HANSEN: All right. Good morning and welcome to the Health and Human Services Committee. My name is Senator Ben Hansen and I represent the 16th Legislative District in Washington, Burt, Cuming, and parts of Stanton Counties and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

DAY: Good morning. Senator Jen Day, represent Legislative District 49 in Sarpy County.

M. CAVANAUGH: Senator Machaela Cavanaugh, District 6, west central Omaha, Douglas County.

RIEPE: Merv Riepe, District 12, which is southwest Omaha and the good folks of Ralston.

HANSEN: Also assisting the committee is our research analyst Bryson Bartels, our committee clerk Christina Campbell, and our committee pages for today are Sophia and Ken. A few notes about our policy and procedures for this morning, please turn off or silence your cell phones. We will be hearing two bills and we will be taking them in the order of listen on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We will use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will turn green. When the light turns yellow, that means you have one minute left. And when the light turns red, it is time to end your testimony and we will ask that you 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. 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. On a side note, the reading of testimony that is not your own is not allowed unless previously approved, and we do have a strict no-prop policy in this committee. So with that, we will begin today's hearing with LB611 and welcome Senator Riepe.

RIEPE: Thank you, Chairman Hansen, and good morning members of the Health and Human Services Committee. My name is Merv Riepe. It's M-e-r-v, Riepe, R-i-e-p-e, and I represent the 12th District, which consists of southwest Omaha and the good folks of Ralston. LB611 saves patients money and has no fiscal note. That's my summary comment. When performing eye surgery such as cataract surgery, ophthalmologists may use only one or two eyedrops from a medical container. There are often a number of drugs still remaining because regulations governing the ability to dispense the remaining portion of stock-item medications for post-discharge use may be unclear or appear overly burdensome. Many facilities do not allow the ophthalmologist to give that container to the patient to take home. The ophthalmologist instead must write a prescription for the patient and the rest of the medication is tossed. 6B11-- I'm sorry, LB611 would resolve this issue. It tells the surgeon they may give the patient the unused portion of medication: ointments, eyedrops and topical creams, and the patient may take it home. LB611 would apply to topical stock-item medications, unlabeled ointments or drops that a hospital operating room, emergency room, or ambulatory surgical treatment center staff has on standby or is retrieved from a dispensing system for a specific specified patient for use during a procedure or visit. We often hear many individuals who come before this committee voice their concerns about the price of medications. Right now, even if a patient has not used an entire container of medication while in a medical facility, the patient may not leave with the unused portion after discharge. Even when the patient was charged the full amount and still needs the medication. Patients may need to purchase duplicate medications for post-discharge use increasing patient costs and creating medical waste. Each year in the United States up to 3.8 million cataract surgeries are performed. Unlabeled topical ointment costs about $25 a tube and topical drops cost about $56 a bottle. Both of these

medications are often used in cataract surgeries. Americans could save $95 million on topical ointments and $212.8 million on topical antibiotic drugs. This is just two examples. LB611 would make it so Nebraska patients don't have to shoulder the additional burden of going to the pharmacy after surgery to fill a prescription. LB611 will better ensure medication compliance and relieve patients of the financial burden of having to make the difficult decision of choosing medication or other daily essentials. You also received a handout, committee members, of AM310, which was shared with you, and it expands the language beyond hospitals to include ambulatory surgery centers and healthcare practitioner facilities given the fact that the majority of cases do not require hospitalizations. Thank you for your time and attention. I would be happy to take questions. With that, I conclude.

HANSEN: Thank you for that opening. Are there any questions from the committee? Senator Ballard.

BALLARD: I'll ask a question. Thank you, Chair Hansen. Thank you for being here, Mr.-- or Senator Riepe. This seems like common sense. Can you give some reasons why this would be permitted this, this year or why this wasn't made law in the past?

RIEPE: Well, I think it was, it was just unclear. And so rather than take the chance, the ophthalmologist would go ahead and say rather than run the risk, I'm just going to-- we're just going to dispose of those and we'll give you a new one, which is the safest--

BALLARD: Yeah.

RIEPE: --from a legal standpoint, but it's not, in my opinion, as you said common sense, doesn't make any, and it's a burden to people who don't. Medications or pharmaceutical items are expensive and a lot of people have a long way to go to the pharmacy. It doesn't make any sense to me.

BALLARD: Thank you.

HANSEN: Any other questions? All right. Seeing none, thank you. See you at the close.

RIEPE: Thank you.

HANSEN: All right. We'll take our first testifier in support of LB611.

PATTY TERP: Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Dr. Patty Terp, P-a-t-t-y T-e-r-p. I am a board certified eye physician and surgeon practicing with Midwest Eye Care in Fremont. I am grateful to have the opportunity in front of this committee to support LB611 and the Nebraska Academy of Eye Physicians and Surgeons would specifically like to thank Senator Riepe for sponsoring this proposal. And he did such a great job introducing, he really has kind of summarized a lot of what I'll be about to say. In general, the healthcare sector generates approximately 9 percent of total greenhouse gas emissions in the United States and is the second largest source of landfill trash. Prescription drugs account for approximately 10 percent of healthcare costs in the United States. Operating rooms contribute up to 30 percent of a hospital's waste. Surgical drug waste significantly increases the cost and carbon footprint of eye surgery. Cataract surgery is one of the most common surgical procedures in medicine, with a large projected increase in global volume. This gives us ophthalmologists a unique opportunity and imperative to prioritize the financial and environmental sustainability of quality eye care delivery. Aside from cost and environmental considerations, needless waste also increases the potential for and impact of periodic drug shortages, which unfortunately have become increasingly common. LB611 proposes that when a topical medication is administered to a patient at a healthcare facility, that any unused portion of the medication shall be offered to the patient upon discharge when it is required for continuing treatment. This would include topical antibiotic, anti-inflammatory dilation or glaucoma drops and ointments. This bill would apply to topical stock-item medications. Topical stock-item medications are unlabeled ointments or eyedrops that a hospital operating room, ambulatory surgical center or facility staff has on standby or is retrieved from a dispensing system for a specific patient for use during a procedure or visit. When performing eye surgery, eye surgeons may only use one or two drops from a medicine container. There are often many drops still left in that container. Because the regulations governing the ability to dispense, the remaining portion of stock-item medications for post-discharge use can be unclear or appear overly burdensome, many facilities do not allow the ophthalmologist to give that container to the patient to take home with them. The ophthalmologist instead must write a new prescription for the patient and the rest of the unused medication is thrown away. This piece of legislation would resolve that issue. It tells the surgeon that they shall offer to give that patient that unused portion of medication. If a medication needs to be continued after discharge

from the hospital, emergency room or surgery center, it is wasteful to throw away the newly opened multiuse bottle and instead require the patient to purchase the same medication from the outpatient pharmacy. Furthermore, this bill would eliminate the burden on the patient of going to the pharmacy after surgery to fill a prescription. This bill will better ensure medication compliance, relieve patients of the financial burden of having to choose between medications and essential items. Estimates are, as Senator Riepe mentioned, Americans could be saving $95 million on topical ointments, $212.8 million on topical antibiotic drops if this legislation was passed in every state. Please vote yes on LB611. This is an important step in promoting medical waste reduction and reducing healthcare costs. And Senator Ballard, to answer your question, also, a lot of facilities won't let us give the patient the medicine. We try, but the number of times I've had in-patients on a drop, and then I have to write a new drop for them to get the same medicine, like, there's so much left, but a lot of it's been-- and so far in the current statute, it says facilities can, but we want this language to be stronger because most facilities won't let us. So by changing the language and specifying more clearly that the patient shall be offered the medicine, we really want to eliminate that burden where most facilities to this point have not allowed us to, despite us kind of outcrying for years. So we want this to just happen and be commonplace.

WALZ: Very good. Any other questions from the committee? I don't see any. Thank you so much for coming today.

PATTY TERP: Yeah. Thanks for the time.

WALZ: Yep. Next proponent. Any opponents? Anybody who would like to come and speak in the neutral capacity? We did have one position comment from the Nebraska Medical Association as a proponent. Senator Riepe, would you, would you like to close? Senator Riepe waives his closing so that would end our hearing on LB611 and we will open up our hearing on LB810. Senator Murman.

MURMAN: Good morning, Vice Chair Walz and members of the Health and Human Services Committee. My name is Dave Murman. I'm from Glenvil in District 38. District 38 is eight counties along the southern border in the middle part of the state. I'm here today to introduce LB810, which would adopt the Medical Ethics and Diversity Act. LB810 seeks to protect the tradition and professional calling for healthcare workers and providers. It would protect, protect their fundamental beliefs, their conscience, and the integrity of the care they provide in their

medical practice. I first became aware of the attacks on conscience protections through my son-in-law, Grant Hewitt. Grant is southeast regional director of the Christian Medical and Dental Association. From him, I learned that 23 percent of doctors, nurses, and other medical providers have experienced discrimination in the workplace due to their moral and religious beliefs. Thirty-six percent experienced discrimination or pressure from their medical school faculty because of their ethical beliefs and 20 percent decided not to pursue, pursue a particular medical specialty because of hostility towards their beliefs in that area of practice. The same survey conducted by Christian Medical and Dental Association found that nine out of ten doctors, nurses, and other medical providers would stop practicing medicine rather than violate their ethical, moral, or religious beliefs. Section 4 is the main component of the bill. Among other things, it provides a medical practitioner healthcare institution or healthcare payer has a right not to participate in or pay for any healthcare service which violates such persons or entities conscience, and it prohibits any discrimination against such persons or entities where they assert a conscience concern, where they assert a conscience concern. This section makes clear that the exercise of conscience is limited to conscience-based objections to a particular healthcare service. The legislation does not waive or modify any duty that an individual or entity may have to provide other medical services that do not violate such persons or entities conscience. To be clear then, the Med Act is procedure specific, not patient specific. My office and I have been working with the Attorney General, DHHS, and PRO on an amendment to Sections 5 and 6 that would work within the state's obligation to protect patients from mistreatment or maltreatment and will strike the 14-day requirement on providing notice of a complaint against a medical provider. State statute elsewhere prohibits the state from providing the medical provider with such a complaint. At the end of the day, LB810 is doing something very simple, it is protecting the diversity of belief within the medical field. Whether you're a Democrat or a Republican, liberal or progressive-- liberal progressive, or a social conservative, atheist, or a person of faith, whether you are Jewish, Muslim, Christian or Hindu, this legislation recognize that those serving in the healthcare are moral agents. They are individual and personal human beings with consciences that deserve protection. LB810 manages to appropriately balance the conscience of healthcare practitioners and entities while remaining committed to providing ongoing, compassionate, and professional care to patients. Vice Chair Walz and committee members, thank you for your consideration of LB810. I'll happy-- I'm happy to take any questions

you may have, but there are also several behind me healthcare practitioners and policy experts that can also help address any questions.

WALZ: Thank you, Senator Murman. And Senator Hansen-- because we have so many testifiers and we want to be able to hear everybody-- Senator Hansen-- we're going to do three-minute testimony on LB810. Let's see if we have any questions before-- any questions from the committee? I don't see any. Thank you, Senator Murman. So we'll go with our first proponent. Good morning.

DAVID J. HILGER: Good morning. Hi. OK, I think I'll get started here.

WALZ: Sure.

DAVID J. HILGER: OK. Members of the HHS committee, thank you for your service to Nebraska first. My name is David J. Hilger, M.D., D-a-v-i-d J. H-i-l-g-e-r, and I am here to testify in favor of LB810. I am a diagnostic radiologist and have practiced for over 40 years, mostly at the two of the larger hospital systems in Lincoln and Omaha. I am here on behalf of the future of medical students, young physicians, and medical providers, and to protect the doctor-patient relationship which depends on conscience. As medical providers, my conscience-- our conscience is formed by ethics/values, as well as our medical knowledge and experience. It is not possible to separate these components of conscience. I would like to share some data. In 2016, a review of over 1,000 studies showed that less than 50 percent had good that is moderate or, or very good evidence supporting specific medical interventions. So less than 50 percent, over 50 percent did not have those criteria. A repeat study in 2020 showed no significant change. The references are attached to my testimony. Good science takes time, often decades to resolve complex issues. There is often uncertainty in medical science, which is a reason that good clinicians differ on complex ethical issues. Conscience is essential when science becomes unclear. Over ten years ago, the Nebraska Medical Association passed a resolution supporting conscience protection, and I testified on behalf of the NMA supporting a bill based on that resolution. While working on that project, I spoke to a well-known past president of the NMA. We differed on our values and belief systems, however, he said to me that he supported this resolution since he knew that by defending another's conscience, he defended his own. The issues and outside forces have increased over these ten-plus years. The medical profession and the rights of conscience are being eroded by rules and regulations by large government and corporations, often influenced by ideological and

financial reasons. By far, the greatest concern I hear is from medical students whether they will be able to practice medicine according to their ethics and beliefs. It is a fear that they might have to compromise or face economic and personal hardship. This fear is real and is a form of discrimination. This will likely discourage many good students from entering the profession when there is an increasing demand. By the way, there are several students that were interested in testifying today but were fearful of the consequences. Patients need these future providers, since they reflect the values of a large number of patients and offer diversity that is needed in medicine. Patients seek physicians not only based on their competence, but also based on their ethics and values. In summary, conscience protection protects the integrity and future of our profession, allows for a diverse opinion and open scientific dialog, and protects the rights of patients to choose a physician who reflects their own values. Thank you for allowing me to testify and I'll take any questions.

HANSEN: All right. Thank you for that. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. I believe you testified maybe ten years ago, and at that time the Nebraska Medical Association, I believe, embraced the idea of protecting and respecting the right for confidentiality or conflict of interest or conscientious objection. What has changed in that period of time, in your opinion?

DAVID J. HILGER: So there's a long, a long answer to that and a short answer to that.

RIEPE: You're off the light now, so maybe-- I'm not encouraging you-- [LAUGHTER]

DAVID J. HILGER: You know, of course, of course, the culture has changed and, and politics has changed and that's, that's kind of the short answer. You know, like all the issues of ethics, there's a broad spectrum of what physicians and other healthcare providers, and as Dr. Rosenquist said the other day, I listened to the testimony on ethics, it's not a bell curve, it's, it's a, it's a, it's a broad curve. And so I, I think that the, the-- if anything, what's changed is the increased pressure on the profession to from government sources, from industry, outside influences. So I think, I think if anything, there's more of a need for this, for this bill than there it was ten years ago. There has been discussions-- I'm on, I'm on one of the NMA committees, legislative committee, and there is, there is some ongoing

discussion to try to come to some agreement on some of the provisions of the bill. And so I'm, I'm hopeful that, that at some point in time, we can, we can come to agreement on those things. Thank you.

RIEPE: I have a second question, Mr.--

HANSEN: Yes.

RIEPE: Thank you. You're a physician?

DAVID J. HILGER: Yes.

RIEPE: Yes, you are a specialist, but you also-- what does it look like in a, in a clinical setting with a patient in discussing the conscientious objection? I mean, what, what would that generally look like?

DAVID J. HILGER: Yeah, and since I am a diagnostic radiologist, I, I, unfortunately, I don't have to, to run into a lot of those issues. I see them and talk to my colleagues about them because I talk-- in radiology, we kind of see a broad spectrum of what happens in, in medicine so I, I-- my specialty is, is-- well, subspecialty is women's imaging and women's healthcare so I do a lot of-- I talk to a lot of patients about their, their mammogram results and the consequences of that. So fortunately, I don't run into that. I kind of run into things a little bit peripherally, but I don't directly run into those things. But the main thing with the doctor-patient relationship, I think, is that patients expect you to be honest and that honesty may include when you have to tell them something that might not be the best for their health. And for me, the science and the ethics aren't separate. My ethics and my [INAUDIBLE] supports the science that I believe in and vice versa. So I think some my colleagues might be able to answer that question a little better for you, Senator.

RIEPE: I very, very much appreciate your being here. Thank you.

DAVID J. HILGER: Thank you.

RIEPE: Thank you, Chair.

HANSEN: Senator Day.

DAY: Thank you, Chairman Hansen. And thank you, Dr. Hilger, for being here today. Can you just give me an example of if this bill were to pass in your practice a time where you feel it would benefit you?

DAVID J. HILGER: In my practice, it's hard to give an example. I did, I did run across a situation many years ago that, or several years ago, where I was being a little bit more conservative on the interpretation of early pregnancy ultrasounds and kind of favoring-- and, and, and we, we kind of consider that everything in medicine may be [INAUDIBLE]-- you know, it is, it's so, it's so black and white. I'm a radiologist, I see a lot of shades of gray, but so, so anyway, I was more conservative than some, than some of my colleagues and I wanted to give the baby every chance and the mother every chance for having that child. And so I, I received some criticism on my-- some of my reports. And so the way I dealt with that is I reached out to the medical literature and, and found some good references where we could, where we could have some standardization of how we interpret these studies. And, and those were-- theirs were subsequently adopted. And so I, I think in medicine, we have a unique opportunity to reach across and, and talk to our colleagues and, and resolve issues like that.

DAY: OK. So, so the example would be specifically with pregnancy or, or termination or abortion?

DAVID J. HILGER: No, I never had that. Well, it was-- yeah, whether to-- yeah, indirectly [INAUDIBLE] the termination. If there was no, no fetal viability, then there would be a--

DAY: OK.

DAVID J. HILGER: --termination.

DAY: OK. Thank you. I appreciate that.

DAVID J. HILGER: You bet. Sure.

HANSEN: Any other questions from the committee? Seeing none, thank you for coming.

DAVID J. HILGER: Thank you.

HANSEN: Take our next testifier in support of LB810. Welcome.

DALE MICHELS: Good morning, Senator Hansen, members of the Health and Human Services Committee. My name is Dr. Dale Michels, D-a-l-e M-i-c-h-e-l-s. I'm a retired family physician and the Nebraska representative of the American Academy of Medical Ethics. I'm here to testify in support of LB810 for health professionals involved in

various fields throughout the state of Nebraska. Health professionals should have the opportunity to provide healthcare based on their deeply held belief in the correctness of the care they provide and not the requirement that-- if the activity is legal, they must do it. Attached as well is a statement on the healthcare right of conscience from the American Academy of Medical Ethics. Imagine, if you will, the following scenario. An individual wants some electrical work done on his home. The electrician looks at the job and is both capable of doing the work and it's legal to do so, but the electrician is unwilling to do it because of the high risk of burning the house down. The electrician not only believes it would be unprofessional to take it on the job, but feels morally convicted against taking on the job because of the high risk of harm. While the electrician declines to work, he provides a list of other electricians in the area. The homeowner contacts several electricians until he finds one who does the job. Unfortunately, the house burns down. My question is, does the first electrician have any complicity in the house burning down? I don't believe so. What if the first electrician had recommended the specific electrician that would do what the homeowner wanted done and the house burned down? The first electrician could be considered morally complicit in the resulting house fire, even though he recommended against, against it based on experience and the sincere belief that a fire would result since he recommended the second electrician. This plausible scenario sheds light on an issue that has been raised in the past about LB810. Some have objected to this bill because it lacks a direct referral component where healthcare practitioners unable due to conscience reasons to provide particular healthcare service, but requiring a healthcare practitioner to directly refer for a service they themselves wouldn't provide raises serious moral issues as demonstrated in the example I just provided. This is a reason that a directed referral should not be required as a part of LB810, although referral and transfer of records is appropriate. There are several other issues that have been objected to but are not real-life issues. For example, my 44 years of experience has shown time and time again patients who wanted me to provide a service I was unwilling to do so quickly found someone else who would provide that service. They didn't need me to help them figure out where else to find somebody to provide them the healthcare service they wanted. This is a good bill. It will protect any healthcare practitioner who has a conscience, which means it will protect every healthcare practitioner. So I'm asking you to advance LB810 to the floor of the Legislature. Thank you for your time. Be happy to answer questions.

HANSEN: All right. Thank you for coming. Are there any questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. And thank you, Doctor, for being here today. I appreciate your example of the electrician and the house burning down. But could you-- so you mentioned-- I'm going to ask you the same question I asked the previous testifier.

DALE MICHELS: Sure.

DAY: Can you give me an example of a time in your practice that you-- what were, what were the circumstances around the situation where you were-- you felt you were morally objecting to providing a service? What, what, what was that?

DALE MICHELS: There were a certain number of services, in fact, during my 44 years, some things that initially I was willing to do, but as I studied more, learned more, I chose not to be able to do some of those things. And in those cases, if patients came to me and said, I would like you to do this or provide this service, and I felt I couldn't morally do that, I would tell them I couldn't morally do it. I'm sorry. If they wanted to find someone else, I would be happy to send whatever records I did, or in some cases I didn't do an exam. I just simply didn't charge them and gave them the information, explained my position, and they were out the door, able to-- usually, as far as I know, in all cases, they found somebody else.

DAY: OK. So but specifically what were-- what-- can you--

DALE MICHELS: Well--

DAY: --give me an example of a service that you wouldn't be willing--

DALE MICHELS: One of the things that originally I was willing, and this is just one example, but originally I was willing to use IUDs--

DAY: OK.

DALE MICHELS: --for female patients who didn't want to get pregnant. I chose after some time and understanding of how the IUD worked to no longer perform that service. So I didn't do it. I explained to patients why I wouldn't do it, what my concerns were, and then went from there. If I did their exam, then I would send copies of the records. In some cases I didn't even do the exam, I just didn't charge them, explained it to them and moved on.

DAY: OK. Thank you.

HANSEN: Senator Ballard.

BALLARD: Thank you, Chair Hansen. I'm going to give you an opportunity to respond to some of the correspondence that I've-- at least I've received that Nebraska has a workforce shortage, especially in the medical field, and that this bill is going to limit access to care. Can you respond to, to that a little bit?

DALE MICHELS: From my personal experience, no, I don't think it's going to limit access to care. It's going to allow certain healthcare professionals to say, no, we can't do this. But it doesn't mean that they can't find the care in other places or in other ways. I practiced-- in addition to being here in Lincoln for 44 years, I practiced in a small community part time for 35 years, and we had patients who would come in to see us. We would take care of their problem and then they would drive to Lincoln for their prescription or for something else. So I think access is somewhat of a smokescreen. I really don't think that it is involved. I found patients who could often-- would do things, you know, find ways to do things without necessarily needing something from me if I felt I couldn't do the service. So I don't believe access to care is limited.

BALLARD: OK. And you don't see this as a problem in, in rural Nebraska?

DALE MICHELS: No, I really don't. I mean, many of my friends, colleagues, family members in rural Nebraska have to drive long distances just to buy groceries, for instance. They're used to that. And I have found in my experience that the patients learn pretty quickly that if Dr. such and such won't do this, I won't go there. I'll go somewhere else and they may go the other direction or a different direction. So I don't think that's a, a, a problem realistically.

BALLARD: Thank you for being here.

HANSEN: Any other questions? Senator Day.

DAY: Thank you. Sorry, I have one more question for you.

DALE MICHELS: Sure.

DAY: Related to the example that you gave, you talked about IUDs and pregnancy. So that would only apply to women.

DALE MICHELS: Um-hum.

DAY: Do you feel like it's discriminating against women in terms of not providing them medical care? We're not talking about buying groceries or a house repair, we're talking about a human being that needs--

DALE MICHELS: Sure.

DAY: --medical care. Do you feel like that's discriminating against the patient?

DALE MICHELS: I don't think we didn't-- we did not provide them the medical care. We said that we could not or I could not, in my case, provide that particular service. But I gave them all of the options in the, in, in the community or in the area or whatever you may say to provide the service. We didn't say that this is an illegal service, this is a service that you can't get. We didn't-- I've seen in some other states where a pharmacist, for instance, withheld the prescription and refused to give the prescription back to a patient. I think that's inappropriate. I don't think that's a part of this bill at all. It's just simply, no, we can't do that, but there are other options.

DAY: OK. Thank you.

HANSEN: Any other questions? All right. Seeing none, thank you for testifying.

DALE MICHELS: OK. Thank you.

HANSEN: We'll take our next testifier in support of LB810. Welcome.

STEPHANIE NICHOLS: Mr. Chair, members of the committee, my name is Stephanie Nichols, S-t-e-p-a-n-i-e N-i-c-h-o-l-s, and I serve as legal counsel for Alliance Defending Freedom. I work throughout the country on legal issues affecting medical rights of conscience for doctors and nurses and others in the medical profession. We stand at a precipice in our country regarding the culture of medicine. The demands being placed on doctors, nurses, and others in the medical profession are changing. Patients and institutions now often treat physicians like vending machines, demanding that they perform procedures or give out

drugs that might actually harm and cause the physician to violate their Hippocratic Oath to do no harm. In some cases, patients even sue when they are turned down. LB810 will help reverse this dangerous trend by accomplishing three main things: Protecting the right of conscience of doctors and nurses to decline to provide specific medical procedures that violate their conscience. Protecting doctors and nurses from being suddenly forced or coerced to participate in, in an abortion through requiring written opt-in first. And number three, protecting the First Amendment rights of doctors and nurses, except in situations where harm to their patients might result. There are some things to note about how this bill accomplishes these goals in a balanced and legally appropriate manner. First, I would like you to recognize that the duty to provide emergency care is recognized on line 3, page 7 of the bill. So we are talking about nonemergency situations. Also, I would like you to pay attention to lines 20 and-- 22 and 23 on page 5 that state, "The exercise of the right of conscience is limited to conscience-based objections to a particular health care service." You can't have a conscience objection to serving a person. You can only have a conscience objection to a particular service. And we also have a long-standing track record of how these laws work in the real world. They've been passed in five other states, most notably Illinois and Mississippi, that have had their conscience law since 1977 and 2004. And the medical community and patients have been able to prosper in those states. The conscience bills work by drawing a line in the sand that conscience needs to be respected and then institutions, patients, and doctors are able to work together to this end. What this bill does is codifies what is actually best practice, what's good for the patient, what's good for institutions, and what's good for doctors, and encourages them to work, to work together. It also protects the free speech rights of doctors to discuss methods of treatment that may pose a risk to patient health. This is important because good science equals good medicine, and good science requires freedom of speech and freedom to debate. The final thing I would like to leave you with is who wants a doctor without a conscience? And now I'm free to take any questions the committee may have for me.

HANSEN: All right. Thank you for coming to testify. Are there any questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. I'm going to keep asking the same question that I've been asking of every testifier. Can you give me an example of a service for which you have heard doctors would not be willing to provide, like, a specific type of service?

STEPHANIE NICHOLS: Yes, absolutely. So I have had conversations with many physicians throughout the country. They often are being compelled or coerced into feeling like they have to participate in surgeries that would sterilize minors or remove healthy body parts for minors, physician-assisted suicide is a major pressure on doctors, and technology is changing very quickly. So it's important-- you know, we get questions about this bill that, OK, why does it not just list out specific services? We couldn't have known as a country five years ago what today's conscience objections would be and what physicians would be asked to do today five years ago. So if you pass this bill with a specific list of services, then it's obsolete very soon as technology rapidly changes. I'll give you a good example. Gene editing is now becoming prevalent in assisted reproductive technology. So you could have, you could have someone who works in that field being asked to do gene editing procedures, and that may be against the conscience of someone who is a fertility doctor and that's on the forefront of changing technology.

DAY: OK.

STEPHANIE NICHOLS: Thank you for that question.

DAY: Thank you.

HANSEN: Senator Ballard.

BALLARD: Thank you, Chair Hansen. Thank you for being here, Ms. Nichols. I like that you mentioned the real world. How does this work in the real world from a legal perspective, like what, what steps does a physician have to go through?

STEPHANIE NICHOLS: OK. So when the, when the patient presents to the physician and the physician has a conscience objection under this bill, they have to-- if they are employed by an institution, they have to let the institution know that, OK, this patient has presented to me and I have turned them down, you know, due to reasons of conscience. So within a healthcare facility, there will often be other practitioners who can morally provide that service to the patient who's requesting it. But the main thing to remember as you go through the bill is you will see that there are a few references that the, the practitioner must continue to serve the patient with all other appropriate healthcare services. And this is how this bill actually goes beyond the AMA code of ethics, which actually lets a physician let go of a patient who they can't serve with a particular healthcare

service. This bill protects the patient by saying, hey, you get to keep your doctor. They have to continue serving you with all other appropriate healthcare services that do not violate your conscience. So, for example, nobody loses their primary care physician just because they-- that patient has asked the physician for a service that they can't provide.

BALLARD: And one more question, if I may?

HANSEN: Yep.

BALLARD: And then you said-- what two states already have a medical conscience?

STEPHANIE NICHOLS: There are five.

BALLARD: Five, sorry about that.

STEPHANIE NICHOLS: Three are more recent. So Arkansas and Ohio passed these laws in 2021 and South Carolina passed a law last year. But the two states that have a long-standing track record that let you have confidence in how this works in the real world are Illinois and Mississippi. Illinois, blue state, has had the law since 1977 without any type of major issues. Same way with Mississippi. There have only been a handful of cases brought under the conscience laws because what the conscience laws do is draw that important principle out and they encourage the institutions and the employees to work together to make sure patient needs are met, but still practitioners' consciences are respected. That's actually very important for access to care, because nine out of ten practitioners who are people of faith would rather quit practicing medicine then be forced to violate their conscience.

BALLARD: Thank you.

HANSEN: Any other questions? Senator Riepe.

RIEPE: Thank you. I have friends in east Texas. My I guess and speculate you're from Texas?

STEPHANIE NICHOLS: Close. I am from the neighboring state of Arkansas.

RIEPE: Oh, OK. OK, kissing cousins. We talked a lot-- and I-- where I was going to go with that is if you were from Texas, you didn't list Texas as one of the states that has this law and Texas is particularly conservative.

STEPHANIE NICHOLS: Texas had-- they have a filed bill this year and--

RIEPE: Oh, do they?

STEPHANIE NICHOLS: Yes. Yes.

RIEPE: OK. That was my question, why-- then why would they not be included in that list--

STEPHANIE NICHOLS: Right, that they--

RIEPE: --because they are pretty active right now with--

STEPHANIE NICHOLS: Right.

RIEPE: --a number pieces of legislation?

STEPHANIE NICHOLS: Definitely. There is a doctor in Texas who is a strong legislator who is running the bill in Texas this year.

RIEPE: OK.

STEPHANIE NICHOLS: They may likely have the bill this year. It's also a legislative priority for Governor DeSantis in Florida.

RIEPE: OK.

STEPHANIE NICHOLS: There have been more bills filed on this this year than any other legislative year. I think we're up to around 11 states that have filed legislation on this this year because it's such an upcoming issue and something that's really pressing upon doctors and nurses in our time.

RIEPE: I'll tell Governor Huckabee hello for you, so.

STEPHANIE NICHOLS: I'll send your regards. Yeah.

RIEPE: OK. Thank you. Thank you for being here.

STEPHANIE NICHOLS: Thank you.

HANSEN: Any other questions? I have a few questions. Appreciate your legal analysis with this.

STEPHANIE NICHOLS: Thank you.

HANSEN: You kind of touched on this a little bit of other states have done this, and I think you, you might have answered it, but has, has there been any, like, litigation or any lawsuits that-- from the states that have passed this?

STEPHANIE NICHOLS: There have been only a handful of cases filed. They have been in things like the abortion context, Catholic healthcare practitioners who didn't want to be forced to provide contraception when others within the healthcare facility who were employees could easily provide that service instead. And, you know, honestly, it hasn't come up in the hospital context that I'm aware of, but there have been a few cases involving clinics. And one thing that's important that I did want to call attention to. Some people assert that the practice of medicine can't function because the bill prohibits transfer of job duties from a practitioner to other job duties. And that's actually not correct. If you will look at the definition of discrimination in the bill, the way the medical community is still able to function from a business perspective is that discriminatory, adverse transfers are prohibited. For example, if you take that nurse, it's not that you can't ask her to take on other job duties instead, but you can't take a day shift nurse and now punish her with switching her to night shift just because she refused to participate in an abortion or other service. And there's also good case law. There is a case in Illinois that articulates very well that conscience must be interpreted from a reasonable business perspective as the legislature would have intended. So, for example, in the case of Rojas v. Martell an employee can't expect to do no job duties under conscience and then get a paycheck. That was not the issue in the case, abortion and contraception was the issue in the case. But the court went further and articulated that transfer of this employee was appropriate to other job duties. That's actually what the employee wanted, was transferred to other job duties. But at the same time that the medical community was not to be hamstrung in that way, only discriminatory retaliatory transfers that put someone in an adverse position were prohibited.

HANSEN: OK. I think that's kind of what I was wondering about--

STEPHANIE NICHOLS: Yes.

HANSEN: --is we're trying to protect the doctor, but I also want to make sure that the business is protected as well.

STEPHANIE NICHOLS: Right.

HANSEN: And so, like, if we're-- it's a private clinic and they start maybe moving more towards doing-- use an example, you know, of like more-- becoming more-- do more abortions, right, and you might have a doctor who's already been, you know, employed there and he's, like, I'm-- it's against my conscience. Is the business able then to fire him because now he's primarily not doing his duties according to the clinic?

STEPHANIE NICHOLS: No, the business would not be able to fire him in that context. What the business would have is on the front end for example, Planned Parenthood doesn't have to hire a pro-life employee under principles of freedom of association. They get to ask on the front end, you know, can you do these job duties? But let's say, for example, you have a nurse that's been employed 30 years for a healthcare institution, and suddenly she is asked to participate in an abortion or have her job threatened. That's really neither right nor fair. But on the front end, it's a different story. And that's why this bill does not cover employment on the front end and why it's important to recognize freedom of association on the front end. And that's a good way to draw that line of balance.

HANSEN: OK. And more for clarity sake. So is this allowing doctors to do whatever they want or is it more about, like, not doing certain procedures or recommendations?

STEPHANIE NICHOLS: Great question. Thank you, Mr. Chair, for that question. Conscience is always the right to decline to participate in something. And that's why the way conscientious objection has always been interpreted in our case law in the country. But it's also the way this bill has been drafted. It's the right to decline to participate in a specific procedure. It's not the right to do any procedure or prescribe any drug you wish.

HANSEN: So I'm sorry for asking more questions.

STEPHANIE NICHOLS: Sure.

HANSEN: So where's the line then end for, like, where's the line that where a business can then say, OK, doctor, you are not doing your primary duties of the clinic because we're doing more cloning now of, of whatever. You know, we're going to clone animals now. And the doctor will, like, well, I don't like cloning, it's against my religion. They cannot let him go because now he doesn't-- he's not primarily doing his duties according to what the business wants? Can,

can they still not let him go or does he just stay there and be employed and not do anything or--

STEPHANIE NICHOLS: I think the ins-- the responsibilities of the institution in that case would be to find other job duties for him to do that were not discriminatory. So it's not retaliatory or punishment, but, you know, have it-- the way it has worked in other states is conversations are had, and, and maybe it is the responsibility of the business to work with their medical practitioners. You know, on the front end, it's easy. It's, OK, can you, can you provide these services that we provide? When things change dramatically on the back end it can be a little bit harder, but it is the responsibility of the institution to work with their doctors and nurses to see what they can provide.

