FREDRICKSON: All right. Welcome to the Health and Human Services Committee. I'm Senator John Fredrickson, representing Legislative District 20, and I serve as vice chair of the committee. The committee will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table in the back of the room. Please be sure to print clearly and fill it out completely. Please move to the front row and be ready to testify. When it is your turn to come forward, give the green testifier sheet to the page. If you do not wish to testify, but would like to indicate your position on a bill, there are also yellow sign-in sheets on the back-- back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name and spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally by, by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We will be using a 3-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have 1 minute remaining, and the red light will indicate that you need to wrap up your final thoughts and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It is just part of the process, as senators may have bills to introduce in other committees. A few final items to facilitate today's hearing. If you have any handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that only written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included

on the committee statement. I will now have the committee members with us today introduce themselves, starting on my far left.

RIEPE: Thank you, Chairman. Merv Riepe. I represent southwest Omaha and a fine little town of Ralston, so that's District 12.

HARDIN: Brian Hardin, District 48, the real west: Banner, Kimble, Scotts Bluff County.

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

QUICK: Dan Quick, District 35, Grand Island.

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

FREDRICKSON: Also assisting the committee today, to my left is our legal counsel, John Duggar. And to my far left is our committee clerk, Barb Dorn. Our pages, pages for the committee today are Sydney Cochran and Tate Smith, both students at UNL. Today's agenda is posted outside the hearing room. With that, we will begin today's hearing with LB655 and I will turn it over to our chair.

HARDIN: Welcome.

MURMAN: Well, good afternoon, Chair Hardin and members of the Health and Human Services Committee. I'm Senator Dave Murman from District 38, and that's D-a-v-e M-u-r-m-a-n. Today, I have the privilege to introduce LB655, which establishes and protects the right of conscience of our health care providers and payors. The goal here is simple: We live in a free society made up with diverse cultures, faiths, and values. This is a great thing and we can learn from our differences. But the medical field and medical professionals are no different. And with these differences comes the need to protect our professionals' individual beliefs. So why is this needed? A 2019 Christian Medical Association poll of religious health professionals reported that 23% felt they had been discriminated against in the workplace or training because of moral or religious beliefs. The same poll found that 32% felt that they had been pressured, forced, or punished to participate in a training, perform a procedure, or write a prescription to which they had moral, ethical, or religious objections. And, most alarmingly, in a state where we are struggling to find enough medical professionals, 20% decided not to pursue a career in a particular medical specialty because of attitudes

prevalent in that specialty that are not considered tolerant of their medical, ethical, or religious beliefs. This bill seeks to protect those professionals. In Section 3, it describes that a health care provider or payor may opt out of participating in a health care service due to a conscience-based objection. They must provide written notices of the objection and inform patients of that objection to a service before scheduling. Let me be clear, very clear, the conscience-based objections protected in this bill are objections to services, not patients. While a provider would absolutely have the right to object to participating in a specific service based on conscience, they would absolutely not be able-- be allowed to refuse patients based on their characteristics or lifestyle choices. For example, some concerned constituents reached out to me with the example that a provider who made-- who may object to divorce may deny divorced patients treatment. That would absolutely not be allowed under this bill. This bill is about objections to specific services, not patients. This bill also contains exceptions for emergency medical treatment and remains fully compliant with federal law, such as the Emergency Medical Treatment and Active Labor Act. Likewise, medical payors could not object to covering a procedure they are contractually obligated to cover. For example, if an employer is a small business that has a conscientious objection, they would want to choose a health plan from an insurer that does not have these objections. They cannot suddenly revoke access as that would be unfair. I have had some conversations with Blue Cross Blue Shield about an amendment to clarify some of the legal responsibilities that would be involved with this. But that amendment is still in drafting. I will get that to the committee once that piece is worked out. Finally, to ensure our providers are protected, those that are aggrieved by a violation of this bill could file a complaint with the Attorney General. They could also file if a provider faced adverse action for reporting a violation of this bill, or speaking out against a medical service. It is important to note that this is not a radical idea. In fact, several states including Montana, Florida, Ohio, Arkansas, Mississippi, and Illinois all have substantially similar laws on their books. The Illinois law has even been in effect since 1977. While opponents may claim this bill would flood the state with lawsuits, that has not been the case in these states. Furthermore, because this bill leaves the civil action to the Attorney General, we can expect that if a civil action were to be brought, it had been reviewed and vetted before seeing any legal action. Opponents will likely tell you that this bill is a green light to discriminate. What they will not tell you is where in the actual language of this bill allows that discrimination,

because such language does not exist. Both this bill and federal law are very clear that discrimination based on characteristics is illegal. Declining to participate in a specific service is absolutely not the same thing as declining all treatments available to a patient and their comprehensive care. Opponents may tell you that this is even unconstitutional. I would simply ask if it is unconstitutional, why have several states had the law on the books for years or even decades, and it hasn't been struck down? Opponents may also tell you that this will lower access to medical care and push providers out of the industry. But let's go back to that survey data. If 20% of medical providers reported they will not pursue a specialty because of concerns their conscience would not be protected, that in itself creates a big limitation of access to care. At the end of the day, LB655 is about protecting rights of providers. Medical professionals should never have to provide-- should never have to choose between their conscience and their career. I'll conclude by reading a passage from the American Medical Association's Code of Ethics stating, and I quote, Preserving the opportunity for physicians to act in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession, as well as the integrity of the individual physician on which patients and the public rely. Thus, physicians should have considerable latitude to practice in accord with their well considered, deeply held beliefs that are central to their self identities. And I unquote. I'd be happy to take questions, but there are professionals behind me that may be able to more completely answer your specific questions.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Murman, for, for being here and for your opening here. So can you, can you walk me a little bit through how, how this-- I know you mentioned a few other states have this in practice. So what does this actually look like in practice when it's-- once it's passed in those states?

MURMAN: Well, I think I walked through it pretty good. But say someone would call a doctor and want to have a proce-- a specific procedure done by that doctor, the doctor would have to let them know, let the caller know that the doctor doesn't provide that service if it goes against their deeply held conscience.

FREDRICKSON: OK. Yeah, no, I, I, I appreciate you adding that, because one of my concerns was if someone scheduled an appointment, maybe

travel the distance to see a provider then shows up only to find out that the-- so that-- I think that's--

MURMAN: Yeah, that's covered.

FREDRICKSON: --an important part of the bill.

MURMAN: Yeah.

FREDRICKSON: Are you aware-- are, are there any instances that you're aware of in the state of Nebraska where a provider has been sanctioned for refusing to provide care?

MURMAN: I, I have heard of instances, and there may be some people behind me that can give some examples.

FREDRICKSON: OK. OK. My, my other question was, so if, if a provider has a deeply held belief or a, a, a sincerely held moral belief, for example, that a person should have access to abortion care past a 12-week period, for example, this bill, would that protect them to allow to practice that way and opt out of the rules and regulations?

MURMAN: The doctor, if abortion would go against their right of conscience and religious beliefs, they would be obligated to tell the-- you said someone called in again, was that what it is? They'd be obligated to let them know they would provide--

FREDRICKSON: Well, the, the question was almost sort of the reverse of that, right?

MURMAN: OK.

FREDRICKSON: So currently we have promulgated rules and regulations from DHHS based on LB574 that limits access to an abortion past, for example, 12 weeks, or access to gender-affirming care. You might have a provider in the state who has deeply held beliefs that patients should have access to those things. And so in, in those cases, those providers would be able to opt out of the rules to provide that care even though we have a bill in place or a law in place, I should say, that restricts it?

MURMAN: No, this, this bill doesn't change any laws that are on the books now.

FREDRICKSON: Right. But, but it allows providers to provide care based on deeply held beliefs?

MURMAN: No, it only restricts providers from-- they'd be allowed to not provide care.

FREDRICKSON: So it's opt-- strictly opting out.

MURMAN: It doesn't force them to provide care. Yeah.

FREDRICKSON: OK. OK. My other question is, you, you mentioned that it protects patients and it sort of is specific to procedures per se. I don't know if you have a copy of the bill in front of you, but on page-- I think you're referring to page 4, lines 11-12. It says: allow a health care provider or payor to opt out of providing health care services to any patient or potential patient based on the patient or potential patient's race, color, religion, sex, or national origin. Is, is there a reason that sexual orientation or gender identity is not included in that?

