APPROPRIATIONS COMMITTEE SEPTEMBER 28, 2018 OMAHA

STINNER: [00:00:00] Welcome to the Appropriations Committee meeting. For the record, my name is John Stinner. I do want to thank UNMC for hosting this event and allowing us to be here. This is a whole lot better than the Appropriations room. If you've ever been to the Appropriations room, it's like a garage. This is kind of neat comparatively. I'd like to start today's proceedings with self-introductions. Senator.

HILKEMANN: [00:00:31] I'm Senator Robert Hilkemann. I represent District 4, west Omaha.

VARGAS: [00:00:35] Senator Tony Vargas. I Represent District 7, which is downtown in south Omaha.

WISHART: [00:00:39] Senator Anna Wishart. I represent District 27 in west Lincoln.

BOLZ: [00:00:44] Senator Kate Bolz. I represent south-central Lincoln.

STINNER: [00:00:46] John Stinner, District 48, Scotts Bluff County.

MCDONNELL: [00:00:49] Mike McDonnell, LD 5, south Omaha.

CLEMENTS: [00:00:52] Rob Clements, District 2, Sarpy and Cass County.

STINNER: [00:00:54] On the table, actually, out by the coffee is cream- or buff-colored testifier sheets. We also have testifier sheets here. If you could fill those out before you testify, when you come up to testify hand them to our clerk, Jennifer. She's right there at the end of the table. If you

also have handouts, please keep those until you come up to testify and then hand them to the committee clerk along with your testifier sheet. We will need 11 copies of any of the handouts. We will begin testimony on each interim study today with the introducer's opening statement. Following the opening statement, we will first hear from invited testimony on each resolution followed by others who would like to testify. We will finish with a closing statement by the introducer if they wish to give one. We ask that you begin your testimony by giving your first and last name and spelling those for the record. We will be using a five-minute timing system. This is a little bit different. We don't have lights so we do have-- and Jennifer will show you-- and we would ask that you abide by that, please, because we do have a lot of testimony. We do have to get back sometime this afternoon for other hearings. So as a matter of the committee policy, I would like to remind everybody that the use of cell phones and other electronic devices is not allowed during public hearings. At this time I would ask for all of us to silence our cell phones or make sure they are on vibrate. With that we will begin the hearing. Senator Wishart, LR445.

WISHART: [00:02:41] Well good morning, Chairman Stinner and members of the Appropriations Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th Legislative District in west Lincoln. I'm here today to discuss LR445, an interim study to look at the long-term fiscal sustainability of the Health Care Cash Fund. The purpose of this interim study is again to look at the long-term fiscal sustainability of the cash fund. This cash fund as we know it today was established in 1998 with the funds from the Nebraska Tobacco Settlement Fund and the Nebraska Medicaid Intergovernmental Trust Fund. And the purpose of the fund was to provide for the healthcare and long-term care services for Nebraskans. In its original intent-- to preserve, improve, and coordinate Nebraska's health infrastructure-- the Health Care Cash Fund was designed to be a permanent asset for the state. The protection and maintenance of the fund has provided Nebraskans with many years of critical healthcare programming. Investing in preventative and public health measures has been economically rewarding as well. In 1998, funding categories included grants for

improving delivery of healthcare to medically underserved areas in cost-effective long-term care facilities. Later the inclusion of biomedical research anticipated the need to grow our knowledge-based economy. Today the Health Care Cash Fund supports biomedical research plus Children's Health Insurance Program, tobacco prevention, developmentally disabled services, and many other valuable and productive programs. The Legislature intended for the Health Care Cash Fund to remain sustainable in order to ensure a healthy future for Nebraskans. Subsequent Legislatures have reinforced this intent, and today we look at how the fund is doing and its sustainability. So in my discussion with staff and some other key stakeholders who are going to be presenting after me today, I think the main thing that I'd like to come out of this interim study is for us to decide as a committee: What is the philosophy behind the sustainability of this cash fund? You know, do we want to continue preserving it in a way that our predecessors have for long-term sustainability, understanding that the route that we're taking-- and you'll hear from some testifiers following me-- we may not be set up to have these funds in perpetuity. And so do we as a committee want to look at other funding sources to come into this fund to continue its financial sustainability or, philosophically, do we as a committee want to look at spending these funds now for immediate needs? So I think that's the decisions we need to have as a committee. And that's what I would like to come out of this interim study. So today we'll hear from the Legislative Fiscal Office, the Nebraska Investment Council, along with representatives from UNMC, Creighton, and providers who will provide further details on the viability of the Health Care Cash Fund and its effect on the state. I will say, too, if we decide as a committee that we do want this-- we do want to step this fund up to continue to be financially sustainable well into the future, not just, you know, in the next 15 years and we decide we can't find any other funding sources available to bring more money into the fund, I think one thing we're going to have to decide is: Are we rigorously looking at what we're spending these dollars on now and requiring some level of a return on investment report from each one of the organizations that receives funding from the Health Care Cash Fund to determine who are our priorities. If we're going to have to-- if we're going to have to stop some of the funding

going to certain organizations? Again, if we want to see this lasting into the future, I think it's important that especially the Nebraska Investment Council will talk to us again about where we're going to run out of funds, you know, at what time if we keep going down the path we are. So again, thank you. I'd be happy to ask-- to answer any questions. And again, I'm going to have to leave for a work obligation at 11:00 and so I won't be able to close.

STINNER: [00:07:05] And you're good at fixing tires.

WISHART: [00:07:08] I did not fix my tire [LAUGHTER].

STINNER: [00:07:14] Any questions? Questions? I just have one. You're contending that today there is nothing in legislation that says this is an endowment-- an annuity to be forever and ever in place, right?

WISHART: [00:07:33] Yeah, I think it's mainly just been the tradition of the Appropriations Committee to look at it this way. But I don't see anything from my research that says we couldn't spend this money right now on immediate needs. And yeah, I think that's up to us philosophically. Or we may want to put something in statute to leave more of a-- to be more clear about what we think this fund should be used for and whether it should be long term or, again, whether we want to use these funds now to address immediate needs.

STINNER: [00:08:16] OK. Thank you. Any additional questions? Seeing none, thank you.

WISHART: [00:08:18] Thank you.

LIZ HRUSKA: [00:09:07] Sorry, this is a different setup than what I'm used to. Morning, Senator

Stinner and members of the Appropriations Committee. My name is Liz Hruska, L-i-z H-r-u-s-k-a, with the Legislative Fiscal Office. I'm presenting an overview of the Health Care Cash Fund. The Health Care Cash Fund initially consisted of two funding sources: the Medicaid Intergovernmental Transfer Funds and the Master Tobacco Settlement Funds. The funds are actually called "trust funds" in the statute but they do not meet the definition of trust funds. Trust funds are those that are held for the condition of the trust. The Legislature can change the amount and the distribution of the funds at any time, as Senator Stinner and Senator Wishart just had a discussion. The fund could be depleted at any point in time if the Legislature so desired. The State Investment Council, who you will hear from, is charged with investing the money and determining the distribution from the two funds that go into the Health Care Cash Fund. A new revenue source was added in 2015. Former Senator Nordquist sponsored LB418, which directs $1,250,000 a year from the cigarette tax into the Health Care Cash Fund. The Medicaid IGT was a loophole in federal law that allowed states to overpay certain nursing facilities and retain the amount of the federal overpayment. Nebraska is the second state to use this mechanism, and in the beginning, over $40 million was used to convert nursing home beds to assisted living. Federal officials came to our hearing and testified in favor of Nebraska's bill. Congress eventually phased down and then eliminated the loophole as states started to take advantage of this. The balance in the fund as of June 30, 2018, was $25.9 million, and this fund will eventually be depleted per the directions of the Legislature. In the future, all distributions then will come just solely from the Tobacco Settlement Fund. Twenty-six states joined together in a lawsuit that resulted in the Master Tobacco Settlement. The basis of the settlement was that states pay more in the Medicaid program for tobacco-related illnesses because of the marketing of tobacco products. The funds come to the state unrestricted. There is a formula for distribution of the funds, which include the amount of tobacco sales in the state, and there are also provisions that states must enforce relating to the nonparticipating manufacturers, and that enforcement is handled by the Attorney General's office and the Department of Revenue. The annual revenue varies but has generally been around $37 million a year. The balance as of June 30 of this year was $451.9

million. Initially only two activities were funded with the Tobacco Settlement Funds, that is: a health grant program and $25 million was set aside for the state match for the Children's Health Insurance Program, which started in 1998. When the initial $25 million for CHIP was used up, the Legislature then continued to fund the state match with a combination of General Funds and Health Care Cash Funds. The health grant program provided funding for a three-year period, and the funding was solely from earnings. After it became apparent that annual earnings would be substantial and would grow even larger over time, legislators decided a better use of the funds would be to change the policy to fund programs for the long term. That is when former Senator Jim Jensen introduced LB692, which created the Health Care Cash Fund in the 2001 session. There was a lot of pent-up demand in the healthcare area in the early 2000s. Nebraska was consistently 48th or 49th in public health funding. Behavioral health providers have not had a rate increase for five or six years. Other areas such as aid for the developmentally disabled, emergency protective services, respite care services, and substance abuse treatment were also considered to have needs that greatly exceeded resources. The new source of revenue from the Tobacco Settlement was also an opportunity to advance biomedical research in the state. Independent of LB692, former Senator Bohlke introduced a separate bill which passed and provided $7 million a year for three years for tobacco prevention. With the economic turndown that occurred after 9/11, the tobacco prevention funding was substantially reduced. You have before you on a list in the Excel spreadsheet attached to my testimony, the list of programs that received ongoing funding from the original activities and programs. More were added. These include funding for the Poison Control Center when other revenue sources declined, Parkinson's disease research, the state match for Medicaid's smoking cessation services, stem cell research, federally qualified health centers and gambling assistance. The gambling assistance funding was only intended to be for two years until a proposed constitutional amendment was passed. However, the amendment failed, and the healthcare cash funding continues. Some of the funding has been used for either one-time or time-limited activities. Three studies received one-year funding. The topics were methamphetamine treatment, a behavioral

health rate study, and Medicaid reform. There is also a current study on medical cannabis, which funding began in 2016 and runs through the end of this year. A behavioral health commission was funded in 2008. There have also been capital construction projects: two were at the regional center, one was in Corrections, and another at UNMC. Legislature passed the Autism Treatment Act and provided $1 million a year for four years. It required that the state apply for and receive a Medicaid waiver and that there was a private funding match. The waiver was approved, but the private funding did not materialize so none of this funding was ever spent. In tight budget times, the Legislature have used the fund to balance the General Fund. In 2004, $3.6 million was reduced to supplement the General Fund state match for Medicaid, and in the current biennium $10 million a year is being transferred to the General Fund. There was also a one-time transfer made to supplement a settlement that the state made with Joseph Sloup trust fund when it was determined that the balance in his trust was not adequate to meet his needs. Joe was inappropriately committed to the Beatrice State Developmental Center even though he did not have a developmental disability. Most recently, due to the tight General Fund budget, the Health Care Cash Fund has been used to temporarily fund A bills. In the 2018 session, LB439 required additional funding for a part-time nursing surveyor in the Department of Health and Human Services and LB793 continued the Aged and Disabled Resource Centers beyond their pilot, and both were funded for only two years with the Health Care Cash Fund with the assumption that the General Fund will continue the programs beyond this biennium.

STINNER: [00:18:23] Thank you. Questions. Senator Bolz.

BOLZ: [00:18:28] I just wanted to raise an issue in this forum that I've raised with the Legislative Fiscal Office, which is-- some of you may have seen the newspaper headline that the state of Nebraska is to receive some lawsuit funding from the Affordable Care Act. The initial amount is $36 million. There will be a federal piece of that that we'll have to return to the federal government.

There may be some strings attached. I wanted to share with the committee and with this audience that I have asked Liz in the Fiscal Office to look at that as a potential one-time opportunity to shore up the Health Care Cash Fund, particularly because of the strategy we used last time around to use the Health Care Cash Fund to balance the General Fund. So I didn't ask Liz to prepare to answer that question today; so when she and the Legislative Fiscal Office have gotten their research done, I'll share it with the rest of the committee. But I wanted to put that out there in this conversation.

STINNER: [00:19:27] Additional questions? So we have, what, $400-- almost $452 million in our Health Care Cash Fund today.

LIZ HRUSKA: [00:19:38] Well, in the Tobacco Settlement, that's the holding fund.

STINNER: [00:19:42] OK.

LIZ HRUSKA: [00:19:42] And another 25 in the IGT. So the Investment Council, depending on the appropriation, the Legislature directs the Investment Council to make the transfers into the Health Care Cash Fund. So right now there is-- we're transferring in just around $60 million here, but the other two are the holding funds.

STINNER: [00:20:06] And we intend to spend the $25.9 million in the Intergovernmental Fund down to zero. So we will only have the Settlement Fund. Is that correct?

