*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

ARCH: Good morning and welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves on my right, starting with Senator Murman.

MURMAN: Hello, I'm Senator Dave Murman and I represent District 38, which is the counties of Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

ARCH: And I'll tell you, we will have other senators joining us and some may be leaving in the middle. Don't be offended. They-- there's other bills that are introducing and, and coming and going, so some of that may happen this morning. Also assisting the committee is one of our legal counsels, T.J. O'Neill, and our committee clerk, Geri Williams, and our committee pages, Sophie and Jordon. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning, we will be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they choose to do so. For those of you who are planning to testify, you'll find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use the light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last names. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today. Please see the new public hearing protocols on the HHS Committee's webpage on

nebraskalegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bill before us today. Due to social-distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. And I'm going to modify this just a little bit this morning for this first bill because we have several opponents in the hall and we can't hold them in the room at the same time. So we're going to have proponents, obviously, first and if you, if you would like to, after proponents, you can leave and then we will allow our opponents to come into the room and, and it'll just make it better for seating. Not kicking you out. If you choose to stay, you are welcome to stay, but it, it would, it would provide some additional room for the opponents to come in. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. This committee has a strict no-props policy. With that, we will begin today's hearing with LB516-- sorry, LB637 and, and Senator Vargas, you're welcome to open.

VARGAS: Good morning, Chairman Arch, members of the Health and Human Services Committee. For the record, my name is Tony Vargas, T-o-n-y V-a-r-g-a-s. I represent District 7 and the communities of downtown and south Omaha here in our Nebraska Legislature. Now I want to start off first by recognizing that LB637 has rung some alarm bells. My office has received a lot of questions about this bill from people all over the state and from many senators' offices. I know that all of you received a lot of communication from folks as well. Now we have public health directors and other experts here to provide some context to this bill and to talk about why they feel these necessary-- these changes are necessary, so I hope you will get all your questions answered and leave this hearing with clarity. Very simply, I introduced this bill because-- not only at the request of Nebraska public health directors, but because, because what I've seen across our state and our country and what I think is an opportunity and a response to the challenges that they have faced-- public health

directors and our public health agencies have faced over the last year as they've attempted to do their jobs and protect the public and the public health of the public-- of our communities amidst the global pandemic. Now before we get into those challenges, I think it would be helpful to provide a brief history of public health in our state. Now previous to 2001, public health was a piecemeal approach, with some counties or cities having public health departments or advisory boards and many others without. But in 2001, the Nebraska Health Care Funding Act was enacted by our Legislature and 16 new multi-county public health departments were created. Now as a result, all Nebraska counties become covered by a local health department. However, this also led to overlapping and multiple layers of public health authorities and that's part of what has led us here today. When the pandemic hit us last spring, public health officials and medical experts told us all that you needed to do-- actions we needed to take to stop the spread, but here's the crux of the issue. Under our laws, they weren't allowed to issue the directed health measures that were necessary and medically indicated to protect the most vulnerable in our communities and to stop the spread of COVID-19. Under our laws, directed health measures from public health departments are required to be approved by the state and unfortunately, even though all the scientific and medical evidence and data supports the directed health measures that our public health departments wanted to issue, they were not approved and therefore not enacted. The reasons they were not approved are purely political. I introduced this bill because I believe that decisions about public health should be made by the experts in the field, especially the localized experts, the public health directors, doctors, and scientists, and not by politicians and that's what this bill really boils down to. We have public health directors and other experts here who can answer all your questions about our state's public health infrastructure and the challenges that they have faced over the last year. The only other thing that I want to share is I think we've seen across the state-- you know, we've had some better times of recent with our cases and thankfully, we have a vaccine, but there was a period of time where there was a real sound of alarm across our state. Our hospitalization numbers were growing up dramatically, exponentially. At one point, we were really concerned about long-term health capacity or hospital capacity and our healthcare infrastructure and it seemed to happen at a alarming rate. And we had a lot of data to support that if there were-- communities were able to put in their own directed health measures at an earlier

point, directed health measures that may have been somewhat less restrictive to many people, maybe-- more than likely, we would have been able to slow the surge and the spread. And I'm not just saying that as likely. We can point to enough data and research that shows that measures put in place, localized measures, have had a significant impact on the spread and surge of cases across the country. But the problem that we have in front of us is that our public health departments and officials and scientists and experts in these fields cannot make these decisions without the approval of the state. And if we were able to do that, I just imagine maybe we'd be able to have gotten the spread under control in different areas, potentially slow not only the case numbers and the surge, also be able to then help with some of the dramatic impact we've seen on businesses and communities. But a lot of that wait-and-see approach and that holdout we have seen across the country hasn't worked. I'm thankful that some time last year, in the later part of the year, localized cities were starting to put in some health measures, but it was, it was a little too late. I say that on behalf of the families that had individuals that are hospitalized or people that lost loved ones like myself. There's no amount of collateral damage that's OK amidst the pandemic. And so we have the ability to save more lives at a local level by making sure our public health experts have the tools they need to better protect individuals amidst the pandemic and that's what this is about. Thank you very much and I'm happy to answer any questions. And there will be others following me that are county health department, public health experts to be able to answer other questions.

ARCH: Thank you. Are there other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator Vargas. One thing I would like to hear about from you or others that are going to follow you is the expertise level in these areas and who is making these decisions from the public health departments and, you know, their membership on their board and, and where that level is. I'd also like to be sure that I understand how this fits with what a local community may want to do through city ordinance or something like that that they would choose to do and maybe you can address that piece under your legislation.

VARGAS: Yep, I will, I will actually ask, in terms of the expertise, some of the county health departments that are here to speak, to speak to that. One thing that I will say that if you-- already seeing in

law, we have structures in law that do enable elected officials and, and/or committees of elected officials and subject matter experts and doctors to then come together to also make these-- the-- have the ability to make these sort of public health directive decisions. That is already in statute and we made-- we didn't change those. All we're simply really doing is going to be expanding it so that the directed-- the public health directors and their agencies have the ability to put in directed health measures, but I will leave part of that to some of the people coming in, in--

WILLIAMS: Thank you.

VARGAS: --as proponents.

ARCH: Thank you. Other questions? I guess just to clarify, the way this bill is written, who-- and maybe there's-- maybe this is a multiple answer. Who has final authority to put the DHM in place? Would the public official, the, the public health official have the authority to put a DHM in place?

VARGAS: A public health official-- so when you say final authority, that's-- I don't want to necessarily address final authority, but right now, public health officials don't have the authority until they have approval from the state--

ARCH: Right, I'm--

VARGAS: --and that's the solution that we're trying-- that's the problem that we're trying to solve with this bill.

ARCH: So, so with this bill, the public health official would have the authority to put a DHM in place. Would cities also have the authority to put a DHM in place?

VARGAS: Cities and, and/or the board of health that they can create still have the authority to put measures in place.

ARCH: OK, so this-- OK, all right-- because we learned a lot, obviously, during this process and realize cities did have authority. They did exercise authority. Now we're talking about the public health officials themselves and they also would have authority.

VARGAS: Yeah.

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ARCH: I understand. Thank you.

VARGAS: Thank you.

ARCH: Any other questions? Seeing none, thank you very much.

VARGAS: Thank you very much.

ARCH: I'm assuming you'll stay to close?

VARGAS: Yes.

ARCH: OK, thank you. First proponent for LB637. Good morning.

ADI POUR: Good morning, senators. I'm Adi Pour and I'm director of the Douglas County Health Department and I'm also the president of Friends, which is an organization where all the local health directors belong to. First, I would like to thank Senator Vargas for introducing LB637. I'm thankful to have a senator actually who really goes to fight for public health.

ARCH: Excuse me, just to sec, could you please spell your name?

ADI POUR: It's A-d-i P-o-u-r. We have learned a lot over the last 12 months and so often, laws are not studied clearly until a situation arises. Let me tell you what happened in Omaha. As the county health director, I created a directed health measure as soon as we saw that the spread of COVID was in the community at this time. Transmission occurred there. That was the first and the only DHM that I was able to put in place. We get this information from our contact tracing, from our epidemiologists that we have internally in the department. I have a senior epidemiologist, an M.D., and that type of information is really only available if you look into cases and that goes a little bit to your question about the expertise that local public health have, yet look-- as, as I told you before, then the next DHM was done by the state, DHHS, together with the Governor's Office. Yes, we did have some input, but very limited input in those DHMs. The Governor's Office, not even the chief medical officer, called me the night before and informed me that the local health director does not have the authority to implement a mandatory public health measure for Douglas County, but that this would require the approval of the chief medical officer who, at this time, is Dr. Anthone. Dr. Anthone wasn't going to give me the authority. He wasn't going to give me the approval. This

created a lot of confusion, especially in Omaha, and what we were able to do is the city council has ordinance power and they were able to put an ordinance in place in regards to a mask mandate, for example. But as you know, ordinances have their own processes. It took three weeks, three readings until actually the mandate could put in place. In our-- so and since then, which is even more, we had to extend the mandate two additional times because every time when they do a public health ordinance, they have to put a final date on it and they now already have to project how long should we do this? When should we expand this again? And so it is very cumbersome and some of the city council members have told me-- have said, you know, local public health has failed us. That's not what we are about at the city council. We do not understand these local public health issues. You may also hear today that the-- a DHM should be applicable for the entire state. This may not always be the case, since rural and urban areas are different and may have different infectious disease outbreaks and I'm giving you an example. In the early 2000s, we had an active case of TB in Douglas County. The person was not willing to isolate, was not willing to go under direct observed therapy until I put an order in place. And at that time, I had a very close relationship with the chief medical officer at the state. I was able to call her quickly, she gave me the authority, and she said I approve of it and I was able to put in the order. But this should not depend on the person. It should actually give the authority, therefore, to the local level. In summary, we saw that the law that, as written, is not protective of public health at the local level, but it's dependent on politics. Nebraska has a decentralized system. You may hear that too. We are different in Iowa, where everything goes back to the state health and human services. Here, really the authority lies with local public health and their board of health. And so I encourage you, as lawmakers, to give the authority in public health emergencies to where it should be placed, with the local health departments and its board of health. This would prevent undue delay based on allowing local health departments to act quickly. It would also prevent inaction in targeted communities. That's kind of my, my plea to you today. I would like to-- if you'd let me, Senator, let me get-- on the board of health, by statute, we have to have M.D.s on the board of health. So in Omaha, we go through the Metro Omaha Medical Society. We ask them to provide us an individual to be on the board of health. By statute, we need to have a dentist on the board of health. By statute, we need to have a representative of an elected office, county commissioner in

our case, but in our case, we also have a city council member on our board of health. So it is not a local health director who is making this decision by themselves, but it is with all the board of health members together.

ARCH: Thank you.

ADI POUR: Thank you.

ARCH: Are there questions? Seeing none, thank you very much.

ADI POUR: Thank you.

ARCH: Thank you for coming to testify. Next proponent for LB637.

TANA FYE: Good morning, senators. My name is Tana Fye, spelled T-a-n-a F-y-e. I'm an attorney at Fye Law Office in Holdrege, Nebraska, and I serve as legal counsel for Two Rivers Public Health Department and Southwest Nebraska Public Health Department, which collectively cover 15 counties in south-central to southwestern Nebraska. I can't tell you anything about infection rates, positivity rates, or some of the other things that other people here testifying today can tell you about. What I can tell you about is the current state of the law in Nebraska regarding public health departments, directed health measures, why we need some of the statutes changed, and how LB637 fixes some of the problems that we discovered during the COVID pandemic. Our current status, public health departments are created by statutes, either single county or through interlocal agreements between multiple counties. Their authority, therefore, is derived from county powers. The public health departments are controlled by boards of health made up of members of the county boards, citizen members that are appointed by those county boards, as well as subject matter experts. And I'll let some of the later testifiers tell you a little bit about those experts and what their expertise exactly is. For public health departments to enact directed health measures, they must first enact regulations. Those regulations have to be approved by each of the county boards as well as by the state. Most, if not all, of the public health departments, prior to the pandemic, had those regulations in place and believed themselves to be ready to move forward with directed health measures should they be necessary. In March of 2020, the Department of Health and Human Services issued basically an opinion that the public health departments needed to have

memorandums of understanding in place with each of the municipalities in their, in their district for those DHMs to therefore be enforceable within city limits due to the inherent authority of city governments to enact measures to control infectious disease. Essentially, what that meant is that then all of the public health departments had to reach out to the municipalities in their district. In the case of Two Rivers Public Health Department specifically, that's over 50 municipalities to try to get that authority so that there would be uniform enforceability of those directed health measures across the district. Two Rivers did, in fact, do that. I was involved in that effort. Some of those municipalities enacted the memorandum of understanding. Some did not. Some refused to bring it to a vote. Some passed it and then later rescinded it. And so what you end up with is a patchwork of memorandums of understanding between the public health departments and the cities. That also then consequently means a patchwork of enforceability of local directed health measures, which is a problem. In addition, directed health measures, as you, you've heard, have to be approved by the state chief medical officer. So in effect, under their current statutory scheme, one political appointee can unilaterally hold up the decision that's made by a local public health department that serves the interests of multiple communities. LB637-- I want to talk about this because I think you're going to hear later testimony about how this is an overreach of government power and I don't believe that's the case. LB637 doesn't create any new powers for any government entity, just none. Instead, it reallocates government powers that are already delegated from the state to local governments, reallocates the power so that the public health departments can do exactly what they're designed to do, which is control the spread of infectious disease and also ensures that there are subject matter expertise that goes into those decisions. Quite frankly, the cities don't have staff that are essentially tasked with dealing with these kinds of issues. They don't have doctors. They don't have dentists. They don't have veterinarians on staff. Public health departments do have all of those folks either employed by the public health department as staff or on the board of health and so all of those people would have input into those situations. Under the United States Constitution, as I'm sure you know, all of those powers that are not specifically retained by the federal government are delegated to the state and the state can therefore delegate it to lower levels of government. What we're talking about here today are simply those state powers that existing statute had given to city and

county governments and reallocating exactly how that power division works between those two entities. As I view it, LB637 really is a clean-up bill. It cleans up the situation so that cities and counties no longer have these overlapping powers with questions of who ultimately has jurisdiction to enact what's necessary. And I think as you'll, you'll hear some additional testimony, in a lot of these situations, the municipalities don't want to get involved in this. They would rather have the public health departments do it. We also then, of course, have situations where some cities are refusing to act and then the state is forced into the situation of enacting statewide directed health measures because there are no local entities that either can do it or can do it uniformly across a district. Ultimately, I think that there's an additional piece that I just want to mention here, that if there's a concern about the constitutionality of directed health measures being enacted by a public health department, there's a procedure laid out in the regulations for each of the direct-- the public health departments that allows for those to be challenged through the process set aside in the regulations, as well as to then be challenged in court. In court, those directed health measures would be--

ARCH: I'lI have to ask you to wrap it up, please.

TANA FYE: --sure-- would be reviewed by the courts to determine whether they pass constitutional muster. And in the vast majority of these situations, they would be reviewed under rational basis scrutiny and likely would pass the constitutional challenge. So in conclusion, I see this as a clean-up bill. The problems that we discovered during the pandemic with our, our current statutory scheme, we just can't allow to continue in the future since we now know that these are problems.

ARCH: Thank you.

TANA FYE: I'm happy to take any questions that any of you have.

ARCH: Are there any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you for being here. You talked about the-- I, I want to under-- be clear in understanding the relationship between a directed health measure and the memorandum of understanding that in your case with Two Rivers, you would have

with over 50 communities. If we passed LB637 and then Two Rivers had the ability to issue a directed health measure, how does that work in conjunction with any of the memorandums of understanding that you have with communities or do you even need to have those at that point?

TANA FYE: I think at that point, you no longer need to have a memorandum of understanding with any of the, the municipalities. In those situations--

WILLIAMS: So the directed health measure, if it were enacted by Two Rivers, it would apply to the geographic boundaries of Two Rivers and every community would fall under--

TANA FYE: Correct.

WILLIAMS: --needing to comply with those directed health measures.

TANA FYE: Correct. It would be applied uniformly across the district rather than just in the rural areas outside of those municipalities.

WILLIAMS: All right. I just wanted to be sure I understood that correctly. Thank you.

ARCH: Thank you. Senator Murman.

MURMAN: Thank you, Senator Arch and thanks for testifying. I have a question that if LB637 is not passed, right now, you mentioned your directed health measure would have to be approved by a municipality and then later you mentioned counties. If a county would approve the directed health measure and the city does not, how, how would that work?

TANA FYE: So let me clarify. So the counties have delegated their public health authority to the public health departments through the interlocal agreement. So counties no longer are under any obligation to just act through the county boards in and of themselves. They've delegated their authority to the public health departments. Cities have currently, under the, the current code, the ability to enact any ordinances that they wish to deal with the spread of infectious disease. So under some of the city ordinances, at least-- I'm going to talk specifically within the Two Rivers district. Some of those city codes talk about how they have an obligation to work with the public health department. Some do not, so you'll see in some situations,

going back to the mask mandate as an example, where you have some city councils who have chosen to bring that up, have passed it, some who have-- will not bring it up for a vote, some who voted on it and, and decided not to pass it. So I think-- I'm hoping I'm answering your question. If I'm not, please, please tell me. So I think in these situations where you don't have any kind of agreement that the public health department can act and cover the boundaries of that city, of that municipality, you just basically have a situation where then the public health department can enact a directed health measure because it would have unequal application across the district. So then you end up with a situation where then the state basically has to come in and say here's the directed health measure that will cover everybody. So I hope that answers your question. If not, please tell me.

MURMAN: Well, I'm wondering about a county in relation to a city or municipality.

TANA FYE: OK.

MURMAN: Yeah.

TANA FYE: So the county, the counties and the city don't have an interlocal agreement per se. The cities can have their own board of health that are made up of typically, like, the mayor, chief administrator of the city, sometimes a doctor, sometimes chief of police, those sorts of folks. So it's a much smaller organization, but it's basically separate. So the city process is separate from the county process, which is the public health department.

MURMAN: Thank you.

TANA FYE: Does that help? OK.

ARCH: One, one other question.

TANA FYE: Sure.

ARCH: Would this in any way change any authority that the state government would have for a statewide DHM?

TANA FYE: No, the state would still have the authority to enact a statewide directed health measure--

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ARCH: OK.

TANA FYE: --even with the passage of LB637.

ARCH: Thank you. Any other questions? Seeing none, thank you very much.

TANA FYE: Thank you.

ARCH: Next proponent for LB637.

TERESA ANDERSON: Good morning, senators. My name is Teresa Anderson, T-e-r-e-s-a A-n-d-e-r-s-o-n, and I am the health director at Central District Health Department for the past 18 years. Our office is in Grand Island, but we cover Hall, Hamilton, and Merrick Counties and we thank you very much for considering LB637. It's very important to, to us and to the citizens of Nebraska. I would like to tell you a story that pretty much lets you know in practice how all of this kind of muddled process actually plays out and it is fairly muddled. So I'm going to take you on a trip. Remember last-- a time trip. Last March-- I'm going to take you back in time for a minute and tell you a story about Central District Health Department and COVID-19. Grand Island, as you may recall, was quickly becoming Nebraska's first hot spot for the pandemic and it hit very hard in our district. We had two positive cases that were not related to each other, hadn't been around each other. Neither one had traveled, so we knew immediately that we had community spread. The next day, we had our first death from COVID, so it hit us really fast. On March 27, I wanted to issue a directed health measure because we've been able, as Dr. Pour said, to get that approval from the chief medical officer and found out that I could not get it, so I submitted our first DHM to DHHS to sign off on. Three days later, he did sign off. The chief medical officer did sign off on March 30, I think, because he realized the severity of our situation. The virus spread very quickly and our hospitals were flooded. We had positives in three long-term care facilities, which is a very bad sign. So on April 2 then, three, four days later-- maybe, yeah-- I sent an email to DHHS as follows. We need help here. Our numbers are growing too fast. We have over 10 percent of the total cases in the state. Can we get a message to the Governor requesting a shelter in place order? Physicians and hospitals are going to reach capacity very quickly if we don't slow down. That request was made as I'm hearing from my physicians and from the hospitals saying, oh, we've got

problems here. We need to do something immediately. Around 1:00 p.m. that same day, I followed up with this. The attached DHM built on the previous DHM and closes parks, but keeps trails open. It closes salons as well. We have been getting feedback requesting the closure of salons. We have met with city administration and law enforcement and we all agree that this step is in order. At about 5:00 p.m., I send additional reminder and at this time, you know, we're just feeling like our hands are totally tied. On April 4, around 9:00 a.m., I sent this. I am again requesting assistance. Last evening, ten of our 33 lab-confirmed cases are JBS meatpacking plant employees. Our providers estimate ten times that many have been diagnosed clinically. We have done everything possible to get voluntary compliance on work modification to reduce the spread within the meatpacking industry. We need stronger action, request your assistance. We have got to take measures now to flatten our rapidly rising curve in the central district. There is a saying that all public health is local. We take our responsibilities very seriously and we know that time is of the essence in preventing the spread of disease. DHHS did eventually respond, but what we learned is that the current process is extremely cumbersome and inefficient. It decreases our effectiveness. We are unable to respond in a timely fashion. We miss opportunities to mitigate spread of disease while we wait for permission to practice public health. Now fast forward with me to November of this last year, we were headed for another surge, as you recall. Our positivity rate was 44 percent, meaning 44 out of every 100 cases that we tested were positive. We had 826 positives in one week, which is huge for us, even worse than what we had the previous spring. CDC's updated guidance stated that masks worn properly and universally work well to prevent the spread of COVID-19. Knowing the Governor's stand on masks, we worked with the city of Grand Island and we had to form a city health board and on that city health board was me and our medical consultant for the health department, the mayor, chief of police, and city administrator. But we had to do that in order to take the recommendation for the central district to that health board, the city health board, to get it to the city council for approval. And we were able to get an emergency ordinance passed with a February 23 sunset date and we know that similar ordinances were passed at that time in Kearney and Hastings. Now on February 9, we had support from UNMC, Creighton College of Medicine, as well as a letter signed by over 150 area physicians, healthcare providers, and nurses recommending the extension of that February 23 deadline to the end of school. We know

that when we can do that, we can protect the community better if people in the schools are wearing masks, people in the community are wearing masks.

ARCH: I'm going to need to ask you to wrap up your testimony.

TERESA ANDERSON: Oh, sorry. OK, so I just want to end this with the mayor said that's not our responsibility. That's your responsibility. City council said that's not us. That's on you. And so what we know is that our hands are completely tied. We can hardly take action. The, the ordinance will sunset next week.

ARCH: Thank you. Are there any questions? Senator Walz.

WALZ: Thank you, Senator Arch. Thanks for coming today. I, I want to go back to the emails that you sent and just more specific on-- can you clarify DHHS?

TERESA ANDERSON: OK, so when I started with the first email-- and DHHS is always evolving, so who you send it to changes over time. I started out with Sue Medinger with that first email, "Ccing" Dr. Safranek, who was there in DHHS as-- I'm not sure what his capacity was, but he's been the one that we've been working with-- and Dr. Anthone as well, saying we need to have this.

WALZ: OK. All right, thank you.

TERESA ANDERSON: Yes.

ARCH: Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you for being here. I'd like to go back to quickly again who is on your board, but then more importantly, after that, would you take me through what you would expect the process to be of how the board would analyze whether to implement a directed health measure?

TERESA ANDERSON: So our board, again, by statute, is composed of a physician, a dentist, a-- and, and, and every community is a little bit different. Because we are partners with Grand Island and Aurora, we have city council members from there. We have one county board member from each of our three counties. We have a public-spirited individual from each county and we also have a minority

representative. When-- if we were to take this, say it was for us to decide, then I would again consult the experts, as we always do, at CDC, University Med Center, and Creighton, and ask what their opinions are, along with our local physicians. We have really strong working relationships with our local physicians and hospitals. We would again, as we did before, talk to law enforcement, talk to city administrators, and try to get it all squared away. Like, are we doing what you think we should be doing? We're not going to get total consensus, but we'll do our very best to at least be informed on what the community wants. Then we take it to our board and say this is what we need to do. Do we have your approval to do it? And we discuss it. If we need to bring in some expert testimony, we would do that, but it's a, it's a process that we can lay out very systematically and not a lot different from what the state's doing, except that when I said all public health is local, any time we ask the state or need to have their participation, we can count on a week delay. And in the middle of a pandemic, we have learned that that's too long to have to wait.

WILLIAMS: Thank you. That's helpful.

TERESA ANDERSON: Thank you.

ARCH: Thank you. Any other questions? Seeing none, thank you very much.

TERESA ANDERSON: Thank you for your time.

ARCH: Next proponent for LB367.

