[LB518 LB526 LB527]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, March 21, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB518, LB526, and LB527. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None.

SENATOR CAMPBELL: I want to welcome you to the afternoon hearings for the Health and Human Services Committee. I'm Kathy Campbell and I serve District 25, which is east Lincoln and eastern Lancaster County. I'm going to go through some of the procedures of the committee, and then we'll have the senators introduce themselves. If you are planning to testify today, you need to have one of those bright orange sheets that are located on either side of the room. And please print very legibly. When you come forward to testify, you give the materials to the clerk, Diane Johnson, and the pages will assist her in distributing any materials that you have. You do not need to have a handout to testify, however. As you sit down, we do use the light system in the Health and Human Services Committee. You will start out with five minutes, and it'll be on green. And you'll keep looking, thinking boy, it's green for a long time. And then with one minute left, it'll go to yellow. And then when it goes to red, I'll be probably trying to get your attention to finish out your comments. As you come forward and sit down, please state your name for the record and spell it. And it's not that we can't read your name off the orange sheet, but the transcribers who listen need to hear you say your name and spell it. So that's why we require that. If you have a cell phone with you or anything that makes noise--let's put it that way--would you make sure that it's on silent or is turned off so you don't disturb someone who's testifying? And with that, we'll start with introductions. And, Senator, would you start us off, please?

SENATOR WATERMEIER: I'm Dan Watermeier from Syracuse, District 1.

SENATOR HOWARD: I'm Senator Sara Howard. I represent District 9 in midtown Omaha.

SENATOR KRIST: Bob Krist, District 10, Omaha and unincorporated parts of Douglas County, and Bennington.

MICHELLE CHAFFEE: I'm Michelle Chaffee. I serve as legal counsel.

SENATOR GLOOR: Mike Gloor, District 35, Grand Island.

SENATOR CRAWFORD: Sue Crawford, District 45, Bellevue, Offutt, eastern Sarpy County.

DIANE JOHNSON: And I'm Diane Johnson, the committee clerk.

SENATOR CAMPBELL: And our two pages today are Deven and Kaitlyn. And if you need assistance with anything, they're very helpful and would be glad to assist you. All right. Senator Janssen is here; I saw him. We will open the public hearings this afternoon with LB518, which is Senator Janssen's bill to change certain eligibility provisions of the Medicaid Assistance Act. Welcome, Senator Janssen. [LB518]

SENATOR JANSSEN: Thank you. [LB518]

SENATOR CAMPBELL: And you can just begin whenever. [LB518]

SENATOR JANSSEN: Okay, perfect. Thank you, Chairwoman Campbell and members of the committee. I'm Charlie Janssen, C-h-a-r-l-i-e J-a-n-s-s-e-n. I represent District 15 in the Nebraska Legislature, which is Dodge County, Fremont, and towns such as Winslow, Uehling, Hooper, Nickerson, to name a few. I would say I appreciate the way that you introduce your committee, having them do that. I've never seen that before, so that was... [LB518]

SENATOR CAMPBELL: It's a long tradition here at the Health Committee. [LB518]

SENATOR JANSSEN: It's interesting and good. I appear before you to introduce LB518. LB518 would repeal LB599, passed in the 2012 legislative session. It expanded coverage for certain benefits under the medical assistance program to previously ineligible persons, including persons unlawfully present in the United States. The passage of LB599 was controversial, and I feel it was appropriate that we revisit the issue in the 103rd Legislature. We have new members who do not have an opportunity to weigh in on this issue. LB599 was controversial because the Unicameral went back on our previous policy to prohibit giving public benefits to those who are not lawfully present in the United States. We worked hard in 2009 to achieve a consensus on the state policy to prohibit nonemergency healthcare benefits and other state taxpayer-funded benefits to those who are not lawfully present in the United States. And LB403, at that time, passed 44 to 0. I'm concerned that when we allow these state benefits at public expense, we reward illegal behavior and divert limited resources from necessary services for legal residents. None of Nebraska's border states provide this taxpayer-funded healthcare benefit to those unlawfully present in the United States. We are now, in effect, a sanctuary for illegal immigrants. An illegal immigrant from any boarding city...bordering city or town can establish residency in Nebraska and shortly thereafter apply for these taxpayer-funded benefits. Taxpayers of Nebraska should not be required to assume responsibility for people who came here and broke the laws and are now being encouraged to come from neighboring states to receive free medical care. It is widely understand, and we all agree, that prenatal care is important. Every mother needs to make sure that they responsibly take care of themselves during

pregnancy. Most Nebraskans pay for prenatal care themselves. Asking taxpayers to work hard, pay their taxes, and follow the law to pay for prenatal services for persons who broke the immigration laws, became pregnant, and are in Nebraska at the time of their pregnancies, is fundamentally unfair. If we pass LB518, health centers, hospitals, clinics, private donors or other benefactors across the state will not be prohibited from assisting those who request it regardless of immigration status. Most states--35 at last count--have determined that this is the most appropriate policy. I thank you for your consideration and appreciate your time today. [LB518]

SENATOR CAMPBELL: Any questions? Senator Krist. [LB518]

SENATOR KRIST: There was a Lincoln Journal Star article that quoted you as saying that we are looking at the fact that Nebraska is the only state that offers this. If somebody in the country illegally is in one of our bordering states, the natural inclination is going to come to Nebraska and further sap the Nebraska taxpayers. You said in your opening that that just applied to the border states. Do you still contend that this is illegal or this is not done in all the states? [LB518]

SENATOR JANSSEN: I won't say that I was misquoted. I'd say they misquoted me in that article. [LB518]

SENATOR KRIST: Okay. So for the record, I would point out that there are 14 states that actually do it, there are 5 pending adding onto it, and Iowa is one of those that is considering it in the legislature this session. Secondly, I guess because you brought the issue back up again, I guess I have to go through the diatribe that I did on the mike that night and remind people that we did this. We did this for pretty much our entire history. And then the Governor got a letter from CMS, and that ended up in our pocket...in the state's pocket, in December of 2009. The Governor chose not to bring it to the Legislature's attention until the wee hours of the morning after bill submission date had come and gone, thinking that he was going to be able to go through what he considered to be a campaign promise not to give money to illegal immigration. In the course of doing that...and we tried...we suspended the rules, if you recall. We tried to change it that year, and we were ill-prepared to go forward and we lost votes. The following year, we came back with--the following year, two years--we came back with LB599, which was well-conceived, well-planned. And the problem, Senator Janssen, is that when the Governor decided to do what he did, the CEO of Health and Human Services and the Department of Medicaid director went forward and took those services away. There were at least as many Nebraska residents who are below the poverty line that were hurt by that initiative as what you term "illegal aliens." I don't like that word, but that's what the common... [LB518]

SENATOR JANSSEN: I didn't say that word. [LB518]

SENATOR KRIST: No. I mean what we say, what they say, what the Governor says is an illegal alien. My point in saying this is that we had a longstanding tradition to take care of people below the poverty line. And, by the way, the CMS, in one of their actual statements...it is statement C regarding this program: The state covers pregnant women regardless of their immigration status under the CHIP unborn child option. So when the letter came in, the federal government said: Nebraska, you're not doing it right. You're taking the money out of the wrong pot. You need to take it out of this pot. So the letter told us exactly how to change it--which, by the way, is pretty much what we did with LB599--and restored the effort. I'd say that the Governor in doing that and withholding the information--lack of respect between the two branches, but I won't talk to that too much today--but you've put your name in to be the Governor so I guess I'm going to ask you. If you were the Governor, would you have played the game that way? [LB518]

SENATOR JANSSEN: I don't consider this a game, Senator Krist. [LB518]

SENATOR KRIST: Well, neither do I. And I think that what needs to be said here is, LB599 was a restoration of our program that existed in the state of Nebraska for years. And I take offense to people making immigration, illegal or not, a campaign issue. So my question is, would you have done the same thing that Governor Heineman did? [LB518]

SENATOR JANSSEN: I would have worked proactively to enforce the laws of Nebraska and the United States. [LB518]

SENATOR KRIST: Which at the time was that we provided the service. We had the service, and the federal government reminded us that we were taking money out of the wrong pot. Would you have taken the money out of the right pot and kept this service in place if you were the Governor? [LB518]

SENATOR JANSSEN: I'm not following you, there, Senator Krist. [LB518]

SENATOR KRIST: Okay, let me see if I can be more specific. The Governor got a letter and said your program is being run the way it needs to be run, however, the funding mechanism is incorrect. You're taking the money out of the wrong program. Here's how you fix it. Here's how you restore not only the services that have continued for 30-some years in the state of Nebraska but you fund them correctly, taking the money out of the right pot. So my question is, if you were Governor, would you do the same thing? [LB518]

SENATOR JANSSEN: You know, you're asking me about something that I wasn't privy to at the time. And I can't answer that, what would happen. [LB518]

SENATOR KRIST: Okay. We normally in Health and Human Services wait at least a

day to Exec on something. If I had my way, I'd IPP this thing when you walked out the door. I just want to tell you how strongly I feel about it. Thank you, Senator. [LB518]

SENATOR JANSSEN: Thank you, Senator Krist. [LB518]

SENATOR CAMPBELL: Senator Howard. [LB518]

SENATOR HOWARD: I...thank you, Senator Campbell. I actually have a slightly technical question. My colleagues on the body may be getting a little sick of my technical questions; but I'm still learning, so they're being very patient with me. [LB518]

SENATOR JANSSEN: I know your mom. [LB518]

SENATOR HOWARD: So my question is, actually your bill deals specifically with undocumented. And since I wasn't here last year, do you know how we handle healthcare for folks who are legal permanent residents or LPRs or folks who are on work visas? [LB518]

SENATOR JANSSEN: No. I didn't come here today to speak to that. [LB518]

SENATOR HOWARD: Oh, okay. [LB518]

SENATOR JANSSEN: So I couldn't give you the background on all that. [LB518]

SENATOR HOWARD: Okay. Thank you. [LB518]

SENATOR JANSSEN: But you're on the Health Committee, so... [LB518]

SENATOR HOWARD: Just...I know. Maybe somebody behind you will be able to answer that question. [LB518]

SENATOR JANSSEN: I'm hopeful. [LB518]

SENATOR HOWARD: Thank...me too. Thank you. [LB518]

SENATOR JANSSEN: You bet. Thank you, Senator Howard. [LB518]

SENATOR CAMPBELL: Any other questions? Thank you, Senator Janssen. [LB518]

SENATOR JANSSEN: Thank you. I appreciate it. [LB518]

SENATOR CAMPBELL: Will you be staying to close? [LB518]

SENATOR JANSSEN: I may. [LB518]

SENATOR CAMPBELL: Okay. All right. Our first proponent? Good afternoon. [LB518]

VIVIANNE CHAUMONT: (Exhibit 1) How are you? [LB518]

SENATOR CAMPBELL: I'm good. You can go right ahead. [LB518]

VIVIANNE CHAUMONT: Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, and I'm the Director of the Nebraska Department of Health and Human Services' Division of Medicaid and Long-Term Care. I am here to testify in support of LB518. If LB518 were to pass, Nebraska would eliminate the separate stand-alone Children's Health Insurance Program that we implemented on July 19, 2012. The separate stand-alone CHIP was created solely for pregnant women who are ineligible for coverage under Medicaid. In the majority of cases, these women are not eligible for Medicaid because they are in this country illegally. The elimination of the standard stand-alone CHIP program would provide significant savings. These savings, approximately $2.8 million, were included in the department's budget request as well as the Governor's budget recommendation. The key issue remains whether illegal immigrants should be receiving taxpayer-funded benefits. LB599 was an expansion of coverage to illegal immigrants at a time when we were making difficult choices about the services we provide. For these reasons, we support the passage of LB518. I'd be happy to answer questions. [LB518]

SENATOR CAMPBELL: Director, I'm sure that you can answer Senator Howard's question. Would you like it repeated? [LB518]

VIVIANNE CHAUMONT: Please. [LB518]

SENATOR HOWARD: Well, so my question was about, well, this bill deals with undocumented individuals. How do we manage healthcare or do we offer any healthcare for legal permanent residents or folks who are here on work visas? [LB518]

VIVIANNE CHAUMONT: We do offer...the Legislature adopted a statute a few years ago to offer legal permanent residents that qualify, pregnant women, and children who are legal permanent residents... [LB518]

SENATOR HOWARD: Okay. [LB518]

VIVIANNE CHAUMONT: ...Medicaid... [LB518]

SENATOR HOWARD: Medicaid. [LB518]

VIVIANNE CHAUMONT: ...and CHIP, yeah. [LB518]

SENATOR HOWARD: And CHIP? Both? [LB518]

VIVIANNE CHAUMONT: Well, remember Nebraska runs its CHIP program as a Medicaid expansion other than this particular program. And so the rules are the same for both. [LB518]

SENATOR HOWARD: Okay. Thank you. [LB518]

SENATOR CAMPBELL: Senator Krist. [LB518]

SENATOR KRIST: Director, thanks for coming. My question is maybe not one that you want to answer or you can answer. But what happens when anyone presents themself in an emergency room? If I walk into an emergency room right now, what are they required to do by federal law? [LB518]

VIVIANNE CHAUMONT: If you have an emergency condition, they're required to treat your emergency condition. [LB518]

SENATOR KRIST: So if a woman walked in at 8 months and 31 days and had a baby in the emergency room, which by all standards would be considered an emergency birth in the emergency room, would we have to pay for that? [LB518]

VIVIANNE CHAUMONT: Medicaid would pay for that, yes... [LB518]

SENATOR KRIST: Okay. [LB518]

VIVIANNE CHAUMONT: ...if they are otherwise eligible. [LB518]

SENATOR KRIST: And if that baby had no benefit of prenatal care--which by all concerns as we went through LB599 debate, is rather cheap, folic acid, those kind of things that are taken care of within the gestation cycle--if that baby had a birth defect, who would be responsible for paying for the hospitalization? [LB518]

VIVIANNE CHAUMONT: If Medicaid paid for the birth, that child would be Medicaid eligible. [LB518]

SENATOR KRIST: Medicaid eligible. And how much of that would be the Nebraska portion of that? [LB518]

VIVIANNE CHAUMONT: Of Medicaid expenditures? [LB518]

SENATOR KRIST: Presently? [LB518]

VIVIANNE CHAUMONT: Approximately 46 percent. [LB518]

SENATOR KRIST: Okay. So if a patient comes into an emergency room and has a baby, the baby has not been provided any prenatal care, the baby is born with a birth defect and spends one day in a NICU, do you know approximately how much that costs to have them there in the NICU? [LB518]

VIVIANNE CHAUMONT: No, I don't. [LB518]

SENATOR KRIST: How much? [LB518]

VIVIANNE CHAUMONT: I don't know. [LB518]

SENATOR KRIST: Don't know. Well, maybe somebody else behind you can. My point is that we can pay you now, pay you later. If we provide rather cheap prenatal care, by all standards, we would avoid huge bills in the NICU. But I'll ask that question. Thank you for being here. [LB518]

VIVIANNE CHAUMONT: I can just tell you the data didn't show that. [LB518]

SENATOR KRIST: Pardon? [LB518]

VIVIANNE CHAUMONT: During the time that we didn't have this program, the data did not show that women for whom Medicaid was paying under emergency treatment for the birth that those babies weren't any more expensive than women who were Medicaid eligible, presumably were getting prenatal care. The data didn't show that there was an increase. As a matter of fact, the data showed that those babies were cheaper babies after three months, after 30 days, three months, nine months, a year. [LB518]

SENATOR KRIST: How many more people presented themselves after we implemented the program? [LB518]

VIVIANNE CHAUMONT: Pardon me? [LB518]

SENATOR KRIST: How many additional people participated in this program after we implemented the program after the gap of one year of not being around? [LB518]

VIVIANNE CHAUMONT: There were I think, initially, about 400 people. But to assume that they were not getting prenatal care prior to that time is not accurate because you can't assume that a Medicaid-covered woman is getting prenatal care. And you cannot

assume that a woman who is not covered is not getting prenatal care. A lot of people pay for their prenatal care. [LB518]