HANSEN: I thought that was kind of a outside-the-ballpark example.

STEPHANIE NICHOLS: Sure, but when--

HANSEN: I mean, it's not going to happen that often, but you still want to work through the nuts and bolts of this.

STEPHANIE NICHOLS: Right. Right. And, and when technology is changing at a, at a rapid pace that, you know, that may be a question for the future.

HANSEN: And one more question if I can. How would this pertain to vaccines? So some-- I know some people, there's-- they, they believe there's stem cells in vaccines and so, OK, or aborted fetal cells in vaccines or it's against their conscience to provide an mRNA vaccine because of whatever reasons. Right? Again, kind of an outside question, but it could occur within the next five years like you, like you said. How would that work?

STEPHANIE NICHOLS: That's, that's a great question. Thank you, Mr. Chair. So this would not protect employees of healthcare institutions from having to take a vaccine themselves. It would protect the situation-- for example, I'll give you a situation out of Virginia. A pharmacist who administered COVID vaccines to adults was fired and lost her job because she did not feel confident in the, the science and research safety studies in giving it to young children. So she lost her job as a pharmacist because, although she would give the vaccine to adults, she would not give it to young children. So that

would protect that pharmacist if that was grounded in a conscience belief and not just a scientific belief.

HANSEN: OK. And same for, like, a medical doctor in a hospital?

STEPHANIE NICHOLS: Absolutely.

HANSEN: OK.

STEPHANIE NICHOLS: Yes. Now, an important thing to know is vaccines are easily accessible. So if you have one doctor-- I've actually never met a doctor who was anti-vaccine wholly. You know, there might be some who weren't confident about this or that new vaccine on the market, but I've never met an anti-vaccine doctor yet in all my travels and conversations. So you know it's easy to access a vaccine from another provider so that shouldn't raise any major red flags on the vaccine issue.

HANSEN: OK. Thank you for that. Appreciate that.

STEPHANIE NICHOLS: Thank you.

HANSEN: Senator Day.

DAY: Sorry, I just thought of one more question related to what Senator Hansen was talking about in terms of the institution. So just to clarify one more thing. It sounds like if a doctor refuses to provide services based on conscientious, conscientious objection, that institution cannot-- they're, they're protected under this bill from being fired by the institution?

STEPHANIE NICHOLS: They are.

DAY: OK. So I guess the thing that I struggle with with that in what other industry or terms of employment, can an employee refuse to provide the services that are required of employment and still not be fired?

STEPHANIE NICHOLS: What's important to recognize in this situation is there's a major issue of shortages of doctors and nurses and like I mentioned earlier, nine out of ten who are people of faith would rather leave the practice than be forced to violate their conscience. So this is the type of circumstance that if you don't legally protect conscience, it's actually exacerbating the physician and nurse shortages in this country.

DAY: But because of the shortage, wouldn't we need more medical professionals to be willing to provide services instead of having medical professionals who are unwilling to provide services? Because if they're not willing to provide the services that they are employed to do, then effectively they're not useful in terms of access to medical care.

STEPHANIE NICHOLS: But they are useful for all the other services that they will provide to their patients besides that one or two specific healthcare services that might violate their conscience. So, for example, a doctor might not provide abortion services, but they're bringing babies into the world. They're caring for the elderly, they're making sure kids get antibiotics on time. We need to make sure, as a country, that we are fully deploying as many licensed doctors and nurses as we can, that we are not closing the door to practice for them, that we are not forcing them to violate their conscience and exacerbating shortages that way.

DAY: OK. Thank you.

STEPHANIE NICHOLS: Thank you for the question.

HANSEN: Any other questions? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. My question is this. There have been other cases of conscientious objection in terms of baking wedding cakes and flower arrangements, is there any CPG crossover between this particular medical specific legislation and other precedent set-- legal precedent set in those cases?

STEPHANIE NICHOLS: That's a great question. Honestly, this is my area of focus and employment, so I am not probably qualified to answer that question on the case law on other fronts.

RIEPE: OK, so you're not into cakes and flowers.

STEPHANIE NICHOLS: I love cakes and flowers, but I don't have any legal expertise on those--

RIEPE: OK.

STEPHANIE NICHOLS: --issues, but thank you for the question.

RIEPE: Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. I'm sorry, I was introducing another bill so I missed the beginning of your testimony. And, and your-- the name of your organization is Alliance Defending Freedom?

STEPHANIE NICHOLS: Yes.

M. CAVANAUGH: And are you here in an official capacity for them? Are you an invited testifier?

STEPHANIE NICHOLS: I am an invited testifier and I am appearing in my official capacity to support this legislation.

M. CAVANAUGH: OK. I ask because I didn't see you registered as a lobbyist, which is a, a nice protocol to have, but not necessary. But I'm just-- I wanted--

STEPHANIE NICHOLS: I am only here to testify and I will be leaving the state thereafter.

M. CAVANAUGH: You don't have to leave the state. I'm not, I am not inviting you to leave the state. I'm just kind of saying for the general public that it is a nice process to have our people who are lobbying to, to register for lobbying. But you are an invited testifier, so thank you for the clarification. You're, you are-- well, you just said you're leaving the state, so this might-- you might not be the right person to ask about this, but abortion has been discussed since I've been back in the room. And I-- is there an instance where people are being forced to perform abortions in Nebraska where it, it is against their-- that they are conscientious objectors because I am not aware of these instances?

STEPHANIE NICHOLS: I am not aware of a specific instance involving abortion in Nebraska. I am aware of many issues throughout the country. It would--

M. CAVANAUGH: Because in Nebraska you can only get an abortion that's not an emergency at an abortion clinic, so I would say that it would probably not be appropriate to seek employment at an abortion clinic.

STEPHANIE NICHOLS: I would, I would agree with you. If you have a conscience objection to abortion, this bill would not impact the ability of the abortion clinic under constitutional principles or

freedom of association to hire who they want to further their goals and objectives.

M. CAVANAUGH: Right. So then that brings us to most abortions out-- well, not most, all abortions outside of an abortion clinic setting in the state of Nebraska are an emergency. And so this would mean that if you are a medical provider working in a hospital setting and a woman is going to die, you can delay access to care for that patient because you disagree with saving her life.

STEPHANIE NICHOLS: Well, we, we do reference emergency medical treatment. So [INAUDIBLE], the federal statute would require that that woman be given, given emergency care to, you know, preserve her life. And we recognize that in this bill, this is for nonemergency--

M. CAVANAUGH: OK.

STEPHANIE NICHOLS: --situations.

M. CAVANAUGH: So this basically doesn't cover abortion in the state of Nebraska then?

STEPHANIE NICHOLS: Well, so that's, that's another question. So in states like Arkansas, it's easy for on paper it to look like abortions don't happen in hospitals.

M. CAVANAUGH: They do happen in hospitals in Nebraska. They happen in hospitals to save the life of the mother and so we're providing abortion care in hospitals as an emergency.

STEPHANIE NICHOLS: And that's definitely what the letter of the law says. But we have been involved in enough cases as Alliance Defending Freedom to know that abortions also happen in nonemergency situations, even where it's not legally permitted.

M. CAVANAUGH: Well, then that would be a crime so that would be totally different. We don't need this bill to address crimes.

STEPHANIE NICHOLS: But do you need this bill to address the situation where a nurse is, you know, coerced into participating in an abortion against her will? Does she have any legal--

M. CAVANAUGH: Not if she's-- if it's a crime, then no.

STEPHANIE NICHOLS: She should have civil recourse and this would provide that civil recourse for her.

M. CAVANAUGH: Civil recourse against committing a crime?

STEPHANIE NICHOLS: No, civil recourse if she is forced or coerced. What happens often in situations--

M. CAVANAUGH: But you literally cannot per-- there is no hospital in the state of Nebraska that will provide an abortion unless it is an emergency. There's not a single hospital in the state of Nebraska. If they thought that we thought that they were performing abortions, they would be in here telling us that they are not performing abortions. They have been very outspoken about the fact that they do not perform abortions in hospital settings in the state of Nebraska. And so I'm just trying to get clarification that this bill actually has nothing to do with abortion, because you can have an abortion in an abortion clinic. You should not seek employment at an abortion clinic.

STEPHANIE NICHOLS: No, and this would not affect that.

M. CAVANAUGH: And you cannot have an abortion in a hospital setting unless it is a medical necessity and so you would be denying them emergency care. And if it's not in that setting, then everything's fine.

STEPHANIE NICHOLS: I agree that this bill would not impact--

M. CAVANAUGH: OK.

STEPHANIE NICHOLS: --abortions [INAUDIBLE].

M. CAVANAUGH: That's what I was trying to get at.

STEPHANIE NICHOLS: Yes.

M. CAVANAUGH: Thank you.

HANSEN: Senator Day.

DAY: One more question. I appreciate your willingness to answer all of these questions. So Nebraska isn't at will an employment state, meaning you can be fired for any reason or no reason at any time? How would this interact with that?

STEPHANIE NICHOLS: By protecting conscience, you would find more rights for employees who are in the medical field.

DAY: So but-- so we would essentially be creating a carve out only for physicians, but not anybody else?

STEPHANIE NICHOLS: Well, not just physicians, but nurses and others in the medical field. Only those who are directly involved in the provision of an actual healthcare service.

DAY: OK, so only for--

STEPHANIE NICHOLS: So for example--

DAY: --medical-related people, but no one else. So we're an at-will employment state, but those that work in medicine would be protected, but no one, no one working in any other industry would be protected from being--

STEPHANIE NICHOLS: That is true. This does not have conscience protections for those in other fields. It's only in the medical field and many other states that have passed this are at-will employment states as well, like Arkansas has passed this. It is a carve out like you recognized. And we had a conversation with-- so this has been in place in Arkansas for two years now. The Arkansas Hospital Association director was asked, have there been any issues with the medical conscience law in the state? And she said there have been no issues, so no cases filed in two years and no, no employment problems for hospitals.

DAY: OK. Thank you.

STEPHANIE NICHOLS: Thank you.

HANSEN: Any other questions from the committee? All right. Seeing none, thank you for coming. Appreciate your testimony.

STEPHANIE NICHOLS: Thank you for your time.

HANSEN: We'll take our next testifier in support of LB810. Welcome.

CAROLYN MANHART: Dear Chairman Hansen and members of the Health and Human Services Committee, my name is Dr. Carolyn Manhart, C-a-r-o-l-y-n M-a-n-h-a-r-t. Thank you for your service and for your time today. I'm a general internal medicine physician providing

primary care for adults for over 22 years. Twelve years ago, a 70-year-old man came from three hours away to see me as his doctor. He had diabetes and erectile dysfunction, and I began prescribing Viagra to him. Eventually, he shared that he drove to Omaha to see prostitutes, claiming he was helping the girls get through school. After much reflection, I told my patient I would no longer prescribe Viagra to him. He was dismayed and tried to change my mind about once a year, but continued to see me for several more years. Three years ago, I was prescribing Viagra to another patient. Both he and his wife were my patients. When he told me he was using Viagra to have affairs, I could no longer prescribe it for him and he was furious. Don't impose your values on me, he said. He called the office threatening lawsuits. He didn't want to find another doctor because he felt I was the first doctor to listen to him. Fortunately, he never sued. When I forewarned another doctor that this patient had an appointment to see him for Viagra, and I explained the situation, this doctor replied, it's legal, so I don't have a problem with it. State Senators, which doctor do you think is acting in this patient's best interest? I know I offer good care, and I, I cherish my patients, my 1,600 patients. But if I had to prescribe or directly refer for treatments that I believe are harmful or immoral, I would have to leave my practice. I'm also here today because many qualified and compassionate young people are told to suppress their deeply held values to be able to practice medicine today. There are medical organizations I'm involved with, have had the honor of mentoring several medical students. Last Sunday, 12 of these students were in my home wrestling with whether they should testify here in support of this bill. The reason the students are not here is the very reason this bill needs to be passed. They're afraid that publicly testifying for a physician conscience protection will harm their chances of a competitive residency, future fellowships, and getting the job they worked so hard for. In summary, I am not forcing my patients to believe what I believe. I'm not withholding lifesaving care. I'm doing what I think is best for my patients and the types of services that I do not provide comprise a tiny portion of all the care I do provide. Please pass LB810 and ensure that all physicians can continue to practice in Nebraska without the threat of discrimination, lawsuits, or the loss of employment because they have followed their consciences while still ensuring patients are cared for. Thank you.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. Thank you, Doctor. I didn't catch your name. Can you--

CAROLYN MANHART: Carolyn Manhart, C-a-r-o-l-y-n M-a-n-h-a-r-t.

DAY: And you're from here in Nebraska?

CAROLYN MANHART: From Omaha.

DAY: OK, perfect. Thank you. And then, just like I asked the other testifiers, can you give me an example of a service that you would be objected-- morally objected to providing?

CAROLYN MANHART: Well, the reason I came here today, because I thought my two stories were so impactful because these are Viagra patients and we see Viagra patients every single day. And it's not that I don't prescribe Viagra, but there are certain situations in which I think it's wrong. And I hope you can see, even if you don't agree with my decision, where my conscience came into play in these two situations, one in which a gentleman was using the Viagra for prostitution and, and the second one in which he was using it to have affairs. So this is a perfect example, I think, something besides abortion in which a physician would use his or her conscience to say no to a patient.

DAY: OK. Thank you.

CAROLYN MANHART: You're welcome.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Dr. Manhart. I don't think that this would apply in your situation. This is a moral objection to-- if you didn't prescribe Viagra across the board, but applying it disparately, this would not apply to you. I just wanted to make that clear.

CAROLYN MANHART: This bill wouldn't protect me from being sued?

M. CAVANAUGH: No. No.

CAROLYN MANHART: The way I understood it, and I'm not a lawyer, but that this bill would protect any physician who, for moral reasons or ethical reasons, would deny care, specific care.

M. CAVANAUGH: Not for specific reasons.

CAROLYN MANHART: Well, the specific reason is a conscientious objection.

M. CAVANAUGH: Right. But you cannot deny care to your patients because you don't like or agree with them. You-- this protects you from-- if you don't agree with prescribing Viagra to patients, this would protect you. But not prescribing Viagra to patients for reasons that you object with their use of it, it would not protect you at all.

CAROLYN MANHART: Senator Cavanaugh, I, I just want to give an example. Like every day I'm giving Percocet to patients. So I will give Percocet to a patient who has had an ankle fracture, but I won't give Percocet to a patient that has had a back strain. So the, the type of treatment that I'm giving is specific to the context in which the patient is asking for the treatment.

M. CAVANAUGH: I, I understand.

CAROLYN MANHART: And so-- yeah.

M. CAVANAUGH: I was just trying to clarify for you that this, this does not apply to the specific example that you gave, and, and that's fine. I just wanted to clarify that for the record.

HANSEN: Any other questions from the committee? Seeing none, thanks for your testimony.

CAROLYN MANHART: Thank you.

HANSEN: We'll take the next testifier in support.

PAUL ESPOSITO: Hey, good morning. My name's Paul Esposito, M.D., P-a-u-l E-s-p-o-s-i-t-o. Good morning, Mr. Chairman and members of the Health and Human Services Committee. I appreciate the opportunity to speak before you in support of this Medical Ethics and Diversity Act. I'm a recently retired pediatric orthopedic surgeon from the University of Nebraska Medical Center, where I'm an emeritus professor of orthopedic surgery and pediatrics. I also worked for the Children's Hospital Medical Center where I last served as surgeon in chief. I have a lot of experience in administrative activities. I continue to be an active member of state, local, and national medical societies. I'm here to testify to my personal beliefs and opinions related to this bill and do not represent any of my prior employers or the organizations that I'm a member of. I've been an educator throughout my career to thousands of surgical and medical resident physicians,

medical students, nurse practitioners, physician assistants, and nursing students. I've had their ear for many, many years. Over the years, they are more and more expressing concerns and anxiety over how medicine is evolving and if they will be able to practice in a manner they believe is morally and ethically acceptable. Shortly after the passage of Roe, when I was a medical student, before things like that got even more complex. If a student physician chose to participate in procedures such as abortion, they could do it and it's perfectly acceptable to decline. The complexity and increasing numbers of such potentially morally conflicting circumstances has increased rapidly in the past decade, especially as both technological and medical and social ethics have changed. This is placing increasing pressure on all students and medical practitioners. Asking anyone to do something unconscionable is itself unconscionable. I've had the opportunity to work with and lead a very diverse group of highly-skilled, trained practitioners from a variety of backgrounds. There is an increasing concern amongst them regarding federal and medical mandates. This is having a chilling effect on those presently working in healthcare and on individuals considering entering nursing and allied health careers, as well as the physician's choice of specialty. When these concerns are based on religious beliefs and moral conviction, they must be respected. Quality care will be greatly harmed if individuals are not bound to their patients through mutual agreement and principles of treatment. This potentially could lead to increased morbidity and mortality, despite technical medical advances. Individuals who have a medical vocation bring their deeply held beliefs to their practice. Those who are constantly questioning of what is being offered their patient is moral and ethical, in my opinion, are better clinicians. Placing people in what they firmly believe are unethical or immoral positions will drive them away and further contribute to the shortage of healthcare workers in our state and region. It's my opinion that LB810 clearly provides the protections to practitioners required in an ever more complex medical environment which is changing constantly without limiting access to care. If the protections of LB810 are not enacted, in my opinion, there will be a precipitous decrease in the availability of thoughtful, well-trained medical providers to the citizens of our state and region. Thank you and I'll be glad to answer any questions.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? Yes, Senator Day.

DAY: Thank you, Chairman Hansen. And thank you, Dr. Esposito.

PAUL ESPOSITO: Yes, Senator.

DAY: I'm going to ask the same question I've been asking everybody. Can you give me an example of a service that in your practice you would morally object, or previous practice, I guess, you would morally object to providing to someone?

PAUL ESPOSITO: I can give you things that I would personally object to, things that I've helped other people work through. For me, the, the classic is the, the person with Jehovah's Witness who won't have blood. I mean, that's a decision you have to make. Are you willing to put that child through-- when I was a scoliosis surgeon, that child through the risk of having a transfusion, or should they go somewhere else where they may or may not be willing to do that? I've done it both ways. I've talked to the families, what my beliefs are. Are you willing to work within my belief system that I will give you blood-- your child blood rather than let them die or do you want to go somewhere else? And I've had people choose both ways. Choices are more than one way, so.

DAY: OK. So thank you for that. And then my other question is, as an earlier testifier mentioned, we don't list specific services in the bill, and I understand the reasoning for that. But I also am concerned about, you know, we'll say you're the patient and you go in and you need some kind of treatment from a physician and, and they say, oh, you know, I saw him talking about this on the news or we saw that he was at the Legislature and I object to providing this person care based on my moral beliefs. How are we protecting the patient from broad discrimination because we don't list specific services in the bill? So you-- really anybody could object for any reason to providing a service. And I understand what Senator Murman said about it not being patient specific, it's service specific. But how are we protecting the patients in this bill from discrimination in these cases?

PAUL ESPOSITO: That is a very complex question. I'll try and answer it as much as I can.

DAY: OK.

PAUL ESPOSITO: If I don't do it, please. The, the number of times this comes up are relatively small--

DAY: Um-hum.

PAUL ESPOSITO: --for one. There are a variety of opinions and beliefs within our medical system. Our, our system at Children's, for example, has people from all over the world, all different religious backgrounds, there's different ways to do that. I don't personally-- when I have someone approach me personally or someone else who has a specific thing they want, they come to me asking my opinion and opinion is what we do in medicine. We don't claim to have all the right and wrong answers. If I were practicing the same way that I practiced 45 years ago, I'd be complicit in malpractice. I don't do that. We learn, we grow, we change. So my obligation to my patient and I think every physician, every nurses is to do the very best we can and let them know do we believe that's going to help or harm them and do I believe that this is moral and ethical. If I were asked not to do, to do things that I don't believe in, I would not practice medicine, because that's not what medicine is. It's about being honest with your patients and their families and saying this is what I believe is the right thing to do, this is what I'm comfortable doing. I think you're wrong. There are other people, there are other-- you know, in this day and age with the Internet, I have patients from all over the country, all over the world who come to find me. And it's not because somebody's referring them to me, it's because there's so much information available about who can provide what services and where that it's, it's, it's privy that the argument about not doing a direct referral is kind of out of, out of the question right now in my mind.

DAY: OK. And then when you say-- sorry, just one more question, Chairman.

HANSEN: Yeah.

DAY: I appreciate that. Thank you. When your-- when patients are consulting with you about what is the right thing to do, does a physician not have the responsibility of providing them with information about what the right thing to do is based on their health and not based on some religious or whatever? I mean, you're there to provide medicine, not to provide the perspective from religion or perspective from any kind of moral belief. It's, it's the practice of medicine--

PAUL ESPOSITO: My, my--

DAY: --based on the patient's health outcomes and not necessarily what is morally objectionable. Correct?

PAUL ESPOSITO: But when, when I take the Hippocratic Oath, I take, I take that oath to do no harm--

DAY: Right.

PAUL ESPOSITO: --and that's based on who I am, how informed, what my belief systems are. I believe there is black and white. I think there are, there are decisions you make about is this reasonable? Is this in the best interest of this patient's health? That's a judgment I make based on everything I am, my experience and background. Those things change over time with experience. You know, I don't believe absolutely everything I did when I started my practice, but I am who I am. I owe it to my patients to be honest with them. And if they take that away from me, then I can't be the kind of physician I would want to be for that I want my family to have.

DAY: OK. Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your testimony.

PAUL ESPOSITO: Yes, Senator.

M. CAVANAUGH: I wanted to follow up on-- Senator Day asked a question about a procedure or something that you would deny and you, you gave a great example with the patient that's Jehovah's Witness and blood transfusion. But you have that in your practice and this wasn't enacted, were there any repercussions for, for talking with a patient or their parents because you did pediatrics, correct? So in talking with the patient's parents and saying this is the course of treatment, it conflicts with your religious views, but this is the course of treatment that I would pursue as your physician. I mean, I, I guess I don't see how this would have protected you differently. It sounds like you were doing your job.

PAUL ESPOSITO: I think the world has changed, though. I mean, when the State of the Union address says you're going to be mandated to do these things. The world I grew up in didn't say that. I, I think the issues are much more complex than they used to be. And I'm sorry I got away from your question.

M. CAVANAUGH: Oh, I just-- what you-- the example you gave I thought was a really excellent example of when you have to use, whether it's your judgment or your expertise or you said your belief system, you

were confronted with a belief system other than your own and your profession--

PAUL ESPOSITO: Yes.

M. CAVANAUGH: --and the way you handled it, this bill wasn't enacted. And if somebody had that exact same, like you said, times have changed, if someone had that exact same interaction today without this bill enacted, I don't-- and I'm not a doctor, so I don't know if this is right or wrong, I'm asking you-- I don't see how that would be-- how they would be in conflict with doing no harm and, and living up to the Hippocratic Oath and providing the best care possible. Like, I don't, I don't see a religious belief being necessary to protect you in that.

PAUL ESPOSITO: But I thought the point of this was because I told that family I wouldn't do that procedure, I'm treating them differently than other patients with scoliosis.

M. CAVANAUGH: You told them you would do--

PAUL ESPOSITO: I wouldn't do it.

M. CAVANAUGH: You wouldn't do blood transfusions?

PAUL ESPOSITO: Right, or if they wanted to have the surgery done without blood transfusion, they'd go to see someone else.

M. CAVANAUGH: Oh, I, I see. They wanted-- if they-- you would do--

PAUL ESPOSITO: I would do it if they would be willing to have blood.

M. CAVANAUGH: Right. OK. Yes.

PAUL ESPOSITO: If they weren't willing to have blood, they would have to go somewhere else.

M. CAVANAUGH: Right.

PAUL ESPOSITO: If they absolutely insisted that I do it, I'd have to tell them my, my conscience would tell me, I would give them blood.

M. CAVANAUGH: And your--

PAUL ESPOSITO: It's a really complex thing.

M. CAVANAUGH: --and your conscience, and your conscience would tell you to give them blood based on your medical training?

PAUL ESPOSITO: I would not allow the child to die based on my medical training.

M. CAVANAUGH: Right. So, again, that's not-- this would not protect you in any way, shape, or form. You were living up to your, your scope of practice, your training, your Hippocratic Oath. I'm just-- I think what Senator Day is trying to get at, and, and I as well, I'm trying to understand what situations, because they're not detailed here, what situations are we seeking to protect? And in your situation, even today, that's still protected because you are providing a standard of care. And as long as you are providing a standard of care, you don't need this.

PAUL ESPOSITO: There's a lot of controversy related to that particular scenario to this day--

M. CAVANAUGH: I--

PAUL ESPOSITO: --and there's a lot of legal things.

M. CAVANAUGH: Right.

PAUL ESPOSITO: There are many other things I could give you as examples of why this bill is needed. I was asked to give one.

M. CAVANAUGH: Would-- if you would, if you'd like to, please feel free to give a second example.

PAUL ESPOSITO: Sure. I mean, we, we in medicine have been able to work through a lot of things together with common sense. You know, we have a policy called a DCD policy where--

M. CAVANAUGH: What does that stand for?

PAUL ESPOSITO: Deceased-- not-- it's-- I can't remember exactly. It's when an individual is brain dead.

M. CAVANAUGH: OK.

_____: Deceased cardiac donor.

PAUL ESPOSITO: Yes. Thank you.

M. CAVANAUGH: Deceased cardiac-- can you say that for the record?

PAUL ESPOSITO: Deceased cardiac donor.

M. CAVANAUGH: Thank you.

PAUL ESPOSITO: Where the, the individual is legally brain dead and very clearly is and the organs are harvested before the heart stopped.

M. CAVANAUGH: OK.

PAUL ESPOSITO: Now, to me, that's a very morale, acceptable thing. We made a policy, though, because there were no protections like this law to say that people could be excluded from that if they found that morally reprehensible and unethical. So there are ways that we've been doing it piecemeal, piecemeal. With the new challenges, with a lot of things that are coming up, there are people that have very valid, moral concerns. And we could use all those examples. Gender identity right now is obviously the hot button topic. A lot of people feel very strongly about that on both sides. I think we need to respect the opinions on both sides until the science catches up.

M. CAVANAUGH: So with the, the DCD example, you said that policies were created.

PAUL ESPOSITO: Put, put in place.

M. CAVANAUGH: Put into place. Who put-- who does that? Who put--

PAUL ESPOSITO: That was in a hospital level.

M. CAVANAUGH: OK.

PAUL ESPOSITO: And I think that's one of the things we have to protect is make sure we represent our hospitals and our, our facilities, too. And I think this bill does that.

M. CAVANAUGH: OK. That's very helpful. Thank you for that clarification.

WALZ: Other questions? Senator Riepe.

RIEPE: Thank you.

PAUL ESPOSITO: Yes, sir.

RIEPE: Dr. Esposito, welcome. I know you as an excellent physician from Children's and an individual of high quality and--

PAUL ESPOSITO: Thank you, sir.

RIEPE: --and I, I respect you so very much. My question is this, not so much it's you, but is the residents that you see, the medical students that you talk to, and you talked a little bit or some of the testifiers before have talked about the contradiction, the challenge of should they go into medicine or should they do something different with their life? Can you give us a little insight in terms of the degree of that anxiety, if you will, that you see in, in younger physicians coming along?

PAUL ESPOSITO: I, I think, Senator Murman, if I remember testified, gave numbers on those things, which are pretty compelling to me. I, I know I'm speaking only from my own experience--

RIEPE: Sure.

PAUL ESPOSITO: --where I've mentored and counseled a lot of individuals, and, and some of them been told you, you-- if will not do this procedure, which is maybe one-half of 1 percent of all the stuff that specialty does, you can't be in this residency.

RIEPE: Wow.

PAUL ESPOSITO: They just do something else. And for me to have somebody-- if, if, if it is so important you do that one procedure and you would be an outstanding physician in that specialty for 99.5 percent otherwise, I think that's bad because that's taking a choice away from people, what kind of individual that they want to take care of them and their families. So that's the kind of anxiety I'm seeing. I'm seeing them go into specialties they don't like necessarily, they're not their first choices because they're frightened. Are they going to make me do these things as I go forward? And, and, and I think that's my answer to your question, sir.

RIEPE: Thank you. Thanks for being here.

PAUL ESPOSITO: Thank you, sir.

WALZ: Other questions from the committee? I see none.

PAUL ESPOSITO: Thank you.

WALZ: Thanks for coming today. Next proponent. Good morning.

FRANCESCA URSUA: Good morning. Trying to find a spot where I can touch the ground here. My name is Francesca Ursula. I'm a-- oh, sorry, F-r-a-n-c-e-s-c-a U-r-s-u-a. I'm a current family medicine resident and will be beginning my fellowship training obstetrics in July. I speak on behalf of myself, and none of my comments or statements reflect any of the opinions of the institutions for which I serve, including the U.S. government and the Air Force. As a minority female, it is with grave earnestness that I say that I am most fearful of and have experienced more discrimination against my conscience than I have against my race or my gender. Conscience defined as the inner sense of right or wrong must be protected throughout all levels of healthcare and the hierarchical structure of medical training. It's crucial that the trainees conscience is not seen or treated as less right than the conscience of a supervisor or attending or other authority above them. My colleagues and I have been refused training opportunities, looked down upon, and berated due to our consciences. Medical students and college students have approached me, saying that they are losing hope in believing that it would be possible to pursue a career in medicine without their conscience being compromised. If our trainees and our prospective trainees lose hope, we lose the future of medicine. As a current resident in family medicine and a future fellow in obstetrics, I'm here to be a voice in defense of current and future trainees that desire to hope-- desire and hope to practice according to their conscience. Thank you for allowing me to speak today.

WALZ: Thank you. Questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Sorry, I think I, I was going to steal your question.

DAY: Go ahead.

M. CAVANAUGH: What, what have you objected to in your training?

FRANCESCA URSUA: Sure. One of the common ones that I do not do is prescribe any sort of hormonal or device contraceptive.

M. CAVANAUGH: OK. And you're going into obste-- I'm not to say the word right.

FRANCESCA URSUA: Obstetrics. Yes.

M. CAVANAUGH: Obstetrics, thank you. OK. So that's your-- you're a resident in family medicine and you're going into obstetrics and

you're-- you object-- conscientiously object to hormonal prescriptions. Thank you.

FRANCESCA URSUA: Yes.

WALZ: Other questions? Go ahead.

BALLARD: Thank you. Thank you, Senator Walz. Can you talk a little more about where this pressure is coming from? Is it from professors, colleagues, the world? Just-- can you give us a little insight?

FRANCESCA URSUA: Sure. Generally speaking, yes, it's all of the above.

BALLARD: Yes to all of the above? OK. Thank you.

FRANCESCA URSUA: Um-hum.

WALZ: Other questions? I see none. Thanks for coming today. Next proponent.

SANDY DANEK: Good morning, members of the committee. My name is Sandy Danek, S-a-n-d-y D-a-n-e-k, and I'm executive director of Nebraska Right To Life and I come before you today in support of LB810. Many medical professionals do not want to be forced into participating in certain controversial technologies and treatments such as abortion, assisted suicide, or unethical research. By providing conscience protections, LB810 would ensure that Nebraska does not lose well-trained medical professionals who wish to exercise their professional judgment for the best interests of their patients, born and preborn. Nebraska medical professionals guided by the Hippocratic Oath should not be subject to hostility or coercion because of their ethical, moral, or religious beliefs and should be able to care for the sick and suffering without fear of negative career or legal implications as a result of the care they provide their patients. When deciding which medical provider is best for one's care, Nebraskans will often consider a physician's moral and ethical standard of medicine. Some would not consider going to a physician who believes in the taking of innocent human life by either performing or supporting abortion or assisted suicide. And Nebraskans should be allowed to make that judgment. Medical conscience is a civil right worthy of legal protection, which is vital to providing medical care to especially the vulnerable. More and more healthcare workers have been coming forward with stories of intimidation, isolation, and discrimination because of their convictions. Medical conscience protects the health and dignity of all patients and empowers diversity among medical professionals.

The Medical Ethics and Diversity Act offers that protection. We ask that the committee advance LB810 out for full debate. Thank you.

WALZ: Thank you. Questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Assisted suicide is illegal in Nebraska.

SANDY DANEK: Yes, it is currently, but we do see it growing throughout the nation.

M. CAVANAUGH: OK. But it's illegal in Nebraska--

SANDY DANEK: It is currently.

M. CAVANAUGH: --so this bill would do nothing for somebody objecting to assisted suicide because they'd be committing a crime.

SANDY DANEK: It's an example I use because it is coming in our direction. It is growing in the nation.

M. CAVANAUGH: OK. But currently,--

SANDY DANEK: Yes.

M. CAVANAUGH: --it's illegal. And as we previously discussed, this actually would not impact abortion unless you wanted to go work at an abortion clinic, which--

SANDY DANEK: That's not true, Senator. As a matter of fact, I stepped out of the room to verify what I know that abortion is legal in Nebraska hospitals.

M. CAVANAUGH: It is legal.

SANDY DANEK: Yes.

M. CAVANAUGH: Yes.

SANDY DANEK: And it can be performed in Nebraska hospitals.

M. CAVANAUGH: It can be per-- it is legal and it can be performed. It is, however, against the policies of the hospitals in the state of Nebraska.

SANDY DANEK: That's not true.

M. CAVANAUGH: What hospital will--

SANDY DANEK: Well, I don't want to say which hospital it is because it's a Nebraska hospital here in Lincoln. And I stepped out of the room to call. I worked at that hospital years ago, so.

M. CAVANAUGH: And they perform abortions that--

SANDY DANEK: And if you'd let me finish my comment, I called this medical professional and I said, please clarify for me what I know to be true, that if a physician wanted to perform an abortion in your hospital, could it be done? Yes, it could be done. It is not typically done because there are abortion facilities in the state now that provide that service. But it could be done if a physician chose to do it.

M. CAVANAUGH: They don't have a policy prohibiting it?

SANDY DANEK: No, they do not.

M. CAVANAUGH: And you don't want to say what hospital it is because--

SANDY DANEK: Bryan East.

M. CAVANAUGH: OK. Bryan East does not have a policy stating that you cannot do elective--

SANDY DANEK: Exactly.

M. CAVANAUGH: --abortions?

SANDY DANEK: Exactly.

M. CAVANAUGH: I'm just saying that so that they have the opportunity to come in and give us an answer on that.

SANDY DANEK: This is a high-level executive in, in the hospital--

M. CAVANAUGH: OK.

SANDY DANEK: --so I would trust her judgment.

M. CAVANAUGH: Because I know for a fact that the hospitals in Omaha have policies that prohibit elective abortions, that you can only get an abortion in a hospital setting in Omaha if your life is in danger.

SANDY DANEK: I can research that for you and find that out.

M. CAVANAUGH: I, I don't need you to research that.

SANDY DANEK: OK.