MURMAN: No, I didn't even notice that, that, that terminology was not included here. But all federal laws would apply.

FREDRICKSON: OK.

MURMAN: So I'm not sure exactly what the federal law says, but--

FREDRICKSON: OK. So would--

MURMAN: --that would still apply.

FREDRICKSON: --would you be open to including those?

MURMAN: I'd sure look at it.

FREDRICKSON: OK. Great. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, Senator, for being here. I guess my first question is, do you know of any firsthand situations where someone has been forced in a nonemergency thing to provide something that would object to their moral conscience?

MURMAN: No, this bill wouldn't force a provider to provide anything. It only allows a provider to not provide a specific service.

RIEPE: But it seems-- and, you know, having spent 40 years between Bergen and Children's-- in my 40 years in the business, I've never known in one situation in 40 years where we demanded someone perform something that they were objection-- objective to or objecting to, regardless of what it was.

MURMAN: No.

RIEPE: We just didn't do that. Now, when I come back around to my emergency thing is, you know, sometimes you might have an emergency and a hemorrhaging. I don't know what the other parts of the condition might be, but you've got to have them step in. And I think also when people go into, like, say, nursing, my experience is that nursing is either-- nurses either want to become an emergency nurse or an-- and but they might avoid maternal and infant care just because of the more, you know, reproductive pieces and the concerns there. But they choose, we never, we never ever once forced anyone to, to do anything that they really didn't want to do.

MURMAN: Well, of course, with an emergency situation, the provider is-- needs to provide the care. And that's covered in this bill and in federal law. As far as has it ever happened, well, where you were employed apparently did a really good job of, you know, all the guidelines with this bill. So this bill wouldn't affect--

RIEPE: But to find out--

MURMAN: --as long as everybody knew ahead of time, you know, what they could and couldn't-- what they couldn't do. Sounds like you had that covered. So that's great.

RIEPE: Well, and I made some calls, too, because I know a number of other current CEOs or thereabouts, and none of them-- and their concern is it becomes a staffing problem of trying to say who might-- it's one more equation to put into the staffing requirement, and I just hope it's not a problem that's really not there, maybe not there, particularly, with Nebraska culture.

MURMAN: Well--

RIEPE: Now, it might happen in New York City, I don't know, and I don't-- we're not there.

MURMAN: I have heard of situations where it has happened, I guess more probably with medical schools, but-- and, and, you know, a lot of my

incentive for bringing this bill was so that medical care wouldn't be limited because of a potential medical student's religious or deeply held conscientious beliefs. And, and it helps the patient, too, to know that-- it's, it's important for a patient to know that they are going to a doctor or provider that has the same beliefs that they do, so that's another positive about the bill.

RIEPE: I assume they would do that at the time when they're selecting, or if they get a chance to choose or select their physician. You don't get to choose your anesthesiologist, oftentimes, but that's a different case. Thank you very much. Thanks for being here. I know you feel strongly about this and I respect that.

MURMAN: Thank you.

HARDIN: Other questions?

HANSEN: I got some.

HARDIN: Senator Hansen.

HANSEN: Thank you. I think Senator Fredrickson makes a good point about looking at the constitutionally protected classes. They're on that page 4, just make sure that it is constitutional, because I think that's where we might run into an issue legally. Piggybacking on what Senator Riepe was asking you, but just kind of the opposite way, does this bill now provide an avenue for providers to object to care where they were not able to before because they're going to get fired? So he says he's never heard of anybody in a hospital-- we never had to force anybody. Well, of course not, because they're gonna get fired if they do. So no one's going to object to it, right? You know. So now, if they know they have this protection in place, I don't think it's gonna happen very often, honestly. But there may be an instance because of religious reasons or who knows what, somebody says I, too-- I, I have a religious issue with performing this kind of procedure. Now they have an avenue to say I object to it, whereas before they never did before. Well, I can see where that's never really happened very often before. So I think a better question to ask-- and I don't even know the answer to it, maybe you don't either, is in the states that have passed this, have there been instances of providers saying they, they object to certain procedures because of various reasons that are included in your bill? Do you know that answer at all?

MURMAN: No, I don't. Maybe someone behind me may.

HANSEN: Somebody might.

MURMAN: But, no, I don't know the specific answer to that. I do know that the employee has to let the employer know what-- you know, if there are procedures that they would object to.

HANSEN: Ahead of time.

MURMAN: Yeah, ahead of time. Yeah.

HANSEN: OK. I think that's important. OK. Thanks.

HARDIN: Other questions? Will you stick around?

MURMAN: Yes, I will.

HARDIN: Wonderful. Proponents, LB655? Welcome.

PAUL ESPOSITO: Thank you, sir. Thank you, Senators, for the opportunity to be here in support of LB655. I'm a pediatric orthopedic surgeon and I have had many leadership roles in hospitals prior to administration, surgeon in chief, and have recently had a lot of interaction with medical students because that's what I've done throughout my career is mentor medical students and resident physicians and other health care providers. I, I think the world has changed dramatically in terms of the challenges they're facing. And I think that there's a lot of subtle bullying that's going on in the world. I've been personally called a number of different names for stances I've taken on things I object to, which I'm a big boy, I can take that, but I think--

HARDIN: Can, can we have you spell your name--

PAUL ESPOSITO: My apologies.

HARDIN: --real quick, sir?

PAUL ESPOSITO: Paul, P-a-u-l, E-s-p-o-s-i-t-o.

HARDIN: Thanks.

PAUL ESPOSITO: So the science of medicine is expanding and accelerating at an unbelievable rate, medical knowledge doubles in just a matter of months, not decades now. Societal changes are changing, too, without full consideration of all the ethical and moral issues. The issues my medical colleagues, nurses, pharmacists, and

other health care providers and students are facing, such as increasing numbers of medical abortions, with now 80% of them being medical. So these could be done on the side without anyone else being even aware and people can be participating without knowing they're participating. I would never have anticipated that as health care providers taking an oath to always protect the health and well-being of the patients entrusted to us, that we'd be asked to support egregious procedures, like removing a perfectly functional organ in children or asked to remove a normal extremity for list-- limb dystorpia-- dystopia-- dysphoria. I'm sorry. So things are happening, they're changing. Assisted suicide, euthanasia is a movement that's moving along around the country. So we're not facing that now, so we can't respond to it, we haven't seen that happen yet. But it's coming. It's in other countries, others-- it's in Canada. It's in the northwest of our country. But I believe this bill is necessary to protect health care providers, including students, so they can't be forced to practice in a manner incompatible with their moral, ethical, and religious convictions. I also think by having rules in place, it simplifies things for hospital administrators saying this is the mechanism we do. It's OK for you to object. It allows for hospitals to staff appropriately if they find they have a number of people that disagree with one particular procedure. But I think that by being complicit with care they believe immoral or unethical, whether they are forced to do that or feel forced to do that, contributes greatly to professional dissatisfaction and burnout, leading to the loss of precious health care providers from our already underserved state. I think it's vital to have this clearly defined conscience protection for all health care providers, especially students that are being told they can't go into specific professions if they don't do specific procedures. And is this something that's in writing? No, it's always subtle and on the side. This will increase the retention and recruitment of health care providers and improve the overall access and quality of care in our state. And thank you very much for your consideration.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Dr. Esposito,--

PAUL ESPOSITO: Yes, sir.

FREDRICKSON: --for being here and for your willingness to testify. A couple questions about some things you, you brought up. I think you mentioned medically assisted suicide and, and abortion specifically.

PAUL ESPOSITO: Yes.

FREDRICKSON: So, so my, my understanding is-- so for non-emergency abortions are only provided at two clinics in the state of Nebraska.

PAUL ESPOSITO: Legally, yes.

FREDRICKSON: So I guess my question is my understanding from the introducer's opening was that emergency medical care would be exempt in this bill.

PAUL ESPOSITO: Absolutely, in every case.

FREDRICKSON: So do you think there are providers who are opposed to providing nonemergency abortions working at an abortion clinic?

PAUL ESPOSITO: No, not at an abortion clinic, sir. My, my concern is more that I think as things are changing, we have to be ready to say what are the rules to help protect these people if these things do come up. Obviously, abortion is not there now illegally. And I'm sorry I didn't follow the other part of the question, sir.