SENATOR KRIST: So for 30-some years we were providing this care, we decided not to provide it for a year and a half; it's restored. And you're telling me that the data shows that before, during, and after the suspension that the data doesn't show that we have... [LB518]

VIVIANNE CHAUMONT: The data that we were asked for was the data for the time period when Medicaid did not pay, when we were not covering pregnant women who were illegal as Medicaid clients. That's the period that the data was for. And the data indicated that the costs of the babies was actually less for those folks that we weren't covering than it was for the folks that we were covering. [LB518]

SENATOR KRIST: Well, I think there's people that would conflict or tell you that that data is in conflict with things that we know, but neither here nor there. It goes back to the point if you don't ask the right question, you're not going to get the right answer. So thank you for your testimony. [LB518]

VIVIANNE CHAUMONT: Okay. [LB518]

SENATOR CAMPBELL: Any other questions? [LB518]

SENATOR COOK: I have a question, Madam Chair. [LB518]

SENATOR CAMPBELL: Oh. Senator Cook. [LB518]

SENATOR COOK: Thank you, Madam Chair. Thank you, Director Chaumont, for coming today to testify. I'm recalling from our floor debate and from some of the background information that approximately 30 percent of the women who were disqualified after the directive came from D.C. and after Nebraska stopped doing presumptive eligibility, is...are they included in this what you're calling a savings of $2.8 million? In other words, is this pot of money solely dedicated to undocumented women who would be eligible for prenatal care under Medicaid, or is that the other 30 percent Americans... [LB518]

VIVIANNE CHAUMONT: Nope. That's a good question. What happened was that when we put in the state plan amendment, we included some of the women that were contemplated in LB599. And that was women who were in jail, and CMS said that we could not cover those. So the women that we ended up covering through the approved state plan are--the large majority of them--are undocumented women. [LB518]

SENATOR COOK: Okay. Thank you. [LB518]

SENATOR CAMPBELL: Any other questions? Senator Crawford. [LB518]

SENATOR CRAWFORD: Thank you, Senator Campbell. When you were talking about the cost of babies that were born that you were covering, did you mean you're comparing the cost of all children...all babies that receive Medicaid coverage after they're born or are you talking about just, in general, the cost comparing all babies born...people who we do cover versus people we don't cover? When you were making that...what is the comparison? [LB518]

VIVIANNE CHAUMONT: Let me...yeah. Let me explain where the comparison was. As Senator Krist pointed out, Medicaid has to pay for an undocumented woman...has to pay for the labor and delivery because by definition, federal law, labor and delivery is an emergency. And I think we can all agree on that. So if Medicaid pays for the birth, for the labor and delivery, federal law also requires that that child is eligible for a year. So we had folks whose baby Medicaid paid for the delivery and then those...we have those babies covered under Medicaid for a year. So we compared the women that we paid for...the babies of the women that we paid for through emergency medical for a year versus the babies that we covered under regular...the births that we covered under regular Medicaid and then those babies for a year. That's the comparison and the data's claims payment data out of our system. [LB518]

SENATOR CRAWFORD: That didn't necessarily have any measure of whether they received prenatal care. [LB518]

VIVIANNE CHAUMONT: Absolutely. It doesn't say anything about whether the women on Medicaid received prenatal care. And it doesn't say, by the same token, whether the women who weren't on Medicaid received prenatal care. [LB518]

SENATOR CRAWFORD: Okay. So it can't answer that question, really, about whether providing the prenatal care addresses the cost. [LB518]

VIVIANNE CHAUMONT: Well, it covers...it does answer the question about these cost savings that are out there. [LB518]

SENATOR CAMPBELL: Senator Gloor. [LB518]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Director, for coming. But how did we know whether the mothers were illegal or not? [LB518]

VIVIANNE CHAUMONT: Because to be eligible for emergency medical services, that's the criteria. It's...emergency medical coverage for Medicaid is for a woman who would be eligible for the Medicaid program but for the fact that she doesn't meet the citizenship

criteria. [LB518]

SENATOR GLOOR: Okay. [LB518]

VIVIANNE CHAUMONT: Uh-huh. [LB518]

SENATOR GLOOR: Thank you. [LB518]

SENATOR CAMPBELL: Director, in your testimony you talked about that you had suggested that the money be removed from your budget. When the Legislature overrode LB599, wouldn't that become a mandatory program? [LB518]

VIVIANNE CHAUMONT: And we implemented it exactly as the Legislature told us to on July 19. [LB518]

SENATOR CAMPBELL: But why would it be put into the budget then to remove it? It would take legislative action to do that. [LB518]

VIVIANNE CHAUMONT: That's why there's...this bill would require the legislative action. Correct. Uh-huh. [LB518]

SENATOR CAMPBELL: I know, I understand that. But the budget came forward prior to Senator Janssen's putting in the bill. I guess I'm somewhat concerned that we have a mandatory program here that the Legislature passed and yet, it can be removed or suggested to be removed. [LB518]

VIVIANNE CHAUMONT: I think the plan would have been to run a statute, I think. It's real clear that it cannot be removed without the Legislature adopting a statute. [LB518]

SENATOR CAMPBELL: Thank you. Any other questions? Thanks, Director. [LB518]

VIVIANNE CHAUMONT: Thank you. [LB518]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB518]

MARTY BROWN: (Exhibits 2, 3 and 4) Good afternoon, Senator Campbell and committee. Marty Brown, M-a-r-t-y B-r-o-w-n. Today I represent Nebraska Taxpayers for Freedom out of Omaha. I'm vice president of project. We've been working on this project for over three years. Yesterday a good friend, Michael Cutler, senior special agent, INS, retired, testified for the Senate Judiciary Committee in Washington. Most of my research I have...contribute to him. Here are a few comments from his hearing. American immigration laws were enacted to achieve two critical goals: protect innocent lives, and protect the jobs of American workers. A view of the Title 8, United States

Code, Section 1182 will make the purpose and the intention of our immigration laws clear. This section of the Immigration and Nationality Act enumerates the category of aliens who are ineligible to enter the United States. Among those categories are aliens who have dangerous communicable diseases, suffer extreme mental illness, and are prone to violence, or are sex offenders. Criminals who have also committed serious crimes are also excluded as spies, terrorists, human rights violators, and war criminals. Finally, aliens who work in a violation of law or become public charges are also deemed deductible. For the committee, I have made copies of the Title 8 of the U.S. Immigration Code so you can read them firsthand how Nebraska is breaking our laws. I encourage you to read the whole document, plus I made the document from the hearing from the Judicial Committee in Washington that Michael Cutler had hearings for. He has been represented on 11 congressional hearings for this for the federal government. I also have an obligation as an American citizen, father, and grandfather to protect my family with the rule of law, and Nebraska needs to do the same. Nebraska's costs of illegal immigrants is over $252 million or $501 per citizen. In other words, Nebraska is a free feeding tube for illegal aliens. I had made a detailed list of these costs in Nebraska for your review, I'll be sending out to thousands throughout Nebraska. By adding the cost of prenatal care, you add another burden to Nebraska citizens and another example of government gone wild. Because of this free feeding tube, Uncle Sam's plantation will keep adding more to the public dole since only 25 percent of illegals have finished high school. And because they don't qualify for high-end jobs, they'll be added to our welfare rolls. I have seen the lines at our charities; I have worked the charities. I have seen the growth throughout Nebraska in which Hispanics' growth has reached 100 percent, and so will our welfare costs. It is up to our state to enforce their laws and not to break them. Thank you. [LB518]

SENATOR CAMPBELL: Question? Senator Gloor. [LB518]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for taking the time to come down here. But I'm a bit confused by your testimony. We're talking about unborn children who, when born, will become U.S. citizens. And the testimony provided by special agent...former special agent Michael Cutler talks about people who have committed serious crimes, spies, terrorists, war criminals, terms that you relayed also. Are we talking about the same people here, sir? [LB518]

MARTY BROWN: Well, we're talking in reference to the law. The final is that if they're on the public dole, they're ineligible in the United States; which this, to me, is a public dole when you have people coming onto prenatal care because they can't pay their fair share. [LB518]

SENATOR GLOOR: And so that child, when they're born and are a citizen at the time of their birth, our argument might be whether any of those benefits then extend to them when they're in the womb or are you saying just when they're born they're eligible for all

those rights? [LB518]

MARTY BROWN: Senator, I've had five grandchildren. We all paid our own way. Okay? When people come here, they take advantage of my offerings. It's a charity that I give, not that the government needs to control. [LB518]

SENATOR GLOOR: So is your argument that when that child is born it shouldn't be a citizen? [LB518]

MARTY BROWN: Right. [LB518]

SENATOR GLOOR: Thank you. [LB518]

SENATOR CAMPBELL: Senator Krist. [LB518]

SENATOR KRIST: Is that consistent with the United States Constitution? [LB518]

MARTY BROWN: Well, you've got me on that one, Senator Krist. I don't know for sure. All I'm doing is following the immigration laws. And I've listened to several laws in regards to that. But it seems like that we're pandering to the illegals, and we shouldn't be doing this because we have no control on who's coming in our country and who's going out. [LB518]

SENATOR KRIST: Okay. And I would respect your opinion. And I would say that if we walk through this process, in order for a woman--illegal or not--to provide for the care of the future U.S. citizen that she is carrying, she can identify herself as a resident someplace in the state. She has to give an address, she has to prove she's there, she has to give contact information. And then the Department of Medicaid or the Department of Health and Human Services has to recognize this person is an illegal alien and is receiving treatment--not for her. In fact, in some cases they're not even giving the woman aspirin because that would be conceived for her...perceived that it would be for her. [LB518]

MARTY BROWN: I understand. [LB518]

SENATOR KRIST: They are providing prenatal care for the future U.S. citizen. And the last time I looked at the constitution--I'm not being facetious... [LB518]

MARTY BROWN: Yeah. [LB518]

SENATOR KRIST: ...I'm just being honest with you--it said that once that baby was born, if presented for citizenship, it would be a citizen. I, too, have some kids and grandkids...a grandkid. My son was born in Iceland; he has dual citizenship. But we had

to apply for both of those at the time. I've been on the road and in foreign countries where I needed emergency room care. And I wasn't there illegally, I was there on a passport. But no one is turned away pretty much by international law. So the only point I'll make is we are being put in a situation where the U.S. Code, particularly Immigration Code, is in conflict with the Constitution of the United States. And I think right in the preamble it says when everything else goes away, this takes priority over everything. So I understand your argument. I don't like to pay for things that I need to pay for either, but I think that's our dilemma, is looking at the Constitution as the overriding document in going forward. So, again, thank you especially for your testimony. And I would say that it is...it's a conflict, and I wish INS, immigration, would do their job. We wouldn't be having this conversation. [LB518]

MARTY BROWN: That's true. [LB518]

SENATOR KRIST: Thank you, Mr. Brown. [LB518]

MARTY BROWN: You're welcome. [LB518]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Brown. Our next proponent? Good afternoon. [LB518]

SUSAN GUMM: (Exhibit 5) Good afternoon, Senator Campbell and committee members. My name is Susan Gumm, S-u-s-a-n G-u-m-m. I am testifying as a Nebraska taxpayer. I support LB518. I do not think illegal alien women should be eligible for prenatal care. No one can deny that pregnant women come across the border illegally with the specific intent of their unborn children becoming birthright citizens who enjoy the same rights and are entitled to the same benefits as the children of U.S. citizens. An illegal alien woman who cannot pay for her own prenatal care will most likely bring her child into a life of poverty, dependent on government service; in other words, the taxpayer. The issue of prenatal care for illegal alien women is about money, not bias or discrimination. Americans are caring, charitable people; but taxpayers cannot afford the additional burden of prenatal care and support our own poor children and other needy Nebraskans. Why should law-abiding taxpayers that struggle to take care of their own families be required to support those who disrespect our laws and enter our country illegally? Nebraska taxpayers shouldn't have to subsidize cheap, illegal, immigrant labor for businesses. The assumption is that prenatal care will ultimately save the state money on long-term medical costs. However, free prenatal care will serve as a magnet that will draw more illegal alien women to our state, each giving birth to another birthright citizen that Nebraska taxpayers will be obligated to support. In 2010, the cost of illegal immigration in Nebraska was $252 million and is undoubtedly even higher now. We can't afford to encourage more illegal aliens to come to our state. While prenatal care may improve the chances of having a healthy baby, no one can guarantee a healthy pregnancy or healthy baby. Avoiding long-term medical costs is also dependent

upon the woman maintaining a healthy lifestyle. Our tax dollars will be wasted if the mother doesn't take personal responsibility for her pregnancy, and we have no assurance she will. Proper nutrition, genetics, drug, tobacco, and alcohol use can all affect the health of the baby. Even if we provide free prenatal care, we could still be responsible for any long-term medical costs of the birthright citizens. Taxpayers are the ones who must pay the price for pro illegal immigration policies. Rather than mandated taxpayer charity, all the organizations that are sympathetic to illegal aliens could provide the funding for prenatal care. Private funding is a win-win situation, showing compassion for the taxpayer as well as the illegal alien woman. [LB518]

SENATOR CAMPBELL: Thank you. Questions? Senator Krist. [LB518]

SENATOR KRIST: Your...I don't understand your testimony. And here's a couple of things that I'd just like to...thank you for coming. Respectfully, I understand that you have your opinion. But there seems to be a contradiction. First you want to...what you said was, that we're a magnet by providing these services on the state roll, but yet you're encouraging private 501s' fund-raising activities to provide those services in the state. If I understand that correctly, that means whether we pay for it or they pay for it, when the birth mother gives birth to that child, under the Constitution of the United States, that person is and always will be a citizen of the United States. [LB518]

SUSAN GUMM: That's true. [LB518]

SENATOR KRIST: So it seems to me that what you're asking is, as soon as that person identifies themself as a person who is here in illegal status--because I don't like illegal alien, but that's just my point--then we should deport them. We should turn their name over to the INS and say goodbye, because otherwise if we allow the 501s to fund the program, all we're doing is shirking the responsibility in a different way. [LB518]

SUSAN GUMM: But they are...charity is done freely. And they're saying they want to do this. But if you'd ask taxpayers and take a vote, they may say no. I don't...I want that money...in my opinion, I want our tax dollars to be going to Nebraska citizens because I know there's great need there. If people feel that this is something that a pro-illegal charity wants to do, and it's not against the law--because I know that's been brought up as well. Are all these things we're doing because we're not...are they being done, you know, really unlawfully because we're really not following all of our immigration laws? And just none of them are being enforced. [LB518]

SENATOR KRIST: So the process as it exists, just to review, is that a woman would have to identify herself with an address in the state of Nebraska. At that point, we should turn that address and person over to the INS for deportation because they're here illegally. And my point is, the person that's in her womb is not here illegally after they are born. [LB518]

SUSAN GUMM: Right. That's true. That's absolutely true. [LB518]

SENATOR KRIST: So you're suggesting that we allow a nonprofit to pay for that service, and then the child stays here. So I don't understand what enforcement you...I don't understand what you want us to do as a state. Immigration is a federal matter, and we are assisting in the federal matter by basically allowing the nonprofit to allow the illegal alien, as you put it, to stay here? [LB518]

SUSAN GUMM: Yeah. I'm not really sure whether the state providing a service or the private providing the service is both...would really both be against the law. [LB518]

SENATOR KRIST: According to Section 8 of the INS law, yes, according to code. [LB518]

SUSAN GUMM: Right. [LB518]

SENATOR KRIST: According to the Constitution of the United States, no. [LB518]

SUSAN GUMM: Right. [LB518]

SENATOR KRIST: So there we go back again. Thank you so much for testifying. [LB518]

SUSAN GUMM: You're welcome. [LB518]

SENATOR CAMPBELL: Any other questions? Thank you. [LB518]

SUSAN GUMM: Thank you. [LB518]

SENATOR CAMPBELL: Our next proponent? Okay. We will go to those who wish to speak in opposition to the bill. Good afternoon. [LB518]

MORA JAMES: (Exhibit 6) Good afternoon, Senators. [LB518]

SENATOR CAMPBELL: How many people wish to testify in opposition? Okay. Those in a neutral position? [LB518]