M. CAVANAUGH: I know for a fact that that is the case. So I, I guess we will ask other hospitals to let us know if that is not the case with them, but--

SANDY DANEK: It's just commonly not done,--

M. CAVANAUGH: OK.

SANDY DANEK: --as I understand it, because of the freestanding abortion facilities like Planned Parenthood.

M. CAVANAUGH: So do you know of an instance in a hospital setting in Nebraska where somebody has objected to providing an abortion that was not an emergency?

SANDY DANEK: I do not directly know that. I would have to check with my sources to find that information.

M. CAVANAUGH: OK. So we don't have-- assisted suicide isn't legal, abortions, we are not aware of any instances of anybody being forced to perform abortions in a nonemergency setting. So what are-- what is left? What are you trying to protect by supporting this bill?

SANDY DANEK: Well, there are, there are a couple of different things I could cite the example for, so. As I said years ago, I worked at this hospital. And when you would see the surgery, the daily surgery schedule, you wouldn't necessarily see it openly stated as a termination of pregnancy.

M. CAVANAUGH: I--

SANDY DANEK: Perhaps you would see it as a D&C.

M. CAVANAUGH: I wasn't-- I'm asking, I'm asking--

SANDY DANEK: I just wanted to clarify that.

M. CAVANAUGH: Right. But I'm, I'm asking that we put a pin in, in abortion and assisted suicide. I'd like to understand the scope of what, what you think this is helping?

SANDY DANEK: So I think others have commented to this, and I, and I would say the same thing. It's indirect in terms of people that I know that I've communicated with that have assisted us in the work that we provide. It's, it's very underlying. There's definitely an outward discrimination that comes when your position is known that you do not support performance of abortion. So for instance, I had an OB-GYN resident that I communicated with wanted to seek her testimony and she was concerned for the repercussions she might suffer in her setting if she were to come out outwardly.

M. CAVANAUGH: This, this would not protect her.

SANDY DANEK: No, I'm just trying to explain, though,--

M. CAVANAUGH: OK.

SANDY DANEK: --that the discrimination, the, the pressure that these medical professionals are feeling are very evident.

M. CAVANAUGH: OK. I-- and I, I, I appreciate that. What I'm trying to understand in this bill is what it does and who it's protecting and in what way.

SANDY DANEK: And I think the medical professionals that have testified and will come after me can address that more directly.

M. CAVANAUGH: OK. Thank you.

SANDY DANEK: Um-hum.

HANSEN: Any other questions from the committee? Seeing none, thank you for--

SANDY DANEK: Thank you.

HANSEN: --coming. We'll take the next testifier in support of LB810. Welcome.

WARD GREISEN: Good morning, everybody. Excuse me. My name is Ward Greisen. That's W-a-r-d G-r-e-i-s-e-n, and I am testifying in support of 810-- LB810. So our healthcare industry has fallen into the phenomenon called "groupthink." For those that are not familiar with the term, it is used to describe suboptimal decisions that are made by a group due to social pressures. There are eight symptoms used to identify when groupthink has-- or when a group has fallen into

groupthink. Invulnerability: members of the group share an illusion of invulnerability that creates excessive optimism, encourage normal-- abnormal risk. Rationale: victims ignore, ignore and discount warnings and negative feedback that may cause the group to reconsider their previous assumptions. Morality: victims ignore ethic-- ethical and moral consequences of their decisions they believe unquestionable and immoral in their group. Stereotype: members of the group possess negative or stereotypical views of their, quote unquote, enemies. Pressure: victims apply pressure to any individual who momentarily expresses concern or doubt. Members are not able to express their own individual arguments against the group. Self-censorship: victims avoid deviating from what the group consensus is to keep quiet. Illusion of Unanimity: victims share an, an illusion of unanimity that the major view of the judgments of the group are unanimous. Mind Guards: victims of the groupthink, groupthink protect the group from information that may be problematic or contrary to the group's view, decisions, or cohesiveness. Even well-intentioned people are prone to making irrational decisions when faced with overwhelming pressure from the group. How can groupthink get started? Here are three main ways. Group identity: it tends to be-- occur more when a situation where group members are very familiar with one another. When there is a strong identity, members among the group tend to perceive their group as correct or superior while expressing disdain or disapproval toward an outside coalition. So examples of that is lack of diversity in the industry, we see consolidation is happening all, all across the board, whether it's in insurance companies, whether it's in pharmaceuticals. And so we're getting a group identity and we're lacking diversity. Another influencer is leader influence, and who's the leader in this particular case? We see pharmaceutical companies being a huge leader in this case. They're spending billions on lobbyists and, and voting to doctors and so on and so forth. And the last one is stress. Stress from social pressures can also cause groupthink-type scenarios. So what is in a recent example of groupthink that would apply to this bill? I think the opioid epidemic is one of those. My wife's a pharmacist, and during that time ten years ago, she was working, you know, this over-counter-type stuff. She knew the harm that these opioids that were getting prescribed by doctors was causing. And-- but she, she could do nothing about it other than follow what she had to do as far as an employment standpoint. Even though she had people coming into the pharmacy, she knows were getting prescribed-- and I know I'm at a red light, so let me finish my thought, please.

HANSEN: Really briefly, yeah.

WARD GREISEN: Yeah. OK, I will-- getting prescribed volumes of the drug or levels of the drug that would literally kill somebody. And-- but, yet, she could do nothing about that. So it is for that reason that I am in support of LB810.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you for coming.

WARD GREISEN: Thank you.

HANSEN: We'll take our next testifier in support.

NATE GRASZ: Good morning, Chairman Hansen and members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z. I'm testifying in support of LB810 on behalf of the Nebraska Family Alliance. Respect for the conscience of every individual and for individual differences and deeply held beliefs is an essential aspect of our free society and the practice of medicine. LB810 protects diversity of belief within the medical profession and ensures that medical providers are never forced to participate in procedures or treatments that conflict with their ethical, moral, or religious beliefs. Federal law and the professional code of ethics and the bill itself rightfully require medical providers to provide examinations and treatments to anyone with an emergency medical condition. This bill does not change that. It simply protects providers from being required to perform a specific procedure if doing so would violate their conscience. It is unsurprising that in a diverse and pluralistic society like ours that there are different sincerely held beliefs on a wide variety of issues, including in the medical field. But we should all agree that medical providers should not be forced to choose between their ethical, moral, or religious values and their life's calling to practice medicine and help people heal. Medical conscience laws like LB810 promote a diverse medical field that welcomes people from different backgrounds and faiths, leading to more nurses, doctors, pharmacists, and other healthcare providers. We encourage the committee to advance LB810 so that the public policy of the state of Nebraska is to protect the right of conscience for all of our medical providers. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you for testifying. Is there anybody else who wishes to testify in support of LB810? Welcome.

EDWARD DeSIMONE: My name is Edward DeSimone, Ph.D., E-d-w-a-r-d D-e-S-i-m-o-n-e, and I'm here to speak in favor of LB810. I appreciate the opportunity to do so. So I've been a pharmacist for 51 years. Licensed to practice in Nebraska. I've spent the last 46 years as a pharmacy educator. I'm a member of Pharmacists for Life, Business and Professional People for Life, and the Catholic Medical Association. I am speaking for myself, however, but I can state with certainty that my comments are representative of pharmacists who believe in the right of conscience as a core tenet of how they live their lives and serve their patients and the practice of pharmacy. The past 25 years, pharmacists around the country have been fired for refusing to fill prescriptions for various drugs based on perceived harm to the patient and/or unborn child. These case decisions were made based on informed conscience and a do-no-harm commitment as a healthcare practitioner. In 1999, Levonorgestrel was approved for use as an emergency contraceptive known as the morning after pill. And since then that accelerated this problem because it's-- acts part as an abortifacient drug. Two cases that I worked on as an expert witness, one in Illinois, referred to by a previous speaker, when the governor said that the right of conscience does not apply to pharmacists in Illinois issued an executive order to force all pharmacists in the state, as well as the pharmacies to stock and dispense emergency contraceptives. And a pharmacist-- pharmacists in a number of chain pharmacies, in particular Walmart, Walgreens, CVS, were fired for refusing to sell or dispense it. And ironically, Illinois has one of the best conscience acts in the country, as we heard previously. In the end, the courts agreed that pharmacists have a right of conscience according to the law, and as well in the second case, pharmacies also have the right not to stock them or sell them. That's the Morr-Fitz citation that's on your document. And after that, Washington state where the governor tried to force pharmacists to dispense all drugs regardless. And there's an amicus brief in there by pharmacists as well that addresses that case. The American Pharmacists Association has a conscience clause, a conscience policy. I've been a member of the organization for over 50 years, and I was a member of the House of Delegates that passed this in 1998. And it says briefly: APhA recognizes the individual pharmacist's right to conscient-- to exercise conscientious refusal, supports the establishment of systems to ensure this without compromising the pharmacist's right of conscience. I know my time is up. So that's-- I'm a professor so you have plenty of material to read.

HANSEN: Yeah. Great. We have homework, huh?

EDWARD DeSIMONE: Yes, sir.

HANSEN: All right. All right. Thank you for your testimony. Is there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Were you educated at Creighton University?

EDWARD DeSIMONE: No, ma'am.

M. CAVANAUGH: OK. I, I was just curious because you have Creighton University listed on here, and so I didn't know if that was listing it--

EDWARD DeSIMONE: No, I'm a New Yorker.

M. CAVANAUGH: I'm sorry?

EDWARD DeSIMONE: I'm a New Yorker.

M. CAVANAUGH: OK. All right. So they're not-- that's not part of your education credentials is--

EDWARD DeSIMONE: No.

M. CAVANAUGH: --what I was trying to ask. Thank you.

EDWARD DeSIMONE: You're welcome.

HANSEN: Senator Riepe.

RIEPE: Thank you. The University of Nebraska has reported a low enrollment of students in the School of Pharmacy. I don't know whether Creighton is experiencing low interest and if some of that interest is a matter of the ethics and the concern as to what the previous testifier talked about his wife having to fill opioid prescriptions, which overrode her conscience. Tell me, if you can, what your perception is as why more students aren't going into pharmacy?

EDWARD DeSIMONE: Well, it's multifaceted. I can tell you that. We look at the, you know, applications and admission. Certainly, one, one aspect of this is workload. And the COVID epidemic has really accelerated the problem. But the workload that pharmacists have to work under has just been debilitating. If you read-- you see the paper every day, we have the same problem in hospitals with nurses and physicians. Everyone in healthcare is suffering from that. So I, I can

say that definitively that this conscience issue has contributed-- excuse me, has contributed to that. I can tell you, I lecture every year in our ethics, because we have a pharmacy ethics course, and my particular lecture is on this topic conscience, right of conscientious refusal and, and all the issues pertaining to that. And it's after that, I, I give that I get contacted by the students who are now getting-- in the third year who are getting ready to sign up for their rotations in this for the fourth year. And the questions that I get is I don't want to dispense these things, I don't want to be involved in this, what do I do? So I put them in touch with the appropriate people to help deal with that issue. So I can tell you, you know, they're students so a lot of times these things don't come up until we discuss it in the classroom. And so once that discussion-- excuse me, once that discussion occurs, then they find out, oh my God, I didn't even think about that. And so that is an issue for many of the students. And I've talked to medical students about, you know, in the same way, particularly those interested in OB-GYN, what do I do? And so that's a problem.

RIEPE: So new students considering pharmacy is that a point of discussion before they make a three-year commitment and find out in your class that kind of at the end it's maybe a, oh, I didn't know that?

EDWARD DeSIMONE: No, that, that's an issue. If they-- if the student-- if the applicant raises that question, we certainly will address that and answer that question. But it's not something--

RIEPE: You're not trying to scare them off in the beginning?

EDWARD DeSIMONE: No, not trying to scare them off.

RIEPE: Thank you for being here.

HANSEN: Any other questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. And thank you for being here today. So the Creighton University that you have on your, your packet that you gave out, that's where you are a professor, is that correct? Is that where you're teaching?

EDWARD DeSIMONE: Yes,--

DAY: OK.

EDWARD DeSIMONE: --I've been there 34 years.

DAY: OK. And then-- so you mentioned Plan B earlier and the objection there is that it's-- you see it as an abortifacient. Is that correct?

EDWARD DeSIMONE: If you look at the medical literature, it says the mechanism of action is still unknown. Sometimes it acts as an abortifacient, sometimes it acts as a contraceptive, depending on a very narrow timeline of when the individual takes the, the drug. And so when I, when I talk to the students, I, I have what I call the "gun-and-bullet analogy." I say, if I take a gun, put one bullet in it and spin the, spin the cylinder and hand it to you, will you shoot someone in the head if I ask you to do that? And they look at me, no, I'm not going to do that. I said, well, that's the same thing. We don't know when this is an abortifacient and when this acts as a contraceptive. And since I don't know the answer to that question, I'm not going to dispense that because I'm not going to participate in that process. It's that simple.

DAY: OK. And so I'll ask the same question I've asked a, a couple of other testifiers. What protections are in this bill for people who are seeking medical care or prescriptions and their rights to receive that when they are asking for it and protecting them against discrimination based on the failure to provide services when asked?

EDWARD DeSIMONE: I'm not sure I understand who you are referring to.

DAY: The patient.

EDWARD DeSIMONE: OK.

DAY: So if somebody asks-- has a prescription filled for contraceptives or opioids or whatever it might be, what, what is-- what recourse is there in the bill for people who feel as though they've been discriminated against? Is there any?

EDWARD DeSIMONE: I can't answer that. I don't know exactly what those protections are. However, if, if we go back to that Illinois case, prior to that, that time, the pharmacies in, in question had signs for the patient or they had two pharmacists there when they knew one would dispense it, if the other one wouldn't you can step away. So the, the onus was on the institutions to provide for situations in which this drug would not be dispensed. And we know-- let's, let's be honest, we don't see this in the paper every day. This is not a, a major, you know, headline type of issue. This is something that happens quietly

between two individuals in a given situation. And my recommendation certainly to our students is that before you take a job, you need to ask your potential employer what happens in this situation? That's one recommendation that I make to every student in class. The worst time to decide what you really believe is when you have a prescription in your hand. And so if-- assuming if this bill gets passed into law, I would encourage the facilities that provide for these drugs to be proactive so that they can-- they want to protect their patients. Fine. And that's part two of that pharmacist conscience clause that I read. And I voted for that. I was OK with it because it said pharmacists have the right of conscientious refusal. But part two says systems should be in place to take care of the patient. But whatever systems are in place should not impinge on the pharmacist's right of conscience. So I think under the APhA policy statement, the onus again is on the institutions to do something to protect-- to, to assist their patients. And I'm OK with that as long as-- because in Catholic teaching, formal cooperation s a violation. I'm not going to call somebody up and say will you fill the prescription, I might as well do it myself. But if the, if the institutions provide for that, I can step away and say, I'm not formally cooperating with this issue and I'm OK with that.

DAY: Thank you. I appreciate that.

EDWARD DeSIMONE: You're welcome.

HANSEN: Senator Ballard.

BALLARD: Thank you, Chair Hansen.

EDWARD DeSIMONE: Oh.

BALLARD: I'm sorry. So can you walk me-- I kind of piggybacking off that. Can you walk me through this? So as a pharmacist, you receive a prescription and you have, you have a conscience objection to it. What happens next?

EDWARD DeSIMONE: OK. If-- it depends on who I work for, let me put it that way. So let me give you a personal example, because you were asking personal examples. When I lived in Indiana before I came here, I was teaching at another university, but I worked one day a week. But I went to the-- this hospital that was close to where I, I lived, and I said I'd like to work here one day a week, if that's OK. And we-- I got-- I did the interview and everything and the, the, the pharmacist

in charge said we'd like to hire you. I said, OK, but I have one, one condition. I don't dispense any meds that are abortifacients. And his response to me was, I want, I want you to come here so we'll make-- we'll work with you so that, that doesn't happen. And it was never a problem and matter of fact, I, I got a prescription once in the hospital for an abortifacient suppository, and I went down to the ER, talked to the ER physician who prescribed it and he said, well, the woman has had a miscarriage, a partial miscarriage and we want to deal with that. No problem. I went up to the pharmacy, I filled the prescription and brought it down personally to the ER. So there are ways to handling that. In the Illinois case, prior to this time, Walmart, Walgreens, and all those, they had signs up. So if they only had one pharmacist on duty, it said if the pharmacist cannot fill your prescription, call this number. The institution took care of the problem. What happened in Illinois is when the governor issued an executive order, all of these companies got squeamish and they didn't want to be involved in lawsuits so they just went in and fired the pharmacists who wouldn't do it instead of fighting this out. Ultimately, the courts ruled that the Illinois right of conscience includes pharmacists and protects them, and it also protects them from any type of retaliation. And that's what we're looking for. That's what's in this bill, not just the protection of, not just the protection of conscience, but protection from retaliation. So I don't know if I answered your question.

BALLARD: Yeah, of course. I mean, still, maybe what I'm getting at. So in your 30-plus years of experience, you've never seen a patient not receive their prescription?

EDWARD DeSIMONE: I'm sorry?

BALLARD: So in your 30-plus years of experience, you've never seen a patient not receive a prescription in one way, they can go to another pharmacy?

EDWARD DeSIMONE: Right. I've never, I've never seen that. Now, I've been teaching for 44 years so my involvement-- the first 12 years of that I did work in hospitals. Prior to that, I was in a community pharmacy in suburban Philadelphia, so.

BALLARD: Thank you.

EDWARD DeSIMONE: But it's never been an issue--

BALLARD: OK. Thank you.

EDWARD DeSIMONE: --in my experience.

HANSEN: Any other questions? Senator Riepe.

RIEPE: Thank you, Chairman. We were talking to somebody, you were talking to someone about the employment. It would seem to me, and I want you to respond to this, the American Disabilities Act requires employers to seek accommodation for employees. So wouldn't employers, be it pharmacies, hospitals have a legal responsibility to try to accommodate whether it's a physical disability or it's a-- an objection to certain procedure? It seems to me like the employer is on the hook here to make some concessions to make it work.

EDWARD DeSIMONE: I don't-- I'm not an attorney, so I can't-- I don't-- I'm not familiar with the, the wording of that type of legislation, certainly. But that's exactly my point. I think, one, if, if there-- if the wording of that law says that they should be making accommodations and they should know that and make accommodations. But on the other hand, there is an onus on pharmacists, in particular, who or physicians, healthcare practitioners of all types. If you're going to put yourself in a situation where something like this might happen, I think they need to be proactive and say, look, I don't--just like I did in the hospital, this is my situation. If you want me to come here and work for you, this is the condition that I have for employment. Will you make the accommodation? The hospital decided to make that accommodation, so I never had a problem in, in the next nine years or so that I worked there, so. Yeah, I, I think-- there's a, there's a requirement on both ends. I think there's a requirement on the part of the employee to make their feelings known if they think-- if, if they know they're going to be put in a position like that. I hate to, to plead ignorance, you know, so think about, you know, what position you're going to put yourself in and then make sure your employer is, is aware of it. To be--and in regard to your previous question with numbers of pharmacists, for example, there's plenty of jobs out there. If somebody won't hire you, somebody else will. Right now, their role-- I was in a pharmacy yesterday and they apologized because they're short staffed. Everyone is short staffed. There are plenty of positions so deal with it.

RIEPE: Thank you.

EDWARD DeSIMONE: Thanks.

HANSEN: All right. Any other questions from the committee? All right. Seeing none,--

EDWARD DeSIMONE: Thank you.

HANSEN: --thank you for testifying. Is there anybody else who wishes to testify in support of LB810? Welcome.

LLOYD A. PIERRE, JR.: Hi, my name is Lloyd A. Pierre, JR., L-l-o-y-d A. Pierre, P-i-e-r-r-e, JR. I'm here in support of LB810. Good day, Chairman Hansen and committee members. My name is Lloyd A. Pierre, JR. I'm a cofounder of a faith-based clinic here in Omaha, Nebraska. I took the Hippocratic Oath to "first, do no harm" when I became a doctor of medicine in 1994. I am now a board-certified family medicine physician since 2001, and I've done limited hospice and palliative care medicine. When you think about this issue and others, such as the freedom of speech, freedom of religion, freedom of the press, you ultimately realize that those like freedom of conscience are simply about freedom. I started a primary care clinic in Omaha, Nebraska, more than ten years ago after retiring from the United States Air Force. While I was active duty, I went to many places around the world. I saw how medical care was delivered in austere areas of the world. Many people around the world have no choice in the care they receive. This is due to several factors too complex to get into. I noticed in my opinion that when leaders of countries do not make conscientious medical care delivery a priority, excellence in medical care suffers. And thus, so do the people in those countries. People around the world saw the U.S. as a model in medical care delivery and would travel here for better medical care. They still do. While I was stationed overseas, many foreign medics told me how lucky I was to practice medicine in the United States. Yet when I came back home, I noticed that many medical institutions here were starting to lose that desire for excellence. In some institutions, conscience and science were not priorities anymore. I was shocked to find out that many medical schools were no longer requiring doctors to take the Hippocratic Oath. Many doctors were even arguing against the oath. That's one of the reasons why I started a medical clinic that would offer a dignified faith-- faith-based medicine with a conscience that would first do no harm. During the recent pandemic, we have had droves of patients switch to our clinic because they were being pressured into certain forms of medical care that conflicted with their values, with their principles, with their well-formed conscience. I would hear, and I still do. Dr. Pierre, thanks for offering this type of medical care. We have patients from all walks of life, ages, colors,

religions, sexual identifications, and they know when they sign in for care that we deliver faith-based care. And they acknowledge there are certain services we cannot provide, that's upfront before they even start seeing any one of our providers. They understand what the expectations are and they still take that care. Why do they take that care? I've asked some of the atheists that are in our clinic and they say, because we realize that you guys will respect our rights as well as those who are not Christian or not Jewish. Unfortunately, as many of you are aware, disastrous events happened in our past that it illustrates what happens when medics ignore their oath to first do no harm. Medics ignored their oath to exercise a well-formed conscience when they chose to infect innocent black men with syphilis without their informed consent.

HANSEN: We have to interrupt you. Sorry.

LLOYD A. PIERRE, JR.: Yes.

HANSEN: We got the red light. So we'll have to wrap up our thoughts pretty quick.

LLOYD A. PIERRE, JR.: I'll wrap it up. Lest you say this talk about atrocities infecting black men with syphilis and torturing Jews in the Holocaust, for example, is over the top. I say it's not. Removing people's right to freedom of conscience opens the doors to a holocaust. Medics need to be able to freedom-- to have the freedom of conscience to follow their Hippocratic Oath, to first do no harm, to, for example, continue to choose to alleviate pain and suffering as patients are transitioning to death instead of being forced to assist them in suicide.

HANSEN: OK, I've gonna have to interrupt you. I think we're pretty good.

LLOYD A. PIERRE, JR.: Good.

HANSEN: Just got to make sure I extend the same courtesy to everybody else.

LLOYD A. PIERRE, JR.: Yes.

HANSEN: All right.

LLOYD A. PIERRE, JR.: I think you have the rest of that in there.

HANSEN: Yes, we do.

LLOYD A. PIERRE, JR.: Because taking away my freedom of conscience ultimately can take away yours.

HANSEN: Let's see if there's any questions from the committee? Are there any questions from the committee? You're off the hook.

LLOYD A. PIERRE, JR.: Great.

HANSEN: We'll take our next testifier in support of LB810.

RICHARD FRENCH: Good morning and thank you. I am Dr. Richard French, R-i-c-h-a-r-d F-r-e-n-c-h, a doctor of internal medicine from Hastings, Nebraska, where I practiced for 40 years. Regarding LB810, which I am in favor of, it involves medical ethics and preserving a right of conscience for medical professionals. This is a big deal for physicians, as you've already heard. All of us live by one set of ethics from society. We live by another set of personal ethics. In medicine, we have a third set of ethics, it's our professional medical ethics. Those may be distinguished in this example. Society's ethics tell us that it's okay to drink alcohol responsibly, socially, but some of us may choose to forego alcohol completely as a choice of personal ethics. Usually these ethics overlap. Sometimes there are some differences, and that's what we have to pay attention to. The Hippocratic Oath that I took stated, first of all, do no harm. But there was a second corollary to that which said, I will give no medicine to a pregnant woman to abort her child. Interesting, 2,000 years ago, that unborn baby was called a child by the Greeks. Where are we now? At any rate, as you know, doctors are faced with life and death decisions repeatedly. They must weigh the potential benefits of every medicine and every treatment and every procedure on a daily basis. They weigh that potential benefit against potential side effects and risk of harm. This is a process of judgment that doctors must go through every day. Now, however, there are many third parties who desire to control doctors' practices and decisions. Among them, as mentioned, insurance companies, government agencies, pharmacies, pharmaceuticals in particular, whose chi-- their chief objectives may be financial gain or political policy over and above patient welfare. Yet these third parties bear little or no liability or responsibility for harmful outcomes. The responsibility still remains on the shoulders of us physicians. We doctors form different opinions from the same information, so there's often differences of opinion about the same thing. Medicine is not an exact science. That's why we call

it the art of medicine. That's why doctors consult one another, why doctors refer patients for second opinions. I'm sorry, but doctors will not work under conditions that violate their right of conscience. That right of conscience must be respected and protected proactively, not after it's already been violated. Thank you.

HANSEN: All right, thank you for your testimony. Are there any questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. And thank you, Dr. French, for your testimony today. You said you were a family medicine--

RICHARD FRENCH: Internal medicine.

DAY: Internal medicine.

RICHARD FRENCH: Yes.

DAY: I'm sorry. OK, so you mentioned the ethics surrounding abortion--

RICHARD FRENCH: Yes.

DAY: --in your testimony, as have several--

RICHARD FRENCH: Yes.

DAY: --other testifiers. In your practice in internal medicine, do you have anything related to your specific practice that you would object to? Because I assume abortion is not under your practice. Would be--

RICHARD FRENCH: Correct. But the oath is taken as a medical student graduating from medical school, regardless of where they're going. In my practice, I can relate-- we're talking about procedures, but we're also talking about many treatments become equivalent to a procedure. So prescriptions in, in that sense. But in my practice, the first nine months of the COVID pandemic, we were told by experts out of our government agencies that there were really no treatments that you could offer a patient. Oh, make sure they wear a mask, make sure they wash their hands, social distance. Let's lock down the economy. But for the frontline doctors who were treating patients in ICUs, they were told that we have really nothing to recommend and prescribe and treat patients with. Now, there were dozens of articles, research studies which came out of Europe, South America and other countries by reputable hospital systems and physicians that said there were benefits to hydroxychloroquine, to ivermectin, and that they were

seeing reduced severity of illness and reduced mortalities. So there were frontline physicians in America that first nine months of 2020 that said, well, let's try hydroxychloroquine. We've got nothing else to give these patients, but we got to try something. Let's try ivermectin, we've got to try something. And we know that these medicines are safer than the medicines that came out later. Remdesivir that we're now treating people with, that gives 2 or 3 percent benefit over nothing. But doctors were mandated and threatened if they did prescribe hydroxychloroquine, ivermectin, which I prescribed. I thought, I've got to try something. Let me go on. We know of doctors who were threatened to lose their license because of prescribing those medicines. We know doctors that lost their jobs in high-level medical centers because they prescribed those medicines. But that's where the right of conscience, medical judgment, medical experience comes into play, because medicine is not an exact science. It's got to be dealt with by each doctor's own conscience and best medical judgment. Another question?

DAY: OK. Thank you for that explanation. This bill would not apply to those situations because this bill provides protection and the right to decline a service.

RICHARD FRENCH: Well, I see this bill without having specific procedures enumerated being open to provide doctors some latitude in what they are mandated to prescribe or not prescribe according to their own conscience. To treat or not treat according to their conscience proactively. I think your bill should take that into account, that we see things coming down the road that maybe we ought to make some allowance for, for future problems that are going to arise rather than waiting till after the fact that we've already got a problem that has created issues--

DAY: OK.

RICHARD FRENCH: --and, and driven some doctors out of their practice accordingly. Because doctors do not want to be mandated. We're not robots. We don't want to be robots. And you don't want a robot for your physician, I'm sure.

DAY: OK. Thank you, Doctor.

RICHARD FRENCH: Anybody else?

HANSEN: Are there any questions from the committee? All right, seeing none, thank you.

RICHARD FRENCH: Yes.

HANSEN: Is there anybody else wishing to testify in support?

ELIZABETH HEIDT KOZISEK: Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Elizabeth Heidt Kozisek, E-l-i-z-a-b-e-t-h H-e-i-d-t K-o-z-i-s-e-k, I'm a clinical psychologist and I have been licensed in the state of Nebraska for more than 25 years. Throughout the course of my career, I've served rural Nebraskans through my work in hospitals, mental health centers, private practice offices and nonprofit organizations. Protecting the conscience rights of providers is in everyone's interest. Licensure as a psychologist in the state of Nebraska requires adherence to the ethical standards of psychologists of the American Psychological Association. The primary purpose of this is to ensure the well-being of the people that we serve, as well as the public good. The APA Code of Conduct-- of Ethics states: Psychologists respect the dignity and worth of all people and recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures and services being conducted by psychologists. And while no profession is immune to impaired professionals, the numerous providers I have had the opportunity to know across the state are genuinely concerned with the well-being of their clients, and they do not take lightly their obligations to fairness, justice and dignity. And that is why passing LB810 is so important. In the interest of their clients, psychologists are called by their code of ethics to exercise reasonable judgment and to take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expert-- expertise do not lead to or condone unjust practices. Ethical practice requires that psychologists work within the boundaries of their competence and refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair their objectivity, their competence, or their effectiveness in performing their functions as psychologists. LB810 will help preserve the ability of psychologists and other mental health providers to engage in ethical practice. In the absence of such laws, some practitioners for fear of litigation or loss of employment, will undoubtedly be compelled to violate their ethical code, thus placing their clients at risk of harm. Left without the protection of laws

such as LB810, good, upright, ethical providers may be forced out of practice in our state, where the majority, the vast majority of counties are designated as mental health professional shortage areages-- areas by the Federal Office of Rural Health Policy. Nebraskans need our government to support ethical healthcare providers in our state. We cannot tie their hands and further decrease their numbers by failing to support them in ethical practice. The State Licensing Board is in place to identify impaired providers and to root out those with intentions to harm or who would misuse the ethics code to justify or defend the violation of human rights. LB810 supports the practice of ethical providers. LB810 promotes justice and respect for the rights and dignity of all who seek care in our state.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you. Is there anyone else wishing to testify in support? Welcome.

TOM VENZOR: Good afternoon, Chairman Hansen, members of the HHS committee. My name is Tom Venzor, T-o-m V-e-n-z-o-r, I'm the executive director of the Nebraska Catholic Conference. I'll send my more formal testimony later, I just kind of wanted to kind of hit on some points that have kind of hit-- heard throughout. I think one thing that's important kind of upfront with this bill, is I think it's pretty important to think big in terms of the kind of conscience claims that can be made. This bill isn't just for any sort of one small subset of religious adherents or people with certain ethical values or philosophical values. It, it, it runs a spectrum, I think, as Senator Murman said in his opening. Atheists, persons of faith, you know, left, right, you name it. If you've got a conscience claim, then, then you can come to the table. This bill, this bill is protective for you. And so I think that's pretty important. And that's also part of the reason why you can't spell out all the services, because there's a broad array of conscience issues that might arise from any number of different types of people. And I think that's needs to be considered as you're thinking about this. Think big, don't think small. I think there were some things said about, you know, in certain situations maybe there isn't repercussions where you assert an ethical claim or a moral claim or a religious claim. And I would say that that probably occurs where you don't have, you know, a controversial issue at hand. But as we know, the types of issues that are becoming more hotly disputed, just politically, culturally, etcetera, are growing. I often share people this quote. So Ezekiel Emanuel, who's kind of the architect of, of, of Obamacare, he had said, you know, this was probably about six, seven years ago in a journal article, The New

England Journal of Medicine. Basically telling people, look, if you can't, if you can't do abortions, do that, this, you know, contraceptive services, then you either need to get out of medicine or go practice in an area where, where you don't have to worry about conscience issues such as, you know, radiology. No offense to my friend, Dr. Hilger. But, but let's talk about that, right? So, in other words, go escape somewhere else. Don't practice in the field, of your preferred field, maybe the field that you're actually better at. And so we need to take into consideration those kind of things. I will just also say on the abortion issue, you know, look, you know, even if you don't have those situations arising in the ways that Senator Cavanaugh said, and you know that directly in abortion, but the thing is, in the bill it asks the practitioner to state potential medical conscience issues upfront. And so that's happening in med, in med schools and residencies and fellowships, in the, in the clinics, in the hospitals. So when they state that upfront, if adverse action is taken against them, and it does happen, you know, they can, they can sort of use this as well. And finally, I will say just from the Catholic Conference's side, we've dealt with this issue from the Board of Psychology and the Board of Mental Health Practice at an administrative level. And I can tell you that we've had areas where our faith-based mental health practitioners, they won't do certain types of services, and we've tried to negotiate referral language on that. And there's been no movement on that because the opposition only wants direct referrals. And if you can't do a direct referral, then you ought not be in the profession and you'll have to shut your clinic down and you just ought to get out of the business. And I think that's a pretty bad signal to be sending. So that's all I got. Thank you.

HANSEN: Thank you. Any questions from the committee? Yes, Senator Day?

DAY: Thank you, Chairman Hansen. Thank you, Mr. Venzor, for being here today. You mentioned mental behavioral healthcare--

TOM VENZOR: Yep.

DAY: --related to this bill.

TOM VENZOR: Um-hum.

DAY: What would the services be underneath the umbrella of mental behavioral healthcare that someone would have an objection to providing?

TOM VENZOR: Yep, yeah, so I can just-- you know, our experience, again, with the Board of-- Board of Psychology and Board of Mental Health Practice underneath the Department of Health and Human Services, the examples there have been typically the attempts by those boards to try to insert, you know, language regarding sexual orientation, gender identity. And we have stated concerns on our side of that to say, if these are essentially going to force, you know, faith-based practitioners who have sincerely held religious beliefs or moral beliefs or also professional judgments from a mental health perspective, this is going to force them to engage in things like same-sex counseling or, or let's say you've got a client going through like gender transitioning counseling or something like that. This is going to force them to engage in those type of practices. We've always said that that needed to have robust referral language, so in those situations those providers could say, you know, I can't, I can't provide the service in this area. That's, that's, you know, against my conscience. You know, those would be examples of things that we had. You know, we-- that all kind of entailed also a fight over what would be an adequate referral where you can't provide the service. And I know that's been an issue here on this bill, too, and hopefully we can work through a solution on that. But those would be examples in that context of the mental health field.

DAY: OK. Thank you.

TOM VENZOR: Um-hum.

DAY: So one more question related to that. There seems to be a little bit of a theme with several testifiers, that the major objections are in the areas of reproductive healthcare, contraceptives, abortion, that type of thing.

TOM VENZOR: Um-hum.