JEREMY ESCHLIMAN: Good morning, Senator Arch, fellow senators on the Health and Human Services Committee. My name is Jeremy Eschliman, J-e-r-e-m-y E-s-c-h-l-i-m-a-n, and I'm the health director at Two Rivers Public Health Department, including population centers in Kearney, Lexington, Holdrege. We cover seven counties in south-central Nebraska. I'm here today to testify in support of LB637 to change provisions related to control of contagious disease and want to thank Senator Vargas for presenting this bill and thank their-- thank really the committee, the Health and Human Services committee, over last year just providing tremendous support. I think we can all agree this is a year we want to have behind us in so many ways. The, the current local public health infrastructure was created in 2002 with the intent of providing public health access, local public health department

services for all counties in Nebraska. As district health departments were formed, the boards of health were formed. Health directors were hired according to state statute. Governance and authority is local and the system is decentralized. And to really get to Senator Williams, your questions as far as expertise on the, on the board-- so as I feel my colleagues have mentioned, it's required to have a physician. It's required to have a dentist. It's required to have county commissioners and supervisors from each county we're in, in addition to county-appointed, public-spirited individuals. Let me talk a lot more about the expertise within the staff. Most public health departments have significant expertise as far as nurses, microbiologists, environmental health specialists, dental hygienists, epidemiologists. We're fortunate, through the pandemic, been able to bring on an epidemiologist, a Ph.D. in public health. So it's-- those decisions that were being made are being made with the very best of science in so many ways. In addition to-- at Two Rivers, we have a veterinarian on our board. We have a mid-- mid-level practitioner, which is a physician assistant, and a minority health representative. Those are additions beyond state statute, what our, our Two Rivers public board has, so-- by statute, the local public health already centralizes, as I mentioned, from the Department of Human Services, with local governance and authority and are responsible for carrying out within the counties, within the jurisdictions that we have, the three core functions of public health, the ten essential services, and as Ms. Fye had mentioned, regulation of, of contagious disease. And so we know these are tried and true public health measures. We've seen that play out through the pandemic. So as we can all agree, when-- just last year, quarantine, isolation, close contact have really became household topics in so many ways. Beyond behind the scenes, those are things that public health-- we've always done, we've always known, and for those of us working in public health, this challenge this last year, while initially daunting, became a trepidation as local public health control of disease was supplanted by state mandates or the lack thereof, as we've seen in Nebraska. While these locally designed and state-approved contagious disease regulations have been in place in many instances since-- in our case in Two Rivers since 2006, where county boards have approved that. As-- and as you, as you have heard, they do require the state chief medical officer's signature prior to enacting them every time. According to our regulations in Two Rivers, the health director, in consultation with the board physician, can develop and promote directed health measures

to protect the public's health and that's exactly what we did this last year. In April-- on April 2 and April 5, we, we promoted directed health measures. We presented that to DHHS. They were approved. We presented again on the 9th and it was crickets, didn't hear anything, and then after prodding multiple times, we're told that the Governor's Office was not going to approve it, so-- and just to be clear, the state chief medical officer is a gubernatorial appointee. Furthermore, as the politics vacillate over the use of face coverings, research and science was clear. Local-level policies on face coverings were needed to protect the public's health to control this new strain of coronavirus. While the idea promulgated by local public health departments in concurrence with some of our best experts in this region, the University of Nebraska's Global Center for Health Security, and the CDC, the answer was clear. There would be no health-- no local health department directed health measures instituting mask mandates approved by the state, state chief medical officers. While many of us, especially those in the local public health, apply evidence-based practices and rely on the science-- scientific basis, it's really in our DNA. We commonly work in partnerships with all entities within our communities. With-- we work with cities all the time and honestly, through the enactment of the directed health measures in our district, I had conversations with the city of Lex manager, the mayor in, in Lex, the mayor in Kearney, the city council in Kearney. That's commonly what we do. We're in our communities all the time. While the admin to a directed health measure via local health permits was unattainable, we did what we do best. We worked within our communities to find alternative solutions. In our district, in Two Rivers, we held community forums to discuss this. What are the options cities want to take? Do they want to go down that route? Do they not? And we really found that to be a, a really piecemeal approach in, in a lot of ways, but the end solution was city-level policies instituting mask mandates. While this alternative solution seems ideal, driving decisions down to the lowest level of government is quite the opposite: inefficient, burdensome, and ineffective.

ARCH: I'm going to need to ask--

JEREMY ESCHLIMAN: So while a mask mandate could have originally been--

ARCH: Excuse me. I'm, I'm going to need to ask you to wrap up.

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JEREMY ESCHLIMAN: OK. Yep, thank you. I just have one more sentence. As more than one city council representative said to me, why are we deciding these things at the city council level when we have little technical knowledge and experience, while local public health department has-- is the technical expert in this area? Thank you.

ARCH: Thank you. Questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Jeremy, for being here. And, and I'd like to publicly thank you for all the work you've done in my legislative district with those mayors that you talked about and, and all of those things. If we were to pass LB637, how do you see the different public health departments working together? I see some differences geographically in our state. We've got public health areas that have a significant population. We've got other public health areas that are in the less-populated areas. Can you just talk generally about how you would see that coordinating?

JEREMY ESCHLIMAN: Sure and we saw this early on. Behind the scenes, we're communicating all the time with my colleagues. I mean, that's just part of what we do very well in public health is collaborate. Whether you're in Lincoln, you're in Omaha, you're in Kearney or Scottsbluff, we're talking about the same types of issues. And what's really unique about public health is our environments are so different and so the ways applied can be quite different than Lincoln or Omaha than it is in Kearney or Gothenburg or Scottsbluff. And so with this particular instance where we saw hotspots initially-- we saw those arise in Grand Island. We saw that in Lexington. Quite honestly, those are areas we should have applied directed health measures quite early to really contain this. We were unfortunate in the fact that in early summer, when most of the state was pretty quiet, in Kearney, we had a really-- a budding epidemic and that's really what caused the epidemic through our whole area, really tracing that back to college-age adults-- is what we saw that would spread of the disease. Did I answer your question, Senator?

ARCH: Thank you. Senator Murman.

MURMAN: Thank you, Senator Arch, and thank you for coming in, Jeremy. I, too, would like to publicly thank you. I know it's been a thankless job, what you've been doing, especially the last year or so, and, and it's really been tough. I have questions also. A little more-- kind of

has to do with geography. If LB637 would pass, could the health department have a directed health measure that would only affect, like, say, for instance, a, a city in the district like Kearney or Holdrege and not be effective for the rural areas of the district or the smaller towns?

JEREMY ESCHLIMAN: You know, that's a great question. I probably have to defer to an attorney on the specifics of how that would work. My understanding, at least-- and it's preliminary at this point-- on the way the directed health measures work when it's a large-scale disease, it's across the district. But I guess it, it really would be getting into the fine print of how a bill is written, what the intent is, and it would make sense in some ways, if you look at the spread of disease. That, that's one of the serious concerns we had early on. Do we look at the focus of within a county, within our district? And honestly, a lot of what we've done, we've looked at from a district lens because we have people that travel so much from Kearney to Holdrege to Lexington and even several of my team members. And so to somehow say, for example, that Lexington-- we really want to isolate that-- or Dawson County-- in a lot of ways is a little bit erroneous because we just have the human nature that people travel a lot. And so with contagious diseases, very tough to just limit it to a very small geography.

MURMAN: Thank you.

JEREMY ESCHLIMAN: Thank you.

ARCH: Other questions? Senator Hansen.

B. HANSEN: I also would like to echo a thank you for everything that you do here and I know you got your hands full with anything that's going on and so--

JEREMY ESCHLIMAN: Thank you.

B. HANSEN: --I just-- be remiss if I didn't say that and I don't mean-- some of my questions to make it sound like I don't appreciate what you do. Some of my questions are more about the consequences or unintended consequences we do as a Legislature that allows certain people to make certain decisions on behalf of constituents, right? So I think that's where some of this kind of pertains to. And so one of

the things you kind of closed with is somebody said why do city council-- why should city councils make decisions instead of public health, local boards of public health? And so-- and I just had a kind of question about that. Are, are local boards of health elected or are they typically appointed?

JEREMY ESCHLIMAN: So-- great question, Senator Hansen. So according to state statute currently, boards of health for-- at least for-- I'll talk for Two Rivers. I know it varies a little bit across Nebraska, but they're comprised of both elected officials-- approximately half of the board is elected. Approximately about the other half is appointed by county boards.

B. HANSEN: Um-hum. OK and so I think that's what kind of rub is at with me, right? Like, I always appreciated the idea of elected officials, all elected officials, like a city council making decisions on the behalf of their constituents with getting their information from people who understand the science, people who understand the consequences of, of actions-- like a board of health, right? So the board of health advises the representatives of the people and that's-- then you have a meeting and then that's how you have the best decision. So that's where my kind of hesitancy is a little bit with some of this, is that we're kind of going around that a little bit and going more to elected and also appointed officials, just like the same way I have issues with having executive orders from our government, you know, as opposed to having more localized decisions with stuff like this, which I think it was the intent of some of this as well. And so that's where I just wanted to clarify a little bit and ask you some of those questions as well. So I appreciate you coming here and answering a lot of questions for us, though, too.

JEREMY ESCHLIMAN: Yeah, thank you. And, and one thing just to add with the, the board of health, at least the way, the way it functions for us at Two Rivers, whether elected official, whether appointed by the county boards, our board really comes to consensus on so many topics and so they, they have vigorous debate, but at the end of the day, it-- they do come to a consensus on most major ideas.

B. HANSEN: Sure. All right, thank you.

JEREMY ESCHLIMAN: Thank you.

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ARCH: Any other questions? Seeing none, thank you very much for your testimony.

JEREMY ESCHLIMAN: Thank you.

***JASON HAYES:** Good morning, Senator Arch, and members of the Health and Human Services Committee. For the record, I am Jason Hayes, Director of Government Relations for the Nebraska State Education Association. NSEA supports LB637 and thanks Senator Vargas for introducing this bill and for his advocacy during the pandemic. We are extremely proud of the work school employees across this state have done to keep our students learning and our schools open as much as is safely possible during this most difficult last year. Once all accounting has been completed, we are confident Nebraska will post of the highest student attendance rates in the nation during this pandemic. When that happens, it will be because of the yeoman's work completed by school staff across our state. Teachers, paraprofessionals, school secretaries, custodians, bus drivers, cafeteria workers - there is no question that all have done extraordinary work. Unfortunately, many times their jobs were made more difficult by incomplete or inaccurate health information and by the fact that not every school district was diligent in following health directives. We heard often from staff who feared for their health because their school districts were not accurately reporting cases, utilizing mitigation procedures to slow the virus spread, or conducting appropriate contract tracing. This problem was exacerbated by public health districts whose decision-making hands were tied as they needed approval from the state Department of Health and Human Services to investigate and adopt measures to slow the spread of COVID-19 in their communities. We believe this experience shows that it is clearly in the best interest of all Nebraskans to decentralize the decision-making process and allow local public health districts the authority to manage the local responses to health emergencies in their communities and issue their own locally appropriate Directed Health Measures. These local authorities are in the best situation to see first-hand how quickly situations are escalating and are nimble enough to institute measures that are in the best interest of public health and safety in their area. The NSEA, on behalf of our 28,000 members across the state, asks you to advance LB637 to General File for consideration by the full body. Thank you.

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ARCH: Next proponent for LB637. OK, I don't see any other proponents, so we're going to allow the opponents to come into the room at this time and if you would like to exit, the exit is on the left-- my left, excuse me, your right. Are you from the department?

ASHLEY NEWMYER: I am, yes.

ARCH: Yes, I think we would like you to testify first.

ASHLEY NEWMYER: OK.

ARCH: So if you could please come as an opponent.

ASHLEY NEWMYER: Absolutely.

ARCH: Welcome.

ASHLEY NEWMYER: Thank you, Senator.

ARCH: You may proceed.

ASHLEY NEWMYER: OK, good morning, Chairperson Arch and members of the Health and Human Services Committee. My name is Ashley Newmeyer, A-s-h-l-e-y N-e-w-m-y-e-r, and I am the chief data strategist for the Department of Health and Human Services. I'm here to testify in opposition to LB637, which removes DHHS's authority to control infectious diseases and directed health measures. LB637 eliminates the Department of Health and Human Services' ability to review and approve directed health measures prior to being enacted by local health departments. While responding to the coronavirus pandemic, we have seen that a cohesive response strategy is key to stopping the spread of the virus and keeping Nebraskans safe and healthy. If LB637 is enacted, it would be impossible for the state to coordinate a united front on any statewide health emergency. If passed, LB637 would enable individual health districts to enact their own directed health measures to control transmission of infectious disease. Health districts could enact health measures that are more restrictive than a state-issued directive or enact health measures that are less restrictive than a state-issued directive. With a large-scale emergency like the current COVID-19 pandemic, inconsistent approaches to preventing disease transmission could be devastating to Nebraskans. Viruses and infectious diseases like COVID-19 do not recognize county lines. Therefore, it is critical that we utilize a statewide approach

to respond. LB637 would prevent the state of Nebraska from utilizing this approach during future pandemics, limiting our ability to prevent the spread of disease and keep Nebraskans safe and healthy. We respectfully request that the committee not advance this legislation. Thank you for the opportunity to testify today and I would be happy to answer any questions.

ARCH: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you. So you're saying then that LB637 takes away the ability to offer a statewide directed health measure?

ASHLEY NEWMYER: No, let me clarify. So it would still allow--

WILLIAMS: I want to make sure that--

ASHLEY NEWMYER: Thank you. It would still allow for a statewide directed health measure. However, it would create some inconsistencies. For example, if LB637 is passed, a local health district could enact their DHM and then the state DHHS could also enact a DHM and so you would run into inconsistencies. One could be more or less restrictive than the other. Local law enforcement or county law enforcement would have to determine which one are we enforcing? And so it creates-- it would also create ultimately confusion for the public. Which one are they supposed to abide by? And the intent of directed health measures is to impact the health behavior of people, you know, so they, they know what precautions they need to take. That requires very consistent messaging to the public, you know, affecting health behavior. Often they say you-- a person has to hear that message, you know, seven or more times in order for them to retain it and know what they, they are supposed to do. And so I think that that is, that is the key point of our argument, is that we want to make sure that we have a consistent message, a consistent approach for how we respond to this pandemic and future pandemics and so that's the point that we want to get-- make, make.

WILLIAMS: Thank, thank you.

ARCH: Thank you. Senator Cavanaugh.

M. CAVANAUGH: That was my question.

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ARCH: Oh, that was your question? OK. Senator Walz.

WALZ: Thank you. Thanks for coming today. So you talked about consistency and the ability to have a statewide unified plan. That does not offer then any flexibility for, let's say Lexington to, to come up with their own plan as opposed to somebody in Omaha? When it's statewide, it's statewide and there's no flexibility?

ASHLEY NEWMYER: So I think it is dependent on the scenario. So for example, with, with our current COVID-19, I think that we have needed to have a consistent statewide approach. I think for some of the other infectious diseases that were mentioned earlier, if it is a more localized outbreak and it is not something that, you know, pre-COVID--- it's, it's tuberculosis or, or, or some other infectious disease, there is still that current flexibility for us to approve a local DHM if that scenario-- if it's an appropriate thing for that scenario.

WALZ: OK, but was COVID-- say that again with-- regarding COVID?

ASHLEY NEWMYER: Yeah, so regarding COVID, I think because it is-- because coronavirus has been such a widespread virus, we have really needed a statewide, consistent approach in order to, to manage and, and mitigate the spread. And another example I would give is that, you know, we have really tried to protect our hospital capacity and so in order to do so, we need consistent-- maybe restrictions. I mean, earlier on in the fall, we had some restrictions on our hospitals as to if they could do elective procedures. If so, in one instance, they needed to have 10 percent of their additional capacity in order to perform those elective procedures. And so if we are not able to leverage our entire statewide healthcare system because there's different restrictions on hospitals in this area versus different restrictions on hospitals in this area, I think that puts us at a disadvantage to prevent the transmission.

WALZ: What is the communication like between your department and the local public health direct-- offices? Because to me it sounds like there's a lot of good communication, so what you're explaining, you know, regarding hospital capacity, I kind of felt like that's already happening with--

ASHLEY NEWMYER: It--

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WALZ: --communication, so--

ASHLEY NEWMYER: It--

WALZ: --I'm still having a hard time understanding the problem with making sure that there is a consistent-- everybody's on the same page because--

ASHLEY NEWMYER: Yes.

WALZ: --I kind of feel like they are on the same page--

ASHLEY NEWMYER: Yes.

WALZ: --as far as communication.

ASHLEY NEWMYER: Yeah, so we have very frequent communication with the local health directors. We have-- currently, we have twice-a-week calls with them. In the spring and throughout the summer and really into the fall, it was a daily meeting, a daily conference call that we had with all of the health directors at the department and, and all of those health directors. So it's very frequent communication. You know, with our current vaccination efforts, it's even additional communication. So we have kind of a, a, a leadership team that meets with them and then we will have these specific, you know, vaccination teams that meets with their vaccination teams. So it's more than twice a week that we are meeting with their staff or, or the directors. It is a lot of, a lot of communication between us.

WALZ: Right, yeah. All right, thank you.

ASHLEY NEWMYER: Yeah. You're welcome.

ARCH: Any other questions? Seeing none, thank you for your testimony.

ASHLEY NEWMYER: OK. Thank you, senators.

ARCH: Is there another proponent in the room? Yes, there is. Please come forward.

B. HANSEN: Opponent.

WALZ: Opponent.

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ARCH: Oh, I'm sorry. Opponent.

CHRISTY ABRAHAM: Senator Arch and members of the Health Committee, my name is Christy Abraham, C-h-r-i-s-t-y A-b-r-a-h-a-m. I'm here representing the League of Nebraska Municipalities and I want to start by saying we certainly appreciate Senator Vargas' commitment to public health and to keep-- keeping people safe. And we are grateful that he's introduced this bill, but we respectfully need to oppose this bill. LB637 may do a lot of good things, but it outright repeals authority for municipalities so we cannot support it. The authority to help prevent the control and spread of contagious diseases has been in statute as an authority for municipalities for decades and decades. And what this bill does is for certain classes of cities, it just outright repeals that authority. And for first-class cities, not only does it outright repeal that authority, it also eliminates their own board of health. And what I think it's important to know is municipalities use their-- and I know there's a lot of board of health terms, so I will try to call them the municipal board of health. They are used for things other than pandemics. They've been used for years on nuisance abatement. So not anything obviously as detrimental as the COVID pandemic has been, but if there is a cesspool or if there's standing water, these municipal board of health deal with those types of situations as well. So we certainly appreciate the intent of this bill and we certainly look forward to our municipalities having a more close relationship with the local public health district. So when they're making decisions about public health, they have that relationship-- that they have that, that relationship so they can get, as Senator Hansen said, sort of get that authority to make those decisions. And we are happy to work with this committee and Senator Vargas on that, but as written, we cannot support this bill. So I'm happy to answer any questions you might have.

ARCH: Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. So we heard Dr. Pour testify that the city of Omaha didn't want to have this authority. They wanted her to have the authority.

CHRISTY ABRAHAM: Yes, yes and I, and I heard that from other-- of the local health districts as well, that you had city councils sort of indicating wow, you have the expertise. We want you to do that. And I certainly appreciate that there are instances of that, but the league

can't ever support a bill where it's outright repealing authority that municipalities have had for decades. So we need to come in here, oppose this bill, but certainly, Senator Cavanaugh, we are most happy to work with this committee and Senator Vargas to come to a more workable solution to this.

M. CAVANAUGH: OK, thank you.

CHRISTY ABRAHAM: You're welcome.

ARCH: Senator Hansen.

B. HANSEN: Thank you. You kind of-- you, you brought something up that kind of perked my ears a little bit. So I'm always thinking of this as like contagious diseases such as COVID, so are there other instances where maybe, like, the local board of health can, like, override a municipality or a city council for other kinds of things like-- maybe that's not a contagious disease? Because I, I don't know if-- I think in the bill, he specifically put contagious disease, but are there other things that maybe this can relate to?

CHRISTY ABRAHAM: That's a great question. And, and I apologize, I'm not as familiar with the, the local public health districts that you've heard support this bill. When I referred to the municipal board of health, they are given quite explicit authority to deal with things like privies, water closets, cesspools, cisterns. I mean, they're dealing with all sorts of things that aren't necessarily contagious diseases. And so when this bill outright repeals a municipal board of health, it's really taking away that municipality's ability to deal with these other nuisances that they deal with on a more day-to-day basis.

B. HANSEN: OK and can I ask one more question?

CHRISTY ABRAHAM: Of course.

B. HANSEN: And I probably shouldn't ask it, but would this allow a local board of health to mandate and-- mandate people in a-- and they're in their district-- to get a vaccine? So they decided they thought that was great and they mandated it. Could they do-- do they have the authority to do that?

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CHRISTY ABRAHAM: Senator Hansen, you are asking such a good question and I think that might be even beyond the authority of the local public health districts. I think that's more of an employment law issue about whether you can force people to have vaccines. And I apologize, I'm not an expert on this, so I better not answer it.

B. HANSEN: That's fine and I don't want to say it too loud. I don't want to open up Pandora's box, but that is the question I think I, I have to ask, along-- you know, because it's an interest of mine, so--

CHRISTY ABRAHAM: Yeah, I-- yes.

B. HANSEN: Thank you, appreciate it.

CHRISTY ABRAHAM: No, thank you, Senator Hansen. I appreciate it.

ARCH: Any other questions? Seeing none, thank you very much.

CHRISTY ABRAHAM: Thank you so much. I appreciate your time.

ARCH: Is there anybody else who would like to testify in opposition? OK, we're going to take a pause here and we'll allow other opponents to come into the room. I just want to make a, a couple of statements. One is that this is, this is opponent testimony we're on now. We are, we are going to have a light system up front here. For those of you that have not testified here before, when that light hits red, I'm going to ask you to stop. I mean, we, we want to make sure that everybody gets a chance that wants to speak. We have other bills this morning to hear as well and so we'll move, we'll move it as expeditiously as possible. There is a five-minute limit on testimony, your testimony. Senators will have an opportunity to ask you questions after the red light comes on. There may, there may or may not be questions, but we would ask you to stop at that point so that everybody can have a chance to speak. And with that, we will ask for the first opponent that would like to speak.

ROBERT BORER: Good morning, members of the committee. My name is Robert Borer, B-o-r-e-r. Medical malpractice went from being the third-leading cause of death this past year to being the first. Big Pharma, medical tyranny via constant fear mongering was and still is the cause of the pandemic. I explain that in my correspondence to you this morning. We don't need more of it. We don't need more medical tyranny with this bill. Local public health experts aren't health

experts. They are political pawns. The fact that pandemic rules aren't consistent from one city and state to the next testifies to the arbitrary and political health nature of public health expert edicts. Why do politicians insist on treating us like children? Why is it so hard for you to keep your oath and follow the Constitution? There is no emergency exception clause in the Constitution to our inherent and inalienable rights as Judge Stickman so grace-- gracefully and wisely articulated in his Pennsylvania case in the-- mid, mid last year. There is no infectious disease exception clause in the Constitution to our inherent and inalienable rights. There's no public health expert edict exception clause in the Constitution to our inherent and inalienable rights. With 27 years of emergency medical technician experience, I have been in close proximity to many patients with the conditions referenced in state statute as infectious. Not one of these patients ever infected me. I was never worried about any of them infecting me. Neither HIV nor anything else ever concerned me. I was never afraid of germs and I never wore a mask. Fear-filled providers do not make for good providers. I took the same approach from day one of this current "scamdemic" and I haven't had a sniffle since it started. Despite being 62-- that is, I'm in Big Pharma's alleged high-risk category-- and traveling widely-- since June, I've been to Florida and back, Wisconsin and back, Colorado and back, Missouri and back. I've traveled extensively and socialized extensively and I've never worn a mask and I haven't had a sniffle all year. I want to know where your boogie man is. Big Pharma medicine is germophobia religion. Health doesn't come from fearing germs. Nobody wants me healthy more than I want me healthy. I'm a free and independent person. Give me the facts and let me make my own decisions. Thank you. Any questions?

ARCH: Thank you. Are there any questions? I see none. Thank you very much for your testimony. Next opponent. Welcome.

MARY HAMILTON: Mary Hamilton, M-a-r-y H-a-m-i-l-t-o-n. Chairman Vargas [SIC] and members of the Health and Human Services Committee, my name is Mary Hamilton. I'm here representing myself in opposition to LB637. I thought about not coming down here today and sitting here hours so you could hear my testimony. I also thought about how much time I would spend writing up this testimony, but then I thought about my children and my grandchildren. I know how important this topic is to me because of what we have gone through this past year. Frankly, I cannot believe that we are having to address this issue because of what we have seen in-- with unelected appointed people such as Pat

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Lopez, who has given the authority to close down certain businesses, schools, churches, and many other important events in our lives with unending deadlines and with no concern for the harm this has done to many lives and livelihoods of the people they serve. This was all done with the premise of an emergency. While emergency does not create power, emergency may furnish the occasion for the exercise of power. Quarantine is when you restrict the liberty of people who aren't sick. Tyranny is when you restrict the liberty of people who are healthy. I am totally opposed to giving any kind of jurisdiction to a division of government to control our lives any further and impose impossible mandates for eternity. When the threat level went down, we were and are-- and still under these draconian rules with no end in sight. The biggest threat we face now is mandatory vaccines. If our bodies are not protected by the Constitution, then what is? I am referring to what Fauci said about wanting all-- to have all Americans vaccinated, conflating public health with security rather than focusing on well-established measures for protecting the lives and health of Americans. Policymakers have recently embraced an approach that views public health policy through the prism of national security and law enforcement. This model assumes that we must trade liberty for security. As a result, instead of helping individuals and communities through education and provision of healthcare, today's pandemic prevention focuses on taking aggressive, coercive actions against not only those who are sick, but also the healthy. This is when people, rather than the disease become the enemy, therefore giving local public health departments authority over these health-related issues in LB637-- it is giving these nonelected officials too much power to impose the restrictions on the public without any input from the public and therefore usurping their legislative authority and this cannot be allowed. And also, I might add that I'm a school teacher. I have been in the school system for a long time and I'm 62 years old. I have never, ever been afraid of the children giving me any kind of disease or any kind of illness and I am very healthy. I take good care of myself. Of course, I get the flu once in a while. I get colds, but I don't let that stop me from living. Thank you.

ARCH: Thank you for your testimony. Seeing no questions, thank you very much.

MARY HAMILTON: Uh-huh, thank you.

ARCH: Next opponent. Good morning.