LIZ HRUSKA: [00:20:20] Right. And also the cigarette money that's relatively new. The cigarette money does not go to the Investment Council. It is directly deposited into the Health Care Cash Fund.

STINNER: [00:20:31] That's a million, two--

LIZ HRUSKA: [00:20:33] Fifty.

STINNER: [00:20:34] Fifty. OK. So we can use the million two-fifty-- we can use the earnings on the-- and we get about $30-some million in Tobacco Settlement? Thirty-five? Thirty-six?

LIZ HRUSKA: [00:20:46] It varies year to year because of the formula. I looked back, and it was roughly around $37 million a year most recently. Maybe Mike from the Investment Council can confirm that or provide new information as far as what-- the level of funding.

STINNER: [00:21:07] So to support the Health Care Cash Fund, we'll have, say, $37 million coming in every year, we'll have the interest that we earn on the fund, and then we'll have the million two-fifty. Those would be the three sources to fund what we're trying to do. Now it looks like we were at $60-- transfer $61.2 Million and $61.6 for the two years, fiscal year ended '18 and fiscal year ended '19. So these-- in order for this to be sustainable, or to go on forever and ever, the flow of funds have got to come in to support the $61.6 million.

LIZ HRUSKA: [00:21:52] At our current level, yes.

STINNER: [00:21:53] OK. Thank you for that. Any additional questions? Seeing none, thank you.

LIZ HRUSKA: [00:22:00] Thank you.

STINNER: [00:22:14] I don't think you have to put that on. I think you could just lay it on the [INAUDIBLE]. Just lay it down. I think it'll pick you up. I hope.

MICHAEL WALDEN-NEWMAN: [00:22:21] We'll try it.

STINNER: [00:22:23] If it doesn't, I'll tell you to put it on.

MICHAEL WALDEN-NEWMAN: [00:22:26] All right. How's that?

STINNER: [00:22:27] People hear you or no? Put it on. I was just trying to make things simple.

MICHAEL WALDEN-NEWMAN: [00:22:35] How's that?

_____: [00:22:35] Better.

MICHAEL WALDEN-NEWMAN: [00:22:35] Well, one thing about this room-- it's not as scary as the Appropriations Committee room. I'll say that. [LAUGHTER] Mr. Chairman and members of the Committee, my name's Michael Walden-Newman. That's M-i-c-h-a-e-l. Last name is W-a-l-d-e-n-N-e-w-m-a-n. I'm the State Investment Officer with the Nebraska Investment Council, and as you all know, the Investment Council invests $27 billion in state funds. Part of that is the $450 million in the fund we're talking about today. You're going to hear me talk about the "Health Care Endowment Fund"-- that's what we call it-- which is the combination of the two sources of revenue from the Medicaid and Tobacco Settlement money. As you also know, under state law we're required to report to the Legislature every even-numbered year on the sustainability of transfers from that fund into perpetuity. I've been at the Investment Council now four years, so I have made two reports. The most recent report-- those are due October 1, and I had the report in the middle of September. This year's report you'll see with the Clerk of the Legislature. It's filed. And for any of the folks in the audience, you can look it up on the legislative Web site. It has a cover memo from

me, it has the statute itself that requires that report, it has Liz Hruska's terrific report on the fund itself, which she also presented at our July Investment Council meeting when we discussed this fund. And it has a report that we asked our consultant, Aon-- it is up in Chicago-- to do on the sustainability of transfer. So that'll be a one-stop shop for you online. But what I brought today is the one-pager that you see in front of you. I've got a yellow copy so I can make some notes on it and not give you mine by mistake, but it's in front of you with our letterhead. I'll cut to the bottom line and then I'll back up. The bottom line, you'll see at the end of that memo, is that with current spending, the funds are not sustainable into perpetuity. Specifically we've found that the net distributions, which are distributions less the contributions, are running $25 to $35 million a year through 2035, which is the length of time we have projections on the inflows. And, based on our current capital market assumptions for our investment portfolios, asset class by asset class. In other words, how much we expect to get from equities-- various types of equities-- what we expect to get in the long term from bonds combined-- show that there is net outflows of $17 to $18 million a year being the top end of what really should be coming out of the fund versus the current amount. In other words, the returns are projected another way of looking at it. We have returns projected at 6.6 Percent, possibly a little lower. Sustainable outflows of those funds as an endowment would be in the 4 to 4.5 percent range, and current outflows are in the 6 to 9 percent range. So that's-- to not vary the headline-- that's the bottom line, and then I'll back up. We invest the funds currently in a 75 equity-- and by equities I mean stocks, also some private real estate and private equity investments-- and 25 percent bonds. All the other endowments of the state, we pool into what we call the general endowment, and those endowments are invested at 50 percent bond, 50 percent equity of portfolio. The difference being is that those endowments are sensitive to the income, and we tried to have a portfolio for those that would generate a little more income versus this portfolio with the equity allocation having more protection in the long run for the corpus of the fund. Senator knows-- because he was there-- that we did discuss this at our July Investment Council meeting, which we use each year as a retreat format to discuss broader policies rather than specifics on, say, a manager

or asset class. And we discussed this fund because it's troubling for me as the State Investment Officer to be named in a state law asking me to comment every other year on the sustainability of a fund and have my comments every other year be the same, and that is, the rate of spending is not sustainable. So I tried two-- my first report you'll recall two years ago-- I thought rather than repeating my predecessors with the same song, I suggested you drop the spending from $60 million a year to $55 million, or even $50 million a year to be safe. I will tell you that generated a couple of calls from folks who are the beneficiaries of some of the funds out of this. So I met some new friends [LAUGHTER] as a relative newcomer. But I was trying to be concrete, because one option is, is to frankly take the Investment Council out of the statute and not ask us to make this report every other year if the message is the same. And the intention is perhaps shifted from what it originally was, which was perhaps to set up a permanent inviolate corpus of an endowment and spend only the investment income. So, Mr. Chairman, again, that's the short version of a longer report we put online a couple of times, and as I say it's great to see you all this morning.

STINNER: [00:29:38] Questions. I do have some questions.

MICHAEL WALDEN-NEWMAN: [00:29:40] All right. I was going to get this off.

STINNER: [00:29:43] It's been reported $450 million is in the fund right now-- or at the end of June, excuse me. I saw something here and I was trying to find it: Tobacco Settlement Trust Fund 331, 2018 was 402. So we've actually had a buildup because obviously tobacco funds probably came in in that last quarter. Is that how that works?

MICHAEL WALDEN-NEWMAN: [00:30:11] You know--

STINNER: [00:30:12] Do they get distributed all at one time?

MICHAEL WALDEN-NEWMAN: [00:30:14] You know, I'm not the expert, I hate to tell you, on how the distributions work. I just know when the money gets there what we do with it.

STINNER: [00:30:22] Also in this you demonstrate 6.4 percent rate of return is a reasonable rate of return to expect. So if it's $400 million times 6 percent, you're at $24 million. Thirty-seven gets you-- that comes in from the Tobacco Settlement Fund-- gets you to $61 million, which is approximately the same amount we're taking out.

MICHAEL WALDEN-NEWMAN: [00:30:47] Um-hum. Part of our calculation, Mr. Chairman-- I appreciate the question-- is to also protect the fund against inflation. And so part of our calculations there take in an inflation factor so that you protect the corpus going forward to be able to withdraw, rather than a simple straightforward calculation like that. And that could be part of the difference.

STINNER: [00:31:08] So you've figured in that we're going to grow the expense portion of this even though we have something to say about it in terms of maintaining $61 million versus some inflation factor. That's what you built in?

MICHAEL WALDEN-NEWMAN: [00:31:21] Right, and to protect-- to look at the fund itself, Mr. Chairman, in terms of the real buying power of the fund in future years. And so you'll see in the longer report that we posted with the Clerk of the Legislature a range of possible returns to the fund as optimistic and less-- less optimistic.

STINNER: [00:31:46] I saw that and I agree with the analysis, by the way--

MICHAEL WALDEN-NEWMAN: [00:31:49] Appreciate that.

STINNER: [00:31:51] Because we're always dealing in a range. But it's interesting-- when I started four years ago this fund was in the $300 millions? It's now grown over $400 million, and you continue to report that it's not sustainable. I can't get there from here. Could you help me out on that?

MICHAEL WALDEN-NEWMAN: [00:32:14] Mr. Chairman, we could pull up the-- if I'd brought for everyone the charts, we could go through those charts, and that might be helpful in getting us to the end. But under those scenarios, the fund in fact will run out of money.

STINNER: [00:32:28] OK. Just for historical purposes, could you provide me the last four, five years of ending fund balances at the end of June so-- I'm pretty sure my memory-- if memory serves me, we were in the $360, $370 area. Now we're in the $400. And I continue to get these reports that said we're not sustainable. And I get what you're trying to say.

MICHAEL WALDEN-NEWMAN: [00:32:56] Right.

STINNER: [00:32:56] OK. Any additional questions? Senator Hilkemann.

HILKEMANN: [00:32:59] That prompts a question in me then. So if we're taking out the 6.2 percent or whatever it is, what percentage is-- would make it sustainable?

MICHAEL WALDEN-NEWMAN: [00:33:11] That's where we're looking at if it were a true endowment. Endowments in general run on-- these days they've lowered. But you would-- what you would do, Mr. Chairman, Senator, in plain English, if you were trying to protect this fund in

perpetu-- forever-- and I mean forever. Not-- 2035 sounds like a long time away. It's not. Seventeen years is not a long time from now. Twenty years is not a long time from now. Fifty years is not perpetuity. Fifty years is-- is 50 years. If you were literally going to treat this as an endowment with an inviolate corpus, what you would do is you would do what other endowments do. You would set it up so that-- with a spending policy that would be set not on a dollar amount but on a percent. And you would tie it to the investment earnings that way. You could conceivably have an investment policy that would-- and you would determine just what are you going to spend? Are you going to spend the interest income from the bond portfolio? Are you going to spend the dividend income in your stock portfolio? Are you going to spend realized capital gains from the stock portfolio and treat that as income as well? So you'd make that decision. That would leave the corpus inviolate, but you could also then set a spending policy of X percent, and in the-- and a conservative enough-- at a conservative enough number so that in the years when investment earnings exceeded that number, you could reinvest the excess earnings above that amount back into the corpus to further protect and grow the corpus over time. But the difference here is that the spending policy is set by the legislature as a dollar amount rather than a percent. And, you know, I'm-- I'm just-- as I say, I'd take whatever money comes and do the best we can with it. But-- but that is an option. Not to get too much into the policy of it. Again, to repeat, the awkward part for me as the state investment officer is that fine line between what is policy on my side versus just sticking to my knitting and investing the money as it comes.

STINNER: [00:35:39] Senator Vargas.

VARGAS: [00:35:42] So just for clarity-- thank you for being here by the way.

MICHAEL WALDEN-NEWMAN: [00:35:45] Appreciate it.

VARGAS: [00:35:46] Are you saying that part of the reason it is not sustainable from your opinion is because we don't have a policy in place that sets how we spend and instead we're just basing it off of cash, I guess, but-- is that what you're saying?

MICHAEL WALDEN-NEWMAN: [00:36:04] Again, Senator and Mr. Chairman, in the plainest English possible, the spending and-- according to our study that we do every other year-- the spending amount is simply too high.

VARGAS: [00:36:22] The spending amount is too high historically overall? Or are you looking at just like the last five years?

MICHAEL WALDEN-NEWMAN: [00:36:28] The spend-- Mr. Chairman and Senator, the spending that's set in statute.

VARGAS: [00:36:35] OK.

MICHAEL WALDEN-NEWMAN: [00:36:36] So we'd recommend paring it back if you want to keep the money around forever.

CLEMENTS: [00:36:39] I have a question.

STINNER: [00:36:44] Senator Clements.

CLEMENTS: [00:36:45] Thank you, sir.

MICHAEL WALDEN-NEWMAN: [00:36:45] We're growing-- we're finding a way to get the

corpus [INAUDIBLE].

VARGAS: [00:36:51] Setting a policy.

MICHAEL WALDEN-NEWMAN: [00:36:51] In other words, we can't-- I can't promise that we're going to invest our way to the current spending level.

CLEMENTS: [00:36:57] When you talk about protecting the corpus, are you also wanting it to grow with inflation so its same purchasing power, so $400 million level, in the future is not enough; you would grow it by retaining dividends or earnings? OK, that's another reason why you say it's not sustainable then.

MICHAEL WALDEN-NEWMAN: [00:37:23] Mr. Chairman and Senator, that's absolutely correct.

CLEMENTS: [00:37:25] All right. Thank you.

STINNER: [00:37:28] Senator Bolz.

