDA. One is-- the most common known one is Plan B. It's levonorgestrel pill, and it's over-the-counter. You can take it up to three days after sexual intercourse. The second one is Ella. It's a ulipristal acetate. It's a prescription only. It's an oral pill as well. You can take that up to five days afterwards-- after intercourse. And then the final one is actually a-- it's not a pill at all. It's a copper IUD. And how it works is it prevents the sperm from getting to the egg. And that can be placed within the woman-- in the woman within five days after. And then that would be also birth control for the next 12 years if she chooses.

MEYER: Thank you. That was very helpful. I appreciate that. Thank you.

FREDRICKSON: Thank you. Any other questions? Senator Riepe.

RIEPE: Yes. You've, you've hit my curiosity button. How do they put a, a-- this copper device five days after--

JULIE TYLER: Sure.

RIEPE: --the sperm is there? I'm kind of like, how do you get ahead of the, the sperm, if you will? I mean, I-- the, the logic on that--

JULIE TYLER: Sure.

RIEPE: You said you-- I think you said-- corr-- that you have up to five days.

JULIE TYLER: That is correct. Five days.

RIEPE: I would think you'd be a little-- day late and a dollar short on that. Help me. Educate me.

JULIE TYLER: Sure. Just the-- depending on ovulation and how the egg travels and the glucose in the sperm would-- pregnancy just doesn't happen in a matter of hours. It's a process of getting the sperm there and the egg. So it's just shown that, that record-- or-- I guess I can't speak specifically without notes in front of me, like the timeline of how-- when the sperm and the egg ovulate, you know, the timing. But--

RIEPE: I'm just curious how you have any assurance that you're going to-- because you're not going to ju-- it's not going to be just one sperm.

JULIE TYLER: No, it's going to be many. Thousands.

RIEPE: OK. So how do you make sure that you have them all? Because it only takes one to impregnate.

JULIE TYLER: Sure.

RIEPE: I mean, that's, that's-- I, I--

JULIE TYLER: Well, the copper disrupts the glucose in the sperm, so.

RIEPE: OK.

JULIE TYLER: It makes it not--

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

JULIE TYLER: Uncomfortable words.

FREDRICKSON: Thank you, Senator Riepe. Other questions from the committee? So just to clarify-- so there, there's been some questions seems like about how this bill different-- I know you, you practice at

Methodist. It sounds like you guys provide kind of gold standard of care. My understanding of this legislation-- and please correct me if I'm wrong with this-- is that the goal with this is to ensure that survivors are able to receive that gold standard of care even if they're not going to Methodist, right? So maybe if they're--

JULIE TYLER: Absolutely.

FREDRICKSON: --looking at a different part of the state that might not be providing the level of care you are in Methodist, that they, they have access to this type of support--

JULIE TYLER: Sure. And I can speak to that if that's OK for--

FREDRICKSON: Sure. Please do.

JULIE TYLER: --quite a bit. Or-- I also do rural nursing. Actually an eight-bed hospital. So what sexual assault victims go through there is very different than at Methodist Hospital. We have a cortex forensic camera at Methodist. We have a number of resources. I have access to a doctor that is very knowledgeable. I have a kit that I am very familiar with at all times. Working in rural nursing, the equipment itself is not always accessible. And-- and I think a lot of misconceptions about what can and can't be done and how reporting goes, it feels very-- people fumble through it. There's a lot of phone calls. It's messy. What rights do the woman's-- do the women have? Do-- how do I do this? It's usually a telehealth. Same nurse that's walking-- a late nurse working at the hospital through the whole process. So access to con-- emergency contraceptives is very much talked about. Education is provided. We have pamphlets. It's ad nauseam. In rural nursing settings, I have found there's a lot of misconceptions of, I don't want to have an abortion. I don't want people to know. And often even when I correct them, it's not-- they don't believe me often, so.

FREDRICKSON: And then there, there also seem, seems to have been some questions on sort of emergency contraception versus something like mifepristone or misoprostol, which would be a--

JULIE TYLER: Chemical abortion.

FREDRICKSON: --a chemical abortion. So-- just to be clear. So with emergency contraception, my understanding is that if, if a person is already pregnant, that emergency contraception would not prevent that pregnancy. In other words, this is some-- this is an individual who would not yet be pregnant. It would be able to prevent that pregnancy.

JULIE TYLER: Right. They absolutely are not pregnant. It works by delaying ovulation or the fertilization of the egg. And if she were to take it and was already pregnant, she would be fine for the most part to have a happy, healthy baby.

FREDRICKSON: All right. Thank you. Other questions? Sen-- Senator Riepe.

RIEPE: Thank you, Vice Chair. I have a quick question. Do you provide the same service at your 84th and Dodge main hospital, and the one out at 160th-- the Women's Hospital--

JULIE TYLER: Yes.

RIEPE: --at 160th and Dodge and--

JULIE TYLER: I go to both hospitals.

RIEPE: The-- so you have the same program at both locations?

JULIE TYLER: Yes, we do.

RIEPE: OK. Thank you. Thank you.

FREDRICKSON: All right. Thank you for your testimony. Next proponent for LB67. Welcome.

TIA MANNING: Welcome. Hi. Welcome. Hi. I am a little nervous, so I will throw that out there just for folks to know. Oh my gosh. Hello, Vice Chair Fredrickson and members of the Health and Human Services Committee. Thank you for the opportunity to speak today. My name is Tia Manning. That's T-i-a M-a-n-n-i-n-g. And I have spent over 20 years working with survivors of violence in the Omaha metro area as a licensed mental health therapist and a licensed alcohol and drug counselor. I am here in strong support of LB67 because survivors of sexual assault deserve access to comprehensive, trauma-informed medical care, including timely emergency contraception, which is a critical intervention that prevents re-- retraumatization by the very systems meant to support the survivor. Sexual assault violates a survivor's autonomy and control over their own body. In the aftermath, being denied or delayed emergency contraceptive forces survivors to relive the powerlessness, this time within a health care system that should be prioritizing a survivor's well-being. As a mental health professional, I see firsthand how these barriers compound trauma and worsen long-term mental health outcomes. Survivors of sexual assault are, are at significantly increased risks of PTSD, depression, anxiety, substance

use, and suicide. When emergency contraception is delayed or denied, survivors often experience deepened distress, helplessness, and disengagement from further medical or mental health care. Nebraska already struggles to meet mental health needs, ranking 33rd in the nation for access to mental health care. Only 35% of individuals in Nebraska who need addiction treatment receive it, according to the Substance Abuse and Mental Health Services Administration. For survivors of sexual violence, being denied timely contraception-- emergency contraception-- excuse me-- only intensifies their trauma and increases reliance on already overburdened crisis services. The disparities in care are even greater for black, Indigenous, and other survivors of color who experience higher rate of sexual violence but are more likely to receive care at hospitals that do not provide emergency contraception. No survivor should have to negotiate, beg, or search for basic medical treatment simply because of where they live. An estimated 3 million individuals in the U.S. have experienced a rape-related pregnancy. The trauma of sexual assault is already profound. Currently, Nebraska hospitals follow inconsistent policies regarding emergency contraception. This means a survivor's care is dictated by chance, by which hospital they go to, which provider's on shift, or what policies are in place. 17 states have already enacted or-- laws requiring hospitals to offer emergency contraception to sexual assault survivors. Nebraska should be a leader, not an outlier. LB67 ensures a consistent standard of care, removing barriers, preventing retraumatization, and prioritizing survivors' dignity. Sexual violence may have a lifelong impact, and we have the power to prevent some of the most devastating consequences. Survivors should not have to fight for, for basic medical care, relive the loss of control from their assault, or face additional harm due to systemic failures. I strongly urge you to support 6-- LB67. Thank you for your time. And I welcome any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Vice Chair. First of all, I-- you did a nice job.

TIA MANNING: Thank you.

RIEPE: So. My question's along the line of, what's the payment source, say, for a professional like yourself? Do, do you get paid? Is there a lot of bad debt or is it commercial or is it Medicaid or-- what, what's your, what's your primary payment source?

TIA MANNING: As a clinician?

RIEPE: Yes.

TIA MANNING: So Medicaid and private insurance. And sometimes I do self-pay.

RIEPE: OK. OK. Thank you, Chair.

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

TIA MANNING: Thank you.

FREDRICKSON: Next proponent for LB67. Dr. Feichtinger.

ERIN FEICHTINGER: Vice Chair Fredrickson.

FREDRICKSON: Welcome.

ERIN FEICHTINGER: Happy Friday, y'all. Vice Chair Fredrickson, members of the Health and Human Services Committee. My name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r. And I'm the policy director for the Women's Fund of Omaha. We are committed to supporting survivors of gender-based violence in our local communities, which includes survivors of sexual assault and domestic violence. And as such, we offer our full support for LB67, recognizing its efforts to ensure survivors are provided trauma-informed, medically accurate, and comprehensive health care post-assault. As Ms. MacTaggart pointed out before me: while some health care providers do provide this and provide it very well, some do not. Denying or withholding information about and access to emergency contraception leaves survivors vulnerable to an unplanned pregnancy. 1 in 20 women in the United States have experienced a pregnancy from rape, sexual coercion, or both during their lifetimes, and carrying an unplanned pregnancy to term, the re-- as a result of that assault can be incredibly traumatic, as you've heard, to a survivor for their short- and long-term well-being. Considering the intersection between rape-related pregnancy and intimate partner violence, carrying an unplanned pregnancy to term can also make it increasingly difficult for a survivor of sexual and domestic violence to leave an abusive partner. In fact, one of the most dangerous women-- or, times for a woman experiencing intimate partner violence is when she is pregnant. Homicide is the leading cause of death for pregnant and postpartum women. A person's odds of experiencing intimate partner violence increases 10% with each pregnancy, and 80% of victims who experience pregnancy resulting from rape were fearful for their safety. No survivor should have to face the reality of being forced to remain pregnant as a result of an assault,

coupled with the trauma they are already experiencing from the assault itself. This bill does not require that sexual assault survivors take emergency contraception. I want to be very clear about that. It is restoring a survivor's choice that was taken away by the assault and ensuring that, no matter where that assault occurs, the survivor gets the chance and the choice back in their lives. For some Nebraskans, this legislation is going to be life-changing, and we urge this committee to show their support for survivors of sexual assault and domestic violence in this state and invest in their healing after an assault by advancing LB67. And I would be happy to answer any questions that you may have to the best of my abilities.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Vice Chair.