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RAEGAN HAIN: Good morning, senators. My name is Raegan Hain, R-a-e-g-a-n, last name, Hain, H-a-i-n. I'd like to thank you for taking the time to listen to us this morning. The last time I was here, I was much more tearful. I'm much more collected today, not that this bill doesn't affect us anymore than the other did. I'm here today to echo what has been said by the previous opponents to this bill, but I also would like to state that each city should have the right to choose what mandates or regulations should be placed on their individual communities. Each city or town should be able to follow their own guidelines based on the population and the people that are within that community. The health departments have been given so much control already and they don't even follow their own health directives. Case in point, I am willing to share with you I live within the Four Corners Health Department. My children were quarantined after I was exposed and tested positive for COVID-19. My son had already been quarantined two months prior and was home from school for ten days as a result of that. He did not have any symptoms, but he was exposed to a child at his lunch table who also didn't have symptoms, but had tested because his-- he had had a parent who tested positive. So at this time, my child-- my son has been quarantined two times within this last school year and I can tell you that that is a detriment to his education and it is also a detriment to my employment because I do not have childcare for them that is readily available, so I was forced to take time off of work. I too work in the school systems. I'm an occupational therapist and I serve children with special needs. My daughter, who's here with me today-- they don't have school-- when I was quarantined, my son was quarantined. She was quarantined as well. They were going to require that she be quarantined from school for one month. And I'd like to explain this to you based on the recommendations that were made by Four Corners Health District at that time. Because I had tested positive on a Tuesday, my son was then taken in to be tested as well on a Thursday. My daughter, who had symptoms, but did not test positive, she was given a different date for return to school, which was two weeks after the date that my son could return to school, which would have been an entire month that she would have been out of, out of school. She's a first-grader. My children are twins. The recommendation was also made not only that we isolate my son and myself from the rest of my family because we tested positive, but that we should also quarantine my daughter in an isolated room as well. I can tell you I was not going to follow those recommendations or those directions from the health department because

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that is not in the best interests of my children. My son suffers from an anxiety disorder as a result of a car accident that he was in over a year and a half ago. That would have been detrimental to his mental health and the quarantine in itself was detrimental because he was not able to socialize with his friends. The instruction that he was given was in packet form. I am not a teacher. I'm an occupational therapist. I don't know how to teach or instruct my children in that information. I was not able to get on the Zoom visits that were offered at that time. This is information that is coming from our public health department telling us what to do. Because of that, because of what was going on in our family situation, the person in charge of our health department allowed my daughter to return to school earlier than the recommendation because she had not had any symptoms and she had been exposed. She did not follow the directed health-- their directions at that time and allowed my daughter to go back to school earlier because of a situation. That is the way that things should be run and it should be left to our local governments to be able to determine what is in the best interests of our communities. Another point that I'd like to make is that these officials should also be elected. Not all of them are. Many of them are appointed and they should be elected officials. We the people should be able to say I agree with this person being appointed because I believe in what they stand for and I believe that they're going to listen to what's in the best interests of our community. And what are the guidelines that the health departments are going to follow? We've already heard from multiple people in favor of this bill saying that they don't know that and that they can't answer that and that it is going to be a case-by-case basis because you can't give a blanket statement to an entire health district. That's not what's in the best interests of the people. So I strongly encourage you to oppose this bill because there is, there is too much at stake being given to the health departments directly. Thank you.

ARCH: Thank you for your time. Questions?

RAEGAN HAIN: Does anybody have any questions?

ARCH: Seeing none, thank you very much.

RAEGAN HAIN: Thank you.

ARCH: Next opponent.

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ALLIE FRENCH: Hello, my name is Allie French, A-l-l-i-e F-r-e-n-c-h. I am the founder and leader of Nebraskans Against Government Overreach. I am here to represent our extreme opposition to LB637. For nearly a year now, we have been under rule and regulation of the government and public health officials' idea of prevention and quite frankly, it's a tragic failure. We, the individual citizens of this state, get to determine our own prevention and treatment. The medical errors of allopathic medicine is the third-leading cause of death in the United States annually and that's only according to their generous data. We should never blindly follow a profession for which we find out decades later, their methods, recommendations, and procedures and treatments were often not nearly as safe as they claimed. This proposed legislation makes it just that much easier for these misguided and often harmful rules and regulations to be implemented and the citizens to be cut out of the process. If our local government and public health officials want to impose unavoidably unsafe policies and procedures on the general public, then they should be required to jump through every hoop and red tape we can possibly throw at them. They never are forced to prove anything, sometimes even to the extent of being encouraged to blatantly lie to the public. They've successfully manipulated the system to do as they please. They've proven they can force compliance, but we are not going to completely circumvent the checks and balances in the process. Every time we see a bill such as this being driven on the curtail of the COVID-19 pandemic, it has made even more clear why such legislation is dangerous. Our government has proven that in the face of a politically driven emergency, they, local, state, and national, will take advantage to chip away at our civil liberties. This bill needs to be thrown out and rather, we should be limiting the powers of local government and public health officials to permit only recommendations and mandates only under the conditions of unsanitary conditions that pose an imminent public health threat. The only manner under which this proposed legislation would be acceptable-- if it was made clear that they are not law, as law is only made through legislation. Also, I ask that we do not strike out the citizens' advisory health council, as it may be a last hope for the citizens to regain control of their health and lives and to strike it would further prove the true goal of this legislation is about control and not about the health and wellness of the citizens of Nebraska. This bill right here is the fast lane to medical tyranny, socialized healthcare, and communist control.

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WILLIAMS: Thank you, Ms. French. Any questions? Seeing none, thank you for your testimony.

ALLIE FRENCH: Thank you.

WILLIAMS: Invite the next opponent. Welcome.

AMBER WELLS: Hi, my name is Amber Wells, A-m-b-e-r W-e-l-l-s. I am here today to strongly urge you to vote no to LB637. Giving more power to local unelected health department officials only serves to take away the ability of our elected officials to balance our individual freedoms with public safety. Egregious government overreach has been witnessed this year in the form of mask mandates, the closing of our churches and houses of worship, closing of schools, restrictions on the ability to gather and assemble, and dictation of government who is essential enough to work. In short, this bill would allow local health departments, which just listening to the testimony by many of the proponents outside, many of these health department boards are mainly made of the allopathic model. So there are medical providers on there, there are dentists on there, but where are the other health officials that-- you know, where are the chiropractors, where are the naturopaths, where the mental health professionals that are representative of serving the community? So as I was saying, this bill would allow health departments to enact mandates without having to obtain approval from the local government. Unelected health officials will be able to restrict citizens in the name of infectious disease. We are a country of checks and balances and at no point should we allow unelected officials to have "unreined" authority over the people. Again, I request that you vote no to this legislation and I would also like to draw your attention to the Omaha City Council meeting that was, that was on February 2. At the three hour and 39-minute mark, Adi Pour stated on the record that if the leaders of our nation have access to the best scientists and they're making the recommendations, masks or whatever health official-- whatever health recommendations that need to be put into place, who are we to question them? We absolutely have the right to question what mandates and what restrictions are being placed on us. Thank you. Any questions?

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony. Next opponent. Welcome.

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LOREEN REYNANTE: Good morning. Hi, my name is Loreen Reynante, that is L-o-r-e-e-n. I reside in Papillion, Nebraska, and I'm here to--

ARCH: Excuse me, did you spell your last name?

LOREEN REYNANTE: OK, I apologize. It's R-e-y-n-a-n-t-e.

ARCH: Thank you.

LOREEN REYNANTE: I know that's a lot of letters in there. I'm here to ask you to oppose the bill, L-- LB637. So what is public health? The science of protecting the safety and improving the health and communities through education, policymaking, and research for disease and injury prevention. While this proposed bill sounds good on the first read, I can't help but think that this is just another chip at removing the freedoms and liberties of the residents of Nebraska by the state via their local city. This bill will allow cities to unilaterally make decisions by a mostly appointed local board of health individuals without having any checks and balances. Although the local board of health may hold a public meeting, it would end there after the vote. There wouldn't need to be the next step to the city council for proper representation for the, for the residents. The residents need to have their elected officials be involved with any mandates from recommendation from the local board of health. This bill will also remove the need for the Nebraska Department of Health and Human Services to approve any investigation measures of any existence of any contagious or infectious disease. We have processes for a reason and it needs to continue. The words in this bill are very alarming: "to provide county or district health departments with exclusive powers," "eliminate certain local health director powers." That should raise the hair on your arms. I wonder how many small cities around the state have no idea that this bill has been proposed. We need to have people held accountable for any and all decisions that are made regarding all public health ordinances, mandates, or actual laws. Taking the checks and balances away from the people by Nebraska law for every city and county is giving too much power to each respective city and/or county by mostly appointed individuals. Thank you.

ARCH: Thank you. Thank you for your testimony. Any questions? Seeing none, thank you very much. Next opponent. Welcome.

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NICHOLE HRABAN: Hi. My name is Nichole Hraban. It's N-i-c-h-o-l-e H-r-a-b-a-n and I reside in Bellevue. I hope you all are hearing us today-- not being too busy on your computers and listening. I'm here to oppose LB637. Two hundred years ago, Dr. Benjamin Rush, who signed the declaration, warned us that delivery of healthcare could be hijacked by undercover dictatorships. He warned us that these special interest corporations would do anything to maximize their profits. And I would ask you to follow the money. Who got rich? They would use media to censor alternative therapies. Does this sound familiar? If anybody spoke about COVID treatments that didn't meet the wear a mask, use sand-- hand sanitizer, they were silenced. They were censored. This bill gives unlimited restrictive power to the health department who we've heard, you know, is mostly unelected. If we give away our freedoms in the name of emergency, there will always be an emergency. The same people who sell the panic sell the pills. So I come here today to plead with you to vote no to LB637 to ensure our medical liberties and I leave you with this quote. Emergencies have always been the pretext of which safeguards of individual liberties have been eroded. And that was from Friedrich Hayek. Thank you.

ARCH: Thank you. Any questions? Seeing none, thank you very much. Next opponent.

KATHRYN DOLL: Good morning.

ARCH: Good morning.

KATHRYN DOLL: My name is Kathryn Doll, K-a-t-h-r-y-n D-o-l-l. I'm here this morning to strongly oppose LB637. Myself and other Nebraskans can find plenty of help and guidance on a daily basis from our neighbors, churches, hospitals, clinics, community outreach groups, police, fire departments, city council, mayors, county boards, sheriffs, State Patrol, Governor, health and human services, the National Guard, the Department of Homeland Security, and six U.S. military branches to deal with any real or imagined "plandemic." The goal of LB637 is to take away the authority of elected officials and turn it over to nonelected persons. This is unconstitutional, as it goes against we the people's First Amendment right to have our grievances redressed. If I had to describe this bill in one word, it would be nefarious. We need to use discernment. People are not dying in the streets, the hospitals are not overrun, and the morgues are not filled with bodies. Thank you.

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ARCH: Thank you for your testimony. Next opponent.

BRITTANY HOLTMEYER: Hi.

ARCH: Good morning.

BRITTANY HOLTMEYER: Brittany Holtmeyer, B-r-i-t-t-a-n-y H-o-l-t-m-e-y-e-r, and I'm from Papillion, Nebraska. So today I'm here in opposition of LB637. And it's just two weeks, it's just six feet, it's just a mask, it's just nonessential business, it's just six months, it's just church, it's just Easter, it's just school, it's just nonessential travel, it's just Thanksgiving, it's just Christmas, it's just a vaccine, it's just two masks, it's just two vaccines, it's just till 2022, it's just three masks, it's just three vaccines, it's just an anal swab, and it's just a vaccine passport. It's just tyranny. It's just my medical freedoms. It's just insanity and it's just crimes against humanity. Here we are upcoming the year anniversary of the 14-day flattening the curve. Government-- Governor, Governor Ricketts declared an emergency when we had one positive COVID case. We have been to countless city council mandate meetings all throughout Nebraska and we have heard it all. We have heard from the leaders of UNMC. We have heard from Adi Pour, the health director who is no doctor. We have heard from all the paid speakers from UNMC telling us what we can and what we can't do. And let me tell you, I have not complied and I will not comply. To me, it's a conflict, conflict of interest having her husband as one of the top doctors at UNMC. Why not hear out the other doctors in Nebraska that are speaking out? Do they not follow the agenda by speaking truth? If we're going to get these mandates and recommendations from the leaders of our area for all these pandemics, why not get involved with the Boys Town hotline, who is up more than 300 percent right now? Why not make it a pandemic for having Children's Hospital question as to why they have had more than a six-month waitlist for a child psychiatrist? And if this was a pandemic, I'm sure we wouldn't have had a Super Bowl, we wouldn't have Golden Globes, we wouldn't have even kids playing sports. We wouldn't even be going to the grocery stores. So what we need to do is have all these city council members, Adi Pour, and the power leaders held accountable, held accountable for the real pandemic that is taking place. Thanks.

ARCH: Thank you. Thank you for your testimony. Next opponent. Welcome.

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JENNIFER HICKS: Hi, my name is Jennifer Hicks, J-e-n-n-i-f-e-r H-i-c-k-s, and I live in Peru, Nebraska, and this wasn't part of my planned speech, but I do kind of want to point out that I brought my-- I'm a homeschool parent and I brought my kids here to, to get to see what you do today. And I want to point out that even our COVID response has affected that because they had to wait to even get in when there were a couple of dozen, at least, free seats in this room and we're required to be so spaced out that they had to wait to even get a seat. So I just want to point that out. I also want to say that we need to look at who's been guiding us in our COVID response for the past year. The two most prominent people guiding the COVID response are Dr. Fauci, who is listed by Forbes.com as the highest-paid federal employee in the entire U.S. government, and Bill Gates, who is no public health expert, but is currently the third-richest person in the world. This paints a picture of privilege and those who would advocate for so much power to be placed in the hands of a couple of older white men cannot also claim to be proponents of diversity. When the voices of others whom are qualified to advise on public health, many of the women and people of color are silenced and shunned. While this bill may be intended to address local concerns, we have seen that it is guidance from the CDC and Fauci and Gates that has been adopted in even the most rural communities. What we have also seen is that the guidance we've been given so far is often unreliable. Here's what Fauci had to say in September of 2020-- and this is a quote-- in all the history of respiratory-borne viruses of any type, asymptomatic transmission has never been the driver of outbreaks. The driver of outbreaks is always a symptomatic person. In November of 2020, Fauci said in a TV interview, if you look at the data, the spread among children and from children is not really very big at all. So why did we disrupt our children's education the way that we did and why are school kids still in masks all day long? The foremost expert and highest-paid federal employee in the country has, from his very own mouth, emphatically put forth statements that expose much of the COVID response is being rooted in fraud and deception. Fauci's guidance, inconsistent and contradictory as it may be, has been adopted nationwide. From 30 days to stop the spread to flattening the curve to don't wear a mask, no, do wear a mask. Heck, wear two or three. Fauci himself, the leading expert, has told us that in all of history, viral outbreaks were never caused by those who didn't show symptoms. That means that your mask actually doesn't protect me and mine doesn't protect you. So what is this all really about and where does it end?

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The science du jour now tells us that the final solution has arrived in the form of an experimental vaccine that has no long-proven history of safety or effectiveness. We all just need to wait a little longer and keep wearing a mask. And so you can see why many might have concerns with legislation that proposes, quote, "to provide county and district health departments with exclusive powers to control contagious or infectious disease." I will add that the responses I received from Senators Cavanaugh and Hunt didn't lessen my concern that the intent of this bill was to remove some of the oversight and to place far too much power and authority in the hands of boards of health. Senator Cavanaugh's reply stated that the bill, quote, would eliminate the veto power the state of Nebraska currently has over health departments. Senator Hunt also confirmed that the bill would remove currently existing oversight and increase the power of boards of health to issue directed health measures. While this could be expedient and helpful to some communities, it holds far too much potential for abuse by those who seek their guidance only from the rich and the most privileged. So I would respectfully ask that you please vote against the LB637. Thank you.

ARCH: Thank you for your testimony. Next opponent for LB637.

MARILYN GOURE: Hello.

ARCH: Good morning.

MARILYN GOURE: My name is Marilyn Goure. I live in Omaha, Nebraska, and I'm just going to read to you the bill.

ARCH: Could you please, could you please spell your name for us?

MARILYN GOURE: Sure. M-a-r-i-l-y-n G-o-u-r-e.

ARCH: Thank you.

MARILYN GOURE: And I hope you have read the bill. When I read the bill, I was appalled. And this is my first time ever protesting anything. I didn't even know where to park today.

ARCH: That's a challenge, by the way.

MARILYN GOURE: Yes.

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ARCH: Yes.

MARILYN GOURE: And so I am in shock that somebody would put some-- these words down and I just want to know if you know about them. So it's-- right on page 1, it talks about having exclusive powers. Then on-- I'll skip quite a bit of it, but on page 2, it's talking about just five people. One could be a physician if one is found willing to serve, but shall be. It doesn't mean there will be a physician. It just says one should-- shall be one, but only one is a doctor. Really? This is a health problem. This is a health-- and this is supposed to be the-- a bill to regulate health and you're only going to have one health professional? Then it goes on to say on page 2 that-- then, then it goes on to say that, that the majority, which would only then be three people out of those five, can pass-- shall enforce and effect of the law. So you only need three people, not even the doctor-- you only have one doctor that's required-- and you're not even going to say that they would have a say so. You just-- you can vote them right out. And then it goes on to say that they're going to have-- be able to enforce and provide fines and punishment. So these three people who are not doctors are going to be able to enforce fines and punishments? That's just outlandish. What if those three people don't even agree with the doctor? What if the doctor is trying to actually state facts and the truth by his oath that he takes and he don't say well, we don't agree with you and you're voted out. So that's a big problem. Then on page 3, it says the board of health shall also have control of hospitals. Really, you have control of hospitals? You're going to let these three people who are appointed, not voted, control hospitals? Who would put that in here? OK, that is wrong. Then-- OK, later on, it says the "ordinance shall include a procedure for such removal, demotion, or suspension without pay of any police officer." So you're going to now threaten police officers. It sounds like this is threatening police officers. Page-- the rest part of page 3 and page 4 goes on to say that there will be-- and at the bottom, it says pending the hearing authorized in this section. So you're going to threaten police officers with-- that they don't listen to these three appointed people, not people who were voted in, who are not health professionals, most of them. Most of them are not going to be health professionals. They're not qualified, OK? They're not qualified to make these laws that they even want to be making. Then you're going to threaten the police officers if they don't listen to them. So then on page 5, it goes on to talk about again, for village-size communities--

again, the same wording, except they're out-- they're actually breaking that down to just three people. So they went from five to three. Again, if a doctor can be found, not required. Nope, we'll not have a professional, qualified person, just if they can be found. Then it says the board of health shall enforce any such rules and regulations and provide fines and punishments for violations. So now you've got people who just, again, are not qualified. They are being very demanding, very controlling. That's what this statement is. This whole thing is about controlling people and it's only a few people get to do that. Oh, and then-- let's see-- on page 7, it says select the health director of such department who shall be well-trained in public health, though he or she need not be a graduate of an accredited medical school. Boom!

ARCH: I need to ask you to end your testimony. The red light has, the red light has come on.

MARILYN GOURE: OK, well, the rest of it goes on to how they're going to pay these people. Cha-ching, cha-ching, cha-ching--

ARCH: All right.

MARILYN GOURE: --OK?

ARCH: Thank you very much for your testimony.

MARILYN GOURE: You're welcome.

ARCH: Are there any questions? Senator Walz has a question. Please wait. Wait, wait, wait.

MARILYN GOURE: Oh, ding!

ARCH: Wait, Senator Walz has a question.

WALZ: Thanks for coming today. I just have a quick question. It sounds-- you, during your testimony, repeatedly said, you know, there's a lack of doctor, lack of doctor, lack of medical health professional. So I just want to clarify, it sounds like you do value the opinion of a qualified medical health professional or doctors?

MARILYN GOURE: Yes.

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WALZ: Yes. OK, that's all I needed, thanks.

MARILYN GOURE: Oh, you're welcome.

ARCH: All right.

MARILYN GOURE: Any other questions?

ARCH: No other questions. Thank you.

MARILYN GOURE: OK.

ARCH: Next opponent. Seeing no other opponents, is there anyone that would like to testify in a neutral capacity? Seeing no one, Senator Vargas, you are welcome to close. As you are coming up, I would mention that we received one written testimony as a proponent this morning from NSEA and we have received 27 letters on LB637, three proponents and 24 opponents. You're welcome to close.

VARGAS: Thank you, Chairman Arch, members of the Health and Human Services Committee. First, I want to thank everybody for testifying, both proponents and opponents. I've had a lot of nice conversations outside, both before and after. You know, this process, it's-- you know, it's not a hearing-- it's a hearing, but we're not, we're not fact-checking or pressure-checking. It's why I do like that I get to close. I want to-- there's a couple of things I want to make sure that I correct because they're helpful and correct for point of information for yourselves and for those behind me because there was a lot of what I heard from opponents that I do generally support. You know, they're-- I understand some of the concerns people share. The only way that I see, you know, government working overall is when we have this public dialog that exists where we can engage in this. And so there's a couple of things I want to address. The, the first is, you know, some of the opposition we heard is that we're putting power in the hands of unelected officials. I know Senator Hansen, that's one, one of the concerns that you had shared and, and if I'm misunderstanding that, we, we can talk about it, but, but I did hear that from some opposition. Colleagues, I think you all know how many elected officials exist at different levels: ESUs, school boards, city councils, all the way up to the Governor. I also want you to think for a moment how many appointed officials currently exist in state government. How many appointed officials are making decisions at the

state level unilaterally, currently, that have to even do with public health? This isn't a question of whether or not we are putting more power or less power in the hands of an unelected-- right now, there are positions like the chief medical officer that has a unilateral say to make recommendations as an appointed individual on how we approach things as a state and I'm not even touching that. That's still the ability of the state to implement their own directed health measures and the chief medical officer to do, to do these things. I also want you to think in your local municipalities, how many appointed positions have say to make a lot of different decisions. So the argument that we're putting more in the hands of unelected individuals, I want to remind you that we're actually probably putting more balance in place. We-- a direct-- a director of public health would not be able to unilaterally make a decision for a directed health measure. The board of health that exists in each area/region on that map that I shared with you that has both elected officials and appointed people and the public, are the ones that would have to decide with a majority vote on whether or not a directed health measure would have to pass. That actually sounds like probably one of the best hybrids we might be able to get. Instead of having a state unilateral appointed official making a set of recommendations, we actually have a city council person, maybe a county board member, potentially somebody from sort of-- maybe not typically considered an M.D., members of the public that may meet some of the needs that people express, maybe people from different different sides of the health spectrum, you know, beyond osteopathic medicine, right? And, and there's no maximum number of individuals that can be on these boards. These boards are truly local control boards. Members of the public that even testified here can be appointed to these boards. And if they're appointed to these boards, they have a say and they have the ability to vote on it. We're actually empowering them to make-- be part of the decision-making process. I actually think that's probably a better form for something that is both temporary, localized, and, in a period of emergency, probably better than relying on whether or not the state says yes or no. Also, a reminder, each city can still put in place their own ordinances. We're not touching that. A city-- any city that you can think of in any of your areas that you represent can put in place ordinances. We're not touching that. Any county-- and this is kind of getting to Senator Murman's question-- counties currently cannot put in place some sort of a directed health measure on their own. They've, in statute, have sort of abdicated that authority to

public health regions, right, and these public health boards. Public health boards and their directors are the ones that manage those decisions, so that means that a city can still put in place ordinances. A county couldn't because of the way statute currently is and a public health department technically can't either because they have to get approval from the state. And so what we're saying is let's make sure to give them the local control approval so that they don't have to go and get permission from the state. And keep in mind that that county board of health is fairly diverse and is both elected and appointed officials that can include the public. The citizens' advisory health-- I had a really good-- and I'm terrible with names-- good conversation with a couple of people outside and they voiced the opposition to the citizen to removal in the bill of that citizen-- I'm going to make sure I get this right-- it's the citizens' advisory health council. I'm more than happy to work on putting back this language that implements that portion of it. One of the reasons why we took it out is because we thought it might be redundant. If there could be members of the public that are actually on these boards of health, we didn't want to create another mechanism. But if we need another mechanism for input and the voices of the citizens, more than happy to then put that back in as, as another avenue for the public to have some very necessary input to things that are going to affect their lives, so I just want to address that piece as well. As a reminder, some of the things that I heard, which are real concerns-- and I don't necessarily agree with all of these concerns as an individual person, but everybody has the right to say, you know, it was overreach to some extent, some people shared, for closing of large gatherings and churches or "redecreasing" the percentage of individuals in, in let's say restaurant establishments or any other things that happened at a, at a state level. But bear in mind, those were state directed health measures put in place. This is not this bill. If they have concerns around some of those measures, those were done at the state level, across the state, and in some ways hyper-- hyperlocalized, but those hyperlocalized decisions could be made by implementing this bill. I want you to imagine that if a county health-- the board of health would be able to put in place some directed health measures, maybe-- not even maybe, I think it's a pretty good, strong certainty, looking at data, that we would have been able to slow the spread. Community spread wasn't what initially happened. That happened over time. So this is trying to solve a problem before it becomes a bigger problem and we've seen other states

that have been successfully trying to address this through this avenue. There was some concern about having allopathic medicine in, in other individuals. Again, the, the appointed officials on these boards can be members of the public and these are, these are local decisions. There's some county boards of health that have 10-plus members. Some only have five or seven. It is decided by the area. So there can be individuals that represent different perspectives. I think that's healthy for government in a lot of different ways, so-- but we don't have that right now. Right now, one person or set of appointed officials make that decision at the state level. I actually think this is a better, better avenue. Somebody said that they're concerned that they don't have the right to question mandates. I absolutely believe that people have the right to question mandates. The citizens' advisory-- having individuals on the public on this board of health, that provides an ability to question these mandates and technically, this, you know, this hearing, but we're not talking about a mandate. We're talking about giving the authority for an entity that is pretty balanced to put in place measures. So I don't want to circumvent people's ability to provide feedback at all and I think that's still going to be in place because while they had public hearings. Even the decisions made at the state level with the DHMs didn't technically in statute say they have to have public hearings. These technically have to have public hearings for these decisions and they're transparent and have to meet public records-- Open Meetings Act, whereas the decisions made at the state level don't technically have to because they're still done by one appointed person. And to answer your other question-- and I got an answer on this. I wanted it-- if this were extended or even right now not, a county board of health cannot mandate vaccines. I really wanted to make sure to address that question because I know it's come up as an overarching concern, but also a question you posed. They cannot mandate vaccines for the individuals in the county and I-- we, we double-checked on that. So colleagues, I, I ask you to support this bill because we are going to be in a place where we have localized decisions that have localized solutions and this is an opportunity for us to do that with a balanced, public, appointed, and elected officials, with Open Meetings Act to be able to slow the spread of a pandemic should this happen again. And we know it could and we now know what happens if we don't have quick solutions to these problems. And it ultimately is about the public's health and I'm happy that the people that came here probably had better health outcomes. They didn't catch the virus. But I'm also

talking on behalf of those that have been hospitalized, have been sick, had to miss work, or those that have lost loved ones. And I guarantee you do not want to have that feeling. I think about it every single day. This is a pragmatic solution to a problem which we had. So I ask you to support it and I'm happy to answer any questions.