DAY: And then also issues with sexual orientation or gender identity. Do you see it as problematic that this bill would essentially be eliminating access to healthcare for two very specific groups in society?

TOM VENZOR: It's not, it's not-- that's not what the bill is doing. And again, as I said at the beginning of my-- it's allowing healthcare provider, professional to object to a particular healthcare service. And so the bill, the bill isn't about, you know, trying to ensure that these people can't have any access healthcare and to-- I think to

frame the bill in that way is not correct. That's not what the bill is doing. It ensures that-- as we-- I think as one testifier said earlier, you're talking a very minimal amount of services in very particular circumstances, with probably a limited number healthcare providers. And so there's a lot of other people out there in the world who will provide those types of services. But the point is that a patient can't demand and force a physician or another healthcare practitioner to, to have to provide the service that they're necessarily seeking. And like I said earlier as well, I think it's really important to think big on this, too. Don't-- of course, I think a lot of the testifiers have probably framed a little bit of how this hearing is going so far. But I mean, I would invite everybody to ask the, the healthcare professionals that they interact with, whether they're, again, atheist, whatever political side of the spectrum they're on, because I've seen, I've seen issues related to circumcision, vaccination schedule, blood transfusion, as you've heard, organ harvesting, gene editing, opioids, counseling centers, gender issues, abortion. I mean, they're just-- it runs a spectrum of things. And so I think to frame the bill as sort of eliminating access to healthcare for certain populations is just the incorrect way to frame the bill.

DAY: But you do agree that those are the two major areas here that we're talking about, is gender identity--

TOM VENZOR: Um-hum.

DAY: --and reproductive healthcare. And so if we are, we are saying medical practitioners can refuse to provide that type of care.

TOM VENZOR: Um-hum.

DAY: We are essentially limiting access to care for specific groups of people, right?

TOM VENZOR: Well, what you're, what you're trying to do on the whole with this bill is ensure that you have access to all sorts of care, generally speaking as well, because like we've talked about earlier, you've got, I think, a number of the physicians who came up already, these are individuals who provide a number of different services across the board and across the spectrum. But they won't violate their conscience. And if they're forced to violate their conscience, they will do things like quit their job and leave their profession. And so, in other words, you know, without this bill, what you're going to be

doing is also limiting access to all sorts of general healthcare, because those providers are not going to continue in the field. They're one, like you've heard, too, from residents and students who didn't even want to come to the hearing because they're afraid of the repercussions that they would have from med school or supervisors or fellowships or what have you, that you're going to limit their ability to, to serve in the field with their conscience intact. So I think that's also-- that's what the bill is doing here.

DAY: I'm sorry, I have one more question.

TOM VENZOR: Um-hum.

DAY: OK. So related to that, how-- similar question to what Senator Cavanaugh was asking earlier, if someone goes-- does not want to provide the services required of their profession, maybe that's not the appropriate profession for them to go into. And that, is it necessarily a bad thing if we're saying to physicians, if you are not willing to provide the services that are required of someone who provides those services, maybe you should provide other services?

TOM VENZOR: So that's basically the Ezekial Emanuel quote. If you won't do-- if you want to go into OB-GYN practice but you won't do abortion or contraception, then you should not be in the field at all. And maybe you should go get out, get out of medicine, period, or go pursue a different, different profession. But I think it's-- and I think the testifiers before this were getting to this point. That's a fundamentally bizarre notion, that because you can't provide a limited subset of the services in this area, that you ought to not practice at all. I mean, that it-- you would, you would--

DAY: I don't think anyone's arguing that you shouldn't practice at all. You're just, it's-- if I were to go apply for a job and the job was to, you know, I wanted to be a professor of a particular area--

TOM VENZOR: Um-hum.

DAY: --but I didn't want to teach about a subset of that area, then maybe teaching in another area that I would be willing to provide the entire breadth of knowledge would maybe be a better fit for me. And that's not necessarily a bad thing if we are-- do you see--

TOM VENZOR: Yep, yep I see where you're going.

DAY: Sorry, I'm not articulating it--

TOM VENZOR: No, no, no, no, no, you're, you're making total sense. And again, you're treating everything, I think here as, as clear, 100 percent black and white. And you're not recognizing the fact that in the area of medicine, right, ethics and medicine are going hand in hand. You know, you can't come into the field of medicine and sort of like, well, I'm going into medicine, so now I'm going to put on my ethical coat. And then, and then when they ask me to do something objectionable, I'll take off my coat or what have you. Because, because people's values, their medical judgments, their moral judgments, all those things are intertwined. But I go back to this point about why would we want to tell somebody, here's, here's a place of disputation on medicine or on ethics or on religious beliefs or what have you? And these place-- some of the places we're talking about, these are very controversial things. So to treat them as if they're-- everybody's got a common judgment about them and everybody is 100 percent on board with them, I think demeans the fact that there's legitimate controversy about some of these things, ethical, medical, religious, etcetera. And this bill makes room for all sorts of people with different values on both sides of the aisle, on both sides of the-- again, on all sorts of sides of the faith sides, it protects all of those people to be in the field so that we have as many practitioners as possible who come to the place of medicine with their whole person, including their ethics, their religion, their philosophical views.

DAY: OK. Thank you.

TOM VENZOR: Yeah, no, thank you.

HANSEN: Any other questions from the committee? Seeing none, thank you.

TOM VENZOR: Thank you very much.

HANSEN: Is there anybody else wishing to testify in support of LB810? Welcome.

ALEX STEPHENS: Thank you. My name is Alex Stephens, A-l-e-x S-t-e-p-h-e-n-s, and I'm here in support, as a proponent of LB810. Pluralism is the belief or practice of enabling many different doctrines to coexist. A more modern phrase referring to the coexistence of ethnicities and races is multiculturalism, but that's actually only a subset of the broader liberal idea of pluralism. Pluralism is what protects the patient, and it's this bill that will

protect the medical worker. Pluralism is a core attribute of liberalism, that is, that freedom of conscience is a fundamental right, right along with the right of property from which all other rights stem. All sorts of people are driven towards a life of care and charity within the healthcare industry and other fields as a result of their deeply held beliefs. It's why they ended up going into medical practice in the first place. I decided to go into biotechnology, the biotechnology field, as a result of learning about the works of Norman Borlaug and the Green Revolution, and my deeply held beliefs do the most good. Medicine is not an amoral practice. It's a-- medicine is an inherently ethical and moral act. One way you can't separate ethics from outcomes is what outcomes are considered good are based off of your ethics. Ethics are derived from your moral values. Innumerable hospitals, charities and other healthcare providers are founded by different people of different backgrounds to fulfill their desire to perform the common good. Methodist, Catholic, Jewish and Baptist hospitals exist all around the world whose sole purpose is to help everybody, not just their denomination. No hospital that I know of has denied care entirely on the basis that someone is not from their tribe, but rather from a belief that the so-called care that the person wants to perform is considered harm by the hospital. This bill puts into practice the desire for Nebraska to be a liberal, pluralistic society where people of different backgrounds may perform the varieties of care they wish will not be forced to perform acts they might describe as barbaric or harmful. Opponents of this legislation might say that this enables discrimination, but the opposite is true. By curtailing the rights of people of faith or the people who have secular beliefs to act upon their beliefs to participate in the healthcare field, you are simply eliminating people from the healthcare field and denying people access to care altogether. You do not create more people who are willing to do care by simply requiring a top-down system of what is and is not ethical. That's a, that is not liberalism. That's an authoritarian belief system upon which you believe that the people who are to orchestrate healthcare acts are robots for the purposes of your idea of ethics. Medicine is an ethical act, one that is built around the ethics of the doctor and not the ethics of the government. This law does not enable discrimination, it prevents it from being done by major medical associations and government entities that wish to do things that might not be in the best interests of patients. And the person who knows the patient best is going to be the doctor. Thank you.

HANSEN: Thank you. I always appreciate your coming because you fit so much into such a small amount of time. Good job. Any questions from the committee? OK, seeing none, thank you.

ALEX STEPHENS: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB810? Is-- OK, it looks like there's no more testifiers in support. If I could, could I get those who are wishing to testify in opposition to raise their hands, please? OK. All right. So what we're going to do now, we're just going to take a short, like, ten minute break. So it gives us, the senators a chance to maybe get something to eat and, and stretch our legs for just a second. So we're going to reconvene probably about maybe like 12:15, we'll back for opposition.

[BREAK]

HANSEN: OK, everyone. I think we're ready to start. And even if those who are testifying in opposition, if they, if they can even kind of move up to the front a little bit, if they want to, and kind of line up, it might make things go a bit smoother. It's up to you. So with that, we will take our first testifier in opposition to LB810. Welcome.

LESLIE SPRY: Good afternoon. Senator Hansen, members of the committee, my name is Dr. Leslie Spry, L-e-s-l-i-e, Spry is S-p-r-y. I'm testifying in opposition to the green copy of the, of LB810 on behalf of the Nebraska Medical Association. The American Medical Association agrees with Senator Murman that a practitioner should be allowed to practice within the dictates of their conscience. However, we also must recognize that patients have rights. It is our duty to the patient-- I'm sorry, our duty to the patient requires that we facilitate or otherwise arrange for the care of that patient. The AMA Code of Ethics provides that for exercise of conscience, physicians must uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects. In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services. One of the difficulties of the legislation that has been introduced on this subject over the years is coming to an agreement on what language

provides adequate protection for patients to be informed of their options and to be directed to resources to access care they feel best for them. The green copy of the bill does not adequately address, address the NMA's concern in this regard. The bill provides that a practitioner has a right not to refer, counsel for or advise with regard to any healthcare service which violates their conscience. The bill provides that upon request, the practitioner must promptly release the patient's medical records to the patient. The NMA does not feel this meets the practitioner's ethical duties to the patient, especially when a practitioner has a longstanding patient/physician relationship, there is a duty to the patient to discuss all potential options for the patient. I would add that for many patients, they have no idea what services they need or expect-- and expect to hear that recommendation from a trusted physician source. We have a duty to educate the patient. On refer-- on the referral piece, I would add that in 2013, the Nebraska Medical Association formed a task force on this issue, and the outcome of that task force was to recommend that when a physician feels that it would conflict with their beliefs to refer a physician for a specific treatment, they should at minimum provide contact information for a third party entity such as the State Medical Association or local county medical association. I understand that Senator Murman is currently working on an amendment to address some of these concerns in particular. I know that he has an amendment to align the release of medical records provision in Section 4 with the requirements of HIPAA, and I think that's a step in the right direction. We appreciate Senator Murman being open to the feedback on this, and we welcome an opportunity to continue those observations. Thank you for your time, and I'm happy to answer questions.

HANSEN: All right, thank you, Dr. Spry. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. I apologize, my office is in the tower and there's--

LESLIE SPRY: You were running.

M. CAVANAUGH: I was-- well, we have student groups here and limited elevator access. So I apologize for not being here for the start of your testimony. Thank you for being here. The NMA, you talked about Section 4, which is on page 5. So there's an amendment coming, I also missed the introducer's introduction. So there's an amendment coming that would address some HIPAA compliance concerns?

LESLIE SPRY: The amendment would address the, the referral piece on, on referral for care that violates that practitioner's conscience. And that, that language that we've seen at least tentatively goes part way, doesn't go enough.

M. CAVANAUGH: OK. So as it is written right now, they're not required to do a referral?

LESLIE SPRY: No.

M. CAVANAUGH: And what-- it goes partway, what would you like to see it do?

LESLIE SPRY: So I would prefer-- and when the Nebraska Medical Association, that's the policy that came out of our task force, is that we wish to have a specific target for the referral. And that target could be the local medical society. That target could be the Nebraska Medical Association. That target could be any trusted physician organization so that that patient knows where to turn. If I just turn that patient away and say, I can't do this, I'm not caring for that patient. And so we want them to actually have a target for that. And I think there was a mention earlier, I think, Senator Riepe's question had to do with whether or not the NMA has ever supported this legislation in the past. And the answer to that is no. We, we're stuck on this referral piece. I will not abandon my patient. My patient's conscience and my conscience are on the same plane. I can't impose their will on them, and so I need to make sure that their-- that I value their morals and conscience as well.

M. CAVANAUGH: I'm sorry to be asking you to catch me up on the earlier part of this hearing, but you said Senator Riepe asked if the NMA has ever been in support of this?

LESLIE SPRY: Yeah, there was a question earlier about that perhaps ten years ago when we were, I think it was 2013 is what I remember-- or 2012, I'm looking at my notes. 2012, there was a similar bill brought forward and we had the similar objection in the past. So this is-- our objection to this has been out there for ten years, and our objection remains the same, that we need specific language on referral. And in the, the previous iterations of this bill, there was always this notion and, and allusion to the fact that the patient had to be cared for. And we, we all agree with that, the patient had to be cared for in the interim. But if there was a-- if there was something that I couldn't perform, then we wanted a specific target of referral. And

that targeted referral does not necessarily have to be a specific practitioner, but the target-- target of referral could be some, you know, as I said, the, the both medical societies, the Lancaster County Medical Society and the Omaha Medical Association-- Omaha Medical-- I'm sorry, medical-- Metro Omaha Medical Association agreed that we, we would take-- that they would take calls and the Nebraska Medical Association agreed that they would take call for Greater Nebraska as well. And if they would, they would offer their phone number as a contact information for someone seeking information about potential referrals.

M. CAVANAUGH: OK. Sorry, may I?

HANSEN: Yep.

M. CAVANAUGH: Was it represented in earlier testimony that the NMA had taken a pre-- a different position previously?

LESLIE SPRY: Well, so there was a, in the previous iteration of the bill, there was-- that there was some discussion of duty, of a, what a, what a practitioner's duty was. We agreed with that statement, but it was never adopted. And so we continued to be opposed to the bill because of this specific issue.

M. CAVANAUGH: OK, thank you for that clarification. I do have one more question.

HANSEN: But any other questions from the committee?

BALLARD: Go ahead, Senator Cavanaugh.

HANSEN: Yeah.

M. CAVANAUGH: We've heard from about the pharmacy piece of this. And I honestly find it a little bit confusing because pharmacists can currently have a conscientious objection, correct?

LESLIE SPRY: That's right. I mean, and this comes up quite a bit, where I get a phone call from the pharmacist saying they don't want to do this. And-- but they, they either provide another store or another opportunity for this, and we call it in to a different store.

M. CAVANAUGH: And it, does it matter who their employer-- is it dependent upon who their employer is? It kind of sounds--

LESLIE SPRY: No, those are conversations between a pharmacist and myself.

M. CAVANAUGH: But any pharmacist, like, with any national chain, it doesn't matter who they work for. They can work for Hy-Vee, Target, CVS, Walgreens, Walmart, it doesn't matter who they work for. They as an individual pharmacist have the right to refuse currently?

LESLIE SPRY: And they call my office and we figure out a way around that. And so as was testified by the pharmacist from Creighton that was here, we figure out a way to do that. And I'm not going to violate anybody's conscience as a result of this. And there's a way to get around some of this stuff.

M. CAVANAUGH: OK. I was just trying to figure out the landscape. Thanks for bringing me up to speed.

LESLIE SPRY: You betcha.

M. CAVANAUGH: I apologize.

LESLIE SPRY: And I didn't take any notes.

M. CAVANAUGH: I had a, I had a bill introduction this morning, so I was a little behind. But thank you.

HANSEN: I might have just one quick question, since I think some of the senators have been touching on this, and it's more kind of a clarification on some of your testimony. Does the NMA believe that a doctor has to refer an abortion if they have like a moral objection, like a strong moral objection to abortion. Like, say, recommend that the medical doctor has to refer to somebody else in that case?

LESLIE SPRY: No. In that fact, that's, that's the crux of the issue. We didn't want to refer to a specific individual. In other words, if I, if I have a conscientious objection to abortion and I don't want to refer it to someone I know does abortions, then I, I can get around that by referring to the medical association, the medical association hears the concern. They have a list of docs who are willing to see these kinds of folks, and we maintain that list. So that, that's, that-- we needed a target of referral. What they said was that they would just hand the, the folks the medical records and be on your merry way. And that was not enough. That's, that's not good patient care.

HANSEN: OK, I think that clears it up for me, I think, is that you're looking at some language, I think, the specifics to use, an amendment that might--

LESLIE SPRY: The target--

HANSEN: --alleviate your concerns.

LESLIE SPRY: Our target of referral.

HANSEN: Yeah.

LESLIE SPRY: We need a target of referral. There is not this nebulous wordage that would go on to say, "arrange for care". Well, we-- the target needs to be a target of referral. If it's not a specific physician that's for referral, then it should be through the medical society. And we're willing to undertake that, that responsibility.

HANSEN: OK. And so then if, if Senator Murman does craft some of that language and comes with the appropriate amendment, would, would you guys-- would the, in your opinion, you know, would the NMA probably end up coming out in a neutral position?

LESLIE SPRY: So those words have been--

HANSEN: Or in support?

LESLIE SPRY: --have said, come up with language. We will review it and we will make a determination.

HANSEN: OK.

LESLIE SPRY: That, that's what I-- that's what our demand or our ask is, if you will, that we need a target of referral. Our patients don't know what-- don't know what they need or desire. They're just looking for help. And if we can give them a phone number, that seems like a target of referral.

HANSEN: OK. Good, thank you for answering my question. Oh, Senator Ballard.

BALLARD: Thank you, Mr. Chairman. A couple of testifiers brought up the issue of medical students and residents. Can you-- I'm assuming you've been around or mentored residents in your time. Can you talk

about how you would approach a resident that has some medical conscience?

LESLIE SPRY: Well, so I've talked to several of them. And my observation of this is that they're very young in this. And sometimes you don't know what you don't know. And so many of them have strong-- strongly held beliefs. And I don't know I, I don't know of a single instance where anybody's been compelled to do anything that they don't want to do. Now, I'm aware of it in other instances around the country, but I'm not aware of it. Now. I know that there are, you know, I can't speak for nurses, I can't speak for other individuals, but I know for physicians, we can usually figure out a way to get around this. But our concern is the patient. We need the patient to have a respond-- have, have an, a surety that they have access to care. And they don't know what they don't know and they don't know what they desire, and they don't know what they need. But if they can get someone trusted to give them that information. So what I've told the residents and the students is, you know, keep those strongly held-- but, you know, put them up front for us, let us know what we want to do. And if you don't want to do something, those are considerations you have to make as you're going into professions. I can't vouch for every, you know, mentor, professor or peer that might be out there that might condemn you for it, but those are the breaks of life. I mean, as we get to be physicians, you got to take a few incoming sometimes, because those are the things that teach us how to take care of patients. And I, I have frequently said, every patient teaches me how to take care of the next one. That's what they ought to rely on.

BALLARD: Thank you.

HANSEN: Any other questions from the committee? Seeing none, thank you for your testimony. We'll take the next testifier in opposition.

JOHN TRAPP: So good morning-- or good afternoon now, Chairman Hansen and members of the Health and Human Services Committee. My name is John Trapp, John Trapp. I'm a physician, I currently serve as Chief Medical Officer at Bryan Medical Center. My background is also in pulmonary medicine, critical care medicine and sleep. I've been in practice in Nebraska for approximately 24 years. I come to you today on behalf of the Nebraska Hospital Association, and a number of my fellow hospital colleagues, in opposition of LB810. LB810 aims to solve a problem that rarely exists in medicine. When it does occur, as you've heard discussion, we find ways to navigate this. At present,

when a physician, nurse or any other healthcare member finds themselves in a setting that they may feel compromised to their personal religious beliefs, they work with a colleague to assume care of that patient, prescribe for that patient, or provide other types of procedural care for that patient. This transition of care is generally seamless, done so oftentimes without delay to the care of the patient. In addition, we do have Title VII in place that does require employers in the healthcare industry to provide a reasonable accommodation to employees who have a sincerely held religious belief. The U.S. Department of Health and Human Services protecting statutory rights in healthcare rule implements and enforces federal conscience and anti-discrimination laws protecting the rights of employees who refuse to assist in the performance of healthcare services to which they object on religious or moral ground. Again, we work to navigate this with those individuals within our healthcare system. This bill does not include any protections for the employer that Title VII includes, particularly the undue burden provision, while at the same time significantly expanding the definition of discrimination to include any change in employment, such as putting an employee in a different position where they may not be challenged with some of their conscience. This bill would take away a number of the current options for accommodating this religious belief of the employee. So LB810 creates more challenges than it solves. It will be difficult to operationalize and is unnecessary government oversight into patient care. Thank you for the opportunity to share the issues identified in LB810 and really this discussion of medical ethics, which is integral to what we do every day. This-- we believe this bill would have a negative impact on Nebraska hospitals as well as many medical professionals. As you hear from myself and others today, I ask that you do not take action on LB810, allowing hospitals and medical professionals to continue their great work unencumbered by statutes such as this. I would welcome any questions you may have.

HANSEN: Thank you. Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here, Dr. Trapp. Bryan. You work at Bryan Hospital?

JOHN TRAPP: I do.

M. CAVANAUGH: You gonna answer the million dollar question for us today? What's your policy as a hospital? And, of course, if you can't answer this, please feel free to let us know that. What's your policy

as a hospital of performing abortions that are not medically necessary or an emergency?

JOHN TRAPP: We did not credential any provider to provide elective abortions.

M. CAVANAUGH: Oh, you do not--

JOHN TRAPP: Do not credential--

M. CAVANAUGH: --credential--

JOHN TRAPP: --providers to do elective abortions. That's correct.

M. CAVANAUGH: Interesting. OK. Well, thank you for that.

JOHN TRAPP: We do do abortions in limited cases, ectopics--

M. CAVANAUGH: Yes.

JOHN TRAPP: --risk to the mother.

M. CAVANAUGH: Medically necessary.

JOHN TRAPP: Correct.

M. CAVANAUGH: Yes.

JOHN TRAPP: I'm not an OB-GYN, but if those are happening, it does not follow with our hospital policy.

M. CAVANAUGH: OK. Also, as a hospital, I assume you follow the law that was passed in 1977 that allows any medical provider to object to participating in an abortion?

JOHN TRAPP: Correct.

M. CAVANAUGH: OK. Great.

JOHN TRAPP: Yeah.

M. CAVANAUGH: Thank you for that.

JOHN TRAPP: We worked with individuals, if they expressed that concern anywhere along the hospital line, we do work with that individual to put them in a position of success.

M. CAVANAUGH: Thank you. I just would add on a personal note, you said that you also work in the area of sleep?

JOHN TRAPP: Correct.

M. CAVANAUGH: I think you might have some patients in the Legislature by the end of the session.

JOHN TRAPP: OK.

M. CAVANAUGH: But thank you for answering my questions.

JOHN TRAPP: Yes, I knew that was one was probably coming.

HANSEN: Senator Ballard.

BALLARD: Thank you, Chairman. Can you unpack when you say it will be diffic-- difficult to operationalize? Can you unpack what do you mean by that?

JOHN TRAPP: Well, what was coming up-- let's, let's look at COVID vaccinations. A lot of different discussion on that, right? And so in the hospital, we will administer COVID vaccines. Let's say the provider writes a prescription for this. The patient agrees. We have alignment with that. Now, imagine that as described in this bill, I think on page 5, they describe a medical practitioner, who that might mean. This includes anybody that's employed by a hospital. So vaccine arrives in, let's say, a box of the hospital. Anywhere along the line, someone could say, I have a conscientious objection to this vaccine. I may not unload it, I may not take it to the pharmacy, the pharmacist may not fill it into the syringe, the nurse may not administer it. So potentially, this bill impacts our ability to really deliver great healthcare for-- particularly for patients who want that.

BALLARD: OK. Thank you.

HANSEN: I might have, maybe a couple of questions.

JOHN TRAPP: Sure.

HANSEN: One, because I just don't know. Just touching on what Senator Cavanaugh said. So when somebody does come to the hospital for an abortion, who do you, like, you just then refer them out typically then?

JOHN TRAPP: When you say an abortion, elective abortion?

HANSEN: Elective abortion, yeah. Sorry.

JOHN TRAPP: Generally they present to the outpatient setting. Oftentimes they are-- again, I'm not an OB-GYN. They're referred to centers or other places where that might be performed as an elective procedure, as opposed to our emergency room, where if it is endangering the mother, then our OB-GYNs do what they do best. They take care of the patient and the mother and work with that patient to determine where do you stand on this, and understand that risk. So we spend a lot of time in the patient/physician relationship having the discussion. Please understand what this means, what we believe will happen to you, that this is a medical emergency. If this pregnancy progresses, it is likely to cause you harm or danger.

HANSEN: OK. And I appreciate that because I was trying to fit that in with the bill, when we're talking about the referral and how that works and how that would work on your end with the hospital. And you mentioned in your testimony the last paragraph this will have negative impacts on medical professionals. Can you explain that a little further?

JOHN TRAPP: Well, I have lots of examples of the past several years with regard to COVID and other things like that. You can have a strong personal conviction, and we've heard it may not be based on science. It may not be proven. You may not agree with what literature was put out there. You may, in fact, choose alternate literature. These become really difficult to navigate. And so, how do we work together to get the right patient-- the right tribute to each patient? And so in the intensive care unit, oftentimes we are faced with ethical dilemmas. We have patients who may have progressed to end of life and still families saying, please do everything. The patient may say, do everything. We have discussions that we don't think this is survivable. We offer other options, palliative care, hospice. But I will tell you at times that we've had to navigate that as well. And we may do things that we feel are probably not the best interests of that patient, providing prolonged life support, feeding tubes, even though we know this is probably not a survival-- survivable illness. So when we have people that may say, gosh, you know, where along the line can I object to this? I mean, that could be anybody in the entire service line, because they defined this as anybody within the hospital, any hospital employee, clinic employee, medical assistance, pharmacies, pharmacy techs, etcetera. This may make it difficult to say we have to

have the entire team aligned from start to finish on what we're doing. In a case where it is an abortion, an emergent situation, even then, we may still have some people say, I just am uncomfortable with this. We'll work to, to switch them out so that people who are comfortable doing that procedure, because those are difficult.

HANSEN: OK, thank you. Yeah, there's a lot of complexities when it comes to this, especially in a hospital. I can only imagine.

JOHN TRAPP: Ethics is really a complex issue, and I think you've heard that with the testimony today. And I will tell you, we've found ways to navigate this. You've heard about some of our practitioners, who I deeply respect, who have held these deep personal beliefs for, for many, many years. I also heard, I've practiced for 40 years. I've practiced, I've practice and retired, almost all those practitioners practiced 30 to 40 years. They navigated this every day, and these moral dilemmas, ethical dilemmas didn't just appear in the last few years. We've dealt with these for decades, and they've navigated that through their practice successfully. None of them quit their practice. They were actually able to retire successfully and do that. So we do do that.

HANSEN: Yeah, I think, and I'm, on their point, I would think, though, too, I think because of their experience and what they've seen 40 years ago compared to now, I think that it's a lot more of a litigious environment, I think, you know, now than it was 40 years ago. And so I think when they're talking being proactive with this bill, you're kind of seeing stuff on the horizon. I mean, and so this is the ability to protect physicians specifically, I think, you know, and with their conscious objections to certain procedures. So I think now is a different environment than definitely it was 40 years ago, especially when it comes to, you know, opinions and emotion and, and lawyers and lawsuits. And so I think that might be one of their kind of arguments about why this bill is needed.

JOHN TRAPP: And this bill extends beyond even licensed providers to really, again, the entire list on page 5 of anybody who would be involved in the healthcare line.

HANSEN: I think it's a good point on that one. Any other questions? Yes, Senator Cavanaugh.

M. CAVANAUGH: Sorry. I realize I probably need to make some clarifications since I'm not a medical professional. I think I was

misusing some terms. So elective is, is anything that's not like an emergent medical emergency, correct?

JOHN TRAPP: Correct. I mean--

M. CAVANAUGH: So when I said that it-- medically necessary, something could be elective and medically necessary?

JOHN TRAPP: Correct.

M. CAVANAUGH: OK. Because I was kind of--

JOHN TRAPP: There are some pregnancies that may occur in the fallopian tube that we know will result in--

M. CAVANAUGH: Right.

JOHN TRAPP: --eventually risking the mother. We don't wait until it ruptures and causes that fallopian tube to rupture.

M. CAVANAUGH: Right.

JOHN TRAPP: We intervene ahead of time--

M. CAVANAUGH: Right.

JOHN TRAPP: --and do a procedure that was described, you know, a dilation and curettage, D&C procedure. We do those in anticipation that this will eventually, nonviable pregnancy. If medical science changes at some time, we can implant that somewhere else. Wouldn't that be great?

M. CAVANAUGH: Yes.

JOHN TRAPP: Right now, in talking with the, our OB-GYNs, medically we can't do that once that pregnancy implants at the wrong place.

M. CAVANAUGH: So just to clarify for the record, you are-- you do perform medically emergent necessary procedures. I was misusing medical terms, so I just wanted that--

JOHN TRAPP: We follow the law, we follow our credentialing policy.

M. CAVANAUGH: Yeah.

JOHN TRAPP: We don't do the elective abortions that, that do go to these clinics that you've described.

M. CAVANAUGH: Right.

JOHN TRAPP: All of these are medically indicated, medically appropriate for the risk of the mother.

M. CAVANAUGH: OK. Thank you, I just wanted to make sure I clarified for the record my misuse of terminology. Thank you.

JOHN TRAPP: It's good to get that clarification.

HANSEN: Any other questions from the committee? All right, seeing none.

JOHN TRAPP: Thank you for your time.

HANSEN: Yeah, thank you. We'll take our next testifier in opposition, please.

ECHO KOEHLER: Hi, committee. Thank you for having me this afternoon. My name is Dr. Echo Koehler, E-c-h-o K-o-e-h-l-e-r, I have a doctor of nursing practice degree, have been a registered nurse for 20 years and a nurse educator for 15 years. I am here on behalf of the Nebraska Nurses Association, speaking in opposition to LB810. Supporters of the LB810 claim that it will protect a lengthy list of healthcare workers and institutions who object to procedures or prescriptions on moral, ethical or religious grounds from discrimination, retaliation or punishment. Nebraska Nurses Association seeks to support the delivery of safe, cost-effective care for Nebraskans, and we recognize the need to provide healthcare services without discrimination. If passed, LB810 would remove fundamental protections against discrimination on a broad basis. LB810 will allow healthcare providers to selectively exclude populations from their care and further marginalize disadvantaged groups. healthcare providers are already able to decline to provide services based on their competencies and training, but ethically, they cannot discriminate based on selective personal beliefs. No patient should ever be obstructed from receiving legal healthcare based solely on a provider's personal biases. Conscience bills such as LB810 lead to dysfunctional healthcare delivery and compromise the quality of care by creating barriers to meet patients' needs. Conscience legislation such as LB810 also complicates the healthcare system and compromises any united standard of care. The strain this would put on minimally staffed healthcare facilities and

patients in rural areas with sparse access to care is unreasonable and unconscionable. NNA opposes violating patients' autonomy in choosing the type of healthcare services they deem most appropriate to their own needs. NNA also opposes legislation such as LB810 that regresses healthcare and to a paternalistic system where the provider is the ultimate decision maker, rather than the patient. The Nebraska Nurses Association is the overarching organizations for the over 30,000 registered nurses in Nebraska. All nurses are bound by our already established code of ethics and our professional duty to our patients. For these reasons, the Nebraska Nurses Association is opposed to LB810 and we ask the committee to stop the advancement of this bill. Thanks.

HANSEN: Thank you for testifying. Are there any questions from the committee? I might have one again, a clarification question. It sounded like from previous testimony and even the NMA, it sounds like somebody can choose not to treat somebody based on personal beliefs so long as they refer them.

ECHO KOEHLER: Yeah. So I think you heard a lot of examples this morning of specific examples from a lot of providers where they already have in their practice experienced all of these different unique situations and they already were able to make conscience decisions and then effectively refer or provide services in another way. So we already have established ethics committee for really complicated situations that are major institutions. Even in rural settings where there aren't as many providers to have like a formal ethics committee per se, we have staff meetings where we're able to discuss really complicated patient care issues. So if there is one provider per se that has a conscious objection, we're able to figure out how to navigate those situations to make it so we can have effective care. So that's why it's our belief we don't need this kind of language that then creates more complicated issues where, where someone could blur the lines of what, what that looks like.

HANSEN: OK. Well, you can just said in your testimony though, but they can do that. But they ethically, they can-- they cannot discriminate based on selective personal beliefs. But you just said they could.

ECHO KOEHLER: You have to be able to provide access to services. So if someone's trying to obstruct services somewhere where there aren't very many services based on their own ethical dilemma, then that's not ethical care. They're not providing ethical care or they're not meeting the duty of their profession. So we already have situations where, yeah, we have conscious objection, but then we have, we have a

duty, we have to provide referral services. So as the NMA expressed concern about the referral process, that's definitely a concern for us. But I think this bill creates a situation where a provider could impose their personal beliefs on someone and not provide additional access or help to getting additional access. That's our concern.

HANSEN: OK. And just another question about the Nebraska Nurses Association in particular.

ECHO KOEHLER: Yeah.

HANSEN: Because I've had some nurses, and we've had emails and phone calls about they like this bill. So do-- is this representative of all nurses, or like do you guys have like-- do a poll of nurses to see who's in favor of this, or is it more of a board that makes the decision to oppose bills like this?

ECHO KOEHLER: Yeah, no, that's a really fair question. So the Nebraska Nurses Association is a member organization. We represent our membership. We have a legislative committee. So those of us that testify are on the legislative committee. We follow the standards of the-- our practice with our code of ethics. The American Nurses Association has policy statements. We're a member of the American Nurses Association as the Nebraska Nurses Association. You know, you've heard providers of different beliefs, and we support all beliefs, but we are bound by our duty of code of ethics. And we are-- as a profession, we come together and and have a standard of care that we, we then advocate for.

HANSEN: OK. So more the legislative committee is one of them makes the decision to oppose or support a bill?

ECHO KOEHLER: No, we have-- the members of the legislative committee are elected by the members of our organization.

HANSEN: And they're the ones who make the decision on whether to oppose a bill or not?

ECHO KOEHLER: Our legislative committee analyzes all the bills of the legislative session and then makes--

HANSEN: I guess, [INAUDIBLE] now I know how to communicate this to people who are for this and then like, why is the Nurses Association come out against this? This helps me communicate this--

ECHO KOEHLER: Right.

HANSEN: --with my constituents too. So I appreciate that clarification.

ECHO KOEHLER: And we, and we, we have a legislative day. We hope you guys all come very soon, where we have our members become more active in legislation. Because we listen to our-- we, and we have constituents, too, that are members of our organization. So we do get feedback from our members sometimes on what, on what they think. And then we take that all into consideration, all with that overarching code of ethics that we look at and evaluate all the legislation. Yeah.

HANSEN: Thanks for all you do, by the way. I know you guys are kind of overworked right now, with all the nurses, and so I appreciate what you do.

ECHO KOEHLER: Thank you.

HANSEN: Any other questions? All right, thank you for testifying.