BOLZ: [00:37:30] I debated whether or not to speak up and-- I guess I think it's important to address the issue that you have brought to us as the Investment Officer about whether or not you have a continuing role in reporting out to us, which is basically calling us accountable, in my perspective, which is that-- you know, the numbers say that our spending rate is not sustainable. I guess what I want to say out loud and put on the record is that I think your role is essential and it is-- it is part of the original intent of the statute. That original intent of the statute hasn't changed. Our decision-making around expenditures has changed. And from my perspective, the biggest difference

has been when in difficult fiscal times we moved things that should be generally funded into the Health Care Cash Fund. For example, developmental disability aid and behavioral health rate increases. So I think we do need to have this conversation on a regular basis, because we have moved away from the original intent of the statute and have started using this for General Fund purposes in a way that-- that obviously is not sustainable. So what I want to add to the conversation is that we need to take a look in the mirror and decide whether or not it's time for us to move those General Fund expenditures back into the General Fund. Thank you.

STINNER: [00:38:59] And I'll just add, good luck on that idea. [LAUGHTER] Just for the record, though, 2005, we started taking $52 million out. We're at $60 million, so there has been a movement ahead as far as expenses are concerned, and your comments are well taken about inflation and the endowment side of things. So I do appreciate your testimony. Additional questions? Seeing none, thank you.

MICHAEL WALDEN-NEWMAN: [00:39:27] Thanks very much. Appreciate it.

[00:39:28] [BREAK]

TOM MURRAY: [00:39:52] Good morning, Chairman Stinner and members of the Appropriations Committee. I'm Dr. Tom Murray, T-o-m M-u-r-r-a-y. I'm the Provost at Creighton University. I greatly appreciate the opportunity to appear before the committee today as well. And today I appear on behalf of Creighton University, the University of Nebraska Medical Center, Boys Town National Research Hospital, and the University of Nebraska of Lincoln in support-- all of us in support of the Health Care Cash Fund. And all of our research institutions have used this fund to grow biomedical research in the state of Nebraska, and representatives from all the institutions are here with me today. An investment in biomedical research pays a lifetime of dividends in better

health and quality of life for Nebraskans. Research funding is essential to advance the state of Nebraska in many ways. With every dollar invested, biomedical researchers are a step closer to new treatments and better outcomes. The steady stream of funding provided by the Health Care Cash Fund allows Nebraska research institutions to attract world-class researchers who come to the state to share their talents and their discoveries. The researchers and investigators conducting these studies are dedicated individuals who really represent the "brain gain" of our state. My own move to Nebraska from the University of Georgia was in large part due to the Nebraska Unicameral's enlightened decision in 2001 to direct Tobacco Settlement money into biomedical research. The biomedical research enterprise represents an important economic driver that increases the attractiveness of the state of Nebraska to either startup or relocation of businesses to our state. The high level of cooperation existing between the state's research-intensive institutions has fostered a continued expansion of Nebraska's research enterprise. All research in this state have moreover been outstanding stewards of this resource as reflected on the return of the investment. At Creighton University, use of the Health Care Cash Fund has resulted in a 9.3-fold return on the investment with every dollar spent from the fund, generating over $9 of new federal grant awards coming into the state. Creighton University is experiencing a banner year in new federally funded research awards supporting our faculty working to find new treatments for disorders such as hearing loss, autism, childhood asthma, epilepsy, and coronary artery disease. Just in the last four months, Creighton faculty have generated $18.3 million in new NIH and Department of Defense grants. At UNMC, the Health Care Cash Fund from its inception through 2017 has generated a return on investment of $14 for every dollar spent, directly contributing to a new record for research awards in 2017-18 of over $135 million, up 16 percent from the year previously. This has allowed the recruitment of faculty, the development of facilities, and many other impacts. Just within the last year, commitments from these funds has helped UNMC attract new leaders, focus on our capacity to develop new drugs, develop new approaches in heart disease and infectious disease, as well as support pilot grants in rural occupational safety and health, and health disparities, nutrition, and

obesity. At University of Nebraska-Lincoln, Health Care Cash Fund investments have generated a return of $12 in external funding, again, for every dollar invested from the Health Care Cash Fund. This has improved their funding to $144 million in FY 2018. That's a 33 percent growth in 10 years. These investments support new faculty hires working on therapies to combat influenza, manage diabetes and obesity, promote kids' healthy psychosocial development. The fund supported the Minority Health Disparities Initiative, whose statewide programs emphasize rural and community health, new collaborations with UNMC, and researchers developing robotics and novel drug delivery systems, which have the potential, again, for commercialization. The Nebraska Health Care Cash Fund has allowed Boys Town National Research Hospital to expand its research program in exciting new directions over the past decade. With financial support provided by the fund, Boys Town has successfully recruited leading scientists in hearing, language, and neuroscience. The investment has led to a 46 percent increase in federal research funding in Boys Town over the last five years. The findings of research from Boys Town scientists supported by the fund have helped to improve the care provided to Nebraskans for hearing, language, and neurobehavioral disorders. The Health Care Cash Fund is critical to the continued growth of research in Nebraska to improve the health of all Nebraskans. The Nebraska Unicameral has shown exceptional stewardship of the Tobacco Settlement funds, and our research institutions in the state have been outstanding partners in this stewardship. We urge you to continually review the value of this nationally unique program and the potential for additional strategic funding in the future. Improving people's lives, giving our citizens hope, and serving as the foundation for a knowledge-based economy in Nebraska merits continued support and investment. Thank you.

STINNER: [00:45:36] Thank you. Questions? Senator Hilkemann.

HILKEMANN: [00:45:39] Thank you, Dr. Murray, for being here. Kind of going back to the testimony we just have had, when you're working with research dollars, are we better to have

sustainable research or sustainable funding?

TOM MURRAY: [00:45:52] Well, we view this as a-- this sustainable funding allows us to have the sustainable research and to go beyond sustainable to expand our research. So I spoke for every institution about the return on the investment. So that's, you know, as a-- as a research administrator, that's my report card at Creighton and the report card of all of my colleagues for research institutions in this state. So we make sure that we invest these funds in research that has the ability to generate new dollars-- federal dollars coming back into the state.

HILKEMANN: [00:46:30] But in some ways if-- if we're going to-- instead of having the $25 million or whatever the number is that we-- if some years that drops down to $15 million because of what the investment rate, or some year you have $30 million-- doesn't that throw you off when you're planning for your research?

TOM MURRAY: [00:46:49] Yes, absolutely. You're-- you're right on target. When we make-- when we invest in new faculty recruits, for example, we make three- to five-year commitments into those faculty and we have to be able to meet those requirements.

HILKEMANN: [00:47:03] So that's why, if we have a more of a-- of a level funding for that fund, it makes it easier to administrate so that you can continue on your programs.

TOM MURRAY: [00:47:13] Absolutely. Absolutely.

HILKEMANN: [00:47:15] Thank you.

MURRAY: [00:47:16] Yeah.

STINNER: [00:47:17] Additional questions? Seeing none, thank you. Any additional testifiers?

JULIE ERICKSON: [00:47:58] Hopefully I get extra points for testimony because we aren't going to have a whole bunch of providers come in, so I slightly go over five minutes but I'm going to try to talk fast. Chairman Stinner and members of the Appropriations Committee, my name is Julie Erickson, J-u-l-i-e E-r-i-c-k-s-o-n, and I'm here today to cover two issues related to the Health Care Cash Fund. First, to relate the early history of the fund and provide some context and the implementation and, second, to express the importance-- do I need to put this [INAUDIBLE].

STINNER: [00:48:40] Yes, put that on.

JULIE ERICKSON: [00:48:40] OK, So I am here to provide some context on the fund as well as to talk a little bit about the provider community and what it means to them. We have-- I represent several clients including Friends of Public Health, the American Cancer Society, Nebraska Association of Behavioral Health Organizations, Health Center Association of Nebraska, and the American Association of Retired Persons. Each of those organizations provided to you detailed written remarks-- either today that are being passed out, or they came electronically to you-- on current use of the Health Care Cash Funds critical to their missions. All of those statewide organizations in partnership with others in the healthcare community were involved in advocacy during the 1990s as states began to respond to the healthcare costs they had to deal with associated with addictive tobacco products and the corresponding disease and death tobacco causes. After many lawsuits were filed by states across the country, 46 Attorney Generals stepped up and began negotiating with the four largest tobacco companies to settle those lawsuits for the recovery of tobacco-related healthcare costs. Nebraska's Don Stenberg was one of those Attorney Generals. In 1997, it became clear that there would be a substantial tobacco settlement agreement and that the

individual states would receive significant yearly distributions from the settlement. In 1998, the settlement was signed and in that same year legislation passed in the Nebraska Legislature sponsoring the healthcare-- Health and-- sponsored by the Health and Human Services Committee Chair, Don Wesely. That set up the original fund to deposit Nebraskans' portions of the settlement distribution. Of course, as you can imagine, the real fun started when the Legislature began to discuss how those dollars would be distributed. In the 2000 Session of the Nebraska Legislature, the new Chair of the Health and Human Services Committee, Senator Jim Jensen, introduced LB1427, which refined the fund to use the income from investment of Tobacco Settlement dollars for healthcare services. Specifically investment income from the fund was to be utilized for healthcare priorities including alternatives, traditional long-term care services, community public health services, healthcare across-- access and delivery for the medically underserved, and the healthcare quality and cost containment. Between passage of LB1427 in 2000 and passage of LB692 in 2001, there was much debate on how to specifically appropriate investment and revenue. But there was no question that the dollars would go towards healthcare. Nebraska was unique in that respect. No other state was focused solely on healthcare and designed an endowment-like mechanism to ensure dollars would be available far into the future. The Master Settlement Agreement was to reimburse states for healthcare costs, and that is what Nebraska did and has continued to do for almost two decades. As you have heard today, LB692, introduced by Senator Dennis Byars, Vice Chair of the Health and Human Services Committee at the time, and made the hard decisions on the distribution of the fund's investment income. Although there were some changes made in the bill, and in the end, debate was focused and the bill passed unanimously. Although it was a much different time than today, Health Committee and the Appropriations Committee did work together to identify how the money should be spent. It would also like to point-- I would also like to point out that the 14 cosponsors of LB692-- 3 were Democrats; 11 were Republicans. The funding was used to deal with crisis situation the state was facing in healthcare. The original LB692 developed health departments across the state for the first time focused on prevention and education. It funded the Nebraska

Lifespan Respite Services [SIC] Program, putting payments to caregivers. It moved toward a progressive funding mechanism for nursing homes and set in motion the conversion of nursing homes to assisted living facilities. It directed a stream of revenue to improve racial and ethnic minority health. It increased rates to providers of inpatient hospital mental health services and community-based mental health, and substance use treatment service dollars were specifically directed toward emergency protective custody treatment and distributed through the mental health regions to provide mental health services to juvenile offenders. Dollars were used to respond to developmental disability service waiting lists. The initial bill was also-- appropriated dollars to the Legislative Council to study delivery of public-funded health and human services in the state in Nebraska and for biomedical research at the University of Nebraska. At the beginning Senator Jensen was focused on tobacco control and prevention including cessation services as a key component of the Master Settlement Agreement. You won't find a distribtion for money of those services in the original LB692. He felt it was important enough to take it out of the Settlement Agreement dollars before the money was deposited in the Health Care Cash Fund. Appropriations bills over three years took $7 million out of the Settlement distribution for a total of $21 million. Eventually the tobacco control and prevention component was incorporated into the fund's annual distribution. Unfortunately that money was reduced substantially during lean budget years to where it is now, about $2.5 million. All of these items perhaps sound very familiar. Most of the services funded in the initial passage of LB692 have received some increases over the years but certainly not enough to cover costs. Unfortunately, in behavioral health, developmental disability services, and underserved populations, funding has not kept up, and today we are again in a crisis in healthcare. Access to services was one of the points of critical debate in LB692. Our healthcare system has changed dramatically since then, and our population and need have grown. Reinvesting in the Health Care Cash Fund and thinking about what we can do to improve access should be a focus in the next biennium budget rather than what we cannot do. There are-- were many people to thank who had the vision to ensure the Tobacco Settlement dollars were used to fund key areas of

healthcare in Nebraska. I'm going to list a few today and I'm-- thank goodness Don Wesley isn't here because he'd have a really big head [LAUGHTER] since I'm talking about him a lot today: former State Senators Jim Jensen, Dennis Byars, Don Wesely, Nancy Thompson, Jennie Robak; former Health and Human Services Counsels Gina Dunning, Jeff Santema; and current legislative staffer Janet Anderson. And of course Liz Hruska has kept us all in line over the years. The initial implementation of the Health Care Cash Fund has grown to a level today that all of us that were there in the early years couldn't fathom. It funds key-- it funds key programs in healthcare that in reality saved the state a great deal in expenditures for things like Medicaid and Corrections. But even more importantly, it saved lives. In fact, you cannot point to a more critical public policy decision made by state senators in our bipartisan Legislature that directly impacted people's lives. Thank you.

STINNER: [00:56:11] Thank you. Questions? I have one question.

JULIE ERICKSON: [00:56:18] Yes.

STINNER: [00:56:19] If we have to go to a sustainability number-- and I think that sustainability number is like 55? I think it's somewhere in that neighborhood. Would it be best if we cut out programs on a selected basis, or could we do it on a pro rata basis?