ARCH: Are there any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator Vargas. I've got two quick questions and would like to hear your response. DHHS testified that they were concerned that this would create inconsistent and confusing regulation across the state because you could have state-issued DHMs and you could also have public health department DHHMs [SIC]. Do you have a response to that?

VARGAS: We have state-- we have local laws, we have local ordinances, and we have state level ones. I, I hear their concern, but I don't see that concern because we, we have that right now with a lot of different, a lot of different things. Probably the more important thing is going to be, is there ongoing communication that's still going to exist? And I think what you heard from these county boards of health-- individually the directors or legal councils-- is they have a history and a record of engaging with the state and the local municipalities and elected officials when making decisions. They're not done in isolation, so I'm confident that even if there might be, let's say, a patchwork and that's a concern, I hear the opposite side of the story, which is we have local control and localized solutions for areas that need, need to be treated differently. And I know that the state, state can manage that because we do that outside of things in public health. We're managing that right now with a, with, with a lot of different statutes that touch-- we have, we have different localized statutes that, that touch county health departments, are treated differently, so--

WILLIAMS: The second question then is the League of Municipalities had testimony that-- concerning LB637 stripping some powers with, with some other functions that really are kind of outside the area of directed health measures. Do you have a response to that?

VARGAS: I'm happy to work to address those issues. Looking at the statutes, I still see that municipalities, specifically cities, have the ability and the-- to put in their own ordinances. We're not

stopping or stripping that ability to put in ordinances. But at the end of the day, the local county health departments having say means there's going to have to be a dialog between those local municipalities and the public health departments because those municipalities have elected officials on those boards. So I'm happy to work on something that would make it operational and I can guarantee you we're not stripping away their authority. We have not touched those, those different parts of statutes for, for municipalities. It's that same statute that was referenced at the end of this last year when cities were putting in mask mandates. That's still in place. That's not being touched.

WALZ: Thank you.

ARCH: Any other questions? Senator Murman.

MURMAN: Thank you. I just have one quick question. In your closing there, you mentioned that cities-- I think you used the word cities-- would still have the authority to make healthcare decisions. I, I assume you mean directed health measures?

VARGAS: Cities would have the authority to put in ordinances. So like, like I'd say in-- the city of Omaha putting in an ordinance that has an end date and having to extend it, cities still have the ability to put ordinances in place, which could be to stop the spread of preventable-- of a, of a disease, so yes.

ARCH: So that would just-- their decision would not be the same as the health department, that you would go with-- LB637 would go with the most restrictive?

VARGAS: It would go with the most restrictive, but this is the reason why the structure has elected officials on the board. So I use Omaha as an example because it's the one I know. There's a city council person and a county board commissioner and two elected officials on that board. So any of sort of the, the work-arounds of what's the best avenue is going to be worked out. In some instances, I imagine that a city might put in ordinances and maybe the county board of health doesn't. In some instances, the county board of health might do it because they think maybe it's the better option for that area or community. We're just making sure that this option is available for the county board of health to put in place.

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MURMAN: OK, thanks.

ARCH: Senator Hansen.

B. HANSEN: Thank you. I was going to-- well, first of all, if people don't know-- listening don't know, Senator Vargas, he is always willing to listen and I appreciate that-- opposition and everybody else, so-- and just as I don't know your-- you know, I understand your history with COVID and your experience with that with your family and everybody else that you know of and so in respect of that, as well as trying to be empathetic to the people who might have other concerns is where some of these questions kind of come from. So to piggyback off what Senator Murman said, so if a city does make an ordinance would-- according to LB637, could they-- could the local public board have the ability to override the city ordinance? If you don't know, we can always talk about it later.

VARGAS: No, no and I'll, I'll get a more firm answer, but the, the term "override" is the hard part. If let's say, for example, the city put in an ordinance that was more restrictive than what the county health-- board of health did, then that more restrictive ordinance is going to be what stands--

B. HANSEN: OK.

VARGAS: --and vice versa. If the county board of health put in a more restrictive ordinance and the city put in an ordinance that was less, the county board of health one would stand. The balance here is the elected official that is part of the board of health is also part of the city council, let's say. So there is a balance there, so--

B. HANSEN: And so-- and you mentioned earlier that some pub-- local public health boards can have, like, five members and some can have more.

VARGAS: Yeah.

B. HANSEN: And they can determine then-- so-- but they just have to have maybe at least two elected officials on there or three?

VARGAS: They can have more than that.

B. HANSEN: Yeah, but they can also--

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VARGAS: They're just required to have two.

B. HANSEN: --have two, but they also have, like, eight people they appoint, right?

VARGAS: Yes, yes.

B. HANSEN: OK.

VARGAS: So as you can imagine-- again, I'm not speaking for-- let's say not Omaha. Let's, let's say-- I don't know-- Custer County, you know, or, or that, that region. That area is going to then appoint people to this board of health and they can be a minimum number of elected officials. There could be more elected officials. There could be more members of the public. You know, there's, there's really no limit to the number of people that can be on these board-- there's no-- but there's also not a limit on who can be on these boards, so that's what makes it, I think, a little bit more localized.

B. HANSEN: I think that makes sense and I think that's kind of where some of the concern comes from, the opposition, is we can have-- like, we talk about having elected officials on this board, but it could be minimal. It could be a lot, but it also could be minimal. And then you have a whole bunch of appointed people who weren't really voted in, who may not represent the people a certain way that they see fit and I think that is some of the concern that the opposition is saying and so I think that's where the concern is. We're giving power to a group of maybe a lot of appointed officials or not, but it depends on the locality, like you said.

VARGAS: Yeah and the locality-- local-- I mean, that's what's really lovely about this in some ways. The local area decides who's on that board of health for the most part, right, so that--

B. HANSEN: Or the mayor might, right? The mayor can appoint all--

VARGAS: --or the mayor, right? Yeah and so-- yeah, so they get to-- the local area gets to decide who's on these committees. It's, it's a lot better than-- I mean, my opinion, it, it, it provides some level of localized balance rather than one person that's appointed at the state level making a unilateral or no decision at all because the local area can still have, have that say--

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B. HANSEN: OK--

VARGAS: --so--

B. HANSEN: --and if I could have just a couple more? Can the local board of health make decisions without a declaration for an emergency?

VARGAS: I'm going to check on that, but my understanding is they, they can't. I think their local-- I think the declaration of emergency sort of empowers them to sort of take a say in this, but before I say a definitive yes, I'll double-check.

B. HANSEN: That's fine. I'm just kind of curious about that. Then I get the concern is also we're, we're-- I think we have the intent that this might be during a declaration of emergency, but then we-- if we construe these powers onto local health boards forever, that's where maybe some--

VARGAS: Yeah--

B. HANSEN: --where some of the rub might be.

VARGAS: --which is real fair. You know, we, we don't-- I don't want to extend these things beyond what we consider to be a, a disease that is-- there's a public health emergency. Now I'll figure out whether or not that-- the actual public health emergency has to happen with the Governor, but as you can imagine, the state can then decide whether or not it's a public health emergency. If that's a barrier, that means that they still can't put it in place. If the federal government or, I don't know, the CDC identified it, that there was a communicable disease that sort of met a level, that does concern me. And I don't want to sort of create another hampering of the ability for local areas to do something, but I don't know how our laws read for the public health emergency and what they can and cannot do--

B. HANSEN: OK--

VARGAS: --and so--

B. HANSEN: --and I just wanted to-- that kind of leads to one of my other questions that I had earlier from, from one of the-- I, I think she was one of the opponents-- or supporters-- about does this-- does their power strictly relate to kind of controlling contagious diseases

or could it be for pretty much any kind of local health concern that they might have? And I think that ability might-- I think it said contagious disease, but I didn't know if it, it was specific with that or if it was pretty much anything, like they see we have too many cats in our town and so now we're going make a mandate to do something about cats, you know?

VARGAS: Are you saying cats are contagious diseases, Senator?

B. HANSEN: No, no, I said if--

VARGAS: Cat lovers everywhere are extremely frustrated right now.

B. HANSEN: I'll say dogs, so I cover all of them. It depends on whatever they think, you know, might be a problem. And then we-- we're, we're establishing power to them that they can make decisions above what a city council can do. And this is kind of a random example, so I didn't know if it was just specifically contagious diseases that they would have this kind of authority or could it be, you know, construed to other things?

VARGAS: So my, my reading is contagious or infectious diseases.

B. HANSEN: OK.

VARGAS: Yep.

B. HANSEN: All right, OK. And one more here: will the local board of health-- you answered the vaccine one, which I appreciate-- and could they also override, like, a school board? So if the school decides--the school board decides they want to stay open, but the local board of health decides no, we want you to be closed, can they override a decision of a school board?

VARGAS: That I do not know, but I think what we saw at the state level, through directed health measures, they can-- they, they were able to sort of decrease the-- have-- they had that authority, so let me find out a definitive answer.

B. HANSEN: OK, that's fine.

VARGAS: But I can imagine that there is some say over that, but that-- yeah, let me get a definitive answer on that.

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B. HANSEN: That's fine. I appreciate it. And my final question, if I could just quickly, it was on page 11. I was hoping for just a little bit of clarification. Lines 2 through 3 establish-- I think it talked about what they have authority over. They have exclusive control and authority over the investigation of the existence of a contagious or infectious disease and be authorized to adopt such measures, that have the effect and force of law, as it deems necessary to limit the spread. So what does that mean by the authority to-- the investigation of the existence? Like, can they go into people's homes, can they go into businesses with, with, with law and then, like, we think there might be-- you're not wearing a mask and so there might be contagious disease here. I'm just trying to figure out-- again, that's kind of maybe, maybe a far-fetched example, but-- sometimes where this might go. I'm trying to limit any kind of unintended consequences. So can you clarify on that a little bit, maybe what that means, the investigation of existence of disease?

VARGAS: Yes and no. So one, I mean, it's making sure they have the authority to then investigate, along with the powers that go along with slowing communicable or infectious disease. If we need to clarify what that kind of looks like, I can look-- we can look into that. I try to avoid being too specific and overly broad, but we, we can look into that.

B. HANSEN: OK--

VARGAS: I mean--

B. HANSEN: Yeah, no problem.

VARGAS: --I think the, the more important thing that I wanted-- we wanted to do or I wanted to do here is make sure that they have the ability and the authority to, to investigate to the extent to which things are actually-- are or not happening because then if they're making decisions and they don't have the ability to do that, they could be making decisions that are less informed, right, and that's part of the issue. I don't want to make-- I don't want the public health agency to not be able to do investigations or, or figure out whether or not there's actually a problem without making some of these decisions. So I think it kind of helps them to have that authority explicitly written in, but happy to look at that.

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B. HANSEN: And, and that makes sense from what you're saying. They do have to kind of look and see kind of what's going on. And, and that's typically, I think, what we would assume with something like this. But then-- I can maybe-- also in a random kind of example, assume that they could say, well, we're concerned that this business isn't following our directed health measures, so we're going to send police into that business or that restaurant or that bar or that establishment saying, look, we want to make sure that you're following it. And so if they have the authority to send police into-- or authorities into somebody's business, that's where I have a little bit of a concern.

VARGAS: Yeah, I mean, I don't have an answer for you, but I will say that currently has-- that authority does exist for municipalities and-- yeah.

B. HANSEN: OK, that's all right. Thanks and I appreciate you answering all the questions.

VARGAS: Yeah, yeah, of course, Senator Hansen, thank you.

B. HANSEN: Thank you.

ARCH: Are there other questions? I have one final, so does-- under our existing statutes, does the Governor at this point have the authority to grant a request from the board of health of a local county to institute DHMs?

VARGAS: The only line that we're changing that I think gets to at least the heart of the question, at least I believe, is on page 8 and it's in a couple of different places, which subject to the-- top of page 8, "subject to the review and approval of such rules and regulations by the Department of Health and Human Services." So an appointed agency with nonelected officials are the ones that have to review and approve these plans. That's just at the state level. We're just saying let's make it at the local level. And then the other part here in-- on line 20, "with the approval of the Department of Health and Human Services." So that's really the place where the decision is made, not made at the Governor's Office, with their approval. That's not in statute.

ARCH: OK, we can, we can talk more, but--

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VARGAS: Yeah.

ARCH: --but, but thank you. Seeing no other questions, thank you very much.

VARGAS: All right, thank you very much, everyone.

ARCH: This will close the hearing for LB637.

M. CAVANAUGH: This is the entirety, both opponents and proponents, just so you're aware.

ARCH: We will now open the hearing for LB494 and Senator Cavanaugh, you are welcome to open.

M. CAVANAUGH: Thank you, Chairman Arch and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h. I represent District 6, west-central Omaha in Douglas County, and I am here today to introduce LB494. The latest federal COVID relief package is called the Consolidated Appropriations Act 2021, public law 116-260. In that federal act is a grant that states-- to, to states to create or improve a database called an all-payer claims database. The grant is for $2.5 million over three years. The federal government has offered grants before to create this type of database. Nebraska has passed on the opportunity. For states that have used those funds and built an all-payer claims database, results have been very good. I've-- oh, I've handed out-- I haven't yet. I have a handout, apologies. There you go-- some information about the all-payer claim database in other states, in the national and local efforts over the last 15 years or so to improve health care, improve care coordination by healthcare providers, to provide care in a more holistic manner, and to try to reduce overall costs of care. Data has played a huge part. A few of you were here when the patient-centered medical, medical home was being talked about a lot. One of the main goals of that effort by former Senator Mike Gloor was to coalesce healthcare providers and insurance companies to focus on a common set of measures, data finding-- finding a way to measure healthcare improvement efforts, particularly when it comes to addressing healthcare disparities. In states where Medicaid is a participant in the all-payer claims database, accountable care organizations are participants. The healthcare providers in Nebraska have organized around 14 accountable

care organizations. They would be big players in the Nebraska all-payer, all-payer claims database. You'll hear more about that in the following testimony. This bill continues to search for a cohesive way to measure health outcomes, particularly disparities in outcomes of minority populations, to determine what works and what doesn't when implementing healthcare initiatives and give providers and consumers a comprehensive data set to use in making healthcare decisions. Plus a database of this nature would give us-- the Legislature and the Department of Health and Human Services a better way to measure the work of managed care contractors. The mechanisms of the, of the bill is this. The department applies for the federal grant. The department, in conjunction with UNMC College of Public Health, create a plan to establish the database with all the necessary, necessary protections on health-- on personal healthcare information and proprietary business information. What its focus should be-- would be what data would be included and all other necessary parameters. They would set up the governance of the database and how it would be maintained. The database would give healthcare providers, healthcare consumers, and, and public health entities, including the state of Nebraska, better ways to measure health outcomes and design future efforts to improve healthcare. All-payer claims databases are not easy to accomplish. Many entities need to be partners in this effort, including the Health Information Exchange. The foundational work to reform healthcare in Nebraska has, has been done. The college of public health is knowledgeable and eager to bring Nebraska entities together to build a database at a, at a competition-neutral location. This grant is an opportunity we should take advantage of. The dollars to create and maintain an all-payer claims database is an investment that can produce a high return. It can help reduce the total cost of care and drive healthcare innovations through analysis. Currently, federal law has mandated transparency in pricing, so hospitals and insurance companies have made pricing information available on their websites, but not everyone has an insurance company to turn to. There can be a wide variety of pricing for some procedures in a different-- in different facilities. There are usually multiple providers involved in medical care. Having that information in a single place would hugely benefit consumers and providers. Thank you and I'll take any questions, but I would recommend saving them for the experts.

ARCH: Are there any questions? Seeing none, thank you.

M. CAVANAUGH: OK.

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ARCH: First proponent for LB494. Do you have a, do you have a green sheet for the page? If, if, if you don't fill one out, before you leave the room, so that they have--

DAVE PALM: All right. Good morning. My name is Dave Palm and Senator Arch and members of the Health and Human Services Committee, I'm here to testify in support of LB494. My name is spelled D-a-v-e P-a-l-m and I'm an associate professor in the college of public health at the University of Nebraska Medical Center. However, I am here today speaking for myself and not on behalf of the Medical Center. My observations today about the health-- excuse me, the all-payer claims database are based on several reviews of reports and also, I've interviewed staff from states in Oregon and also Arkansas. So we have seen, according to the National Conference of State Legislators [SIC], there are 24 states that have an all-payer claims database at this time and that number has been growing over the past five to ten years or so. An all-payer claims database allows collecting healthcare claims data from a variety of payer sources, including, of course, private insurers, Medicare, Medicaid, and others. The information typically collected includes patient demographic characteristics, clinical data, financial data, and utilization data. And there are several benefits from collecting this type of data for policymakers like yourselves, researchers, and, of course, other healthcare organizations, especially to answer questions about how can we improve access to care? How can we enhance the quality of healthcare services? And, of course, how can we control healthcare costs? The state of Colorado puts out an annual report in which they look at quality-- they compare quality measures. They compare regional price differences as well as differences in hospital prices, but these data can also be used for a lot of other different kinds of things in terms of how can we improve the health outcomes of the population. We could link the all-payer claims data with cancer registry data, with our vital records date of birth and death records to really get a better understanding of how, how well we're doing in terms of keeping people healthy. So states have done a, a number of different things. I could give you several examples, but we don't have time for that today. These data can help-- also help us assess the performance of the healthcare system, as I mentioned. And Vermont, for example, has looked at their accountable care organizations and how well they have performed in terms of quality measures and cost measures. I'd also like to mention just a couple of things about the cost of healthcare--

of the all-payer claims database. When the University of Nebraska Medical Center did, did a fiscal note, we found that-- and in general, looking at other states, we found that the $2.5 million in grant funds that would be available should certainly be adequate to organize and establish and plan for an all-payer claims database. In terms of the amount of annual revenue that would take to operate the system, that varies, but generally from $1 million to $1.5 million up to $2 million to $2.5 million, depending on, of course, how extensive and robust the system is. The $2.5 million in federal grant money would allow Nebraska to convene and engage stakeholders and other partners in the development of a comprehensive plan for establishing this all-payer claims database. And this-- we anticipate that this planning process would take probably at least a year. There are many, many questions that need to be answered. For example, the governance structure, formulating a specification and release rules of the data, obviously, computing, operational and storage capacity, developing privacy and security policies, and also identifying sustainability costs and, and of course, revenues.

ARCH: Mr. Palm, the red light has come on and I would-- I'd ask you to end your testimony.

DAVE PALM: OK, that completes my testimony at this time.

ARCH: Thank you. Are there, are there questions? I have one question and that is you're obviously familiar with NeHII, CyncHealth.

DAVE PALM: With what?

ARCH: NeHII.

DAVE PALM: Yes.

ARCH: Yes. So how does this relate to our current health information exchange?

DAVE PALM: Well, I think-- I'm not as familiar with all the data they collect, but I think this would give us a better understanding of the costs of healthcare services and allow us to link these data to other databases that I mentioned, such as a cancer registry and, and also our vital records. That-- so I think that it would give us a better-- a more complete picture of what, what our costs are, what our quality would be, and also help us to better understand our health outcomes.

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ARCH: All right, thank you. Any other questions? Seeing none, thank you for your testimony and just a reminder, please fill out the green sheet.

DAVE PALM: Thank you very much.

ARCH: Thank you. Next proponent. Welcome.

BOB RAUNER: My name is Bob, B-o-b, Rauner, R-a-u-n-e-r. I'm testifying on behalf of the Nebraska Academy of Family Physicians. I did email the handouts to the staff, so hopefully they made it to you. Essentially, what I'm going to talk about is, is that it's not, it's not just having the payer claims database. It's what you do with the claims database. So if nothing happens, that data just sits there, it doesn't really do you any good. And so I, I sent some slides, kind of some examples of the accountability and transparency, things you could use to, to improve public health. And so, you know, one of the things we've been working on for years now, Nebraska has been losing ground in America's health rankings for several decades now. Unfortunately, we used to be the top five. We're down in the--

ARCH: I'm sorry, we don't allow props.

BOB RAUNER: OK, sorry. OK, well--

ARCH: It's because cam--

BOB RAUNER: --if they didn't give you the handout, then I'll describe the handouts that I have--

ARCH: Thank you.

BOB RAUNER: --essentially. I put together an example of Medicare claims data on colon cancer screening, for example. And so for colon cancer screening, we can use that map to see across the state how well we're doing. Are we doing good or bad? The map I sent is wrong and the reason it's wrong is because it's only Medicare claims data. And if someone has a colonoscopy at age 62, it doesn't show up in Medicare because they were under Blue Cross or they were under UHC, for example, and so it doesn't show up, so our data is wrong. It still gives us some comparability across the state, though, at least. The mammogram-- mammography screening, mammography screening data that's on the slides-- I hope, hope your staff will forward it to-- shows

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that that's a little bit more accurate. It also shows that the urban-rural disparities we have aren't as bad for mammography because there's a few bright spots across Nebraska and we know that because of the claims data. And so if you look at that map, it'll show that the highest area is actually in the Columbus-Albion area. And I know some of the family doctors in those areas and it's no accident that their numbers are that good and it's because they're part of accountable care organizations that do some organized quality improvement. Also on that data is the payment for primary care spend rates. So one of the reasons we don't have enough rural primary care doctors is we don't pay enough to attract them there. So they're not there because of restrictive laws, it's-- or credentialing, it's-- frankly, there's just not enough pay to keep them there. And I started out my career as a rural family doctor in my small town of Sidney, Nebraska, my wife and I. We didn't stay partly for economic reasons. It's hard to make a go of it in a rural area, unfortunately, so that primary care spend rate is essential for healthcare planning. The other one, I can't use a prop, but I did send a handout that's an analysis of how the Nebraska accountable care organizations are doing for Medicare right now. So you can look at how Bryan's doing versus CHI versus OneHealth versus SERPA and see who's doing it best. One example that's helpful is that, for example, one of the things we're judged on is influenza vaccination rates and the influenza vaccination rates across Nebraska are very twofold, as low as 35 percent all the way to 70 percent. We're in the midst of a pandemic right now. It would be kind of nice to know where you're going to have your biggest challenges and where you're not. Also on that list of the accountable care organizations, it's-- well, I'll just show-- it's the one that looks like this. So you can see the influenza vaccination rates across the state and see who's doing it the best. Well, if you're having a hard time with your vaccinations, maybe you ought to talk to the ones who are doing it best. That's the most comparable way of vaccinating. We do that every year, year in and year out, and several of those accountable care organizations regularly get 80, 90 percent of their patients vaccinated every single year. So why didn't we bring them and get them involved when we planned a coronavirus vaccine rollout? Also the cost side of things, by tracking total cost, you can see how people are doing. And I-- one of my day jobs, I run one of those accountable care organizations. In the last five years on both Blue Cross and Medicare contracts, we've saved anywhere from 1.5 to 12.6 percent of the total cost of healthcare. Nebraska spends $2 billion a year on Medicaid, so

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if-- let's say you even got 2 to 3 percent savings. That's $40 million to $60 million a year. So maybe this database is going to cost us $2 million or $3 million to put together, but if it helps us figure out how we can make even a 2 or 3 percent cost reduction in Medicaid, well, what does that pay off itself tenfold every year potentially? My other hat I wear is I'm on Lincoln Public School's school board. We spend $70 million a year on healthcare at Lincoln Public Schools. If I get a 5 to 10 percent reduction in our healthcare costs, I could cut our tax levy 2 to 5 cents just from that alone. And so we have the ability to do this. We're literally already doing it in Nebraska. The problem is we can only see it on Medicare because that's the only database we have that's accessible. And everything that-- and if I didn't get it to you, I'll send it when I get out of here. All, all these are here-- this is just based on two guys, Ted and I, putting this together with one database. And so this isn't a full time gig. Ted and I do this on the side. And if two of us can do this with Medicare claims data alone, imagine what we can do with the multiplayer claims database. An example I also use in there is where we're doing well-child checks right now in Nebraska under Medicaid. We're at 52 to 55 percent, which is really bad actually. National averages for Medicaid are 65 percent. And if we're going to catch back up on childhood vaccinations, we need to get those kids in and so that database can help us generate some accountability for Medicaid. So you guys can see are these Medicaid MCOs doing what they should be doing? If not, let's find somebody who can. And so plenty of examples to use and I'll wrap it up and apparently you didn't get the hand out, so I'll email them to all your personal emails or the emails listed when I get out of here, so--

ARCH: Thank you. Are there questions? Seeing none, thank you very much for your testimony. Next proponent for LB494. Seeing none, first opponent for LB494. Good morning.