ECHO KOEHLER: Thank you very much.

HANSEN: Anybody else wishing to testify in opposition to LB810. Welcome. You're missing somebody.

NYOMI THOMPSON: Yeah, right. No, she's at daycare this time. Thank God.

HANSEN: I was looking forward to it.

NYOMI THOMPSON: It was a tough day for me. All right. Good afternoon, my name is Nyomi Thompson, that's N-y-o-m-i T-h-o-m-p-s-o-n, and I'm representing I Be Black girl. We are reproductive justice organization that centers black women, femmes and girls, because when we do, everybody benefits. I am testifying in opposition to LB810 because patient needs, not personal beliefs, should come in first-- come first in healthcare decisions. Conscience-- conscious objection negatively impacts the health of the most vulnerable, perpetuating the racism and discrimination already present in the healthcare system. Allowing conscious objection places burdens on patients and lowers the quality of healthcare. It will create inconsistent care since treatment can become dependent on the values of a given medical practitioner. Limiting the choice of healthcare professionals will be detrimental to any patient, but has even more of an impact on the black community,

low-income folks and those living in rural areas who already lack the access to healthcare. Being referred to another doctor requires-- requiring another appointment will take resources: child care, transportation and lost wages for taking yet another day off work. This is a burden for those struggling to care for their families. In particular, this would compound the negative health outcomes experienced in maternal health for a black women and folks with a reproductive system. Black women die from pregnancy-related causes more than three times the rate of white women and experience severe maternal morbidity or near-death experiences at the rate two times of white women. To achieve optimal black maternal health outcomes in the state of Nebraska, it is essential to further expand meaningful access to affordable and consistent healthcare for black birthing folks, wherever they live throughout their lives. Doctors have a duty to do no harm. This can only happen when patients have access to timely, quality healthcare that is not dependent on the provider's own personal beliefs. Please consider valuing the health outcomes of Nebraskans and stop LB810 from moving forward.

HANSEN: Thanks for your testimony. Any questions from the committee? I don't see any. Thanks for coming.

NYOMI THOMPSON: Yes.

HANSEN: We'll take our next testifier in opposition. Welcome.

JANE SEU: Good afternoon. My name is Jane Seu, J-a-n-e S-e-u, and I'm testifying on behalf of the ACLU of Nebraska. Freedom of religion and association are among one of our most fundamental rights, but that freedom does not give us the right to harm others. This bill would provide an unbridled license to healthcare provide-- for healthcare professionals to discriminate against our patients for almost any reason, refuse to provide them with care, and limit any professional accountability for those acts of discrimination. This measure contains many vague and undefined terms, would be impossible to implement, and would have a chilling effect on the health of all Nebraskans, but most specifically, the most vulnerable in their times of need. This license to discriminate will be felt more severely in rural areas where patients already have limited choice of medical providers. Our government should never make it more difficult for individuals to access healthcare. This bill legitimizes unequal treatment or the denial of treatment of patients by healthcare providers, organizations, and insurers. Religious freedom does not mean the right to discriminate. Medical standards, not religious beliefs, should,

should guide and govern medical care. Denying patient healthcare is not liberty. We must do what we can to ensure that all Nebraskans, regardless of background or circumstance, have access to the best possible healthcare. And with that, we urge the committee to indefinitely postpone this bill. And I'm happy to answer any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you. We'll take our next testifier in opposition. Welcome.

ABBI SWATSWORTH: Good afternoon, Senator Hansen and members of the Health and Human Services Committee. Thank you for listening to my testimony today. My name is Abbi Swatsworth, A-b-b-i S-w-a-t-s-w-o-r-t-h, I'm the executive director of OutNebraska, a statewide nonpartisan nonprofit working to celebrate and empower lesbian, gay, bisexual, transgender and queer-questioning Nebraskans. OutNebraska is here today in strong opposition LB810. No matter what we look like, where we live, or how we express our genders, we all want the freedom to be ourselves and live healthy lives. This law seeks to enshrine discrimination by healthcare providers and endangers our health, our futures, and denies us the good life. Religious freedom and the right of conscience, are deeply held values that we share. But LB810 is not basic religious freedom. It goes far beyond the careful balance already struck by existing law, which we have heard from other testifiers, and it endangers LGBTQ+ community members, among other marginalized communities. The so-called Medical Ethics and Diversity Act would allow any health provider or healthcare organization or any employee therein the ability to deny any specific healthcare service to anyone, which I believe we heard would make it very difficult to operationalize, because how would you know whether someone unloading a truck agrees with the issue or someone providing the actual service? There's a long line of people there to get in alignment to provide a care in a large system. The law is exceedingly broad, which could mean an individual staff member, as I've just described, in a larger hospital or insurance system could make a refer-- refusal of the service already approved by a doctor or an insurance payer. The law would allow employers to deny counseling for someone exploring gender identity, blood transfusions for an individual struggling to recover from COVID, IVF for a family that struggles with infertility, or HIV prevention medications for a sexually active adult. All of this creates patient harm, something that the ethics of healthcare is supposed to protect against. For

these reasons, OutNebraska ask that you not advance LB810, and I'm happy to answer any questions.

HANSEN: All right, thank you for your testimony.

ABBI SWATSWORTH: Thank you.

HANSEN: Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here.

ABBI SWATSWORTH: Yes.

M. CAVANAUGH: You talked about how the law is exceedingly broad, which would mean an individual staff member in a larger hospital or insurance system could make a refusal of service already approved by a doctor or insurance payer. Can you talk a bit more about how the broadness of this, I guess?

ABBI SWATSWORTH: It doesn't just include doctors and pharmacists, right? It says systems, and that includes all the employees therein, as we understand the bill being written. So it could be someone in the billing department or someone in the department that unloads the trucks that carries the vaccine. As we heard from the medical-- or the hospital association talking about the difficulty of having the alignment of the whole long group of people, because they're all included under this bill. It isn't clear that it only covers nurses, physicians and pharmacists.

M. CAVANAUGH: OK, thank you.

ABBI SWATSWORTH: You're welcome.

HANSEN: Any other questions? Seeing none, thanks for coming.

ABBI SWATSWORTH: Thank you.

HANSEN: We'll take the next testifier in opposition, please. Welcome.

LACIE BOLTE: Thank you. Good afternoon, Chair Hansen, members of the committee. My name is Lacie Bolte, L-a-c-i-e B-o-l-t-e, and I am a representative of Nebraska AIDS Project. Nebraska AIDS Project is a nonprofit organization leading the community to overcome HIV and its stigma through supportive services, advocacy and education. I am here today to request your opposal of LB810. At Nebraska AIDS Project, we

provide medical case management services to over 1,000 Nebraskans living with HIV throughout the entire state of Nebraska. We also serve parts of Wyoming, southwest Iowa. And one of the greatest needs of our community is access to safe healthcare. LB810 would allow a wide range of medical practitioners to refuse to treat anyone for ethical, moral or religious beliefs. This also applies to pharmacists who could refuse to provide an already prescribed medication. Based on the broad range of language used in this bill, I'm incredibly fearful that healthcare payers such as insurance or employers could refuse to cover life-saving HIV treatment medications. Off script a little bit, HIV medications cost about $3,000 a month. I feel like this bill is sort of incentivizing employers or insurance companies to discriminate against people with HIV for a cost-saving benefit. They don't have to cover this medication because they don't agree with it for whatever reason. They don't have to cover that large out-of-pocket expense. Additionally, practitioners can refuse coverage for LGBTQ+ related care. This includes HIV prevention treatments, HIV antiretroviral treatments and birth control. Anti-LGBTQ plus bias further enables the spread of HIV. This discourages many in our community from getting tested or treated for HIV for fear of harassment. We know that LGBTQ+ individuals already struggle to access healthcare. A 2013 Kaiser Family Foundation survey of gay and bisexual men in the U.S. found that 15 percent of them had already received poor treatment from a medical professional as a result of their sexual orientation. HIV continues to disproportionately impact certain populations, particularly racial and ethnic minorities, gay, bisexual and other men who have sex with men and transgender women. In 2020, 68 percent of all new HIV diagnoses in the United States were among gay and bisexual men. We know that people living with HIV who have access to medical care and treatment can live long and healthy lives. LB810 is unsafe, unethical and a dangerous precedent to set in the medical field, and I urge you to oppose LB810. Thank you for your consideration and I would take any questions.

HANSEN: Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your testimony. This is an angle I had not considered, so I appreciate you testifying about it. And now I'm looking at page 6 of the bill, lines 15-18, and it says: the decision to decline to participate in or pay for healthcare services on the basis of conscience. And I'm seeing now, is that kind of the area where you're extrapolating this from?

LACIE BOLTE: Yes, I'm very concerned that employers or insurance companies will discriminate against people living with HIV under-- using this bill, but perhaps maybe it's a financial incentive because the medications are so expensive. I also think about hepatitis very related, similarly costs tens of-- thousands of dollars for treatment, so there's a financial incentive to discriminate here.

M. CAVANAUGH: OK. Thank you.

LACIE BOLTE: You're welcome.

HANSEN: Any other questions from the committee? Seeing none, thank you.

LACIE BOLTE: Thank you.

HANSEN: Take our next testifier in opposition. Welcome.

SARAH MARESH: Hello. Chairperson Hansen and members of the Health and Human Services Committee, my name is Sarah Maresh, S-a-r-a-h M-a-r-e-s-h, and I'm the healthcare access program director at Nebraska Appleseed, testifying in opposition to LB810 on behalf of Appleseed. We're a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. And one of our key priorities is ensuring that all Nebraskans have access to quality, affordable healthcare. And a key component of that is also ensuring there's equitable access to healthcare. Because this bill effectively restricts healthcare, access to services and disproportionately impacts communities that have been marginalized, Nebraska Appleseed opposes this bill. This bill, as you heard, is harmfully broad. It very vaguely defines what types of services can be denied, and it provides that medical services means medical research or care provided to any patient at any time over the entire course of treatment, and then goes on to list wide-ranging, nonexclusive examples. What will this look like in practice is hard to consider. It's difficult to imagine a service that could not be permissibly refused under this bill. And as you've heard from testifiers before me, this bill applies more broadly than providers. It also implies to entire institutions and even payers and insurers who could broadly deny paying for types of services. And not only is this bill overly broad, it also has negative impacts on Nebraskans and their health communities that have been continuously marginalized, including those with low incomes, people of color and members of the LGBTQ+ community already disproportionately facing barriers to healthcare access for a myriad

of reasons. This bill will effectively create more barriers to further exasperate deep health disparities and inequities. When providers can deny any nearly type of care based on their broadly defined conscience, Nebraskans will have to scramble and expend extra time, money and resources to find appropriate care. And that's if Nebraskans are even aware that they are being denied care options based on their provider's beliefs. LB810 also lacks guardrails to protect patients. There aren't any requirements to inform patients their care is being limited by their provider's personal beliefs, and it certainly isn't required in advance of the treatment or relationship development. Data shows that patients are often unaware of limits on care, and providers often feel like they do not have to disclose their limits on care to patients in these contexts. This bill could also have a chilling effect on patient/provider relationships and prevent disclosure of information to their providers, and that would also harm the administer of healthcare and harm outcomes for Nebraskans. And finally, as you've heard a little bit more about today, LB810 isn't needed. You've heard from medical professionals that this is already operating in practice in some ways, but healthcare providers and entities already have protections under current law. Federal laws permit providers to refuse certain healthcare services on religious and moral grounds. And Nebraska's own state laws protect separately for entities as well. Nebraska Appleseed is committed to ensuring all Nebraskans have equitable access to healthcare services and therefore opposes this bill. Thank you, and happy to answer any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Senator Ballard.

BALLARD: Thank you, Chair. Thank you, Chair. Excuse me. Can you impact the, the federal law? I know a previous testifier talked about Title VII. Can you unpack that little more for us?

SARAH MARESH: Yeah. So I guess I'm more specifically can talk about the abortion. There's some permiss-- there's some laws that permit individuals, I think Senator Cavanaugh referred to it earlier. I think one is called the Church Amendments, is just the name of the bill that permitted folks to deny abortion care under federal law. And there's also a couple of other federal laws that permit entities to have flexibility in that way for abortion, since that came up frequently as well. And then the state law component as well, there is a separate protection for entities as well.

BALLARD: OK, thank you.

HANSEN: I might have one question.

SARAH MARESH: Yeah.

HANSEN: Because maybe piggybacking off what he mentioned, Senator Ballard.

SARAH MARESH: Yeah.

HANSEN: So if this bill passes-- so is there, is there already federal law in place to prevent a doctor from providing care to somebody based on sexual orientation?

SARAH MARESH: So, I mean, there there are like broad protections under federal law, antidiscriminatory practices. Yeah. So there's, I think, some constitutional claims where, you know, you can't per-- you can't have discrimination basis, on the basis of sex and things like that.

HANSEN: And that was supersede anything in this bill then, right? So I see where you're coming from.

SARAH MARESH: Yes.

HANSEN: But I don't think in that aspect, nothing would change with this bill passed legally anyway, right?

SARAH MARESH: Sure. Well, I think, I think, yes, that's a fair question and fair point. I think more broadly speaking, though, really broad bill like this can have the impact still of encouraging disproportionate and discriminatory practices. And so even, you know, if it would be superseded by federal law, the remedy would be the person would have to go sue them, right? And then the court would determine down the line that, yes, you shouldn't have been denied that care on the basis of your sexual orientation. And so, you know, in a court, yes, that's the practice. But in reality, we're concerned that a bill like this would encourage providers, encourage other entities to have that sort of discriminatory practices in practice.

HANSEN: OK. That's what I kind of wanted to say. Your concern is it might encourage them to do it. It's still illegal either way, but this might just embolden them to behave or act as or that's still illegal, but it might make them do it more often--

SARAH MARESH: Yes.

HANSEN: --if something like this passed. OK. OK, thank you. Senator Cavanaugh.

M. CAVANAUGH: Thank you. That spurred a question for me. So if we were to pass this, then we wouldn't be compliant with that federal nondiscrimination law. Would we potentially risk losing federal funding for Medicaid and Medicare?

SARAH MARESH: Yeah, I think that's a really good question, Senator Cavanaugh. I don't have a great answer for you right now, but I do know, I think the fiscal note provided with this bill, the Department of Health and Human Services provided some information about how it would interact with federal law and state law. And I think maybe expressed some concerns about federal law and how that would interact, but--

M. CAVANAUGH: Thank you, I have it here. I should have referenced that myself. Thank you.

HANSEN: Any other questions? Seeing none, thank you.

SARAH MARESH: All right, thank you so much.

HANSEN: We'll take our next testifier in opposition to LB810. Welcome.

MARIEL HARDING: Hi. Good afternoon. It is warm in here, you guys are holding up well. Thank you all for the time to testify this afternoon. My name is Mariel Harding, M-a-r-i-e-l H-a-r-d-i-n-g, I am the senior director of programs and initiatives at Nebraska Family Planning, and I am here to express opposition to LB810 on behalf of Nebraska Family Planning and our board. Nebraska Family Planning is a nonprofit organization, and we work with agencies across the state to improve access, quality and equity to family planning services. The services that we provide across the state are provided at no cost or on a sliding fee scale. Our clinics do accept insurance as well. In 2021, our network served over 20,000 individuals, with over 60 percent having incomes below 100 percent of the poverty line. We are opposing this bill because it could allow any medical or health professional to refuse treat, to treat any patient and any payers who refuse to pay for services or medications based on any ethical, moral or religious reason. While the impacts across the healthcare system could be grave as you, as you've heard, impacts to sexual reproductive health are likely to be particularly marked. As context, I'd like to share a few statistics about sexual reproductive health with you for the state of

Nebraska. Gonorrhea has increased from about 3,000 cases in 2019 to about 3,500 cases in 2020. That is a trend that is continuing year over year of an increase. Syphilis has increased rapidly over the past several years, rising from 70 cases in 2017 to 255 cases in 2021. And in 2021, the highest number of new HIV diagnoses was reported since 2010 at 107 cases. And this trend was particularly marked among rural, non-Hispanic white men. All of those statistics come from Nebraska DHHS or from the CDC. So what these statistics demonstrate is that there are already barriers in place to accessing quality sexual reproductive healthcare. Some of those are provider availability, cost, stigma, and this bill could exacerbate all of those barriers. We've heard a lot about the perspectives of providers, and I'd like to invite you to think about the experience of a patient. So given the shortage of providers in our state, and just to be specific, every county outside of Douglas and Lancaster County report a shortage of at least one type of primary care specialty. So in those counties, let's imagine individuals seek services for treatment for a sexually transmitted infection and is denied care to the ethical, moral or religious leanings of any member of staff at the clinic that they seek that care. What will happen to that individual? Will another staff member follow up? It does not appear to be required in the bill. Will they receive a referral to another clinic? We've heard that's not required in the bill. And then how far will they have to drive to receive that care? Will they have to take off work? Will they have to find child care? And in this context, how many people will find that too burdensome to follow through? I think these are really important questions to think about within our state as we think about the rural nature of our state and the health disparities that already exist. This bill will perpetuate and exacerbate the existing health disparities and reduce care for Nebraskans statewide. We've also heard about the challenges of continuity of care, and without those stipulations, or even with them, continuity of care is very difficult. This bill would also reinforce stigma and discrimination. Even if a patient is not blocked from services, it could discourage people from seeking treatment and cause stigma around these necessary healthcare services. We believe that one's ethical, religious or moral liberty should not be on a crash course with another's access to healthcare. These broad exemptions will cause harm to patients, and we at NEFP stand in support of our fellow Nebraskans' right to equitable quality and accessible care and in opposition to this harmful bill. Thank you for your time.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you.

MARIEL HARDING: Thank you.

HANSEN: We'll take the next testifier in opposition, please. Good afternoon.

JUDY KING: Hi. My name is Judy King, J-u-d-y K-i-n-g, and I am an opponent of this bill. Oh, is my light going? OK. I've been at all these bills, these national right to life bills, abortion bills, bills against LGBTQ people, everything like that, along with Tom and Karen Bowling, Tom Venzor. And it's the Catholic Church just pushing ahead with more bills, or the religious right pushing more bills to stop the care of LGBTQ people and women. And I had my daughter, who's over 30 now, at the Catholic Hospital, CHI, and I had just absolutely wonderful care there. I, I-- it was just wonderful. And but nowadays, knowing what the-- if you're going to tell doctors how they can treat and how they can't treat, allow them to do whatever they want, I would never go to CHI again. And I used to work at the NMA, and the doctors need to have their-- they've been hit by insurance companies telling them what to do. They should have the freedom to practice as they want, they don't need your bill to tell them that they can or can't do the things. They should do what the doctors decide to do, or what the medical society decides to do. And I think Mike Mancuso, I think is here, he's on the board of the NFA. And I think we need to boycott him. He works-- he's works at a bank. And let's see, Karen Bowling is on the board of directors with the NFA, and that's a national hate group. So that's all I have to say. It's just another bill against women. That's all it is. Anybody that has LGBTQ or women in it, those people are here to--

HANSEN: Let's see if there's any questions real quick, just to make sure. Any questions from the committee?

JUDY KING: There's never any questions.

HANSEN: All right. Might surprise you some, sometime, you know.

JUDY KING: No, I'll never [INAUDIBLE].

HANSEN: We'll take the next testifier in opposition, please. Welcome.

HANNAH WROBLEWSKI: Thank you. Good afternoon, Chairman Hansen and members of the committee. My name is Hannah Wroblewski, H-a-n-n-a-h

W-r-o-b-l-e-w-s-k-i, and I am here in opposition to LB810 and to read part of a statement from the American Atheists. I'm not going to read the whole thing. A lot of it has already been covered today, and I gave you all a copy. But I am here because LB810 allows the CEOs and boards of hospitals and insurance companies to place their religious beliefs above the health and safety of patients by allowing them to refuse to provide necessary medical care. There's simply no evidence that healthcare workers are regularly forced to provide health services that violate their religious beliefs. In fact, the opposite is true. Hospitals and other healthcare institutions regularly accommodate the desire of workers to avoid certain procedures that do not align with their religious beliefs, as we've heard in testimony today from them. Although this addresses a nonexistent problem, LB810 will have a real-- a very real cost in terms of harm to Nebraska patients, particularly for women and LGBTQ people and people living with HIV, people living in rural areas who may not have another doctor or pharmacy to go to. This will allow any provider, institution or payer to refuse to provide any healthcare service and then justify this denial with religious or philosophical belief. A couple of examples, counselors could refuse to care for a young LGBTQ person in crisis and then refuse to even provide a referral. Pharmacists could refuse to fill prescriptions for Viagra, PrEP, HIV medication or birth control. Although the proponents claim that LB810 is about religious freedom and consciousness of individual healthcare workers, this bill is actually about denying care to anyone that seeks medical care for which they disagree, especially women and LGBTQ people. LB810 lacks basic measures to ensure the safety of patients is not affected by healthcare provider institutions or payers' religious refusal. There's no obligation to inform the patient that their health is being subject to religious ideology rather than medical best practices or that certain services will not be provided, even if medically warranted. There is no obligation to refer patients to other providers for relevant services. This bill, simply framed, will endanger countless lives in Nebraska under the guise of religious freedom. We urge you to reject this remarkably dangerous legislation. Please do not put the interests of a few outlier religious healthcare institutions above the health and safety of Nebraskans. Thank you so much.

HANSEN: Thank you for coming to testify. Any questions from the committee?

HANNAH WROBLEWSKI: Thank you.

HANSEN: I, I have one question.

HANNAH WROBLEWSKI: Yes.

HANSEN: Maybe a comment, I don't really know for sure, because I'm not 100 percent certain. But this is what I should have asked one of the lawyers before. I don't-- is the hospital, I think they cannot ask your religious affiliation, can they?

HANNAH WROBLEWSKI: I am not a lawyer, so I--

HANSEN: See, I'm not either.

HANNAH WROBLEWSKI: --don't know for sure either.

HANSEN: So I just didn't want to say something with that being 100 percent sure. So maybe I-- sometimes we put it out there and somebody usually responds to it when we're done with the hearing so.

HANNAH WROBLEWSKI: Yeah.

HANSEN: OK. Just question about that is all.

HANNAH WROBLEWSKI: OK.

HANSEN: Thank you very much.

HANNAH WROBLEWSKI: Thank you.

HANSEN: Appreciate it. Anyone else wishing to testify in opposition? And, oh, yeah, we got one more. Welcome.

PENELOPE HARDING: Hey. Hey, Senators, members of the committee. I'm Penelope Harding, P-e-n-e-l-o-p-e H-a-r-d-i-n-g, I'm not representing an organization, I'm representing myself. I wanted to give some insight on what it was like for somebody who was in a similar situation to many others that would be affected by a bill such as this. So I am a queer woman living in Nebraska, originally from very rural Nebraska. I had several troubles with my mental health growing up, with an attempt on my life both when I was 15 years old and again when I was 18 years old. My doctor had provided all the care that they could think to give me. Giving me a therapist to go to, referring me to a hospital that I could check in to, to stay in overnight to try to see what was going on. Like, why I kept having these tendencies over and over again. And through all the introspection and through all the therapy that I did go through, I had realized that I was transgender-- a transgender women. And it's something that came very out of left

field. But I knew that once, you know, I had gotten there, that I figured it out that's what the issue was, and sure enough, the past few years since I figured it out have been the best years of my life. When I originally went to go get gender-affirming care in the way of hormone therapy, I had gone to my doctor saying-- the doctor that I had gone through with my past two attempts on my life, who was with me through that and told her the situation and how transgender-affirming care would help me. And she stated how, you know, and her time before, this was seen as a mental illness, that she had asked, who am I, religious affiliationwise? What, like what my relationship with-- my relationship with God was like specifically. She had asked what my family situation was like. She had promised upon much goading from me that she would seek out help for me in terms of finding other doctors that would be able to provide this care for me. She beat around the bush a lot. I never heard back. I see my time is up.

HANSEN: You can wrap up your final thoughts.

PENELOPE HARDING: OK.

HANSEN: I think you're our last opposition, so.

PENELOPE HARDING: OK.

HANSEN: So you can have a minute.

PENELOPE HARDING: She was a huge contributor to churches in Nebraska, and specifically the Catholic Church over in David City. And, you know, I know that's where part of it was coming from, where if a bill like this were to be in place, that would be them saying that it doesn't go with their conscience or their religious code. It would be a guise for the discrimination that they're placing against queer people in Nebraska.

HANSEN: OK, thank you for your testimony. Any questions from the committee at all? Seeing none, thanks for coming to testify.

PENELOPE HARDING: Thank you.

HANSEN: We'll take the next opposition testimony. Oh.

ELIANA SIEBE-WALLES: Forgot to make copies this time. My Eagle Scout "be prepared" is shaming on me. Hello, my name is Eliana Siebe-Walles, E-l-i-a-n-a S-i-e-b-e-W-a-l-l-e-s. Please refer to me with they/them pronouns. I am from District 49. I come to you representing myself. As

a Christian, I understand the notion of protecting conscience. However, the implications of this particular bill deeply worry me, particularly regarding contraception and gender-affirming care. As we saw on Wednesday, people very clearly are interested in protecting gender-affirming care. Even if you don't advance LB574, this bill would fundamentally circumvent that opposition to this bill and therefore make it harder on an already burdened population to receive healthcare. However, I'm also deeply concerned about contraception. I have a condition called PCOS. In order to treat the symptoms of this condition, I use birth control. While my date-- dating life may be dry, this is a fundamental medication to help me manage these symptoms of my condition. Without it, my condition is debilitating. I have memories of staring at my painkiller bottle and being unable to stand because I was in so much pain, I couldn't grab it. Fundamentally, I have a system to get my medication that works with my insurance. Under this bill, though, my doctor could then potentially deny me my prescription and put me back at square one. Even with a referral, it could end up becoming a significant financial time-intensive and energy-- energy-intensive burden on my family. I come from a legacy of fear. My parents are LGBTQ, and I remember hearing stories of them worrying about being denied care because they were gay. While the proponents of this bill claim that no patient can be turned away because of who they are, I don't want anyone to experience that type of fear that they won't receive care, especially in a medical context where people's lives could be at stake. I ask you to oppose LB810 because I believe the implications of this legislation will do far more harm than they will good. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I don't see any. Thanks for coming. Anybody else wishing to testify in opposition? All right, seeing none, is there anybody who wishes to testify in a neutral capacity?

BO BOTELHO: Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Bo Botelho, B-o Bo-t-e-l-h-o, I'm general counsel for the Department of Health and Human Services. I'm here today to testify in a neutral capacity on LB810. The department has been working with Senator Murman and the Nebraska Attorney General's Office about some concerns with the-- concerns with the bill as drafted. We want to thank the Senator for entertaining our concerns and working with us to draft an amendment to resolve these issues. For your reference, the concerns we have had with the green copy of the bill are as follows. DHHS had concerns that LB810 as introduced would have conflicted with existing statutes created to

support the health, safety and protection of the public. Specifically, it will require DHHS to provide a medical practitioner with any complaints that it has received that may result in revocation of the medical practitioner's license, certification or registration within 14 days after receipt of the complaint. DHHS does not make the decision to pursue discipline that may result in revocation of a license under the UCA. The Attorney General has the authority to initiate a petition for discipline and makes a decision to pursue revocation or a lesser sanction. When DHHS receives a complaint, there is no way to know with certainty if the complaint may result in revocation of the license at that time. DHHS has first to determine if the agency has the authority to investigate the complaint. If an investigation is undertaken, this is done in consultation with the Attorney General and ultimately the professional board of jurisdiction. The process will inevitably exceed the 14-day reporting period. The notification requirement of the LB810 could also have discouraged members of the public from filing complaints against practitioners out of fear of retaliation. The confidential aspect of an alleged victim's reporting best serves the patient and the overall public interest. LB810 would have proposed other problems for the healthcare patients and the department. The $5 per day penalty that may be imposed in LB810 have exposed HHS and the state of Nebraska to significant financial liability. Further, the department would be exposed to civil litigation, since the bill provides for injunctive and reinstatement relief, as well as monetary damages by healthcare professionals and institutions and any party aggrieved by a violation of [INAUDIBLE]. This would greatly impair the Attorney General and DHHS's ability to bring these cases forward. Again, we worked with the senator on an amendment that would resolve these concerns. I thank Senator Murman, and I thank you for your time and the opportunity to testify today. Happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? All right, thank you. Anybody else wishing to testify in the neutral capacity? All right, seeing none, we will welcome up Senator Murman to close. But before he does, we did, for the record, have 114 letters in opposition to LB810 and 126 letters in support of LB810.

MURMAN: Thank you very much. I really appreciate everybody sticking around this long. I didn't think the hearing would go quite this long, but there's very-- a lot of interest. And, and I can tell by you guys' questions, you have very thoughtful questions, and I really appreciate that. And I think it was worth all that extra time. I do have a long

list of answers to a lot of the situations that were brought up, but I know we're short of time, so I won't go through all that.

HANSEN: Just fit it into 3 minutes, if you can.

MURMAN: OK.

HANSEN: I'm just joking.

MURMAN: It's good for patients also, this bill, because patients can more easily select a provider that fits their values, so I think that's very important. And another important thing we talked about quite a bit, we want to increase the pool of medical professionals, and I think this bill will increase the pool. A big effect that it could have is right now medical providers or students are kept out of medical school because of their deeply held religious and conscientious beliefs, and especially certain fields of of medical care. So just an example that there's a pro-life OB-GYN in a state south of here, and she has just a huge waiting list of women, you know, that want to access her care. And, you know, we hear about this is limiting access of care to women, but actually it could-- it would very likely increase care to women. And also, we heard a lot about cost being a factor. Cost is, is not a factor at all in this legislation. There's never been a civil lawsuit because of cost, and that's not even part of this bill. And also, you can of course, you can't discriminate because of who the person is at all. It's all medical procedures that, that you can provide or not provide with this bill. So I think I've covered most of what I wanted to answer, so I'd be open to any more questions, if anybody has any.

HANSEN: All right, thank you. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Sorry, I didn't mean to hit the microphone there. Yes, I do have questions. I want to get to that cost question. But before that, I wanted to ask if-- OK, if the standard of care conflicts-- I wrote this down because I didn't want to misstate it. If the standard of care conflicts with moral, ethical or seriously held religious beliefs under this bill is a provider-- a provider is not held to providing that care. So if, if it's, if the standard of care is to provide emergency contraception, under this, they don't have to do that, correct? Because of their religious beliefs?

MURMAN: Correct.

M. CAVANAUGH: OK.

MURMAN: Emergency contraception would not. They wouldn't have to provide. Correct.

M. CAVANAUGH: And if they didn't agree with emergency contraception, not because of religious beliefs, but because of moral or ethical beliefs, something different than religious beliefs, that still would apply?

MURMAN: Repeat that one more time.

M. CAVANAUGH: So if, if, if, if a physician was an atheist, so they-- it wasn't because they were a Christian or, or something like that, that they didn't want to provide emergency contraception, but they didn't believe in emergency contraception as a, as the standard of care for a victim of rape that comes to the emergency room. Because that's a moral belief of theirs, then under this, they would not be obligated to provide that care, correct?

MURMAN: Correct. If that's a deeply held--

M. CAVANAUGH: OK.

MURMAN: --conscientious belief. Yes.

M. CAVANAUGH: OK. So if LB626 were passed into law in our medical providers disagreed with the new standard of care that LB626, that's the abortion ban, were to establish, then if we also enacted this into law, they would not have to-- they would not be obligated by the state to abide by LB626. Yes.

MURMAN: Well, the individual--

M. CAVANAUGH: Providers.

MURMAN: --caregiver would not be. Correct.

M. CAVANAUGH: OK. Thank you for that. My other question under this was on page-- do you have a copy of your bill?

MURMAN: Yes.

M. CAVANAUGH: OK. On page 6, lines 15 to 18, that's where the Nebraska AIDS Project came and testified. And, and that's where they were talking about the cost and the discrimination based on if you didn't

want to provide gender-affirming care, or not even gender-affirming care, just expensive medications for-- their example was AIDS patients. The way that I read it is that it would allow a payer to deny those claims, and you said that that wasn't the case. So I'm giving you the chance to say perhaps that wasn't your intention in this legislation. Is that something that you would be willing to work on additionally?

MURMAN: The way I understand it, and I think this would be right, I'm not a lawyer, but if the payer had that state in their moral-- or their, I don't know what their statement of belief-- I think there's a better term for it.

M. CAVANAUGH: A mission statement or a values statement.

MURMAN: A mission statement, that's what I was trying to think of.

M. CAVANAUGH: Yeah.

MURMAN: Thank you. If they did have it in the mission statement, I think that would be true. But as far as I know, no insurance--

M. CAVANAUGH: But--

MURMAN: --company has that.

M. CAVANAUGH: So this-- right, they don't. But this is very broadly written, and I understand some of the reasoning behind the broad language. The concern that was expressed, and I would say it's a concern that I also have, is that it is so broadly written that even though they don't have that as a mission statement or a value statement, currently, they could say that they would refuse to pay for this because of their missions-- their mission or their values.

MURMAN: Well, I don't think that's true unless they had it in their mission statement.

M. CAVANAUGH: OK. Perhaps we can talk further about how we can tighten this language to be more clear.

MURMAN: Sure. Always open to suggestions.

M. CAVANAUGH: OK.

MURMAN: But yeah, I think they would have to have it in their mission statement to do that.

M. CAVANAUGH: OK. I have another question, but I'll--

HANSEN: Make sure are there any other questions, just to see? All right. Yep.

M. CAVANAUGH: OK, I think this is my last question, but-- no, I'm sorry. I have more than one question. But what is the mechanism to prohibit abuse for this? So like you just said, if it's not in their mission statement, they wouldn't be allowed to do that. So if an insurance company-- in this, in this specific example, if an insurance company does not have this in their mission value statement and they deny treatment claiming that it goes against their values, what is the mechanism for enforcing abuse of this?

MURMAN: Well, the insurance company would have to have it in their mission statement.

M. CAVANAUGH: But if they don't and they just go ahead and deny a patient's claim for, for payment and they say-- they just say, well, it's because of this legislation that we denied it, what is the mechanism in which there's recourse either for the medical community to recoup those dollars or the patient to recoup those dollars?

MURMAN: I think there would be a civil action could happen, or I don't know if there's other methods of disciplining insurance companies, but that, that--

M. CAVANAUGH: I'm just using the insurance company as, as the example. I mean, if there's abuse in this, I guess if it's a doctor that's abusing it, what is the mechanism for-- is there-- does it go to the board of health? Do they lose their license?

MURMAN: Well, I would assume it would go the same way as any complaint against the doctor is handled to the--

M. CAVANAUGH: They're handled.

MURMAN: --board of physicians. I don't know what the term is--

M. CAVANAUGH: They're handled--

MURMAN: --board of physicians.