ERIN FEICHTINGER: I'm not that kind of doctor, just to warn you. Based on your previous questions.

RIEPE: OK. Well, I'll check that one [INAUDIBLE]. I like the fact that you always come with facts.

ERIN FEICHTINGER: Uh-huh.

RIEPE: Facts are helpful for differentiating from emotions. The whole-- question I have is a little bit of a left field one, is, is this strictly a wo-- woman's issue?

ERIN FEICHTINGER: Well, men can't get pregnant.

RIEPE: No, but I mean-- and sexual assault could be--

ERIN FEICHTINGER: No, it is not strictly a women's issue. And I would be happy to follow up. I do have that data, particularly in Nebraska, about the amount of men and amount of women who experience sexual assault in their lifetimes. And I would be happy to provide those exact numbers-- because I know you like facts-- after this hearing.

RIEPE: Well, that was just a-- one big question. I don't know that-- OK. Thank you, Chairman.

FREDRICKSON: Thank you. Are there questions from the committee? Seeing none. Thank you for being here. Next proponent for LB67. Welcome.

REBECCA WELLS: Good afternoon, committee. My name is Rebecca Wells. That's R-e-b-e-c-c-a W-e-l-l-s. And I'm here as a citizen that's gotten very interested in legislative bills. Also, my work history is a nurse. And I am a certified nurse midwife-- currently not practicing, but did that for many years. And this I think is an extremely important bill. We've had great testifiers before me that are heavily involved in providing this kind of care. And, you know, it-- people are so uninformed about how pregnancy works. So many people do not realize that, most often, fertilization does not occur in conjunction with, with intercourse. Most of the time, sperm-- which live up to five days-- are sitting in the female reproductive tract. They're viable for five days. And the woman is ovulating some time afterward. And that is why this emergency contraception, that is why it is so important. It is not stopping a pregnancy. There are, as several have mentioned, three different forms of emergency contraception, which-- I've dealt with all of them in my career. The Plan B is an over-the-counter one. It isn't quite as effective. But as they mentioned, it is a-- it's a progesterone. And again, im-- it stops that egg from being released. A little more effective is Ella, which is a little different comb-- combination of hormones that is effective for se-- up to five days. The other one's just three. And it is prescription only. And then of course the, the copper IUD. And the copper IUD-- again, what it does, it causes a chemical change in the sperm and ova where they do not-- it does not fertilize. And so the way it occurs-- usually, there have to be a lot of sperm, and a whole bunch of them together make it where one of them can get through. But the copper IUD is, is kind of preventing all that. But anyway, there are methods to prevent conception and a pregnancy, and I think this is a very important thing. And again, if you're in a hospital that has great protocols and is doing standard of care, that's great. But it's not right that there are places that-- where women may show up and may not be getting full care that they deserve. Any questions?

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none. Thank you for being here.

REBECCA WELLS: Thank you.

FREDRICKSON: Other proponents for LB67? Seeing none. Anyone here to testify in opposition to LB67? Welcome.

MARION MINER: Thank you. Excuse me. Thank you, Vice Chair Fredrickson and members of the HHS Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r. I'm Associate Director of Pro-Life and Family Policy at the Nebraska Catholic Conference. You have my written testimony in front of

you. I'm going to move off of that just a little bit in order to address a few things that were brought up. I do want to-- this is in my written testimony. The, the thing I actually want to lead with is the-- some of you are familiar with this already, but the ethical and religious directives that are in place for Catholic hospitals and all Catholic hospitals must, must follow. With regard to incidences of sexual assault, these directives read as follows: compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support, as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. So you see right here, there's no problem in the ERDs and from Catholic health care-- the Catholic health care perspective and, and rules with regard to administering emergency contraceptives so long as you can be confident that it is acting as a contraceptive and not as an abortifacient. That's where we have problems. If after appropriate testing-- to get back to the ERDs-- there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum, close quote. OK. So I, I want to draw your attention to a coup-- the, the two exhibits I have. One is just a real quick reference. If you go to WebMD and they ask you about when Plan B is and is not appropriate, the very first bullet point on there is that if you are or think that you're pregnant, it's not appropriate and you should not take it. The second exhibit in there specifically regards Ella, and this is an article in The Atlantic-- which is no foe to abortion or to contraception-- and simply pointing out that Ella is quite an effective abortifacient if you want to use it that way. I would also point out The New York Times had an article that came out just a couple of weeks ago exposing lots of abuses in Planned Parenthood locations, including in Omaha, and pointed out that they did not bother to check one woman who was pregnant. She was four months pregnant. They inserted an IUD, and that had the effect of killing that unborn child and causing her to deliver a stillborn child. So in addition to that-- and I don't have this in my testimony, but I'm happy to provide it to you-- I have probably a dozen peer-reviewed studies that-- may I finish my sentence? I'm sorry.

FREDRICKSON: You may, yes.

MARION MINER: Thank you-- that study the effect of these emergency contraceptives and point out that the effect on ovulation versus disturbance of a pregnancy that has already occurred, beginning with fertilization, is unknown or then it seems to be actually much more effective as an intercepting or abortifacient drug, all of these, than it is as an antiovulatory drug. But thank you. I don't want to abuse my time. Appreciate it.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. The thing-- and I'm trying to sort through in my head is, how do you protect the rights of a woman who might present versus the rights of the institution--

MARION MINER: Yeah.

RIEPE: --to live by their own values?

MARION MINER: Right.

RIEPE: And under a-- the [INAUDIBLE] legislation, you would have to take care of the woman who presents in a Catholic hospital or in, in another hospital that have those very same policies. So it's kind of-- I'm trying to figure out what if it-- if the only hospital in, say, one of our rural communities is a hospital that doesn't have a policy that will do that-- I'm not trying to say just-- might not be just a Catholic hospital, but--

MARION MINER: Sure.

RIEPE: --for purposes of discussion. How do we then, in essence, divide the child here?

MARION MINER: Mm-hmm. Yeah. Good question. So what I would say is this, is that-- so I can only speak with regard to how this would apply to Catholic institutions. I can speculate on the other stuff, but maybe it's not a great idea for me to do that. With regard to Catholic institutions, this bill actually would not be a problem, I don't think, if we defined pregnancy as, as beginning at fertilization and made clear that in the event that conception, fertilization has already occurred, there's no obligation to give what amounts to abortifacient drugs in those cases. Because the rest of it, when we're talking about a woman presents-- if a woman presents now at a Catholic hospital-- at least everyone that I'm aware of-- and all the Catholic hospitals have to follow the ERDs-- if she presents to a Catholic hospital and she has

been sexually assaulted and there's no evidence that, that conception has already occurred, they, they can and will offer emergency contraceptions to defend her against pregnancy. The only objection comes when it is determined that pregnancy has likely already occurred. And in that case, they won't do it.

RIEPE: I notice that you used the term good Catholic hospitals. I, I don't know any bad ones, but--

MARION MINER: Oh. I-- if I did, I didn't mean to. But thanks.

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

MARION MINER: Sure.

FREDRICKSON: Thank you, Senator Riepe. Other questions? I have one. I-- so I, I guess I'm trying to make sure I, I, I'm understanding this correctly. So your position is such that you want to ensure that if a pregnancy, it hasn't-- has occurred, that there's, that there's not an abortion that takes place, but, but not opposed per se to an emergency contraception--

MARION MINER: Right.

FREDRICKSON: --if a pregnancy is-- am I understanding--

MARION MINER: Yep. Absolutely. Yeah. The ERDs, the Catholic ethical and religious directives, are not opposed at all to offering emergency contraception so long as they can be sure that conception hasn't already occurred.

FREDRICKSON: OK.

MARION MINER: And so that's what we need clarity here, which we don't have. So it says in-- the language that it says is that: but which does not disrupt an existing pregnancy. The problem is that oftentimes that is defined in the health care setting as beginning at implantation, which is some time after fertilization. So I hope that's helpful.

FREDRICKSON: OK. And, and my understanding is that what-- the emergency contraception is that if, if there is a pregnancy, it's-- it does not-- it doesn't end the pregnancy.

MARION MINER: So couple things I would point you to-- one, one specifically with regard to Ella is the exhibit that I have there, which shows that it clearly has an abortifacient effect. The second

thing I would say is-- I didn't include them here. I didn't want to overwhelm you with exhibits. But if you want, I can-- there-- the science in this is actually pretty heavily disputed. And there have been many, many peer-reviewed journal articles that have been published stating that, actually, it's unknown how often-- it's really, really effective-- Plan B, to take an example-- Ella, copper IUD. They're all three really effective at-- at the end of the day, there's no-- the pregnancy is stopped. Right? The question is, how did that happen? And some cases, it prevents ovulation. But there's a lot of evidence that says the closer to ovulation you get, the lea-- less effective it is actually preventing ovulation. But those pregnancies still come out the other end. The, the test will come back negative after some time. So what has happened in those cases is that ovulation has occurred-- and this is documented-- but there's no pregnancy, which mean it's-- it means it's having an abortifacient effect in most circumstances.

FREDRICKSON: So-- and, and, and, and for this legislation in particular, obviously-- so we're talking about ind-- individuals who have, who have been sexually assaulted. So-- against an individual's will. So is you-- is your position that, that individual, should they be pregnant, should be carri-- should not have a choice-- like, should be carrying that child to term?