SENATOR KRIST: Is that ten or eight? [LB518]

SENATOR CAMPBELL: I thought I had eight. [LB518]

SENATOR KRIST: 8. Okay. [LB518]

SENATOR CAMPBELL: Anyone in a neutral position? Okay. Thank you. I'm sorry, go right ahead. [LB518]

MORA JAMES: No problem. Good afternoon, Chairman Campbell and distinguished members of this committee. First of all, I want to thank you for all your hard work that you did at LB599. And for the new senators, I hope that you will join us in providing prenatal care for U.S. citizen babies. My name is Shirl A. Mora James, that's S-h-i-r-l A. M-o-r-a J-a-m-e-s. I am a civil rights and immigration attorney from Lincoln. I am licensed in all the Nebraska state courts, the U.S. federal courts of the district of Nebraska, the United States Court of Appeals for the Eighth Circuit, and the United States Supreme Court, and the United States Immigration Court in Omaha. I am here speaking as the president of the Hispanic Bar Association and as the president of SOMOS Independents, a national organization led by Latinas to register and empower Latinas and Latinos to support politicians that support our issues, which include providing prenatal care for all U.S. citizen babies. Today my purpose is to give a voice to the silent U.S. citizen babies and the mothers in this debate. These babies could be denied prenatal care if you allow LB518 out of committee. Personally, I was raised in western Nebraska and taught in the Catholic teachings, which value babies above all else, and especially above one's self-interest. Simply put, no mother, whether she has legal presence or not, should ever have to ponder the possibility of aborting her wanted, unborn baby because she cannot afford prenatal care. I ask you all to consider this truth. These are U.S. citizen babies and their mothers are part of our human family and must be treated as such. Now it's high time to call out the author of LB518 and other antipoliticians who attempt to dehumanize these U.S. citizen babies by calling them anchor babies or by denying them prenatal care for their own political, pathetic gain. To the author of LB518, I say to you, you are a coward who attacks innocent, helpless, U.S. babies. Where in the world is your moral compass? Stop and think. What would you do if these children were yours? You profess to be pro-life and have family values? Then talk your walk and stop attacking the health and the very lives of these innocent U.S. babies. And you need to start protecting and advocating for them or else you're nothing but a hypocrite for political self gain. And moreover, shame to all the antilife politicians that attack U.S. citizen babies because of the status of their mothers. Finally, let's ponder this moral question. What have we become? In what kind of society is it okay to deny certain U.S. citizen babies prenatal care and an attempt to force a mother to ponder a needless abortion? And what does it say about our so-called pro-life politician leaders that promote the killing or the disabling of certain U.S. citizen babies by denying them prenatal care? Honorable members of the committee, once again I ask you, please save these babies from the evilness that has seeped into the core of a very small segment of Nebraska society. Please, I respectfully request that you all vote for our Nebraska U.S. citizen babies and kill LB518 in committee and allow our unborn Nebraska babies the opportunity to obtain the necessary prenatal care regardless of the wealth or the status of the mother. I thank you for listening to me and your kind

consideration. If you have any questions, I'd be happy to answer them now. [LB518]

SENATOR CAMPBELL: Thank you. Questions? Senator Gloor. [LB518]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you, Ms. Mora James. I have a question that hopefully you can help me with that relates to the rate of illegal immigration. And I'm specifically interested in Latin or Hispanic immigration since we don't debate Irish illegal immigrants or folks from the former Soviet Union who are illegal immigrants. What I read is that that has slowed down considerably because of the economic downturn in this country. Is that true? [LB518]

MORA JAMES: Not only has it slowed down, people are leaving back to Mexico, Central American, and South America. [LB518]

SENATOR GLOOR: Is that...and so in your experience is that also now true in Nebraska? [LB518]

MORA JAMES: It is true in Nebraska. They are leaving. [LB518]

SENATOR GLOOR: Okay, thank you. [LB518]

MORA JAMES: You bet. [LB518]

SENATOR CAMPBELL: Any other questions? Thank you for your testimony. [LB518]

MORA JAMES: Thank you. [LB518]

SENATOR CAMPBELL: Our next opponent? Good afternoon. [LB518]

YAZMIN GAMEZ: (Exhibit 7) Good afternoon. Thank you for letting me come. [LB518]

SENATOR CAMPBELL: You have a helper today. [LB518]

YAZMIN GAMEZ: Yes, we do. My name is Yazmin Gamez, Y-a-z-m-i-n G-a-m-e-z. I'm the cofounder and affiliate lead of the Nebraska Dream Alliance, affiliated with the national organization, United We Dream. I used to be one of these women currently being attacked by LB518 by some who only seek political gain on the backs of our babies. I am a college student, aspiring engineer, and a single mother of a four-year-old daughter. [LB518]

SENATOR CAMPBELL: Ms. James, I think it's okay. [LB518]

YAZMIN GAMEZ: I am undocumented. I am a dreamer. And I am in the process of

adjusting my status through DACA which is Deferred Action for Childhood Arrivals, which will give me legal presence and the right to seek gainful employment legally. I am pro-life, and I made the decision to have my daughter even at the huge possibility of having to do it on my own. When I was pregnant, I had access to Medicaid, to prenatal care, and it made a huge difference. I'm sorry. When I was pregnant, I was diagnosed with iron-deficiency anemia. Without the proper prenatal care, I would have not known about this illness because I didn't show any symptoms. Iron deficiency...I'm sorry...iron-deficiency anemia has adverse effects on a pregnancy which are very harsh. According to the article, "Iron-Deficiency Anemia in Pregnancy" from the Web page BabyCenter at BabyCenter.com, "Iron-deficiency anemia during pregnancy is linked to an increased risk of preterm delivery and low birthweight. It's also associated with a higher risk of stillbirth or newborn death, so it's something to take seriously." This could have happened to my daughter. Thankfully, I had access to prenatal care. A simple routine pregnancy test prevented this from happening. If LB518 is voted out of this committee there will be other cases like mine, but this time with devastating results. Do you want to carry on your conscience preterm births that you can prevent? Even worse, stillbirths or newborn deaths? Will you allow a small segment of Nebraska women to experience third-world pregnancies where there is no access to prenatal care, or will you stand with me and protect the innocent unborn babies? Remember that change starts with one person, with you. Please oppose LB518. I thank you for your listening to my story. If you have any questions, please feel free to ask me now. [LB518]

SENATOR CAMPBELL: Would you like to introduce your daughter? [LB518]

YAZMIN GAMEZ: Yes. Her name is Yariana Gamez. [LB518]

SENATOR CAMPBELL: And how old is she? [LB518]

YAZMIN GAMEZ: How old are you? [LB518]

YARIANA GAMEZ: 4. [LB518]

SENATOR CAMPBELL: 4? This many? Well, you are probably one of the best behaved, quiet people in this audience. So she can come back any time, that's for sure. Questions from the senators or comments? Thank you for sharing your personal story. [LB518]

YAZMIN GAMEZ: You're welcome. [LB518]

SENATOR CAMPBELL: We always appreciate how difficult that is. [LB518]

YAZMIN GAMEZ: Thank you for listening. [LB518]

SENATOR CAMPBELL: And thanks for coming. Good afternoon. [LB518]

TONI LEIJA-WILSON: (Exhibit 8) Good afternoon, senators and committee members. My name is Toni Leija-Wilson. That's T-o-n-i L-e-i-j-a-W-i-l-s-o-n. I'm an attorney, and my areas of practice of law are family law, immigration law, and criminal defense. I am here to speak as a member of the Hispanic Bar Association as well as the president of the Nebraska Chapter of SOMOS Independents. I'm also speaking as a woman, a mother, and as a Nebraskan. Today my purpose is to give a voice to Nebraska's unborn children who are helpless and cannot be here to fight for their rights and their mothers' rights. I would like to take a moment and share with you a recent study that was published by the Journal of the American Medical Association. The study followed 85,176 children. And that study found that women who took folic acid supplements before and then during early pregnancy were 39 percent less likely to have autistic children. Folic acid is known to be a supplement which is found in prenatal vitamins. It is recommended to prevent neural tube defects, which are severe malformations of the brain. Interestingly, other vitamin supplements like fish oil pills--which we can get over the counter at low cost--have no relation to autism rates, meaning it had no relation to decrease autism in children. Another study conducted in 2011 by UC Davis Medical Investigation of Neurodevelopment Disorders out of California found similar findings. For women with a particular high risk of a genetic makeup who reported not taking prenatal vitamins, the estimated risk of having a child with autism was as much as seven times greater than in women who did report taking prenatal vitamins who had more favorable gene variants. I would like to shift our focus from a scientific standpoint right now. Nebraska invested in me and my education. And when I talk about investment, I am talking about being able to attend college here in Nebraska with the benefit of in-state tuition. The question arises for me, why would Nebraska not want to continue to invest in our fellow Nebraskans? Specifically, if LB518 were to be passed in Nebraska, Nebraska would not be investing in our U.S. citizen children. Our children are our future. They are Nebraska's future. Why would we want to undermine and cut off a healthy life for our children? We continue to grow as a community and as a state. Why would Nebraska not want to flourish with healthy people to continue Nebraskan traditions and to make our state the good life, as we call it. Going back to the two studies I talked about earlier, without prenatal vitamins, babies are at more risk for autism and malformations of the brain. I do not think...or should I say, I hope that this is not what Nebraska would want, to raise a community of ill health. Why take a risk to expose our unborn children to such malice when this problem is simply reduced by providing prenatal care? I'm a godmother to an autistic boy. Day in and day out I live the horrible struggles with him and his biological parents, the therapists, the speech pathologists, the team meetings at his school, the countless doctor visits. This is what a normal day looks like to him. This is no good life for any child or human being in our country, let alone in Nebraska. The extreme pain and heartbreak I feel for my godson and his biological parents cannot be measured on any scale. If Nebraska allows LB518 to be passed, it would be nothing but an inhumane action on the part of our state that

would only send the message that we permit creating a community of illness and deprivation of prosperity by not allowing prenatal care to our citizen-born babies. I was here to support LB599 last year. If LB599 was not what Nebraska wanted, it simply would not have passed. Please let's not lose sight of what we believe in and what we have already taken a stance on. Let's continue to fight for the rights of our Nebraskan babies and our Nebraskan children who are our future. Today I speak as a woman, a mother, and as a Nebraskan. I respectfully ask that LB518 be struck down, as it has no heartfelt place in our Nebraskan heartland. [LB518]

SENATOR CAMPBELL: Thank you for your testimony. Questions? Seeing none, thank you very much. Good afternoon. [LB518]

JIM CUNNINGHAM: (Exhibit 9) Good afternoon. Senator Campbell and members of the Health and Human Services Committee, good afternoon. My name is Jim Cunningham, J-i-m C-u-n-n-i-n-g-h-a-m. I'm the executive director of the Nebraska Catholic Conference which represents the mutual interests and concerns of the Archdiocese of Omaha and the dioceses of Lincoln and Grand Island under the direction of the diocesan bishops. And I'm appearing on behalf of the Bishops' Conference in opposition to LB518. It is the Conference's firmly held view that providing access to prenatal care services for unborn children from impoverished families, regardless of their mothers' own ineligibility, which includes immigration status, is a vitally important pro-life and social-justice matter. Denying coverage of prenatal care in these stressful circumstances of family poverty is contrary to human dignity and an injustice that can do great harm to the lives of children at a very vulnerable stage in their development. For these reasons, the Conference supported LB599 throughout its journey in 2011 and 2012, resulting in enactment last year, and also its predecessor legislation, LB1110 in 2010. Most assuredly, the Conference has not changed its position on this matter and, therefore, is opposed to reversing last year's decision. We understand that there are legitimate concerns regarding the predominantly federal issue of illegal immigration. We wish that every otherwise eligible, materially poor, pregnant woman in Nebraska had lawful status. But the realities of a broken federal immigration system and the compelling need for comprehensive immigration reform do not support that condition, although I would have to add that there are some hopeful signs. Nevertheless, on this particular matter involving prenatal care, our urging to you as policymakers is that the proper and necessary balance should favor the health and well-being of the unborn children from impoverished circumstances. These unborn children should not be made to suffer the consequences of their mothers' unlawful immigration status. Please indefinitely postpone LB518. Thank you for your time and attention. [LB518]

SENATOR CAMPBELL: Thank you, Mr. Cunningham. Any questions? And I certainly want to thank you as one of the prime advocate voices last year. [LB518]

JIM CUNNINGHAM: Thank you very much. Thank you. [LB518]

SENATOR CAMPBELL: Our next opponent? Good afternoon. Go right ahead. [LB518]

KRISTINE McVEA: (Exhibits 10 and 11) Senator Campbell, members of the committee, my name is Dr. Kristine McVea, K-r-i-s-t-i-n-e M-c-V-e-a. I am the chief medical officer at the OneWorld Community Health Center. In addition to our center, I am speaking on behalf of the Health Center Association of Nebraska, which represents our state's six federally-qualified health centers. I am also speaking on behalf of the Nebraska Medical Association, representing over 3,000 physician members across the state. I'm also presenting a letter from the March of Dimes; I serve on their board. We are all in opposition to LB518. Nebraska's community health centers provide primary healthcare services, including prenatal care, to over 63,000 patients per year, the majority of whom are low income, underinsured, and medically underserved. These populations are those who would be impacted the most by this bill. It is important that Nebraska's community health centers continue to ensure that every baby born in this state has access to prenatal care, regardless of their mother's race, ethnicity, income, or immigration status. We are committed to providing Medicaid coverage for prenatal care because it is the right thing to do. It saves lives, it prevents birth defects, and it saves money. Babies born to mothers who receive no prenatal care are five times more likely to die. They are three times more likely to be born at low birthweight or prematurely. Comprehensive early prenatal care lowers infant mortality, and it also is the best way to prevent birth defects since many develop in the first few months of pregnancy. Preterm babies who survive often have lifetime health complications, including breathing problems, cerebral palsy, and intellectual disabilities. The costs of providing care to infants born prematurely or with birth defects far outweigh the costs of prenatal care. It is estimated that for every $1 spent on prenatal care, $1.50 is saved within the first two months of life. There is good scientific evidence that supports the benefits of prenatal care, but the impact of the loss of Medicaid coverage for Nebraska's unborn children is not just theoretical. I saw it firsthand. In January 2010, changes in Medicaid rules meant that thousands of unborn children lost access to preventive care. Without help, many low-income women found they could not afford the cost of office visits, basic lab services, ultrasounds and other recommended tests. They began to seek care later and to skip appointments. In rural areas, women found that they could no longer seek care in their hometown. Within two months, Nebraska's community health centers began to see their rates of early prenatal care drop from 77 percent in the first trimester to 68 percent. As a comparison group, the Iowa community health centers saw their rates increase 4 percent during that time period. Did babies die because of this barrier to prenatal care? Yes. We saw one infant deliver prematurely in our clinic and die before we could get the mother to the hospital. Her infant could have been saved by a $10 antibiotic prescription had she sought care in time. Did we see cost issues related to premature births here in Nebraska? Yes. Before prenatal care was reinstated, one single, preterm baby cared for by the Good Neighbor Community Health Center in Columbus, had a hospital bill of over $600,000. Infant deaths, disability, higher

costs--that was the reality of Nebraska for nearly two years without prenatal care for the unborn. The good news is, you fixed this. And I would like to thank the Nebraska Legislature and especially Senator Campbell for introducing LB599, as well as Senator Gloor, Krist, and Cook for restoring prenatal care in the last session. After a long and thoughtful debate, you determined it was the right thing to do. Your actions are already making a big impact. Since Medicaid was restored in August, our prenatal care rates rose to 85 percent in the first trimester. Now Nebraska's babies will have healthier futures, avoiding being forever challenged by a physical or mental condition that good prenatal care could have prevented. Our tax money can now be invested more wisely in prevention. Nebraska's community health centers want a commonsense approach that is fiscally sound and protects the lives of the unborn. Thank you for making a wise decision last session. Please continue to support the unborn by opposing LB518. I would be happy to answer any questions you might have. [LB518]

SENATOR CAMPBELL: Thank you, Dr. McVea. Senator Krist. [LB518]