FREDRICKSON: Yeah, I, yeah, I, I guess I was just trying to make the connection between-- I was trying to find a situation or understand a situation where a provider was being forced to perform a nonemergency abortion. That was-- I, I was trying to hope that you could thread that needle a bit for me.

PAUL ESPOSITO: No, I think any emergency care is emergency care, and every physician is-- we're obligated to provide that care.

FREDRICKSON: OK.

PAUL ESPOSITO: But for in terms of elective abortions, no, that's not an issue at this point.

FREDRICKSON: OK. OK. And then the, the medically assisted suicide part, you know that that's not currently legal in, in our state.

PAUL ESPOSITO: Correct.

FREDRICKSON: OK. Great. Thank you.

HARDIN: Other questions? Senator Meyer.

MEYER: Thank you, Mr. Chairman. So my understanding is this clarifies policy prior to an issue coming up. So it's clarification and essentially codification of policy so that if an issue does come up, everybody understands exactly what the limitations are so there can be no misunderstanding as far as providing care. I guess that's, that's my layman's portion of looking at this, so essentially it is establishing policy. From my experience, if you don't have a policy written and/or very, very clear policy, problems can arise. So I take this as a clarification of policy for medical facilities so everybody knows what the guardrails are with providing policy whether it's the provider or the institution. Is that an oversimplification or is that a total misunderstanding of what, of what this does?

PAUL ESPOSITO: No, sir. I think this is a basic setting the ground rules for every institution, because right now every institution has a policy. And as Senator Riepe said, when we worked at Children's, there's a policy there and how to address this. It's very similar to this, but not every facility has that.

MEYER: OK. Thank you.

PAUL ESPOSITO: Yes, sir.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you.

PAUL ESPOSITO: Yes, sir.

RIEPE: Good to see you again,--

PAUL ESPOSITO: You too.

RIEPE: --Dr. Esposito. You're a great man. Do you know if Creighton University is a Jesuit school? Do they have a specific policy that would accommodate anyone that might have an objection to some because they're in the surgical business and, and medical as well?

PAUL ESPOSITO: I don't know what their policy is. Sorry.

RIEPE: OK. I was just curious. OK. Thank you.

PAUL ESPOSITO: I was in the other university all my career.

RIEPE: OK. Good to you. God bless.

PAUL ESPOSITO: Thank you, sir.

HARDIN: Other questions? Seeing none, thank you.

PAUL ESPOSITO: Thank you.

HARDIN: Proponents, LB655? Welcome.

CAROLYN MANHART: Thank you. Dear Chairman Hardin 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. I'm a general internal medicine physician providing primary care for adults for over 24 years in Nebraska. I chose internal medicine for my vocation after shadowing an internal medicine physician in high school. I immediately sensed the special bond between Dr. Jackson [PHONETIC] and his patients. A bond based on trust and mutual respect. I'm here to urge you to support LB655 to ensure that physicians, medical professionals, and medical professional students can be protected as they use their good judgment to serve their patients in this most important physician-patient relationship. A physician who will do whatever the patient asks is not a good physician, but simply a vending machine or a salesman. When you ask your doctor for an antibiotic that might cause more harm than good, wouldn't you expect him to say no? But let's be frank, the types of medical treatments that physicians need the right to refuse are more serious than an antibiotic. The treatments that patients request that I decline mostly fall in the area of sexuality. From what I learned in anatomy and physiology, I believe that the body, in all of its order and detail, was created good. The body is to be respected and not made unhealthy through sterilization or through medications or surgeries that cause it to malfunction. When I shared with a long-time transgender patient that I did not believe cross-sex hormones were safe or healthy and would not prescribe them, my patient did not demand them from me. Instead, after deliberation, she continued to see me as her primary care physician and went elsewhere for hormonal treatment. This is how mutual respect plays out in the doctor-patient relationship. Senators, imagine for a moment that you were forced to carry a bill that stated that children above the age of 10 could purchase cigarettes and alcohol. You would be distressed. You may even desire to quit your job as a state senator, so that you wouldn't have to do something you knew was dangerous to children. The ability to live in accord with one's conscience is fundamental for a free society. Many qualified and compassionate young people of faith are being frightened from the noble practice of medicine, because of the concern that they will not be able to follow their consciences. The

reason why more medical students are not here are the very reasons why this bill needs to be passed. They're afraid that in the current culture, publicly testifying for a physician-conscience protection will harm their chances of a competitive residency. I'll just finish my thought, if that's OK?

HARDIN: You're in the red. Keep going.

CAROLYN MANHART: OK. In summary, I'm not forcing my patients to believe what I believe. I'm doing what I believe is best for my patients, and the types of services that I do not provide comprise just a tiny portion of the care that I do provide. Please pass LB655 to ensure that all physicians can continue to be protected in Nebraska without the threat of discrimination, lawsuits, or loss of employment because they've opted out of services they find morally, ethically, or religiously problematic. I want to be able to continue my good care for my patients with my best judgment and with integrity. Thank you very much.

HARDIN: Thank you. Question? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your, for your testimony.

CAROLYN MANHART: Sure.

FREDRICKSON: So I-- actually, I appreciated you sharing kind of that anecdotal experience in your own practice where you and your patient were kind of able to come to an agreement based on your comfort levels or sort of what your beliefs were versus what the patient was, was requesting. And I, I guess my question then is-- so, so you were-- you weren't forced to provide something you didn't want to provide to that patient?

CAROLYN MANHART: No, and I would say I was not forced in that instance. But there have been other instances, I feel like patients are getting bolder,--

FREDRICKSON: Sure.

CAROLYN MANHART: --you know. And so with other requests, I was, I was saying no to the request and the patient threatened to sue me, you know, calling back, please don't, don't impose your values on me. I'm going to lawyer up, all this stuff. So I feel like maybe when I first began practice 24 years ago, this may not have been necessary, but now

the more patients feel, I would just say more brazen, you know, they, they feel like they, because it's legal and it's available and other doctors do prescribe them, that they also should get what they want.

FREDRICKSON: Um-hum. Um-hum.

CAROLYN MANHART: So-- in that situation. And I think that's something that's special to primary care is that we know our patients well and they want to stay with us because they have a relationship with us. And I think it's a relationship that is built on, as I said, mutual respect. You know, I don't think this is good for you. I want to help you, but I don't think this is the right treatment. And if this is in place, it allows physicians to do what we truly believe is in the best interest of the patient. We're not trying to harm the patient. We're trying to help the patient. It's just like a parent, you know, you have to sometimes say no because you don't think it's good for them. And that's what this whole bill is about.

FREDRICKSON: OK. Thank you.

HARDIN: Other questions? Sometimes-- you're not in an academic situation, you're practicing. Correct?

CAROLYN MANHART: Well, I do have medical students and residents that work with me--

HARDIN: OK.

CAROLYN MANHART: --in Creighton. Um-hum.

HARDIN: And so in-- excuse me-- in your interactions with them, have they expressed this pressure that they feel they, they need to answer a certain way or they're being shaped a certain way? Can you comment on that?

CAROLYN MANHART: Sure. I definitely feel that academia is hostile to people of faith, particularly in the field of obstetrics and gynecology. All the attendings assume that students feel a certain way. And so when, when they're teaching the students or even when, you know, Roe v. Wade was overturned, the attendings, majority, not everybody, were up in arms, you know, thinking that all the students are pro-choice. And the students who feel that abortion is not health care felt silenced. And they feel like if they speak up against the attendings that they will receive bad marks. And so I, I think it's a culture in which they feel that speaking out is detrimental to their

future, to their grade, to advancement, to getting a good residency, that they feel like they have, they have to suppress their true concern about what is being offered as health care.

HARDIN: And those residencies are limited. There's a lot of students and maybe not as many places to land.

CAROLYN MANHART: Well, I think there are many residencies, but many of them are-- they're pro-abortion. Almost all ob/gyn residencies are pro-abortion, and so they feel like they, maybe, they shouldn't go into the fields that they were called to go into because they will be discriminated against. And they will be, I guess, they will be ridiculed.

HARDIN: Do you have a sense in terms of how many of those potential opportunities out there for residencies that are available might be available and encouraging of someone with a pro-life stance?