M. CAVANAUGH: --different ways. And I, I'm sorry, I am not as familiar with all of the language in this, this particular bill, but I, I didn't see-- we've seen mechanisms in other legislation around medical care that-- and again, this is a potential for an amendment, but I don't see a mechanism that says that it goes to the Board of Health for review or anything like that. And that is more clearly stated in that--

MURMAN: Yeah, I think that's just a given, since it's not talked about in the bill.

M. CAVANAUGH: OK. I forgot what-- oh, I know what my last question was. OK, I swear, this is the last one. I know, this is like, it's 1:40. OK, on page 6 at the top-- well, one word is on page 5, "upon", but "Upon patient request, the medical practitioner shall assist in the transfer of the patient's care". So I think this is part of where the NMA had their opposition, is that this is too broad. But I would say that this sort of ties into one of our previous testimonies-- testimoners-- testifiers, Penelope Harding, who said that they had asked for those referrals and weren't giving them. So in Penelope's case, when she asked for that referral, this would require that they had to do that referral.

MURMAN: Yeah, we were-- we've been working with the NMA to have a clearer, I guess, a better mechanism or a different mechanism of referral.

M. CAVANAUGH: Sure.

MURMAN: And we weren't able to come to an agreement with that.

M. CAVANAUGH: OK.

MURMAN: But what was your question then about the referral?

M. CAVANAUGH: Well, and specifically in the patient's case, and our testifier had spoken about how she had tried to get her doctor to give her referrals for appropriate care. And in her words, that was slow-walked and she never got the referrals that she was seeking. This would require the doctor, if a patient said I would like a referral for appropriate care, it would require the doctor to give them that referral.

MURMAN: Yes. There-- you know, we did address, address, referral in the bill.

M. CAVANAUGH: OK.

MURMAN: And of course--

M. CAVANAUGH: So then if LB574, which was the bill we had earlier this week on gender-affirming care, if that were to not pass and a patient asked for, for gender-affirming care, their doctor would be required, whether they agreed with the care or not, they would be required.

MURMAN: Well, a doctor would be required to give information on the referral. That's the referral that we're--

M. CAVANAUGH: OK.

MURMAN: --the amendment we're working on. Some kind of information on referral.

M. CAVANAUGH: OK. But you have not come to an agreement with the NMA on what that referral process would look like?

MURMAN: No, it wouldn't be definitely to another doctor that would be different than the religious beliefs of the referring doctor.

M. CAVANAUGH: OK, thank you.

HANSEN: Any other questions from the committee? I didn't have--

MURMAN: Thanks.

HANSEN: I didn't have one, but I have one now.

MURMAN: Yeah. No, go ahead.

HANSEN: Thanks to Senator Cavanaugh. We tend to do this. She brought up LB626, the heartbeat bill.

MURMAN: Yeah.

HANSEN: And so then if your bill passes, this would allow them to, if I'm hearing it right, then to, to supersede the heartbeat bill. But I think this-- your bill would not allow somebody to supersede something that's law, correct?

MURMAN: Correct. Yes, they would only-- a doctor, a medical provider would not be forced to provide a procedure that they disagree with.

HANSEN: Cause I think it's-- you-- we're talking about conscientious objection.

MURMAN: Yeah.

HANSEN: That's until we pass-- like it's something-- you're not, you're just being prevented from forcing to do something, not being able to, you know, break the law because you have a moral conscious objection?

MURMAN: Right.

HANSEN: OK.

MURMAN: Just like right now, you wouldn't expect an orthopedic doctor to perform an abortion, similar type thing. But this is because the right of conscience--

HANSEN: This just--

MURMAN: --not [INAUDIBLE].

HANSEN: Yeah. This mainly prevents you from forced to do something--

MURMAN: Yeah.

HANSEN: --from my understanding.

MURMAN: Yeah.

HANSEN: OK, I just wanted to make sure I cleared that up so. Any other questions from the committee?

MURMAN: No forcing of procedures, only refusing to do a procedure that is against your religious and conscientious belief.

HANSEN: Good. All right. Well, seeing no more questions, thank you.

MURMAN: Thanks a lot.

HANSEN: That will close the hearing for LB810, and we are actually going to take a short little break, so we can get something to eat real quick. Since we were supposed take a lunch break at noon. So we are going to come back at 1-- what time is it? We're going to come back at 2:15, actually.

[BREAK]

HANSEN: OK. Good afternoon and welcome to the Health and Human Services Committee. Some would say the best committee ever. I would not disagree. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming and parts of Stanton counties and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

WALZ: Good afternoon. My name is Lynne Walz and I represent Legislative District 15, which is Dodge County and Valley.

M. CAVANAUGH: Machaela Cavanaugh, Legislative District 6, west central Omaha, Douglas County.

HANSEN: Also assisting the committee is our legal counsel, Benson Wallace, and our committee clerk, Christina Campbell. And our committee pages for today are Payton and Delanie this afternoon. A few notes about our policy and procedures. Please turn off or silence your cell phones. We will be hearing four bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifiers sheets. If you're planning to testify today, please fill one up and hand it to Christina or one of the pages when you come up to testify. This will help keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring 10 copies and give them to the page. We will be using a light system for testifying. Each testifier will have 5 minutes to testify. When you begin, the light will turn 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'll 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. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from the 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. And on a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we do have a note. We have a strict "no prop" policy in this committee. With that, we will begin this afternoon's hearing with LB772 and welcome up Senator Hughes to open. And no pressure with your daughter right behind you, staring at you.

HUGHES: None. I feel like there's a Cedars reference and I feel like I should bring a cedar branch, but that would be a prop, so. OK. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Jana Hughes J-a-n-a H-u-g-h-e-s, representing District 24. I am here to introduce LB772, a bill to aid in the construction of a facility for pregnant and parenting homeless youth in Nebraska. I would like to thank the co-sponsors of LB772, Senator Dungan of Lincoln and Senator Brewer of Gordon. So why are we here today to hear about LB772? It's exactly as Governor Pillen stated during his inaugural address, that we should never, ever give up on a kid. Colleagues, we must work hard to support our young people in difficult circumstances. This is especially important when poverty, homelessness, a lack of education and healthcare threatens to become a multi-generational issue. Last year there were 85 homeless teenagers in Lincoln area alone who were either pregnant or parenting a young child. This is not an issue limited to Lincoln, but is indicative of a larger problem statewide. LB772 will create a grant for constructing a fac-- facility to care for homeless, pregnant or parenting teens from across Nebraska. This facility is not simply providing a roof over the heads of the homeless pregnant teenagers, although that's a very important function. This facility is intended to provide the training and the skills to manage being both a successful parent to their child and becoming a productive citizen. This facility is not only preventative care and support for the young mother and her child, but also a preventative measure for our state in terms of averting costs down the road. I also would like to take the opportunity to point out a few specifics of the bill, LB772. This bill directs the facility to be located in a city of a primary class. Why would a senator from District 24 introduce a bill that limits the placement of such a city to a city of the primary class? Because related facilities that work

with homeless youth who are in the foster care system or who are diverted from the criminal system, presently exist in cities of the primary class. We need to leverage our tax dollars wisely and utilize such existing facilities, programs and organizations that already interact with these at-risk kids. I will reiterate that the youth who will benefit from this program will be from our entire state, from your districts and mine. Homelessness is not a problem limited to our cities. Rural Nebraska also has homeless teenagers, many of whom are also pregnant or are parenting an infant. Actually, the first youth who is currently piloting this program is from the very center of our state, from Senator Brewer's district. LB772 also requires that the applicant for the grant created by this legislation must be a licensed residential child-caring agency. In short, we want the applicant for this grant to be licensed to have youth in their care. The bill also further specifies that the applicant must be providing out-- street outreach services to homeless youth. Again, we want the provider of these services to be experts in the field. Knowing how to work with the youth who have, have experienced this kind-- specific kind of trauma in homelessness and to already have the trust of the kids currently on the streets is important. There will be others behind me who will talk more about the specifics of the program that will be built out and I am excited for you to hear about how we, as the Legislature, can partner with them to help serve these kids. Any questions?

HANSEN: All right. Thank you for that.

HUGHES: Yeah. Thank you.

HANSEN: Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Hughes. So the intention is to build a facility?

HUGHES: The intention is to-- it, it would-- the intention is to add on to a facility that they already have, to do it, but it would be for capital-- yes, to build.

M. CAVANAUGH: In, in Omaha or Lincoln? Is there a specific facility?

HUGHES: There is a specific facility, Cedars program--

M. CAVANAUGH: OK.

HUGHES: --in Lincoln.

M. CAVANAUGH: In Lincoln?

HUGHES: Yes.

M. CAVANAUGH: OK. I ask because we-- the Department of Health and Human Services, just sold a large property that previously housed parenting youth--

HUGHES: Is that right?

M. CAVANAUGH: --in Geneva for $250,000, I think, was the auction, on governmentauctions.com or something like that. Senator Brandt can certainly fill us in. He has a long memo about it.

HUGHES: I'm sure he would be happy to do that.

M. CAVANAUGH: And I'm sure Cedar can also fill us in because I think that they were interested in the property prior to that, but that's just some historical context for you.

HUGHES: Thank you. I appreciate that.

M. CAVANAUGH: So this is a program-- I, I, I mean, obviously it's written and if others qualify that they can apply for it, but the intention behind it is that Cedars would like to create this program in the, the Lincoln area.

HUGHES: That is correct, in addition to some that they already have. And the intention is the program-- they're not there a-- like long term. It, it's around like 120 days to kind of learn, I mean, just learn how to do laundry, learn how to, you know, live. And then, they can help them get into services where they get their own apartment and things like that, but the fact that they can function on their own and teach them those skills.

M. CAVANAUGH: OK. And is Cedars testifying because--

HUGHES: Yeah, they are.

M. CAVANAUGH: --I have some other questions.

HUGHES: Yes.

M. CAVANAUGH: Thank you.

HUGHES: Yep. They'll be behind me.

HANSEN: Any other questions from the committee? All right. Seeing none--

HUGHES: All right. Thank you

HANSEN: --[INAUDIBLE] we'll see you at the close.

HUGHES: I will be here.

HANSEN: All right. And so with that, we will take our first testifier in support of LB772. Welcome.

CHRISTINA LLOYD: Thank you. Chairperson Hansen and members of the Health and Human Services Committee, my name is Christina Lloyd, C-h-r-i-s-t-i-n-a, and I serve as the director of the Cedars Bridges Transitional Living Program and the Youth Opportunity Center, Lincoln's drop-in center for youth in crisis and those experiencing homelessness. Over our 75-year history, Cedars has evolved along with emerging best practices to provide excellent, nurturing, nationally accredited care for Nebraska's most vulnerable kids. Its legacy of responding to the changing needs of kids in our community continues to this day. Cedars' founding program, Emergency Shelter for Kids, remains at the core of our now broad array of services and it has operated, operated at near capacity since the disruption of the pandemic. Accompanying the critical need for Cedars' current services has been a significant number of referrals for youth experiencing homelessness, who are pregnant or parenting their own young children. Every month, Cedars receives dozens of referrals from various sources. Each of these young people need a safe place to spend the night and each one deserves the stability of a home. Based on various studies, it is estimated that there are more than 350 youth experiencing homelessness or in an unstable living situation on any given day in the Lincoln area. Of those, 85 are pregnant or parenting their own young children. We are comfortable with the number of youth in this often desperate situation to be proportionally larger in the Omaha area. To serve this access-- excuse me, to serve this vulnerable population, Cedars is planning to build the Carriage House, a 6,800-square foot structure on our five-acre campus at 6601 Pioneers Boulevard in Lincoln. This structure will include four one-bedroom apartments and two two-bedroom apartments, as well as a common space for youth and staff space for regular supervision and support. Cedars will provide 90- to 120-day intense5

program focused on building independent living skills and education support. We plan to serve up to 24 youth per year in this program. Mental health and therapeutic services will also be in place to provide specialized prenatal and postpartum support for the young moms. Once safety and stability have been achieved, the goal for each youth in this vital program is to prepare them for successful community living by giving them the skills they need to change the trajectory of their family's life in a positive direction. On a personal note, the Carriage House would have been very beneficial when I found myself pregnant at 16. I'm much older now. I didn't think I'd be emotional about it, but.

HANSEN: That's it. Nobody ever cries on this committee.

CHRISTINA LLOYD: I just got told if you can get through it without crying, you're doing good.

HANSEN: When I say that, I mean 80 percent of the people end up crying. You're fine, doing good.

CHRISTINA LLOYD: My parents made it very clear they did not support the pregnancy, which left me very limited options. I knew I wanted to finish high school, I wanted to go to college. I had goals and I didn't know how I would achieve those goals with an infant. So after my daughter spent two weeks in respite care, I did place her for adoption. Not because I didn't want to try and parent, excuse me, but because of unsupportive parents and a lack of resources in our community, I felt I had no other choice but to place her for adoption. Had the Carriage House existed, I would have had the chance to finish school, go to college and learn to parent my daughter in a supportive and safe environment. So with that being said, I am respectfully requesting your approval of this one-time grant fund for the kids in this very difficult situation. This $2 million will be a historic help towards the $3 million cost of making it a reality. Thank you for your consideration and I'm happy to answer any questions.

HANSEN: All right. You made it. OK. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much. Thank you for sharing your personal story, as well. And I cry like every day in this committee. It's, it's kind of a rite of passage. I wanted to know a little bit

more about how this would work, How would the, the youth that would come through this facility, how, how are they referred or how do they come to you?

CHRISTINA LLOYD: So we currently have multiple referral sources which include the Department of Health and Human Services, juvenile probation and then-- but for this particular program, we anticipate a lot of young people coming from the streets, so [INAUDIBLE], potentially just reaching out to us themselves, like they've filled out a contact form on our website, which is then put us in contact with them.

M. CAVANAUGH: And how, how many youth would you be able to take in? I'm sorry.

CHRISTINA LLOYD: So currently it would be six youth at a time and we anticipate with that 90-120 day programming to move them into their own community-based apartment or maybe Lincoln housing authority with a voucher and then be able to serve at least 24 youth per year.

M. CAVANAUGH: OK. And I don't know how familiar you are with our youth rehabilitation treatment facilities, but some of them-- we do have a girls campus in Hastings, Hastings now. And so would this facility have the potential of having a youth that might be sent there referred to you instead?

CHRISTINA LLOYD: I am not familiar with that facility.

M. CAVANAUGH: That's OK.

CHRISTINA LLOYD: So sorry, I'm unable to answer that.

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

HANSEN: Any other questions from the committee? All right. Seeing none, thank you very much.

CHRISTINA LLOYD: Thank you.

HANSEN: We'll take our next testifier in support.

ASHLEY SCHUM: Hi. OK. Can I go ahead and--

HANSEN: Yep. You can start whenever you're ready.

ASHLEY SCHUM: --OK. I'm Ashley Schum and that's spelled A-s-h-l-e-y S-c-h-u-m as in mother. I am currently the assistant program director of the Cedars Youth Emergency Shelter. We run 24/7. And I just wanted to start by saying, in a perfect world, young teen parents would have community care, supportive funding, and available medical professionals and mentors. I was 18 years old when I found out I was pregnant with my daughter, Lexi [PHONETIC]. The thought of becoming a teen mom was difficult, but my life was already in shambles as 9/11 had just occurred and I was soon shipping off to boot camp in the Navy. I had a decision to make, keep the baby and have no clue about how to parent or not keep the baby and walk into a war zone. I chose to keep my daughter and live through one of the most critical times of my life, but not regretting one moment of it. I had little to no family support during and after my pregnancy. My mom wanted, my mom wanted me to have an abortion because it would ruin my life. She eventually came around after my daughter's birth, but I missed out on that connection I so badly needed with my own mother. My boyfriend's family made me feel guilty if I chose not to keep the baby. They made it very clear that they would financially help their son raise the child with or without me. I had my mother who thought I should end the pregnancy and my boyfriend's family who wanted me to give them the baby and raise it themselves. I knew at this point his family and mine would never respect my opinions, thoughts or any sort of parenting that I did in the future. I felt devastated and alone. His parents had the financial stability that my parents could not provide for us. Unfortunately, there was always the if we help you out, you need to help us out with this mentality. Others may have seen this as a support system, but this was not a support system. This was toxic and it was not, it was not about safety and stability. Cedars Carriage House will provide knowledge and access to safety, stability and community support for these young youth. During and after my pregnancy, I had no idea on how to gain access to resources, not only for myself but for my child. I needed support enrolling in college myself as my parents did not have any money to pay for my college and joining the military was the only option for me to go into college. I needed childcare funding so I wouldn't be forced into having my child's paternal grandmother babysit my daughter. That would potentially cause my daughter to miss out on any social interaction that she had-- that she needed to have with other children, as this is a part of child development. I needed support with parenting classes, health insurance and food. Sorry. I deserved access and support as a young teen mom during this and after my pregnancy. Carriage House will provide stability and independent living for these kids to gain access

and knowledge to these resources. Sorry. Postpartum depression is real. Having a new unplanned baby and trying to manage my stress was extremely difficult. I couldn't breastfeed, which made me feel even more inadequate as a mother. I did not have a support system. Sorry. So I felt sad, scared and overwhelmed. At that time, I never considered that I had postpartum depression symptoms, let alone even know what postpartum depression was. I figured I was just angry about my circumstances, but somehow I managed to struggle through depression after her birth. When I brought Lexi [PHONETIC] home, the stress became worse. I quit taking care of myself. I didn't feel worthy and in my mind, taking care of myself meant taking care-- taking time away from her. My daughter's father was there for me, but he was also an 18 year old with little to no knowledge about how to raise a baby himself. I was terrified that I would feel this way forever, so I reached out to someone on my own to get help. I'll never forget the one time when I was feeling down, I talked to another mother who told me, in my day we didn't have postpartum depression. We just had to snap out of it. She made me feel guilty and embarrassed, like I was weak and wanted the easy way out. She made me feel guilty-- excuse me. Postpartum depression is not something you just can snap out of or deal with. It is a real problem with serious consequences if you don't help those that are in need, especially young, pregnant mothers. Looking back, I clearly needed the help and was lucky enough to make it through without any interventions. Carriage House will provide knowledge and access to professional care to help with their mental health. We are respectfully requesting your approval of this one-time grant fund for the kids in this very difficult situation. The $2 million will be a historic help toward the $3 million cost of making this a reality. And if I would have had a place like Carriage House, I would have had the support, I would have had the access to resources given to me and I would have been able to have help with my mental health. Any questions?

HANSEN: Are there any questions from the committee? Yes, Senator Walz.

WALZ: Thank you, Chair Hansen. Thank you for coming today.

ASHLEY SCHUM: Thank you.

WALZ: My question is, once the, the time is up, the 120 days is up, 90 or 120 days, and you're kind of out on your own and you feel like you need support again, what kind of follow up is there? Do you?

ASHLEY SCHUM: So it's my understanding that once they are-- they're going to be given everything that they need to go out onto their own. That's what Bridges provides for everybody that need to do that independent living transition. With this particular program, it's my understanding that-- or part of the program is my understanding that once they get transitioned out into independent living with all the resources, everything that the Carriage House is going to provide for them, we still will have individuals that can reach out to them for out, out placements or out-- sorry. I'm very nervous-- services once they've left our care. So it's just really the opportunity for them to help with that, that portion of their life that a lot of youth that are homeless don't have.

WALZ: Yeah. That's good to hear. Thank you.

ASHLEY SCHUM: Yeah.

HANSEN: Any other questions from the committee? Seeing none--

ASHLEY SCHUM: OK.

HANSEN: Wait, did you have a question?

M. CAVANAUGH: No.

HANSEN: Oh, I guess-- I'm so used to asking-- you asking questions, it must mean, it's like unconsciously, I look towards [INAUDIBLE].

M. CAVANAUGH: I can ask, I mean, I can come up with stuff.

HANSEN: Oh, no. That was-- no-- seeing no more questions--

ASHLEY SCHUM: OK. Thank you.

HANSEN: --thank you very much.

ASHLEY SCHUM: Yes.

HANSEN: We'll take our next testifier in support. Welcome.

RACHAEL STEELE: Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. My name is Rachael Steele, that is R-a-c-h-a-e-l S-t-e-e-l-e, and I am testifying today on behalf of young parents who need the support. It is my understanding that this bill will allocate funding for a residential youth parenting facility. I was removed from my home at six months of age and at seven years

old, placed with the family that adopted me into what should have been my forever home. However, I had very many placements from the age of ten to the point I became a legal adult in Nebraska. I lived in TLC group home at age 16 when I was pregnant with my son. TLC was a facility provided-- that provided housing for pregnant youth and even included a daycare. The facility was preparing to close, so I was the only pregnant teen in the facility and the option available to my child and I, as this program closed, was independent living, which meant figuring it out primarily on my own how to be an adult and a parent. At the time I was leaving TLC and transitioning to independent living, I thought I was prepared. I was 16 years old, 7 months pregnant and sure that I could do it on my own. And the staff at TLC were honest that this was not the best plan for success, but it was what was available. In my experience, had I had the guidance and support, such as the transportation, child care, independent living skill development with staff on hand, my son and I would have greatly benefitted from that support. Being a parent when you're a kid yourself is challenging. I did not have the opportunity to have positive parenting role model to me and I always felt like I was making it up as I went. I was not prepared to live independently, as I truly did not have the skills I needed. I was a kid trying to survive in charge of another life without the needed support. I was lucky that my first-born son was a very easy baby, but the risk of postpartum depression is higher with first-time moms and those under 25 years of age. I've had two more children since then and experienced postpartum depression and I cannot imagine navigating that with my first son without support. There are many reasons a child has to leave their home, but when it is a child who is having a child, they deserve the resources to feel safe and to become adequately prepared to be a parent. Because I know how important support is during this transition, I urge you to advance this bill. Thank you for your time. Do you have any questions?

HANSEN: All right. Thank you. It's your first time testifying?

RACHAEL STEELE: Yeah.

HANSEN: You did pretty good. All right. Any questions from the committee? And you didn't get any questions either, so that's real-- ex, ex, extra good. All right.

RACHAEL STEELE: Thanks.

HANSEN: Thank you very much. Appreciate it. We'll take our next testifier in support. Welcome.

TEBAA ALHAIKEL: Good afternoon. My name is Tebaa Alhaikel, T-e-b-a-a A-l-h-a-i-k-e-l. I was a youth at Cedars multiple times since I was 15 years old. My placements have always been short term and Cedars was always a safe place for me to return to. They have taught me a lot and prepared me for adulthood. I have recently experienced not having anywhere to go with my one-month-old baby at the time. And knowing the stress I have-- I felt, this Carriage House would have been very helpful for me at the time. I believe this would be very helpful to a lot of young parents in similar situations. And I'm here for any questions you have.

HANSEN: Thank you for testifying. Are there any questions from the committee? Seeing none, thank you for coming.

TEBAA ALHAIKEL: Thank you.

HANSEN: Appreciate it. We'll take our next testifier in support. Welcome.

EILEEN VAUTRAVERS: Senator Hansen and members of the Health and Human Services Committee, my name is Dr. Eileen Vautravers. I'm speaking today in support of LB772. I'm a retired pediatrician who practiced 31 years in Lincoln. I chose pediatrics as a specialty because of the opportunities it afforded me to prevent so many adult problems, such as heart disease, obesity, mental health problems and employment issues related to unrecognized and untreated learning disabilities.

HANSEN: Doctor?

EILEEN VAUTRAVERS: From my--

HANSEN: Can, can, can I interrupt you really quick? Can you spell your--

EILEEN VAUTRAVERS: Spell my name.

HANSEN: --yes, thank you.

EILEEN VAUTRAVERS: Eileen, E-i-l-e-e-n-- usually that's what they ask for reservations at a restaurant, too-- Vautravers, V as in victory, a-u-t-r-a-v- as in victory, -t-r-s. The long name allows me a few seconds more to talk today.

HANSEN: Yeah. Thank you.

EILEEN VAUTRAVERS: From my 31 years of experience and from 40 years of early brain and child development research by Harvard University, the value of prevention in terms of outcomes and return on investment cannot be equaled by any subsequent interventions or treatments later in life. As Benjamin Franklin said, an ounce of prevention is worth a pound of cure. LB772 is unique, in that it will support a statewide program designed to intervene at nearly the earliest possible time to prevent so many problems, for not only mother and child, but society. Allow me to explain. Most teenage runaways and youth in the foster care system have had difficult lives and likely have high ACE scores. ACE stands for adverse childhood experiences, of which there are ten. Examples of ACEs are experiencing in their home: substance abuse, mental health problems, parental divorce or incarcerated parent. Research has shown that youth with high ACE scores often have learning and behavior problems. The pregnant or parenting homeless youth served by this program most likely have high ACE scores and need stability in their lives. They need modeling in how to handle the daily routines of life and to handle emotions successfully. They also need guidance in navigating the challenges of their education. As a result of their success with these, youth develop resilience. Resilience is the antidote or treatment for high ACE scores. With resilience, youth are better prepared to lead more successful lives as parents, prevent their own children from developing high ACE scores and be more successful employees. Without resilience, research shows that with increasing ACE scores, there is a significant increase in learning and behavior problems in young people. There's a similar significant increase in physical and mental health problems in adults when resilience is not developed. We have a unique opportunity by funding LB772 to halt this intergenerational cycle of adverse childhood experiences as early as possible and to halt the resultant learning, behavior, mental and physical health problems. Research shows that a baby's brain development in utero is affected by a mother's nutrition, drug, alcohol and toxin exposure and her emotions, such as anxiety or depression during pregnancy. In this program, homeless mothers will receive good nutrition, be in a healthy, safe environment, receive mental health services and experience positive interactions, all of which have been shown to contribute to good brain development in a baby. So when mother benefits indirectly, the baby also benefits in these ways. In addition to providing services for mothers, babies of mothers in this program will directly reap lifetime benefits. Moms will receive evidence-based parenting instruction in how to provide

the serve and return interactive experiences with their babies associated with stronger cognitive skills, language development and fewer behavior problems. In summary, research has shown that the environment and experiences of a pregnant mother affect her baby's brain development and the environment and experiences of a baby after birth directly affect the baby's brain development. The most fascinating and alarming research shows that the environment and experiences of a pregnant mother can alter-- also alters the genes of the eggs or sperm of that baby that she is carrying. These genetic alterations in those eggs and sperm cause the negative influences of mothers' poor environment and experiences to be passed on and inherited by her grandchild. This is the negative intergenerational cycle that this program also intends to stop. The hope with LB772 is to create a statewide program to intervene as early as possible in a fetus's life, to create a positive environment and positive experiences for maximal brain development in the baby and to provide stability, modeling and guidance for homeless mothers of those babies. As a result, those pregnant and parenting youth will develop resilience and be mentally healthy, contributing members of society. Healthy child development is the foundation for our community, our state and our economic well-being. Thank you.

HANSEN: Thank you. I didn't want to interrupt you. It was actually interesting information.

EILEEN VAUTRAVERS: Yes. Thank you for allowing me to finish. Happy to answer questions.

HANSEN: Yeah. Let's see-- are there any questions from the committee? OK. I didn't-- I don't know if you said in your testimony, that you're-- you said you were a doctor, of what?

EILEEN VAUTRAVERS: Yes, a pediatrician.

HANSEN: That was it. OK. All right. OK.

EILEEN VAUTRAVERS: And I spent ten years in my retirement studying the early brain in child development of, of Harvard's research and working on dyslexia legislation for those with-- we got bills passed for that. So I appreciate the Legislature's work on that. Thank you very much.

HANSEN: Thank you. Appreciate it. We'll take our next testifier in support. Is there anybody else wishing to testify in support of LB772? Welcome.

MARION MINER: Thank you. Good afternoon, Chairman Hansen and members of the HHS committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating and empowering public officials, Catholic laity and the general public. And I'm here to express support for the goals of LB772 on behalf of the Conference. And I'll shorten my testimony a little bit. I don't need to repeat what has been said. But these goals are in accord with the Church's vision for the advancement of a culture of life which would welcome, protect and support women, children and families, as well as help them place their lives on a better trajectory. This also seems to us to be complementary to the efforts taking place already in our state, perhaps in some places more robustly than others, where private charities are providing women in these situations with protection, housing and many other services until they can find a better situation for themselves and their children. Efforts in this direction are substantive expressions of solidarity with people who are, are vulnerable to abuse and suffering and have little or no assistance from family, which is often the case as we've heard this afternoon. So we support these efforts and believe them worthy of the state's support. And I'm happy to take any questions if you have them.

HANSEN: Are there any questions from the committee? I have one. The Catholic Church has, like, shelters or facilities that would qualify for this?

MARION MINER: So, so that would-- to answer that question, I would have to study that a little bit more closely, in terms of what you would need to do to qualify, what, what type of qualifications you have to qualify for this particular program. There is a residential facility in Lincoln already, a Catholic facility where they take care of women who specifically, are victims of domestic violence to help them get away from that situation until they can find a better place. But that would be a little bit different situation, I think, than you're probably.

HANSEN: And what's that place called?

MARION MINER: It's called-- they're called St Gianna's Homes. Yeah.

HANSEN: OK. That's right. OK. OK. Seeing no questions, thank you for your testimony.

MARION MINER: Thank you.

HANSEN: I'll take a next supporter.

SPIKE EICKHOLT: Good afternoon, Chair Hansen and members of the committee. My name is Spike Eickholt, S-p-i-k-e, last name is spelled E-i-c-k-h-o-l-t. I'm appearing on behalf of Voices for Children in Nebraska. You've got a copy of my written testimony. I know the committee's been here all day, so I'm not going to read it all to you. I want to summarize some of the points. Voices for Children is an advocacy group that advocates for and works with children who are involved in the child welfare system and the juvenile justice system. You've heard firsthand today from people who would benefit from this type of bill and this program. And we want to thank Senator Hughes and the co-sponsors for introducing this. Some statistics just for you. The other people have not said: youth in foster care are 2 to 3 times more likely to end up pregnant. And some statistics have that up to 50 percent of girls who are in foster care are pregnant by the age 19. This would benefit children who are system impacted, who have experienced trauma. If they don't have a place to stay, if they don't have a place to go, then you have pregnant and parenting teens who will either be on the street or be in some other place where they're not safe or they're not supported or they're not sober possibly, and they'll end up getting system-involved all over again or perhaps even worse. This is a very good bill. I urge the committee to advance it and support it. I'll answer any questions if you have any.

HANSEN: Thank you. Are there any questions from the committee?

M. CAVANAUGH: I've just been waiting for years to be able to question Mr. Eickholt so I just thought I would, now that you're here. How are you?

SPIKE EICKHOLT: Fine.

M. CAVANAUGH: That's all I got today. [LAUGHTER]. Maybe next time I'll have more. Thank you,

HANSEN: Any other questions? All right. Seeing none, thank you.

SPIKE EICKHOLT: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB772? All right, seeing none, is there anybody who wishes to testify in opposition to LB772? Is there anybody that wishes to testify in a

neutral capacity to LB772? All right. Seeing none, we will welcome up Senator Hughes to close. And I believe, yes, we do have two letters in support for LB772, one from the ACLU of Nebraska and the other one from, uh, Carol Dennison, who's representing herself. And actually, there is another one in neutral, a neutral letter from the Department of Health and Human Services. Thank you.

HUGHES: So, Senator Hansen, members of the committee, thank you. I urge you to report LB772 to the General File. I also urge you to take a tour of Cedars right here in Lincoln, which has a 75-year history of preparing at-risk youth for success by support and training to become productive members of our communities. They are doing the outreach to our at-risk youth, bringing them in from the streets, diverting them from jails and propping them up when no one else would. I took a tour of there last month and was floored by the amount of work that they do there. And despite the discouraging fact that some of, and despite the discouraging fact that some of our youth face tremendous obstacles, I was highly impressed and encouraged by the work that they do. I was even more impressed by those young people that I met, the smiles on their faces and the young man who ran to make his bed before he would show me his room. I wish my son would do that sometimes. As our Governor stated when he took office last month, we can never, ever give up on our children. Thank you and I look forward to seeing LB772 on the General File.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you.

HUGHES: Uh-oh.

RIEPE: Senator. Glad-- good to see you. Thank you for being here. Is Cedars a tax exempt 501(c)(3) organization?

HUGHES: I believe so, but I can get back to you 100 percent.

RIEPE: My guess is

HUGHES: Yes, they are.

RIEPE: I guess--

HUGHES: I assumed so.

RIEPE: --you know and maybe this less of a question, more of a concern is it used to be that when community projects would be there, we would rally and have a--

HUGHES: Fundraiser.

RIEPE: --community-wide campaign to raise money.

HUGHES: Well, and, and--

RIEPE: And it seems now, more organizations turn to the state--

HUGHES: Sure.

RIEPE: --for, for fundamentally, taxpayer moneys.

HUGHES: Sure.

RIEPE: And this has been somewhat true. I'll pick on Lincoln here a little bit, because we have, you know, Madonna coming for money. Others, you know--

HUGHES: I, I understand that and I think--

RIEPE: --and we don't see that so much from outside of Lincoln. I'm sorry for those of you who live in Lincoln, but that's the way I see it.

HUGHES: Yeah. For the record, the facility, they're not asking for full funding of it, so I think this could be used as money to get matching funds when you fundraise. And then second, I think and I guess you could argue with all nonprofits, right? A lot of nonprofits take, take money. They're saving the government money because we're they're doing-- we-- I'm part of many nonprofits, are doing things like, like they said, down the road, if we don't do something with this mother and the child, it's potential that they will be on the back of the government the rest of their lives. So if we can get them upright and on their own and commun-- and contributing members of society, that is saving us money down the road. And that's how you can look at it that way. But that's a lot of the nonprofit work that is done, so I, I totally see that.

RIEPE: I appreciate your being here and for, for taking this cause on.

HUGHES: It's, it is a good one, but I know there's many good ones out there, so.

RIEPE: Thank you.

HUGHES: Yeah. Other--

HANSEN: Senator Cavanugh.

M. CAVANAUGH: Thank you. I just wanted to go back to-- it was govdeals.com and the property sold for $313,000.

HUGHES: Oh. I'm like, wait a minute. I'm like-- govdeals.com. The property in Geneva.

M. CAVANAUGH: The Geneva campus and farm ground sold for $313,000-- $313,950. And that's less than what they spent to renovate one of the buildings during the YRTC disruption of 2019. I know, right? It's unfortunate. And they also lost a lot of jobs there. So I'm really just doing the advocacy work here that Senator Brandt probably would do if he were sitting on this committee right now.

HUGHES: Yeah.

M. CAVANAUGH: Yeah, but yeah, govdeals.com is where apparently, you can buy government property.

HUGHES: Really cheap. Yeah. Real cheap. Good deal.

M. CAVANAUGH: Real cheap property. I very much appreciate Cedars' work and thank you for bringing this bill.

HUGHES: Absolutely. And I, and I will-- and to piggyback that a little bit, it is a little bit about location. And what's nice about Cedars is they've got an established place that they can-- so when we went and toured it, the-- this part of the facility will be still on that main campus but off a little bit so they, they kind of feel like they are living in a-- you know, they're not just part of the residential program. They're a little bit off, starting to learn those skills and it's just kind of that that bridge point then to get them off into the, you know, off-site, actually on their own with still some support. It's just kind of that in between. And so, that's where it's like-- the Geneva place wouldn't work for this because they've already got the people there that are staffed and all that, but I mean, you guys know that.