KEVIN BAGLEY: Good afternoon.

ARCH: Yes, it is. Good afternoon.

KEVIN BAGLEY: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y, and I am the director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I'm here to testify in opposition to LB494, which will direct the

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Department of Health and Human Services to apply for grants in order to establish and maintain a healthcare insurance claims database and payment information database whose data would be publicly available. LB494 requires DHHS to apply for federal grants that, if awarded, must be used to establish and maintain a new database to publish claims and payment information from health insurers throughout the state. The resources needed to apply for the federal grant, develop and maintain the database, and establish secure access for external entities are costly and present considerable risk to the department. In addition, without near universal cooperation from insurers throughout the state, it's unlikely that the stated goals of the database could be achieved. When considering the cost of such an undertaking, a federal grant awarded to Nebraska would remove some of the financial burden from the state General Fund. However, looking at the $2.5 million described in the Consolidated Appropriations Act of 2021, it, it would likely be insufficient to cover the cost of that endeavor. The anticipated federal award needed to establish and maintain the database for the next five years is roughly $47 million. This estimated cost includes requirements gathering to the tune of around $200-- $2.5 million, development in the range of about $15 million, and infrastructure in the range of about $30 million. The infrastructure estimate includes initial infrastructure build and maintenance for five years. The grant would eventually expire and the ongoing maintenance costs would need to be budgeted from state General Fund at approximately $6 million a year. As I previously mentioned, there are also significant risks associated with collecting, storing, and ultimately making the data publicly available. The language of the bill does not outline what, if any, level of the de-identification would be required. Leaving this data open for external users has the potential to compromise the private health information of residents across the state. In addition, as has been noted, this may also duplicate efforts by CyncHealth, which has already established a mechanism for collecting and managing claims information across the state. The bill outlines the goals of the database, including tracking information surrounding utilization, quality, and cost, monitoring the efficacy of population health initiatives, and analyzing trends in those areas geographically and demographically. In order to achieve those goals with this data set, there would need to be near universal acceptance and cooperation from health insurers across the state, including Medicare, TRICARE, and other federally managed plans. In addition to the information technology resources that would be-- need to be allocated, the

department would likely need to employ additional resources to provide outreach and support to insurers who submit information to the database. The department is committed to transparency and sharing of aggregate data. If there are reports or aggregate data of significant interest to the committee or other stakeholders, the department is happy to share upon request. To be clear, my testimony is in opposition to LB494 because of the resource-intense nature of the work that's already underway by CyncHealth, the sustainability of the project if relying on a grant from federal-- from a federal awarding agency, and the limited applicability of the information without intense, ongoing engagement of the health insurance entities serving Nebraska residents. It's not in opposition to transparency or the sharing of data or even the opportunity to identify trends and utilization and how we might be able to improve the population health of our, our fellow residents in Nebraska. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

ARCH: Are there any questions? Seeing none, thank you very much for your testimony.

KEVIN BAGLEY: Thank you.

ARCH: Next opponent for LB494. Good afternoon.

ERIC DUNNING: Good afternoon. Mr. Chairman, members of the Health and Human Services Committee, for the record, my name is Eric Dunning, D-u-n-n-i-n-g, first name is spelled E-r-i-c. I appear today before you as a registered lobbyist for Blue Cross and Blue Shield of Nebraska in opposition to LB494. All-payer claims databases have been a goal for advocates from various perspectives since passage of the Affordable Care Act in 2010. Early versions of these all-payer claims databases appeared to be focused primarily on cost transparency initiatives, such as Colorado's efforts to create a website that had price data for a limited number of procedures. However, as Senator Cavanaugh alluded to, aff-- efforts to improve cost transparency for consumers have now shifted away from all-payer claims databases and moved to insurer-specific tools. We saw this most recently in a series of rules from the federal government that require insurers to provide information and negotiated rates to consumers and in a machine-readable format with the explicit goal of, of allowing software developers to use that information and to combine it in new and interesting ways in response to the market. In addition, I-- and

again, that's an effort that Senator Cavanaugh mentioned. In addition, I think it's important to know that hospitals now have similar obligations. They actually got started on, on that project and now have that obligation as of June-- or excuse me, January 1, 2021. Further, on the claim side, it appears that the private sector is moving ahead to collect this data on its own. Last Friday, The Wall Street Journal reported just-- that a group of major hospital systems is launching a company, company to pull together and sell access to anonymized data on their millions of patients for use, including research and drug development. I would note that among the 14 developers of Truveta is CommonSpirit Health, which obviously has some ties to CHI Health in Nebraska. The stated goal is to make this data available to all ethical research. This is just the most recent effort that I've seen to pull together streams of data in the space. Further, since the all-payer claims databases were initially launched, the U.S. Supreme Court has decided that ERISA preempts state efforts to obtain claims data for self-employer-- self-funded, employer-sponsored group plans. Those self-funded group plans cover about 50 percent of people covered by the private sector. This preemption makes all-payer a bit beyond reach at this point. Nebraska has looked at the issue of all-payer claims databases in the past. In 2014, LB76 tasked the Department of Insurance with investigating the possibility of creating one of these. As a result of that evaluation, the database did not move forward in Nebraska. This all-payer claims database has been restarted by last year's end-of-the-year federal spending bill with the grants of $2.5 million, as noted earlier. Let's see-- but since the idea of the all-payer claims databases was initially brought forward, Nebraska has made great strides in the development of HIE and NeHII, otherwise known as CyncHealth. That tool has moved beyond pure HIE and-- for example, having been tasked by the state with creating the prescription drug monitoring program and other healthcare data projects. Blue Cross and Blue Shield of Nebraska has long championed NeHII/Cync as a solution to the state's HIE infrastructure needs. While we don't believe they currently do this kind of work, we'd love for them to be part of that conversation. As the need from-- for the all-payer claims databases has moved for-- moved on from cost transparency goals, Blue Cross Blue Shield Nebraska is here today to hear about the goals that proponents have for the use of these new federal grant funds. And with that, Mr. Chairman and members of the committee, I'm happy to answer any questions.

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ARCH: Are there any questions? Seeing none, thank you for your testimony.

ERIC DUNNING: Thank you, sir.

ARCH: Next opponent for LB494.

ROBERT BELL: Hello.

ARCH: Welcome.

ROBERT BELL: Chairman Arch and members of the Health and Human Services Committee, my name is Robert Bell, last name is spelled B-e-l-l. I am the executive director and registered lobbyist for the Nebraska Insurance Federation. The Insurance Federation is a primary trade association of Nebraska insurers. I am here today to testify in opposition to LB494. And as you've already-- as Mr. Dunning already mentioned, back in 2014, the Legislature passed a law that directed the director of insurance to appoint a committee to make recommendations related to the creation of a claims database in Nebraska. The committee included insurers, employers, public health officials, medical providers, the Department of Health and Human Services, and NeHII. Ultimately, after months of presentation and study, the committee recommended that funding be appropriated to the Department of Insurance to issue a request for information to study further, to study further the many questions, both contained within LB76 and that arose from the study of the issue. Of note in the committee's final report were challenges posed by the creation of a database in Nebraska. These challenges included the availability of self-funded or ERISA data, funding of the database itself, entity and data governance, privacy and security, sustainability, cost-- the cost benefit analysis of the value of the data versus the cost, implementation management, and overlap with existing tools available in both the public and private sectors. I know the committee heard presentations-- the Health Care Database Committee back in 2014 heard presentations from the Colorado database and from the Health Cost-- Health Care Cost Institute, which maintains a set of national data. The Colorado data appeared to be more driven at consumer data, while the HCCI, which is the Health Care Cost Institute, is more research driven. And relevant to this discussion, many of those private and public tools still exist. In fact, I was just tooling around on HCCI's website. They got some interesting stuff going on. I would submit to

the committee that many of these challenges have yet to be resolved in that I think the proponents' goals and the goals of health insurance companies are very similar and that is to lower cost, to, to have better outcomes while we lower costs to policyholders and consumers. And the insurance industry doesn't really necessarily feel like we need a law to do that. If we want to have discussions and sit down with CyncHealth or UNMC or whoever else, we should, we should have those discussions first before we pass a law. For those reasons, I, I appreciate-- I know it's late and I appreciate the committee's time and the opportunity to testify. Thank you very much.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony.

ROBERT BELL: You're welcome.

***JAMES WATSON:** Chairman Arch and Members of the Committee, good Morning. My name is James Watson, and I am the Executive Director of the Nebraska Association of Medicaid Health Plans (NAMHP). Those plans include Nebraska Total Care, UnitedHealthcare Community Plan and Healthy Blue Nebraska. Thank you for this opportunity to testify before your committee. I am here to respectfully express the Association's opposition to Legislative Bill 494 (LB494) as a measure which duplicates the activities of DHHS's health care data and analysis section as established in Neb. Rev. Stat.§ 81-676 (Laws 2019). LB494 also establishes the University of Nebraska Medical Center ("UNMC") at the forefront of the required data base despite its conflicted interests as a provider of medical care. Neb. Rev. Stat.§ 81-676 (Laws 2019) required DHHS to establish a health care data analysis section to conduct data and research initiatives to improve the efficiency and effectiveness of health care in Nebraska. In contrast to LB494, the DHHS section is to conduct its research using existing health care databases. Historically Nebraska previously investigated establishing a health care claims database in 2014 with the passage of LB76, called the Heath Care Transparency Act. The legislation established an advisory group of stakeholders that met six times in 2014 and delivered a required report to the Legislature in December of that year. The advisory group report recommended that a Request for Information ("RFI") be funded and issued to enable the Committee to learn more about set up and management costs of an All-Payor Claims Database as well as whether Nebraska's database could be standardized with other efforts in other states. Funding for the

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RFI was requested, however it was not forthcoming. The legislation was ultimately repealed in LB644 (2017). It also should be noted that a goal of LB494 is to "Promote accountability for state medicaid contracts to assure the effectiveness of managed care and providing an objective way for the state to monitor the performance of medicaid managed care or value-based purchasing contracts." The three managed care organizations that serve Medicaid clients file claims data daily as part of the encounter reporting process. By contract 98% of the encounters must be acceptable. The encounter acceptance rate is part of the annual measures in the quality performance programs. The MCOs have approximately $1.8M at risk if they do not perform at or above that level. The MCOs also submit all claims for each calendar year to Nebraska's consulting actuaries for rate setting purposes. Furthermore, DHHS already compiles a public dashboard of the performance, membership, finances, customer service, outreach, and health outcomes for all three managed care organizations. NAMHP respectfully suggests that the accountability LB494 seeks is already in place. A possible legal hurdle for the database required by LB494 is a 2016 Supreme Court decision, Gobeille v. Liberty Mutual Insurance Co., which held that states may not require data collection from non-governmental self-insured group health plans. Because self-insured plans represent 61% of enrollment in employer coverage-and about one-third of all covered people-this decision leaves a large gap in state claims databases. In summary, NAMHP urges the Committee to indefinitely postpone LB494 in favor of the DHHS health care data and analysis section established by Neb. Rev. Stat.§ 81-676 (Laws 2019).

***DAVID SLATTERY:** Chairman Arch and members of the Health and Human Services Committee. I am David Slattery, Director of Advocacy at the Nebraska Hospital Association (NHA) and I thank you for this opportunity to present this testimony on their behalf. I am expressing (for the public record) the NHA's OPPOSITION for LB494 introduced by Senator Machaela Cavanaugh. LB494 directs the Nebraska Department of Health and Human Services to apply for a grant to establish and maintain a database to publish claims and payment information from health insurers. Since 1992, the Nebraska Hospital Association has been collecting claims data from all our member hospitals through the Nebraska Hospital Information System (NHIS). Any efforts to pass LB494 are unnecessary and duplicative of the system the NHA currently has in place. The NHIS analyzes accurate and reliable Nebraska hospital administrative claims data. The NHIS data is used for analysis and

decision-making relative to the health care needs of the State of Nebraska and its residents. In fulfilling this purpose, major goals of the NHIS are: To protect the privacy of patient health information and confidentiality of hospital data; To establish non-public processes for collection and aggregating hospital health data; To comply with Nebraska Department of Health and Human Services (DHHS) data mandates; To collect hospital advocacy data and information; To participate in NHA Quality Improvement Initiatives. Although the NHIS is voluntary, hospitals are committed to sending all claims data for inpatient, ambulatory surgery and outpatient services to the NHIS. We currently have a 100% voluntary participation rate amongst all hospitals. Hospitals are also sending all payer data including self-pay and workers compensation claims to NHIS. The NHIS is a primary source of hospital health care information on which to base future health planning activities. An agreement between the Nebraska Hospital Association (NHA) and Blue Cross and Blue Shield of Nebraska enabled the NHA to utilize the electronic claims filing system to access a wide range of hospital health care data for the state. Plans for the data collection system were developed by a broad-based Task Force that began meeting in October 1992 to address the question of how best to collect health data in Nebraska. The Task Force included representatives of hospitals, physicians, insurance companies, state health agencies and the Nebraska Legislature's Health & Human Services Committee. The NHA is responsible for data usage activities including collection, database administration, analysis, evaluation, maintaining confidentiality and publishing reports. All information gathered is collected to ensure that patient and facility identities are secure and confidential. Claims Data Collection. The NHIS collects data through a process that allows hospitals to choose how to submit copies of their claims data. Under this process, a hospital may use any software or clearinghouse of their choice. The process allows for the following formats to submit claims data. It is possible to use a combination of the formats. HIPAA 837i compliant transaction; File extract in NHA predefined layout. Data files are transmitted to the NHA using a new secure data portal that allow hospitals to access information at will, create reports and determine benchmarking standards. DHHS Reporting. The NHA reports on behalf of Nebraska hospitals to the Nebraska DHHSfor state mandates. Data reporting mandates include the following: External Cause of Injury (Neb. Rev. Stat. 71-2078 to 71-2082; NAC 186-3); Head, Brain & Spinal Injury (Neb. Rev. Stat. 81-653 to 81-661; NAC 186-2); Ambulatory Surgical

Center (Neb. Rev. Stat. 81-6,111 to 81-6,119; NAC 186-6); Communicable Diseases (Neb. Rev. Stat. 71-532; NAC 173-1); Parkinson Disease Registry (Neb. Rev. Stat. 81-697 to 81-6,110; NAC 186-4); Cancer Registry Early Case Capture (Neb. Rev. Stat. 81-642 to 81-650; NAC 186-1); Contagious, Infectious, or Poisoning (Neb. Rev. Stat. 71-503). In addition to the reporting mandates, general inpatient, emergency and Crash Outcomes Data Evaluation System (CODES)data sets are provided to Nebraska DHHSfor public health purposes. We have also worked with DHHS to provide information for Geographical Information System Mapping which helps to visualize health data and hospitalization usage across Nebraska. Additionally, there is language in LB1158 (2020) that currently allows for the department to pursue grant opportunities with the federal government so there is no need for a duplicative statute. I urge the Committee to oppose LB494. Thank you for consideration.

ARCH: Next opponent for LB494. Seeing none, is there anybody they would like to testify in a neutral capacity? Seeing none, Senator Cavanaugh, you're welcome to close and as you are coming, I would mention that we received no letters regarding LB494, but we did receive two written testimonies, one from the Nebraska Hospital Association and the Nebraska Association of Medicaid Health Plans, both in opposition.

M. CAVANAUGH: Well, thank you, Chairman Arch and committee members. I will make this brief, I, I think it's always a great thing when we can collect more data to have more informed decision-making, especially in healthcare. And if we can do that and find a way to do that, that we can draw down federal dollars, not use General Funds, I think it's a good opportunity for us as a state. And I appreciate the comments from the opposition and I look forward to talking with them further about it. Thank you.

ARCH: Thank you. Are there any questions for Senator Cavanaugh? Senator Walz.

WALZ: This may be a-- I don't really understand the whole thing, first of all, and I'm trying to understand it, but I just-- I do have a question. Is there any way that the University of Nebraska could establish and maintain this system or does it have to be the Department of Health and Human Services?

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M. CAVANAUGH: That is an excellent question that I don't know the answer to, so I will follow up with you.

WALZ: All right. OK, thanks.

ARCH: Any other questions? Seeing none, thank you and this will close the hearing for LB494. We will open the hearing for LB328, which I will be introducing. Before I introduce, I might mention that we did not receive any letters on LB328 and no written testimony. Senator Walz, could you--

WALZ: Oh sure. LB-- OK. [INAUDIBLE] Oh, good. I did not understand that one. I mean, I get that it's a database. Senator Arch, would you like to begin?

ARCH: Thank you. Good afternoon, fellow members of the Health and Human Services Committee. My name is Senator John Arch, J-o-h-n A-r-c-h, and I represent District 14. This bill would amend the Health Care Facility Licensure Act to require one member's signature of a limited liability company instead of two to apply for a license to operate a healthcare facility. This bill was introduced last year by Senator Howard and amended with new language prior to the committee hearing. We had a hearing on the introduced amendment instead of this particular bill. Thank you for your time and attention.

WALZ: Thank you. Any questions from the committee? Any questions? Oh, all right. Any proponents? Any opponents? Anybody who would like to speak in the neutral? I see none. Senator Arch waives and that concludes our hearing on LB328 and our hearings today.

[BREAK]

ARCH: Good afternoon and welcome to the Health and Human Services Committee. My name is John, Arch, I represent the 14th Legislative District in Sarpy County, and I serve as Chair of the HHS Committee. I'd like to invite the member of the committee who is with us at this moment-- I'm sure there will be others that'll be coming in-- to introduce himself, please.

WILLIAMS: Do I get to vote more than once if I'm the only one?

ARCH: That's right.

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WILLIAMS: I thought so. Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer and the north portion of Buffalo Counties.

ARCH: Also assisting the committee is one of our legal counsels, Paul Henderson, our committee clerk, Geri Williams, and our committee pages, Kate and Rebecca. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon we will be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will be given-- you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony, we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, please see the new public hearing protocols on the HHS Committee's Web page at nebraskalegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding testimony. Pages will sanitize the front table and chair between testifiers. This

committee has a strict no props policy. And with that, we will begin this afternoon's hearing with LB516 and welcome Senator McKinney.

McKINNEY: Thank you, Chair Arch and members of the HHS Committee. LB516 acknowledges that the current global pandemic has rendered some workplaces and educational institutions entirely remote. This bill intends to amend provisions to allow TANF recipients to complete monthly work activity requirements through remote and online coursework, including coursework over the Internet and any educational program that would otherwise qualify. For participants engaged in remote or online coursework, this bill also intends to permit self-attestation to verify their compliance with the program's standards. Under this provision, any information provided by applicants is subject to review or audit if the information provided by the applicant in a self-attestation is questionable. It would be irresponsible of us to fail to respond to the pandemic and the changes caused by it. Policies should be adjusted to meet Nebraska's, Nebraska's and families' unique situations, needs and challenges. I also would like to address the fiscal note that was attached to this bill. It provides that there is no ability to allow for self-attestation. However, much like when an individual applies for any type of public assistance, any information provided can always be verified. There is federal guidance that specifically says self-attestation is allowable and follows states to take more restrictive measures. If self-attestation causes issues, LB516 addresses this concern. However, I am of the school of thought that there is more than one way to skin a cat, and I am open to providing an amendment to add language that reiterate, reiterates that the bill only requires DHHS to use, to use self-attestation to the extent it is allowed under federal TANF rules. I ask that you move this bill out of committee on to General File, and I'll be happy to open-- answer, answer any questions. Thank you.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: Thank you, Senator McKinney. So because I read the opposition from the, and the fiscal note and the opposition from the department said. So they're saying pretty much if we pass this bill, we will be out of compliance.

McKINNEY: Yes.

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B. HANSEN: Would you agree with that? Or are you saying with an amendment that we would have to do then that would, you know, fix the problem?

McKINNEY: I don't think we would be out of compliance, but with an amendment to clarify the language--

B. HANSEN: Your thoughts on it.

McKINNEY: --then we wouldn't be.

B. HANSEN: Just curious to know your thoughts on that.

McKINNEY: Yep.

B. HANSEN: Thank you.

McKINNEY: No problem.

ARCH: Other questions? I have, I have one. The other issue that, that is raised is this allowing remote or online coursework. The department says that they allow that starting November 2020. Is that, has that been allowed or is that just is that just a COVID waiver or do you happen to know?

McKINNEY: I believe it's allowed because of COVID, but from my understanding it's not necessarily permanent. So it could change.

ARCH: OK.

McKINNEY: This would make it.

ARCH: Maybe we can look into that and see--

McKINNEY: Right.

ARCH: --see if that's temporary or if that's permanent. OK, very good. Any other questions? Seeing none, thank you.

McKINNEY: No problem.

ARCH: First proponent for LB516. Welcome.

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DIANE AMDOR: Hello, good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Diane Amdor, D-i-a-n-e A-m-d-o-r, and I'm the staff attorney for the Economic Justice Program at Nebraska Appleseed. Nebraska Appleseed is a nonprofit law and policy organization that fights for justice and opportunity for all Nebraskans. We've long been supporters of educational opportunities within TANF, and I'm very pleased to be here today in support of LB516. We want to thank Senator McKinney for introducing this bill. I'd like to start by briefly addressing the fiscal note. It, so they're basically saying conclusively that this cannot be done. We've reviewed the federal regulations and guidance documents and simply, respectfully disagree. I've provided you with a handout with some of the relevant documents that we have reviewed. To your point, Senator Hansen, we do think there is flexibility in what's allowed from the federal level, and we think the current language of the bill is sufficient. However, if the committee thinks the bill needs further clarification, we would be more than happy to help make this work. A bit of background for the record, as I'm sure you all know already, the federal Temporary Assistance for Needy Families, or TANF program, is intended to help working families build a bridge out of poverty while being able to meet their children's needs. States receive annual block grants and have broad flexibility in using TANF funds. Nebraska uses TANF funds to provide direct cash assistance to children living in poverty through the Aid to Dependent Children, or ADC program. Only families with very low incomes can receive assistance and work requirements apply to most adults receiving ADC. An individual's plan for how to meet work requirements and transition off the program is embodied in a self-sufficiency contract. One way to satisfy the work requirement is through education. We support LB516 because education is the surest pathway out of poverty. People who are taking online classes should get credit towards their TANF work requirements, just like people who are enrolled in in-person classes. But right now, even though we're in the middle of a pandemic and it seems like almost everything has moved to a virtual option, if at all possible, except for the Legislature, it is extremely difficult for someone taking online classes to get them included in their self-sufficiency contract. Back in September, our organization was contacted by several individuals who were directly impacted by this issue. I passed out a statement from Mary along with my written testimony, and I hope that you've received a letter from Brittany via email. Their letters provide a bit more detail, but I will briefly

summarize their stories. Mary was accepted into a retraining initiative implemented by the Nebraska Workforce Development, a program which was funded by the CARES Act. The course work leads to a highly respected certification in the IT field. She started the program in the first week of September and was subsequently notified that she would be sanctioned or disqualified from receiving TANF funds. This temporary assistance had been a critical support for her and her two young children to get back on their feet after stepping out of a domestic violence situation. Even though she had enrolled in the program with the encouragement of her caseworker and the course was intentionally set up as an online course because of the pandemic, she was told she had two choices: agree, agree to a new plan that did not include the course or lose the financial assistance for her two children. Brittany is studying to obtain a nursing degree so that she can have a meaningful career that allows her to support herself and her child. In September, she was sanctioned for attending online classes, even though she no longer had the option of taking in-person classes due to the pandemic. Her instructors were not able to fill out time sheets verifying her attendance because her school's online system doesn't have the capability of tracking when a student is logged in, she continued to complete her assignments and maintain good grades, which her caseworker acknowledged, but because of the cumbersome reporting requirements, she was sanctioned for noncompliance. Over the course of the next few months, our office corresponded with DHHS regarding Mary and Brittany's cases. To their credit, DHHS did reside-- revise the state's TANF work verification plan, as I think you mentioned, Senator Arch, to remove some of the limitations on online coursework. Unfortunately, these changes did not go far enough. To this date, Mary's course has still not been approved as an acceptable work activity for her self-sufficiency contract. Brittany opted to forgo the stress of reapplying for TANF funds, and she's working extremely hard to make ends meet while she completes her coursework online. The purpose of the TANF program is to move low-income families out of poverty as quickly as possible by helping them reach economic self-sufficiency. The barriers that are currently limiting online opportunities are counterproductive to that purpose. LB516 would remove those barriers. We appreciate the committee's attention to this issue and we encourage you to advance LB516. I'd be happy to answer any questions you might have.

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ARCH: Thank you. Are there any questions? Seeing none, thank you very much.

DIANE AMDOR: Thank you.

***SPIKE EICKHOLT:** Thank you Chairman Arch and members of the Health and Human Services Committee. My name is Spike Eickholt and I am a registered lobbyist with the ACLU of Nebraska. The ACLU offers its support of LB516 and we would like to extend our gratitude to Senator McKinney for introducing this legislation. As more and more Nebraskans have come to rely on public assistance during the coronavirus pandemic and resulting rise in lost jobs, the ACLU is working nationwide to ensure the burdens of the outbreak and the government's actions do not unfairly fall on our most vulnerable communities. LB516 modernizes provisions of work activity requirements and self-sufficiency contracts to allow remote or online education to fulfill education requirements. This is vital because not only are more and more educational programs shifting to online programs during the pandemic, explicitly recognizing online education ensures that no one is forced to make the impossible choice of receiving necessary benefits and risking their health and safety and the health and safety of those in the community. We recognize that due to systemic racism and sexism, women and people of color are disproportionately denied economic opportunities making LB516 key to advancing economic justice, gender justice, and racial justice. As such, we again thank Senator McKinney and offer our support for LB516.