MARION MINER: Our position is and the church's position has always been that a woman who has been a victim of sexual assault has the right to defend herself against pregnancy. If she has become pregnant already, OK, that's, that's unquestionably a very difficult situation for her. There's no getting around that at all. But it's, it's not-- it should not be state policy, and it's certainly not the way that the church approaches this issue, that the solution-- the best solution to that problem is to kill another innocent human being. That's, that's not the best way to address that situation.

FREDRICKSON: OK. Other questions? Seeing none. Thank you.

MARION MINER: Thank you.

FREDRICKSON: Any other opponents to LB67? Seeing none. Is there anyone here to testify in the neutral capacity? Seeing none. Senator Raybould, you are welcome to close. While you come up, we did have online comments. We had 27 proponents, 1 opponent, and 1 in the neutral capacity.

RAYBOULD: Well, thank you, Vice Chair, and thank you, committee, for listening to the testimony provided. I'd like to address some of the,

the questions and clear up some misinformation. I forgot who asked how often do sexual assaults in the United States occur. And this is available in your online testimony from the League of Women Voters of Nebraska. One person experiences sexual assault in the United States every 68 seconds. LB67 cannot eradicate this prevalent problem, but it will secure a standard of care for survivors who have experienced trauma-- and I'm going to just go off the remarks-- a standard of care applied throughout our state of Nebraska. It goes on to say, in the past decade, sexual assault-related emergency room visits have increased by tenfold. Currently, 21 states and the District of Columbia require emergency rooms to provide emergency contraception information to sexual assault survivors. I do want to point out that in this online comment, they cite all their references and sources for what they're saying in this online testimony. As our country continues to tighten restrictions on reproductive health care, we need a high standard of care for sexual assault survivors in Nebraska, throughout Nebraska, now more than ever. Now I want to jump over to the Cleveland Clinic. And we were looking up and had a nice discussion on ovulation and pregnancy and the, the-- many emergency contraceptions prevent ovulation. The Cleveland Clinic reports it is impossible for a woman to ovulate while pregnant. Because she's pregnant. And during pregnancy, a woman's menstrual cycle ceases. So I just wanted to make sure that was completely cleared up. I also want to talk about Ella and the medication, Ella, and how it works. Ella may work as-- and I believe this may have been per-- provided by Mr. Miner as well. Ella. How does Ella work? Ella may work as an emergency contraception by preventing or delaying the release of the egg from the ovary. Ella may also make it harder for a fertilized egg to attach to the uterus. And I want to point out that one of the most common birth control methods out there is an IUD. An IUD operates in that same fashion that prevents a fertilized egg from attaching to the uterus. Pregnancy occurs at that point in time when the fertilized egg attaches to the uterus, and that's why IUDs are considered one of the safest contraceptions to be used consistently. Thank you. Thank you all for listening and, most importantly, for hearing why LB67 is a bill that deserves our utmost attention and care for survivors of sexual assault throughout our state of Nebraska. LB67 provides this consistent, evidence-based medical care throughout our state, in our rural communities, in our urban centers. Last year, Ballot Initiative 434 was passed--

FREDRICKSON: Can we please turn off the cell phone that someone's got-- thank you.

RAYBOULD: Last year, Ballot Initiative 434 was passed by Nebraska voters and includes protections for victims of sexual assault. The

ballot language stated, except when a woman seeks an abortion necessitated by a medical emergency or when the pregnancy results from sexual assault or incest, unborn children shall be protected from abortion in the second and third trimesters. Not only was the ballot initiative supported by 55% of Nebraska voters, it was even supported by three bishops of Nebraska-- and, by the way, there's only three bishops in our state of Nebraska-- and through the Catholic Conference, stated that it was morally permissible and encouraged for Nebraskans to support the proposed Initiative 434, Protect Women and Children. So I thank you again, and I encourage you to vote affirmatively for this and exec out of the committee. And I'm happy to answer any additional questions.

FREDRICKSON: Thank you, Senator Raybould. Questions from the committee? Senator Meyer.

MEYER: Thank you, Vice Chair Fredrickson. The testimony I've heard today-- once again, thank you, thank you for your-- for bringing this and, and being here today. It seems like our urban centers probably are, are pretty much up to speed with providing services, forensic services, and, and the medications necessary to address this issue. And it seems like there was some focus on rural hospitals not being in the same position. I see there's no fiscal note on this. And so is there something prohibiting rural hospitals from having the meds on hand or, or having this training? I, I don't think requiring a hospital to, to train additionally over what they already do is, is necessarily a financially-- financial burden on them in any way, shape, or form. And I'm, I'm not proposing that. Is there-- the availability of meds in a rural community or shelf life or the, the frequency of use, is, is that an issue? Because I think we did focus a little bit on rural communities not having access or this available.

RAYBOULD: Ideally, it would be wonderful if those rural hospitals and rural clinics and other accredited health care providers would keep this type of medication available. However, they do have the ability to write that prescription for either Ella or the over-counter Plan B. So-- but it becomes a sense of urgency. And I think that is why this legislation is so helpful for those rural communities, that they can explain, you know, you have to take this medication within three days after sexual inc-- intercourse if it's Plan B. Or in the case of Ella, you must have access to this medication within five days. Or certainly with the copper IUD, it is the same, same concept. But it-- there is a sense of urgency to prevent this unintended pregnancy from occurring. And so it would be ideal if hospitals and other clinics throughout our rural communities would, would have some of this type of medication

available. I'm-- I am not certain of the availability in pharmacies throughout our, our state of Nebraska, but I think this law sets-- LB67 sets that high standard of responsiveness as part of medical care for those that have been traumatized by a sexual assault. And I would consider it-- it's a high duty of them to, to do what they can to make sure the-- those type of medications are readily available as much as they can.

MEYER: Just, just briefly. Thank you. It seems like time frame probably isn't prohibitive, three to five days. So I, I, I don't think that's-- in today's world, that's probably a prohibitive factor. Do you have any idea on cost, which would be, you know, a reason for a pharmacy not to have it on hand if the cost was prohibitive. And you may not be able to answer cost. And I, and I totally understand that. But is--

RAYBOULD: I'm a grandma. I'm an older lady, so I don't-- I, I couldn't tell you that.

MEYER: OK. I-- just curious if that was one of the prohibiting factors for local hospitals not having on hand if they don't. So. Thank you.

RAYBOULD: You bet.

FREDRICKSON: Other questions? Senator Riepe.

RIEPE: Thank you, Vice Chair. I have a few questions. My first one is-- I'm going back to my Section 2(4) about the prevent pregnancy without disrupting an existing pregnancy. And I think it will-- this is what I heard-- the Cleveland Clinic said ovulation stops when a woman becomes pregnant. So that would--

RAYBOULD: A pregnant woman does not ovulate. And so I think that's--

RIEPE: So the-- she cannot be-- once pregnant, she cannot become pregnant twice.

RAYBOULD: It would be--

RIEPE: You could have twins, but you're not going to--

RAYBOULD: --be near impossible. That's the language the Cleveland Clinic used. It's impossible--

RIEPE: OK. So I think that--

RAYBOULD: --for women--

RIEPE: --challenges this point 4 in Section 2. But let's not dwell there. I think my next one-- my next question was, is-- just out of curiosity, did someone or group ask you to bring this particular bill?

RAYBOULD: Yes. The Women's Fund asked me to, to bring this forward.

RIEPE: The Women's Fund. OK. Thank you.

RAYBOULD: And of course I wholeheartedly support it. And I was more than happy to, to introduce it.

RIEPE: My third and next-- final question would be is, do we need to amend this bill with language that's currently in the DHHS policy? And I don't know-- I was a little bit surprised that they didn't have someone that would come if they had any concerns.

RAYBOULD: They, they provided comments in the neutral online.

RIEPE: Oh. OK.

RAYBOULD: I don't know if I can have access to it here.

RIEPE: Well, I don't know whether they're-- do you think there's any merit of anything that they have to amend this to modify this particular bill?

RAYBOULD: I think-- their concerns were raised on if a complaint is filed against a hospital for failure to provide this option, option to a victim of sex-- sexual assault. It's an option that they have to be able to provide. And the, the, the victim of the sexual assault would have to say they, they declined or, or, thank you. I'm not interested in that. And I'm trying to find what DHHS said, but I think it is in the process that's detailed after a complaint is filed and the procedures that the hospital goes through to investigate the complaint, to follow up with the complaint, to get the reports from the pertinent stakeholders where-- that concern the complaint, and make a determination. And they have to notify DHHS because DHHS is notified of a, a complaint of this nature in any hospital situation. So I think they were saying some of the language is a little bit repetitive, but I don't think that has ever stopped any of us from passing legislation that might have repetitive language.

RIEPE: I think as a-- we have to be at least tuned in to the fact that as we make policies, it's quite frankly oftentimes varies from an urban to a rural application. Maybe in the urban center we have more opportunity or ability to comply, whereas you might not in a more rural

area, if you will. So my question then leads to-- my last one. Would-- does this truly add value to the delivery and the pra-- the patient care? And, and if so, kind of how-- how does it improve what we're currently doing? Because-- my own opinion, being an urban kind of guy and, and with a health background, I think that we've got a pretty good process in the urban market. I don't know anything about-- outside of maybe an urban area.

RAYBOULD: I think the, the message that we want to send very clearly is to take immediate, urgent steps to prevent an unwanted pregnancy, to prevent an unwanted pregnancy, and to reduce the, the number of abortions in our state of Nebraska. I think that message should be conveyed as loudly and clearly as possible, particularly since 55% of Nebraskans voted for Ballot Initiative 434. And so I think it's important that we take steps to be in compliance with the intent of that ballot initiative and make sure that statewide there is this consistent policy and practice. I can understand your concern that it might be challenging for a rural hospital or rural health clinic to be able to provide, but I think administratively there are already best practices in place to handle a victim of a sexual assault. But this is another opportunity to make sure that patient is aware of the options available to them in this very confusing, traumatic period in their life, both in a written form and an oral form that the patient can voluntarily accept or decline. So it's a consistency and a-- and if there is a complaint, it is more of an administrative complaint. Most rural clinics and rural hospitals are used to a process of dealing with complaints and the process of how to follow up and investigate and then have the appropriate determination in that report back to DHHS. This just says very clearly that this is a high standard that we're requiring for victims of sexual assault.