M. CAVANAUGH: I will, I will add-- no, the Geneva obviously would not work for this because it's attached [INAUDIBLE].

HUGHES: But that is a shame.

M. CAVANAUGH: But the Geneva campus did have a chapel, a high school--

HUGHES: Really.

M. CAVANAUGH: --it had a farm, it had multiple cottages, one of them newly renovated. It was very nice.

HUGHES: So I wonder what that person that bought it's going to do with it.

M. CAVANAUGH: I don't know, but I sure hope they invite us.

HUGHES: Maybe it'll be like summer camp. We could-- like legislative summer camp.That'd be fun.

M. CAVANAUGH: Thank you, Senator Hughes.

HUGHES: Sorry.

HANSEN: I don't think any of us are buying it on our salary. Any other questions?

HUGHES: Yeah, right. That, that would-- way out prices us. Anyway, sorry.

HANSEN: I still-- I'm a little surprised the-- what Mr. Eickholt shared about the data with youth and foster care and the pregnancy rates.

HUGHES: It's sad, isn't it?

HANSEN: Pregnancy at two or three times the rate of the general population and it is estimated that 50 percent of girls in foster care will become pregnant by the age of 19. So facilities such as Cedar, do they do any kind of education at all? Like when they-- when somebody comes in about-- it's like sex education or, you know, along with helping them, you know?

HUGHES: I know they do a, a lot of training, just life and I would imagine that. Are we? Yes, we're getting a big nod. I would imagine so. Yeah.

HANSEN: I was just kind of curious. It's like, it's kind of a shocking statistic.

HUGHES: That is a shocking-- it's a sad-- it's very sad because then you [INAUDIBLE]--

HANSEN: And, and--

HUGHES: --that's for another conversation.

HANSEN: To not like, build up govdeals too much, there is another one called govplan that Senator Brewer always shows me all the time, about how you can buy a Hummer on there so. Yeah.

HUGHES: It's like government merchandise that you can buy?

HANSEN: Yes.

HUGHES: I got to get on these.

HANSEN: Yeah. I just didn't want to show favoritism to one website over another.

HUGHES: OK, fair enough.

HANSEN: Yeah. OK. Any other questions? Seeing none--

HUGHES: All right.

HANSEN: Thank you very much.

HUGHES: Thank you, guys. Thanks for your time. I know it's been a long day.

HANSEN: And now we'll close the hearing for LB772. And then we will-- OK. And then we're going to open it up now for LB227.

WALZ: Welcome.

HANSEN: Thank you.

WALZ: Senator Hansen. Chairman Hansen.

HANSEN: All right. Well, good afternoon. Fellow members of the Health and Human Services Committee. My name is Senator Ben Hansen, that's B-e-n H-a-n-s-e-n, and I represent District 16 in the Nebraska

Legislature. I'm here today to introduce LB227, a bill to direct the Department of Human-- Health and Human-- Department of Health and Human Services to reimburse hospitals for nursing facility level of care services when Medicaid patients remain in hospital beds with no place to go. I am also introducing an amendment to the bill to clear up confusion about what hospitals are eligible for reimbursement, what patients are included and where the funding comes from. For those of you new to the committee, last fall, this committee held a hearing on LR417. It was an interim study that provided a greater look at the challenges facing staffed bed capacity at hospitals in Nebraska, including the challenge of hard-to-place patients. With the inability to transfer patients to the appropriate level of care, some patients essentially live in hospital rooms, receiving care and taking up precious, precious bed capacity with no compensation provided to the hospital. These difficult to transfer patients may have mental health problems, physical disabilities, alcohol and drug abuse, function poorly and have a greater need of care or they may have a combination of all these problems. This means that hospitals are housing patients who need care but don't need to be hospitalized, denying other patients with immediate needs. They are receiving no compensation for the bed, room, equipment, staff time, food and medications. There isn't a quick fix to finding a solution for difficult to transfer patients, but there are a handful of bills in front of our committee that are trying to address the problem. LB227 and the amendment will direct DHHS to pay hospitals 100 percent of statewide average nursing facility per diem rates for Medicaid patients eligible for discharge remaining in their care. It does not cover the cost of the daily hospital rate, but if hospitals are required to care for medically complex, medically complex Medicaid patients, they should receive some compensation in return. It is important to note that this amendment also ensures that funding is contingent on federal approval from CMS. Thank you for your time this afternoon. I'm happy to answer any questions, but there are healthcare experts behind me that may shed more insight on the difficult to transfer patient challenges.

WALZ: Thank you. Questions from the committee?

RIEPE: Should we wait to go to the fiscal note? I'm sorry.

WALZ: Senator Riepe.

RIEPE: Should we wait to go to the fiscal note?

HANSEN: There might be better healthcare experts behind me to better answer your questions and shed more light on those questions.

RIEPE: Well done. Thank you.

WALZ: Any other questions?

HANSEN: I'll stay to close.

WALZ: All right. First proponent.

LISA VAIL: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Dr. Lisa Vail, L-i-s-a V-a-i-l. I'm the vice president of patient care services and the system chief nursing officer for Bryan Health, a locally owned and governed Nebraska hospital system comprised of six medical centers. I've been a registered nurse for over 40 years and I come to you today on behalf of the Nebraska Hospital Association in support of LB227. A patient's qualified in-patient episode of care is paid for via what is called a DRG, or diagnosis-related group reimbursement. This is a fixed amount payment based upon an ICD-11 code assigned for that diagnosis, not based on the direct cost of providing care. For example utilizing easy math, if a patient is admitted to a facility for pneumonia, assume the DRG payment would be $10. If a patient with pneumonia is admitted for two days and the cost of care is $6 a day, then the hospital loses $2 on the cost of caring for that patient over the two-day stay. Every day the patient is in the hospital past those two days, no reimbursement is received for the care of the patient, resulting in greater financial loss, while we are still providing for that patient. This week at Bryan Medical Center, we have 11 patients with lengths of stay over 100 days, including one patient with a stay of over 480 days. Our direct costs per day for room and board is on average about $1,000. This fluctuates slightly when labor and supply costs are higher. When patients experience barriers to discharging to the next level of care, every day they stay in the hospital in excess of the DRG-approved length of stay is a day that the hospital is not reimbursed. If one patient is in the hospital 15 extra days, the point of medical necessity-- beyond the point of medical necessity because of barriers to a placement in a long-term acute care hospital or a rehab-- rehabilitation, assisted living, skilled nursing or long-term care facility, that's $15,000 of unreimbursed cost to the hospital. Multiply that by 10, 20 or 50 patients and you can see the significant challenge this poses in our hospitals. In the case of our current patient sitting at a length of stay of over 480 days who still doesn't

have placement at the appropriate level of care and will continue to be in our hospital for the foreseeable future, this is almost a half a million dollars of unreimbursed care for one patient who no longer even requires our acute care services. This figure will continue to grow as they await post-acute placement. It is our mission to care for those who need us and to ensure that they have every resource needed to be safely discharged. When barriers to discharge are present for so many patients, it limits our ability to fulfill our mission and care for everyone that acutely needs our services. LB227 provides assistance in filling this gap. It does not cover the direct costs of patient care entirely, but serves as a support to the hospitals and as an incentive for insurers to get the patient to the appropriate level of care in a more timely manner. LB227 will not fix the complex case placement challenges in our state. This bill is a piece of the patchwork of solutions that are before the Legislature this session. Yesterday you heard testimony on LB353, today on LB227 and will on LB517. It will take approaching this issue from a variety of angles to completely solve the crisis. LB227 will provide support for hospitals as we seek the right level of care for our patients, some of which wait between 100 and 400-plus days for placement. I am grateful for the opportunity to give you a glimpse of the challenges our Nebraska hospitals and the patients, friends and neighbors we mutually serve face. As you hear from myself and others later today, I ask that you be moved to take action in support of LB227. Thank you for your time and I'm happy to answer any questions.

WALZ: Thank you so much. Questions from the Committee? Senator Ballard.

BALLARD: Thank you. Thank you for being here. Can you describe some of the barriers that are experienced in placing these patients?

LISA VAIL: There are very many and multiple-- I would say, homelessness, patients who are deemed non-decisional, therefore guardianship issues come into play and there aren't enough guardians in the state of Nebraska. And once a patient goes on that list, we can wait months and months for them to get to the top of the list for OBG-- OPG. We have waiting for Medicaid eligibility for payor source, because post-acute providers will not accept a patient until there is a decision maker-- a legal decision maker and a payor source. We have bariatric issues or patients who are very large who are difficult to handle. We have mental health and behavioral issues. We have seen sex offenders, illegal immigrants who have no pathway for payment in the

United States of America because they're not citizens. So these are just some of the different types of barriers that we see.

BALLARD: Thank you.

WALZ: Any other questions? Senator Riepe.

RIEPE: I have a question for-- requesting clarification, I guess. The issues, as you've described it, and I understand that hospitals get, for lack of a better term, stuck with patients who they can't place out. So I'm a little bit surprised that the fiscal note looks like it's $3.5 million in year one. I was surprised it's not more like $305 (million) by the time you look across the entire state of Nebraska--

LISA VAIL: Um-hum.

RIEPE: --and when everyone starts sending in their tickets. I mean, this might be chump change as we get started. So that's why I'm interested in the fiscal note.

LISA VAIL: Sure.

RIEPE: I rarely say that I don't think it's enough, but it's probably not enough.

LISA VAIL: I would agree with you.

RIEPE: Oh. Well. OK.

LISA VAIL: Yes.

WALZ: Any other--

RIEPE: Thank you.

LISA VAIL: Um-hum.

WALZ: Any other questions?

LISA VAIL: Thank you.

WALZ: Thank you. Good afternoon.

CARY WARD: Ready. OK. Good afternoon, Chairman Hansen, and good afternoon, members of Health and Human Services Committee. My name is Dr. Cary Ward. I'm the chief medical officer for CHI Health. My, my

name is spelled C-a-r-y W-a-r-d. We're much in the same boat as, as Lisa Vail mentioned. Before I get to that, I want to say just a little bit about our system. We're-- our Midwest Regional Division consists of 28 hospitals, 2 stand-alone behavioral health centers. We have 12,500 employees, 1,100 employed physicians and advanced practice providers. We're in Nebraska, Iowa, Minnesota and North Dakota. And I'm here today representing CHI Health, the Nebraska Hospital Association and the Nebraska Chamber of Commerce and Industry, who's healthcare policy counsel and board of directors recognizes the need for adequate Medicaid reimbursements for our hospitals and skilled nursing facilities. Thank you very much for the opportunity to express our support on behalf of LB227. So every day at noon I co-lead a call with all of our presidents of our hospitals and Omaha and Lincoln to look at long lists of patients that are needing transfers out of our hospitals, while looking at a list of patients that are trying to get into our hospitals. And about 10-20 percent of our patients at any given time do not have a safe and suitable placement for discharge. Our care management and our discharge planning team diligently calls. We even have an expensive software program, AIDA, that tries to send these messages out within a 250-mile radius, trying to get placement for our patients, to find some facility that would take them. We, of course, continue to care for these individuals while trying to find these places, but it extends their stay in the most costly site of care and also delays their recovery. So we keep track of these numbers and in the past year, our CHI Health Nebraska hospitals recorded 29,079 hospital days that were defined as avoidable delays [SIC], meaning the patient was medically ready for discharge to the next level of care, but a suitable placement option did not exist. This is significant because, as Lisa Wail described, Medicaid reimburses based on the DRG system. So if acute care is no longer deemed necessary but we're unable to secure post-acute placement, we're left in a precarious position. This is also significant because well over 800 patients stayed longer in our hospitals than was medically necessary last year. These delays also impair our ability to accept new patients. On any given day, we may have 20-plus patients in any one of our EDs that are ready to go up to the floor to be admitted and there's no place for them. And we may have ten patients on our transfer list to accept at any given time to try to get into our hospitals. And with all of these patients in our beds, we have difficulty finding placement for them. So just one example, so Lisa mentioned an example. We have very similar example. We had a patient that stayed 785 days. This patient, during one of their stays, was in for 222 days. They were in so long because they had behavioral

cognitive issues that required one-on-one care and none of these facilities were able to take the patient. So for these 222 days, Medicaid only covered 8 of those days, so 96 percent of their, of their stay resulted in uncompensated care. These are referred to as difficult to place patients, multifactorial, as Lisa mentioned, and requires a full complement of strategies. But this is just one strategy, because it provides a reasonable per diem rate. You know, whether it's 150 percent, 100 percent, it still doesn't cover all of our acute care costs. Our costs are very similar to what Bryan has, but we do believe this still represents a viable partnership as we all work together on more long-term solutions, such as building capacity within our post-acute care and skilled nursing system throughout the state. So in closing, I'd like to thank again, Senator Hansen, for this interest in this issue, giving us a chance to speak and for introducing this bill. I'd also like to thank Health and Human Services Committee for its consideration in this issue. Be happy to answer any questions if you have any.

WALZ: Questions from the committee? Senator Riepe.

RIEPE: Curious George here. Based on your, I'll round it up because I'm a simple guy, 30,000 hospital days that were avoidable days, which-- what would be the per diem on that?

CARY WARD: Our per diem is similar. We-- our math shows it's about $1,200-$1,300 per day. About $700 is indirect costs and about $600 are direct costs for each of those.

RIEPE: So, have you seen the fiscal note?

CARY WARD: Yes, I have. I just glanced at it. Yes, sir. I agree that it-- the number is small.

RIEPE: OK.

CARY WARD: But, you know, again, like I said, we, we want to do our part.

RIEPE: [INAUDIBLE] calculations.

CARY WARD: Yeah, we, we don't expect full reimbursement, but, but we appreciate we're all in this together and, and any amount. I think all, all of our healthcare facilities respect it.

RIEPE: You might be willing to settle as they say in the furniture business, pennies on the dollar.

CARY WARD: Yeah, that's one way to look at it.

RIEPE: OK. Great. Thank you. Thank you. Thanks for being here.

CARY WARD: Yeah. Thanks.

WALZ: Any other questions? I see none. Thank you so much.

CARY WARD: OK. Thank you.

SUZANNE NUSS: Can we start?

WALZ: Yeah.

SUZANNE NUSS: Good afternoon, Chairman Hansen-- he's not there anymore. Sorry. Members of the Health and Human Services Committee, I am Dr. Suzanne Nuss, that's S-u-z-a-n-n-e N-u-s-s, and I am the chief nursing officer for Nebraska Medicine, which is a nonprofit integrated healthcare system. Our health system includes two hospitals, Nebraska Medical Center and Bellevue Medical Center, and nearly 70 specialty and primary healthcare centers in the Omaha area and beyond. I want to thank Drs. Vail and Drs. War-- and Dr. Ward for presenting pretty much what I'm going to say but I'll be high level. We support LB227, as it represents an important opportunity to support hospitals in addressing their challenges to post-acute placement and [INAUDIBLE] we thank Senator Hansen for his interest and commitment to this issue, which is a top priority for our health system. Over this past week, we've had 77, that's seven seven, patients in our hospitals that are medically stable and ready for discharge but unable to access appropriate post-acute placement. To put this into perspective, that 77 patients is equivalent to an entire hospital, similar to the size of our own Bellevue Medical Center, Methodist Fremont or Kearney Regional, full of patients who no longer require acute inpatient level care. This high number of patients waiting for discharge has become our new normal. Our hospitals are set up to provide acute care where a patient receives short-term treatment for a severe episode of illness or injury. Post-acute care refers to a range of services that support the individual's continued recovery from illness or management of a chronic condition. Our hospitals are not built to provide longer term rehab and therapy services or extended care for people who cannot care for themselves. To continue to use acute hospital beds for patients who no longer have acute care needs is inefficient and it's costly to

our entire healthcare system. Our hospitals are reimbursed a set amount based on diagnosis and complexity, not based on length of stay, as has already been stated today. We receive the same amount of reimbursement, whether the patient is stabilized and ready to discharge in 6.8 days, which is our average length of stay or 68 days or 368 days, like we just heard. For the reimbursement we receive, we are responsible for providing care to the patient to meet their short-term, urgent medical needs. The problem is that once we stabilize the patient, we have no control over whether or not there is available post-acute facility willing to accept the patient for their next level of care. As these medically stable patients are waiting to transition to post-acute services, our health system receives no additional funding to continue their care. Approximately 18 percent of our patients in our hospitals awaiting discharge are insured by Medicaid. In the past year, our Medicaid patients accrued over 4,500 avoidable days, this is just our Medicaid patients, which are days that, as Dr. Ward said, are ready to discharge, medically stable, but they remain in our hospital. These are avoidable days for Medicaid patients added about $3.3 million in uncompensated care costs on top of the already low reimbursement rates, which typically only reimburses $0.88 for every dollar spent on caring for a Medicaid patient. LB227 is an important part of the solution to this healthcare traffic jam. It will help our hospitals cover some of the uncompensated costs associated with providing longer term care to patients as they await transfer to post-acute settings. Our health system is facing one of the most difficult financial situations in recent history, with the combination of skyrocketing expenses, significant staffing challenges, more complicated patients and longer lengths of stay. In the last two years alone, our health system's labor costs are up over 20 percent, with an increase in the cost of contract labor of 941 percent. Supply costs are up 19 percent and the cost of drugs increased by more than 20 percent. This additional reimbursement in LB227 will be a meaningful-- will be meaningful during this very difficult financial time, for not only the urban hospitals or these larger hospitals, but also other hospitals across the state. What is also important about LB227 is the structural incentives it creates to ensure we will all be working to move the patient to the right level of care. Our hospital still maintains an incentive to try to move the patient to a lower level of care, because although we are being reimbursed, but-- sorry, we are being reimbursed something, the reimbursement amount in LB227 will not fully cover our costs. It also provides an incentive to our state's Medicaid program to ensure that post-acute facilities accept transfers for Medicaid

patients because it would be more cost effective for the state to get the patient to the appropriate level of care. LB227 ensures that financial incentives are aligned with what is best for patients. Hospitals have little control over who comes through their door seeking care. We are not allowed to deny patients medically necessary care if they have no insurance or are underinsured or no legal guardian. It is embedded in our mission to extend serious medicine and extraordinary care to all Nebraskans. We also cannot control how and when patients leave our hospital, because we rely on these post-acute facilities to accept patients who are ready to discharge to a lower level of care. It is in the best interest of all stakeholders-- patients, hospitals, policymakers-- to ensure that we are creating efficient transitions through our healthcare system and ensuring continued access to acute care. Doing so will improve patient health outcomes, reduce uncompensated care costs and ensure patient, patient choice and access to the right type of healthcare at the right time. Thank you for your consideration and I'd be happy to answer any questions.

WALZ: Thank you so much. Senator Riepe.

RIEPE: Thank you.

SUZANNE NUSS: Yes, it's [INAUDIBLE].

RIEPE: At one time, hospitals were-- for accreditation, were required to have written transfer agreements with nursing homes. Is that still the case?

SUZANNE NUSS: I believe so. And we do have.

RIEPE: And that's obviously not working, because for the 77 that you have, you, you said you're not-- so the transfer agreement sounds like it's null and void.

SUZANNE NUSS: No, I would say that the 77 have complex issues like Dr. Vail mentioned. And so, the facilities are unable to care for them because they either don't have the specialized trained staff or they don't have the right type of bed or in the sex offender issue, they can't take them in those areas or the patients are what we call incapacitated and they need the public guardian and so we're waiting months for them. So some of them fit into that complex group.

RIEPE: So while in concept, it sounds like problem solved, but it's not the case because it doesn't function [INAUDIBLE]--

SUZANNE NUSS: It functions--

RIEPE: --acuity of the patients.

SUZANNE NUSS: --it functions sometimes. It does function sometimes. And I would also state that the post-acute facilities are experiencing workforce shortages, just as we are in the acute care setting. So sometimes, they just-- they don't have enough staff to care for the patients.

RIEPE: Second, if I may, Chair Walz.

WALZ: Yes.

RIEPE: OK. Thank you. The second one is, is given a choice, would you prefer to have this block grant or would you choose to have rate increases?

SUZANNE NUSS: Oh, my goodness gracious.

RIEPE: Time's up.

SUZANNE NUSS: Yeah. I would want to give that a little bit more thought, to be honest. And to your previous questions of the other speakers--

RIEPE: This is not Jeopardy.

SUZANNE NUSS: --this is not enough money. However, there are several other bills that are asking for money, so I think we're trying to be good financial stewards and asking for some and not asking for everything here because there are other requests that we have.

RIEPE: The one asking for money is probably going to the Revenue Committee, which is a much easier committee than this committee.

SUZANNE NUSS: Well, then I think maybe I need to go to that committee.

RIEPE: Thank you for being here.

SUZANNE NUSS: You're welcome. Thank you.

WALZ: Other questions? I have one.

SUZANNE NUSS: Yes.

WALZ: And it, it might be kind of a, a big question to--

SUZANNE NUSS: Oh, boy.

WALZ: --to answer. But, you know, obviously, this is a big problem.

SUZANNE NUSS: It is.

WALZ: We had an interim study last summer and you can see the bills that we're trying to bring forth today to try to address the problem. But considering that, you know, this is such a huge problem and it involves so many people, DHHS, guardians, hospitals, nursing homes, behavioral health. Has there been an effort to bring all of those-- and I know that's part of our process. But on the healthcare side, is there an effort to bring all of those entities together and devise a plan that you can bring forward?

SUZANNE NUSS: I would say there is. Nebraska Hospital Association has graciously pulled all of us together over the last-- they're in the back of the room, maybe two years, 18 months to two years and it's been facilities from across the state, so it hasn't just been the larger urban hospitals. It's been hospitals across the state that have come together and some of the recommendations that we put forward came from that group within HA-- from the NHA.

WALZ: OK.

SUZANNE NUSS: So we can continue to do that if you think that would be most helpful.

WALZ: I do. Senator Riepe.

SUZANNE NUSS: Oh, my goodness. Yes, is my time up? There's no red anymore.

RIEPE: [INAUDIBLE]. My question would be back is within Medicaid, you know, do they have their priorities not in order in the sense that in the process of building new programs, they're not funding the programs they already have?

SUZANNE NUSS: I appreciate that question. I'm not sure that I am-- I have enough information to answer that right now. I would want to do a little more investigating before I could truly answer that.

RIEPE: You should have gone through politics.

SUZANNE NUSS: No, thank you.

RIEPE: Thank you.

SUZANNE NUSS: You're welcome.

WALZ: Any other questions? I don't see any. Thank you so much for coming.

SUZANNE NUSS: I'll be back.

WALZ: Thanks. Oh. Next proponent. Sorry. Any opponents? Anybody that would like to speak in a neutral capacity? Come on down.

KEVIN BAGLEY: Good afternoon.

WALZ: Good afternoon.

KEVIN BAGLEY: [INAUDIBLE] committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services, here to testify in a neutral capacity for LB227 which, as you all have heard, reimburses hospitals at-- for the, the nursing facility level of care to a patient who no longer meets that inpatient level of care. So I'm going to try and keep my comments a little bit more brief. I know there are questions and so in the interest of time, I'll try to keep them brief. I want to thank Chairman Hansen for the opportunity to meet with him to discuss the bill and some of the Department's concerns that we saw with the green copy. We also appreciate his willingness to work with us on potential amendments. My comments today are, are primarily on the green copy, but I'm happy to speak to the amendment, as well. To be clear, we recognize the need to facilitate more efficient transitions for care for patients ready to leave hospitals. As you've heard, this is a pretty substantive and complicated issue and so I, I want to make sure that you all hear from us at the Department that we recognize that. LB227 sets the rate of reimbursement at 150 percent and the amendment changes that to 100 percent of the statewide average nursing facility per diem rate. This is similar in terms of a service category definition to what our partners at the federal level would call a swing bed. Swing beds are typically available in rural hospitals with fewer than 100 beds, but it is paying, excuse me, paying for a nursing facility level of care for an individual who still is at a hospital. Using CMS's definition and requirements around swing beds, it would limit just to rural hospitals and, and would, by default at that point, inhibit hospitals

in Lincoln and Omaha or any rural hospitals with more than 100 beds from participating, unless we had special federal approval. Absent that federal approval, we would be required to expend all state dollars. The green copy initially would have us seek that authority through the existing 1135 waiver. But technicality aside, that is an emergency declaration waiver that gives states flexibility on how we administer these. According to what we've heard from our federal partners, that will expire in May. By addressing some of these issues and, and bringing the bill into compliance with existing federal requirements, we would effectively be requiring the Department to pay for swing bed services, which we currently already pay for. But like I mentioned, that would preclude our hospitals in Lincoln and Omaha from receiving that payment. And we've heard from them, particularly today, that they experience this issue just as much, if not more, than any of our other hospitals. We remain committed to addressing the multifaceted problem of hospitals struggling to discharge patients. And we are open and continue to work with our hospital association, our nursing home association, legislators, patients and other community stakeholders to address these issues. We welcome those conversations. We're committed to facilitating efficient, safe and orderly transition of care for patients who are able to leave our hospitals. Appreciate the opportunity to testify today. I'm happy to answer any questions, including Senator Riepe, on the fiscal note.

RIEPE: I get one?

KEVIN BAGLEY: I might.

WALZ: Senator Riepe.

RIEPE: Thank you. Even within DHHS, it's been described as a very generous state Medicare-- Medicaid I'm sorry-- program, which I take some exception to in the sense that I believe in Medicaid, I just don't think it should be the platinum health plan. And it seems, seems to me that you've been busy expanding Medicaid while failing to support those that already need support. Like, you know, we're, we're bringing on new programs, be it dental, be it behavioral health, be it whatever. Under the philosophy that we want every federal dollar we can pick up by giving as many programs as we can give and yet, we're failing on the other side of not taking care of the programs that we already have. That was an easy question. I have some tougher ones.

KEVIN BAGLEY: Well, I'd love to, I'd love to hear what the tougher ones are.

RIEPE: Oh, you might.

KEVIN BAGLEY: I'm sure I will. You know, without trying to speak to some of the other elements of, of the Medicaid program, I think on this front, I will say a lot of the complication with this does not come from a lack of willingness on the part of the Medicaid program to pay for the services. It comes from a federal regulatory apparatus that makes it incredibly difficult to navigate these waters. And it puts the burden pretty squarely on our hospitals to deal with. You heard from them that their-- part of their mission and part of their requirements are to take patients regardless of ability to pay, regardless of some of the complicating factors that they experience. Our nursing homes are in a position where the federal regulatory apparatus makes it very difficult for them to discharge someone once they've been admitted. And for a lot of these patients that, that need that lower level of care, it puts all of the downside risk on our nursing homes without giving them any real incentive to navigate that. And, and I think this reflects and, and-- Senator, you'll appreciate a good soapbox moment. This puts us in a position where we are really unable to administer the level of long-term services and supports that we need to. And it puts the state in a position where we're unable to, to provide an apparatus that, that works in a way that our patients need. So I will say, we are willing and, and able to put in a request to our federal partners for this type of authority. We put in a similar request during the pandemic to receive Medicaid dollars to help facilitate some of these transitions or to allow patients to stay in the hospital. We were flatly denied. That doesn't give me a lot of confidence that we'll receive federal approval for this type of request, but we are committed to helping ease this, this burden and make this process work smooth-- more smoothly. And so, I-- as I've shared with, with others in conversations, we're happy to make the request.

RIEPE: It sounds to me like the providers, though, don't want more management help, they want more financial help.

KEVIN BAGLEY: I, I would say that's--

RIEPE: You know, it's just the, the process is there, there just-- not the, not the fuel, not the money to make it happen.

KEVIN BAGLEY: --and, and I would--

RIEPE: And, and to me, that is setting priorities within Medicaid that says what, what, pieces do we have to feed to support, to make sure that they're meeting the minimum standard, before we take on more new programs? That's where-- that's my concern.

KEVIN BAGLEY: And I think that's fair. Senator. I would say this one falls squarely into the realm, I think, of where our federal partners have put us, between a rock and a hard place, in terms of what we are able to do. And I'm happy to work with anyone on, on resolving that but, but I don't even think in this case the money is the issue.

RIEPE: I think the hospitals and the nursing homes feel like they're between a rock and a hard place.

KEVIN BAGLEY: I absolutely agree.

RIEPE: So there must be a lot of rocks out there.

KEVIN BAGLEY: I, I, I agree and I think most of them say CMS, property of CMS on them.

RIEPE: OK. Thank you, Chairwoman--

KEVIN BAGLEY: Sure.

RIEPE: --thank you.

WALZ: Of course.

RIEPE: Thank you. Thank you for being here.

KEVIN BAGLEY: Thank you, Senator.

WALZ: Any other tough questions?

BALLARD: She's putting me on the spot. Thank you for being here, Mr. Bagley. I'm kind of piggybacking off of Senator Riepe's question to the last testifier. This, this doesn't solve the problem. This is a symptom of the problem. For those of us that were not on the interim study last, last year, what-- I mean, if you had a silver bullet, what would you tackle? What would you--

KEVIN BAGLEY: I'm trying to think of how I express this without going on a 20-minute soapbox, Senator. I apologize. I think the, the silver bullet is and I don't even know that I would call it that. I think this solution needs to come down to really thinking about how we

support every facet of the continuum of care and, and the, the way that the regulatory apparatus at the federal level, in particular, is set up right now. It, it penalizes some providers for trying to solve problems that are difficult to solve. So an example of that may be dealing with behaviorally complex patients who are just difficult to care for and, and have a lot of complicated issues. If our nursing homes take on too many members who have co-occurring behavioral health conditions, then they may fall subject to regulations that preclude them from being a nursing home and tell them that they're an institution for mental disease and that now they no longer qualify for Medicaid dollars. And, and so there is just this web of regulations that try to deal with aspects of that continuum, but don't take-- they lose the forest for the trees, if I can put it that way. Maybe I've muddied the water more in trying to comment on that. But I, I think really what it comes down to is we're hearing a symptom of the problem and the underlying problem is that the continuum of care, particularly for our long-term care patients, is broken. And, and I don't, I don't think there's an easy solution to it. And if I'm totally honest, it's usually not an issue of no one's willing to pay for it. It is an expensive continuum of care, but there is a lot of money already being allocated to this continuum of care. But, but a lot of it goes to dealing with a regulatory apparatus that really isn't focused on the continuum, it's focused on individual elements of it.

BALLARD: OK. Thank you.

KEVIN BAGLEY: I'm sorry. I hope that wasn't a confusing answer, but it's a complicated problem.

BALLARD: Yeah, of course.

WALZ: Senator Riepe.

RIEPE: Well, it's a softball.

KEVIN BAGLEY: All right.

RIEPE: A few years ago, there were-- there was a movement towards block grants, which, quite frankly, I would like to see you empowered or us empowered to decide where we want to spend the money rather than get dictated, that to get, to get "B", you have to give me "A", you know, from the federal standpoint. And I, you know, I take exception to that. We know better where we need to spend our dollars to get what

we want and so. See? That was fairly nice. I want to leave on a nice note.

KEVIN BAGLEY: And I appreciate that. I think the ability of the state to, to be flexible in addressing the specific needs of our population is critical.

RIEPE: Is there any more [INAUDIBLE]?

KEVIN BAGLEY: I have not seen a lot of movement at the federal level.

RIEPE: That's what happens when you get white hair. You know, you, you, you been around long enough to hear about some of these things,

KEVIN BAGLEY: You know, and someday I hope to know what color my hair will actually be.

RIEPE: I didn't mean to offend anyone. Thank you.

KEVIN BAGLEY: Thank you, Senator.

WALZ: Any other questions? Thank you so much for being here today. Appreciate it.

KEVIN BAGLEY: Thank you, Senator.

WALZ: Any other in the neutral capacity? All right. Where's Senator-- OK. We did have three letters, one proponent and two opponents.

HANSEN: OK. I'll try to address some of the questions that we had. But the previous testifiers brought some good points about why we're in this shape that we're in and why we have so many patients stuck in hospitals instead of post-acute care facilities. And, and I think, Senator Walz, you kind of brought up that we are trying to address this with different bills and got together. There's some other Senators who are bringing in different bills to address, like guardianship, you know, the facilities, you know, the infrastructure of the facilities and stuff like that. So it's not, kind of, a silver bullet type approach, you kind of, it's somewhat like a shotgun. It takes a lot of different spots to correct. And it is, I think, what Mr. Bagley said about and I think even Senator Ballard was addressing it, is like this is kind of addressing the symptoms. And I'm a fiscal conservative and I'm not a big fan of fixing symptoms and trying to actually just fix the cause. However, I think this bill is appropriate if we're going to spend taxpayer money on something and if we're going

to force somebody to take care of people, I think it's only just that we, we help them take care of those patients financially. And then-- to remember, these are Medicaid patients only. And the-- I think the average cost per day for a Medicaid patient in the long-term healthcare facility is $294. And the fiscal note is off because it's from our original bill and not the amendment. The amendment changed the swing bed part of it and so more hospitals will be eligible for this. And also the fiscal note had it at 150 percent instead of 100 percent, so that will lower it, too. So it's going to go up, but not exponentially. And this is, to remind you, it is contingent upon federal approval. So we haven't even been approved for this yet. We can pass this and put it out there and the federal government says no and then nobody gets anything. But I think when we talk about addressing the symptoms, I think the underlying cause we also have to do is addressed the education of our citizens about living a healthy lifestyle so they don't end up in these facilities in the first place, having a proper support system in place that's fiscally responsible and also encourage personal responsibility. I think those, those three things kind of collaborate to, to address symptoms instead of just kind of throwing money at a problem. So I know we're just addressing the symptoms with this, but I think it is appropriate, along with some of the other bills that have to deal with the overlying issue of why these patients are in hospitals still. With that, I will take any questions.

WALZ: Questions?

HANSEN: I got off scot free? All right. OK. Well, thank you very much.

WALZ: Oh. We're going to close on LB227 and open on LB434, Senator Jacobson.

HANSEN: Welcome, Senator Jacobson.

JACOBSON: Thank you.

HANSEN: You noticed how a whole bunch of people in the committee left?

JACOBSON: I noticed I lost those who were the weak ones INAUDIBLE]. And I did, I specifically took my tie off today. I think it was a little tight yesterday on my close, so I thought I'd not wear one today.

HANSEN: Well, welcome.