CAROLYN MANHART: In the country, I would say-- well, there are some that are-- that will work with you. And those-- the resident-- the students that I know will apply to those programs, but they may not be the strongest in terms of, like, academic standing. So if they want to be a professor, if they want to be, you know, work up and, and be an academician-- did I say that right-- they, they may not want to go to one of those community programs that are more inviting.

HARDIN: Thank you.

CAROLYN MANHART: Um-hum.

HARDIN: Senator Hansen.

HANSEN: Thank you. We're talking about things being mutually beneficial.

CAROLYN MANHART: Yes.

HANSEN: Do you think this would, do you think this would be mutually beneficial for the provider and the hospital? And I can pose this question to, to somebody else who is maybe an administrator or hospital-- from the Hospital Association, whereas this would decrease the chance of litigation against a hospital, because if they know up front, your ability-- you're saying patients are becoming a little more brazen. I think social media makes a big part of that as well. All it takes is one social media post for a hospital to get destroyed.

CAROLYN MANHART: Right.

HANSEN: Right? And the provider. And so if they know ahead of time maybe which procedures the provider feels uncomfortable doing, so they're not put in that situation in the first place, wouldn't you think that would reduce the chance of a hospital getting sued?

CAROLYN MANHART: Sure, I think so. Yeah. If a nurse or, say, somebody that was involved in a surgery-- was in an emergency situation, had to do something they thought was absolutely wrong, yes, I can see that person, you know, pursuing litigation. I think that a hospital-- if this passed and everybody that worked in the hospital felt the hospital had their backs, I think that would make for a very strong working environment.

HANSEN: Yeah. And I thinking also of getting sued from a patient who felt--

CAROLYN MANHART: Oh, OK.

HANSEN: --in that kind of situation you talked about, right, patients are becoming more brazen, I guess, or there's not that mutual respect maybe where they might be. And then somebody goes on social media and posts about how they were not cared for in a certain way that they felt they should have been. And then all of a sudden that caused it, you know-- that-- you know, that can really hurt a hospital, I think, you know, and not just optically but also the potential for being sued as well. And so if they know ahead of time, the hospital knows ahead of time, we don't want to put that provider in that instance where we may be sued, I would think this bill would-- the hospitals would encourage a bill such as this, because I think it opens up the line of communication between the provider and the hospital maybe more and less likely for litigation.

CAROLYN MANHART: It may be inconvenient for the hospital, initially, but I think, as Dr. Esposito mentioned, having everything in place, having a procedure that is followed makes for a great, mutually respectful environment for everybody. And so there may be some inconveniences, but inconveniences for a great reason. Has anybody seen Hacksaw Ridge? The movie about the Seventh Day Adventist who is a conscientious [INAUDIBLE] in World War II. Anyhow, it was a huge inconvenience for everybody that he didn't want to hold a gun. Everybody, everybody made this, this accommodation for him. And he ended up saving the lives of 75 of his comrades. So people that have a

conscience want to be part of health care. And it might be inconvenient, but it's also for the good of our whole community. It's good for everybody if conscience rights are protected. And it's not something just for health care, but health care-- it's essential in health care.

HANSEN: Thank you.

HARDIN: Other questions? Thank you.

CAROLYN MANHART: Thank you so much.

HARDIN: Proponents, LB655? Welcome.

ALI MAURITSEN: Thank you, Senators. My name is Ali Mauritsen, A-l-i M-a-u-r-i-t-s-e-n. So I plan to start with some, some principles about the importance of moral diversity in medical education and for patient care, as well as talking about some contributions that I've seen that very principled physicians have made to their fields precisely because of their, of their conscientious objection, and why, a few reasons why I think that those are in danger. But I'll leave that to questions if you'd like to know more, because where I would like to go is somewhere I hope it will resonate with you as a former health care executive, Senator Riepe, is institutional integrity because LB655 also protects institutions as a whole as well as health care payors. So a quote from the Blavatnik School of Government from Oxford: Public institutional integrity is the robust disposition of a public institution to legitimately pursue its legitimate purpose to the best of its abilities, consistent with its commitments. So in our case, health care institutions and payors have as their legitimate purpose healing and health. Consistent-- consistency with commitments, then, for example, Catholic health, health care systems have a commitment through the teachings of the Catholic Church, requires a harmony between the stated values and what actually goes on. So the reason I mentioned Catholic health care, in particular, is because that's the training system that I will be trained in. Also, one in every seven patients are cared for in a Catholic health care system in the U.S., so it's, it's a very large portion of the care that is being received. Third, Catholic health care has very explicit public documents of the values that Catholic health care has, and they're called the ethical and religious directives. And these ethical and religious directives make very clear, among many, among other things, what kind of care will and will not be provided at a Catholic institution. So institutional integrity would require that there be some sort of

balance between the [INAUDIBLE], the stated values, and the ability to pursue them. Now, this is jeopardized by the ACGME, which is the accreditation board for residencies, has required-- has switched its requirements for ob/gyn residencies, no longer allows institutions to opt out of, of abortion education. Previously, the institution, like a Catholic institution, could opt out and say, as an institution, this does not align with our values and any residents that would like that training could opt in. Currently, it's now the opposite. Institutions cannot opt out. Individual residents can opt out. So LB655 would provide a framework for protecting institutions like Catholic health care to stay in line with their values and have an institutional integrity that is important.

HARDIN: You're in the red, but can I ask you-- thank you for spelling your name. That's the part I always forget. You're talking about residencies and whatnot, are you a student?

ALI MAURITSEN: Yes.

HARDIN: OK. And where?

ALI MAURITSEN: At Creighton.

HARDIN: At Creighton. OK. Are there any other student testifiers here with you?

ALI MAURITSEN: There are not.

HARDIN: Why not? Do you think that maybe they were afraid of the very issue that this bill is discussing?

ALI MAURITSEN: Frankly, I don't know. But what I do know is that I asked a lot of them their opinions.

HARDIN: And they said?

ALI MAURITSEN: And they didn't, they didn't give me any-- I didn't ask them why they would, would or would not come.

HARDIN: How do they feel about this issue in general?

ALI MAURITSEN: They're-- I'm very blessed to have colleagues that are on both sides of this. We have a very rich showing of moral diversity. And all are concerned about what, what is the effect on, on patient care. Some are concerned about what-- how this would affect access to

both. If conscience is not protected, would access be decreased because providers who are uncomfortable, for example, in a rural setting not being-- that they might be pushed out of a rural setting because of the need for-- to have a referral should they deny care? But also others on the other side are saying this would hurt rural care because, because of the fact that a rural care provider could object to providing services. So those are some of the arguments that both are concerned about, what, what is the effect on, on patients and different-- my-- I have friends who see it, see it on both sides.

HARDIN: Would you ever consider practicing in a rural environment? I'm just curious.

ALI MAURITSEN: I very much would. I grew up in a small town and--

HARDIN: It warms my heart. Other questions? Thanks for being here.

ALI MAURITSEN: My pleasure.

HARDIN: I appreciate it.

ALI MAURITSEN: Thank you.

HARDIN: Thanks. Proponents, LB655?

ELIZABETH HEIDT KOZISEK: I have one copy of my testimony that I can share.

HARDIN: We require push-ups if you only bring one.

ELIZABETH HEIDT KOZISEK: I might fail on that.

HARDIN: It's a-- this is a health committee, so. Well, thank you for being here. They'll get us copies.