SENATOR KRIST: Thank you for coming to present the statistics that needed to be asked for, which has the human value and not just the readout on a Medicaid...or a line number on an invoice. In terms of the number of cases, you gave us a few examples. Those are probably the most dramatic examples that you would choose to talk about. Do you have data that shows the others, maybe less dramatic, but those that were in that database that you could share with us? If we...I mean, not now I understand, but... [LB518]

KRISTINE McVEA: Uh-huh. I think in general what this did was to shift risk into prenatal care. And I guess I would make the analogy to playing Russian roulette. You can pull the trigger once, and it's probably, the chances are, you're going to be okay. But if you continue to pull that trigger, eventually you're going to have very devastating things happen. We saw a lot of very risky things happening where we were able to at the last minute, you know, rush a woman into the emergency room, pour a lot of resources into her care, and turn things around. And we had good outcomes. But you can't keep doing that forever, because your luck is going to run out. And so that's what, unfortunately, happened to one particular infant at our center who died. That's what happened to another infant who was born very prematurely in Columbus. So I think that, overall, you can see that this was not a sustainable way to provide medicine during those two years. [LB518]

SENATOR KRIST: Thank you, Doctor. [LB518]

SENATOR CAMPBELL: Any other questions? Dr. McVea, you were one of the very first people to testify when we started on that journey, so thank you. [LB518]

KRISTINE McVEA: Thank you, again. [LB518]

SENATOR CAMPBELL: Our next opponent? [LB518]

LAZARO SPINDOLA: (Exhibit 12) What does the saying says? This feels like deja vu all over again. [LB518]

SENATOR CAMPBELL: I think that's a Yogi Berra quote, if I remember right. [LB518]

LAZARO SPINDOLA: Good afternoon, Senator Campbell and all the members of the Health and Human Services Committee. Thank you for receiving me today. For the record, my name is Lazaro Spindola. That is spelled L-a-z-a-r-o S-p-i-n-d-o-l-a. I am the executive director of the Latino-American Commission, and I'm also here as a father and a grandfather. I am here in opposition to LB518. Since 2009, there has been confusion about who prenatal care referred to. Was it the unborn? Was it the mother? This led me to coin a phrase "conceptual conundrum" which Senator Gloor particularly liked. But in 2012, LB599--and thank you for LB599--clarified this issue when it specified that "the Legislature finds that unborn children do not have immigration status." And curiously enough, LB518 ratifies this assertion. On the opening paragraph on line number 5, it clearly states "to eliminate prenatal care for certain children." What kind of children? Unborn ones, since this is a section eliminated from the Nebraska Revised Statute 4-110 of the medical assistance program. The purpose of this bill is to eliminate prenatal care for unborn children. It is the only purpose. So I'm not going to speculate about the possible economic costs. I'm not going to speculate about the morality of this measure. I will not even talk or speculate about where my tax dollars are going or whether Nebraska will become a magnet for whoever. No. I'm going to talk about what we know. During the years 2009 and 2010, we had a number of hearings where people, I included, tried to warn the Legislature about what could happen unless prenatal care was provided to all pregnant women. In March 2011, our predictions came true. Testifiers informed that in OneWorld Community Health Center in Omaha there had been nine premature births. By the by, Senator Krist, the cost of a prenatal intensive...I mean, neonatal intensive care ranges between $10,000 and $25,000 a day. [LB518]

SENATOR KRIST: Thank you, sir. [LB518]

LAZARO SPINDOLA: Nine premature births including the delivery of a baby who was 20 weeks old, and four additional babies born at home. Only 44 percent of the uninsured moms received adequate prenatal care compared with 79 percent of women who have insurance. From Lexington, we heard about a young mother who lost her baby due to lack of prenatal care. From the Good Neighbor Community Health Center in Columbus we heard about four infant deaths in uterus, whereas in the previous seven years, there had been only one. We heard and heard about children dying and mothers suffering from preventable complications stemming from conditions such as gestational diabetes, malnutrition problems. These result in more C-sections and drove up the cost

of healthcare. Nine premature babies, an additional five deaths, and yet LB518 clearly states "to eliminate prenatal care for certain children," even though we know--we know--that this bill will lead to the death of unborn children. I wonder what the introducer of this bill would have said--he was a rescue diver for the Navy--if he had to dive in ice cold water and the Navy had told him we don't have the wet suit to protect you because we don't want our tax dollars spent on that. There is no doubt about it, this bill will kill children. The body count is five. How many more will it take? Senators, I urge you to kill this bill. Kill this bill because otherwise this bill will kill children and their mothers. I implore you, Senator Krist, as soon as we walk out that door, kill this bill. This is not a speculation. This is already a proven fact. Thank you. And I will take any questions if I can. [LB518]

SENATOR CAMPBELL: Any questions for the doctor? Thank you very much. Our next testifier? [LB518]

JAMES GODDARD: (Exhibits 13, 14 and 15) Good afternoon. [LB518]

SENATOR CAMPBELL: Good afternoon. [LB518]

JAMES GODDARD: My name is James Goddard, that's J-a-m-e-s G-o-d-d-a-r-d. And I'm the director of the Economic Justice and Health Care Access Programs at Nebraska Appleseed, here today to testify in opposition to LB518. We've already heard--and many of you committee members know--for decades we had the commonsense policy to provide prenatal care to all low-income women regardless of their immigration status. Unfortunately, that came to a halt in 2010 when the Department of Health and Human Services chose to discontinue this coverage. But in 2012, the full Legislature had a thoughtful and reasoned debate on the merits of providing this care and subsequently passed LB599. Passing LB599 was the right thing to do last year, and it remains the right thing today. Arguments in favor of prenatal care, as we've already heard today, have not changed. Prenatal care leads to cost savings. It helps to avoid serious expense to the state by avoiding birth complications, complications which lead to significant costs when a child utilizes medical assistance services later. In fact, the fiscal note reminds us that every dollar spent on prenatal care results in overall cost savings. Speaking of the fiscal note, it's noteworthy that the department estimates of savings are equal to the appropriation given to the program last year rather than an analysis of what they've actually spent to date, nor is there any accounting for future savings that the state will forego with the repeal of this policy. Lastly, providing prenatal care to all low-income women in Nebraska is simply the right thing to do. Prenatal care can help prevent complications that damage a child and a family for life. Our current policy ensures that the most vulnerable among us, unborn children, have the best start in life and the best chance to grow up healthy. For these reasons, we urge the committee to indefinitely postpone LB518. And I'd be happy to answer any questions if I can. [LB518]

SENATOR CAMPBELL: Any questions for Mr. Goddard? Senator Gloor. [LB518]

SENATOR GLOOR: Thank you, Senator Campbell. Mr. Goddard, do you have a copy of the fiscal note with you? [LB518]

JAMES GODDARD: I actually do not, Senator. I'm sorry. [LB518]

SENATOR GLOOR: Okay. Would you then walk through again your analysis of the fiscal note and your concerns about the fiscal note and what it shows? [LB518]

JAMES GODDARD: Well, my understanding is what the department seems to be indicating is is that if we repeal this policy, then that would save the amount of money that was appropriated for this bill last year. That's my understanding of what the note says. But it doesn't tell us how much money have they actually spent on the program since it went into effect in July. And I know notes don't necessarily cover the amount of future savings that we might see, but it doesn't tell us how much the program has actually cost to date. [LB518]

SENATOR GLOOR: Thank you. [LB518]

SENATOR CAMPBELL: Any other questions for Mr. Goddard? Thank you. [LB518]

JAMES GODDARD: Thank you. I'm also handing in testimony in opposition on behalf of the Children and Family Coalition of Nebraska and the American Academy of Pediatrics, Nebraska Chapter. [LB518]

SENATOR CAMPBELL: Good afternoon. [LB518]

JULIE SCHMIT-ALBIN: Good afternoon. Madam Chairman and members of the committee, my name is Julie Schmit-Albin, S-c-h-m-i-t-A-l-b-i-n. And I'm executive director of Nebraska Right to Life. Nebraska Right to Life would like to go on record in opposition to LB518. Even the bill's heading, "to eliminate prenatal care for certain children" speaks to the idea that some unborn babies are more deserving of prenatal care than others. As we have with prior legislation on this topic, we soundly reject the premise that Nebraska should be picking and choosing which babies deserve care and which babies don't by virtue of the legal status of their mothers. Unborn children have no control over the circumstances of their conception nor the legal status of their mothers. They're the innocent parties in this tussle. And it's easy to dismiss the humanity of unborn babies because they're hidden in the womb. No one would dream of denying medical care to a needy newborn baby born here of illegal parents. Please acknowledge the humanity of all unborn babies and reject LB518. Thank you. [LB518]

SENATOR CAMPBELL: We need to have you say your name and spell it because the

clerk did not get it. I'm sorry. [LB518]

JULIE SCHMIT-ALBIN: Julie, J-u-l-i-e, Schmit-Albin, S-c-h-m-i-t-A-l-b-i-n. [LB518]

SENATOR CAMPBELL: And the page will get you a testifier sheet. [LB518]

JULIE SCHMIT-ALBIN: Okay. [LB518]

SENATOR CAMPBELL: And I, too, want to thank you as one of the prime advocates last year. [LB518]

JULIE SCHMIT-ALBIN: Thank you, Senator. [LB518]

SENATOR CAMPBELL: Thank you. Our next testifier? [LB518]

AUBREY MANCUSO: (Exhibit 16) Good afternoon... [LB518]

SENATOR CAMPBELL: Good afternoon. [LB518]

AUBREY MANCUSO: ...Senator Campbell and members of the committee. My name is Aubrey Mancuso, A-u-b-r-e-y M-a-n-c-u-s-o, and I'm here on behalf of Voices for Children in Nebraska. We're here in opposition to LB518 because we believe that all Nebraska children deserve the best possible start in life. Research continues to support the fact that prenatal care is both essential to healthy birth outcomes and cost effective when compared to the cost of treating babies born with complications. A lack of prenatal care can result in lifelong health issues and even stillbirth and can ultimately impact a child's educational success. The primary and most significant beneficiary of this care is not the mother. And the Legislature and our current state policy recognize that by covering the unborn child and not the mother. We know that this committee has worked very hard in the last few years to reform the systems that serve vulnerable children and that you take your responsibility to Nebraska's kids very seriously. Prenatal care is a simple and cost-effective way to help ensure that all Nebraska kids get the best possible start in life. And we'd urge you to indefinitely postpone LB518. Thank you. [LB518]

SENATOR CAMPBELL: Questions? Thank you, Ms. Mancuso. You represent a number of advocates who are here today and were here last year. Thank you. [LB518]

AUBREY MANCUSO: Thank you. [LB518]

SENATOR CAMPBELL: Our next testifier? Is there anyone else that wants to testify in opposition to the bill? Okay. Sorry, I didn't see you back there. Good afternoon. [LB518]

BRUCE RIEKER: (Exhibits 17, 18 and 19) Good afternoon. Nice to see you all again.

My name is Bruce Rieker, B-r-u-c-e R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. On behalf of the 89 hospitals that we represent and the 43,000 people they employ, I'm here to testify in opposition to LB518. A couple of comments: one, some discussion about LB599. We applaud all of you who championed that issue last year for us. It was a great partnership. And it truly was a defining moment for the Legislature because it was a shining example of statesmanly leadership arising above politics. And as I look at...oh, I also need to mention that I'm also submitting letters on behalf of Bryan Health as well as Crete Area Medical Center in opposition to LB518 as well. Simply put, repealing LB599 is not responsible fiscal policy or responsible healthcare. Newborns and mothers, it's already been pointed out, that do not receive prenatal care are three times more likely to have low birthweight babies and five times more likely that those babies would die if not receiving that care. I've talked about it in other hearings, but a low birthweight baby that's on...that eventually ends up on Medicaid for its entire life will cost the state Medicaid program well over $1 million. These are...this is information that we gained from a national study a few years ago working on another issue. My hunch is that that number has probably gone up. Senator Krist, to answer your question about the cost of the NICU, the Neonatal Intensive Care Unit, usually starts at about $6,000 to $8,000 a day with the number going up. And I know that one testifier talked about $600,000 for a baby. It doesn't take that long for a baby with complications to hit that level. Last, I'll just close with this, that we've talked about it in tax policy, tax hearings as well as in this. One of the roles of government is to protect those who cannot protect themselves, and we're talking about a baby. And the baby cannot protect themselves, and they deserve to have the best care possible. And we should be there to help provide that care. And without providing that care, it will lead to life...or it could lead to life complications for that child which will grow up to adulthood, as well as more or higher healthcare costs. So I think that we have a responsibility to uphold or maintain the policy of LB599, oppose LB518, and we would hope that you would indefinitely postpone it. [LB518]

SENATOR CAMPBELL: Questions? Senator Krist. [LB518]

SENATOR KRIST: Thanks for coming, Mr. Rieker. Just to confirm and for the record, there, in the prenatal services that are provided by the hospitals that you represent, there is a clear line drawn between service to what is termed as an illegal alien and the baby itself, is there not? [LB518]

BRUCE RIEKER: Well, there's a clear...I think that there's a clear line drawn, I mean, that the prenatal care for the child, yes. To maybe clarify a little bit there, the prenatal care is provided in a clinic. We're on the tail end. We deal with the consequences of the lack of prenatal care or the providing of the prenatal care. But from what I understand of the clinics that provide the prenatal care, yes, there is a clear line of demarcation. [LB518]

SENATOR KRIST: We had a testifier here during LB599 that I think put it very rudely, but it was accepted. That is, if it has to do with the life-support system for the baby and that's essential for the baby's health, then money would be expended to do that. But optional services for that life-support system--if you will, and I don't like that terminology either--but I think they drew a clear line. So would you agree with that assessment? [LB518]

BRUCE RIEKER: Yes. [LB518]

SENATOR KRIST: Thank you. [LB518]

BRUCE RIEKER: Yes. I should say it louder. Yes. [LB518]

SENATOR CAMPBELL: Other questions? Senator Gloor. [LB518]

SENATOR GLOOR: Thank you, Senator Campbell and Bruce. You know, we've had some...well, let me start off by saying my recollection--correct me if I'm wrong--is that your association makes decisions about which bills to support, oppose, or just take sort of an observe standpoint based upon a committee made up of the execs from a variety of hospitals from across the state. Is that correct? You still do that? [LB518]

BRUCE RIEKER: Yes. It's a very rigorous process. [LB518]

SENATOR GLOOR: So during your discussions last year and during your discussions this year--last year to support LB599, this year to oppose this bill--have those same CEOs provided some testimonials about the difference they've seen the lack of coverage make and the improvement they've seen now that there is coverage? [LB518]

BRUCE RIEKER: Yes. In fact, just in the last two days we've had discussions about that. You know, periodically we bring those individuals in. In anticipation of our advocacy day yesterday, we had our policy development committee, which is about 30 hospital executives. We had them on Tuesday. We also have priority issue teams. We have some statistics. We have a great degree of observation as to improved health with prenatal care coverage that...now to which individuals receive what kind of prenatal care, that's a difficult assessment to make. And then there's some areas where, once again, thorough data collection would help us much more in that area to prove just how beneficial providing prenatal care is. But for the information that we're able to collect, being very cognizant that we do not ask an immigration question because that is not the place, it has also been defined at higher levels that it's in the best interest of states and providing public health that we are not the place...hospitals are not the place to decide whether or not somebody is legal or illegal because of the higher priority placed upon the health of the individuals both for their health as well as the public's health. So we...there have been folks that wanted us to be that defining element. But that is not...it

hasn't been determined to be that, and we would argue that we are not the place to determine eligibility. Our place is to provide care. Did that come close to...I'm trying to answer your question but yet... [LB518]

SENATOR GLOOR: Thank you. It made a difference. [LB518]

BRUCE RIEKER: Made a difference, absolutely. [LB518]

SENATOR CAMPBELL: Any other questions? Mr. Rieker, thanks, because last year we did turn to the hospitals and at least asked for some anecdotal information and data. And you were helpful in putting us in contact with the hospitals. And that's where we began picking up some idea of the cost. And Dr. McVea talked to that, and so we appreciate that. [LB518]