JULIE ERICKSON: [00:56:38] Well, from the healthcare community it's hard to say that an across-the-board cut is the best policy decision because you really have to set priorities. That's what everybody's job is. So, obviously a lot of those folks are the people we represent, and a lot of those services have not increased with costs even remotely over the last 18 years. So bottom line is there's going to be some-- some decisions that will have to be made or, instead of just saying what we can cut, how can we assign a stream of revenue to support this fund? I want to really make it clear that

Nebraska is the only state that did this-- the only state that used all the money from tobacco settlement dollars for healthcare. And we should be really proud of that, I think overall, and that we continue to do that, and it's-- it's great to hear new senators talk about it and how important it is. So I would hope that we all try to think about perhaps a proactive stream-of-revenue issue rather than cuts. But I do think it's important to set priorities, and so I would hate to see across-the-board kind of cuts, rather-- and really focusing on the priorities and the crisis that we are in, in some circumstances.

STINNER: [00:58:03] Thank you. Additional questions?

CLEMENTS: [00:58:03] I have a question. The demand for the fund-- has it come from increased needs for provider rates or from new programs, new types of treatments that have been added to expenditures from the fund?

JULIE ERICKSON: [00:58:25] I think it's probably a combination of the two. In the case of provider rates and particularly in the area of behavioral health and developmental disability areas. The bottom line is, you know, almost 20 years have gone by and we haven't kept up even remotely with inflation and what it's actually costing those providers to provide services. So the reality of the situation is you got to keep up with some of those to be able to build capacity particularly in the rural parts of the state. So from that standpoint I think it's probably a combination, and some of those things are new programs. I never really recognized that in the list of folks that have over the years been funded out of the Health Care Cash Fund.

CLEMENTS: [00:59:12] Thank you.

STINNER: [00:59:12] Additional questions? Senator Bolz.

BOLZ: [00:59:21] Since we've gone down this path of talking about the programs that are funded out of the Health Care Cash Fund, I guess I want to have a little bit more discussion about that. So the Children's Health Insurance Program is an entitlement program, correct?

JULIE ERICKSON: [00:59:34] Yes.

BOLZ: [00:59:34] So, in other states, entitlement programs would only be paid out of the general funds, and because they're an entitlement we don't-- we don't have a choice about whether or not to pay for increased utilization because it-- it's an entitlement. And so I think when we're thinking about prioritization and where things belong, we also need to think about whether or not we have a responsibility to those entitlement programs that we've set policy for that are above and beyond a funding stream that may or may not be sustainable.

JULIE ERICKSON: [01:00:09] There's a combination of things here, but one of the issues in that-- and to be perfectly honest we were somewhat surprised when that got added to the Health Care Cash Fund, and I'm sure it was a decision internally made by the committee-- in reality, it should be part of the budget when it really comes down to it. And this year is a situation where you have the enhanced CHIP match on the federal side that in at least the agency-- the department agency budget request indicates that it is just going to balance out the money and not being used to help out with either increasing services or doing something else with the match. I don't know if there's any way to utilize that to help put more money into the fund or not, but bottom line to your question, Senator Bolz, I would say, between that-- probably some of the provider rates-- some of those things are really direct budget items. But that's a hard thing to move now when-- when it's been there for awhile.

STINNER: [01:01:31] Any additional questions? Seeing none, thank you.

JULIE ERICKSON: [01:01:34] Thank you.

STINNER: [01:01:44] Any additional testifiers? Seeing none. Senator Wishart. You're going to waive, huh? It's after 11:00, by the way, so. OK, that concludes the hearing on LR445. We will now open LR384. Senator Williams. Just a second. I do have letters of support. And I-- I don't have a list of them, do I? Letters of support from-- from Nick Faustman, Michele Bever, Julie Rother, Brian Krannawitter, and Britt Thedinger. OK. Senator Williams.

WILLIAMS: [01:02:51] Good morning and thank you. And welcome, Senator Stinner and members of the Appropriations Committee. I'll move that down there. Appreciate the opportunity to be here today to introduce LR384, an interim study, and it's unique and special that we're having this hearing right here at UNMC, just a few blocks from the Cancer Center. And it's also, I believe, unique that we're having this hearing the day after the annual Team Jack telethon that took place all day yesterday and again raised for the sixth year in a row a substantial amount of money for pediatric cancer research. The purpose of LR384 is threefold. It's time for the Legislature to be updated on the trends in various cancers in Nebraska, what cancers have the highest incidence, and what cancers have the most prevalence in our state. In particular, the research that you're going to hear about today is focused some on pancreatic cancer, pediatric cancer, and certain types of women's cancer. Secondly, LB-- LR, excuse me, 384 is to give you an opportunity to receive additional information from cancer research experts about what they're thinking about and what the future holds and how we're looking and determining early detection methods that can and will make a significant difference for the lives of many Nebraskans. We're also here today to discuss the existing funding and how it matches with the trends that we are now seeing. And that's also clearly important. I hope that you will agree that investing in cancer research and new treatment methods is

one of the wisest and most productive actions we can take as a state body. This kind of investment enables scientists and physicians to discover new research breakthroughs and provide Nebraskans state-of-the-art treatment and care. This investment also leverages the investment of federal funds and private philanthropic dollars to support cancer research and care. This investment also spawns the acquisition of additional research dollars that provide well-paying jobs and help retain Nebraska's best and brightest. And also this kind of investment provides hope and healing. Today you're going to hear from three of our top docs that you know that are here and that have devoted their lives and energies to this type of research. You're also going to hear from several cancer patients that have benefited from the type of research that we're talking about. And with that, I will hold the balance of my comments for closing. Thank you, Chairman.

STINNER: [01:06:01] Thank you. Questions? Seeing none, thank you. Morning.

KENNETH COWAN: [01:06:23] Good morning. Chairman Stinner, members of the Committee--

STINNER: [01:06:30] I'm going to have to have you put your-- and if you could spell your name.

KENNETH COWAN: [01:06:41] Chairman, members of the committee, and resolution sponsor Senator Williams, good morning. I'm Dr. Kenneth Cowan, K-e-n-n-e-t-h C-o-w-a-n, Director of the Fred & Pamela Buffett Cancer Center. I'm honored to be here today speaking in support of Legislative Resolution 384. I want to start by thanking the Nebraska Legislature for its support for cancer research programs, equipment, and facilities at the Fred & Pamela Buffett Cancer Center. This includes funding for the construction of the Suzanne and Walter Scott Cancer Research Tower. Today I would like to briefly highlight four points as they pertain or relate to LR384. First, thanks in good part to the state Legislature, UNMC emerged as a major cancer research and treatment center in the world. The state's investment in cancer research has catapulted Nebraska into this

leadership position. For example, the Fred & Pamela Buffett Cancer Center is one of only 70 national Cancer Institute-designated cancer centers in the country and the only one in Nebraska. In addition, the Cancer Center includes research faculty from the University of Nebraska at Lincoln and the University of Nebraska at Omaha, and currently there are-- the Cancer Center has over 250 members on three separate campuses of the University of Nebraska. Extramural research funding from grants awarded to the Cancer Center researchers has grown significantly over the past 20 years. The Buffett Cancer Center has become nationally recognized as a major center for healing and hope for cancer patients throughout the world. Cancer physicians and researchers work side by side on a daily basis in our new facility in order to promote multidisciplinary research collaboration for the benefit of patients. Our mission is to reduce the burden of cancer in Nebraska. We must remain focused on the prevalence and mortality of different cancers in the state in order to accomplish this. In 2018, approximately 1.7 million Americans were diagnosed with cancer. Nebraska ranks 20th overall in the U.S. in the incidence of cancer in the state, and cancer has been the leading cause of death in Nebraska for the past five years. Cancers of the lung, breast, prostate, colon, and pancreatic cancer account for over half of the cancer deaths in Nebraska each year. We will and must continue to focus on these five types of cancers, although we obviously see patients with all types of cancer and will do research on all types of cancer. Lung cancer is the second most frequently diagnosed cancer among Nebraskans. It's the leading cause of cancer deaths in the state, accounting for over 26 percent of the cancer deaths in Nebraska. In 2015, approximately 1,200 Nebraskans were diagnosed with lung cancer, and there were over 900 deaths. Due to the relatively small number of patients that are diagnosed at an early stage with lung cancer, the five-year survival rate for people diagnosed with this disease is less than 20 percent. Nebraska currently ranks eighth in the United States in the incidence of colon cancer. In 2015, colorectal cancer was the fourth most frequently diagnosed cancer among Nebraska residents, and colon cancer is the second leading cause of cancer death in Nebraska. Unfortunately, one-third of Nebraskans over the age of 50 have never had endoscopic screening for colon or rectal cancer. Breast cancer is the most common cancer

among women in Nebraska and the second most frequent cause of female cancer death. In-- 1,400-- it should be noted that only nine other states have lower rates of screening for breast cancer than Nebraska. In 2015, over 1,400 women in Nebraska were diagnosed with breast cancer, and [INAUDIBLE] 1,200 women died from this disease. Pancreatic cancer is the fourth leading cause of cancer deaths in Nebraska, and the incidence of pancreatic cancer has been increasing in Nebraska every year. It is a particularly difficult cancer to diagnose early and is among the most deadly with only 8 percent of people surviving five years or more after being diagnosed with pancreatic cancer. Prostate cancer is the most common cancer in men and the second leading cause of cancer deaths in men each year. In 2015, Nebraska ranked 16th overall in the U.S. in both the incidence and deaths from prostate cancer. Lastly, my last point speaks to economic development and job creation. Approximately 80 percent of every grant awarded to Cancer Center members is spent on hiring specially trained personnel to work in Cancer Center laboratories. Cancer Center extramural funding has increased from $19 million in 1999 to over $65 million annually this year. This increase of greater than $45 million in annual funding for cancer research at the Buffett Cancer Center has in turn resulted in a significant number of well-paying jobs at UNMC. Federal studies indicate that every one million dollars in external funding generates approximately 30 to 32 jobs directly or indirectly in the community. Growth in the cancer research funding since 2000 has generated over 1,400 new well-paying jobs in Nebraska. In closing, there is no question that a diagnosis of cancer is life changing for patients and their families. Every Nebraskan has been affected by cancer by either having a personal diagnosis of cancer or having a family member or close friend diagnosed with cancer. As a medical oncologist specializing in the treatment of breast cancer who continues to see breast cancer patients, I am confident that with strategic support by the state and community philanthropists, the Buffett Cancer Center will continue to be at the forefront of cancer research and care in the state, country, and around the world. Following me today will be some-- several speakers, including a cancer researcher, physician scientist, cancer patients, and the parent of a child cancer patient, who will personally demonstrate what the state's investment means

to them. Mr. Chairman, members of the committee, thank you for the opportunity to appear today, and I welcome your comments and questions.

STINNER: [01:13:17] Thank you. Questions? Senator Bolz.

BOLZ: [01:13:23] Dr. Cowan, you touched on it a little bit. Could you tell me just a little bit more about some of the disparities you see in cancer prevalance based on race-- race, age, geography, ethnicity, gender, those kinds of things?

KENNETH COWAN: [01:13:37] Yeah, so it's-- we do have important disparities. First and foremost, our state is very rural, and obviously finding state-of-the-art cancer care in the rural community is very difficult. We are here to service the entire state and therefore provide as much as we can in terms of expertise and training and advice to cancer patients across the entire state. And, actually, our cancer center actually services an area with the highest population of rural cancer patients in the United States, so that is are our principal mission. But also, disparities in our racial and ethnic communities-- so, for example, in 2011 to 2015, Hispanics in Nebraska had the fourth highest incidence of cancer compared to their corresponding communities in other states around the country. African-Americans in Nebraska had the ninth highest incidence of cancer, and Native Americans in Nebraska had the 11th highest incidence of cancer in the United States. Death from cancer is higher in Hispanics, African-Americans, Native Americans living in Nebraska compared to other states. Between 2011 and 2015, children under the age of 20-- as we've heard before and you'll hear again today-- in Nebraska has the 10th highest incidence of cancer and has the highest death rate for cancer compared to children in other states. So it is an important issue in terms of addressing disparities across our state.

BOLZ: [01:15:01] Thank you.

STINNER: [01:15:05] Senator Hilkemann.

HILKEMANN: [01:15:07] Dr. Cowan, what new technologies or treatments have been introduced since this Fred and-- Fred & Pamela Buffett Center has been opened?