ELIZABETH HEIDT KOZISEK: Well, thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. 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 licensed psychologist in the state of Nebraska, where I have served rural Nebraskans through my work in clinical practice and program development for more than 25 years. Protecting conscience rights of physicians and mental health providers is, is good for everyone. And what I would like to express to you today is how it helps support ethical practice. So you may be aware, as members of this committee, that the Ethical Standards for Psychologists by the

American Psychological Association are a condition of licensure in the United States following these ethical guidelines and that they are set forth to protect both the dignity and worth of our individuals we serve, and just access to care for all. And that in the interest of our clients, we're called to this code of conduct, to work within the boundaries of our competence, and to refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to impair our objectivity, our competence, or our effectiveness in performing our functions as psychologists. So bills like LB655 help preserve the ability of psychologists and other mental health professionals to engage in ethical practice. The absence of laws like LB655 place us in a bind when faced with situations that violate our moral beliefs, either risk litigation or loss of employment to practice ethically, or violate our code of ethics and risk harm to our clients or loss of our license. So early in my career, I found myself in the middle of a case where such a bind was a real possibility. I was asked to conduct a cognitive assessment for an individual who was awaiting trial for a crime for which the maximum sentence was the death penalty. And as a young psychologist, deeply rooted in a belief in the life and dignity of every person, I naively took the case without really stopping to think that the results of my assessment of their intellectual functioning would either make them exempt from the death penalty or, or make them eligible for the death penalty. As an ethical practitioner, I accurately assessed, and I reported the results that showed that the individual was not exempt. And then I anguished over what I would do if this individual, this sacred human person, was sentenced to death. A less ethical provider may have been swayed to falsify the results. A more seasoned professional may have recognized the bind, but they may have feared losing their livelihood by refusing the case. I toiled for weeks after knowing that if the individual was sentenced to death, I would be personally compelled to risk my license and my career to engage in a legal and political fight for this individual's life. Left without protection of laws such as LB655, good, upright ethical providers may be forced out of practice in our state, where the vast majority of counties are already designated as mental health professional shortage areas by the Federal Office of Rural Health Policy. Nebraskans need our government to support the ethical health care providers in our state. We cannot tie their hands and further decrease their numbers by failing to support them in ethical practice. LB655 supports the practice of ethical providers. It promotes justice and respect for the

rights and dignity of all who seek care in our state. Thank you for your time.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for, for sharing your testimony. I, I guess my question is, because I was thinking about your experience. And so I'm a licensed mental health provider myself. And I've thought about times in my career where I've maybe received referrals that for whatever reason, whether that was personal beliefs or things along those lines that I would-- I was not the best provider for that individual. In, in cases like that, I've always referred that patient to someone else. So I've been able to sort of say, look, this is not something I'm comfortable doing. I'll provide a referral to a colleague or a peer or someone who maybe has that expertise or who is more willing to do something along those lines. I guess what I'm trying to understand is that option seems-- I'm [INAUDIBLE] how this bill changes that. Like, because it seems to me, like, there's always the option to provide a referral as a clinician or maybe I'm not understanding that.

ELIZABETH HEIDT KOZISEK: There is an option to provide a referral as a clinician. I think individuals that work in agency settings do not always have that option to turn down it-- to turn down a case. I think some of the other protections of this bill that I think are important are just the, the protection for providers to be able to do as I'm doing today, and to, to take a stance regarding legislation they feel is unhealthy or unsafe or not good for, not good for the individuals that they work with. So in the example that I gave, you know, a primary concern for me as I anguished over this case was how would it affect my practice if I did take that political stand or that-- a legal stand to protect this person who I knew as a person, as an individual? What, what impact would that have on me? And so one of the things that I believe that this bill will do is to help give providers that support, that they will not be discriminated against for taking a stand in such a case.

FREDRICKSON: Right. So my understanding is-- so it sounds like your concern would be from, like, a repercussion from your employer, right, like an agency per se. Private employers would still be-- I mean, I'm just thinking the state necessarily-- I'm not hearing repercussions from the state.

ELIZABETH HEIDT KOZISEK: Not repercussions from the state. I think there's concern for largely from repercussions for, repercussions for-- from employers or cases for lawsuits, even, even frivolous lawsuits. I think in our risk management seminars, they always say a lawsuit is in the eye of the beholder. So whether there's anything relevant to it or not, you still have to pay for your defense. You still have the impact on your reputation. So, you know, concerns about your livelihood in terms of how you're going to be, be perceived in the public eye, whether you're going to receive referrals. And then just, just concerns about, you know, can you take a stance in the public realm and still continue to be considered for licensure or for credentialing from third-party payors, etcetera, so?

FREDRICKSON: OK. Thank you.

ELIZABETH HEIDT KOZISEK: Um-hum.

HARDIN: Other questions? Is it your experience that the quagmires of the type that you described earlier in your testimony are something that everyone has scars and some war stories about? In other words, those kinds of challenges come up regularly in the world of medicine. Is there a denial of their reality?

ELIZABETH HEIDT KOZISEK: Of the reality of them occurring in--

HARDIN: Yeah.

ELIZABETH HEIDT KOZISEK: I think, I think it's not always talked about because I think there's a, a, a fear of, of speaking out about it. Whether it's a fear of, as you mentioned, a fear of not complying with the agency that you work for, a fear of how you're being perceived in the public eye. A fear of, you know, whether you'll receive those referrals, that kind of, that kind of thing. Did that answer your question?

HARDIN: It gives me the impression that the medical world sometimes dances around instead of with things, and I'm trying to get a clear picture of that.

ELIZABETH HEIDT KOZISEK: So I think, I think there are always-- an ethical provider is always going to be looking at, you know, what's in the best interest of this individual, who they are trying to serve. And so we need to have that ability to be able to follow our ethical guidelines. If our other guidelines are telling us that we may have a personal conflict that might not be in the best interests of this

client, we need to be able to step back from that. We need to be able to make decisions that are in the interest of our client, that maybe put us out there in the political realm or legal realm, if it's necessary to support that individual in the case that I mentioned. So I do think that there's fear that if we take a stand about something that we believe is right and good and healthy in some cases now in our current culture that we would be in some way or other blacklisted or denied support.

HARDIN: Thank you. Other questions? Seeing none, thank you.

ELIZABETH HEIDT KOZISEK: Thank you.

HARDIN: Proponents, LB655? Welcome.

TOM VENZOR: Good afternoon, Chairman Hardin, members of the HHS Committee. My name is Tom Vensor, T-o-m V-e-n-z-o-r. I'm the executive director of the Nebraska Catholic Conference. You have a copy of my testimony, but I'll probably jump around a little bit in it so I won't be following it directly. But I think what this-- you know, we're supportive of this bill, of course-- what I think really it comes down to is sort of models and frameworks for how you view health care professionals. Do you see them as human persons who have a responsibility to form their consciences well in a manner that basically influences how they make their professional decisions and professional judgments in the realm of health care? Recognizing that when they make their-- when they form their conscience, they also have a right to not be coerced to act contrary to that conscience or are they something like, I think you heard Dr. Manhart say, are they something like a vending machine? Right. You walk up to him, you swipe your insurance card, you press a few buttons, and you sort of demand a service out of them. You know, what is the model by which we understand our health care professionals? I'd argue that this bill is obviously protecting the idea that these are human persons who come to the profession with their conscience, with their beliefs, with their long-life held ideas on ethics, morality, religion, etcetera. And it protects that rather than views them as sort of a, a vending machine or sort of a utility that I pay for and that I get things out of. And in that vein, I think you've heard, too, about just sort of the rapid developments of ideas and issues. And we, we all know that overnight some, you know, issue can become a hot button political issue just like that. In an example I use, is back in 2017, Ezekiel Emanuel, one of the architects and advisers on the Affordable Care Act. He had published an article in the New England Journal of Medicine, which is

a highly, you know, reputable Journal, basically saying that, you know, health care professionals cannot deny patients access to medications for mental health conditions, sexual dysfunction, or contraception based on their conscience. Basically, Emanuel was arguing against medical professionals being able to refuse for reasons of conscience to participate in abortions or provide, for example, abortifacient contraceptions, etcetera. Emanuel basically said health care professionals who are unwilling to accept these kind of limits have two choices: select an area of medicine such as radiology to, to, to escape to, or essentially get out of the profession altogether. And what I think is interesting, right, is you take the statement from 2017 and say, how did this statement age? Can you run off to radiology now and be sort of immune from, from the moral issues? And I think it just takes a cursory look at that field, for example, on the issue of the transgender issue. And you look at the literature online, you know, look at the medical journals and what you see the arguments being the standard of care for that area being, hey, you have to accommodate, you have to offer all the services that the person wants in relation to tran-- gender transition. And if you don't do that, you're violating standards of care as a radiologist. So I would say not even, you know, that statement is not even 10 years old, and already Emanuel's, you know, comments have aged pretty terribly. This idea that you can escape to other areas of the profession and be immune from ethical issues. So I'll leave it there since my light is on, but happy to take any questions.