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

FREDRICKSON: Thank you, Senator Riepe. Are there questions from the committee? Senator Ba-- no. OK. All right. Thank you, Senator Raybould.

RAYBOULD: All right. Thank you so much.

FREDRICKSON: That will end our hearing for LB67. We will now move on to LB153. Senator Guereca.

GUERECA: I do have an amendment to the bill. It's going to be coming here in a sec.

FREDRICKSON: Welcome.

GUERECA: Good afternoon, Vice Chair Fredrickson and members of the HHS Committee. My name is Dunixi Guereca, D-u-n-i-x-i G-u-e-r-e-c-a. I represent District 7, which includes the communities of downtown south Omaha. LB153 is a bill to expand postpartum coverage for mothers who fall under the unborn child option in the Child Health Insurance Program, or CHIP. In Nebraska, these mothers are called CHIP 599 moms, named after LB153, which passed in 2012 and called for prenatal care coverage for all pregnant women who are ineligible for other coverage options. This includes women who are minors, whose parents' income make them ineligible for other coverage for their pregnancy, and undocumented, and any other women who's pregnant but lacks coverage for prenatal care. Most people are familiar with the three trimesters of a woman's pregnancy, but more and more experts are recognizing that the time after a woman gives birth as the fourth and fifth trimester of her pregnancy. The weeks following birth are critical to women, the baby, and the whole family's long-term health. In 2023, the Legislature chose to extend postpartum coverage for mothers who received Medicare coverage for their prenatal care, care. It was Senator Wishart's LB419, which was voted out unanimously out of this HHS Committee. However, LB419 did not include mothers who are covered under the CHIP program. Currently, mothers covered by the, the CHIP unborn child option receive benefits that are limited to only their pregnancy. And this coverage ends the mo-- the month that they give birth, as opposed to 60 days that had previously been offered to others covered under Me-- under Medicaid before LB419 was passed. LB153 calls for a sate plan-- state plan amendment to the CHIP program to extend postpartum coverage for mothers covered under the un-- chil-- unborn child option. It uses innovative options, called health and service initiative, or H-- HSI, to assure a federal match of the benefits offered to these mothers. Currently, the federal match for CHIP is 71%, and we all know this is an allowable usage of HSI because the federal government has approved state plans in four other states: California, Illinois, Minnesota at 12 months, and Virginia at 60 days. I would like to thank all the thoughtful stakeholders that have been helping to get LB153 ready for prime time. I specifically want to thank my friends at the Catholic Conference for working with my office on an amendment that you should now have in front of you that more specifically clarifies who are able to receive these services. There are testifiers behind me who could speak further on to why LB153 is critical in ensuring Nebraska's a state that provides the necessary care to our most vulnerable mothers. With that, I would be happy to take any questions.

FREDRICKSON: Thank you, Senator Guereca. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator. My question is, what would be the number of recipients that-- in a one year's time period?

GUERECA: So--

RIEPE: Because it seems that we've covered the Medicaid in Senator Wishart's LB419. And this is a build on that for CHIP mothers. How many, how many CHIP mothers are there out there that, that aren't already under Medicaid?

GUERECA: Yeah. They're-- the-- I think the experts behind me-- like, I, I have a number in mind, but I want to make sure that's the right one. So I'll work on getting that number if they don't answer it.

RIEPE: Do you think it's a big number or a little number?

GUERECA: I believe it's under 200. So.

RIEPE: In a year's time?

GUERECA: Yeah, mothers. Yeah.

RIEPE: Oh. OK.

GUERECA: So it's not a big population.

RIEPE: OK. Thank you.

GUERECA: But I could be wrong, so. I'd ask again.

RIEPE: We won't put that in the record that you could be wrong.

GUERECA: Yeah. Cut that part out.

RIEPE: Thank you, Vice Chair.

FREDRICKSON: Thank you, Senator Riepe. Other questions? Is this-- is the, is the amendment you have-- it's a white copy amendment?

GUERECA: Yes.

FREDRICKSON: It is. OK. So this replaces the whole bill?

GUERECA: Yes.

FREDRICKSON: OK. And how is this different from--

GUERECA: I think it was the language clean up. So.

FREDRICKSON: OK. OK. All right. Great. Thank you.

GUERECA: All right.

FREDRICKSON: All right. We will now take proponents for LB153. Welcome.

KATHLEEN GRANT: Good afternoon. My name is Kathleen Grant. I'm speaking on behalf of Omaha Together One Community.

FREDRICKSON: And can you spell your name for the record? Sorry.

KATHLEEN GRANT: Sure. K-a-t-h-l-e-e-n G-r-a-n-t.

FREDRICKSON: Thank you.

KATHLEEN GRANT: Mm-hmm. I'm speaking on behalf of Omaha Together One Community. 13 years ago, OTOC worked with our allies to ensure all mothers under the CHIP program would retain access to prenatal care. And today, we are here to support the expansion of postpartum care for mothers, all mothers, under the CHIP program through passing LB153. I'm from western Nebraska, graduated from Creighton University Medical School. I served on the faculties of both Creighton and the University of Nebraska Medical Center. Additionally, I've worked in the Dominican Republic and in Nicaragua and seen the effects of inadequate prenatal and postpartum care. Postpartum care encompasses a series of visits and interventions aimed at ensuring the new mother has the physical and mental health necessary during her recovery period and the first days of her inf-- infant's life to ensure her own and her baby's good health. As you can imagine, many moms have questions about caring for their baby. When they are-- when can they resume sexual intercourse? When-- what happens when unexpected medical problems arise? After their baby's birth, women can experience a tear of their vagina, uterine blood loss, ongoing contractions, mood swings, crying spells, anxiety, difficulty sleeping, as well as postpartum depression, which can be fatal. Imagine having one or more of these conditions and a 7-pound newborn who isn't sleeping, is crying and hungry. In addition to those mentioned above, according to the Mayo Clinic, postpartum mothers are at increased risk for severe headaches, vision changes, breathing difficulties, chest pain, leg swelling, and health issues that can emerge during pregnancy, such as pre-eclampsia or gestational diabetes. Additionally, postpartum visits are essential to ensuring that, that the mother is adequately nursing. Lastly, while we don't believe this should be the primary justification for postpartum care, these postcar-- postpartum visits can also prevent expensive emergency room

visits. OTOC supports LB153, and we look forward to Nebraska providing postpartum care to all Nebraska moms and babies.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you. Thank you for being with us. And do you have an, an answer to help us get over the fiscal note?

KATHLEEN GRANT: I don't.

RIEPE: Oh. I was hoping you did. Thank you very much. Thank you, Vice Chair.

FREDRICKSON: Thank you, Senator Riepe. Other questions from the committee? Seeing none. Thank you for being here. Next proponent for LB153. Welcome.

MARY McKEIGHAN: Welcome. My name is Mary McKeighan, spelled M-a-r-y M-c-K-e-i-g-h-a-n. I am testifying as a proponent of LB153. I'm a registered voter in District 12 and a member of OTOC. I'm a registered nurse and worked for ten years as a nurse on an obstetrics floor. As a nurse, I've seen many complications develop which require extended care after giving birth. Infections, hemorrhages, high blood pressure issues are just some of those that can occur. There is also a mental health issue called postpartum depression. That is the complication I'm going to talk about today. It can develop a few weeks or up to a year after giving birth. According to a Mayo Clinic study done in 2023, there are more than 3 million cases per year. If left untreated, it can last months or even years. If CHIP coverage was extended, it would give mothers the support and care they need should they suffer from postpartum depression and any other complications that can revol-- result from childbirth. You might-- may wonder why I choose this particular issue to talk about in my testimony today. When I was in grade school, we had a young mother in our community who was suffering from postpartum depression. Her husband took her to stay with his parents when he realized she was unable to take care of herself or her baby. She left the house during the night in subzero temperatures and was found frozen to death the next morning. She had not even put on shoes to go outside in the extremely cold weather. A baby lost his mother. A husband lost his wife. A family had a funeral rather than celebration. Our country cannot afford to lose our mothers because of lack of care. Mothers are most often the caregivers of our upcoming generations. In that role, they supply strong building blocks for the foundations of our next generation. Their care contributes to the

success of our children. But to be good mothers, they often need someone to care for them. LB153 can do that by extending postpartum coverage for at least six months. We cannot afford in Nebraska to lose our mothers because of lack of care.

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

RIEPE: More of a question than a comment. You fought-- you brought up District 12, which is a great district, but you also didn't bring up Bergan Mercy, which is where we both served together.

MARY McKEIGHAN: Yes. I knew Merv when he didn't have gray hair. And I had a lot more hair.

RIEPE: This is dyed, Mary. It's very [INAUDIBLE].

FREDRICKSON: Well, Merv ages like a fine wine [INAUDIBLE]. Other questions from the committee? Seeing none. Thank you again for being here. Next proponent for LB153. Welcome.