KENNETH COWAN: [01:15:19] So as you know, the field of cancer care is changing dramatically. In the last five years there's been an evolution to, first, looking at diseases like breast cancer or prostate cancer and trying to figure out what is best therapy for those diseases. Our cancer center and all cancer centers around the country and world are actually focusing more on this term called "precision medicine," using genomic approaches, understanding the cancer genome in each individual patient, and now realizing through research and actually clinical trials that every single cancer patient has a different cancer genome. What drives their cancers to grow is different among every individual patient. So using advanced technology like next-generation sequence like we have at the Buffett Cancer Center allows us almost in real time to address the issues that affect each individual cancer patient and through research hopefully to use that information to develop individualized precision medicine treatments for every single patient developed out of collaboration between the scientists and clinicians who are working in the laboratory-- in the Buffett Cancer Center. You also know that Nebraska has always led-- University of Nebraska and the Cancer Center has always led in technology going back even to the 1980s in terms of developing the current technology to use for bone marrow transplant. Using peripheral blood stem cells was actually given here in Nebraska for the first time in 1984, developed here in Nebraska by Dr. Anne Kessinger, and is now the most common method of performing high-dose bone marrow transplants using stem cells-- that same approach. You'll hear a little bit more later on from Dr. Hollingsworth about some of the new technologies that are being developed to address treatment of pancreatic cancer. A lot of the new fields, including precision medicine, is focusing on how we use the

genomic changes that occur in cancer cells, because those genetic changes alter the proteins in the cancer cells compared to normal cells. So they act like foreign proteins so the immune system is actually-- can target those cancer proteins in each specific cancer patient. But the cancer in every patient is also very efficient at actually trying to turn off the patient's immune system against those cancers. Currently, in the last couple of years, this avenue called CAR T-cells, where you take a patient's lymphocytes and alter the receptors that those lymphocytes have to target person's cancer, has now been studied here in Nebraska at the Buffett Cancer Center and UNMC at Nebraska Medicine. In our lymphona/leukemia group, we're now a center of excellence for CAR T-cells, as they're called, in our state. So patients [SIC] who offer that therapy from lymphona, leukemia, some in pediatric cancer, and also myeloma blood malignancies. There's a lot of interest in using those for solid tumors like pancreatic cancer and other diseases, and I think you'll may hear from Dr. Hollingsworth about a new protocol that he's developing. Two things: One is the first ever in the country establishing a pancreatic cancer screening clinic. Because, again, most patients don't come in early enough to have adequate surgery to-- which could be curative at more advanced stages. So he started with his collaborators the first-ever pancreatic cancer screening clinic and just submitted a grant this week that is actually going to look at using lymphocytes from pancreatic cancer patients which we can actually grow in the laboratory here in an FDA-approved facility. And hopefully we'll be starting a protocol next year where we'll take individual patients with pancreatic cancer, obtain their lymphocytes, grow them up, and then being able to offer them and that will be the first trial and first clinical approach to using that technology anywhere in the country or the world. And it'll be done here in Nebraska.

HILKEMANN: [01:19:28] Thank you, Doctor. It's great to hear about the technologies. It's also very discouraging to hear about colorectal cancer and that we're-- What are we doing to encourage people to have those colorectal screenings?

KENNETH COWAN: [01:19:48] Well, obviously we are working predominately through the College of Public Health, but also they work actively with the Department of Health and Human Services to try to, again, develop a cancer control plan for the-- for the state. And one of the major objectives of the Nebraska Cares Program-- the Cancer Control and Prevention Program for Nebraska, which is CDC funded, is to address the issue of how do you increase colorectal cancer screening? One, increasing awareness about the importance and value-- it can actually eliminate the development of colon cancer if you remove polyps that develop early. Number two, how do you train enough people to get this technology across the state of Nebraska and rural communities and make sure that everybody has access to this technology? It's available but it's obviously-- takes manpower and expertise to do as well. So we'll work with our College of Public Health to develop the cancer control and prevention policies and procedures to help make sure that Nebraska increases this risk [SIC]. There are other approaches that we can do also in increasing vaccination for HPV in our state. If we increase vaccination rates for HPV-- and Dr. [INAUDIBLE] also chime in on this later-- but we can eliminate cervical cancer in Nebraska if we increase the vaccination late for HPV. That is the single cause of cervical cancer.

STINNER: [01:21:10] Additional questions?

CLEMENTS: [01:21:12] Yes.

STINNER: [01:21:13] Senator Clements.

CLEMENTS: [01:21:14] Thank you. Thank you, Doctor. You said that Nebraska rakes 20th in incidence of cancer. How have we historically ranked? Is it higher or lower now?

KENNETH COWAN: [01:21:25] It changes from year to year in terms of the relative statistic, but

that's a common number for Nebraska. Number one, cancer is a disease that actually increases as people live longer-- the risk of getting cancer. Part of that has to do with the genetic changes that occur as our cells divide every month. The risk of getting a genetic change in those cells when they divide that could eventually lead to causing cancer increases over time as we live older. Fortunately the state of Nebraska has a lot of people who are living longer, especially in our rural communities. But that means that the risk of getting cancer in those communities is higher. So that's part of the benefit of actually looking and screening and working with our population, also reducing some of the factors that have a heavy emphasis on developing cancer like tobacco and cigarette smoking and chewing, etcetera. Those are also important issues that we need to address through policy and working with the College of Public Health and Department of Health and Human Services.

CLEMENTS: [01:22:34] Thank you.

STINNER: [01:22:36] Senator Hilkemann.

HILKEMANN: [01:22:37] I just-- go back to that [INAUDIBLE]. You alluded to the fact that there's a difference in the-- does research show that we're less likely in rural areas to do the screening than we are in urban areas on that colorectal cancer?

COWAN: [01:22:51] I don't have good data from the current registry program about actually the screening. All I have is the data from across the state. I don't know if Dr. [INAUDIBLE] has anything specifically. But it would become-- I can tell you that we had the same problem with mammographic screening. It's harder for somebody to drive two hours to go to a mammogram in rural Nebraska and make sure that the woman does it every year as needed. So there are specific issues related to healthcare, specifically cancer care and screening in rural communities compared to urban communities.

HILKEMANN: [01:23:26] Thank you.

STINNER: [01:23:28] Additional questions? Seeing none. Thank you.

KENNETH COWAN: [01:23:31] Thank you very much.

[01:23:31] [BREAK]

TONY HOLLINGSWORTH: [01:24:04] Chairman Stinner, members of the committee, and Senator Williams, I'm Dr. Tony Hollingsworth, T-o-n-y H-o-l-l-i-n-g-s-w-o-r-t-h, Associate Director of Basic Research and Director of Pancreatic Cancer Research at the Fred & Pamela Buffett Cancer Center. It is my honor and pleasure to be here today speaking in support of Legislative Resolution 384. Thank you for the invitation to appear before this committee. I am before you today representing the pancreatic cancer research effort, which I lead at the Fred & Pamela Buffett Cancer Center. Pancreatic cancer is currently the third most deadly cancer in the U.S. The lethality of pancreatic cancer is due in part to the fact that it's difficult to detect in early stages. Most patients come to initial diagnosis in the clinic with advanced cancer. Consequently, many patients die soon after diagnosis, leaving family and friends stunned and saddened. In addition to the problem with the lack of effective early detection strategies, the biology of pancreatic cancer is more aggressive and resistant to treatment than many other cancers, which means that more than 92 percent of those patients diagnosed with this disease will die by five years after their diagnosis. In Nebraska this translates into more than 200 deaths a year. To address these problems, we've built a comprehensive program of research at the Fred & Pamela Cancer Center which seeks to study and improve methods of early detection of pancreatic cancer, to better understand the aggressive biology of the disease, and to develop new therapies for this deadly

disease. This program of research is currently funded by more than $8 million a year in grants from the National Cancer Institute to our investigators. These research grants have allowed us to establish several unique resources in Nebraska that benefit both Nebraskans and all patients with pancreatic cancer in the U.S. and the world. One example is that we've established a new first-of-its-kind research screening clinic for Nebraskans who are considered to be at risk for developing pancreatic cancer. This clinic sees individuals with a high incidence of pancreatic cancer in their families and patients with other conditions or symptoms that indicate that they are at risk for developing pancreatic cancer and will provide for screening visits at no cost every six months. We're developing and testing new therapies for pancreatic cancer, also using new drugs and approaches that were discovered and invented in Nebraska. These are available to patients as clinical trials that are only available at our center at this time. We've also established a robust program of research into the biology of pancreatic cancer. It includes a specialized form of organ donation for cancer patients, it allows scientists and physicians to understand more about this disease, and it allows patients through their organ donation to continue to fight against this cancer even after their death. We've discovered and developed novel methods for studying pancreatic cancer that allow us to develop and test the efficacy of drugs and screening strategies in models before they go into patients. We're convinced that these measures will have a positive impact on the health and welfare of the citizens of our state in the future. The research effort in pancreatic cancer provides substantial additional benefit to the citizens of the state of Nebraska. The funding we've retracted creates high-level jobs and services that are of great value to the state. For example, the current Pancreas Cancer Research Program has created hundreds of jobs for technicians, students, postdoctoral fellows, and faculty members that are funded by sources outside of Nebraska. These are high-level, desirable types of employment. The research activity requires the purchase and transport of many materials to conduct the research and many other support services, which directly benefits businesses in this state. In addition, our current research has produced numerous patents which have resulted in the creation of at least three new startup companies to move forward discoveries that we've made in the

areas of early detection of pancreatic cancer, new therapeutic approaches to pancreatic cancer, and, of course, the production of devices to study and perhaps treat pancreatic cancer. In spite of these small successes, our current effort remains insufficient. I often get asked, "When can we expect a cure?" Or, "How long will it take to find a cure?" Our current funding provides support for about 20 percent of our best ideas for developing new diagnostic tests and therapies. In other words, four out of five of our best ideas for how to better diagnose and treat pancreatic cancer are delayed or not investigated because of insufficient funding. This is the principal reason that we cannot make faster progress in diagnosing and treating pancreatic cancer. Another way to think of this is in terms of the speed limit on the interstate. It takes about six hours at 75 miles an hour without stops to drive the 455 miles of I-80 across Nebraska. At 15 miles an hour, which is 20 percent of 75, it takes 30 hours to drive across Nebraska. I won't ask you today to increase the speed limit. You already considered that. However, I will ask you to consider LR384 as a means to investigate the roadblocks that we encounter in funding sources and how we can enhance the power in our research engine so that we might increase our speed in making progress in fighting pancreatic cancer. Thank you very much for your time and attention to this important issue and to this proposed legislation.

STINNER: [01:29:51] Thank you. Questions? Seeing none, thank you.

[01:29:56] [BREAK]

PATRICIA WOJTKIEWICZ: [01:30:22] Good morning. I'm Patricia Wojtkiewicz. Patricia, P-a-t-r-i-c-i-a W-o-j-t-k-i-e-w-i-c-z. I'm from Omaha, Nebraska. In the winter of 2016-- OK, I'm really sorry-- I had a terrible backache. I went to my doctor. No, I'm OK. I went to my doctor expecting to hear that I'm old, overweight, and out of shape. So of course my back would hurt. A nurse practitioner took great interest in my backache, so much so that in a matter of days I was having x-rays and CT scans done. 5:52 p.m., January 9, 2017, I received a call from my GP. Diagnosis:

adeno--.

_____: [01:31:37] Carcinoma.

[01:31:42] OK. A tumor in the body of my pancreas. At this point I needed some educating, so I Googled what he said. That was a bad decision. I was referred to a pancreatic surgeon who spoke at great length about lymph nodes, invading-- a tumor invading a critical vein, a whipple, radiation, chemo. Not talking to me, the patient, or to my support staff-- i.e. children, husband, friend-- just stating the condition and the prognosis as if it was something we were familiar with and what is generally done for this treatment. My support staff suggested that we get a second opinion. This is where Google was helpful. The Nebraska Medical Center is known for cancer treatment. We met with Dr. Padussis at Nebraska Medicine on January 27, 2017. He had presented my case to a team of doctors and suggested a plan that involved chemo, a distal pancrectomy and spleenectomy, and then more chemo. He knew that we were not doctors, except my middle son was a veterinarian. He drew a picture of a pancreas for us. He knew that we needed enough information to be comfortable with our choices. You know when you're in the right place. Being on chemo-- excuse me, bring on chemo. January 31, 2017, we met with Dr. Klute at the Nebraska Medicine to set up a chemo plan, lovingly referred to as 5FU. Dr. Klute and her staff knew that we were entering into a world of unknowns. While their main task was my treatment plan, they patiently answered my people's questions, caring for my support team as well as me, the patient. Chemo number one was on February 1, 2017. February 8 I had a fever from a respiratory infection and C. diff infection. Do not Google "C. Diff." [LAUGHTER] Fast forward to June 26, 2017. Since my tumor surrendered to the eight rounds of 5FU, it was time to do the surgery. The long eight-hour surgery was a long wait for my team, but the news was good: I have no gallbladder, no spleen, and about 30 percent of my pancreas left, and things looked good. Get well so chemo can be resumed. My last chemo treatment was October 18, 2017. I had 95 appointments here at the Med Center, 31 labs, 16 rounds of chemo,

surgery, and many, many supportive discussions with the Med Center staff. We became familiar with the PanCAN organization, a pancreatic patient support group, early on. They are a great resource. Our first PanCAN Purple Stride team, with the help of my tenacious fundraising friend, raised over $15,000. We were second place to Union Pacific. I cheated. [LAUGHTER] I know that I'm not out of the woods. I will have a checkup-- a checkup scan in a few weeks. Whatever that scan or any future scans reveal, I know I'm in the best place for treatment. When I have those inevitable moments of wonder-- why have I survived so far?-- I suppose being able to raise money and speak to you asking for support for more research for early diagnosis and better treatment plans could be one reason. I will continue to do what I can along with my incredible support staff to bring awareness to pancreatic cancer.