***JULIE ERICKSON:** Thank you Chairman Arch and members of the committee. My name is Julie Erickson and I am representing Voices for Children in Nebraska in support of LB516. LB516 clarifies and updates the requirements of our state's Temporary Assistance for Needy Families (TANF) program, known in Nebraska as Aid to Dependent Children (ADC). The purpose of the program is to provide temporary support to parents who are struggling with meeting their children's basic needs. Over 10,000 children in almost 5,000 families participated in the ADC program in 2019. Due to program requirements, a family must have a very low income to be eligible for ADC. Further, the income provided by the program is also minimal when compared to the cost of basic expenses. The monthly average payment per family in 2019 was just $424. Due to the family's economic circumstances, these children in our state are often most in need of support to ensure that they have meaningful access to opportunity. The federal program requirements for

TANF were updated in the 1990s and are stringent and outdated. For minimal income, families are subject to stringent work or education standards that can be challenging to meet in the best of times. During the pandemic, the challenges of meeting program requirements have been exacerbated. An increasing amount of work and schooling is currently occurring virtually. After the pandemic, there may be work roles that continue remotely and online education has become increasingly more common. It makes sense for Nebraska to ease meeting program requirements where possible and clarify that those who are working or learning remotely are meeting requirements under the ADC program. We urge the committee to advance LB516. Thank you.

***STEPHANIE BEASLEY:** Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Stephanie Beasley (S-T-E-P-H-A-N-I-E-B-E-A-S-L-E-Y), and I serve as the Director for the Division of Children and Family Services within the Department of Health and Human Services (DHHS). I am here to testify in opposition to LB516, which would amend the requirements for Self-Sufficiency Contracts and Work Activities under Nebraska's Employment First (EF) welfare-to-work program. LB516 would allow remote or online course work for qualified educational activities and also require DHHS use self-attestation to verify participation in these educational activities. However, in November 2020, DHHS began allowing remote or online coursework for the educational activities covered by LB516. Federal TANF regulations require states to verify each individual's hours of participation through documentation in their case file. Based on guidance received from the federal Administration for Children and Families, self-attestation does not meet the federal requirements for documentation of participation. DHHS will verify remote or online course work of Employment First participants through electronic records and documentation provided by the educational institution. LB516 would subject Employment First participants who attend class in-person to stricter verification requirements than those who complete their course work remotely or online. Currently, participants who attend class in-person must have their attendance verified weekly by the educational institution. Thank you for the opportunity to testify today.

ARCH: Next proponent for LB516. Seeing none, is there anyone that would like to testify in opposition to LB516? Seeing none, anybody want to testify in a neutral capacity to LB516? Seeing none, Senator McKinney, you're welcome to close. As you come, I will mention that we

received two letters, both letters were in support. We also received one-- oh, excuse me, three, three written testimonies this morning. Two proponents, ACLU and Voices for Children; one opponent, Department of Health and Human Services.

McKINNEY: Thank you. In my closing, I just would like to say that LB516 is a bill to assist Nebraskan families that are dealing with a lot, especially during this pandemic. And as someone with a nephew who's been in and out of the hospital, my brother and his wife haven't been able to leave the home. So if they had the access TANF funds and, you know, complete a work requirement or go to school, I would like for them to be able to not get sanctioned and be able to still take the coursework and gain more education, which could potentially help with their finances in the future. And I, it's not just my family, but there's many families across the state that this bill would help. And I would encourage you to advance it to General File. Thank you.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: I just got to say, I appreciate actually the idea of the bill. That makes sense actually using online coursework, you know, in order to kind of gain some self-momentum in life and move forward and then not having to use TANF funds eventually. And I think that's what Diane mentioned, too, is like education is probably one of the surest ways to get out of poverty. So I, and so I'm curious to see if you do come back with any kind of an amendment or some way to work this to maybe move forward with it, I'd be kind of curious. But thanks.

McKINNEY: All right, no problem. Thank you.

ARCH: Any other questions? Seeing none, thank you very much. Thanks for coming today. That will close a hearing for LB516. And we will now open the hearing for LB626, presented by Senator Vargas.

VARGAS: Good afternoon, Chairman Arch, members of the Health and Human Services Committee. For the record, my name is Tony Vargas, T-o-n-y V-a-r-g-a-s, I represent District 7 in the communities of downtown and south Omaha here in the Nebraska Legislature. The bulk of LB626 puts into statute what is already in practice. Right now, statute lays out that we have a Child and Maternal Death Review Team. A couple of years ago, the group split and the Maternal Death Review Team became kind of a subcommittee under the umbrella of the Child Death Review Team.

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LBB626 makes this organizational realignment more formal by officially splitting the two teams and ensuring that committee members who are selected to serve on them have subject matter expertise in appropriate areas. LB626 also makes two additional substantive changes. The first is that it will allow the Department of Health and Human Services to hire a data abstractor to work with both the Child and Maternal Death Review Teams to obtain and analyze data that is relevant to cases they are reviewing. The second substantive change is that under LB626 both teams would be allowed to submit their annual reports directly to the Legislature rather than through the department first. One challenge we have seen is that through the CMDRT is required, this report is required to submit an annual report, but the annual report is often delayed and outdated by the time it is submitted to the Legislature. For example, the most recent report was published more than four years ago, in February of 2017, in fact, and it was review data from 2015. We're in 2021 when the Child Death Review Team was established in 1993 and then expanded to include maternal death reviews in 2013, the goals of the teams were stated to be the following: to identify patterns of preventable deaths; to recommend changes in system responses to deaths; to refer to law enforcement any newly suspected cases of abuse, malpractice or homicide; and to compile findings into reports designed to educate the public and state policymakers about child and maternal deaths. These goals can't be met without access to timely data for committee members, and we as policymakers cannot make informed decisions about potentially necessary changes in public policy if we don't receive an annual report with accurate and updated information. Now there are testifiers behind me who can talk more about how the Child and Maternal Death Review Teams work now and why these changes are important and necessary. Additionally, I understand the Department of Health and Human Services has submitted a letter to the committee with information about this report as well. Before I close, one of the other reasons why I brought this bill or I've been working in this arena with the child and, and maternal mortality is because, and some of you know this as I shared this in the past, with, with my first, firstborn, my daughter Ava, when my, when my wife was sort of nearing, nearing birth, she had preeclampsia. And it was very significant. It presented a lot of challenges. My daughter was born about five and a half weeks premature and was in the NICU. And my wife was in the hospital for about a week and a half, ten days post, with post-eclampsia, preeclampsia and post-eclampsia, and it dawned on me through learning more how there are many different issues that come

across with maternal mortality. And this one just hit me very close and that there is a need and and there's a structure in place in our state that provides reviews of maternal and child mortality. And we just want to keep making it better. And, and that's what this does. So I appreciate you all, and happy to answer any questions, unless there's some of the questions that can be answered by some of the testifiers after me.

ARCH: Thank you. Are there questions? Seeing none, thank you.

VARGAS: Thank you very much.

ARCH: Will you stay to close?

VARGAS: Yeah.

ARCH: OK, thank you. First proponent for LB4-- LB626.

TERESA BERG: Good afternoon, Chair Arch and members of the Health and Human Services Committee. My name is Dr. Teresa Berg, for the record, T-e-r-e-s-a B-e-r-g, I am a faculty member at UNMC Nebraska Medicine and the division director for maternal and fetal medicine. I also serve on the Maternal Mortality Review Committee for the state of Nebraska. However, I'm speaking not today as a representative of the university, but as a individual and a volunteer member of the Maternal and-- Maternal Mortality Review Committee in regards to LB626. As you are likely aware, the maternal mortality has risen in the United States. It has more than doubled in 30 years, from 7.2 deaths per 100,000 in 1987 to 17.3 deaths per 100,000 in 2017. There are disparities in health outcomes for mothers and newborns alike. According to the recent Surgeon General's call to action to improve maternal health, black women die of pregnancy-related causes at a rate of about three times higher. And African American-- I'm sorry, and American Indian, Alaska Native women die at a rate about two times higher than nonHispanic white women. According to the Centers for Disease Control and Prevention data from 2015, women in rural areas had pregnancy-related mortality that was at a rate of 29.4 per 100,000 live births versus 18.2 in urban areas. Nebraska has many women at risk for mortality based on this information. However, our current mortality review committee work is just in its early stages from the time that it was split up in 2013. The committee and the workflow process needs additional support and some modifications. Maternal

mortality reviews are different from child mortality reviews. Recommendations and resources for maternal reviews are, have been developed as part of a partnership with the Association of Maternal and Child Health Programs with the CDC Foundation and the CDC Division of Reproductive Health. These are published on a website called Review to Action and Outline a way to in detail look at maternal death. LB626 was introduced by Senator Vargas for this current legislative session. The bill calls for improvements in the Child and Maternal Death Review committees. It clarifies some definitions of what, what each committee is looking at, adds needed members and resources to the committee, and aligns the committees with best practice recommendations for the CDC. The bill increases the required members of each committee to include an abstractor, and that's in Section 71- 3406 in the positions defined in Section 71-3408 subsection (3). The addition of this member is critical to the efficiency of the teams and ensures that each review is completed unbiased. The abstractor would also allow for the volunteer members, which are a physicians and other members of the community that look at what the resources are for maternal care, to concentrate on their areas of expertise, rather than trying to decide if there's information that's missing in the record. I was invited to participate in the Maternal Mortality Review Committee just a little more than 18 months ago. This committee has a large number of very dedicated people from across the state, as well as cross-sections of our community. And I think that it's one of the most rewarding things I've been able to do as a physician in the state of Nebraska since I've been practicing here. We need to understand the factors that place the women in Nebraska at increased risk for poor outcomes. The systematic review of maternal deaths, as proposed by the CDC, includes the consideration of multiple risk factors, and the committee utilizes a form called the MMRIA form, which is a maternal mortality review decision making form. There has been considerable focus on creating a committee that is inclusive in all the areas that we find possible risks for the mother and allows for us to look at the maternal physical, mental and social wellbeing when we're looking at cause of death. In conclusion, this proposed initiation-- initiative, I'm sorry, will allow the committee to look at every maternal death with more clarity, it will help us define risks for our state that place women at the risk of death. And by identifying these risks, we will be able to develop or address the gaps in maternal care and move to decrease untoward outcomes such as death and morbidities in Nebraska. The state is a necessary public health partner for us to be able to

ensure the safety for Nebraska families. I'll be happy to answer any questions you may have.

ARCH: Are there any questions from the committee? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. One quick question, Dr. Berg. In your testimony, you said that the bill increases the membership by adding an abstractor.

TERESA BERG: Correct.

WILLIAMS: Can you explain to me what an abstractor is and what--

TERESA BERG: So an abstractor would be, be someone who, when a maternal death is identified, and you know, maternal deaths can occur up to a year after the baby is born, not just during the pregnancy and delivery. And so by identifying that, they will be able to look at their records, see if there's other things that are missing, even talk to members of the committee and say, this is what I found so far, do you think I need to go look for different kinds of records? We've had some difficulty with some of our reviews over the last 18 months, having to table a chart, table a-- table a review and go get more records for reevaluation the next quarter. We only meet four times a year, and to be able to keep this moving in a timely manner, it would be wonderful to have someone who would be able to look at those records before the committee meets and try to keep them as complete and-- as possible before the meetings.

WILLIAMS: Thank you.

ARCH: Any other questions? I have one. Approximately how many records do you review in a year?

TERESA BERG: Well, so when we started, when we started, we were three years behind, so we've caught up. The committee's now are not caught up completely. The committee is now in 2018, we're reviewing between four in eight deaths for every year.

ARCH: Four in eight deaths, so not every death?

TERESA BERG: No, four in eight-- no, four to eight maternal deaths.

ARCH: Would that include every death?

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TERESA BERG: To the best of our knowledge.

ARCH: OK.

TERESA BERG: There are some concerns whether or not every, and I think this is true for every state, Senator Arch, there's concerns that whether or not we catch every death that's associated with the pregnancy. Whether the patient did, or the person did not know they were pregnant, and so it was never recorded that they had a positive pregnancy test and it was something that happened early or that no one at the time of a death afterwards realized that it was within a year and the, and the death certificate was marked incorrectly. And that would, the abstractor would potentially help to make sure that we're not missing any maternal deaths also.

***SPIKE EICKHOLT:** Thank you Chairman Arch and members of the Health and Human Services Committee. My name is Spike Eickholt and I am a registered lobbyist at the ACLU of Nebraska. The ACLU offers its support of LB626 and we would like to thank Senator Vargas for introducing this legislation. The ACLU works to ensure that everyone can make the best decision for themselves with regard to whether and when to have children. However, we know that the decision to have a child in the United States can be dangerous, particularly for women of color. The United States is the only developed nation that has a maternal-mortality rate that is rising. Between 1991 to 2014, the rate more than doubled from 10.3 maternal deaths per 100,000 live births to 23.8 deaths per 100,000 birth in 2014. Racial disparities in these rates cannot be ignored. Black woman are three to four times as likely as white women to die during childbirth. LB626 recognizes that a need for more robust investigations into maternal deaths is needed in Nebraska. It ensures that maternal deaths are investigated separately from preventable child deaths to ensure that investigators and members of the investigation team have expertise in the area of maternal death. This will improve investigations and recommendations that come from these investigations. In addition to advancing LB626, we ask that the Health and Human Services Committee and the Nebraska Legislature as a whole do everything in its power to support healthy parents, healthy pregnancies, and healthy children in Nebraska. As such we offer our support of LB626 and urge its advancement to General File.

ARCH: OK, thank you. Any other questions? Seeing none, thank you for your testimony. Next proponent for LB626. Seeing none, anybody wish to

speak in opposition? Seeing none, anybody wish to speak in the neutral capacity? Seeing none, Senator Vargas, you are welcome to close. And as you are coming up, I will note that we received one written testimony from the ACLU as a proponent of LB626. And give me a moment here. Oh, there it is. And as far as letters for the record, two proponents, no opponents and one neutral submitted.

VARGAS: Great. Well, thank you, everybody. And the only thing I want to make sure to highlight here is there are a lot of things that we, we are tasked with. Even the sheer number that we just heard, eight to 10, we're not talking about, you know, the entire Medicaid system. But it is important that we review these deaths with a lens of informing our policy. Because if we don't, we can be shortsighted and missed opportunities for addressing long-term disparities. We've heard time and time again, one of the reasons why we do this is because there are real disparities by race, ethnicity and socioeconomic status when we look at those that, when we have maternal deaths or child deaths. That's why we do these reviews, because then we can improve the system when we do it case by case and we do it the right way. So these are pragmatic ways to go about doing it. The committee composition matters because the individuals in the room doing the review ensure that there's a good cross-section of diverse perspectives, thoughts, identities, both professional and from life experiences, also ethnicity and race. Data abstraction, and it was a good question, we want somebody that understands and has some expertise and background in, in, in case review, which, as you can imagine, if you're meeting four times a year, it is extremely helpful to have that background and experience. So that's why, why this is the recommendation here in this bill. The findings and recommendation, clarifying that language is in there because if the review doesn't lead to some concrete recommendations and it's still up to us on whether or not we do anything with them, it's a misstep. And so it's clarifying that there needs to be some level of recommendations when we're reviewing this, this subset or sorry, this number of cases. And the annual reporting, yeah, it was surprising to me that we have data from 2015 reported from 2017, and that was the most recent report. They're working on reports, so I'm not-- I don't want to say that DHHS isn't working on the reports. But if the reporting is available to us, it should be made available to all of us at the same time, not just DHHS, also the Nebraska Legislature and senators. And so I appreciate your time. I think this is a good thing that we, we should be doing to continue to

push forward on the momentum that we've had with this, these review teams. Thank you.

ARCH: Any questions for Senator Vargas? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Vargas, for bringing this bill. And I apologize if you talked about this in your opening, I missed it. So this is under DHHS, the review board, and so it's made up of, could you tell me the core members of both teams? It has a-- this is current. It has a DHHS, but then it's not all people that work for DHHS, correct?

VARGAS: No, it's not. And so some of the different components of additional required members or inspector general, child welfare, senior staff members within CPS, not limited, but can be including a county attorney, as you can imagine, you know, an FBI investigator or Native American, Native American reservation social worker. It can also include medical providers, community advocates, social workers. And then also, I think the really particular piece that's important here is members representing communities that are diverse with regards to race, ethnicity, immigration status, English proficiency. We find that there is an overrepresentation of people of color in many of these cases disproportionately. And because we see those numbers nationally and in many instances here, even locally, it's beneficial to have some diversity in those perspectives on the committee as well so.

M. CAVANAUGH: Thank you so much.

ARCH: Any other questions? I guess I just have one thought, and that has to do with the fiscal note, the request. If-- Dr. Berg just testified that we have about four to eight cases a year that are reviewed, we're asking for a full-time fiscal, a data abstractor for that. I guess I would just encourage you, I mean, can the department, with the multitude of employees, can the department perhaps provide us with somebody that could do this work for that group?

VARGAS: Chairman Arch, you don't want another person at DHHS? No, I'm just--

ARCH: Well--

VARGAS: No, I'm just kidding.

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ARCH: If it can be avoided.

VARGAS: Yeah, no. And I, I think that's a fair question. And I'll follow up with DHHS on this.

ARCH: OK.

VARGAS: You know, and I think part of the reason might be the language of specifically asking for an abstractor, that could be part of it. And, you know, it's not like they wouldn't make good use of it in terms of being able to find other things that they can help with, I guarantee you that.

ARCH: That happens.

VARGAS: Yes, that does happen. But, you know, it's important. And, you know, we'll look into the cost.

ARCH: And I agree. I agree, supporting the, supporting the team and making sure they have timely so they can keep up, absolutely. It is just the hiring of an additional staff member for that is my only question.

VARGAS: Especially when we have such amazing experience to volunteer individuals doing this work.

ARCH: Right.

VARGAS: So, and thank you to the proponent testimony.

ARCH: OK, seeing no other questions, thank you very much.

VARGAS: Thank you, everybody.

ARCH: This will close the hearing for LB626. And we will now open the hearing for LB183. Welcome, Senator Hunt.

HUNT: Hi. Hello, Chairman Arch and members of the Health and Human Services Committee. My name is Megan Hunt, M-e-g-a-n H-u-n-t, I represent District eight in midtown Omaha, and today I'm here to present LB183, the Sexual Assault Emergency Care Act. This bill would require emergency rooms to provide information about emergency contraception to all victims of sexual assault and to dispense the

contraception to give them that pill if they want it. This is an update to LB555, which I introduced in 2019, some members of the committee may remember it, which incorporates language from a compromise amendment that we worked out with the Hospital Association to alleviate concerns about penalties for noncompliance. And so this version is like LB555 from 2019 that's been changed to, to diminish some opposition that there was previously. Emergency contraception is a concentrated dose of hormone that's found in birth control pills. So you might know this typically as Plan B, is a brand name of emergency contraception. And what it basically is, is just a super dose of birth control. I want to be really clear and upfront about this, Plan B and emergency contraception does not cause abortion. It will not terminate a pregnancy that's already existing. The way it works is by delaying or inhibiting ovulation, and it will not work if the woman is already pregnant. It's a backup birth control method that's used to prevent unintended pregnancy after unprotected sex or a sexual assault. Emergency contraceptive does not terminate a pregnancy because it works to prevent the pregnancy before any fertilization has occurred. It's effective within about 120 hours after a sexual assault or unprotected sex. So the way, the way pregnancy works, as we all know, is that the sperm comes in, it has to get into an egg, and then the fertilized egg has to implant. I'm like pointing to myself. The, the egg has to implant in the uterus in order for it to start growing and develop a fetus and develop a baby. What emergency contraception does, to be clear, is it prevents the egg from showing up. There's no egg for the sperm to go into. And so if there is a fertilized egg, it's not going to do anything, the woman's going to stay pregnant. And then we can continue the fight later about what she can do with her options when she's pregnant. But what this bill would do is say that when a woman experiences sexual assault, rape, she goes to an emergency room. The people at that emergency room have to say to her, emergency contraception exists and we will give it to you if you would like it. And of course, to be clear once more, that doesn't mean that, that it will terminate a pregnancy if she's already pregnant. Emergency contraception is sometimes confused with medication-induced abortion, mifepristone, misoprostol. People in this committee are probably familiar with that from debates we've had in the past few years. Medication-induced abortion terminates an existing pregnancy, and all types of emergency contraception, Plan B, for example, these are only effective before a pregnancy is established and they are not abortifacients. So I belabored that point, got that on the record.

That's the medical fact around this medicine. Nineteen states and Washington, D.C. require emergency rooms to provide emergency contraceptive services to sexual assault survivors, which is exactly what this bill would do. And the provisions of this bill are all recommended by the American Medical Association and the American College of Obstetricians. And they recommend that physicians provide sexual assault survivors with emergency contraception upon request. You will hear arguments against this bill that it will terminate pregnancies, that kind of thing. These are arguments from people who are anticontraceptives, and I need this committee to be reasonable about what the rights of survivors are and, you know, how we want to support those survivors with regard to their choices after they experience a rape or an assault. You know, if we pass this bill, this doesn't mean that every patient will take emergency contraception, but it does give them the option which they should have. Like, we honestly shouldn't have to put that in a law, but unfortunately, there's several hospitals that decline to provide emergency contraception. And so we have to correct that so that all patients in Nebraska are receiving the standard of care and best practices. Emergency rooms are often the first places that victims of sexual assault turn to for support, and so it's really crucial that providers provide comprehensive, medically accurate, correct information to these patients so that they can make decisions about their future and, and, you know, what they're going to do after they have this horrible experience. We also know, of course, that the percentage of assault survivors who actually make it to the emergency room, who report the assault, who get the rape kit done, et cetera, that percentage is very low in terms of the, the whole number of people who experience assault. So these women have done everything right. They've gone to the emergency room, they've gone to get the help. And what we can do as the state is have their backs by making sure they have the medically accurate information they need to get the best care once they get to the hospital. Local studies have shown that a sizable share of hospitals do not routinely offer counseling, referral, information about emergency contraceptives or dispense emergency contraceptives to assault survivors. Anecdotally, advocates have heard many stories of Nebraska hospitals who have not provided this information or treatment. But hospitals don't publish any reports on this on the record. And because the law is currently silent on this matter, hospitals are currently free to do nothing if they choose, they're free to not give emergency contraception, if that's what they

want to do. When I introduced this bill in 2019, you know, so it's been about three years, and I've had listening sessions, I've listened to storytellers, I've met with many, many women in Nebraska who have told me stories about they went to certain hospitals and after they experienced assault and they were not given information about emergency contraceptive. Several women also told me that they asked for it specifically because they themselves were already informed about it, but they weren't-- the hospital said that they don't provide that medication. I already filed AM276 on this bill, so you can see it on your computer. I didn't distribute it, but you can take a look at that. It's a compromise amendment that addresses opposition from the hospitals and medical malpractice insurers. It also contains some cleanup language from drafters. I have no problem with the amendment. It definitely improves the bill. What the amendment does is it removes references to hospitals potentially losing their license as a result of violating the act, which they wouldn't under this bill. So it's just kind of a clerical error, I guess, like the bill said something that the original bill did in 2019, but this bill doesn't do it all. So it's just like a technical cleanup. We also changed a reference to, quote, best practices, to, quote, currently accepted professional standards of care. This was requested by a medical malpractice insurer. They just said that this is the language that they typically use. And so I said, I have no problem with that. The amendment also removes, quote, attempt thereof in the sexual penetration definition. This makes sense because if penetration didn't occur, there would not be a need for emergency contraception. I mean, there are many types of assault, but if, you know, if there's no penetration then there's no danger of pregnancy. And then there's also some drafters cleanups. Drafters wanted to add a definition of director, I have no problem with that. And we also received some feedback from DHHS over the interim and we incorporated all of that into the introduced version of the bill. I'd like to be clear that the intent of this bill is for hospitals to provide information about emergency contraception and provide the drug itself to those who need it. If the victim is at risk of having an unwanted pregnancy as the result of an assault, they should be informed about their options and provided access to emergency contraception if they want it. Once again, if their egg has already been fertilized, this won't do anything. That person is pregnant and if fertilization has not yet occurred, then this prevents the egg from being released so that they will not become pregnant. It's really unfair for sexual assault survivors to go into an

emergency room, hurt and traumatized, doing everything right and not know whether they're going to get medically accurate information. Right now, survivors have no way of knowing whether their nearest hospital will abide by what is the standard of care for sexual assault, because the law is silent on that in Nebraska. This bill provides uniformity that all hospitals follow the standard of care for sexual assault survivors in Nebraska. And I would be happy to take any questions.

ARCH: All right, I have one question just for clarification. There was an amendment, AM163 originally, or I should say-- I think that was filed previously, is that right, AM163?

HUNT: Oh.

ARCH: Is that--

HUNT: My bad.

ARCH: Is that-- is that been replaced by, by this other amendment?

HUNT: No, it's just the amendment that I filed on it.

ARCH: OK, so it's AM163 was the--

HUNT: Yes, the bill is LB183, which is what I said, but the amendment is AM163.

ARCH: OK.

HUNT: You're right.

ARCH: There's not a second amendment?

HUNT: You're right.

ARCH: OK. OK.

HUNT: Thank you for allowing me to clarify that.

ARCH: Just wanted to clarify that. OK.

HUNT: Yes.

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ARCH: Other questions? Senator Day.

DAY: Thank you, Chairman Arch. I just, so I just want to clarify with the amendment, it removes the discipline action against the hospital's license.

HUNT: Well, the, the discipline was already not in the original bill.

DAY: OK.

HUNT: But there was like a reference to it, and so the amendment just removes the reference.