BRUCE RIEKER: Well, we appreciate all that you did to help to get across the finish line. So thank you. [LB518]

SENATOR CAMPBELL: Our next opponent? And I believe our last, if I read the hands correctly. [LB518]

BRAD MEURRENS: (Exhibit 20) Good afternoon, Senator Campbell, members of the Health and Human Services Committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s. And I am the public policy specialist for Disability Rights Nebraska. We are the designated protection and advocacy organization for persons with disabilities in Nebraska and provide legal assistance, advocacy training, and information to individuals and families with disabilities across the entire state. I am obviously here today to testify in opposition to LB518. To be brief, I will abridge my comments. According to the National Conference on State Legislatures, studies estimate that every $1 spent on prenatal care yields between $1.70 and $3.38 in savings by reducing neonatal complications. These savings increase dramatically when the long-term costs of caring for newborns with physical and developmental disabilities are considered and are even greater when unforeseen maternal complications are avoided. Low birthweight or premature birth is more likely to result in mental or behavioral disabilities, chronic respiratory problems, deafness, blindness, or cerebral palsy. In 2008, Nebraska's own vital statistics indicated that babies with low birthweight were five times more likely to have birth defects than babies of normal birthweight. This bill establishes a policy for Nebraska that penalizes the unborn child for the actions of his or her parents. There may be a debate about using tax dollars to support persons who are undocumented, but there should be no debate that pits a child's life against the political ambitions of any politician in the immigration debate. We must acknowledge the reality; the unborn child of the undocumented immigrant mother is already here. Not to attend to the health needs of that unborn child is, frankly, unconscionable. It assaults our collective humanity. And as a result, we respectfully request that the committee

indefinitely postpone LB518. I'd be happy to answer any questions. [LB518]

SENATOR CAMPBELL: Thank you, Mr. Meurrens. Are there any questions? Thanks for your testimony. [LB518]

BRAD MEURRENS: You're welcome. [LB518]

SENATOR CAMPBELL: Anyone who wishes to testify in a neutral position? Okay, Senator Janssen, I think we've come around back to you. [LB518]

SENATOR JANSSEN: I'll be very brief, Chairwoman Campbell. I just wanted to come up and clarify something for Senator Krist. In our exchange early, you asked me about a newspaper article. I said I was misquoted. I actually misstated the information to that particular journalist, so I just wanted to clarify that for the record and later clarified it for him after that. So that's all I had. And I wasn't going to stay for closing, but I felt I needed to say that. [LB518]

SENATOR KRIST: Thank you, Senator. [LB518]

SENATOR JANSSEN: Thank you. [LB518]

SENATOR CAMPBELL: Thank you, Senator Janssen. Thank you all for coming today to the hearing on LB518. I'm going to take a five-minute break so we can clear the room. And then we will hold the hearing for the two bills together. (See also Exhibits 21, 22, 23, 24 and 25) [LB518]

BREAK

SENATOR CAMPBELL: Could we have everybody take their chairs, please? Okay. I think we...I know the rest of the senators will be coming back to find their chairs. And I appreciate all of your patience. What we're going to try to do this afternoon...and we talked to...Senator Howard, is that we'll combine the hearings on LB526 and LB527 to facilitate your time. And I've also talked to the clerk because, really, it comes down to the clerk always. Can we do this in the records and so forth? And Diane was kind enough to say, yes, of course we can. So when you come up and testify today, you might want to note to us if there's any difference in your testimony between LB526 and LB527 so that the transcribers and the clerk can pick up if you're really here on LB527 and so we don't get mixed up. But we're assuming that a lot of your testimony will encompass both bills. Okay? All right. Senator Howard, go right ahead and open. For the record, we're on LB527 and LB526. Oh, yeah, it's still a five-minute limit. [LB526 LB527]

SENATOR HOWARD: For me? [LB526 LB527]

SENATOR KRIST: You get three. [LB526 LB527]

SENATOR CAMPBELL: No. Everybody else. So, Senator Howard, go right ahead and open. [LB526 LB527]

SENATOR HOWARD: Good afternoon, Senator Campbell and members of the committee. For the record, I am Senator Sara Howard, H-o-w-a-r-d, and I represent District 9. Today, I am introducing LB526 and LB527 at the request of the optometrists. Senator Campbell, I want to thank you for allowing these two bills to be heard jointly today as they essentially take two bites of the same apple and hearing them together will conserve the committee's time. I should note at the outset that we are not asking that these bills be advanced from committee this year. The issues in these bills are now under review by the 407 process. We anticipate that this process will have been concluded by next year in time for us to discuss these bills next session. Every health profession licensed by the state of Nebraska, with the exception of doctors of medicine or osteopathic medicine, is authorized by a scope of practice specifically limited by state law. Physicians are the only profession to enjoy an unlimited scope of practice. For this reason, we, on the Health and Human Services Committee, are from time to time asked to expand the scope of practice of one of the other licensed professions. Sometimes these types of bills are more or less housekeeping in nature and are enacted with little or no opposition. At other times, when more than one profession is authorized to use certain procedures which are the same or nearly the same or are treatments for basically the same conditions, this type of legislation becomes controversial and hotly contested. That intense interest and accompanying controversy, however unpleasant it may be at times, does not in any way relieve the Legislature of our essential duty that accrues to us as the sole constitutional body that makes these decisions in law. LB526 and LB527 together expand the scope of practice for doctors of optometry licensed by the state of Nebraska. LB526 would authorize optometrists to perform injections into the eyelid and surrounding tissue, but not the eye itself, for the treatment of certain conditions such as sties. This bill would also authorize doctors of optometry to perform certain minor surgical procedures like opening sties so they can drain, and the removal of skin tags. But also, again, not to perform surgery on the eye itself and also not to use lasers in such procedures. LB527 would authorize doctors of optometry to prescribe oral steroidal agents, oral immunosuppressive agents, and oral antiglaucoma agents. This revision would essentially authorize doctors of optometry to prescribe as oral medication agents which they are presently authorized to use as topical agents. As healthcare continues to change, every profession--to remain relevant and properly serve their patients--has to change their scope of practice. Without these periodic changes in scope, professions authorized for a limited scope of practice will become out of date and irrelevant. Optometry in Nebraska last saw its authorized scope of practice expanded 15 years ago. A lot has changed both in healthcare and elsewhere in the last decade and a half. And I sincerely believe it is time to adjust optometrists' scope to

more accurately reflect today's world of healthcare and the expectation that healthcare providers change appropriately as well. I would be happy to answer questions, but respectfully suggest that those who will follow me will be able to address this topic in greater detail. I also have to be back in my district by 6:00 p.m. so if we go past 4:30, I will not be able to close. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Senator Howard. [LB526 LB527]

SENATOR HOWARD: I will try to answer any questions you may have. [LB526 LB527]

SENATOR KRIST: Request disapproved. [LB526 LB527]

SENATOR CAMPBELL: If you think you're going back, forget it. No. I don't see any questions. We'll go right into the testimony. [LB526 LB527]

SENATOR HOWARD: Thank you. [LB526 LB527]

SENATOR CAMPBELL: How many wish to testify in favor of the two bills? Somebody help me. One, two, three, four... [LB526 LB527]

SENATOR KRIST: 6. [LB526 LB527]

SENATOR CAMPBELL: 6? Is that right, six, seven? [LB526 LB527]

SENATOR KRIST: Six or seven. [LB526 LB527]

SENATOR CAMPBELL: Six or seven. How many in opposition? [LB526 LB527]

SENATOR KRIST: About six. [LB526 LB527]

SENATOR CAMPBELL: About equal. Okay. And in neutral position? Ah, there is no neutral. [LB526 LB527]

SENATOR KRIST: This side versus this side. [LB526 LB527]

SENATOR CAMPBELL: This side...okay, we will open the testimony today on the proponents for LB526 and LB527. Good afternoon. [LB526 LB527]

CHAD HUDNALL: (Exhibit 26) Good afternoon. My name is Dr. Chad Hudnall, C-h-a-d H-u-d-n-a-l-l. I'm a private practice optometrist with offices in Grand Island and St. Paul and also the president of the Nebraska Optometric Association, here today to speak on behalf of LB526 and LB527. I'm going to give you an overview of the purpose and need for the proposed enhancements to the optometric practice within the two bills being

presented today as well as an overview of the practice of optometry in Nebraska. We're here today because we can only do in our practice what the Legislature allows us to do. As a result, as healthcare advances and as our profession advances, we need to come to you in order to provide the very best care for the citizens of Nebraska. With that being said, it's been 15 years since optometry in Nebraska has had any changes in scope of practice. Since then, several states around us have updated their laws in order to become more current with the knowledge, education and training, and to keep up with current standards of care for the eyes and visual system. Several doctors following me will outline the main components of these bills and will illustrate how Nebraska has fallen behind other states in providing our citizens access to these forms of care. The proposals in these two bills are not intended to represent a quantum leap forward or make Nebraska a pioneer in optometric scope of practice, but rather to stay current with the knowledge, education and training, and capabilities of today's optometrists and allow our patients to receive the standard of care in our profession. There are nearly 400 licensed doctors of optometry in Nebraska with 348 of those actively practicing. They have primary clinics in 48 counties, not including satellite practices. We have provided you with a map that illustrates the number and location of practicing optometrists in relation to the number and location of practicing ophthalmologists in Nebraska. As you can see from the map, optometry provides far more access to eye care to citizens of Nebraska, especially in the more rural areas of the state. You may hear today from others that access to care is not a valid issue in regards to eye care or that there is no demonstrated need or demand for greater access. However, you only need to listen to the radio or turn the television on to hear advertisements for urgent care and outreach clinics and satellite clinics being opened up in many cities across the state to provide better convenience and access to patients. Convenience and accessibility are advertised reasons for hospitals and medical clinics to operate satellite locations for specialty services. If accessibility and convenience is an issue for specialty care, it is certainly a valid issue for primary care needs including eye care. I would encourage you to disregard any suggestion that increasing patient access to care is not a reason to support this legislation. Nebraska optometrists have been licensed to prescribe medications since the 1970s when the law first allowed topical drops for diagnostic purposes. In the '80s, the law was amended to allow topical medications for treatment of ocular conditions. And in 1993, the Legislature authorized prescriptive authority for virtually all oral medications for the treatment of conditions related to the eye as well as topical drops for glaucoma. Only a handful of oral medications were exempted at that time, and LB527 would simply remove those exemptions. Each time the Legislature has updated our scope of practice, our profession has responsibly, effectively, and safely used that authority to care for our patients. The records our licensing board and malpractice insurance rates for our profession validate this. This time will be no different. Doctors of optometry are primary care providers for eye conditions and the visual system. This means that optometrists see patients and problems of the eye and general health. Because the visual system is integrated with other systems of the human body, we have to understand and monitor overall patient

health concerns that can impact or be impacted by eye disease or vision disorders. We are part of an integrated team of healthcare providers for our patients. That may mean referring to another optometrist who may have specific expertise in the treatment of a certain ocular condition, referring to our ophthalmology colleagues when a patient requires more specialized care such as cataract surgery, or to an internist when systemic disease such as hypertension or diabetes is suspected. We communicate closely in the management of these conditions with internists, general physicians, rheumatologists, neurologists, and dermatologists to name a few. Many optometrists in the state are on staff and on call for the hospitals and emergency rooms in their communities. Doctors following me will discuss the education and training of optometrists, the specific proposal related to oral medications, provisions involving injections, and the proposed authority for additional minor procedures. Those witnesses will also be discussing specifics of additional proposed training and education that will be required as part of the bills. Their presentations may address many of the questions that you have at this time, but I am pleased to take any questions as well on anything that I have covered. Thank you for your time and we would appreciate your support. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Doctor. Are there any questions? Senator Gloor. [LB526 LB527]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for making the trip in, Dr. Hudnall. I really don't have any questions; but if I don't recognize you, the committee members will say, gee, somebody came all the way in from Grand Island and Senator Gloor didn't say anything (laughter). So I appreciate the effort that you've put into trying to educate me over the years given the fact that I hadn't spent a lot of time in the presence of optometrists... [LB526 LB527]

CHAD HUDNALL: Uh-huh. [LB526 LB527]

SENATOR GLOOR: ...primarily, as you know, in the presence of ophthalmologists. [LB526 LB527]

CHAD HUDNALL: Yep. [LB526 LB527]

SENATOR GLOOR: But you've been pretty straightforward and very helpful in trying to bring your case forward. So thank you for making the trip. [LB526 LB527]

CHAD HUDNALL: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Thank you very much. [LB526 LB527]

CHAD HUDNALL: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB526 LB527]

ROBERT VANDERVORT: (Exhibit 27) Good afternoon. My name is Dr. Robert Vandervort, spelled V-a-n-d-e-r-v-o-r-t. And I am testifying in support of LB526 and LB527. I will be specifically addressing academic issues related to the bills. I earned my doctorate of optometry at Indiana University School of Optometry in 1979. I then completed a one-year residency in ocular disease at the VA Medical Center in Lexington, Kentucky. I am currently in a specialty eye care practice in Omaha, and I'm on the staff and have hospital privileges at Creighton University Medical Center in Omaha. I've been directly involved in optometric education for over 30 years, starting as a full-time faculty member at Southern California College of Optometry for the first five years after my residency. And since then, in our Omaha practice as an adjunct faculty member of several colleges of optometry where we serve as a clinical externship site for fourth-year optometry students who rotate through our office. I have also served as the chair of the Nebraska Optometric Association Continuing Education Committee for 25 years. Today you will likely hear comparisons between the doctor of optometry and the doctor of medicine degrees and questions about our education, training, and experience. It is important to understand the facts. The doctor of optometry degree is comparable to other doctorate disciplines in healthcare including medicine, dentistry, and podiatry. After earning a bachelor's degree, optometry students must successfully complete four years of postgraduate education in optometry for a total of eight years of study in order to earn the doctoral degree. The first two years of optometry school are primarily intensive classroom study in subjects that include human anatomy, human physiology, pharmacology, that are equivalent to the courses taken by medical students. And in some instances, optometry and medical students take the same classes together. In addition, optometry students also take many courses unique to optometry. These include ocular pharmacology, ocular anatomy, ocular physiology, and ocular microbiology. Optometrists are the only healthcare providers that receive graduate-level academic courses on these topics. It is important to understand that optometric education is not a subset of ophthalmology. We are uniquely trained to care for our patients. The most comparable profession to optometry in terms of length and style of training is dentistry. Clinical training starts in the second year of optometry and expands throughout the third year. And the fourth year is totally dedicated to patient care. During the fourth year, students rotate through a variety of clinical settings including hospitals and medical centers. Optometry schools are accredited by the Accreditation Council on Optometric Education, which is recognized by the U.S. Department of Education, and the Council on Higher Education Accreditation. No optometrist can be licensed in Nebraska without having graduated from an accredited optometry school and having passed a standardized, nationally recognized National Board of Examiners in Optometry. This examination consists of three parts, two written and one clinical, covering all aspects of optometry. In order to be certified to prescribe the medications and perform the procedures described in these two bills, optometrists

currently licensed in Nebraska will be required to take transcript-quality education with testing conducted by a fully accredited optometry school. Once all requirements have been met, the doctor will be eligible to be certified by the Board of Optometry. New graduates or doctors seeking to become licensed in Nebraska will be required to meet the same criteria. It is important to understand the context of this certification process. Some will try to characterize this education as if all of the material and procedures we are learning are new to us. Nothing could be farther from the truth. The education for the expansion of oral medications and injections will be a review. The eyelid anatomy and principles of injections are already familiar to every optometrist. The current scope of practice in Nebraska for the past 20 years has allowed optometrists to perform procedures more complex and higher risk than those proposed in LB526. Therefore, the certification process will already have the foundation of an extensive base of education, training, and clinical experience. Nebraska doctors of optometry are uniquely trained and have a 34-year track record of success in properly and safely implementing the four previous enhancements to our scope of practice authorized by past Legislatures. The implementation of LB526 and LB527 will have the same success for the benefit of the citizens of Nebraska. I respectfully ask that you support these bills. I would be happy to answer any questions about optometric education and the education that will be provided in order to certify optometrists under the provisions of these bills. Thank you. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Doctor. Questions? Thank you for your testimony today. [LB526 LB527]