STINNER: [01:35:24] Thank you. Questions? Thank you for your testimony.

HILKEMANN: [01:35:28] Thank you for coming and sharing your story.

PATRICIA WOJTKIEWICZ: [01:35:30] Thank you.

DON COULTER: [01:35:55] Senator Stinner--

STINNER: [01:35:56] Morning.

DON COULTER: [01:35:57] Senator Williams, Appropriations Committee. My name is Dr. Don Coulter, D-o-n C-o-u-l-t-e-r. I'm privileged to be able to work with patients and the cancer community. But unfortunately someone as eloquent as Patricia is out of my age range. I am a pediatric hematologist oncologist and I don't think I'll be as eloquent as she was. As a pediatric hematologist oncologist, I also serve as the director of the Pediatric Cancer Research Group. I

would like to thank Senator Williams for introducing LR384 and the committee for holding this hearing. I've been honored to speak to the Appropriations Committee in the past regarding the Pediatric Cancer Research Group, which is an entity created by the vision of Nebraska Legislature and is an excellent model of a public/private partnership advancing health research. In my previous testimony in both 2014 and 2015, we reviewed that pediatric cancer is the number one cause of death by disease for America's children. More children lose their battle to cancer than asthma, cystic fibrosis, and AIDS combined. We identify that the incidence rates for children's cancer have been increasing over the last several decades and that this trend is of particular interest to the state of Nebraska. Specifically, Nebraska has the seventh highest incidence of childhood tumors in the United States. And Nebraska has the highest incidence of childhood brain tumors of any state in the nation. Nebraska has the highest incidence of all childhood tumors in the 12 states that comprise the Midwest region as defined by the Centers for Disease Control. Furthermore, the Pediatric Cancer Research Group has mapped out the location of childhood cancer diagnoses within the state over the last 24 years and identified a great deal of geospatial diversity that plays a large role in the impact of the disease. This diversity is especially important to the citizens of Nebraska given our urban and rural populations. Research done in Utah, a state similar to Nebraska not only in population distribution but also in the fact there is one city in Utah that serves to care for pediatric cancer patients just as there's one city in Nebraska that serves to care for pediatric cancer patients. That research in Utah showed that one-third of families of patients with childhood cancer living in a rural area either lost a job or had to move as a result of the diagnosis. The children themselves miss up to 90 days of school in the first six months from their diagnosis. These statistics show that the geography of childhood cancer can have a profound impact on the economy of Nebraska. The reason we've been able to identify these facts regarding childhood cancer in our state is because the Legislature of Nebraska decided to take action and in 2014 supported the creation of the Pediatric Cancer Research Group, an innovative team of research that includes clinicians, geneticists, cell biology experts, epidemiologists, pharmacists, and chemists utilizing the existing resources of the

University of Nebraska system, the Fred & Pamela Buffett Cancer Center, and Children's Hospital and Medical Center to better understand the impact of childhood cancer on the citizens of the state and develop new ways to fight the disease. The investment by the state allowed us to build the infrastructure to complete transformative research. We have grown from the original group of three investigators in 2014 to more than 30. The state investment has allowed us to complete high-impact, cutting-edge research and increase our extramural funding from numerous foundations and from the National Institutes of Health while also having over 25 manuscripts published in scientific journals. Through public/private partnerships, the investment of the state has been leveraged with additional resources developed by private foundations such as Team Jack and other philanthropic groups. Not only have these resources built a successful research enterprise, but they have allowed us to attract innovative investigators to our team. Dr. Donald Durden is a world-renowned pioneer in childhood cancer research completing paradigm-shifting work in computational chemistry and novel therapeutics. Dr. Durden joined our team earlier this month, and the Pediatric Cancer Research Group played a key role in attracting him to Nebraska. His recruitment brings almost $10 million of existing NIH funding to the state and makes Nebraska a sought-after destination for other research visionaries. As Dr. Durden builds the new Division of Computational Chemistry and Innovative Therapeutics, he will be recruiting top talent to make Nebraska a leader in cutting-edge cancer research. The Pediatric Cancer Research Group represents a success story for our state, combining public and private resources to build the infrastructure to understand the multitude of impacts the increased incidence of childhood cancer poses for our families. The investment also helps ensure we have the tools to recruit and retain the sharpest minds to make certain that our patients receive the best care. We are grateful for the Legislature's investment in the future of the children of our state and look forward to continuing this unique model in the years ahead. Thank you so much for allowing me to testify today. I appreciate your attention and welcome any questions.

STINNER: [01:41:19] Thank you. Questions?

DON COULTER: [01:41:20] Yes, sir.

STINNER: [01:41:20] Senator Clements.

CLEMENTS: [01:41:23] Thank you, Doctor. You highlighted the brain cancer. Could you describe what the most common cancers are in the pediatric patients?

DON COULTER: [01:41:34] Yes, sir. So from a pediatric brain tumor perspective, the most common tumors are meningeal blastoma, which are tumors of the back of the brain that present with a child having vomiting and dizziness. Those tumors have the potential to spread to different areas. There are also a number of tumors that don't necessarily spread but have to be identified by the child having a craniotomy and a surgery to cut into the brain-- and those would be considered benign tumors. But in both of those, Nebraska ranks the highest in all of those tumors. From an epidemiological perspective, leukemia is usually the number one diagnosis in children. Leukemia is approximately 30 percent of the cancer that we see in kids. However, in Nebraska, the epidemiology of that is reversed. In Nebraska, brain tumors are the number one disease followed by leukemia.

CLEMENTS: [01:42:20] Thank you.

STINNER: [01:42:20] Additional questions? Seeing none, thank you.

KARRI AHLSCHWEDE: [01:42:55] My name is Karri Ahlschwede, K-a-r-r-i A-h-l-s-c-h-w-e-d-e. I am the parent of a childhood cancer survivor. This is Leyna. I think it always helps to put a face with the name. Since she isn't here to speak for herself, I think it's important for me to do that for

her. I'm the mother of seven children, a registered nurse, and the president of an organization called Pediatric Cancer Action Network. I don't have the medical statistics and figures to present to you that Dr. Coulter and his colleagues had today. What I have is the real-life experience of raising a child with cancer and the suffering and the hopelessness that goes along with that. Prior to 2013, I had no idea that Nebraska was in the state of crisis that we are in, in regards to pediatric cancer. I had seen the same cute photos of bald, smiling children that you have in the St. Jude's commercials and never given it a second thought. And in February of 2013, my whole world was turned upside down when my youngest daughter, Leyna, was diagnosed with Stage IV high-risk neuroblastoma. Neuroblastoma is also a solid tumor cancer. Leyna's was just above her left kidney on her adrenal gland. That's where it started before it made its way to essentially everywhere else in her body. She was initially given a 20 to 25 percent chance of survival, and we were told to call our family and our friends out of state and prepare our goodbyes for her. Leyna's oncologist at that time gave us virtually no hope for her survival, and a few days later Dr. Don Coulter walked in Leyna's room and introduced himself as the oncologist on-call for the week. And it was our first breath of hope in Leyna's journey. He essentially told me that he doesn't believe in saving a child 25 percent or 20 percent or that she's not going to survive only 20 or 25 percent. She was either going to live or she was going to die, and we needed to give Leyna that chance and see what we could do for her. And so our 15- to 18-month journey began with chemotherapy, tumor resection surgery that ended in kidney failure and dialysis for Leyna, a stem cell harvest, radiation, stem cell transplant, immunotherapy, and more to her treatment. Leyna is still one of the luckiest kids I know, and I count myself lucky as well regardless of our journey. Leyna has lifelong health consequences that she's going to live with due to her cancer treatment and she has just recently been hospitalised again for surgery to repair some of the damage that we did to her tiny 18-pound body back in 2013. You might think at the end of Leyna's cancer treatment when she was finally declared "no evidence of disease" in May of 2014 that our family would take a deep breath and relax. That would be incorrect. When Leyna finished treatment at the age of just 2-and-a-half years old we were told that

if she relapsed, the only thing our medical team could offer us was hospice. At that time and after all that she had been through, if her disease came back it would be a death sentence for her. We had spent the last four years of our lives holding our breath and waiting for that to happen. However, today I can tell you that because of the funding that the state Legislature introduced and passed in 2014 provided by the state of Nebraska to the pediatric cancer research team at the University of Nebraska Medical Center and Don Coulter and his team, there are other options for Leyna and her friends should she relapse. That is literally the difference between life and death for this one Nebraska child thanks to the funding that was passed in 2014. There are choices. There are options for her, should this disease come back for her. Leyna can go back to rollerskating and teaching and learning to ride horses and enjoying her zest for life knowing that Dr. Coulter is developing real solutions and treatment possibilities for Leyna and her friends. While Leyna was nearing the end of treatment in 2014, my husband and I threw ourselves into helping other Nebraska families battling childhood cancer by incorporating PCAN. PCAN helps Nebraska families pay their bills while their child is in treatment for cancer. You've heard some testimony about some of the financial struggles that go along with treatment, including the distance to travel for families that are as far as Scottsbluff and beyond to get to Omaha. During our four years of service, we've worked with nearly 100 Nebraska families walking the same path that we did, and what we've learned through this work is that a large number of these families were out of treatment options here in Nebraska and were having to go elsewhere to seek care for their child. It's difficult for me to imagine that Nebraska, with our world-renowned Lied Transplant Center and cutting-edge medical services, that we still lack some of the resources that these families need for their children. Further funding for research from the state can open trials and treatments to these families right here at home close to their family and their support systems. We know that children in treatment and their siblings do better when the family stays intact; but for many Nebraska families, this is simply not an option. Without resources to offer the trials that these children need, families are often forced to live states away from each other. Right now PCAN is funding two families while their child and one parent reside at

St. Jude, and the other parent and the siblings are home trying to keep the lights on and the house payments made. In all reality, the possibility that one or both of these children will die while their father and their siblings are hundreds of miles away. So imagine that for a moment your child is critically ill and you cannot be at the bedside to say your last goodbyes or kiss them one last time. You folks have the power to end some of that and to offer solutions to these Nebraska families that are walking an unimaginable battle by further funding research and opening some of these trial treatments to these families right here in Nebraska. Today Leyna is seven years old and a first grader at Freeman Elementary School and she says that Don Coulter is her best friend [LAUGHTER]. He tells her every time he sees her that she needs to find new friends, but when someone saves your life and devotes their entire life's work to helping make a difference in the world of childhood cancer, you stick with what you know. Thank you for your attention.

STINNER: [01:49:42] Thank you. Questions? Senator Bolz.

BOLZ: [01:49:46] I just wanted to say thank you for your advocacy on this issue. I think I'm the only remaining member of the committee from when you testified in 2014. Hearing your voice made a huge difference.

KARRI AHLSCHWEDE: [01:49:58] Thank you.

BOLZ: [01:49:58] So you should take some credit for the work you've done. It's good to see you again. And I'm so pleased to hear that your daughter is doing well.

KARRI AHLSCHWEDE: [01:50:06] Thank you.

HILKEMANN: [01:50:07] Thank you for sharing your story.

KARRI AHLSCHWEDE: [01:50:08] Thank you.

STINNER: [01:50:09] Any additional questions? Seeing none, thank you very much.

KARRI AHLSCHWEDE: [01:50:09] Thank you.

DAVID JOEKEL: [01:50:09] Are we good there?

STINNER: [01:50:39] Good morning, still. We're almost there.