DAY: OK, so essentially this bill doesn't require or it doesn't provide for the discipline against the license. It's only requiring the hospitals to provide the information or the option?

HUNT: Well, it requires them to provide the information and for them to dispense the medication if it's requested.

DAY: OK.

HUNT: There's no action that can be taken against the hospital's license under this act. But if there is a patient who feels like the hospital has violated this act, they could file a complaint with DHHS just like anyone could for any complaint against a hospital. And DHHS would investigate that complaint, just like they investigate any complaint.

DAY: OK, great. Thank you, Senator.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you. That's all.

ARCH: Senator Hansen.

B. HANSEN: I just have a couple of clarifying questions. So and it's more because I'm unfamiliar, do hospitals currently carry this type of medication? Like do you know if most or all hospitals carry this type of medication?

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HUNT: Yeah, it would be typical to. It's available over the counter, so you can get Plan B at Walgreens or CVS. There are some hospitals that don't carry it and they do not dispense it currently.

B. HANSEN: OK. So if this did pass, would hos-- would there be any kind of barriers from hospitals getting this type medication or would it be some kind of issue? Just I didn't know for sure.

HUNT: No, certainly not.

B. HANSEN: No, I would expect not. So and how would this information be distributed? Would it be like in a pamphlet? Would it be like in a sheet of paper that they sign or--

HUNT: It would be, well, I think that would be up to the-- let me find the section that says that for certain. So what Section 3 of the bill says is that the hospital which provides emergency care for sexual assault survivor, so if the hospital seeing a sexual assault survivor they will provide medically and factually accurate and objective written and oral information about emergency contraception in a language that the survivor understands. There wouldn't be any cost to this because they already have to provide certain kinds of information to survivors. And, you know, honestly, hospitals that are already following the standard of care are already doing this. You know, many hospitals in Omaha are already doing this. It's not unusual. And for a health practitioner, they would know what to do. They would know what the intent of the bill is for sure.

B. HANSEN: Yeah, I was just curious the design, or if there was already a pamphlet--

HUNT: No, I kind of leave that up to the hospital. And then, you know, there would be kind of a presumption that the hospital was giving the information correctly and it would just be up to a patient who has a complaint to file a complaint with DHHS if, if it doesn't happen. It's not like there's going to be, you know, contraceptive police in the hospital saying, are you telling everybody? It would be up to a patient to make a complaint. And that's the same system we have in place already for hospitals.

B. HANSEN: OK. And I think Senator Day answered one of my questions. If somebody does deny this, what the repercussions are, but you said

kind of go through the process of getting ahold of the department to make a formal complaint.

HUNT: Exactly. And it's not, it's not anything unlike what you would do for any other kind of complaint against a health care provider.

B. HANSEN: And can I ask one other question?

ARCH: Please?

B. HANSEN: And so are we talking at hospitals or are we talking about, like, all clinics? Because my-- the reason I ask that is I didn't know if there might be some kind of conflict if there, I don't know if there are or not, hospitals or clinics that based-- or have maybe some kind of religious reason why they may not do this. And then would this infringe upon their policy procedures based on if they're like a Christian hospital who doesn't believe in con-- I don't know if there are hospitals or clinics out there like that, but I know if that might conflict with their religious liberty of not being want-- wanting to provide.

HUNT: So the bill says any any hospital that provides care for sexual assault survivors. So it would include all of those. The hospitals did not request an exemption. I've been in conversation with the major hospital, you know, hospitals in Nebraska and all of us know that several of them are, are religious or Catholic or Christian based. And the hospitals did not request an exception. There are some things that hospitals have to do based on science and not based on religious morality. I tried to take some pains to explain how emergency contraceptives work. There are certainly hospitals that won't provide abortions, that won't provide abortifacients, but that's not what emergency contraceptives are. And so the hospitals did not ask for a exemption. And also under guidance of the Catholic Church, the Catholic bishops, they say emergency contraception is OK. And so, for example, the Catholic hospitals wouldn't have a problem with this.

B. HANSEN: That's what I was mainly curious about.

HUNT: Thank you.

ARCH: Any other questions? Senator Williams.

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WILLIAMS: Thank you, Chairman Arch. Thank you, Senator Hunt. And along a little bit the same line, if I'm, if I'm reading the bill right, this information is given to the patient whether they request or not. It's required by the hospital to give it.

HUNT: The hospital is already required to give information to the patient about the medical reality of assault and what they've experienced and, and what their health outcomes could be because of it, STI, STD treatment, and this would include information about emergency contraception. And like I said, most hospitals are already doing this because it's, it's the standard of care.

WILLIAMS: There are a lot of small hospitals in our state. I have five critical access hospitals in my legislative district alone. And they would be required under this to not only provide the information, but have the drug on hand if necessary again? OK, the next question is, is for you or someone that might follow you on splitting hairs. And I understand your distinction of when pregnancy happens and that description that you gave. Under those circumstances, how is that determined to be certain that that egg has not been fertilized?

HUNT: Because of the way the chemistry of the pill works. The hormone contained in Plan B, which is emergency contraceptive, will not terminate a pregnancy. It, what the mechanics of the chemistry of the pill does is it prevents the egg from being released by the, the ovary.

WILLIAMS: So if the egg were already fertilized, the adminis-- administering the drug would not cause--

HUNT: It would do nothing.

WILLIAMS: OK.

HUNT: It would be like taking a handful of Skittles

WILLIAMS: Thank you.

HUNT: It would do nothing. And also, I mean, I don't need to say this, but for the committee's benefit, there have been many, many studies on the safety of emergency contraception, including for pregnant women. And so if this is a concern for anybody, I'd be happy to talk more

about that, too. Trust me, this is, you guys know this is like the one thing I know a lot about so.

ARCH: Any other questions? Seeing none, thank you very much.

HUNT: Thank you.

ARCH: First proponent. Welcome.

SCOUT RICHTERS: Hello, my name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, I am legal and policy counsel at the ACLU of Nebraska here in support of LB183. Sexual assault and other forms of gender-based violence deprive women and girls of their fundamental ability to live with dignity. Women and girls experience domestic violence and sexual assault at alarming rates. Emergency contraception, as Senator Hunt said, is vital health care for women, particularly for sexual assault survivors. It's a safe way to prevent pregnancy after contraceptive failure, unprotected sex or sexual assault. But it's only if taken quickly. It's most effective within 12 hours, with effectiveness decreasing every 12 hours after that. So providing emergency contraception is part of the comprehensive care that sexual assault survivors must receive. And given how critical time is for emergency contraception, making it available in the emergency room is particularly crucial. As Senator Hunt mentioned, this is the care that's recommended by the American College of Obstetricians and Gynecologists, the American Public Health Association and the American Medical Association, who are the experts in treating sexual assault survivors. By requiring hospitals that provide care to sexual assault survivors to also provide these patients with medically accurate information about emergency contraception and make this care available. We ensure that patients receive comprehensive medical treatment and are able to make autonomous, fully informed decisions about their bodies consistent with constitutional guarantees. So we offer our full support for this legislation and we would urge the committee to advance it.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much.

SCOUT RICHTERS: Thank you.

ARCH: Next proponent.

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TIFFANY JOEKEL: Thank you. Chairperson Arch and members of the Health and Human Services Committee. Well, actually, my name is Tiffany Joekel, T-i-f-f-a-n-y J-o-e-k-e-l, and I'm here to testify in support of LB183 and the amendment on behalf of the Women's Fund of Omaha. Senator Hunt gave a very thorough opening, and so I will not-- I will spare you the reading of my testimony and try to address some of the points that I think are critical. The first is that rape and sexual assault are devastatingly common. They are, occur to a majority of women in our state, 83 percent of sexual assault victims who sought care were women. And a devastating majority of those are young women and a good portion of them are of reproductive age. So it is entirely possible that pregnancies could result from sexual assault and rape, and this bill seeks to ensure that no matter what hospital you seek care at, you will be provided what is recommended as the standard of care by medical experts. The American College of Obstetrics and Gynecology; the National Inst-- or the International Institute-- International Association of Forensic Nurses, who are the specific association that develops the standard of care and provides the care to sexual assault victims; the WHO; the CDC. I mean, you name it, and they will recommend that when a sexual assault survivor presents at the hospital to seek care that they are assessed for pregnancy and STI risk. So, Senator, to your point, Senator Williams, to your point about questions about is this something your hospitals will be required to do? The answer is yes. But in many cases, this is no different than assessing them for other sorts of injuries or potential risks that may have occurred. Do you have pain? Do you need X-rays? Do you need, you know, they're assessing what happened, who was the perpetrator. Are you-- do you menstruate, are you able to be pregnant? Have you had a hysterectomy? I mean, these are the sorts of things that they'll be assessing to determine the course of care. Additionally, before any care is provided, they will ask, are you pregnant? Do you believe you could be pregnant? And before they administer any care at all, they will admin-- if there's a chance a person could be pregnant, they will administer a pregnancy test. So that is how we determine in the moment when a person shows up to the ER, you know, if medically indicated, they will take a pregnancy test. So that is the level of guarantee that they have at the moment that the, the patient is not pregnant. And as Senator Hunt stated, even if they are pregnant, they could provide Plan B. Plan B has been very-- has been demonstrated it does not have an impact on existing pregnancy. And that is clear in research and I'm happy to share that.

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They just wouldn't provide it because you don't need it. It's not going to do any good. You know, it's not going to prevent a pregnancy if you're already pregnant. So that is how that is handled. I also want to really point out why this is important to provide uniformity across the state in the evidence-based standard of care, because in particular, a rape victim is not going to operate as an informed consumer, right? I am not going to call the hospital after my rape to make sure that they are providing the best standard of care. I'm not going to seek out recommendations on Yelp. Are they providing good care? Are they providing the full standard of care? This is a very, a very serious condition that presents urgently, and so I think this bill is desperately needed to ensure that all patients, no matter what hospital you seek care in as a result of your sexual assault, you're provided the best care that you can have access to. Plan B is the most common emergency contraception, provided it is relatively inexpensive, it is relatively easy to store. So it is not a tremendous hurdle for hospitals to access or maintain in their facility. You know, you'll hear from opponents that emergency contraception is an abortifacient. And I don't think I will convince you. We tried that last time, where I spent a lot of time talking about how sex becomes a baby, and I don't think any of us want to do that again. Senator Day, I'm sorry you missed it. But I would say I think there's a couple of additional reassurances. One is that the definition of emergency contraception in the bill clearly states prevents a pregnancy, right? It does not say disrupt. It says prevents. And so that is the mechanism by which emergency contraception operates. Additionally, there is a time requirement for utilization of emergency contraceptives in that it is ineffective if used too late. And that is because, again, we're trying to prevent a pregnancy, not disrupt an implanted one. If we were trying to disrupt an implanted pregnancy like mifepristone, you can take that for several weeks into the pregnancy. But EC is only effective up to 120 hours post pregnancy. The last thing is, yes, you can get EC elsewhere. Yes, you can get EC over the counter, you can go get birth control without a prescription. But time is of the essence to make these work, and to prevent pregnancy, we want to reduce barriers for sexual assault survivors who are already traumatically affected by this. And we would ask that we take those steps to make sure that no matter where they show up, they can receive the standard of care. So with that, I'm happy to answer any questions.

ARCH: Thank you. Are there any questions? Senator Hansen.

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B. HANSEN: You brought up some interesting points.

TIFFANY JOEKEL: Thank you.

B. HANSEN: I was looking, reading through your testimony. I think Senator Hunt brought this up too about how picking-- and I'm just playing devil's advocate--

TIFFANY JOEKEL: Sure.

B. HANSEN: --by what some of the opposition might say as well--

TIFFANY JOEKEL: Sure.

B. HANSEN: --that it does not prevent a pregnancy. I know there's different terms of pregnancy. I know I think according to the science and the research, pregnancy is when the, the sperm meets the egg, now they're pregnant. Some states, I don't know, I can't remember what we have, if we have anything in statute. Some say pregnancy starts when it actually attaches to the uterus. I don't know if that's in Nebraska statute that or if Nebraska says, oh, pregnancy starts when the-- so the sperm meets the egg and is not attached yet.

TIFFANY JOEKEL: Right.

B. HANSEN: And Plan B, from my understanding, because it affects hormone levels and doesn't allow it to attach, right? Yeah. So it could still be fertilized, but as long as it's not attached, you might-- is that wrong? OK, maybe Senator Hunt can clear that up with me a little bit. I'm just trying to figure out kind of where we're at as a state and, you know, what, what nationally they kind of say.

TIFFANY JOEKEL: Sure. I'm happy to speak to that, Senator so--

B. HANSEN: It's up to you, or maybe Senator Hunt can--

TIFFANY JOEKEL: No, I'm--

B. HANSEN: Sure she'll clarify too so.

TIFFANY JOEKEL: I am happy to. To my knowledge, I don't know that Nebraska defines when pregnancy begins.

B. HANSEN: OK.

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TIFFANY JOEKEL: I would say that we have no way of knowing if an egg is fertilized. The way we can tell a pregnancy begins is by the hormones released when a fertilized egg attaches to the lining of the uterus. So it's difficult to even know when an egg is fertilized. And naturally, a woman's, a woman's body will pass fertilized eggs quite commonly without im-- so not every egg that is fertilized becomes an implanted egg on the uterus, uterine wall. You know, you will hear from the opposition some distinctions about how EC occurs. Plan B very clearly prevents ovulation. It prevents the egg from leaving the ovary to meet a sperm available in the fallopian tube, which then moves to the uterus to attach to the lining to become, to become implanted. And so I think that is true. But you don't have to believe me, is the deal right? ACOG, several other people who are medical experts, acknowledge that EC does not disrupt an existing pregnancy, the FDA. It is safe when taken if you are pregnant, so they would not say that if it would disrupt an existing pregnancy.

B. HANSEN: Sure. OK, thanks.

TIFFANY JOEKEL: Thank you.

ARCH: Senator Day.

DAY: Thank you, Chairman Arch. And thank you for being here today and thank you for your testimony. I think-- so we understand that sexual assault is a very traumatizing thing for, to happen to a woman. She was forced to have some kind of sexual activity against her will. This isn't something that she chose. Why would it be important for a woman to-- why, why would she want to prevent a pregnancy resulting from sexual assault?

TIFFANY JOEKEL: I mean, I think it would-- there's clear research that a pregnancy resulting from a sexual assault may traumatize, continually traumatize a survivor. And again, you know, it's not really my call to make about whether a person takes that EC and chooses to present-- prevent the pregnancy. I think all of this bill is asking is that they're provided the information and the option to make the choice for themselves. And, you know, I also think one thing that's important, because we mentioned religious institutions that may be forced to provide emergency contraception under this. I do think the bill, Section 3, sub (3) provides that if a particular provider with an institution has a challenge with providing this, it's up to

the hospital to determine the process by which that can be overcome, right? So if the particular doctor in that moment has religious objections, there could be other, other ways and other methods to overcome that. So I think that's important to name as well.

DAY: Thank you.

ARCH: OK. I have, I have a question, it's a follow up to Senator Hansen. So if Plan B prevents an egg from being released, timing is everything, right?

TIFFANY JOEKEL: Yes.

ARCH: What if the egg has been released already at the time of assault and the egg becomes fertilized? Does it at that point prevent attachment to the, to the uterus?

TIFFANY JOEKEL: Plan B does not prevent attachment. Plan B operates, its primary mechanism is preventing-- or delaying ovulation. Its secondary mechanism is thickening the cervical mucus so that the sperm cannot reach an egg if it were to drop. So there is nothing in Plan B's effective mechanisms that prevent it, prevent a fertilized egg from attaching to the uterine wall.

ARCH: All right, thank you. Any other questions? Seeing none, thank you for your testimony.

TIFFANY JOEKEL: Thank you.

***MEG MIKOLAJCZYK:** Dear Chairperson Arch and members of the HHS Committee, my name is Meg Mikolajczyk and I am the Deputy Director and Legal Counsel for Planned Parenthood North Central States in Nebraska. Central to our mission at Planned Parenthood is the conviction that all people deserve to live in communities where sexual and reproductive rights are recognized for what they are - basic human rights. All people deserve to lead safe, healthy, and meaningful lives. In order for this to become our reality, people should have access to the health care they need regardless of the institution's or the individual provider's religious affiliation or beliefs. And this is particularly true in the context of rape survivors seeking immediate treatment post-assault. Planned Parenthood provides sexual and reproductive health care at two health centers in Nebraska. We strive to treat all our patients with dignity and care while providing

them with the best scientifically-based, nonjudgmental information about their healthcare and their bodies. No matter what. One of the many services we offer is emergency contraception, the medication that is the subject of LB183. Emergency contraception is a hormonal birth control taken after sexual intercourse that works primarily by delaying or inhibiting ovulation.1 Plan B or generic versions of the same medication are offered over-the-counter and can be taken up to 72 hours after intercourse. Another version of emergency contraception, ella, is available via prescription only, and can be used up to five days after intercourse. Finally, the copper IUD, if placed within five days of intercourse, can act as emergency contraception. Planned Parenthood offers all three types of emergency contraception to our patients. Emergency contraception does not induce abortion, and should not be confused with mifepristone, also known as the "abortion pill." According to the National Protocol for Sexual Assault Medical Forensic Examinations, overall wellbeing is improved when sexual assault survivors have a positive experience with the criminal justice system and the medical system after their assault. However, a survivor cannot have a positive experience with a healthcare system that refuses to provide them with everything they need to move. forward after an assault, including, if the patient would like, emergency contraception. The Nebraska Planned Parenthood health centers regularly see patients who were denied access to time-sensitive emergency contraception and other requested health care immediately following a sexual assault. This means that our patients, managing their own recent traumas, receive only part of the care they need, are forced to do their own research on where to find emergency contraception, must obtain additional transportation to our health center, and relive their trauma to more health care providers, in order to get the care they deserved from the beginning. For sexual assault victims in particular, the experience of being denied care during their first interaction with the medical system after an assault can be incredibly traumatic. Patients that seek follow up care from Planned Parenthood have often been denied care by a Catholic institution, which are governed by a set of Bishops' Directives outlining the care they can or cannot deliver to patients, regardless of medical best practice. But, in the United States, Catholic women support policies like LB183. A 2000 poll found that 78% of Catholic women in the United States prefer that their hospital offers emergency contraception for rape victims. Furthermore, 57% of those women want their hospitals to provide it in circumstances broader than rape.

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Planned Parenthood proudly serves anyone who needs care. Our focus is on patients' needs. To be the best advocates we can be for our patients, though, we are strongly advocating that those patients receive all their health care from the provider they see immediately post sexual assault, often an emergency room. Continuity of care and the essence of time are both critical factors to sexual assault survivor patients' health. Planned Parenthood supports LB183 because we want to minimize how many times a patient must relive their trauma before receiving care, and we support policies that get a patient medically accurate information and care as quickly and seamlessly as possible. People living in rural areas of Nebraska face even more barriers. One in six patients in the United·States will visit a Catholic hospital for their care. In Nebraska, a Catholic hospital may be the only healthcare provider in the area. Depending on the institution's and the provider's interpretation of the Catholic Bishops' Directive 366, which governs ethical considerations for provision of emergency contraception, a survivor may be denied access to the standard of care for treating a sexual assault survivor. Rural survivors may not have a choice of provider given the shortage of care, and therefore may be completely foreclosed from treatment post-assault. LB183 closes this gap and ensures that all Nebraskans, regardless of geography or religious beliefs, will experience the same standard of care after an assault. The risk of pregnancy from rape can be a cause of serious trauma to a victim of assault. It is the responsibility of healthcare organizations who work with sexual assault survivors to provide the full range of accurate healthcare options available to them. For these reasons, we respectfully request the committee advance LB183 to general file. Thank you, Senator Hunt, for bringing this issue to light and advocating for better policies.

***KATIE ZULKOSKI:** Chairman Arch and members of the Health and Human Services Committee: My name is Katie Zulkoski testifying in support of LB183 with AM163 on behalf of the Nebraska Coalition to End Sexual and Domestic Violence. I ask that it be included in the committee statement for LB183. The Nebraska Coalition was established to support local programs providing direct services to victims of domestic and sexual violence across Nebraska. These local programs provide advocacy services to victims, including medical advocacy to victims of sexual violence. Medical advocacy is a support service that, in its most basic form, involves being present with a victim who is seeking care as the result of their victimization. Medical advocacy is often

complex and helps the victim of sexual assault engage with a fast-moving, emergency medical system. Rebecca Campbell notes that when a sexual assault victim reaches out for help from systems that are designed to help the victim, that victim is placing trust in the system. Campbell suggests that even though some individuals have positive experiences with various systems, this is often not the case. This often causes secondary victimization to occur, further traumatizing the Victim. In their report, Community Approaches to Sexual Assault: VAWA's Role and Survivors' Experiences, researchers note the decisions many survivors of sexual violence face. Survivors must decide if and when to seek medical care, call advocacy hotlines, seek additional advocacy support services and contact law enforcement. They note that making anyone of these decisions requires the survivor to consider many factors related to the community as well as their own personal history. These considerations are often complicated by emotions related to the sexual assault itself. When survivors enter the medical system because of a sexual assault, they can be overwhelmed. Not only are they dealing with the trauma of the actual assault that has taken place, but they experience things most of us have never considered. The victim's body may be seen as a crime scene. If they choose to undergo a forensic medical exam, the medical provider is tasked with collecting evidence for a criminal investigation. However, Campbell notes that the needs of this patient often go beyond that forensic exam. These needs can include the screening and treatment for sexually transmitted infections, pregnancy testing, and emergency contraception. She notes that even though the focus is often on collecting evidence, all sexual assault victims should be assessed for other medical needs. Unfortunately, many of these needs go unmet, including needs related to pregnancy services. According to the Sexual Assault Victims' Bill of Rights information sheet, created as a result of LB43 (2020), the forensic medical exam should be completed within five days of an assault. The Center for Disease Control and Prevention recommends that emergency contraception be administered within 5 days. Providing information and access to emergency contraception should coincide with other emergency care provided to the sexual assault victim, such as the forensic medical exam, rather than forcing the victim to seek information from another provider. Individuals victimized by a sexual assault have a very limited window to seek information and treatment, let alone having any opportunity to seek a second opinion. LB183 and AM163 help to create consistency when treating sexual assault victims. Knowing that the

information they receive and the treatment options available at an emergency care provider is the same information and options that the patient would receive at any emergency care provider in the state will help develop trust in the medical system and may encourage victims of sexual assault to come forward and engage the system to receive the services they need. The Nebraska Coalition supports LB183 and AM163 and urges you to advance this bill with its amendment for debate by the full Legislature.

ARCH: Next proponent. Seeing none, is there anybody that would like to testify in opposition?

STEPHEN H. ZACH: May I put this with it? [INAUDIBLE] a copy of it. It's a pro-life directory, if anybody needs any help--

ARCH: Excuse me just a second, please have a seat. We need you to-- did you provide a green sheet to the, to the, to the staff? Yes. We just need to have you state your name and spell it for us to be clear.

STEPHEN H. ZACH: Stephen H. Zach, last name is Z-a-c-h. Stephen, S-t-e-p-h-e-n, H. For Henry.

ARCH: Thank you.

STEPHEN H. ZACH: And I wanted to mention I thank you for having this forum today. I just heard about it and I, I'm involved with the Knights of Columbus, joined in 1974 and I'm with Nebraska Embracing Life, a large pro-life group in Omaha, has been around for 50 years, I'm sure. Not quite 50 years because legalized abortion came out in 1973, so since then. And I wanted to state a personal situation where a, a girl, a minor who went to Planned Parenthood, she was taken there not by her mother. And by rights, she shouldn't have been given that, the RU-486 pill, the emergency contraceptive pill that kills the baby. But first of all, she was placed under some sleep, some medication to make her rest at 9:00. At 1:30, a lady came to get her, a social worker. And I won't say what-- who it was. And the-- she didn't want to go home to the mother and she's a minor. So really, I think Planned Parenthood was wrong in doing that. I'm not an attorney, but she went home to another lady's house, laid on a floor and crawled all over the place, vomited, and the baby expelled all on the floor. The baby was expelled and died, of course, and it wasn't very big. I can tell you how big it was, but I don't want to bother you all with that. But they

took the baby to-- the girl and the baby to the hospital, and a priest came and baptized the baby. Well, I, I was going to ask, is this so-called emergency medical pill going to be for minors too? Do you have to have a parental consent to take this particular emergency contraceptive pill? I think that's a question I have. Can minors showing up, show up at Planned Parenthood or the place where they kill babies and and get that pill? And also, I was wondering was she really, really, really raped? Can anybody say I've been raped, I want the pill? I've been raped, I want the pill. Do you have to have proof that you've been raped? I'm sorry, I'm not trying to be mean to, to the women. And, and our Catholic Church, I'm Catholic under the Archdiocese of Omaha, I've gone to cathedral in Omaha for over 50, 52 years. And an usher and tour guide there, mother-- father, we had four children. One of my daughters is a doctor and I can name the other ones, too, are doing well, Catholic education. But I just, I just feel that the Catholic churches and the Knights of Columbus are first and foremost pro-life. That's why this directory of all agencies that will help women and girls, I like to help. Hope you have, all get a copy of it. I submitted it to the clerk. But this family called me, the girl called me, the helpers were trying to help her, the Sancta Familia. There's a reversal pill you can take, so we tried to get that in time. But the lady, the girl, she was fifteen or thirteen, she aborted on the floor. And what a mess, I was told. Anyhow, so I hope that helps stop. And then I had another thing about all hospitals. Our past President Trump, the poor, the poor sisters in New York. I mean, they were mandated to pay for abortion in their hospital insurance. And now is, is this, this so-called bill that you're voting on, is that going to enforce all hospitals or Catholic doctors or to, to, to have to have this pill on their, on their, in their presence, on their companies, on their hospitals, on their care center? And this paper here that I submitted, it's on a website underneath the archdioceseofomaha.org [SIC]. So you can find this here. And, and the reversal is on it, too. So there is a reversal pill. So I'm saying this and I'll try to end, two wrongs don't make a right. So if the person was raped, and I'm not saying she wasn't it, that's one wrong. And to kill the baby with, with the contraceptive pill, which the Catholic Church is against, because we believe egg, egg, once the egg and sperm unite, it's a human being. So whether or not it's getting attached to the uterus or not, it's a human being at the conception, at conception. So two wrongs don't make a right, you've probably heard

that before. She was wrongly abused, raped. Then you're gonna, the child, you're gonna kill the baby, that's a second wrong so.