ROBERT VANDERVORT: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next testifier? [LB526 LB527]

HEIDI LICHTENBERG: (Exhibit 28) Good afternoon, Senators. [LB526 LB527]

SENATOR CAMPBELL: Good afternoon. [LB526 LB527]

HEIDI LICHTENBERG: Good afternoon. I'm Dr. Heidi Lichtenberg, H-e-i-d-i L-i-c-h-t-e-n-b-e-r-g. I practice optometry in Omaha at a private office and also at Creighton University Medical Center in the Department of Surgery. I also have hospital privileges at Creighton and serve as a clinical instructor for the medical students at Creighton University School of Medicine. I am here today to talk about the prescriptive authority of the oral glaucoma, steroid, and immunosuppressive medications proposed in LB527. As part of my optometric education, I was provided with a full year of classroom education dedicated to pharmacology and two years of clinical training with patients, where I gained the knowledge and experience to learn the proper indications, dosages, side effects, and drug interactions for all the medications proposed in LB527. Nebraska optometrists have been prescribing a wide range of pharmaceuticals for many

years. Our current scope of practice allows doctors of optometry to prescribe any oral medication including narcotics and antibiotics except for oral glaucoma, steroid, and immunosuppressive medications. Medications that fall into the classes of oral glaucoma and oral immunosuppressives have multiple uses. There is currently a contradiction in the law that allows me to prescribe them for some conditions, but not for others. We are also able to prescribe all topical medications, including all glaucoma, steroid, and immunosuppressive eye drops, all of which have essentially the same pharmaceutical makeup of the equivalent oral medication. We utilize our professional judgment every day in prescribing these medications. Optometrists have not been negligent with their current prescriptive authority and there is no reason to expect that to change with this additional authority. The ability to prescribe these additional medications will improve patient access to care, especially in rural areas or underserved areas. For example, I routinely see patients at Creighton University who require an interpreter for their services. Each patient that I have to send on to another provider, for services I cannot perform, requires that patient to find an interpreter of their own which oftentimes they don't have access to. Being able to prescribe these few additional medications would minimize the patients' need for referrals and save each one of these patients valuable time and expense. My partner and I also provide after-hours call coverage two weeks per month for a clinic in an underserved area of Omaha. The medical doctors there look to me as a resource and often ask my advice on dosing oral steroids for eye conditions that can be emergent and can lead to blindness if not treated in a timely manner. While everyone has the patient's best interest in mind, this potentially creates a scope of practice issue for me. Another example of when these medications would be valuable to my patients would be when they present with inflammation in the eye, which is often associated with a variety of autoimmune diseases. Many patients are not able to be controlled with only topical medications, requiring the use of oral steroids short term and, possibly, immunosuppressive medications long term. This would be a last resort option, but could effectively be done by co-managing with a rheumatologist, as any ophthalmologist would do. We already routinely co-manage with these specialists with other high-risk medications, as we see patients daily who use these medications. Another interesting point is that some optometrists in the state of Nebraska are already allowed to prescribe these medications as they have...they're also licensed in neighboring states such as Iowa, Kansas, South Dakota, and Colorado to name a few, all of which already allow optometrists to prescribe all these oral medications. As of April 2011, 38 states already allow optometrists to prescribe oral glaucoma meds; 31 states allow optometrists to prescribe oral steroids; and as of April 2012, 32 states allow optometrists to prescribe oral immunosuppressive medications. In summary, we are not proposing that optometrists be authorized to prescribe medications they know nothing about. For more than 20 years, graduating doctors of optometry have been tested in the use of oral glaucoma, steroid, and immunosuppressive medications. Even with that, LB527 proposes an additional four hours of tested education on these medications for every doctor licensed prior to 2000. Optometrists' knowledge of pharmaceuticals is already much broader than just knowing all the medications we currently prescribe. The

interactions. As we see patients every day on a variety of medications and manage the interactions and risks of these medications, it is imperative with how fast the dynamics of our patient population continues to change, and the more and more health conditions that continue to present to us, that we have all the necessary tools in order to treat each patient appropriately and efficiently. Thank you for your time. I would appreciate your support. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Doctor. Are there any questions? Okay. [LB526 LB527]

HEIDI LICHTENBERG: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Thank you for the testimony. [LB526 LB527]

HEIDI LICHTENBERG: Uh-huh. [LB526 LB527]

SENATOR CAMPBELL: Our next proponent? Good afternoon. You go right ahead. [LB526 LB527]

JONNA KOHLE: (Exhibit 29) Good afternoon. Good afternoon. My name is Dr. Jonna Kohle, J-o-n-n-a K-o-h-l-e. And I am here today to show my support for LB526 and LB527 specifically relating to optometrists in Nebraska using injections in two types of situations. I am an optometrist in north-central Nebraska. My husband is a farmer, and we live about six miles from the nearest town of Stuart, which has a population of about 600 people. I commute about 40 miles each way to my private practice location which is in O'Neill, Nebraska, a population of about 3,000. This would be a usual drive distance for many patients in my area to reach their primary care providers. In this rural setting, my patients are also my family members, my friends, my high school classmates, the person who bags my groceries, the person I pay for gas, and the medical doctor who delivered both of my daughters. I call them by name on the street, and I treat them as family because in many cases they are. Optometry for me has charm and challenges that you can't find just anywhere. And for patients in these rural areas, having local, timely access to care is everything. I would like to review the two types of situations in which optometrists in Nebraska are requesting the privilege to use injections with our patients. The first situation is to allow injections for the treatment and prevention of anaphylaxis. Anaphylaxis is a sudden, severe, allergic-type reaction that can lead to death. It can be triggered by foods, environmental factors, or certain drugs. Someone who is at risk for this type of reaction would ideally carry a medically prescribed device called an EpiPen. In the event of an attack, the person could self-inject the EpiPen into their own leg. In the event that the person is not able to provide their own injection either because they are too weak or for whatever reason, any layperson--without any formal training--could perform this injection for them. However, interestingly, under the current law--even though a patient in my waiting room could give the injection--I, as the

optometrist, could not. This is the first situation requested. The second situation requested is to allow injections into the eyelid for the treatment of cysts or infected or inflamed glands of the eyelids. One of the many tiny glands that line the eyelid may become infected or inflamed. The first lines of treatment would become a repeated hot compress to the eyelid and good lid hygiene. Topical drops and creams may be attempted, although they're usually not very effective in this situation. Oral medicines are also another option. However, if these do not work or if the inflammation is longer lasting, injecting a small amount of steroid medicine--bless you--into the eyelid near the problematic gland can improve the problem. This is the procedure being requested. Please note that timely access to this injection may prevent the necessary surgery for this problem. Improved timely access for these patients is important at my clinic because it takes nearly two hours to see a general ophthalmologist of drive time in my area. There is access to an ophthalmologist locally. However, he flies in once a month from Arizona, and the wait time to see him is about four to five months. I can't make stuff like this up. We're glad to see him when he comes. You might wonder what optometrists in other states are doing. Optometrists in 35 other states can perform injections for patient care. Some other states in the Midwest include Minnesota, North Dakota, Colorado, Iowa, and Oklahoma. Some doctors in Nebraska practicing near the borders of Colorado and Iowa may actually be able to provide injections for their patients on one practice on one side of the border, but not when they cross the border back into Nebraska. This isn't an ideal way to practice. I'd like to list for you several professions in Nebraska currently performing injections. These include medical doctors, doctors of osteopathic medicine, physician assistants, podiatrists, dentists, dental hygienists, pharmacists, nurse anesthetists, paramedics, registered nurses, emergency medical technicians, tattoo artists, and permanent makeup artists. And as mentioned before, a layperson with essentially no training may use an EpiPen for anaphylaxis or administer an insulin injection for diabetes. Just to review, the optometry education is at minimum a four-year bachelor degree followed by a four-year doctor of optometry degree, and may be followed by an optional residency. As of 2012, all optometry students are trained and tested on injections. Currently, licensed doctors will undergo transcript-quality training and education by certified sources. This is more completely outlined in the bill. Overall, I believe that Nebraska optometrists will easily be able to join the many other professionals and nonprofessionals in the state who currently provide safe, effective, and local care with specified injection treatments. We would really appreciate your support on these bills. Thank you for listening, and thank you for all that you do for healthcare in Nebraska. We appreciate it. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Doctor. [LB526 LB527]

JONNA KOHLE: Uh-huh. [LB526 LB527]

SENATOR CAMPBELL: And thank you very much for practicing in rural Nebraska. [LB526 LB527]

JONNA KOHLE: You're welcome. It's fun. [LB526 LB527]

SENATOR CAMPBELL: Questions or comments from the senators? Thanks again for coming. [LB526 LB527]

JONNA KOHLE: Okay. Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next proponent? We were just commenting that you were sitting on that side of the room (laughter). [LB526 LB527]

JOHN CROTTY: I could switch. [LB526 LB527]

SENATOR CAMPBELL: Good for you. There is no wrong side. We can emphasize that. [LB526 LB527]

JOHN CROTTY: (Exhibit 30) That's right. Thank you, Senator Campbell. Good afternoon, Senators, Senator Watermeier. My name is John Crotty, Dr. John Crotty, J-o-h-n C-r-o-t-t-y. I've practiced optometry in Auburn, Nebraska, for nearly 37 years. As a past president of the Nebraska Optometric Association, I've had the honor of testifying before legislative committees more than once in my career and I'm honored to have the opportunity to do so again today. I've been blessed to practice with my late father, Dr. Patrick Crotty, for 19 years in our fairly typical, rural optometric practice. And I've also thoroughly enjoyed practicing with my current partner, Dr. Darren Wright, for the last 18 years. We are looking forward to being joined later this year by my son, Russ Crotty, who will complete his doctoral studies in May. Our family is proud to have been part of three continuous generations of excellence in eye care in our community. We truly have been blessed. We have about 13,000 patient files in our system, patients from southeast Nebraska, northwest Missouri, southwest Iowa, and northeast Kansas. We serve as a kind of regional hub for eye care, frequently saving patients anywhere from one-and-a-half to three-plus hours of travel into the Omaha-Lincoln metro areas for care. It's my intent today to express my support for the authority contained in LB526 relating to the performance of procedures for the treatment of cysts or infected or inflamed glands of the eyelids. Patient access to quality care is the primary reason for the proposal of this enhancement to our optometric practice which has not been updated, as you've heard, for 15 years while technology and training have advanced at a rapid rate. A second reason is to inform you of the frustration many of our rural patients experience when they have to be sent to a second practitioner with the additional costs, travel time, and delay of treatment involved, to have a procedure that can be safely and effectively provided by their local optometrist. As you can imagine, when patients have come to their eye doctors in their hometowns for as long as our patients have--in our practice, some for over 70 years--they develop a deep level of trust and comfort that cannot possibly be duplicated in a single visit. They trust our

professional judgment and know that we will get second opinions when appropriate. They view us as their primary care doctors for their eyes and vision, and their frustration with the restrictions on the care we are allowed to provide is real. We are requesting today in LB526 the authority to do simple, in-office procedures that are currently prohibited that would treat various types of cysts or sties on the eyelid. These formations are fairly common when glands become infected or inflamed, and these procedures to treat them would be allowed for cases where the simple application of pressure or injections in the infected gland are not sufficient. One of the procedures involves a minute incision in the back of the eyelid where it is not visible, so no stitches are required. This can be done in the office and would involve the use of an injected local anesthetic, similar to what dentists use, so the patient would not feel the incision. Then therapeutic eye drops or oral antibiotics, which we already prescribe, would be used as needed following the procedure. Many times this procedure simply involves the release of material from the gland, not removal of tissue. However, when any tissue is removed in a procedure from these usually benign cysts, it would typically be sent to a laboratory. Nebraska optometrists have been treating cysts, plugged glands, and other conditions of the eyelids for decades with warm compresses and pressure and, since 1993, with oral antibiotics. The procedures allowed in this bill are not unlike others we currently perform using instrumentation already in our clinics. But because they involve an incision, we have come to the Legislature to amend our law in order to provide this care. For over 20 years, optometrists in Nebraska have safely performed much more precise and delicate procedures than these. We are currently allowed to remove a piece of wood, glass, or rusted metal from the cornea, the delicate, tender surface of the eyeball itself. The minor eyelid procedures in this bill pale in comparison to the complexity, responsibility, and potential for vision reduction of procedures optometrists routinely perform on a daily basis. LB526, as you've already heard, outlines very specific education and training requirements and time lines relative to these procedures. And I personally look forward to the challenge of this new endeavor. Finally, I would ask you to remember that this enhancement of our practices will better serve Nebraskans across our wide state by encouraging the best and brightest new optometrists to come and practice here. We need to continue to attract top healthcare providers to our state, especially those who specialize in primary care services like optometry. Unless Nebraska's law is regularly updated to allow new graduates to fully utilize the range of education and training they're receiving today, they simply will not choose to practice in our state, and that will obviously be a disservice to our citizens. Not all the bright young doctors will have the opportunity to return to a third-generation practice, but those that do will rightfully be expecting to practice at the highest level of their education. Thank you for your kind consideration. Are there any questions? [LB526 LB527]

SENATOR CAMPBELL: Any questions from the senators? Senator Gloor. [LB526 LB527]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you, Dr. Crotty. Don't

take this the wrong way, but you've been in practice long enough so that I'd like to ask you a question that has to do with referral relationships. You, I'm assuming, have got referral relationships with ophthalmologists whom you trust to take care of patients that you send on for care you can't provide. [LB526 LB527]

JOHN CROTTY: Absolutely. [LB526 LB527]

SENATOR GLOOR: And have you had this conversation with them about--not these bills specifically--but about an expanded scope of practice to do some minor surgical procedures? [LB526 LB527]

JOHN CROTTY: On an ongoing basis. [LB526 LB527]

SENATOR GLOOR: And what's their response to you when you have those conversations? [LB526 LB527]

JOHN CROTTY: Oh, I don't know (laughter). You know, they're fairly noncommittal. When you have that kind of relationship back and forth, working with patients together, you try to get along. Pretty much on all of the bills that we've had come through the Legislature through the years, ophthalmology has stood pretty much as a wall. You don't need that, we can do it. [LB526 LB527]

SENATOR GLOOR: And so you've not seen any change in that demeanor with those referring physicians, anyways, over the years? [LB526 LB527]

JOHN CROTTY: During the time of legislation, there's a tension created. Once the legislation passes, everything is back to normal and good. We've done well. Our record stands for itself as optometrists. The things that we've asked to do, we've done, and we've done safely. [LB526 LB527]

SENATOR GLOOR: Thank you. [LB526 LB527]

JOHN CROTTY: Good question, thank you. [LB526 LB527]

SENATOR CAMPBELL: Any other questions? Thank you for your third generation, that's exciting. [LB526 LB527]

JOHN CROTTY: Thank you very much. We're looking forward to it. [LB526 LB527]

SENATOR CAMPBELL: I bet you are. I bet you are. [LB526 LB527]

JOHN CROTTY: Thank you, Senators. [LB526 LB527]

SENATOR CAMPBELL: Thanks for your testimony. Our next proponent? [LB526 LB527]

SENATOR KRIST: I just...I realize my comment may have been...our comment may have been taken out of context. It wasn't a good side or a bad side. It seems like everybody who's doing opponents are...so that's what it is. It has no...yeah. I just want to make sure you understand. [LB526 LB527]

SENATOR CAMPBELL: Yeah, right. We do watch that at hearings. It's interesting. Good afternoon. [LB526 LB527]