DAVID JOEKEL: [01:50:43] Just made it. Thank you, Chairman Stinner. Thank you to the committee. My name is David Joekel, D-a-v-i-d J-o-e-k-e-l. I'm the director of development for the Team Jack Foundation. The mission of the Team Jack Foundation is to raise money to fund impactful pediatric brain cancer research and to create national awareness for the disease. I'd like to first thank the Appropriations Committee for your commitment to address the issue of pediatric cancers in Nebraska. I'd like to thank Senator Williams for his legislative resolution to highlight the impact the funds have made for kids battling cancer. We obviously support this resolution. I'm glad Don Coulter was able to make it, so now I can say that after you heard him it's clear that pediatric cancers are a problem in our state. Nationally only 4 percent of federal cancer research funds are committed to childhood cancers, so the fact that you all continue funds at the state level should be commended. We think it's been a good investment. Because of that, doctors and researchers at UNMC, our elected officials, and other nonprofit groups like the Team Jack Foundation have all come together to create a program that will not only find out the why these cancers are on the rise but, just as important, fund the treatments and trials needed to beat this disease. To be state of the art in battling a disease like brain cancer, it's imperative to have a team of doctors and support staff

that can look at each case and work with the patient for a best course of treatment. For this issue of pediatric brain tumors-- and if I can use a football analogy, the quarterback of your team needs to be a neuro-oncologist, because pediatrics and neuro-oncology are both subspecialties. The number of doctors practicing in this field are few, which means that access to them for our patients can be difficult. For pediatric brain tumor kids in Nebraska, that means accessing treatments in states like Colorado, Massachusetts, or Tennessee or other parts of the country, and that travel burden is simply unacceptable when families are already dealing with a cancer diagnosis. That is, until now. In 2015, the Legislature approved the $3 million in funding for the pediatric cancer research, and the Team Jack Foundation raised another $1.5 million to recruit and hire our state's first pediatric neuro-oncologist. We're pleased to say that the hire was recently completed, and he has begun seeing patients in Omaha since early June. Our hope is that through continued investment he will be able to build out his team with other specialists and clinicians, recruit a comprehensive research team, increase the availability of clinical trials in Omaha, and eventually teach the next group of pediatric neuro-oncologists through a fellowship program. The Team Jack Foundation is fully committed to this public/private partnership, and we'll continue our efforts through annual giving, fundraising events, our annual gala, and other corporate partners-- partnerships. So why is this a good investment for Nebraska? First, when kids and families can access care here, that means the overall burden of care is limited and means better care overall for the patient. Second, the economic impact of a program here means that our families are staying here for treatments and visits, which means that money is also here to help with our university and hospital system and local economy. And finally, we truly believe that the state of Nebraska and UNMC can be a nationally known leader in treating and researching cures for pediatric cancers. That means we can attract the most talented physicians in the field and retain our local talent as we teach them to become the next generation of pediatric neuro-oncologists. We know that your role in appropriations is incredibly tough in every single session, but the investment you've made is already working for Nebraska kids and will continue to address a major local issue for families battling this awful disease. We know

it's worth every-- every dollar. On behalf of the Team Jack Foundation and all the pediatric brain cancer families, thank you, and thank you, Senator Williams, for supporting our fight. We look forward to long-term partnership as we create something special right here in Nebraska.

STINNER: [01:54:28] Thank you [INAUDIBLE]. Any additional questions? Seeing none, thank you.

[01:54:34] [BREAK]

KAREN DENISE BOWEN: [01:55:05] Good afternoon, Chairman Stinner, Senator Williams, and members of the Appropriations Committee, I am Karen Denise Bowen, K-a-r-e-n D-e-n-i-s-e B-o-w-e-n. Thank you for holding this hearing to examine the prevalence of cancer in Nebraska. I am a cancer patient to talk about the value of cancer research in treatments. I would like to share with you what I refer to as my new normal by first telling you a little about me. I am a Desert Storm War disabled veteran, and a licensed professional level special education teacher for the states of Nebraska and North Carolina, and a proud mother of two daughters who encouraged me long before this opportunity presented itself to find a way to share my story. I cannot thank you enough for listening. My journey began last winter just after the New Year. I traveled to North Carolina to visit my two daughters who were college students there, and after spending about a month with them, the day before leaving, I began experiencing what I thought were flu-like symptoms as many-- as many in the state were suffering. Immediately upon returning home to Nebraska, the symptoms only seemed to get worse. Home alone and feeling unable to drive, I called 911 to transport me to the hospital. Upon visiting with the emergency room doctor, I expressed my concerns for having the flu and would like to be tested for such. The doctor immediately had me tested for the flu and decided to also do an x-ray. Shortly thereafter, she returned and shared that I did not have the flu. However, she saw a mass in my colon that she strongly advised that I make arrangements for a colonoscopy.

Following her advice and knowing that my husband and I were leaving in a couple of days to spend Valentine's week in Hawaii, with the help of the VA, the colonoscopy was scheduled and performed by the end of the week. Unfortunately, the day before my departure I received the phone call that has changed my life forever. Hearing the words "you have a tumor, and it is malignant" immediately placed a million questions on my mind. The one question that still hovers over my head is: What if there had been prescreening made available to me? Perhaps my outlook would be different. Perhaps today I could say they removed the polyps. Instead, my story is, the colorectal cancer was already at Stage IV and spread to my liver and lymph nodes. And by the way, I'm the person who doesn't shy away from the doctor. So why wasn't I ever informed that the guidelines for getting a colonoscopy had changed? While the general population is encouraged to have the colonoscopy done at age 50, African-Americans are to have theirs conducted at age 45. I was diagnosed at age 49 and already having a discussion with my primary care physician about scheduling my colonoscopy. Unfortunately this meant now we must be reactive instead of preventive. I am fortunate to be receiving what I consider the best care possible using state-of-the-art technology, scientifically based medicine in an environment that is conducive to healing the whole person at the Buffett Cancer Center. Having said that, I too plead to the Appropriations Committee of the Legislature of our great state of Nebraska to continue allotting funding solely dedicated for cancer research. In doing so, it will bring hope to our children. Others will have a brighter story, and Nebraska will be known worldwide one day as a leader in the fight against cancer. Thank you for listening. Can I answer any [INAUDIBLE] questions?

STINNER: [01:59:23] Questions? Seeing none, thank you.

HILKEMANN: [01:59:28] Thank you for sharing your story.

KAREN DENISE BOWEN: [01:59:30] Thank you.

STINNER: [01:59:30] Any additional testifiers? Seeing none. You're welcome to close, Senator Williams.

WILLIAMS: [01:59:58] Thank you, Chairman Stinner and members of the committee. Wow. What an interesting morning we've had. This committee is charged with the responsibility of dealing with dollars. John and I are bankers. Rob and I are bankers. Dollars and cents. Today we're being asked to use our "sense" in how we spend those dollars. I would first of all like to thank those people that took their time, especially the cancer survivors and patients that have been here today, but also the top docs and also my good friend Senator Kolterman who's sitting over here supporting this resolution and supporting me sitting here. We all have a story to tell. One in four will have this dreaded disease in our state. Since the time each one of you has known me, I have worn these three bracelets that are on my wrist. The orange one I talk about freely, the yellow one I've never talked about. And I'm not going to talk about it today. But it has to do with why I'm here. You've heard today and what we've learned is that cancer is the leading cause of death in our state. And it has been for the last five years. Now the question maybe we should ask is: Before five years ago, what was the leading cause of death? And the leading cause of death prior to cancer becoming the leading cause of death was heart disease. What changed? Partly, cancer has increased. But mostly, research dollars that we have over time put into the heart area has significantly decreased the deaths that we're having in that area. Think about your friends. Think about the early detection, the surgeries that we now have and the things that we are doing there. And I think the goal of 384 is to recognize that we can make those same kind of strides in the area of cancer. This is going to sound a little different, but the two biggest issues that I hear at town halls when I'm around my district are tax reform and workforce development. And I will tell you that I believe as a senator that has looked at nearly every possible solution we can find, the only true solution to those two issues is growing our state. And we have to protect the lives of people in our state to help grow our state.

Every life matters. It's our job as legislators to create the best environment possible for that growth. Investment in cancer research clearly, as you have heard today, creates a better economy. It also provides hope to those people that need it the most. So I'm really happy to be here even though this has kind of been a solemn group of testimony that we've heard-- happy to be here to propose some solutions, some ability for our group to make strategic investments that will encourage federal dollars and will also encourage private philanthropy to come help in this area so that the stories that we hear-- the stories of our friends, the stories of our family-- become better stories in the future. Last night in thinking about this and wondering about what I might say, I was reminded of a speech that was made by Jim Valvano when he was receiving the Arthur Ashe Award a number of years ago at the ESPN ESPYs. And he got up on that stage when he was in the last stage of his life-- and he knew it-- and he said, "Cancer can take away my physical ability but it can't take away my mind, it can't take away my heart, and it can't take away my soul." And I think that's what we're about today. We as senators that have the power to use our minds, use our hearts, and certainly use our souls to make a difference with these people. "Never give up. You can never give up." That's how Jimmy V. ended that speech. And that's how I'll end my closing today. Thank you, Mr. Chairman.

STINNER: [02:05:14] Thank you. Questions?

HILKEMANN: [02:05:16] Not a question; I'm just going to make a comment to-- in mid-August, my 11th grandchild was born at Children's Hospital-- or, Women's Hospital in Houston, and out my daughter's door-- or, window, I saw the big sign: "MD Anderson." And I-- I thought about, when I first came to this city 42 years ago, when people had cancer, that's one of the places that they always went to. And I thought, how wonderful it is that the people of Nebraska have such an institution as the Fred & Pamela Buffett Institute here right now in Omaha, Nebraska. And we ought not forget the wonderful gift that our philanthropists and our state working together. We need to just keep on expanding that and making this the worldwide center that it is. Just a comment.

Thank you.

STINNER: [02:06:11] Any additional questions, comments? Seeing none, thank you, Senator. We do have a letter of support from the American Cancer Society Cancer Action Network. And that concludes our hearing on LR384. We will now open opening comments with LR386. Senator Hilkemann. [BREAK] Good afternoon, Senator.

HILKEMANN: [02:08:55] All right. Good afternoon, Senator-- Chairman Stinner and members of the Appropriations Committee. The reason for this resolution-- I'm Senator Robert Hilkemann, R-o-b-e-r-t H-i-l-k-e-m-a-n-n. I represent District 4, west Omaha. The reason for this resolution is to look into what state spending is related to the use of tobacco products. The examination is one to identify state expenditures that are a result of the use of tobacco products. We are to look at what Medicaid expenditures are related to the use of tobacco products. Thirdly, we're going to examine whether the use of tobacco has an impact on the productivity of state employee workforce. The state has dealt with reducing state spending the last two consecutive years. It is appropriate that as the state looks for ways to control spending, it is valuable to know what data are available about what smoking actually costs the state and whether there are ways to reduce those costs. There are two areas that seem obvious to look at. One is: What are the health impacts for state employees that can be attributed to smoking-related diseases? And the other is whether there is a way to determine what the state spends on smoking-related diseases through our Medicaid program. From my perspective, the goal is what those expenses are and whether we can lower spending on smoking-related healthcare costs. Now the University of Nebraska Med Center is working toward Nebraska being the healthiest state in the nation. Thanks to Dr. Khan [PHONETIC], it was one of the-- as I was running for the Legislature, he said that's my goal, and I said I love that goal. And I'd like him to help reach that. That is a great goal, and I would like to see if we can become even a healthier state. I asked the UNMC College of Public Health to look into these questions, and I look forward to

hearing what information that they have discovered and are going to provide today. I believe this information will provide insight into the costs and benefits of efforts that the state can try in order to reduce health impact and healthcare cost from smoking. We should think about what best practices other states have tried to reduce these healthcare costs. I am hoping there are some simple things that we can identify to move the state down the path to savings and improved health. However, state agencies shouldn't have to figure out what to do about smoking healthcare costs on their own. We should ask, how can we best partner with the private and education sectors to help tackle this issue together? After today's hearing we can start examining what are the logical next steps to lower state cost related to tobacco-- tobacco use and can also be steps towards making us the healthiest state in the union. I would like to add for the committee's information that I invited Dr. Matthew Van Patton, the director for Medicaid and Long-Term Care with the Nebraska Department of Health and Human Services, and Cindy Ostrowski, the Manager for Employee Wellness and Benefits for Nebraska Administrative Services. Neither of them were able to join us to testify today, but I did present a few questions to the legislative liaison at DAS, Doug Wilken. The handouts we have provided you include these questions and the responses. Those questions were: What year was the last state employee wellness survey completed? Secondly, from what-- from that last state employee wellness survey, how many state employees actually returned the survey? Thirdly, from that last available state wellness program survey, how many employees self-reported as being smokers? Well, the responses were-- Health Fitness did the last study in June of 2017, 11,265 employees participated, and the state was not provided a copy of the study results. The study was an internal tool that Health Fitness used to perform their obligations under the contract. Since that contract has expired, we do not have access to the study. We also asked from the most recent available year of data on the state employee health insurance spending data: one, to provide the last available annual state employee medical plan [INAUDIBLE] -- spending on lung disease treatments, provide the last available annual state employee medical plan spending on cardiovascular disease treatment, provide the last available annual state employee medical plan spending on chronic obstructive pulmonary

disease, and to provide the last available annual state employee medical plan spending on asthma. Mr. Wilken responded: We have used UnitedHealthcare for the spending data. UnitedHealthcare is compiling the data but will not-- it will not be available until the 28th. UnitedHealthcare estimated that it would be the middle of next week before they have that data. It is my understanding that the delay is due to the fact that there are potentially hundreds of medical codes associated with each of these health conditions, and it will take time to compile the data. Also, the claims data that UnitedHealthcare process will provide does not include whether the employer [SIC] is a smoker or not. There is also a concern over the fact that these health conditions-- and all of this is quoted-- these health conditions have no direct correlation to smoking. So, for example, cardiovascular disease is closely tied to diabetes and asthma including juvenile asthma. Again, it is impossible for UnitedHealthcare to provide detail on smoking as they do not collect that level of data to process claim. End of quote. As I previously mentioned, I don't believe the state agencies should have to figure out what to do about smoking and healthcare costs on their own. It does seem, however, that there may be a lack of data available, and I would like to work with our agencies to see what can be done to remedy that going forward. For example, I don't entirely understand why we paid a contractor for a wellness study but were not provided with the results of that study. With that, I will turn this hearing back over to you, Mr. Chairman. And there will be some questions, and we have people who are here to testify to these questions.