ANDREA SKOLKIN: Welcome-- or, thank you for welcoming me. Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n. And I am the Chief Executive Officer of OneWorld Community Health Centers. Our main campus is in south Omaha, but we do have 22 service locations in Omaha, Bellevue, and one in Plattsmouth. I'm here today in strong support of LB153. Since 1970, OneWorld has been a cornerstone in south Omaha, offering comprehensive medical, dental, behavioral health, and pharmacy support services to all people regardless of insurance status or ability to pay. We collaborate with lots of organizations in our community to address the nonmedical needs that affect health, such as access to safe housing, food secur-- food security, and economic well-being. Last year, we cared for about 53,000 patients, 87% of whom had incomes at or below 200% of poverty and 42% who were uninsured. In 2024, we provided prenatal care to more than 2,000 moms who gave birth to about 1,200 babies. We offer comprehensive maternal and family health programming, from medical care to education classes, and even have an on-site baby boutique for moms who attend their prenatal appointments in order to be able to meet their basic needs. We have the largest midwifery program in the state. And we're committed to all moms and babies, reducing maternal mortality among our patients. As you know, women of color experience disproportionately higher incidences of pregnancy-related death, postpartum depression, and postpartum medical complications. The-- as you've heard, the months

following childbirth can be a, a unique vulnerability-- time period where people are vulnerable to mental illness, and screenings during this time period is a critical opportunity to detect what's going on with postpartum depression. And as well, if mom is doing well, then the health of the baby can be better. Having a baby can be a wonderful time period, but it also brings worry and uncertainty. Parents-- and moms especially-- have concerns as they face the changes that a new baby brings. Often, parents need support to make good decisions about taking care of themselves and their new baby. The weeks and months following birth lay the foundation of long-term health and well-being from both mom and her baby. It's critical to have reliable postpartum care. As you also heard, in 2012, Nebraska took a bold step in supporting the health and well-being of Nebraska families when Medicaid coverage was extended independent of immigration status. I testified and was part of that initiative.

FREDRICKSON: And you're in your red zone--

ANDREA SKOLKIN: I see my time is done. I'm closing. So LB153 will continue that commitment to supporting children as they grow-- and make no mistake, this is about the children and their moms-- so they can thrive, ensuring they have health care access during that critical time period. I'm happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Vice Chair. Do you have cultural issues that you have to address that maybe culturally, given your population, they might feel that it's a weakness to-- for a, a pregnant woman to have, you know, post-born problems, if you will. Is it-- I'm just--

ANDREA SKOLKIN: I don't want to stereotype any culture. However, depression among the La-- Latino community is less likely to be identified or for them to bring forward. But trusted medical providers have a way of asking the right question. And then it can be addressed after that.

RIEPE: OK. Just, just a curiosity one. Thank you, Chairman.

FREDRICKSON: Are there questions? Senator Meyer.

MEYER: If I may. Thank you, Mr. Chairman. Thank you for being here. I see you have some, some numbers here and specifics. And I know Senator Riepe really appreciates the numbers and-- one number that stands out to me is you provided prenatal care to 217-- 2,017 moms with nearly

1,200 births. Could you explain the discrepancy in the number of prenatal moms that you treated--

ANDREA SKOLKIN: Sure.

MEYER: --and, and the, the fewer birth? Is, is there--

ANDREA SKOLKIN: Because of the-- Senator, that's a good question. But because of timing, not all babies are born within the year. So there's more prenatal patients than there are births in a year.

MEYER: I thought it took 12 months. So it's not within a year? OK.

ANDREA SKOLKIN: Well, unbeknownst, it's really ten months, but, yeah.

MEYER: I, I-- it just seemed like a discrepancy there, but based-- yeah.

ANDREA SKOLKIN: Yeah. It seems like a funny number, but.

MEYER: There's an overlap factor there that I--

ANDREA SKOLKIN: Yeah. Mm-hmm.

MEYER: All right. Well, thank you very much. I appreciate that.

FREDRICKSON: Thank you, Senator Meyer. Are there questions? Seeing none. Thank you for being here.

ANDREA SKOLKIN: Thank you.

FREDRICKSON: Other proponents for LB153.

ROSA PINTO: Good afternoon, members of the Health and Human Services Committee. My name is Rosa Pinto. I'm a community or-- sorry. R-o-s-a P-i-n-t-o. I'm a community organizer with the Heartland Workers Center. The Heartland Workers Center's mission is to develop and organize leaders, promote workers' rights, and foster a culture of civic engagement in order to build power and create change within the immigrant and underrepresented communities. I'm here today to show my strong support for LB153, to provide postpartum care for new mothers in Nebraska who currently have no coverage after they give birth. As a community organizer, I have seen several Nebraska residents struggling with health problems right after giving birth, not being able to see a doctor, nor being in the best shape possible to take care of their newborns simply because they didn't have any health coverage. One story, for example, is of a mother who suffers from epilepsy who had

several episodes of seizures but could not be seen or even get her medicine refilled due to financial strain and no coverage. Another story is a mother who, in the short six weeks after giving birth, she dealt with mastitis but could not go to the doctor due to not being able to pay for the visit, as she was already trying to save for the six-week postpartum check that would allow her to go back to work, which would not be covered either. I strongly believe proper postpartum medical coverage will help mothers of U.S. citizens take better care of their children, as it will allow them to take care of birthing-related problems before they become too serious. As we all know, a baby's quality of life depends, in mostly all cases, 100% on their mother taking procker-- proper care of them. This is why I'm strongly urging you to please vote LB153 out of committee. Thank you so much for your time and attention. And I'm willing to answer your questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Hansen.

ROSA PINTO: Hi.

HANSEN: Rosito? Was, was it-- what was it?

ROSA PINTO: Rosita.

HANSEN: Rosita. That's right. Good to see you again.

ROSA PINTO: Yes. Nice seeing you.

HANSEN: From Columbus, right?

ROSA PINTO: It's been a long time. Yes.

HANSEN: Yeah. Yeah. Well, good. Good testimony. You know, I--

ROSA PINTO: Thank you.

HANSEN: --just want to say.

ROSA PINTO: It's been since Tuesday, but--

HANSEN: Rosita and I talked before. And she was a little nervous about coming up today, so--

ROSA PINTO: Yes.

HANSEN: But you couldn't tell that, that she-- that she did great, so.

ROSA PINTO: Got a little tongue twisted. I apologize for that.

HANSEN: That's all right. It's perfect. Yeah. Thanks for coming.

ROSA PINTO: No problem. Thank you.

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

ROSA PINTO: Thank you.

FREDRICKSON: Next proponent for LB153. Mr. Venzor.

TOM VENZOR: Good afternoon, Vice Chair Fredrickson and members of the HHS Committee. My name is Tom Venzor, T-o-m V-e-n-z-o-r. I'm the Executive Director of the Nebraska Catholic Conference. Catholic social teaching has a rich tradition of contemplating and solving difficult issues that face our society and common humanity. One important principle, among others, offered by Catholic social teaching that we should keep constantly in mind is the preferential option for the poor. Preferential option for the poor is a special form of primacy in the exercise of Christian charity. It affects the life of each Christian in as much as he or she seeks to imitate the life of Christ, but it applies equally to our social responsibilities. This love of preference for the poor and the decisions which it inspires in us cannot but embrace the immense multitudes of the hungry, the needy, the homeless, those without health care, and, above all, those without hope for a better future. And it's this basis of Christian charity due to mothers and families who lack access to basic and necessary health care that's the impetus for our support today on LB153, which would ensure low-income and undocumented mothers do not lose health care coverage shortly after giving birth. That next paragraph is just some data on maternal morbil-- mor-- maternal morbidity and mortality, which I'm-- those have been covered, so I'll skip there to that second page. You know, the, the-- we can address those type of issues. For a mother who has her own set of health care needs, is without adequate support, and is also responsible for taking care of the needs of her child or children, it becomes imperative for the state and federal government to step in and provide the necessary assistance for health care coverage. To draw again from the Catholic social teaching tradition, this type of support, assistance, and care is in line with the principle of subsidiarity. Subsidiarity recognizes the basic fact that there are times when local and intermediar-- intermediate institutions-- like the family, churches, nonprofits, private industry-- that they should step up, but sometimes they cannot fulfill some important needs that the

larger community must come in and step in on. When this occurs, it's wholly appropriate and even necessary for the larger political community-- us as a state-- to assume a proportionate responsibility in our care and concern for those in need. So while the Nebraska Catholic Conference isn't the public health expert on this topic, the personal and public health care benefits of LB153 are numerous. Extended postpartum coverage helps mothers to deal with any number of issues that can present during perinatal and postpartum period, such as gestational diabetes, preterm labor, recovery from caesarean sections in high-risk pregnancies, pre-eclampsia, maternal depression and other mental health concerns, sepsis, pulmonary edema, and acute heart failure. Coverage also provides for the future healthier pregnancies, as well as assisting mothers to be more proactive in their health care as they pursue the care of their newborns and infants. So again, it's-- for those reasons, we think this is very important, and particularly for the conference in this sort of post-Roe v. Wade world and also post-Initiative 434 culture of life that we're trying to build. We think that bills like LB153 are a very important piece in terms of respecting the human dignity of the mother and the child and ensuring that they get the proper care they need. So thank you for your time. And I'll take any questions.

FREDRICKSON: Right on time. That was perfectly timed.

TOM VENZOR: Yeah. I think she was clicking. She was waiting for me to be done. Thank you.

FREDRICKSON: Thank you. Any questions from the committee? Seeing none. Thank you for being here.

TOM VENZOR: All right. Thank you very much.

FREDRICKSON: Next proponent for LB153.

REBECCA WELLS: And I have a handout. And the handout actually-- yeah. It talks about postpartum coverage till 12 months, but. I'm Rebecca Wells. I already introduced myself. Do I need to spell my name again for you?

FREDRICKSON: Please do, yes.