JUSTIN BRADY: Good afternoon. Senator Campbell and members of the committee, my name is Justin Brady, J-u-s-t-i-n B-r-a-d-y. I appear before you today as the registered lobbyist for the Nebraska Optometric Association in support of LB526 and LB527. What I want to do here is to try to give you a little foreshadowing of what you may hear when you go to the other side of the room to the opposition. You may ask yourself, how am I going to know what they have to say about these two bills? And I can tell you, I went back and read every single bill, every hearing transcript, every floor debate since 1979 on optometric bills. There have been three general arguments that ophthalmology--who has opposed the expanded scope every time--has raised. I'll first say there were 22 times that the act has been changed. Of those 22 times, 6 of them I would couch--and I believe when I've asked others they would couch--as actual expanded scope of practice issues, not cleanup issues or whatever that happened in the act. Again, all six of those times ophthalmology opposed the bill. They opposed it on three general arguments: one, lack of proper education and training; two, they opposed that the public will be put in danger; and, three, they said Nebraskans have plenty of access and, therefore, you don't need to expand the scope. With respect to training, I'll give you a couple of examples. In 1979, LB9 dealt with the use of eye drops. Dr. Koefoot (phonetic), opposing the bill stated: Optometry graduates are unqualified to safely use drugs and diagnose and treat the human eye. Dr. Camilla Parson stated in 1998: optometrists are not adequately trained in a clinical, supervised fashion to diagnose and treat glaucoma. Even the primary introducer, Senator Scott Moore, in 1993 on LB429 stated: The key issue will be what are the education requirements? Next, with respect to the public will be put in danger, in 1993 on LB429, Michael Dubinsky (phonetic) from the Nebraska Medical Center stated: The public will be harmed. And next to death, the next worst thing that can happen to a person is blindness. In 1986 on LB131, Carol Drake, a fourth-year ophthalmology student stated: When vision loss occurs as a result of an optometrist's screw up, that will be the Legislature's fault. As far as access, LB...again in 1979, Dr. Koefoot (phonetic) stated: There is not an access issue because family physicians are capable of diagnosing and treating the eye, and there are plenty of family physicians throughout the state. These were just some examples of comments that were stated through those six expanded-scope bills throughout history. And I just want to take a couple of minutes and

go through those three arguments again. Training--as you have heard, LB526 and LB527 specifically go through and lay out what the training and educational requirements are. I would also submit, through the 407 process and this committee--if you believe there are additional training or educational requirements that are needed, I would say the optometrists are more than willing to sit down and discuss those with you. In 1986, there was an Attorney General's Opinion that said this body must state those education and training requirements clearly and specifically; it cannot be generally. And so I believe they've tried in these bills to meet that Attorney General standard. With respect to putting the public in danger, I...through contacting the Department of Health, I asked for complaints against optometrists over the same 34-year history. At no time did the complaints go up after an expanded-scope bill was passed. They've always been...the average has been over those 34 years, 4.6 complaints per year on average. To give you a more specific example, when the glaucoma bill--which was a huge fight that took multiple years and eventually passed--the four years before the glaucoma bill passed, there was an average of 4.7 complaints against optometrists. The four years after, there were four on average per year. So, again, the public wasn't being put in danger, even though they came to this body over and over and said the public will be harmed. As far as access, you've heard about access in rural Nebraska for multiple issues--I know--in front of this body. I know the University of Nebraska Medical Center had recently done a study that I'm sure many of you saw the articles on. That talked about that in rural Nebraska there already is a shortage of 300-plus doctors. And that will only grow as more doctors...family physicians retire. I don't think the opposition can come to you and say anymore, there's not an access issue in Nebraska. Given the facts from the past 34 years, I submit to you that LB526 and LB527 are sound bills. They address the training and education requirements specifically. History has shown that when done in a responsible manner, the public is not put at harm. And the state is facing an access problem. With that, I'd try to answer any questions. [LB526 LB527]

SENATOR CAMPBELL: Questions? Thank you. If I counted right, are there any other proponents? Okay. We will move to opponents to LB526 or LB527. [LB526 LB527]

MILLICENT PALMER: (Exhibit 31) Good afternoon. My name is Millicent Palmer, M-i-l-l-i-c-e-n-t P-a-l-m-e-r. Good afternoon, Senator Campbell and members of the Health and Human Services Committee, colleagues, and guests. I am a board certified medical doctor trained in ophthalmology. That is, in the medical and surgical management of diseases of the eye. I am an associate professor of surgery at Creighton University School of Medicine, an adjunct professor for the University of Nebraska Department of Ophthalmology, and section chief of eye care for the Nebraska-Western Iowa Health Care System. I have fellowship training in diseases of the external eye. My remarks today reflect my opinion as an experienced, practicing ophthalmologist, teacher, and president of the Nebraska Academy of Eye Physicians and Surgeons. I strongly oppose the optometric scope of practice expansion proposed in LB526 and LB527. I would like to now set the stage for the testimony of my

colleagues that follows. First and foremost, the proposed legislation jeopardizes patient safety. No public health risk has been identified to warrant a change in scope of practice legislation. As we evaluate the scope of practice legislation, a discussion regarding access to care is inevitable. The demographic studies that we have performed indicate that citizens of Nebraska have access to an ophthalmologist through a growing network of primary and satellite practices. Furthermore, most eye procedures are nonemergent or elective. In the few cases of true emergencies, it would be most appropriate for these cases to be managed by the provider with the highest level of training, namely the ophthalmologist. The University of Nebraska Ophthalmology Department will soon expand to three residents per year and initiate a rural eye care component to the residency program to attract trainees to western Nebraska. In addition, the University of Nebraska Ophthalmology Department has just matched two incoming residents that are both from rural Nebraska, Kearney and Scottsbluff; both wish to return to their communities to practice. As we discuss access to care, we must also consider the role of telemedicine. Developments in digital imaging and information technology have advanced the role of telemedicine in addressing access and quality of care. The mandates to expand telehealth coverage and reimbursement for telemedicine services is growing. Nebraska legislators, including Senator Cook, have recognized this and are working to take legislative action to further develop telemedicine services in our state. It is inevitable that eye care delivery models will include the use of telemedicine. I am currently working with the Nebraska Statewide Telehealth Network, the University of Nebraska Executive Director of Telehealth, the Nebraska Academy of Eye Physicians and Surgeons' membership, and the University of Nebraska Ophthalmology Department to develop teleophthalmology applications. Services would include emergency room triage, surveillance of chronic eye conditions such as diabetic eye disease, macular degeneration, electronic consultations for the comanagement of difficult cases, and long-distance learning. This will provide a great opportunity for ophthalmologists and optometrists to work collaboratively in providing quality eye care for Nebraskans. LB526 would allow optometrists to administer intramuscular injections for anaphylaxis and to inject cysts, infected or inflamed glands of the eyelid, and perform incision and drainage of lid lesions. I must say that as a specialist in cornea and external disease, I have never injected an inflamed eyelid lesion as described in LB526. Injections of these lid lesions, namely, chalazia or inflamed oil glands of the lid with steroids, is neither common practice nor the standard of care. In most cases, they can be managed simply and conservatively with hot compresses. In addition, these lid lesions are nonemergent, not sight threatening, and pose no significant health risk. Reported ocular complications have been noted including injection into the circulation of the eye and wrongful injection into the eyeball itself. LB527 would permit optometrists to use oral medications, including those to treat glaucoma, steroids, and immunosuppressive agents. Most glaucoma is treated with eye drops, which optometrists are currently allowed to prescribe. Oral glaucoma medications are used primarily for temporary bridge therapy to stabilize the eye pressure in preparation for surgery. Patients that require steroids and immunosuppressives for sight-threatening eye inflammation are often seriously ill

with complex medical problems. The standards of care for the ophthalmologist is to refer and co-manage these patients with a rheumatologist. Why would an optometrist want to manage patients on these strong medications that could potentially cause serious side effects and even death? There are substantial differences in training and experience of the ophthalmologist, a medical doctor, compared to the optometrist. My colleagues will review this in detail. [LB526 LB527]

SENATOR CAMPBELL: Go ahead and sort of summarize the last parts of this. [LB526 LB527]

MILLICENT PALMER: Thank you. Yes. The internal, self regulation of optometrists in the certification process described in these bills raises serious ethical concerns. It is also worrisome that Nebraska Board of Optometry would permit an optometrist certified in another state to exercise these practices. How will competency be truly validated? What systems are in place if the proposed practices are not performed competently? I work with optometrists and have respect for what they do. I strongly believe that we can best serve the citizens of Nebraska by working as a team. In closing, LB526 and LB527 puts the citizens of Nebraska at unnecessary risk. Clinical competency as an ophthalmologist requires years of education and training. It cannot be replaced by legislation. Help protect Nebraskans by opposing LB526 and LB527. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Dr. Palmer. Are there any questions? Okay. Thank you for your testimony today. [LB526 LB527]

MILLICENT PALMER: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next opponent? Good afternoon. [LB526 LB527]

CHARLES GREGORIUS: (Exhibit 32) Senator Campbell, I'm...and members of the committee, I am Dr. Charles Gregorius, that's C-h-a-r-l-e-s G-r-e-g-o-r-i-u-s. I'm the immediate past president of the Nebraska Medical Association. I am here to express the NMA's opposition to LB526 and LB527. These proposals were reviewed by the NMA Commission on Legislation, which made its findings and recommendations to the NMA board of directors. The board of directors, in turn, in its function of representing the NMA, agree that these proposals not be supported. I will briefly summarize the reasons for that position. More detailed discussion will follow. Optometrists are already credentialed to remove superficial foreign bodies from the eyelids, conjectiva, and cornea. These are admittedly emergency conditions. Medical doctors such as family practitioners and emergency medics and physicians are also trained in such emergencies. More serious injuries require the advanced training and experience of ophthalmologists. So nonemergent problems can be seen in scheduled clinics. The minor emergencies are being covered, as I said, by optometrists, family practice, and emergency medical physicians. My own son is an emergency medical physician, and he

tells me he does these, and he thinks that his training in Maimonides in New York and Loma Linda in California was more than adequate to take care of these minor emergencies. And again, anything more serious is going to need an ophthalmologist. Regarding access to care, the last time bills such as these came up and access to care was cited as a reason, opthalmologists maintained and conducted 47 satellite clinics throughout the state. That number is now 54. Those 54 clinics are within 30 miles of 99.5 percent of all Nebraskans and are open a total of 790 days. That's an average of 14 days per clinic per year or one clinic every four weeks. We already heard from an optometrist who herself drives 40 miles to get to her clinic. There are places in Nebraska we must admit--I'm diverting a bit--the nature of our state is such that there are and will always be those people who choose to live a good distance from a lot of things they need, including groceries and gasoline, far more than 30 or 40 miles. That's their choice, and that's the nature of our state. Ninety-one percent of the available clinic time, I might add, in those clinics are currently being used. The two bills before you specify hours of training beyond optometry and support the request for this scope. I am appreciative of the fact that, along with everybody else in medicine, optometric education has improved and expanded over the years. It happens with all of us. But there are those who have not been recently graduated in optometry that obviously would need some help. And I assume that that's where the additional training comes in. And that total training amounts to 28 hours. That's less than a week of training compared to any kind of a residency in ophthalmology, which can take four to eight years. That's beyond medical school. The NMA recognizes the intricate and the delicate nature of the eye. One of the first speakers for proponents used the word intricate. The eye is very intricate and very delicate. And it has a functional relationship with the rest of the body, both in diagnostics and in treatment. The eye does not exist in isolation. Eye problems and the treatment of eye problems have implications throughout the body, its parts, its systems. This must be appreciated, understood, and considered before treating most diagnoses. The medical background is important. The bills ask for certification if such certification has already been granted by another state. Are we to allow or accept another state's certification process? Ophthalmologists meet national standards through their written examinations, they pass national boards, and they pass national board certifying exams, not the state next door. All this is pretty much old hat for me, perhaps more so than anyone on the committee because I've been doing this for almost three decades. And the...my previous experience has been primarily with the nurse anesthetists, but the parallels are very obvious. Nonphysician-healthcare providers of all sorts have and will continue to seek expansion of their care by legislation, whereas physicians have done it by education. For physicians, it's a long, hard, and very expensive road to competence. There is no other road to competence when it comes to the health and medicine. No legislature should be a short cut because, ultimately, it is the patients who may end up being shorted. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Doctor. [LB526 LB527]

CHARLES GREGORIUS: I'd be happy to answer any questions if possible. [LB526 LB527]

SENATOR CAMPBELL: Are there any questions? Senator Gloor. [LB526 LB527]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you, Dr. Gregorius. You were very conciliatory in your comments. I'm not surprised since you were the past president of the NMA--I'm sure that came in handy there with the issues--and by reputation. But you made a comment here that I want to ask about. Minor emergencies are being covered by optometrists, family practice, and emergency medical physicians. And you covered some specific examples. Anything more serious needs an ophthalmologist. But can family practitioners and emergency medical physicians--most of whom are family practice or general practice or perhaps specialists in trauma medicine--but can those M.D.s do all the procedures and prescribe all the medications that are described in these two bills? [LB526 LB527]

CHARLES GREGORIUS: The ones that are mentioned in these bills are things that family practitioners and emergency medicine physicians are trained in. And beyond those that are specified then, I include those in emergency conditions that probably need a specialist. Another thing that was mentioned was, we in medicine have unlimited abilities to do whatever we want if we have an M.D. behind our name. I can practice anesthesia. I can't set bones; I can't operate on the brain; I'm certainly not going to go anywhere near an eye. I do my level best to protect it when under anesthesia. But we are very much limited in what we do, not by the state, but by the credentialing that we have to have in our various hospitals. The other thing was mentioned about getting into access, and that was interpretive procedures, language interpretation. I was president of the county medical society, I have also been president of the NMA, and one of the things that we deal with a lot in medicine is the mandate that we provide interpretative services for all our patients. So I don't know where that came from, the fact that we don't do that and, therefore, for the non-English speaking patient that we would not be available. [LB526 LB527]

SENATOR GLOOR: But you've got a comment that no Legislature should be a shortcut. And I agree and, in fact, spent time trying to change the 407 process to, hopefully, make it less likely that the Legislature would be a shortcut. But this isn't 407. [LB526 LB527]

CHARLES GREGORIUS: No. [LB526 LB527]

SENATOR GLOOR: Currently, I believe, this is in 407. [LB526 LB527]

CHARLES GREGORIUS: Uh-huh, right. [LB526 LB527]

SENATOR GLOOR: These...this is being...if the 407 process came back and allowed or

recommended both of these, would you be supportive of what that review through the 407 said or does the 407 results not... [LB526 LB527]

CHARLES GREGORIUS: I've been through a 407 process a number of times, but now the 407 process is different. And, quite frankly, I'm not familiar enough to answer that question. I think the question needs to be asked...reviewed. We've heard about what their educational background is now. How long has it been that way? What about those who did not have that education the way it is now? And what do they need to do to make up for it? And is that education now sufficient in the minds of those on the 407 process to come up with a recommendation that, yes, they can do this. Well, maybe they can do these things, but not that thing. The process I think is better than putting it before the whole Legislature. That's why we have a 407 process. [LB526 LB527]

SENATOR GLOOR: Amen. [LB526 LB527]

CHARLES GREGORIUS: And so I'd have to see what they had to say, I'd have to review the...and I'm sure the NMA would also review the testimony before the 407 committee. [LB526 LB527]

SENATOR GLOOR: Okay, thank you. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Dr. Gregorius. [LB526 LB527]

CHARLES GREGORIUS: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next opponent? Good afternoon. [LB526 LB527]