STINNER: [02:16:17] Thank you. Any questions? Seeing none, thank you.

HILKEMANN: [02:16:22] Thank you. I will reserve the right to close.

FERNANDO WILSON: [02:16:50] Hi.

STINNER: [02:16:51] Afternoon.

FERNANDO WILSON: [02:16:53] I am Fernando Wilson, spelling is F-e-r-n-a-n-d-o W-i-l-s-o-n, a faculty member in the UNMC College of Public Health and acting director of the UNMC Center for Health Policy.

STINNER: [02:17:07] We might want to ask you to put the--

FERNANDO WILSON: [02:17:07] Oh, sorry. I was invited to testify on behalf of LR386, which seeks to examine the impact of tobacco use on governmental spending for the state of Nebraska. I'm here speaking for myself and not as a representative of the University of Nebraska. The UNMC Center for Health Policy conducted an assessment of the economic impact of tobacco use for the state of Nebraska Medicaid program and for state government employee productivity. This included a review of the academic literature on smoking-related illnesses and the impact of tobacco use on number of sick days taken by employees. Currently among all Nebraskan residents, 17 percent are current smokers compared to 15.5 percent nationally. Prior studies have established the association of tobacco use with cancer, cardiovascular, and other diseases. For example, compared to 11.6 percent of nonsmokers who have asthma, one-third of current smokers have been diagnosed with asthma. Over half of current smokers have received diagnoses of arthritis or related chronic conditions. Using published data on chronic illness, we estimate that smoking among state employees may be associated with 856 cases of arthritis and related diseases, 557 cases of asthma and chronic obstructive pulmonary disease, 167 cases of cancer, and 178 cases of heart attack. Medicaid expenditures associated with smoking are likely significant. Prior studies have estimated that among all state Medicaid programs, 15 percent of expenditures is attributable to smoking. This suggests that smoking may account for up to $242.2 million in total annual Medicaid expenditures in Nebraska, and the state share of these expenditures is about $114.9 million annually. Finally, smokers are significantly more likely to require additional sick days versus nonsmokers. We

estimate an average of 6,100 annual loss workdays among all state government employees as a result of smoking-related health issues. This accounts for 3.8 percent of all sick leave-- sick leave expenditures, or $1.3 million annually for state employees. Thank you for providing me this opportunity to testify.

STINNER: [02:19:41] Thank you. Any questions? Seeing none, thank you. Any additional testifiers?

JOHN DENKOVICH: [02:20:18] Looks like I'm the lucky one to go next, so. Thank you. Good afternoon, Committee. My name is John Carl Denkovich, D-e-n-k-o-v-i-c-h. I reside in Legislative District 4 at 15932 Douglas Circle. I-- and my representative in the Llllegislature is Senator Hilkemann. Thank you for giving me the opportunity to speak today. I wanted to come here today as a representative of the Metro Omaha Tobacco Action Coalition, which is an organization and coalition with a 501(c)(3) status that focuses on tobacco prevention and control efforts within Douglas County, specifically methods of education, prevention, and control through supporting a variety of different community organizations, community advocates, and community members. And speaking in support of LR386 and researching the various ways in which tobacco impacts our community, I wanted to-- because there are so many ways in which it does-- I wanted to speak a little bit about how it specifically impacts our community in terms of multi-family unit housing and provide to you just a little bit of context in Nebraska with regard to the costs associated with that. Research shows that nonsmokers living in multi-family unit housing can be exposed to neighbors' secondhand smoke through transference that occurs through doorways, electrical lines, ventilation systems, plumbing, and wall cracks. And there is no sufficient way to filter or prevent permeation of secondhand smoke in shared dwellings. Each year, Nebraska spends $746 per every household for smoking-related medical expenses and lost productivity. Smoking in and near homes increases the likelihood of fire. The risk to life and property is magnified when smoking occurs in multi-unit

housing. Statewide the most recent three-year compiled data, 2013 through 2015, reveals 521 individuals-- smoking-related home fires, 10 deaths and 35 injuries, and $7.9 million in property damage. Over the course of the same period, 104 multi-unit housing fires occurred, 1 death and 9 injuries, and $3 million in property damage. Smoking-related fires cost the state of Nebraska money in first responder preparedness and resources to address these fires; damage on the local economy when residents are injured, killed, and/or displaced. In addition to the emotional toll it takes on local families and the impact on public health within multi-family unit housing complexes when a devastating event like this occurs, insurance companies report claims, increasing-- which increase premiums. The number of payouts in an area increase premiums for everyone, and quotes collectively for those seeking policy coverage are affected. So I would ask you to consider including this as part of the larger study and how this affects Nebraskans. Today you'll also hear from some of the social cost of tobacco from somebody that we specifically through Metro Omaha Tobacco Action Coalition, or MOTAC, have helped assist. And I would just ask you to listen to some of her more personal testimony and I thank you for your time. And I am happy to yield to any questions you may have.

STINNER: [02:24:16] Any questions? Seeing none, thank you.

JOHN DENKOVICH: [02:24:22] Thank you.

SAMANTHA CHESSMORE: [02:24:48] Dear Chairman Stinner and the members of the Appropriations Committee, my name is Samantha Chessmore. I am the mother of five beautiful girls, ages 11 to 2. My husband is currently in medical school at UNMC, and we live in Legislative District 7, a constituent of Senator Tony Vargas. And I want to share with you some of the devastating effects tobacco has had on my family and I--

STINNER: [02:25:14] Ma'am, could you please spell your name?

SAMANTHA CHESSMORE: [02:25:16] Yes. Samantha, S-a-m-a-n-t-h-a. Chessmore, C-h-e-s-s-m-o-r-e.

STINNER: [02:25:18] Thank you.

SAMANTHA CHESSMORE: [02:25:25] We invested in the American Dream by buying our first home, a townhome in Omaha. Our walls-- we share walls with one of-- a one-bedroom unit in which two people who smoke live. Shared walls with our neighbors means secondhand smoke to travel through our air vents, our electrical outlets, and comes in through our attic. The smoke is constant and heavy. Despite a tobacco-free policy for our townhome community, we are one of the handful of unlucky families that live next to one of the three smokers who remain in the community and are allowed to smoke inside their home-- not outside, because it's a tobacco-free community. We live on a limited income consisting of student loans because my husband is in medical school. Because of our little-- limited income and our high debt-to-income ratio due to medical school, our family cannot afford to just move out as has been offered as a potential solution to our problem. We attempted to make our costly improvements to our home to block secondhand smoke transference, and it doesn't work. We have literally torn down walls adjacent to their theirs and put in spray insulation. And we have rerouted our ventilation so our air wasn't coming from their living room and sealed off the attic. We have exhausted all our finances trying to address this issue. While selling our unit is an option, we are prevented from selling it to a smoker due to our townhome community restrictions. But my family and I would never knowingly sell our unit to a nonsmoker who would suffer from the consequences of secondhand smoke. This goes against all my morals and makes me truly feel trapped in a home that is unsafe and unhealthy for me and my family. If it was just a smell, I would not be sharing my story with you today. I wouldn't have reached out to

Metro Omaha Tobacco Action Coalition, my city councilman, and my state senator asking for changes to my-- changes to multi-unit housing to protect families like mine. I am an athlete and an overall healthy individual. I am an avid runner and I participate in roller derby. My life significantly changed after moving into our first home, and shortly after I was diagnosed with asthma, experiencing experiencing multiple sinus infections and upper-respiratory infections. My daughter Lyla [PHONETIC] has been diagnosed as pre-asthmatic in less than six months after living in our home. My youngest child's birth was plagued with severe complications after secondhand smoke exposure provoked a premature labor and birth. This premature birth and subsequent secondhand smoke exposure caused her to experience complete deafness for a large portion of her young life and permanent hearing loss and related developmental delays, resulting in surgery and causing her to miss key milestones. In consultation with our pediatrician, her father and I are weighing the best options for her next surgery to address her ear infections and hearing loss. As we weigh the best options to ease her pain, and we are forced to carefully consider what choice because any increase in scar tissue will contribute to a permanent hearing loss and contribute to further developmental delays. As parents we are terrified. I wanted to bring my story to all of you today and allow you to hear how easy it is for one of your constituents, someone like me, to become trapped in a situation like this and harmed by tobacco, having permanent effects of our lives-- on our lives. Please consider the importance of addressing the dangers of tobacco in any way possible and help us protect families in any way-- in ways that I cannot without your help. Thank you. Is there any questions? I would be more than happy to answer any questions you may have.

STINNER: [02:29:53] Questions?

VARGAS: [02:29:53] Thank you for coming.

STINNER: [02:29:56] Thank you.

AUTUMN SKY BURNS: [02:30:23] Good morning. My name is Autumn Sky Burns-- that's B-u-r-n-s and first name is A-u-t-u-m-n S-k-y, and I have been involved in tobacco control and prevention for the last three years. I am a staff member at CHI Health as well as the coordinator for Tobacco Education Advocacy of the Midlands. And we are-- Tobacco Free Nebraska developed a statewide coalition model that relies on individuals like ours and our organization that's about 45 other organizations deep to look at, really, grassroots ways to address tobacco. So Sarpy and Cass have been getting money since 2001, and we've made a lot of great progress. We've implemented some tobacco-free parks-- I'm not sure if you're aware, but tobacco is the number one littered item on the planet. Seventy-five percent of people throw their tobacco trash on the ground, and, as we're a farming state, what happens when we throw things on the ground and it rains? Every cigarette has more than 4,000 chemicals in it, and over 50 of those are known carcinogens. So we know they cause cancer. Seventy-five percent of them-- people are throwing them on the ground, it rains, those chemicals get into our storm water. It's used to irrigate our crops. It gets into the grass that our kids are playing on. So that is one of the reasons I am very involved environmentally and that was one of the reasons I wanted to work on tobacco. When I started working on it, though, I realized that it was still the number one cause of preventable death in the United States. And here in Nebraska, 2,500 people a year die every year because of tobacco. That's more than the population of Milford every single year, and that's 48 people a week, 7 people a day. So if West Nile was killing seven people a day, I feel like we would be putting some money behind it. There's actually been some research done, and 78 percent of Nebraskans support funding for tobacco control. Because most people are like me, 90 percent of people start smoking before the age of 18. Two-thirds are regular smokers by 19. Your brain doesn't stop forming until you're 26. And the tobacco industry spends a million dollars per hour on tobacco marketing, and their main group that they maket to: 12- to 15-year-olds. I have a 7th grader, so I take some issue with that. I was given my first cigarette by my babysitter and I was buying cigarettes for, you know, my friends by the time I was 18, which is illegal and I

shouldn't have been doing. But that's what you do. And there is studies that show that if we were to increase the tobacco price, a 10 percent price increase would decrease our smoking percent for youth by 5 percent-- or no, let's see, yeah, that's right. So, one thing that I've found doing this for last three years is that smokers and nonsmokers agree that we don't want the next generation smoking. A lot of us are addicted. We can't stop. I did. I-- luckily I think I've quit five times now. Last time was about three-and-a-half years ago, when I started. It's very hard. The average person takes seven times to quit. So I wanted to present kind of that background of-- it affects everybody. It's not just the nonsmokers, because if you live here, that tobacco-- that nicotine is getting into everything and it's affecting every area. And again, seven people a day. Think about if it was anything else, and seven people a day were dying in Nebraska. It would be all over the news. But because this has been happening for so long, we give them a pass. We let them keep spending a million dollars an hour and we at the local level don't have a whole lot to fight back with it. We need some help. So, thank you today. Does anyone have any questions for me?

STINNER: [02:34:17] Questions? Seeing none, thank you.

AUTUMN SKY BURNS: [02:34:20] Thank you so much for your time.

STINNER: [02:34:31] Any additional testifiers? Seeing none, Senator Hilkemann?

HILKEMANN: [02:34:48] Thank you, Chairman Stinner. And thank you, members of the committee. Well, we may have not gotten as many answers today for this resolution that we had hoped. But that's the way it is with data. This is-- in fact, it's probably easier to ask the questions than it is to find the answers when it's this type of data that we're looking for. But we certainly learned firsthand what this-- tobacco has an effect directly and indirectly on all of us, whether we're state employees or whether we're paying for those costs through our Medicaid [INAUDIBLE]. I

promise you we will continue to work with the agencies. We're going to try to find these answers that they-- as they come available and we're going to certainly report those back to this committee. With that, I'll end my testimony. If there's any questions--

STINNER: [02:35:38] Any additional questions? Seeing none, thank you. We do have a letter of support from the American Cancer Society Cancer Action Network. And that concludes our testimony and hearing on LR386. And that also concludes our hearings for today, so thank you.