HARDIN: Thank you. Questions?

HANSEN: I've got a question.

HARDIN: Senator Hansen.

HANSEN: Is it-- I think-- well, I can't remember, maybe Senator Meyer asked this of another testifier before. So the main concern isn't so much about maybe the past, but more of the future--

TOM VENZOR: Yeah, I think that's--

HANSEN: --in trends maybe, kind of?

TOM VENZOR: Yeah. Yeah, that's-- I think that's the case. I, I interact a lot with a lot of medical professionals in light of the policy work that we're doing at the Catholic Conference, and I think that's what I'm hearing from a lot of them. They're not worried about,

you know, how things went the last 10, 20, 30, 40 years. It's they're seeing a lot more moral, ethical issues, political issues, the politici-- the politicization of medicine and the influence of cultural social issues on medicine. And, again, all of us come to our professions with certain values. You know, we all have certain ideas about how things ought to be. And so I think the real-- they're very much concerned with the influence it has on medicine in the changes that they see potentially in health care, where they see nurses who are lower down, maybe, in that power structure, who are afraid to speak up because they don't know what the repercussions are going to be, or students who are very concerned to speak up because they're worried about future residency, they're worried about fellowship, they're worried about getting that ideal job that they wanted. So they, they keep quiet, but they-- they're not able to bring their whole personhood, you know, to the table. They have to hang it up, you know, at the, at the door and sort of practice without their full personality with them. So I definitely think that it's concerns about what they see going on now and into the future. And it's not so much, as Senator Riepe said, you know, I'm, I'm glad to hear, you know, from him. And we've had this conversation before. I'm glad to hear that, that's how things were handled under his leadership. That's what I would have fully expected from a guy like him. Right? But I think it's more about concerns now and moving forward. And I hear these concerns, too, when I talk to others just around the country, so.

HANSEN: Thanks.

HARDIN: On that note, around the country, other states are wrestling with this?

TOM VENZOR: Yes, I believe that these medical conscience bills exist in, I think, half a dozen other states. I think this version, for example, is modeled after Florida, who I think just passed kind of the similar version about a year ago. Some of these states, for example, I think it's Mississippi, I think has had this for about 20 years already on the books. Some of them are more recent because, again, this is sort of an up-and-coming issue that people are identifying as a need to fill in for policies, so. And, again, you're not seeing, you know, these negative implications of, you know, patient care abandonment or all of a sudden, you know, we're, we're losing out on providers in rural areas or what have you. Again, it, it's facilitating what has been talked about already, which is that balance of being able to come to terms and understand what people are believing in so that those conversations can be had and people can act

appropriately so that, you know, again, so that people's consciences are respected, and so that also people can get the services that they're seeking.

HARDIN: I like to pick on you because you have a great mind. So can I toss one of those questions at you?

TOM VENZOR: Sure. My wife's never said that to me, by the way.

HARDIN: Wrestle with me, wrestle, wrestle with me out loud. What's the difference between a health care patient and a health care service?

TOM VENZOR: Oh, so this bill is about-- this bill is-- has totally to do with health care services. This has nothing to do with the patient who is in front of you. It's about the ability to opt out of services you find problematic. You don't get to pick and choose your patients. You don't get to discriminate against this person or that person. It's about I have a, I have a concern with this particular procedure, this service. And, and that's something that goes across the board. It's not just something you sort of pick at random for one patient and then ditch it for the next patient. That would not be protected by this bill. It's when you have that conscience concern and opt out of a procedure or a service.

HARDIN: OK. Thank you. Any other questions? Seeing none, thank you.

TOM VENZOR: All right. Thank you very much.

HARDIN: Proponents, LB655?

EDWARD DeSIMONE: I said to Senator Hansen a few years ago, that's what you get for having a professor testify.

HARDIN: The professor is here and he has brought material. Welcome.

EDWARD DeSIMONE: Thank you. Thank you, Mr. Chairman, members of the committee for giving me this opportunity to speak today. My name is Dr. Edward DeSimone, E-d-w-a-r-d D-e-S-i-m-o-n-e. I first want to start by saying, although I am employed by Creighton University, I'm speaking on behalf of myself today. I've been a pharmacist for 53 years and I've been licensed to practice in Nebraska. I've spent the last 48 years primarily as an academic pharmacist. As a Catholic, I believe in the sanctity of life from conception to natural death. I am a member of the Catholic Medical Association, long-time member of Pharmacists for Life International, and I serve on the Board of

Directors of Business and Professional People for Life. It's an important part of my life. While I'm speaking for myself, I want to say I can state with certainty that my comments are representative of pharmacists who believe in the right of conscience is a core tenet of how they live their lives and serve their patients, and the practice of pharmacy. For almost 30 years, pharmacists around the country have been fired for refusing to fill prescriptions for various drugs based on the perceived harm to the patient and/or unborn child. While abortion is a primary reason for conscientious refusal to dispense certain drugs, euthanasia is also an important issue, although not necessarily in Nebraska yet. But there are 10 states, and I've listed the 10 states in my written testimony that have some form of euthanasia law. I'm a-- I've been a member of the American Pharmacists Association for over 50 years, and I've served in their house of delegates for most of that time. And-- excuse me-- and I've represented the pharmacists of Nebraska for the last 30 years-plus in that house of delegates. In 1998, in response to cases of pharmacists being fired for conscientious refusal to fill prescriptions, a policy was proposed at the APhA House of Delegates regarding this issue. This policy is called the pharmacist conscience clause, and it goes as follows: APhA recognizes the individual pharmacist's right to exercise conscientious refusal and, two, supports the establishment of systems to ensure patients access to legally prescribed therapy, and then, three, without compromising the pharmacist right of conscientious refusal. And I've put some attachments in my testimony that would support some of these, these issues. And I've served as an expert witness in several states, including Illinois and Washington State. There's a growing trend of government usurpation of our personal liberties. This includes governmental coercion and a violation of each health care professionals, including pharmacists' right to serve patients within the limits of their religious or moral beliefs. May I finish my last two sentences?

HARDIN: Please do.

EDWARD DeSIMONE: There are those who push against religion in our society, but forget that the First Amendment of the U.S. Constitution also states that no law shall prohibit the free exercise of religion. Conscience is a significant part of the exercise of our religious beliefs. This legislation is needed to protect health care professionals from the assault on our religious freedom as guaranteed by the Bill of Rights of the U.S. Constitution. Thank you.

HARDIN: Thank you, Professor. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I got my curiosity question here. On Washington State, where you talk about the government demanded that the pharmacist fill-- was that surrounding some particular prescriptions or what, what pushed her to that wall?

EDWARD DeSIMONE: Both Illinois and-- the Governor of Illinois Blagojevich and Governor Gregoire in Washington, the, the key drugs were the what we call contraceptives.

RIEPE: OK.

EDWARD DeSIMONE: Many of which are half the time abortifacient drugs. And so they wanted pharmacists to dispense these drugs and pharmacists were refusing to dispense it, because they knew that there was a potential to produce an abortion and, thereby, kill the unborn child. And so it was the same situation in both states. Governor Blagojevich said pharmacists will. As a matter of fact, I quote him in my paper. He said that pharmacists do not have a right of conscience in Illinois. Those were his exact words. And so-- Senator Murman actually mentioned the Illinois law. When I worked as an expert witness in Illinois, we looked at that law. And the fact is that Illinois has one of the best conscience acts that exist in the entire country. And so the governor actually lost that case and the courts ruled against him in that he could not do that because pharmacists do have a right of conscience. And so, in, in any event, that's the issue which is primarily the dispensing of abortifacient drugs. In, in that particular case, it was the Levonorgestrel or the morning after pill. But the fact is, if you look at the data, the Levonorgestrel, depending on what day it's taken, the mechanism of action changes from the time intercourse occurs and pregnancy occurs. And so I use the guns-- I, I give a lecture every year in our mandatory ethics course to our pharmacy students. And I tell them when I-- if I were dispensing a drug that had the potential to produce an abortion 50% of the time, which is the-- what the data says about or Levonorgestrel. It's like I would ask this student here, I'm going to give you a gun with only one bullet in the chamber. I want you to aim it at the next student. I want you to pull the trigger. And the student is, I can't do that. I said exactly. You only have a one in six or eight chance of killing that individual. But the fact is, the potential exists. And that's what happens with these, quote, morning after pills and many of these hormonal, quote, contraceptives because, in fact, they are not 100% contraceptives. And, therefore, when you dispense them, there is a potential, depending on which drug it is, the percentage of time that it would actually cause an abortion and not act as a

contraceptive. So for many of us, many people that I know, excuse me, they don't want to dispense these because they don't want to take that chance of firing that bullet.