REBECCA WELLS: R-e-b-e-c-c-a W-e-l-l-s. And I've already introduced myself. And I will tell you, when I saw this bill listed, I'm like, well, didn't we already go through this? I was confused. So of course I got on the internet and I googled, you know, extended postpartum coverage. And what I came up with is the Health and Human Services, a

big thing talking about extended postpartum coverage, frequently asked questions. I'm a bit confused because it talks about effective January 1 of 2024 and LB227 being signed into law. And then it talks about Nebraska extending care for Medicaid for 12 months. So I'm confused. I really am. And I look back here and then it says, will mothers need to apply for Medicaid-- reapply after-- for continuous-- and it says no. Nebraska Medicaid will automatically check to see what mothers were enrolled in Medicaid or CHIP while pregnant and extend their coverage. So I was really confused. And then I found a "Governor Pillen Announces Change to Bolster Medicaid Coverage." Talks about going from, you know, 60 days up to 12 months. Talks about the wonderful benefits, how this is a, you know, a pivotal moment in Nebraska's journey toward improving maternal and child health. So I'm a bit confused about this bill and what happened to this other bill. And I will tell you this is a critical thing. And I know, Senator Riepe, your bill about the criminals at young ages, our 11- and 12-year-olds. You know, you look at a child's early development, what is so critical is their, their circumstances and the health of their mother is, as we had another testifier mentioned, is very critical to a child's development, physical and mental. What I gave you, that is the-- that's the authority on, on maternal health. But 1 in 5 pregnant women in this country has a preg-- a complication in their pregnancy that can lead to later things, heart disease, later hypertension, diabetes if they have gestational diabetes. And cutting them off early, if we're not extending all of them--

FREDRICKSON: If you can just finish your final thoughts here.

REBECCA WELLS: We need to extend the ones that we aren't to at least six months because it's critical. And the mortality rate, even from 6 to 12 months, they're finding suicide and overdose.

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

REBECCA WELLS: Any questions?

FREDRICKSON: Seeing none.

REBECCA WELLS: So, yes, extend whatever isn't extended.

FREDRICKSON: Thank you for your time. Thank you for your testimony.

REBECCA WELLS: Thank you.

FREDRICKSON: Next proponent for LB153. Welcome.

KELSEY ARENDS: Thank you, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s. I'm the senior staff attorney for health care access at Nebraska Appleseed. Testifying in support of LB153 on behalf of Nebraska Appleseed. Because this bill addresses important gaps in access to postpartum care, which is critical for keeping Nebraska moms, babies, families, and our communities healthy, Nebraska Appleseed supports this bill. LB153 provides postpartum care for new Nebraska mothers who currently have no coverage after they give birth. Today, pregnant community members who receive services through 599 CHIP are able to access prenatal labor and delivery services but receive zero coverage for postpartum services. Poor postpartum health is a significant problem in the United States. Postpartum care is critical and tied to improved health outcomes for pregnant people and for newborns. Currently, some longtime Nebraska community members who contribute important talent, work, and taxes to our local communities and programs like Medicaid are unable to access basic, important postpartum services while navigating a complicated immigration process. Becau-- basic postpartum coverage keeps Nebraska moms and babies healthy and reduces costs for communities and health systems. 599 CHIP provides access to services for Nebraskans with limited options for other coverage, including minors who are pregnant but who do not qualify for Medicaid because of their parents' income. Without ensuring coverage of postpartum services, all 599 CHIP mothers are left without access to health care while their bodies are still actively healing from carrying and delivering newborns. Notably, federal funding is available to states that provide postpartum coverage for those who receive care through the-- from conception through the end of pregnancy or unborn child option, which, as you know, we call 599 CHIP in Nebraska. Through a CHIP health services initiative, or HSI, states can leverage federal funding to help improve the health of children with low incomes, subject to federal approval. Currently, eight states use federal matching funds from approved CHIP HSIs to cover people in the postpartum period in this specific category of Medicaid. Other states provide postpartum coverage through other options like using state funds. Federal approval for programs like this one are routinely granted, as you can see by the other states who have been approved and are implementing these programs now. Additionally, we're aware of the amendment that was introduced that will make it extra clear that these postpartum services are appropriately provided under the 599 CHIP program, just as prenatal services are. To be clear, this bill complies with state and federal Medicaid law. The postpartum coverage in LB153 will ensure healthy outcomes for Nebraska moms, babies, and families, and cost savings for individuals, communities, health systems in our

state. Because this bill promotes health coverage stability and-- in the important and impactful postpartum period, Nebraska Appleseed encourages your support of this bill.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Hansen.

HANSEN: Thank you. You seem like the right person to ask.

KELSEY ARENDS: Sure.

HANSEN: So obviously, there's growing concern about the federal government and their participation in programs such as this, SNAP, and all kind-- you know, Medicaid and FMAPs and--

KELSEY ARENDS: Sure.

HANSEN: And I know-- I think you voiced the same kind of concern. Maybe not. But I know that's a concern we as a committee have to kind of wrestle with a little bit. And I think you as an organization might also maybe ha-- have an idea about. But with, with all the bills that have to do with federal funding that we're asking for this year when it comes to health care, do you guys have a priority list of the-- not, like, here's the number one bill we would like to see moved through. Here's number two, here's number three, here's number four. Because I think us as a committee now I think are going to have to figure out, OK. What, what's the priority that we think are important, but then also what do the people think are important?

KELSEY ARENDS: Sure.

HANSEN: You know? Because we don't want to pass a whole bunch of bills that the federal government's going to cover 2/3 of. And then they come here next year and say, we're only covering 1/3 of it now. And then we're up a creek. So.

KELSEY ARENDS: Yeah. It's a great question. And, and I acknowledge for sure there's lots of uncertainty at the federal level. Right now, this program exists and it's fully funded, and that's the state of play right now. There's also, you know, changing messages that we can see. And I don't know how to read the tea leaves, but CHIP provides a lot of services for kids, which, which we know-- as you all know as legislators, people want to take care of kids, for sure. And that's what we're talking about here, so that's a top priority. And in the past, what we've seen is that services for kids were prioritized to be maintained. So I have hope that that would be true again. As far as our

priority list, I'm not an authority to speak on that. But, but you know folks here who would be-- and, and Katie can tell you. Probably she could be more pers-- provide more perspective on that. But this is a really critical bill that does leave-- right now, the way that 599 CHIP works is it leaves babies and moms at huge risk and at a place where they're receiving no services. And so this would be really effective in, in improving health outcomes for babies and moms.

HANSEN: OK. All right. Thank you.

FREDRICKSON: Other questions? Senator Ballard.

BALLARD: Thank you, Vice Chair. Thank you for being here. I just have a question. And it's just because I don't know. It's not a gotcha question. Compared-- and your testimony on the back page said, compared to traditional pregnancy eligibility, 599 CHIP does not require citizenship or specific immigration. Can you describe, like, why, why there's a discrepancy between traditional and 599 CHIP?

KELSEY ARENDS: Yeah. So that's the whole purpose of the 599 CHIP program, is that it's moms who but for usually immigration status or their parents' income would qualify for traditional Medicaid. But because they don't meet those requirements, the 599 CHIP program exists to say, for pregnant folks in this situation, we'll determine their eligibility based on the unborn child-- or, to cover from conception through the end of pregnancy. So it's, it's folks who are locked out of traditional Medicaid po-- pregnancy coverage because of those specific things, their immigration status often, or, for some minors, their parents' income.

BALLARD: OK. Thank you.

KELSEY ARENDS: Yeah.

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

KELSEY ARENDS: Thanks.

FREDRICKSON: Next proponent for LB153. Seeing none. We will move on to o-- opponents for LB153. Dr. Corsi.

STEVE CORSI: Good afternoon, Vice Chairman Fredrickson and members of the Health and Human Services Committee. My name is Steve Corsi, S-t-e-v-e C-o-r-s-i. And I am the Chief Executive Officer of the Department of Health and Human Services. I'm here to testify in opposition to LB153. Our opposition is based on the premise that,

except for emergency situations, public benefits funded by state dollars should be for the purposes and benefit of Nebraska citizens. Currently, this population is not eligible for Medicaid or the Children's Health Insurance Program in their own right, which is why they are receiving coverage for their unborn child under the 599 CHIP program. Members of this population may not be lawfully present in the United States. Providing postcar-- postpartum coverage to individuals not lawfully present conflicts with current state law. This bill would expand Medicaid benefits to this ineligible adult population for an entire year following the child's birth. The bill proposes the use of a CHIP health service initiative, or HSI, to fund the federal share of the cost. CHIP allows states to use part of their annual CHIP allotments and receive the federal CHIP matching rate for expenditures associated with HSIs. Under federal law, claims for HSIs and administrative expenses cannot exceed 10% of the total amount of CHIP funds claimed by the state each quarter. DHHS believes implementing this additional HSI would exceed the 10% cap mentioned above. Nebraska's current HSI program funds the Nebraska Regional Poison Control Center. Adding this additional HSI would exceed that 10% cap. Congress has also generally restricted the use of federal funds to those lawfully present in the United States. In addition, on March 10, 2025, the Centers for Medicare and Medicaid Services issued the Marketplace Integrity and Affordability proposed rule, which amends the definition of lawfully present to exclude previously eligible Deferred Action for Childhood Arrivals individuals from some federal benefits. We ask the Legislature to continue the apro-- the prudent aforementioned policy as codified in Nebraska law, which largely mirrors federal policy and code. Nebraskans should not be forced to subsidize those not lawfully present in the United States, nor should they be forced to incent the continued unlawful presence of individuals in our state or the nation. We respectfully request that the committee not advance the bill to General File. Thank you for your time.

FREDRICKSON: OK. Thank you for being here. Any questions from the committee? Senator Hansen.

HANSEN: I got one. Similar to the previous testifier about the concern of federal funds being used for certain programs, based on what, you know, what you just mentioned about March 10 of 2025, that CMS issued the Marketplace Integrity and Affordability--

STEVE CORSI: Proposed rule.

HANSEN: Yeah. And considering the general philosophy, I guess, of, of the executive branch or federal government, would, would you-- would,

in your opinion, would you view this program as one of-- like, if they had to put a bullseye on certain kind of programs that they were going to kind of maybe go after and try to reduce based on, you know, the budget for the federal government, you know, they're trying to-- I think they're trying to tighten their belt--

STEVE CORSI: Right.