JACOBSON: Well, good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Senator Mike Jacobson,M-i-k-e J-a-c-o-b-s-o-n, and I represent District 42 in the Nebraska Legislature. I'm here today to introduce LB434, a bill to require the Department of Health and Human Services to enroll long-term acute care hospitals as providers under the medical assistance program. Long-term acute care hospitals are facilities that specialize in the treatment of patients with serious mental conditions that require care on an ongoing basis, but no longer require intensive care or extensive diagnostic procedures. These patients are typically discouraged from the intensive care units and require more care than they can receive in rehabilitation centers, skilled nursing facility or at home. In Nebraska, this level of care is provided at Madonna and Select Specialty Hospital in Omaha. Without this care available in Medicaid, patients receive rehabilitation services in acute care hospitals that are not designed to meet their specialized rehabilitation needs. This also takes additional resources away from acute care hospital capacity, which explains my interest in this bill. The Nebraska Hospital Association asked me to introduce this bill because the hospital in my district, Great Plains Health, has experienced patients taking up bed space in their hospital, when they could be much more appropriately cared for in a long-term acute care hospital. Ensuring the long-term acute care hospitals receive Medicaid reimbursement would allow for more long-term acute care patients to be transferred to the appropriate level of care, freeing up precious bed capacity in hospitals. Due to the healthcare workforce shortage, hospital bed capacity across the state is extremely limited. We need to consider all options like LB434 to help hospitals free up bed capacity and to make sure we are best caring, caring for the patients in Nebraska. Again, I would just tell you that you've heard a long litany today of bills that are really designed at how can we help fix this medical problem. I will tell you that I'm very concerned, particularly in rural Nebraska, about the loss of nursing home facilities and the loss that we will see of rural hospitals if we don't do something more than we're doing today. Rural hospitals, just go look at the numbers. Very few rural hospitals were profitable in 2022. We will be losing those hospitals if we don't adequately fund them and provide them with the resources that they need to be able to deal with patients and to be able to cover their costs. And so I thank you for your time and I will hang around for the close and I'll defer for any questions.

HANSEN: All right. Thank you. Are there any questions from the committee? So I like how you get the fiscal note that says zero on it.

JACOBSON: Well, I don't know whether that had anything to do with my close yesterday or not, but I'm happy with the zero.

HANSEN: OK. Seeing no questions, we'll welcome the first testifier in support of LB434.

CARY WARD: Chairman Hansen, members of Health and Services community, thank you for allowing me to speak again. Again, my name is Dr. Cary Ward, C-a-r-y W-a-r-d, CMO for CHI health. I've already described the challenges in navigating patients to the appropriate level of care under LB227, so I'll keep my comments very brief. The issue of expanding access to appropriate level of care requires a variety of solutions, including building capacity within our long-term care acute hospitals. LB434 acknowledges the need for a favorable reimbursement environment so that the long-term care acute, acute care hospitals can accommodate the current demand and forecasted increased demand for long-term acute care services that an aging population requires. These hospitals share many of the same workforce and rising cost pressures that our acute care hospitals do. In order to provide the best possible care of patients at the right time and at the most appropriate care setting, we must fortify each component of the healthcare continuum. If long care hospitals are operating in the red and unable to staff beds, our hospitals feel that impact and manifest in the number of patients who are medically ready to transfer to long-term care, but for whom un-- unable to find placement. So last year, our Nebraska hospitals recorded over 3,000 hospital days where a patient was medically ready for discharge to a long-term care hospital but was unable to successfully transition to the next level of care, possibly due to a lack of capacity or other delays. This constitutes about 12 percent of our hospital days in which we were unable to discharge patients. So LB434 coupled with several complimentary bills, will be-- that will be presented next, I know, each offer distinct and essential solutions to a complex and urgent healthcare capacity challenge that adversely impacts patient care and experience. In closing, I'd like to thank Senator Jacobson for introducing this bill and the Health and Services Committee for your support in strengthening the continuum of care services in Nebraska. Be happy to answer any questions.

HANSEN: All right. Thank you. Are there any questions from the committee? Seeing none, thank you. We'll take the next testifier in support. Welcome.

CHRIS LEE: Thank you. Good afternoon. My name is Chris Lee, C-h-r-i-s L-e-e. I'm representing Madonna Rehabilitation Hospitals and I'd like to thank Chair Hansen and the other members of the committee for this opportunity to speak before you regarding LB434, 434 rather. I'm the vice president and chief operations officer of Madonna and we're a not for profit organization that provides medical and physical rehabilitation to patients from across the U.S. We operate four hospital facilities that have varying certifications, but today, I want to focus on the two specialty hospitals that really focus and specialize on caring for patients with critically ill, complex medical needs. These hospitals are licensed in the state of Nebraska as general acute care hospitals, but certified by the Centers for Medicare and Medicaid as long-term acute care hospitals. For these hospitals to maintain their LTACH certification, they have to maintain at least a 25-day average length of stay, ours is a little over a month and they have to show that a majority of their patients are either on a ventilator or have had a stay in an intensive care unit in an acute care hospital. So these hospitals are specifically designed to care for some of the sickest, most complex patients that are going to require a very long time to recover at a hospital level of care. And so, LTACHs fill an important role in the continuum of care that we have here in Nebraska. Of the 683 patients that we admitted to our LTACHs in the last year, 533 were Nebraskans from 63 different counties. And in my experience, those patients that need this level of care have no other post-acute care options. They cannot be admitted to an inpatient rehabilitation facility because they don't meet the criteria for intensive therapy because they're simply not ready for it yet. And they can't access skilled nursing facilities because of the need for the intensive medical management required by a team of doctors and nurses and respiratory therapists and other therapies and specialists. So this means if they can't access an LTACH, there's really no other choice but for them to stay in an acute care bed for perhaps a month or more. The Nebraska Hospital Association recently released a report stating that over the last month, there were over 227 patients in one month that were waiting for discharge to a more appropriate setting. Of those, almost half had been waiting a month or longer. So this creates a significant backlog in Nebraska's continuum of care and in acute care hospitals in particular. But we've been able to help our acute care partners by taking patients from them directly

out of their ICUs or their step-down units, which allows them to free up beds and staff and other resources to care for new patients. And when we do accept those patients, not only are we managing their medical needs, but we're applying a rehabilitation approach. A multidisciplinary team meets with the physicians every day to talk about how we move patients towards better medical stability, greater independence, greater function, and how we return them to the community and their lives. And that's really our mission. And we're currently able to provide that valuable service for patients with Medicare, with commercial insurance, with worker's comp insurance, and with Medicaid from several surrounding states. However, we are not currently able to take Nebraska Medicaid because LTACHs are not currently enrolled in the Nebraska Medicaid system and we believe a lot of Nebraskans with Medicaid would greatly benefit from this service. And that's why we're supporting LBE for 34 and are requesting your support as well. Not only will it help patients in Nebraska who've experienced life-changing medical events, but it will also bolster the Nebraska healthcare system in a way that allows our acute care hospitals to continue to have beds and staff available for the patients that need their care. So thank you for your consideration today and your time and I'd be happy to entertain any questions that you might have.

HANSEN: Thank you. Are there any questions for the committee? So just for clarification sake, you said that there's two facilities that would qualify for this or is there more?

CHRIS LEE: Madonna operates two facilities and as was mentioned earlier, Select Specialty often operates one facility. I believe there are a total of three LTACHs in the state of Nebraska.

HANSEN: OK. And they currently take Medicaid patients?

CHRIS LEE: From other states, but there is no mechanism, currently, for LTACHs to accept Nebraska Medicaid.

HANSEN: OK. Just trying to get it in my head straight.

CHRIS LEE: So we currently accept patients with Medicaid from Kansas, from Missouri, from South Dakota, for instance.

HANSEN: OK. So then if this-- I think I know what's going on, what's going on with this bill, but-- so what's going to happen when this bill gets passed then?

CHRIS LEE: I think some of those patients with Nebraska Medicaid that are currently stuck in acute care beds, they would move much more quickly into either select LTACHs or one of our LTACHs.

HANSEN: OK. So it would like-- the fiscal note truly is, is zero. Right. I think once it's-- because we're still paying for them now, currently or no, we're not. Right.

CHRIS LEE: I'm not sure that I'm qualified to say that because I'm not an expert on how acute care is paid.

HANSEN: For sure. OK. I get my-- I'm getting my long term and my acute care-- the, the term long, long care acute care facility throws me off. It's an oxymoron.

CHRIS LEE: Yes. It's very confusing. It's, it's acute care in that it's licensed the same as any other general acute care hospital in Nebraska, rather we're talking about you know, one of the CHI hospitals or UNMC or Bryan, but it's certified differently. But we have to meet all of the same Medicare conditions of participation as any other type of acute care hospital. The difference is that we have to maintain that long length of stay and have a very complex medical mix. So the long length of stay being at a minimum 25 days for an average.

HANSEN: OK. Because I know that's what my previous bill was trying to do is pay for Medicaid patients in acute care facilities. And so, I-- OK. That's all. I just wanted to make sure I'm getting my, my analogies or my acronyms down. So. OK. Any other questions from the committee? All right. Seeing none, thank you. We'll take the next testifier in support.

JEREMY NORDQUIST: Good afternoon--

HANSEN: Welcome.

JEREMY NORDQUIST: --Mr. Chairman, members of the committee, I'm Jeremy Nordquist, J-e-r-e-m-y, N-o-r-d-q-u-i-s-t, president of the Nebraska Hospital Association. I'm here today on behalf of our 92 member hospitals. I hope you don't mind, we're in the back talking. We should rebrand this the hospital happy hour on Friday here. I hear we're getting close to it-- but here today in support of LB434. And thank you, Senator Jacobson, for bringing this forward. It, as you heard, directs the department to enroll LTACHs or long-term acute care hospitals as an eligible provider and without that, those Medicaid

patients can't receive that level of care. There would be no source of payment. And as Senator Jacobson mentioned, this was an issue that was actually brought to our attention at the Association by Great Plains Health in North Platte. And since that time, hearing it from hospitals from Omaha all the way to Scottsbluff with patients. And you heard yesterday from Margaret Woeppel, our vice president of workforce, quality and data, with our, our throughput report. And really that report came out of bringing together our, we call transitions of care workforce, which includes hosp-- transitions of care counsel, I should say, which includes hospitals, nursing homes, folks from the Department of Health and Human Services have participated, as well as the Office of Public Guardian. And again, a number of these bills have come out of it. But that report does show over the last four or five months that at any given time and again, that's a monthly snapshot report, so at any given time, 230 patients waiting, 150 in rural hospitals trying to get into our larger hospitals, 90-plus sitting in emergency rooms waiting to get to an inpatient bed, that at any given time there's 8-10 patients waiting for a long-term acute care hospital transition. So it's just another piece of the puzzle that, that we think is necessary to try to solve this. It isn't, you know, going to address all 230 patients at any time waiting, but it certainly would address some. And to your question, we started talking to the Department, some of our folks and Madonna, a couple, it's probably been a month or so now about the impact. And the department really sees this as a net even, in terms of the care, that some of those patients, while some of them are waiting, many of them are, as Mr. Lee said, could be transferred right out of the ICU. So if that patient went into our inpatient, we would get paid for a certain period of time, but if we can get them right over to long-term acute care, Medicaid would just pay for the long-term acute care services. So I think in Medicaid's determination, they didn't see a net addition of cost to it.

HANSEN: Thank you. Are there any questions from the committee? Senator Walz.

WALZ: Thank you. Thank you so much for talking about the--

JEREMY NORDQUIST: Yeah.

WALZ: --coalition of organizations. One of the questions I have is what, what-- when you're giving that report, do you also have information about the capacity available in other, like, nursing

homes, assisted living facilities? Is there a capacity report what's available?

JEREMY NORDQUIST: That, that, that's an issue, actually, within the last probably two or three months that's come up as who's, who's responsible for mapping that capacity. And our, our hospitals will say-- Dr. Ward mentioned the system that they use, but some of the hospitals literally pick up the phone and call 200 facilities or will email 200 facilities. And we've been trying to say, you know, how do we do this in a logical way? I mean, is it-- is-- I mean, is it a protected secure website or something where the nursing homes can come in and the hospitals can say here's who we need to discharge, here's where they need to go. The issue with a lot of these patients, though, are the complicating factors. A nursing home might be able to say, yeah, we'll take a patient, but well, we can't take a mental health patient, we can't take a sex offender, we can't take somebody who doesn't have their payor and guardian lined up yet. So those are all barriers to just, you know, there might be a bed, even a staffed bed for a patient with no complications, but most of these patients have significant complicating factors.

HANSEN: Any other questions from the committee? All right. Seeing none.

JEREMY NORDQUIST: Thank you for your time.

HANSEN: Thank you. Anybody else wishing to testify in support? All right. Seeing none, is there anybody who wishes to testify in opposition? Is there anybody who wishes to testify in a neutral capacity? Seeing none, we'll welcome up Senator Jacobson to close. And I think I had-- just to make sure. Yes, I did. OK. There-- what-- you can go ahead. Sorry, Senator Jacobson. I'll say it afterwards.

JACOBSON: You don't see any letters on this one?

HANSEN: What?

JACOBSON: You're looking for the letters on this one.

HANSEN: Yeah. Are there any?

JACOBSON: Well, it could impact my close, but I'm just going to--

HANSEN: As long as it's not like 100 in opposition.

JACOBSON: Right. Right. That's good. Well.

HANSEN: I'm not seeing any anyway, so.

JACOBSON: All right, that's good. Well, first, let me just say that I, I appreciate the committee's time today. I know it's been a long day and I thought about waiving my closing, but I, I don't think it would be fitting if I did a close yesterday and didn't come back today and give credit where credit is due that, that I do appreciate the fact that this was looked at from a bigger picture standpoint. The trade-offs in coming up with a fiscal note of zero is appreciated. I think that we do have a problem out there. I appreciate the offer-- the efforts of the Department to try to do the right thing here. I think we all are in this together. We've got a significant healthcare challenge across the state. I can tell you, being from a rural part of the state, healthcare is critically important. If we're going to have economic development in our part of the state, try to reverse the tide of loss of population, we have to have a solid healthcare program. I appreciate the partnership that we've had and the hospitals have had with Madonna and other acute care long-term facilities. This is invaluable, and I think this will really help us in terms of being able to move patients that need to get in a place that can get better care and better long-term care and be better for the entire system. So thank you again for your time today. Appreciate it.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you very much.

JACOBSON: Thank you.

HANSEN: We'll now close the hearing for LB434 and we will now open the hearing for LB517 and welcome Senator Walz to open. Ready when you are.

WALZ: Good afternoon, Chairman Hansen and fellow member-- oh, members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent District 15, which is made up of Dodge County and Valley. I'm here today to introduce LB517, a bill to incentivize post-acute care facilities to accept difficult to place patients. The HHS committee has had a number of opportunities to hear about the challenges facing our hospitals and in particular, regarding transferring patients to post-acute care settings. The Nebraska Hospital Association reported that there were 35,500 avoidable days last year among the largest hospital systems. This means that hospital

beds were filled with people who were medically ready to discharge and were not available to people who need that higher level of care. At the October LR417 interim study hearing on this exact issue, there was a discussion about what happens when a patient is being cared for in their local community that needs a higher level of care. And according to the NH-- the NHA, in January, there were 154 patients across the state in that specific situation. I did file and pass out AM170, which replaces the bill. LB517 as amended, would create a financial incentive for post-acute facilities who accept patients with complex needs as a piece of the puzzle in addressing the issue. I'm going to walk through this amendment and what it does. First, the incentive only kicks in when a hospital is at or near full capacity, which is defined at 80 percent of available intensive care unit beds and acute care inpatient medical-surgical beds. Second, the one-time transfer incentivize-- incentives would be $6,000 for each patient placement in a nursing facility and $3,000 for each patient placement in a skilled nursing facility or swing bed hospital. Next, this incentive is only available for patients with complex needs. We are asking DHHS to work with representatives of acute care hospitals, skilled nursing facilities and nursing care facilities to further define who falls under this category. In addition, we're making clear that any Medicaid or Medicare, Medicare patient being transferred to a facility must comply with all reimbursement policies. Finally, we're making it clear that these incentives are not available for transfers that occur between facilities under the same ownership. Again, the intent of LB517 is to be highly targeted and to focus state funds on the specific intent of freeing up additional bed capacity. I believe it's in the state's best interest to make sure that there's capacity at our state's largest hospitals to ensure that they can accept transfers from other hospitals and providers in our state when necessary. An important distinction that should be made between hospitals and post-acute facilities is that hospitals don't get to pick and choose who comes through the door. That is why I think it's so important for us to create mechanisms that help solve this post-acute care traffic jam, which is currently resulting in less access to acute care patients across the state. Equally or even more important, we need to find solutions that prevent someone from accessing care that is specific to their needs. This is a quality of life issue. Like I mentioned previously, I did pass out an amendment that would replace the bill and I filed the amendment last week to give ample time for the public to review. Like so many bills this year, due to bill drive-- drafters' capacity, we were unable to get this version represented in an introduced copy, so the amendment better represents

the intention of the proposal. There will be testifiers after me that could provide more detail from the hospital perspective. I'm more than happy to work further with them, the post acute facilities and other stakeholders to create meaningful-- a meaningful solution to a serious problem in our healthcare system. With that, I would be happy to try and answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Your choice, one or two?

HANSEN: I was going-- no. I was going to say something but I'm not going to.

RIEPE: Thank you, Senator. My question: who was it that requested that you bring this piece of legislation?

WALZ: I talked with the Hospital Association.

RIEPE: It was the Hospital Association?

WALZ: Yes.

RIEPE: OK. On my-- I am two-- I guess, two other questions. About the payments, the $6,000, are those one-time payments or they're not [INAUDIBLE]?

WALZ: One-time payment.

RIEPE: So however long the patient's there and they don't transfer out?

WALZ: It is more of an incentive to bring them patient beds.

RIEPE: It's all up front. It's not spread out.

WALZ: No. I think it's all up front.

RIEPE: And my other-- third and only other question would be is is this only for Medicaid patients or it's for all patients?

WALZ: I believe it's only for Medicaid patients. But I-- let me-- I'll have to check on that.

RIEPE: OK. OK. Thank you. Thank you.

HANSEN: OK. All right. I think you may have addressed this in your opening, but if not, I think the point of like, your bill and mine and Senator Jacobson's and others, they're trying to address this problem is-- if, if the problem gets fixed and this actually works, then we don't need these anymore. You know what I mean? So we talk about fiscal notes and this other kind of stuff, but if we actually address the problem, these bills, we won't need them anymore. Right. And so I think that's one, kind of--

WALZ: Yeah.

HANSEN: --silver lining to look at I think, with all these bills, is that's the goal is to actually address the problem here, hopefully, and fix it, so then, then we're not paying for all these--

WALZ: Right.

HANSEN: --you know, the, the problem in the first place. So that's kind of one of the goals here so.

WALZ: Absolutely.

HANSEN: OK. All right. Well, you'll stay close, I'm assuming?

WALZ: Sure.

HANSEN: OK. I got to run off. OK. We'll take our first testifier in support.

SUZANNE NUSS: So Dr. Vail and I did a coin toss, coin toss. And it's my turn to go first this time. So good afternoon, almost good evening, Chairman Hansen and members of the Health and Human Services Committee. I am Dr. Suzanne Nuss, S-u-z-a-n-n-e N-u-s-s, chief nursing officer for Nebraska Medicine. and I described my facility at my previous testimony. Every day that a medically stable, ready to discharge patient remains in our hospital is called an avoidable day. Our health system absorbs the cost of avoidable days, as we are generally reimbursed a set amount based on diagnosis and complexity, not based on length of stay. Our health system experiences an estimated 27,000 avoidable days at a cost of about $24 million per year and our number of avoidable days is rising. Of the 77 patients that are in our hospital ready to discharge, 40 of them are considered complex discharge patients. These patients with complex health needs often have multiple barriers that result in extended lengths of stay. The average length of stay at Nebraska Medicine for a complex

discharge patient over the past two years has been 167 days. Many of our complex discharge patients have multiple health needs that require post-acute facilities to have specifically trained staff and special medical equipment. As our average daily census rises due to the increased length of stay, our stretched capacity limits the care that we can provide to patients who need us. As the state's tertiary, quaternary academic medical center, there are some services that Nebraska medicine is uniquely suited to provide, including treating certain types of emergencies, cancer care and organ transplants. Our data shows the inverse relationship between our average daily census over the past three years and the average numbers of transfers that we are able to accept from facilities across the state, from an average of approximately 14 patient days per day-- patient transfers per day down to 8.9 in December of 2022. Annual avoidable days equates to approximately 3,900 patients whose care is delayed or denied because of the barriers to efficient post-acute transitions. We're also seeing a backup in our emergency department, with patients waiting significantly longer to be admitted to inpatient beds. Over the past two years, we have seen a 28 percent increase in the hours in which our patients are waiting in the emergency department, which carries a potential safety and privacy risk for patients. LB517 is specifically targeted toward ensuring capacity at our hospitals that provide the highest levels of care. When a patient in a rural area has a stroke or a serious heart attack or other life-threatening health event, we need our larger hospitals like Nebraska Medicine to have beds available to provide specialized and comprehensive care. This bill and the amendment are highly targeted in a few ways. First, the additional financial resources to be provided to post-acute facilities as incentives to accept a patient transfer only apply to patients transferring from our larger hospitals. While our hospitals are struggling with post care transitions, LB517 is targeted at ensuring capacity in our largest hospitals that offer the highest level of care. Secondly, the incentives for post-acute facilities in LB517 only kick in when capacity at these larger hospitals is becoming strained at 80 percent capacity or greater, as reflected in the amendment. It's not available for all transfers from larger hospitals all the time. Finally, the additional financial resources for post-acute facilities under B517 are only available for patients with complex health needs. In this way, this bill is targeted toward the most difficult to place patients. I want to be clear that there's nothing in this legislation that would require any facility to accept a patient. The funding in this legislation is purely intended to offer additional resources for facilities to choose to-- that choose to accept patients with complex

health needs. The amendment requires DHHS to work with stakeholders to set the details regarding the implementation of this process, to determine the process by which to determine and monitor capacity, to define the criteria for complex health needs and any scenarios under which recoupment would be appropriate. This post-acute transition issue is multifaceted, as we've heard all day today and there is not one policy that will solve it. The appeal of this proposal is that it provides a targeted financial incentive to post-acute facilities to care for patients that are the most difficult to place, specifically at a time when hospital capacity is being stretched thin. We thank Senator Walz for her introduction of this concept and we look forward to working with this committee to help our health system address these challenges for our patients, for our hospitals, and for our post-acute facilities across the state. Thank you for your consideration. I'd be happy to answer questions. I actually do have an answer for Dr. Riepe. It's not just Medicaid patients, it's all patients, in case that's helpful.

HANSEN: Because all you said, all patients?

SUZANNE NUSS: It's all patients, right? It's all patients. OK.

HANSEN: So any questions from the committee? Sorry.

BALLARD: I do have a question, Chairman.

HANSEN: All right. Our committee has a question.

BALLARD: Yeah. Big question.

HANSEN: Yes, Senator Ballard.

BALLARD: Thank you. Thank you. You talked about rural areas. Can you talk about the problem in rural Nebraska, especially dealing with the long term? I know Nebraska Medicine in Omaha, you're-- it's going to be a little different, but I-- can you kind of shed a light on it?

SUZANNE NUSS: Well, my understanding, having not worked there. But my understanding from hearing from my colleagues in the rural areas is that they are having the same workforce challenges that we are. So some have actually closed. But the bigger problem is that because we don't have capacity, they are having to hold on to patients or they are having to make numerous phone calls to other systems to see who can take the patients that require a higher level of care. And so we feel bad for that because we like that pipeline and we like to be able

to help to offload rural areas so that we can take the more complex patients. But when we're stuck, not to be crude, we've been calling it constipated. We-- I mean, our system is constipated. We can't get it-- we can't get people out. So. Does that answer your question?

BALLARD: OK. It does. It does. So thank you.

SUZANNE NUSS: You're welcome.

HANSEN: All right. Good. Well, hopefully this collective amount of bills will be the Metamucil for your company. That's going to be great on the transcripts. [LAUGHTER].

SUZANNE NUSS: You know what? It's the end of the day on a Friday. We have to laugh, don't we?

HANSEN: It's been a long week.

SUZANNE NUSS: Sorry. Yeah.

HANSEN: I do have a question. Have you looked at the fiscal note at all?

SUZANNE NUSS: Briefly.

HANSEN: Because they, they do give, like, a report. I think it's the Department, gave a report of the amount of patients that they recorded over 90 percent and 95-100 percent. And in the first month of 2022, you know, you're looking at 30 the first month, then 20, then 18, then 2022. And then look at the last four months, which is October, November, December, and then January of this year, it's like 102, 4,962, 53. Why the big jump all of a sudden? Do you know? Within the last four months it went from like 30 to like 102?

SUZANNE NUSS: I don't know for certain.

HANSEN: Yeah. Just

SUZANNE NUSS: I wouldn't want to-- I wouldn't-- I'd rather investigate before giving you an answer.

HANSEN: Yeah. That's fine. I just figured it'd be higher, I don't know, maybe with COVID or something like that, earlier, but now it's later. Just wondering. OK. Well, seeing no other questions, thank you.

SUZANNE NUSS: Thank you.

HANSEN: We'll take the next testifier in support.

LISA VAIL: Good afternoon. Chairman Hansen and members of the Health and Human Services Committee. I am still Dr. Lisa Vail, the vice president of Patient Care Services and system chief nursing officer at Bryan Health. I come to you today on behalf of the Nebraska Hospital Association in support of LB517. At any given point in time, there are approximately 50 patients effectively stuck in one of the Bryan hospitals due to a myriad of complexities. They no longer have medical necessity for acute services, but require a level of care beyond what they could provide for themselves or what a home health aide might be able to assist them with. In 2022, our complex case care team reviewed cases of 975 patients that had identified barriers to discharging from the hospital. These barriers include guardianship, payor source, behavioral health needs, bariatric body habitus and dialysis, to name a few. These barriers result in days, weeks and even months in the hospital beyond what is medically necessary. For Brian Medical Center, this resulted in 4,061 avoidable days. If the average length of stay for a patient is about four days, that's over a thousand additional tertiary-level care patients we could have-- that could have been admitted to Bryan Medical Center alone. When a patient needs a higher level of care at one of Nebraska's tertiary care centers and we have patients with excessive lengths of stay, it reduces access to needed services for those acutely ill. LB517 will help hospitals create capacity by incentivizing post-acute facilities to take these complex patients at times of high volume, reducing that traffic jam that stretches across the state when a patient in Scottsbluff, Albion, Valentine, you pick the town, needs a higher level of care than can-- that can be provided in their community hospital. Will the challenge of complex patient placement be solved by LB517? No, it will not. It will take approaching this issue from a variety of angles to completely solve the crisis. LB517 is one step toward building capacity in our hospitals for the patients that are most acutely ill. Over the last year, we have worked closely with our colleagues at the Nebraska Health Care Association to find mutually beneficial solutions and remove barriers to establish a smoother operating system for patients, as they navigate the continuum of care. We hope to continue this collaborative work. I'm grateful for the opportunity to share the challenges faced by patients not only at Bryan, but across the state of Nebraska. Barriers to post-acute placement impact every Nebraskan who needs medical care, from critical access to large urban medical centers. LB517 is one of several solutions that will ease capacity for our hospitals and most importantly, get every patient to the level of

care that is most appropriate for them. As you have heard from myself and others today, I ask that you be moved to take action in support of LB517. I thank you for your time and I would welcome any questions you might have.

HANSEN: Thank you. Are there any questions from the committee? All right. Seeing none, thank you.

LISA VAIL: Thank you very much for your time.

HANSEN: We'll take our next testifier in support. OK. Seeing no one else wanting to testify, is there somebody wanting to testify in opposition? In, in the neutral capacity?

KEVIN BAGLEY: I-- I'm going to testify in opposition, but I will, I will be happy to explain where that comes from.

HANSEN: We'll take, we'll take the testifier in opposition.

KEVIN BAGLEY: Thank you.

KEVIN BAGLEY: Please? It will be OK, I promise. I'm always in the, always in the bad seats. [INAUDIBLE] one day, I'm going to come in support of something. Good evening, I think, at this point, Chairman Hansen, members of the committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director for the Division of Medicaid Long-Term Care at DHHS. I will note that while I am, I am here as the Medicaid director, I'm also here on behalf of the Department, as this won't just affect Medicaid patients. I'm here to testify in opposition to the current draft of LB517, which would require DHHS to pay discharge incentives to post-acute placement facilities. I would first like to thank Senator Walz for the opportunity to meet with her and other stakeholders and discuss the bill, as well as some of the Department's concerns. The reality is that there are patients in hospitals who need a safe place to discharge, as we've heard quite a bit today. And the Department is committed to working with our hospitals, nursing facilities and other stakeholders to find systemic and person-centered solutions to the problem. We feel it's unlikely that LB517 will address the underlying issues that we've noted today. As I've met with hospitals, nursing homes and other stakeholders around the state and as we've talked about here, this is a multifaceted and complicated problem. Generally, nursing facilities have every incentive to admit new patients and a decision to deny an admission typically takes one of the following forms: the nursing facility doesn't have adequate

staffing to take new patients regardless of complexity; the nursing facility is not equipped to meet the unique needs of the patient. These patients may require specific equipment, such as bariatric or other specialty beds, that can cost tens of thousands of dollars to procure. Or somewhat relatedly, the nursing facility believes they cannot safely serve the patient, who in many cases, presents with behavioral health com-- behaviorally complex issues, sometimes even including a history of violence. While this isn't an exhaustive list, these are, these are three of the primary concerns that, that I've seen in discussions that I've had with hospitals and nursing homes. When nursing facilities take on these difficult clients, they expose themselves to significant risk. Federal regulations make it incredibly difficult to discharge clients once they're admitted. Additionally, in cases where a resident assaults a staff member or another resident, the facility would potentially become subject to certification findings, civil money penalties and other issues. Given these complicating factors, it seems unlikely that this incentive would substantially impact the underlying issue. As written, LB517 will require hospitals to notify DHHS if capacity reaches or exceeds 90 percent, though the proposed amendment would adjust that threshold to 80 percent. Upon discharge of a complex patient for a hospital that exceeds that capacity threshold, the bill requires the Department to pay a discharge incentive to a post-acute facility accepting the patient. Our existing data suggests that hospitals regularly exceed these thresholds in any given month. DHHS's data systems and payment processes do not currently meet the requirements in order to be compliant with LB517. Should the bill proceed, our payment system would have to be replaced with a more automated system in order to make the required discharge payments. And we would need to procure a system that would allow us to do more management of real time notification from hospitals of admit, discharge and transfer data. The reality is that every case in which hospitals struggle to safely discharge a patient has its own complexities. While the proposed amendment does give the Department the latitude for defining a patient with complex health needs, it will be difficult to appropriately define the criteria. Finally, and, and this is really, I think, the, the primary concern we have and why we're here in opposition, the bill does not establish a ceiling for the total payments that would be made in a year. While we've tried to work out an estimate and, and make that as accurate as possible, the likely outcome for these payments if the number of incentive payments exceed appropriated amounts, the Department would be obligated to continue making those payments

whether or not we had that allocated in our budget. So thank you for the opportunity to testify today. I'm happy to answer any questions.

HANSEN: OK. Are there any questions from the committee? OK. So you mentioned the need for a ceiling and you're talking about like-- are you talking about a dollar amount or more like the amount of patients?

KEVIN BAGLEY: Well, I would say--

HANSEN: They're both kind of the same, you know.

KEVIN BAGLEY: --they're both largely the same. The, the reality for us is absent a ceiling on the amount of money available through these-- for these payments, it would put the Department in a position where whether or not we have the appropriation, we would have an obligation to make the payments.

HANSEN: That makes sense. Do you, do you see the potential-- now I'm not saying it's going to happen, but could there be a potential for abuse with any of this?

KEVIN BAGLEY: I, I think it would put the Department in the position to ensure that we needed to have some accountability on these. We would have to write some rules around that. There's always the potential for that, but I think that would be incumbent upon us to ensure there was appropriate accountability in place.

HANSEN: OK. And can you speak to the fiscal note? I just had-- like, like the-- you're, you're looking to, to hire two employees?

KEVIN BAGLEY: Yeah. And that largely has to do with the kind of administration of these payments. It would function a little bit like a grant--

HANSEN: OK.

KEVIN BAGLEY: --although not quite in the same way. And so those two staff are-- we feel relatively confident about the need for additional staffing to administer these payments. They're not specific to Medicaid. The real large question, I think, is how many of the payments would be made. And, and while I mentioned in my comments, I'm not sure that, that this will address the underlying issue. I would love for the underlying issue to be addressed and if this doesn't, we could potentially have a lot of payments that we'd be making. And I think that's where the, the largest concern for us lies.

HANSEN: Yeah. I think this seems like, like-- I don't know. It is a multifaceted problem. This seems like a cog in the wheel right, like the-- one of the things that can kind of help fix it. Because I think we are hoping the money then, that'll go to the long-term care facility to maybe hire new staff. You know what I mean-- or to-- well, do those other things that we're missing or fix some other infrastructure to take some of those bigger patients. So it's-- at least that's what we're hoping for anyway. So.

KEVIN BAGLEY: Certainly. And so I want to make sure I'm, I'm clear with the committee and Senator Waltz, with you, as well. I-- it's not that we have an opposition to trying to solve the problem.

HANSEN: Yeah. Cool. Just making sure no questions. OK. All right. Thank you very much. Anybody else wishing to testify in opposition LB517? OK. Is there anybody wishing to testify in a neutral capacity? All right. Seeing none, Senator Walz, you're welcome to close.

WALZ: All right.

HANSEN: And with that, we did have one letter for the record in support of LB517 from Nebraska Association of Home Healthcare and Hospice.

WALZ: All right. First of all, Senator Riepe, I was zero for two on your questions. It does include not only Medicaid, but all patients. Correct.

RIEPE: Thank you.

WALZ: And it was not the Hospital Association. It was Nebraska Med.

RIEPE: Oh, OK.

WALZ: OK.

RIEPE: OK. Thank you for [INAUDIBLE]..

WALZ: So sorry about that.

RIEPE: [INAUDIBLE].

WALZ: Well, thank you to all who came to testify on LB517 and really, to everybody who came to testify on all the bills that we heard today. It's really an important or it's really important to keep in mind that

this bill obviously is not the silver bullet, as we talked, it is a very multifaceted issue. And Director Bagley and I, as well as others, had a really good conversation about that yesterday or two days ago. I don't remember what day it was. We have, as a committee, have heard several bills and we will be hearing more bills that address the quality of life and access to care for Nebraskans. I think that when we're discussing these issues, we need to be thinking of the whole picture. We should be thinking of creative solutions brought to us by the experts that are looking to address these very real issues. And I think it's really important to remember that we have the opportunity to do something really special this session and create a thoughtful package of legislation that creates access to the problems we have with our healthcare and providing quality healthcare to Nebraskans. So with that, I try to answer any other questions that you might have.

HANSEN: OK. Are there any questions from the committee? All right. Seeing none, thank you very much.

WALZ: Thank you, Senator.

HANSEN: And that will close the hearing for LB517 and that will close the hearing for today. Christina, whenever you get the-- are we going?