JOHN PETERS: (Exhibits 33 and 34) Good afternoon, folks. My name is John Peters, I'm an ophthalmologist in a solo private practice in Omaha where I've been practicing for nearly 20 years. My training includes medical school at Creighton University School of Medicine, an internship in internal medicine at St. Joseph Hospital, and three years of ophthalmology residency at the University of Nebraska Medical Center. And then I also did a cornea fellowship at the University of Florida. I have also covered trauma call along with my colleagues for the past 20 years, and I've also been teaching residents for that same period of time and continue to do so. I'm speaking to you today in opposition to LB526 and LB527 based upon my personal and professional experience. In 2009, I served on the 407 Technical Review Committee that for roughly six months evaluated LB417, an optometric scope expansion bill. The facets of the bill and the issues surrounding it were discussed in painstaking detail. And the legislation was rejected by the review committee, the Board of Health, and the state's medical director. Much of that extensive evaluation is pertinent to these bills as well. During the 407 process, amongst other items I presented data from Oklahoma regarding performance of certain procedures, some of which are similar to those requested in these bills,

optometrists reportedly performing such procedures we found were conspicuously concentrated in the highly populated areas. While access to care in rural areas is always a potential concern, a state with population demographics fairly similar to ours--namely Oklahoma--seemed not to demonstrate a significant increase in access to care over the course of more than a decade after their scope expansion occurred. In contrast, we demonstrated during the 407 review, the coverage of our state with ophthalmology primary and satellite clinics. And those clinics, as mentioned, have now been expanded further despite the continued population shift toward the urban areas in our state. I provided a map of those clinics for you. Additionally, for those eye care emergencies in areas not currently served by a full-time ophthalmology clinic, these cases are addressed by ERs, primary providers, and sometimes optometrists. And those needing further care are referred to us. I can speak from experience. I've seen patients from the far western portions of Nebraska and the western portion of Iowa the same evening, and many of my colleagues do the same. This practice of a continuum of care is utilized in all specialties, and provides the best outcomes for patients, and is overwhelmingly preferred by patients as documented in patient surveys submitted in the 407 review. Despite the failure of LB417 in 2010 and 2011, optometry yet again attempted to pass legislation via LB316 which was very similar to LB417. And that legislation also failed. And so here we are again faced with two bills for optometric scope expansion containing items previously discussed, previously evaluated, and previously rejected. These bills request, among other things, that optometrists be permitted to inject medication into the eyelids as well as drain and excise various eyelid lesions, prescribe oral antiglaucoma medications, prednisone, and immunosuppressants. Optometry states that they will provide their own training. It appears from what we can tell, this will simply be a relatively brief, one-time course. Please compare this to the training of the ophthalmologist who learns and performs these procedures over the course of three years in their residency with one-on-one supervision and training by an experienced surgeon. That training is deemed requisite by an objective, independent entity, not a board of ophthalmologists. In light of these requests which have been made and were rejected previously, some clinical information is important and some has been mentioned. Most of these eyelid cysts, as mentioned, do not require or respond even to an injection. The vast majority of these lesions are small, they are benign, and are simply observed. For the small number of cases in which intervention is required, complete surgical excision is the usual mode of treatment. And, of course, that requires proper techniques to avoid incomplete excisions, complications, and misdiagnosis. In regard to oral glaucoma medications, these are rarely used or required. As Dr. Palmer had mentioned earlier, I treat hundreds of patients per year, and I use these medications perhaps once every one to two years. When these medications are required, typically they should be seeing an ophthalmologist or glaucoma specialist. Prednisone is a strong anti-inflammatory and immune system suppressing drug with a laundry list of significant and common side effects. Though I have patients referred to me with the eye diseases which require these medications, I typically refer them to physicians with the proper skill and

experience to prescribe the medications. I don't want to be prescribing those things. The rheumatologist or hematologist or oncologist does, and I follow the patient and let them know how the eye is responding or not. Having been directly involved in these issues for more than a decade now, my perspective has actually not changed very much but some things have become readily apparent. In my opinion, it would be far more productive for us to utilize our collective resources--and I mean yours, mine, and optometry's--to actually provide care to patients rather than fighting over patient care in the political and legislative process. I would like to see a more collaborative process amongst all of us. I urge the committee to reject these bills and instead, encourage both sides to work in a collaborative fashion that I'm mentioning and prioritize patient safety. We've talked about the solutions of telemedicine which is being developed as we speak. And the ASCRS, the American Society of Cataract and Refractive Surgeons is now offering a course for optometrists to help integrate them into the healthcare team further. Are there any questions? [LB526 LB527]

SENATOR CAMPBELL: Thank you, Dr. Peters. Seeing no questions, thanks for coming today. [LB526 LB527]

JOHN PETERS: Thank you very much. [LB526 LB527]

SENATOR CAMPBELL: Our next opponent? [LB526 LB527]

ANNA STAGNER: Hello. [LB526 LB527]

SENATOR CAMPBELL: Good afternoon. [LB526 LB527]

ANNA STAGNER: (Exhibits 35 and 36) My name is Dr. Anna Stagner, that's A-n-n-a S-t-a-g-n-e-r. I'm currently finishing the third of my four years of ophthalmology residency at the University of Nebraska. My comments today are made as a private citizen and a medical doctor. Being in the midst of completing the rigorous requirements mandated to practice as an ophthalmologist, I feel qualified to share my experience and the value of all of its components with you today. And I appreciate the opportunity to do so. As physicians in training, we start by spending four years in medical school--as you've heard--studying in a very stepwise manner the workings of each system of the human body, the interactions among these systems from the basic processes at the cellular level to disease states and how best to treat these. We dedicate months of learning to the complex pharmacology that one must know in order to correctly prescribe drugs that affect all organ systems in the body, despite their attempted target of only one. After this foundation has been laid, we then begin to apply this to the care of actual patients, rotating through the various fields of medicine and caring for patients under the direction of experienced clinicians. After successful completion of medical school, including extensive serial examinations that are overseen by a national board, one must complete a one-year internship in a field such as internal medicine or general

surgery. This is an extremely challenging year as one...also of one densely packed with learning. I was responsible for the diagnostic and therapeutic management of very complex patients in a hospital setting, including intensive care, emergency care. The breadth of disease that I saw firsthand during that year provided me knowledge and experience that can really be gained in no other way. I used many medications to treat these patients and learned to handle the sometimes toxic side effects of these medications. I cared for extremely critical ill patients, learned to treat conditions such as heart disease, stroke, autoimmune disease, diabetes, liver and gastrointestinal diseases, sepsis, infectious disease, and performed procedures during that year under the guidance of more senior physicians. It is because of this laborious year in addition to the clinical years in medical school that I'm able to look at the patient as a whole and comfortably prescribe the medications that I do. The following three years of training after this year in medical school focus specifically on the anatomy, physiology, disease states, and medical and surgical treatment of the eye as it relates to the health of the entire body. In addition to the thousands of patients with eye disease we see in the clinical setting, during a quarter to a half of our time in training we are also on call for ocular emergencies and inpatient hospital consults. Experience with these serious conditions is critical and provides exposure to situations that would not otherwise be encountered in an eye-care clinic setting. We begin to spend time in the operating room early on during the three years of residency training. Under the direction of staff ophthalmologists, we begin to perform parts of surgical procedures, building up our skills over years to complete them independently. This includes intraocular surgery, surgery of the eyelids and surrounding tissues, as well as laser surgery. During this time, we are also practicing in a laboratory setting over years with animal eyes and simulators to refine these surgical skills. We simultaneously learn to care for patients both before and after any surgical process, which is equally important as the procedure itself. For examples, prior to performing surgery, one must be aware of a patient's medications, such as blood thinners, and when it is appropriate to alter or discontinue these, and what the ramification of these changes may be. National guidelines are in place governing the amount of surgery a resident must perform entirely on his or her own, under the direct supervision of an attending ophthalmologist. An ophthalmologist in training must participate in 364 surgical procedures. An average UNMC resident performs 646 with additional laser procedures as well. This amount of practice is necessary to be able to manage the unpredictable situations and complications that are inevitably encountered during procedural medicine of any kind. We also participate in didactic teaching, case conferences, research regarding advancement of patient care, and education of medical students and other residents in various fields. We are held to an extremely high standard, as we should be, as those caring for the sight organ. From medical school through residency and licensing, there are national governing boards that enforce standards that all medical students, residency programs, and practicing ophthalmologists must conform to. I hope this description of my medical training allows you to see how ophthalmologists come to be qualified to prescribe the dangerous medications they do and manage complex medical and surgical patients. Ultimately,

everyone in this room and everyone I know who went into medicine or optometry wants what's best for patients. And I work with outstanding optometrists who are a critical piece in providing eye care, and they provide services that I will not provide. However, the training process and scope of practice is different. And the process to becoming a safe, competent, effective physician is long and arduous, but necessary for the safety of the public and cannot be replaced with legislation. [LB526 LB527]

SENATOR CAMPBELL: Thank you for your testimony. [LB526 LB527]

ANNA STAGNER: Any questions? [LB526 LB527]

SENATOR CAMPBELL: Any questions? Good luck with the rest of your residency. [LB526 LB527]

ANNA STAGNER: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next opponent? Good afternoon. [LB526 LB527]

WILLIAM R. PALMER: (Exhibit 37) Good afternoon. Chairman Campbell and other distinguished members of the Health and Human Services Committee, my name is Bill Palmer, William, W-i-l-l-i-a-m, Palmer, P-a-l-m-e-r. No relation to Dr. Millicent Palmer who I've never met before. And I'm here to speak as a rheumatologist requested by the NMA, but on behalf of patients in Nebraska who I feel could be potentially harmed based on some language included in the bill LB527. I'm a native Nebraskan through Lincoln County, North Platte area, educated in Nebraska for medical school and college. Spent five years away, came back as Omaha's first practicing rheumatologist 35 years ago almost. I've worked at the Medical Center and been an adjunct professor there, both part-time and now a volunteer and have participated in the education of residents, interns, and even rheumatology fellows. In the 35 years I've been here, it's been my privilege to educate many of the people here who practice in a variety of fields. A rheumatologist is an internal medicine physician subspecialist. My initial training is three years in internal medicine and two years of specialized rheumatology training. And it is a discipline that deals with a variety of diseases, many of which have basis in either inflammation or autoimmunity. And of most of the health professionals here in the room, I know probably the least about the eye, but I do know about immunosuppressive drugs and corticosteroids. I'm board certified in both, and my statements here are regarding concern I have in some of the language in LB527. Specifically, the ability to prescribe oral steroids, and even more vaguely stated, oral immunosuppressive agents, none of which are named specifically. Oral steroids is a term used to describe corticosteroids, one of the many...one of the drugs in the steroid family. These are synthetically engineered medications at this time, which can strongly suppress the body's immune system, could be used acutely, intermittently, and long term. And if they're used in high doses long term, the side effects are proportionate to the dose and duration of

treatment. And these are drugs that have to be used carefully because they have some potentially serious side effects including infection and whatever. I've enclosed for you a Mayo Clinic patient information handout that we frequently give to our patients who we use these drugs in. Specifically, prednisone which is the most prevalent. As far as the category of oral immunosuppressive, these are drugs that have a real propensity for serious side effects, not the least of which can be infections. If used long enough, some of them can cause malignancies and even as a result, death. Consequently, when you use these agents, you must know exactly what you're treating. You must know what the other accompanying conditions are because these agents can be quite beneficial--almost a double-edged sword--they can be quite beneficial. Even though you want to take care of the condition in the eye, an inflammatory condition--as the young resident said--you have to think what's it doing to the rest of the body. Many of these drugs mentioned here, methotrexate, azathioprine, and cyclophosphamide are also included in those handouts from my American College of Rheumatology. These drugs are systemic. Currently, optometrists can use drugs topically. Well, there's very little systemic effect of topical drug application. But when you use something orally or injectable, it becomes systemic. It means it can affect other organ systems, and it can have serious consequence. Inflammatory eye disease is usually associated with a lot of the diseases that I deal with, systemic lupus, inflammatory myopathy, it could be other diseases including infection. It could turn around and use these medicines in somebody that has an infection you can have potential serious side effects. You also have to have an understanding of the rest of the body. That's why they come to us, hematologists and immunologists when they want to use these agents because we're trained in internal medicine. It's adult medical specialty that we have to understand their coronary artery disease, we have to understand this disease, that disease, and whatever. And many of these agents can have serious side effects if combined with other drugs that treat other conditions. And I'm not certain that the optometrists, with all due respect, have that kind of that education that they would want to use these drugs solely without assistance. And the way this language is worded in this bill suggests you can do whatever you want. And it's true. I'm licensed to do...be a...do physician and surgery, but I don't do surgery. Why? Because I shouldn't do surgery. And until people have the background that they can do things individually, whether they're...no matter what their field of activity, I think the wording has to be more specific and things have to be more specifically stated as to what agents, duration, and things like this. [LB526 LB527]

SENATOR CAMPBELL: Dr. Palmer, we're pretty close to the end here. [LB526 LB527]

WILLIAM R. PALMER: Okay. I'm...I've got one statement. Thirty-five years, I've never seen an ophthalmologist in our community that has used these agents without the aid of another specialist such as myself. And, therefore, I would respect that you not approve this bill based upon the language that's included regarding oral immunosuppressants and oral steroid therapy. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Dr. Palmer. [LB526 LB527]

WILLIAM R. PALMER: Any questions? I'd be happy to answer any you have. [LB526 LB527]

SENATOR CAMPBELL: Any questions? Thank you. [LB526 LB527]

WILLIAM R. PALMER: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Our next opponent? And I believe this is the last opponent or did I miss a...anyone else? Okay. Good afternoon. [LB526 LB527]

SCOTT DeBATES: Good afternoon, Senator Campbell, other esteemed committee members. I appreciate the opportunity to provide comments in opposition to LB526 and LB527. My name is Scott DeBates, S-c-o-t-t D-e-B-a-t-e-s. I'm a dermatologist practicing in Omaha and the president of the Nebraska Dermatology Society which represents over 40 dermatologists throughout Nebraska. Much of today's testimony weighs on the merits of medical and surgical eye care and those individuals who provide it. On one side, we can consider the accessibility of care. On the other side, we reflect on provider competence, quality of treatment, and patient safety. I wish to comment on the aspects of the bill that pertain to the practice of medicine and dermatology. LB526 and LB527 would include in the scope of practice of an optometrist the injection of pharmaceutical agents into the eyelid for treatment of cysts or infected or inflamed glands of the eyelids. LB526 would also include the performance of procedures not often required for the treatment of cysts or infected or inflamed glands of the eyelids. The medical training of a dermatologist to appropriately identify or diagnose or implement a plan of care and then actually perform these procedures is significant. After four years of medical school, dermatologists enter into a four-year residency including one year of general practice. As you've heard, this training helps to ensure knowledge of the entire patient and helps to ensure patients receive the safest and most appropriate treatment of care. In general, it can be extremely challenging to determine whether a lesion is cancerous or not. In reference to LB526 and LB527, it can be extremely challenging to know if a lesion is merely a cyst or a gland or if, in fact, it is a cancer. If misdiagnosed, skin cancer--as you well know--melanomas in particular, but there's other types as well, can be fatal. For these reasons and more, it's critical that patients are treated along a proper continuum of care. Under current scope of practice laws in place in Nebraska, if an optometrist believes advanced treatment to be necessary, that patient is referred on to an ophthalmologist, dermatologist, surgeon, or other practitioner who is more thoroughly versed in the practice of medicine. Ophthalmologists have extensive medical education and training. The Nebraska Dermatology Society asks that you recognize the medical and surgical training, education, and skills of specialty physicians, including dermatologists and ophthalmologists, by opposing this inappropriate scope of practice expansion for

optometrists. Thank you for the opportunity to share these concerns with the committee today. [LB526 LB527]

SENATOR CAMPBELL: Thank you, Doctor. Any questions? Thanks for coming and your testimony. [LB526 LB527]

SCOTT DeBATES: Thank you. [LB526 LB527]

SENATOR CAMPBELL: Anyone else in opposition? Anyone in a neutral position? Senator Howard? [LB526 LB527]

SENATOR HOWARD: May I close from here? [LB526 LB527]

SENATOR CAMPBELL: Sure, that's fine. [LB526 LB527]

SENATOR HOWARD: Thank you. I just want to thank the committee for bearing with me on this afternoon on our last committee hearing and just to reemphasize that we do plan on holding the bill until next session after they've undergone their 407 review process. I would like to speak to access just for a moment. I work at a health clinic, and we have a vision clinic in-house run by optometrists. And our patients see an ophthalmologist, if they can get in, once a month on a Thursday afternoon from 1:00 to 5:00, and that's it. And so I think there is an access issue that needs to be addressed here. But I also think that this might dovetail nicely with the work of LR22 as well. So I look forward to working with the committee on this bill, and I thank you so much for this afternoon. [LB526 LB527]

SENATOR CAMPBELL: Okay. And that concludes our hearings this afternoon. We would ask that you all leave very quietly and take all conversations because we need to see the committee in Executive Session. We need to see you real quickly. (See also Exhibits 38, 39, 40, 41, 42, 43, 44, and 45) [LB526 LB527]