HANSEN: --based on the amount of debt that we have-- would you consider this as one of-- like, a program that they would probably go after first or, like, one of the primary programs of this, especially considering that the, the rule that they proposed on March 10, if we issue this based-- against their, their rule--

STEVE CORSI: Senator, as much as I would love to try to answer that question, I think I would be speculating. Things are changing nearly daily, obviously, but I, I, I think I would be speculating it. I, I think what you're saying is that it looks like, based on this March 10 proposed rule, that, that maybe they're already moving along these lines. That may be true, but I couldn't speculate as to whether that would--

HANSEN: OK.

STEVE CORSI: Yeah. We haven't heard one way or the other.

HANSEN: OK.

STEVE CORSI: Yes, sir.

HANSEN: Thanks.

FREDRICKSON: Thank you, Senator Hansen. Other questions from the committee? I have one. It, it, it, it might be kind of similar to Senator Hansen's, so if, if, if you're unable to pro-- provide that, that's fine as well, but I-- so I, I, I don't recall the department when-- this bill last year, I don't recall opposition last year. So it-- has the shift in position of the department-- is that primarily-- is that related to the shift in the federal administration and trying to be prudent with those changes?

STEVE CORSI: Senator Fredrickson, I apologize. I-- my memory doesn't go back to that-- to the, to the last-- to last year and, and a bill along these lines. So I can't even answer that. I apologize.

FREDRICKSON: OK. That's fine. Thank you.

STEVE CORSI: Yeah, yeah. And I did want to comment, though, back to something Senator Hansen said. When I-- I, I think you have a fiscal note somewhere that you're able to reference, and I believe that this was about $2 million in general funds and about 4-- an additional $4 million in federal funds, Senator Hansen. So-- if I remember the numbers right.

HANSEN: Cash funds?

STEVE CORSI: Mm-hmm. Correct. Yeah.

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

STEVE CORSI: Thank you very much.

FREDRICKSON: Next opponent for LB153. Seeing none. Is there anyone here to testify in the neutral capacity for LB153? Seeing none. Senator Guereca, you are welcome to close. While you come up here, we did have online comments. We had 39 proponents, 1 opponent, and 0 in the neutral capacity.

GUERECA: Thank you, Vice Chairman. Yeah. The fiscal note's interesting. You know, there's a lot of-- I don't know if you guys have this one, but that period of time after birth for, for both the baby-- who's an American baby-- it's really, really important. A lot of the deaths that occur are-- 84% of all deaths that occur in that year period of time are preventable. This is about saving lives that could easily be saved. And we have a duty as leaders in our communities to make sure that these babies and moms that could easily be saved are. And I'll take any questions.

FREDRICKSON: Thank you, Senator Guereca. Questions from the committee? Let you off easy.

GUERECA: All right.

FREDRICKSON: All right. That will end our hearing for LB153. We will let the room shuffle out a little bit. On her way? On her way. OK. Senator Spivey is on her way, so we will wait for her arrival. All righty. Senator Spivey, you are welcome to open on LB442.

SPIVEY: Thank you, Vice Chair Fredrickson and members of the HHS Committee. If I can give you this to pass out to the committee, that would be great. I'm giving you a handout around LB442 as well as a overview document. I am Ashlei Spivey, A-s-h-l-e-i S-p-i-v-e-y. And I'm proud to represent District 13 in northeast and northwest Omaha. LB442

is a child care bill which expands access to affordable child care in Nebraska by establishing a state child care subsidy program to support working families and strengthen the state's workforce. This is a policy modeled after Vermont. And so Vermont, which is one of the handouts you have, is kind of a one-pager over their program set out to say 80% of working families need child care support. Not everyone is eligible for the Title XX or a federable-- federal subsidy, and so how can we ensure our working families are able to stay in the workforce and receive quality child care? And so this is modeled directly after what they have implemented in to be successful there. The main components of this bill are to provide child care assistance to families earning between 130% and 400% of the federal po-- poverty level, ensuring more Nebraskans can afford quality child care while maintaining employment. There is a trigger in this bill because Senator DeBoer is looking at not-- addressing the sunset for our current subsidy. So we have it written as if that would sunset, but we know that that would be an implication of this bill. It would also implement a sliding scale, cost-sharing model, allowing families to contribute to a manageable portion of the income toward child care based on their earnings. And so it's not like a flat rate that if you are a family of four making $80,000 that you get the same rate as a family of four making $60,000. So it would be a sliding scale model. It would expand eligibility for child care assistance to include apprentice workers in Nebraska's registered apprentice programs, helping them access reliable child care while building skilled careers. So while I was campaigning and again thinking about working families, you look at the workforce and especially the trades, apprentices make just enough not to qualify for Title XX, but they don't make enough to actually afford child care. So they're at that weird cliff effect. And so as you know, there's a push to get more women in the trades, younger people in there expanding their families. Well, they don't have child care. They cannot complete a apprenticeship program. And so we built that. And this is in addition to what Vermont's model looks like because we know that that was important across our state. The, the other component of this bill would-- it would fund the program through a payroll tax, 50-- 0.52%, with employers contributing 0.39% and employees contributing 0.13%, ensuring a sustainable funding mechanism without necessarily relying just on general funds. It would adopt a fixed payment-- pay-- payment schedule for child care providers, ensuring stability and consistency in reimbursement rates while maintaining the affordability of parents. So think the same way that Title XX, the federal program, works. That reimbursement process would be the same. This bill does not increase the state's financial burden on General Fund taxpayers because it's funded through payroll contributions, which I think is important. And I

do think the-- you know, we've talked about priorities a lot and the deficit and what's in front of us and the choices we have to make. You have heard for decades in this body from businesses, from working families that workforce is an issue, and child care and housing are key components of that. And so I do think the state needs to invest in child care and what it looks like. And there are a number of senators that have bills that I think represent that buy-in. I also think that the business community needs to buy in. Whether you have employees directly accessing child care at that time or not, it's a community benefit. And it's going to grow our economy. It's going to make their business more successful as well because then people are working and have more disposable income to spend. And so I think that this is important to have that-- the business community buy in as well as the employees. So as you all know, Nebraska's in a child care crisis, and we've been in a crisis. When you do not have access to child care, it makes it difficult for working families, especially those in the middle income or in two-parent households to, to secure reliable care for their children. I, I'll talk a lot when I'm giving my opinions about me personally because I think, you know, this work, we have a perspective that colors how we show up. And my youngest son is 2.5. And for his first two years of life, he was home with me while I worked at my nonprofit. And so I had extreme postpartum depression, anxiety, which really crippled me in feeling comfortable with who can take care of my kid, what does that look like. So I'm navigating this mental health space. And then there were actually no providers that were affordable, had openings, and were close to me and my community. And so even if I, you know, navigated through my postpartum depression, I was like, OK. I'm ready to find some place for him. There was no place available. And we are a working family. And so we cannot afford child care on our own. It's really tough for us now. My-- we found some child care when he was about two years and two months, but it's still really difficult. And both my husband and I, we, we work. And so-- again, like, personally, I've been affected. And then as I was out knocking doors, like, that's what folks are talking about. They want to expand their families, but they're not. They're leaving their jobs because child care costs as much as what their check will be. So why would they work when they can stay home and be with their baby? And so we really have to address the, the high child care costs, which force many parents, particularly women, out of the workforce, which reduces economic productivity and household income. Child care shortages in rural areas leave families with fewer or no options, and it can also show up as really long commutes or forcing folks to leave their jobs. And so this is not just an urban issue in my district in 13, but it's across the state. Apprentices and trade workers often struggle to access child care due

to their irregular work schedules. You know, construction can be unpredictable. And so what does that look like for them as well as-- then it creates a barrier for them to finish their program and start to making a wage that really impacts their economic trajectory. There are other states that have successfully implemented similar child care subsidy programs-- again, showing that there is an investment in the, the child care, which really increases workforce participation and reliance on public assistance and long-term child outcomes. Another piece of this bill that I thought was important from an economic development standpoint is that it creates a grant program for child care providers. And so it's one thing to say we-- right? We're focusing on the working families, but the ecosystem of child care also needs support. There's not enough providers to even meet the demand of families. And so-- and this is for in home and centers. And so say if you are an in-home provider and you need to get a storm shelter so that you can be licensed and take care of kids, the, the way that, that reads for, like, traditional capital access or debt financing, it's harder to get a loan for that. And that can be up-- upwards to $20,000. And so the grant program is really saying we are going to invest in these child care businesses so that they can, one, be successful and then meet the growing need. And so it's a kind of a two-pronged approach, which also Vermont did as well. And so the impact of LB442 would be creating this Nebraska-based subsidy. It's complementary to Title XX. So if you qualify for Title XX, you would still be eligible in the same way that HHS is administering now. But it, it would support that and run next to it for those folks that are ineligible to utilize that federal program. By lowering the child care cost with that sliding scale, the bill enables more working families to enter or remain in the workforce. It makes us more competitive. You know, young folks want to move here, start their families, grow their business. And so having this benefit I think will be really important. And as I just mentioned, it really invests in the child care providers as well. So there are some pending amendments that I am working with Drafters on. I didn't present those to you today because they are still in draft form and I want to make sure I have it a little bit more technically sound. So the first is creating a dedicated cash fund for this program. The-- I forgot that. So it would have been going just to general funds to access even though that subsidy exists. And so we would create a cash fund where Department of Labor would collect the tax, and then HHS would administer the program. And when you look at child care cost and-- you know, some folks utilize some sort of child care through early childhood in, like, elementary school. What we know is that the, the hardest space to access child care is when you're four years old or younger for your children. And so we are looking at an amendment to

change that to 48 months or less, because that's the most expensive and the hardest, because there are other early childhood programs that are either subsidized or in public schools that can really help support those families. And so we thought that that would make this bill a little bit more fiscally respon-- responsible and then responsive to the need out in community. We would build in a trigger to limit the range for the subsidy of the program so that, again, if-- was-- this sunset is being navigated in our body that this bill makes sense if passed. And then we have talked to First Five Nebraska specifically around the eligibility. Right now, the language says that you have to be a licensed child care provider to receive the grant funds. But they and, like, other institutions are working with child care providers that maybe are in the process of getting licensed. And this money would help them start their business. And so we are going to open that up to child care providers that are in the process, in the queue to be licensed-- again, so that they could be successful and meet the growing need of our working families. And so-- again, I appreciate your consideration of LB442. I think this is a necessary and an innovative model to address our child care crisis across the state. And I think we will see outsized impact in how we grow our economy and bring additional revenue in because we are keeping folks in the workforce. And then we are assuring that our most prized possessions are in safe, quality spaces, which is also equally as important. So with that, I urge your support of LB442. And I would be happy to answer any of the questions from the committee.