HARDIN: You have a-- an interesting position in influencing young people to become pharmacists. Here we are in the 21st century, we're looking at LB655. What are your students talking about when they look at these issues?

EDWARD DeSIMONE: After I give my lecture in the ethics course, because the students are-- their focus is primarily, I got to pass the next test. But when I give the lecture in ethics and I talk about these issues and the guns and, you know, bullets analogy and stuff and the cases, the Washington and Illinois cases, I get students who come to me and say I never thought about that. And what I say in, in class is the worst time to decide what you really believe is when you're standing in the pharmacy with the prescription in your hand and say, oh, I don't know what to do. So my goal is to educate the students to think about what do you really believe? And if you do, I advise them when you go looking for a job, you need to be straightforward with your potential employer and tell them what you believe. The, the policy that APhA adopted, which I supported, said systems need to be in place. When the Illinois case came up, that was back in '78. The companies like Walgreens, Walmart, Costco, I'm sorry, CVS, all of them had already had in place systems. So if there was a pharmacist who didn't feel comfortable dispensing the drug, another pharmacist would take over and take care of that prescription. So there was no problem. It wasn't until the governors got involved in this and threatened the companies that they reversed their policies. Matter of fact, I have something in there, if you look, there is the midnight massacre that happened at Walgreens. They went-- they made their pharmacist sign a statement saying, I will not-- I will dispense these drugs. OK? No objection. And pharmacists who didn't do that, they sent people into the pharmacies in the middle of the night, 2 a.m., one of those 24-hour ones and said you didn't sign this. And if they didn't sign the paper, they said go home. And it's called the midnight massacre. And they-- Walgreens said, well, we didn't, we didn't fire them. We put them on unpaid indefinite leave. OK? That was the answer. There's a lot of stories about that.

HARDIN: Senator Riepe.

RIEPE: I had one follow-up question.

EDWARD DeSIMONE: Yes, sir.

RIEPE: When they-- I guess the governors, both in Washington and Illinois, was there demand of all hospitals, whether they were state hospitals, government or private, even private hospitals, even religious hospitals?

EDWARD DeSIMONE: The governor went to the state Board of Pharmacy, and it's described in the, in the document that I gave you, the governor went to the state Board of Pharmacy and ordered the state Board of Pharmacy to change the pharmacy regulations in Washington State to require every pharmacist, regardless of practice, to fill a prescription, whether they had a conscientious objection or not.

RIEPE: OK.

EDWARD DeSIMONE: So.

RIEPE: That answers my question. Thank you.

EDWARD DeSIMONE: Sure. You're welcome.

RIEPE: Thank you for being here.

HARDIN: Other questions? Thank you for being here.

EDWARD DeSIMONE: You're welcome, sir.

HARDIN: Proponents, LB655? Welcome.

BRENNA GRASZ: Thank you. Chairman Hardin, committee members, my name is Brenna Grasz, B-r-e-n-n-a G-r-a-s-z. I am an attorney here in Lincoln, and I am testifying in support of LB655 on behalf of the Nebraska Family Alliance. NFA believes that no medical provider in Nebraska should be forced to violate his or her sincerely held religious, ethical, or moral beliefs in order to fulfill his or her calling to practice medicine. As you know, the world of medicine is not immune from presenting moral and ethical questions. Whether services are being requested for gene editing, cloning, abortifacient, exogenous, human and animal DNA combination, opiate-- opioid abuse, or a service that has yet to exist. In a rapidly developing world, Nebraska medical providers should be protected from forced participation in these services. This bill accomplishes such protections in multiple ways, and I want to touch on three. First, this bill applies to conscience-based protections of a provider

performing a specific service or procedure. Section 3 provides that health care providers may opt out of participating in conscience-objectionable services. The bill does not grant authority to object to a person, nor does it grant the authority to affirmatively perform any service. Rather, it prevents forcing the hand of professionals to perform a specific service that violates his or her religious, ethical, or moral beliefs. Second, this bill is directed at nonemergency services. The duty to provide emergent care under state and federal law is expressly recognized in Section 6(2) of the bill. And third, and finally, the bill offers a limited enforcement mechanism. The Attorney General's Office would handle investigating any alleged violations of medical-conscience rights, and if the AG believes that a violation has occurred, he or she alone has the authority to file a civil lawsuit. This is a noteworthy shift from prior renderings of this bill, and should satisfy any concern about any floodgates of litigation. Entrusting the AG with authority in this professional context is nothing new. The AG's health licensure bureau currently reviews complaints against health care professionals and advises DHHS regarding investigations of alleged violations. Unfortunately, no recourse like what this bill provides is currently available to health care providers in Nebraska. This is troubling, given that too many medical students and professionals would rather leave the practice of medicine entirely than violate their conscience. Medicine and medical technology have the capability to accomplish profound good and allow people and families to flourish. Our state should be eager to codify protections that attract diverse talent to our world-class medical community here. On behalf of NFA, I encourage the committee to advance LB655 so that the public policy of Nebraska is to protect and respect the oath of our medical providers to do no harm. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. I have a little question, it's a little bit different in the sense that it goes to your legal practice. If you have a client that comes to you, I don't know whether you do wills, trust, and that kind of stuff or someone that you know does, are they at, at liberty to say, I won't write into your will that I want a do not resuscitate or if they live in Oregon, if they want to, you know, euthanasia, do you-- do, do attorneys have that same right to walk away?

BRENNA GRASZ: Thank you for the question. And it, it changes depending on whether it's a prospective client and whether it's a current

client. Prospective clients' attorneys have great liberty right now to say, no, I don't want to take on this matter for the specific reasons. And I would say that as practicing attorneys, we don't have to, you know, set our conscience aside at the door. In our practice, we always want to act in an ethical manner. Here, specifically, addressing a question of maybe employers who are looking at candidates to work for them, employers can ask those types of questions of are you going to provide these services, potential employee? And they can evaluate whether they want to hire or choose not to hire that professional if it comes to that sort of a situation. And then if we're looking at medical providers, so the context that this bill is within, if they are presented with a situation where they have an objection, currently, maybe hospitals, partnerships of, of professionals or other associations might have a policy that speaks to that. But there's nothing currently codified in Nebraska state law that requires them to do that. So that's what this bill would do.

RIEPE: I'm a little bit surprised, because I had always believed that you could only ask a question of a new hire of something that was job related.

BRENNA GRASZ: So this bill--

RIEPE: Anything outside of that was a violation.

BRENNA GRASZ: So I-- speaking to the text of this bill itself, there's nothing that prohibits a, a potential employer from, from refusing to hire somebody if they're not going to perform certain services. This bill applies to presently acting physicians, providers, payors to opt out of certain services.

RIEPE: Well, I could say this is a job-related question. I, I was just-- OK. Thank you. Thank you very much. Thank you, sir.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Ms. Grasz. On Section 7 of the bill, the disciplinary action. So what, what recourse does a medical provider have if, for some reason, a hospital says I don't, I don't believe you have-- I, I don't believe this violates this, as written, 6-- LB655? Is there civil recourse? Is there-- what kind of teeth does LB655 have?

BRENNA GRASZ: Yes, that's a great question. So prior renderings of this bill have been different. The way that it is currently written is

everything goes through the Attorney General. So in Section 5 it talks about that a health care provider or payor can file a complaint with the Attorney General alleging any violation of Sections 1 to 7 of the act. So the Attorney General would presumably conduct some sort of an investigation to determine, has there been a violation of this act, maybe the employer retaliated against the physician or the provider for opting out of a certain service or procedure. If the Attorney General finds that there is grounds for something like that happening, then the Attorney General can file a civil action. There's nothing in this bill opening the door to a private right to a cause of action, which is different from prior renderings. So the, the concept of the fear that this is going to bring about all kinds of litigation in Nebraska simply isn't there. If the Attorney General looks at it and determines there's no grounds for bringing a civil action in this case, then the Attorney General wouldn't bring the case.