ARCH: Sir, the red light has, the red light has come on.

STEPHEN H. ZACH: The red light came on.

ARCH: The red light came on.

STEPHEN H. ZACH: I'm done.

ARCH: All right.

STEPHEN H. ZACH: Well, thank you very much. I, I gave you my-- and I'm a father of ten children and grand-- ten grandchildren and four children, pro-life. Thank you.

ARCH: Thank you for your testimony. Next opponent. Welcome.

MARION MINER: Good afternoon. Excuse me, Chairman Arch and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life by engaging, educating and empowering public officials, Catholic laity in the general public. And I'm here today to express the conference's opposition to LB183. LB183 would impose a legal mandate on hospitals to dispense emergency contraception to a woman who's been a victim of sexual assault. Emergency contraception is defined broadly in the bill as a drug approved by the Federal Food and Drug Administration that prevents pregnancy after sexual intercourse. As a practical matter, and I want to emphasize here, too, that the-- we understand there's a difference between RU-486 and mifepristone on the one hand and something like Plan B or Ella, which is properly considered emergency contraception on the other. So those, those are very different things. That being said, Plan B, Ella, other emergency contraceptive drugs do work in, in more than one way. One of the ways in which they work is to prevent ovulation. And that is what-- that's what we've been hearing during proponent testimony, is that ovulation is prevented by these, and that if ovulation is not prevented and fertilization occurs, that nothing would happen to disrupt implantation after that. That is not what the scientific evidence reveals, and I would point you to footnote 1 here on my testimony, and that is a review of a lot of the literature and a

study on exactly how this works. And, and the compel-- the evidence is compelling that in these studies they've shown that in the administration of, of these, you know, emergency contraception, the actual incidence of it stopping ovulation is pretty small. It doesn't actually happen in most cases. Nevertheless, pregnancy occurs or does not occur, I should say, or is stopped from occurring, if you define pregnancy as, as we would, at the moment of fertilization. So these drugs are extremely effective, despite the fact that they often fail at preventing ovulation. That's what the science shows. Now, I also want to emphasize that the Catholic Church actually does not have a position against administering emergency contraception in the case of rape, if they can determine-- if they, there is no evidence that pregnancy has already occurred. So when the woman comes in and presents after she's been sexually assaulted, the normal course of action is for them to actually see where exactly she is in her cycle, do some testing, some blood and urine testing to determine-- they do a series of tests basically to determine where exactly is she in her cycle and is administration of emergency contraception based on where she's at likely to prevent ovulation or not? If it's not likely to prevent ovulation, then the drug, if it's effective, is going to have an interceptive or abortifacient effect, not an inovulatory effect. And in that case, in that case, where the administration of the drug is not likely to prevent ovulation, in that case, a Catholic hospital cannot administer the contraception, the emergency contraception. If, however, it is likely that it will prevent ovulation, they will administer emergency contraception. So that's what's important here, is that this-- that what the bill would do would be, would actually remove the hospital's discretion to determine whether it's morally permissible for them to comply and emerge-- and administer the contraception in specific circumstances. Because Catholic hospitals do administer emergency contraception if it's morally permissible for them to do so according to their religious and ethics-- ethical and religious directives, which I've referenced here in my testimony as well. A hospital's failure to comply would lead first to a formal rebuke and an assurance that the deficiency has been corrected and second to the imposition of a $1,000 fine for each individual failure to comply. And I will say with regard to protection of conscience rights there, what Ms. Joekel referred to with regard to doctors being able to sort of opt out, what it doesn't allow is for hospitals themselves to be able to opt out. They will have to find somebody to

administer it if the individual doctor will not comply. I see my time is up, so I'll stop there.

ARCH: Thank you. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Good afternoon, Mr. Miner.

MARION MINER: Good afternoon.

M. CAVANAUGH: I pulled up this website that you are referencing. And can you tell me a little bit more about Linacre--

MARION MINER: The Linacre Quarterly?

M. CAVANAUGH: Yes, thank you.

MARION MINER: I don't, I don't-- so the Linacre Quarterly, if I recall correctly, is a publication of the Catholic Medical Association. Now, the author of this particular study, I forget her name, Raviele, I think is her last name, if I remember correctly.

M. CAVANAUGH: Yes.

MARION MINER: I don't know a whole, a whole lot about her personally, but the Linacre Quarterly has been around for a very, very long time. It's, it's a very old and established medical journal and still being published, obviously.

M. CAVANAUGH: And is she an obstetrician?

MARION MINER: I, I-- do I have it? Oh, I do have in front of me--

M. CAVANAUGH: Because I'm comparing it with the information on womenshealth.gov--

MARION MINER: Kathleen Raviele, M.D., is a fellow in the American College of Obstetricians and Gynecologists and is past pres-- past president of the Catholic Medical Association. She's in the private practice with gynecology.

M. CAVANAUGH: So her, her presupposition is in direct conflict with the U.S. Department of Health and Human Services Department of Women's Health as to what emergency contraception is and how it works. This is about preventing pregnancy, not terminating pregnancy.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

MARION MINER: Well, again, there's a, there's a critical distinction between-- it really turns on how you define pregnancy, right?

M. CAVANAUGH: Well, an unfertilized egg is not pregnant.

MARION MINER: Correct.

M. CAVANAUGH: That's what we're talking about.

MARION MINER: OK, that's, that's great. Which I was actually--

M. CAVANAUGH: We're not talking about a fertilized egg not getting implanted. We're talking about unfertilized egg.

MARION MINER: Right. There's no pregnancy there.

M. CAVANAUGH: Right.

MARION MINER: Right. So--

M. CAVANAUGH: So what's the problem?

MARION MINER: The problem is that this drug actually has the capability not only to prevent ovulation, but also to prevent fertiliz-- also to prevent implantation of an already fertilized egg.

M. CAVANAUGH: Not according to the U.S. Department of Health--

MARION MINER: I would encourage you to read the study.

M. CAVANAUGH: I will read the study, but the U.S. Department of Health and Human Services probably has more resources to do the study than this woman does.

MARION MINER: There-- no, and this is not-- if you would like--

M. CAVANAUGH: How about this, I'll make you a deal. I'll read that study and you read this, the--

MARION MINER: Oh, I, I certainly will.

M. CAVANAUGH: Thank you.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

MARION MINER: And this isn't the only study that points in this direction. And in fact, in fact there--

M. CAVANAUGH: I'll read your study, you read mine.

MARION MINER: I certainly, I certainly will.

M. CAVANAUGH: Thank you.

MARION MINER: If if, it would be helpful, I would provide more studies as well. But this is, this is the one that I think that makes the strongest case.

M. CAVANAUGH: I don't think I'll have time for more studies, so I'll just read the one you've presented today. Thank you.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: I just have a quick question because I haven't read the study. So a pregnancy test would not be enough evidence for, for--

MARION MINER: No, not in and of itself, that would, that would be part of the protocol because they also have to-- and a previous testifier mentioned this as well as part of just the standard protocol for pretty much everybody. You do a pregnancy test to make sure that she has-- that there's no indication that she wasn't pregnant actually before the sexual assault took place. That's part of the process. But that's only one part of the process. After that, because sperm can live five or six days after the act of intercourse or the act of rape, then what you have to be concerned with is whether ovulation is going to occur within that sort of fertile window. And if it does occur within that fertile window, then fertilization can occur. And if you don't stop that ovulation from happening, that is what is likely to happen. Now, if you administer, and this is my understanding of the science, if you administer the emergency contraception too late, too soon to that ovulation occurring, it's not actually able to prevent it from happening. So the ovulation still occurs despite your administration of the emergency contraception. And then what may happen is that the drug will work in an interceptive or abortifacient function so that it will actually prevent the fertilized egg from implanting in the uterus or in some cases actually have an effect on the uterine line, lining, which will disrupt an already implanted

pregnancy. But I think the evidence for that is weaker than the case for preventing implantation.

WALZ: How are doctors able to determine whether a woman, where she is in her cycle? How accurate is that?

MARION MINER: Yeah, I think that that that can actually be pretty tough in some circumstances.

WALZ: Yeah.

MARION MINER: That's my understanding. And that is another reason why these hospitals have to have some ability to determine, I mean, to have some leeway and make a judgment call in these circumstances. Because what they're, what they do is simply make a judgment call based on whether it's likely that this is going to have-- this is likely to stop ovulation or not. And if the evidence is likely that it's not going to stop ovulation, then they can't proceed and do that morally. If there's no evidence that it's unlikely to prevent ovulation, then they can go ahead and they do. They, they prescribe emergency contraception and dispense in that case.

WALZ: But it's hard to determine that.

MARION MINER: Yes, it sometimes is. Yes.

WALZ: All right. Thank you.

ARCH: Other questions. I have one, and that is are you aware how hospitals currently practice regarding Plan B? Are there hospitals in the state of Nebraska who don't do it at all, who use your, your testing and determine whether they should? Or, I mean, is it all over? I'm not familiar.

MARION MINER: So I know that, actually this is funny.

ARCH: And I don't need necessarily names of hospitals, but--

MARION MINER: Right. I have been in correspondence recently and in the past, in the past with hospitals who apply-- who have told us that they abide by the ethical and religious directives of the Catholic Church, including number 36, which I have referenced here. And that means they go through the protocol. Is it likely that this is going to

stop ovulation or not? And that determines the next step that they take.

ARCH: So if they adhere to those Catholic direct-- directives, is that--

MARION MINER: Right.

ARCH: If they adhere to those, then they would be practicing what you say.

MARION MINER: Right. Correct, yeah. And I apologize too if, if I'm not super clear in the way that I'm explaining that. But the directives, I think, are pretty clear.

ARCH: No, I'm familiar with the Catholic directives, not to the detail you are, but--

MARION MINER: Sure.

ARCH: --but if that's, if that's in there then-- and if they say that that's who they are, then that's what they're abiding by. OK, thank you. Any other questions? Seeing none, thank you for your testimony.

MARION MINER: Thank you.

ARCH: Next opponent for LB183.

DAVID ZEBOLSKY: David Zebolsky, Omaha, Nebraska, D-a-v-i-d Z-e-b-o-l-s-k-y. I'm also with Nebraskans Embracing Life and here to oppose this bill, LB183. I think the questions and the concerns about their being a conceived child present are very important ones to ask. If there's any chance that there's a child and if there's any chance that there could be an abortion, we should certainly air on the side of caution. I just want to point out that if you receive the emergency contraception available over the counter and you open up the package, you'll get a patient, patient information that indicates these possible side effects: cerebral hemorrhage, cerebral thrombosis, melasma, which is skin discoloration, migraine, headaches, dizziness, it can affect the function of the eyes. It can affect the change in corneal curvature, it can affect the heart and the blood, thrombosis and venous thrombosis with and without embolism. It goes on to talk about other blood conditions that could-- complications that could

occur. Pul-- pulmonary embolism, myocardial infarction and on and on. Those are just a few. Senator Hunt just said it would be likened to taking a handful of Skittles. I think you can see how disconnected she is from her own bill. Are these warnings on the legislation? Are these warnings in the amendment? What of the possible side effects to the traumatized mother and what of the real risk to the possible conceived child? I guess that's, that's, that's my testimony. That's just what I'd like to offer. And please, err on the side of life in your consideration. The state has no place in requiring hospitals to offer these, what I would call abortifacients. Thank you.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony.

DAVID ZEBOLSKY: Thank you.

ARCH: Anyone else wish to testify in opposition?

AMBER PARKER: OK. My name is Amber, A-m-b-e-r, last name is Parker, P-a-r-k-e-r. From Senator Hunt's own summarization, or I should say her office, it says the following constitutes the reasons for this bill and the purposes which are sought to be accomplished thereby. LB183, the Sexual Assault Emergency Care Act would require hospital emergency rooms to provide sexual assault survivors with medically and factually accurate information regarding emergency contraception and to provide emergency contraception if the patient requests it. So not only are we going to force our hospitals through LB183 to carry and to go against perhaps their moral or religious convictions, because remember, a hospital is not a building, people work in there. So let me tell you this. If you guys are familiar with a hospital, an emergency room, doctors have emergency surgeries that come up. There are nurses that have to go and assist. So who-- we really need to break it down. Who's going to end up doing this? This bill, and I just-- I want to focus on the core. But under the Constitution of the United States of America, under Amendment 1, you can not impede, you cannot infringe upon freedom of speech, freedom of religion, freedom of press. What are you doing? You are going against all three of those areas when you are telling a hospital who does not want to have anything to do with Plan B. You know, the other area I would like to address is that Plan B, isn't it-- it's interesting, some call it an abortifacient and then others say no, it just prevents ovulation. So we're getting in a terminology war. But what we got to look at in the

governing law in any legislation here in the Nebraska state Legislature, is it, is it under the governing law of the land? Because if it's not and it's infringing upon people's religious liberties, and I want to go to page 2, subsection-- line 19 [SIC], subsection (3), if I'm saying it correctly, "A hospital which provides emergency care for a sexual assault survivor shall ensure compliance with the Sexual Assault Emergency Care Act and shall develop policies and procedures, as necessary, to ensure compliance with the act in the case of moral or religious objections by individual health care providers." So now are we going to put our hospitals in a position to say, I'm sorry, we can't see a sexual assault because the people don't want to have on their conscience that they were part or aiding to an abortion? And I'm just going to be real with you. When you talk with sexual assault victims, they're not in their right mind. They just went through a traumatic experience when they come in. Some of them don't even come in within two hours. It might be six hours, it might be 10 hours, it might be 12 hours. And it depends who, if somebody drives them. But one thing I'm going to say is there's no need for this legislation here, because according to Plan B, anybody can go into the store and pick it up. You don't need an ID or a prescription required. Furthermore, with the time frame that Senator Hunt is pushing and saying it's important that they have this readily available, well, if you know anything about a wait in an ER, sometimes, I mean, if you're in New York, it can take hours. If you're in California, it can take hours. So Nebraska usually isn't as long, but they have the option to go to a store and buy Plan B. And I'm not saying that I support that, but that's the reality. So when we're looking at that legislation here. So what this is doing, it is really a witch hunt on our hospitals for an abortion. And Senator Hunt, I'm guessing, likes abortion by this bill. And it is saying we don't care what your religious beliefs are. This is the case. Furthermore, we need to ask ourselves, there are women, so what-- what is the, the cases against discrepancy in this bill where a lady could come in and say I-- that she was raped and lie about it because she wants a Plan B, which I don't understand, because they can go to a store and do that. So I'm just saying that this really comes down to an unconstitutional-- you are going upon conscience, freedom of thought, religion, press, and you're forcing. It's against the Constitution. You can't force the patient to say here, you got to take this documentation. Here, you just went through a traumatic event and we got to force this to you. That's not fair to any type of, of patient or a sexual assault victim

in that. And quite frankly, in these areas, I hope that all the state senators are being governed by the law of the land, because when we're not and we're operating under a different constitution, my understanding is that would be treason. And so what I'm saying is these state senators need to be expelled when they're not abiding by the Constitution of the United States in targeting our Amendment 1 in our Constitution of the United States of America. This is the foundation of this bill.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony.

AMBER PARKER: Thank you.

***NATE GRASZ:** Chairman Arch and Members of the Health and Human Services Committee, my name is Nate Grasz, and I am the Policy Director for the Nebraska Family Alliance (NFA). NFA is a non-profit policy, research, and education organization that advocates for marriage and the family, life, and religious liberty. We represent a diverse, statewide network of thousands of individuals, families, and faith leaders who are dedicated to protecting human life from conception to natural death. LB183 undermines this commitment to protecting the sanctity of human life and violates the conscience and religious freedom rights of health care providers by requiring all hospitals to dispense abortifacient emergency contraception, regardless of their sincerely held religious or morals beliefs about human life. Any woman who has been sexually assaulted has suffered horrific violence and an injustice that must be prosecuted to the fullest extent of the law. Victims should be given immediate care, compassion, and assistance. We also believe, as is written in Nebraska state statute, that the state of Nebraska and members of the Legislature should provide protection to the lives of unborn children whenever possible. Contraceptives can prevent not only ovulation or fertilization but also the implantation of an already formed embryo - a human being in its earliest form of development - into the uterine wall. This form of contraception, which results in an early abortion, is particularly prevalent with forms of emergency contraception. LB183 takes away the discretion of hospitals to handle sensitive cases on a case-by-case basis and infringes on the rights of health care providers to not be required to dispense abortifacient emergency contraception that can end the life of a new, individual human being.

For this reason, we respectfully ask the committee not to advance LB183. Thank you for your time and consideration.

ARCH: Are there any others that would like to speak in opposition? Is there anyone that would like to speak in a neutral capacity? Seeing none, Senator Hunt, you're welcome to come up and close. While you are, while you were coming up, I would mention that we received two letters for the record in, in favor, as a proponent. We received 15 as opponents for LB183. For written testimony today, we received two proponents: Planned Parenthood North Central States, Nebraska Coalition to End Sexual Domestic Violence, both those proponents. And the Nebraska Family Alliance submitted written testimony in opposition. You may close.

HUNT: Thank you, Senator Arch, Chairman Arch and members of the committee. One reason that it was so important for me to bring this bill is what Ms. Seibert Joekel said from the Women's Fund about uniformity in our state. I know from three years of listening sessions of talking to women who have experienced this from, from my work from before I was elected, honestly, which was very much in this space, that there are hospitals in Nebraska and in Lincoln that do not administer emergency contraception. And so I don't think that it's the intention of the state to have this kind of disparity within our hospital system. Because what, what Tiffany described is really true, that you can go through this really traumatic experience of being raped and the quality of care that you get depends on what hospital you go to. And like she made the great point that it's not like people are Yelping, they're not Googling, like, what's the best hospital for me to go to? Where's the best place for me to get care? You know, who's going to say something crazy to me, like I can't take birth control? Like, these are things that, that women in the know in Nebraska already know about. Like we already have networks where we converse and we talk about, like where do they, where are they going to respect your reproductive rights and where are they not? Like a lot of women know this, but a lot of women don't. And I do not want more women in Nebraska to go to hospitals where they're getting care based on religious doctrine and not based on science. To be clear, the hospitals are OK with this. I specifically spoke to hospitals because I want to pass this bill and I'm not trying to trick people into supporting abortion. I hope, you know I respect you more than that. Like, I know that people have like very firmly held beliefs about this, obviously more than anything else. So that's not what I'm here

trying to do. That would be very silly of me to try to do. The hospitals are OK with this. And to be clear with what Mr. Miner said, you cannot know when a woman is going to ovulate. Speaking as, as an ovary possessor myself, you cannot know when the ovulation is going to happen. Ask anybody who has had an unplanned pregnancy. Many of us have married friends who have, you know, a surprise baby after they, they think that they're done having their children because the woman didn't know that she was ovulating. You can ovulate during your period even. And this is just the miracle of the human body. So there's no way to do a test, for a Catholic hospital to purportedly do a test to see when the woman's going to ovulate to see if it's safe to give them Plan B or not. That's just not a thing. The hospitals are OK with it. I appreciate the conversation. I think the amendment clears up all the opposition that we had from the first time I brought the bill. This is just a bill to support sexual assault survivors, and it's really not deeper than that. It's a very normal thing. It's the standard of care. Most hospitals already do it. We just want to have uniformity in Nebraska for all assault survivors. Thank you.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Hunt. I had an unplanned pregnancy, Barrett.

HUNT: I know.

M. CAVANAUGH: I found out, I found out at a hospital that I was pregnant. I was going to have my gallbladder removed and it turned out I was three weeks pregnant, so that--

HUNT: The same thing happened to my best friend. It's the most common thing in the world.

M. CAVANAUGH: Yeah, and it was my third kid. It's not like I didn't know. So, so yeah, I appreciate that. I was thinking, I lived in, in D.C. when I graduated from college, and if you had to go in an ambulance there, you didn't have control over what hospital you were taken to. And I know that that's not necessarily the case here. Like Omaha and Lincoln are, are really our biggest cities. But the ambulance will take you to the emergency room that is the least crowded if you're needing care. So if that's a Catholic hospital, then that's a Catholic hospital. And so I just appreciate what you're

trying to do here, because even if you-- sometimes you don't even get to choose what hospital you go to, what doors you walk through. You just go to where, where you're sent or where you're dropped off. And so I just thank you for this.

HUNT: Exactly. I mean, I go to a Catholic hospital. People have consumer choice, but we need to make sure that when we're talking about the standard of care, that the standard is the same for everybody and that it's based on medical evidence. We can disagree about morality of things, but we cannot disagree about medical evidence and medical fact.

M. CAVANAUGH: Oh, and I would like to state for the record, best surprise of my life, hands down. Best surprise of my life.

HUNT: Yes.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Barrett is pretty awesome by the way.

HUNT: I know you're like his biggest fan.

B. HANSEN: I held Barrett when he was a little baby [INAUDIBLE], so cute kid. I just, and this is just, I was just briefly kind of trying to look at a couple of things. And I think maybe this is where some of the rub is coming from. Like I, I went to FDA's website and the FDA, according to the FDA, I was looking up how the Plan B pill works. Again, I don't know what kind of studies they're using, but this is just on their website. So there's no, they're not telling kind of where, where their information came from.

HUNT: This is the FDA website or Plan B website?

B. HANSEN: FDA.

HUNT: OK.

B. HANSEN: And they said, yeah, Plan B acts primarily by stopping the release of an egg from the ovary. It may prevent the union of sperm and egg, but if fertilization does occur, Plan B may prevent a fertilized egg from attaching to the womb. And so I, and I looked at WebMD, it's WebMD on the Internet, you know what I mean, I hate to say

that. But they kind of said the same thing. But then I went on to another couple websites and they kind of confirmed what you said too. And so, and so I think in the future, I'll try to do a little more research to see what the Catholic Conference is saying, what other kind of research is saying. So it seems like there is conflicting views out there about whether it does prevent a fertilized egg from attaching or not. According to the FDA it says it does-- it can affect that.

HUNT: I can say with certainty that the pill Plan B prevents ovulation and it does not prevent the implantation of a fertilized egg. There are other kinds of emergency contraception that can prevent the implantation. But the pill that hospitals are using, Plan B, does not do that. And I had one other point that was important, which I hate to forget on the record.

B. HANSEN: I can ask you one more question, while you think about it?

HUNT: Yeah, just keep talking, Ben. I'm just kidding.

B. HANSEN: Easy for me, I'm a politician. And one more thing, just in the future, would you be open to maybe just providing information but not providing a pill? Like amending the bill somehow, like where you're providing the informed consent, which I know we're all talking about informed consent. Because that is kind of informed consent, like, look something did happen, here are your options.

HUNT: I hear you. I, I can't commit to that here in committee.

B. HANSEN: Yeah, makes sense.

HUNT: I think that-- I mean, look, Plan B is available at Walgreens. You can get it at CVS. And Ms. Parker's point was right that, that it's available over the counter. And her argument, well, was, well, then why should hospitals be giving it when, you know, someone can just walk into the drugstore and buy it? Because hospitals are supposed to provide the standard of care. And my objective with this bill is not just to provide information, it's to provide the standard of care. And I would ask, are there other procedures that hospitals would then be able to, like, opt out of or say, we're going to give you information about a treatment, but we're not going administer the treatment? And I guess that there's thresholds for withholding

treatment, like if it's experimental or if it's not proven safe or it hasn't been studied yet. But that's not what we're talking about when we talk about Plan B. It's been proven safe. It's been used for a long time. It's so safe that it's available over the counter and it's indications have been proven to work. And furthermore, you know, the ethical and religious directives for Catholic health care services, which have been referenced a few times, they are not against the use of emergency contraception in this case. The hospitals are not against it. I, I think that the moral argument here is clear that we have to support survivors of assault and provide the standard of care and that this is not a controversial thing to do.

B. HANSEN: OK, thank you.

ARCH: Any other questions? Senator Walz.

WALZ: I just have a quick question. And I'm just curious, do you know what age is the most common for a woman who, like what-- I hate to say this, but age group for women who are raped? Do you know what-- is there like a 20 to 30 or 13 to 18 or--

HUNT: I can tell you that it's most common in young women. And of course, it's young women. And by young, I mean under 30. Those are also the patients and the the survivors who are least likely to report, who are less likely to have support at home for what they've experienced and who are less likely to kind of have the confidence and the experience in the world to know what to do. And that's why so few assaults go unreported. In Nebraska, we keep a lot of data about sexual assault and things like that. And in the 2019-2020 fiscal year, so in the last year, 43 percent of the medical forensic exams, which is a rape kit, 43 percent of those were provided to children 12 and under. So, you know, for some people, 12, 13, 14 is reproductive age. And I think that's why emergency contraception has to be part of the procedure for when they go to the hospital, they report this. They're doing everything right, they need to have the medication, they need to to be OK. And again, if they, if they do get pregnant, then that's a different bill for a different day. But this one is just saying I would like the patient to have the information and be able to prevent ovulation if they would like.

WALZ: All right.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

HUNT: It's their body, it's their future, you know?

ARCH: Other questions? Are you sure? Seeing none, thank you. This will close a hearing for LB183 and will close the hearings for the day.