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

RIEPE: Thank you, Chairman. Thank you for being here. I do applaud you for looking at other states as models. Can you tell us-- are you aware of where Vermont's at? Are they still in the-- is their program still alive and well?

SPIVEY: Yeah, absolutely. So they have implemented this program. On the back, it has an implementation timeline. So you can see where they started. The bill passed in 2023. And so-- again, you know, they're early in the process, but they achieved the goal of 80% of working families having child care. They have not had an issue with businesses buying in or families regardless if they have kids in that child care age. One of the differences with my bill with the amendment versus Vermont's is that they don't have the cap of 48 months or younger, which is four years. And so, again, I, I try to rightsize it for where we are in this environment with inflation, what businesses are navigating. From that standpoint, how can we still take that model bt

have it more adaptive to Nebraska needs? But this is-- I mean, like, going well. Like, they have a full website dedicated. They do speaking engagements around their model and the impact that it has made for working families. And so they have seen outsized success.

RIEPE: The reason I ask is they did-- Vermont did have a health plan that was statewide. They quickly abandoned it as being unaffordable. They just-- they had to walk away from it. My other question, if I may, Vice Chair, is, is there any cutoff-- you know, some of the bills that we see come through and says, well, we won't do it for employers-- or em-- employers under eight or five and-- some number that they would have to participate in the tax too. Or was this across the board?

SPIVEY: That's a great question, Senator Riepe. So I thought about that. And so I'm a small business owner. We have a takeout burger restaurant. We usually have between two and four staff. And what I've found is that, as a small business owner, we cannot pay and offer benefits. And so we're not able to create a competitive market to retain people. And so this felt like-- and as I talked to my husband about this, like, hey, what do you think about this bill? And, like, what is your insight? That this would help us retain talent, and the buy-in for us would be nominal for the outsize impact because child care is one of the issues we have in keeping a workforce. And so, you know-- and I've talked to other small business owners. And so from-- right now, I didn't add that in there. It seemed like that, that was a, a component that people could hopefully get behind from the, the folks that I talked to. But I would be happy to entertain an amendment if, you know, other feedback has come back that, like, this actually really hurts businesses that have five employees or less, then I would carve that out so that it's not a burden.

RIEPE: Then it gets touchy whether it's five, six--

SPIVEY: Yeah.

RIEPE: --four. If I may, Chair-- Vi-- Vice Chair. Senator Machaela Cavanaugh had a bill, it seems to me, early on in session that was about child care. Is that--

SPIVEY: Yeah. So hers is LB13. And that is about--

RIEPE: Good for you. You know your numbers.

SPIVEY: Barely. I ju-- we just talked about this, so. Don't give me too much credit. And that looks at attendance versus aroll-- enrollment. So--

RIEPE: That's right.

SPIVEY: Yeah. Some of the issue is that--

RIEPE: Guaranteed.

SPIVEY: Yep. Guaranteed, because they can't cash-flow their business because, yes, my child is enrolled but they've been sick for two days; or, we have a family trip. And so that then changes the cash-flow model for them to be able to sustain operations.

RIEPE: OK. I do appreciate the fact that you have the employers who would benefit from it. Otherwise, it's a subsidy to them. And, you know, we complain about-- or, they complain about subsidies to everybody else. And all of a sudden--

SPIVEY: Absolutely.

RIEPE: And this wouldn't be the first one that they've got a subs-- received a subsidy from.

SPIVEY: Absolutely, Senator Riepe. And, and you have seen-- like, there's some larger companies like Hudl, you know, that have built child care centers in their building because they know that that is impactful to their workforce. And so I think, again, this is a community benefit that everyone should pay into because it's going to affect our entire workforce. It affects our economy. And these are all shared values and things that we want to see be successful. And so that's why I like the model in Vermont, because I think the business community has to buy in, and then individual employees too.

RIEPE: As, as a hospital [INAUDIBLE] nurses-- you know, both Bergen and Children's, we quickly built-- it was 24 hours a day because it was essential for our workforce.

SPIVEY: Absolutely.

RIEPE: And we paid for, for the building, for the-- everything.

SPIVEY: Yeah. Absolutely, Senator Riepe. Thank you for your questions.

RIEPE: Well, we had the volume to do that. And critical necessity.

SPIVEY: Yeah.

RIEPE: Thank you, Chairman.

FREDRICKSON: Thank you. Any other questions from the committee? Senator Meyer.

MEYER: Just very briefly. You said none, none of the money comes out of General Fund and it's funded by payroll tax.

SPIVEY: Yes. That is correct, Senator Meyer. So--

MEYER: It says here the bill requires a new payroll tax. And since it's not directed to a specific fund, it is assumed the tax would be directed to the General Fund. And so the money comes out of the General Fund.

SPIVEY: So the payroll tax, how it's written would deposit into the General Fund, and then it would be expended. And that's one of the amendments that I said I was working on, is that we should have a cash fund for it to keep it clean. And so the payroll tax, instead of being deposited in the General Fund, would be def-- deposited in that cash fund. And then the expenditures would come out of that cash fund versus having those transactions in the General Fund.

MEYER: $287 million.

SPIVEY: Yes. But it's not from General Fund dollars. It's from the payroll tax from the business and the employee.

MEYER: Which is a tax increase.

SPIVEY: For-- it's a payroll tax, yes, for the business and that employee.

MEYER: OK. Thank you.

SPIVEY: Thank you, Senator Meyer.

FREDRICKSON: Other questions? Seeing none. Thank you.

SPIVEY: Yes. And I will be here to close.

FREDRICKSON: Perfect. Any proponents for LB442? Welcome.

JON NEBEL: Thank you for having me. My name is Jon Nebel, J-o-n N-e-b-e-l. And I'm here on behalf of the Nebraska State Council of Electrical Workers. Want to thank Senator Spivey for bringing this up. It's, it's something that we talk about constantly in our industry. And as she mentioned with the apprenticeship stuff, it's true. The, the apprentices we have, we've had them decline offers to become

apprentices because they can't find child care. And to take that step back and start as an apprentice knowing that eventually you'll get a big increase in pay and be able to make a career out of it is too much to overcome, and so they've had to put these career positions on hold until the child's old enough to maybe go to school. So I like to think of this bill as a way to-- similar to school. And we all care about our students and, and our children in school, and we kind of socialize that cost. So we look at this way. Same thing for the child care side of it. And I think I did the math for a, a family of-- $100,000 a year, the increased tax would be $500. So I look at it. Also, I have a family with young kids. If I'm paying $1,300 a month for child care and I can ask my neighbors to chip in for that for $500 apiece, I think it's a, a good benefit for the community to, to take care of each other's kids without actually watching them for the, for the day. So that's the benefit for us, is to allow these, these apprentices to get to that transition period. A lot of times in construction-- believe it or not, it's not the first choice for a career. But people-- after life happens, they realize that this might be a good place to be a career, not just a job. So there's also a couple instances over the last presidential administration where they passed big infrastructure packages and-- with the commitment of states or-- funding could be provided if you did something to cover child care costs for the construction and the, and the workers onsite. So this would go a long ways in positioning Nebraska to get some of these mega projects and, and make sure that we've covered these child care costs. Like Senator Spivey said, the 48 months is really the critical part of it. So we'll look forward to finding the solution. And I think the fiscal note said 250,000 Nebraska families could benefit from this. So I think it's well worth the endeavor at $500 for every $100,000 I make. That's all. Thank you.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. You have a number of retirees that are not going to be on the payroll tax. How-- do you propose to engage them some way?

JON NEBEL: So as-- do we tax their income?

RIEPE: Yeah. I mean, you'd have to go through the IRS or it would have to be a state tax.

JON NEBEL: And so-- I guess, yeah, we could bring those folks in that wouldn't have a payroll tax, but they do have an income side of it. Could offload some of that burden on the people on the income side.

RIEPE: I don't know. I'm, I'm just-- and-- you know. It's a missed population. And I'm not saying that we're trying to look for more taxes for everybody. I just-- it's one of the challenges that would have to be addressed.

JON NEBEL: Mm-hmm.

FREDRICKSON: Other questions from the-- oh.

RIEPE: Thank you very much. No.

FREDRICKSON: Are there questions from the committee? Seeing none. Thank you for being here.

JON NEBEL: Thank you.

FREDRICKSON: Other proponents for LB442? Seeing none. Anyone here to testify in opposition to LB442? Seeing none. Anyone here in the neutral capacity for LB442? Seeing none. Senator Spivey, as you come up, we had some online comments. We had 20 proponents, 7 opponents, and 0 in the neutral capacity.

SPIVEY: Thank you, Vice Chair Fredrickson. And thank you again, committee members. I'll keep this short and sweet since it's Friday. But again, appreciate your consideration for LB442. My goal with this bill is to really try to address the child care crisis that impacts our workforce and our economy. And so we have to be innovative when we know that we are in a deficit year. How do we engage other stakeholders into really addressing and problem-solving this? Because again, this is a wide community benefit that everyone will see some transformation from. And so I would encourage you to support LB442. I will be sending the committee the amendments once I get that technical language back. And I would be happy to answer any other additional questions that you all may have.

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

SPIVEY: Thank you all.

FREDRICKSON: That will end our hearing for LB442 and our hearings for the day.