BALLARD: OK. Thank you.

HARDIN: This bill would protect health care professionals from being forced to provide a certain service, but it doesn't give them a right to perform a particular service. Is that correct?

BRENNA GRASZ: That's correct. The bill applies only to opting out of certain services, and that language is specifically provided in Section 3 of the bill. It does not give the provider an affirmative right to do anything. So, for example, and I believe there was a question earlier about what if a current law says that certain services are not allowed to be performed, whether it would be certain abortion services or certain other sort of gender-care services, those, those laws would not be changed by this bill if something, let's say, abortion was not allowed after 12 weeks, this bill doesn't allow abortion to be allowed after 12 weeks. It's an opting out rather than an affirmative right to do something.

HARDIN: I see. Other questions? Seeing none, thank you.

BRENNA GRASZ: Thank you.

HARDIN: LB655 proponents? Welcome.

SANDY DANEK: Thank you. Good afternoon, Chairman Hardin and members of the committee. I am Sandy Danek, S-a-n-d-y D-a-n-e-k, Executive Director of Nebraska Right to Life. And I come before you in support of LB655, a bill that provides a right for medical conscience for

health care providers. Many medical professionals do not want to be forced to participate in certain controversial technologies and treatments, such as abortion, assisted suicide, or unethical research. By providing conscience protections, LB655 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 standards of medicine. Some would not consider 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 health care 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. LB655 offers that protection. We encourage the committee to advance LB655 for further debate. Thank you.

HARDIN: Thank you. Questions? Seeing none,--

SANDY DANEK: Thank you.

HARDIN: --thank you. Proponents, LB655? Opponents, LB655? Welcome.

JOHN TRAPP: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. John Trapp, J-o-h-n T-r-a-p-p. I currently serve as the Vice President for Medical Affairs and Chief Medical Officer at Bryan Medical Center. I'm also a pulmonary medicine and critical care physician. I've been in practice in Nebraska for 26 years. I come to you today on behalf of the Nebraska Hospital Association and my fellow hospital colleagues in opposition to LB655. LB655 is attempting to solve a problem for which we already have policies and processes in place to address should a conscientious-- should a conscious objection arise. At present, when a nurse, physician, or any other health care team member identifies a setting that they determine may compromise their strongly held

personal beliefs, the health care worker asks a colleague to assume the care of that patient. The transition of care is generally seamless, respectful, and done so without question or delay of care for the patient. Title VII already requires employers in the health care industry to provide a reasonable accommodation to any employee's sincerely held religious beliefs and practices. In addition, the U.S. Department of Health and Human Services, Protecting Statutory Rights in Health Care Rule, implements and enforces federal conscious and antidiscrimination laws protecting the rights of employees who refuse to assist in the performance of health care services to which they object on religious or moral grounds. LB655 creates more challenges than it attempts to solve. This bill would be difficult to operationalize and is an unnecessary government oversight into patient care. Nothing in the bill requires a person with an objection to notify their employer beforehand. It only says they must notify at the time of the objection or as soon as practicable thereafter. Thank you for the opportunity to share the issues identified in LB655 and the negative impact this will have on Nebraska's hospitals and medical professionals. As you hear from myself and others today, I ask that you do not take action on LB655, allowing hospitals and medical professionals to provide the necessary care for each patient while respectfully addressing an individual's conscious objection with a collaborative approach and process and leave unentangled an issue already addressed by current policy in law. I welcome any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here.

JOHN TRAPP: Absolutely, Senator Riepe.

RIEPE: My question would be, is, in your experience, has there been any situation or is it one of those policies that's generally accepted so that you don't have disruptive challenges on a regular basis of this policy?

JOHN TRAPP: Yeah, we don't really see this happening. Very uncommonly would this-- does this happen in clinical practice. And, generally, when employees see a situation that, that they anticipate will be difficult for them to participate, they let a colleague know and colleague step in and, and take over.

RIEPE: OK. Thank you very much. Thank you for being here. Thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Dr. Trapp, for being here--

JOHN TRAPP: Yes.

FREDRICKSON: --and for your, for your testimony. That, that's actually helpful for me to hear as well, that's, that's always been my experience in clinical settings, where there's options that you have the right to make a decision as a provider. I, I guess my question-- I think it's kind of clicking for me. It almost feels like this almost comes down to an issue of challenges or, like, a fragility, maybe, on a provider's part to self-advocate versus a state statute issue. Would that--

JOHN TRAPP: Well, if you're confronted with a patient who's demanding services that you're uncomfortable delivering because of a conscience objection, that requires a difficult conversation, a crucial conversation to say I have a personal belief that I don't do that. And whether you post that ahead of time so patients know and sometimes patients know by the type of office that you name your office or how you address that, that oftentimes patients choose their physician based on similar beliefs. I agree with that completely. But if somebody demands that, it's-- it requires a difficult conversation to say thank you for that request, but I simply can't do that. I can refer you to someone else. And I think I've heard that again and again today, that each time someone's been confronted with that, oftentimes they are able to transition that to someone else to address the concern or at least have the opportunity to do that.

FREDRICKSON: Yeah. Yeah. No, I would, I would agree with you. I think it's, it's-- it can be a difficult conversation, but it seems like one that is important if you're going to be a provider of a service to be able to have boundaries.

JOHN TRAPP: I don't think this bill makes the conversation go away. You just have to say--

FREDRICKSON: Yep.

JOHN TRAPP: --there is a bill now that protects that.

FREDRICKSON: Yep. Yep.

JOHN TRAPP: Or a law.

FREDRICKSON: Thank you.

JOHN TRAPP: Thank you.

HARDIN: Senator Hansen.

HANSEN: Thank you. Do you recognize the concern that some of the providers that come up here voiced about maybe not so much in the past where there have been issues, but you're starting to see a trend of maybe concern from patients and repercussions from the hospital, possibly about them denying certain services because of the beliefs that there's a growing trend of that?

JOHN TRAPP: I mean, health care is a fluid environment. We've seen some tremendous advancements in what we can do with gene therapies and other types of therapies coming forward. Are those applied in most general medical settings? Probably not. I mean, some of the examples I've heard here are prescribing of oral contraceptives. In this bill, it sounds like that would be a procedure, the prescribing of medications. You know, from time to time we see someone with very strong religious belief or objection. And, and, again, we address that. But I would say that's the exception more than the rule. And, and we've not seen-- in a hospital of over 1,000 providers, we don't see this as a recurring issue or a theme that's brought to us. We have ethicists they are able to consult. We have bylaws, committees, and other groups that can address this, and, and we just don't see this coming forward.

HANSEN: OK. You, you talk about Title VII and the, the health care industry has to provide reasonable accommodation, mainly just because I'm unfamiliar it, what does reasonable accommodation mean?

JOHN TRAPP: Well, looking for an opportunity to say how does that person still perform a functional role? And at least in a temporary setting, if this is a situation where they say I object, I can't do that, how do we continue to fulfill a role that's important for the hospital that still allows him to serve a great purpose in providing care until they can opt back into the regular line of duty? So it's maybe alternate duties. And, again, it's hard to put that into law and to say that for every single job, we can figure out what that will be, that requires probably thoughtful approach by a supervisor to come up and say I understand you can't do this, and, and here's a reasonable

accommodation to, to do another work-- type-- line of work. And I think we see that with injuries and a number of accommodations we try to come up with.

HANSEN: Do you-- or, or is there zero potential for negative repercussions from an employer to an employee if they get denied a service?

JOHN TRAPP: Say that again, zero for-- to deny a service.

HANSEN: So do you think, do you think there's zero possibility of an employee having a negative repercussion from an employer because they deny a service? Because you're saying there's, like, not really a need for it. And so some people here are saying there is a need for it because they feel like if I get-- or a student, right, if I do not have some kind of protection to be able to maybe not want to do something because of my beliefs, they feel like the protections aren't there. And so-- but you're saying it's not happening at all and there would be no repercussions from an employer, maybe not on your end, but there could be from the possibility of others. But it sounds like what you're putting forth says they're all fine, nobody, nothing is ever going to happen there to anybody negatively if they, if, if they deny a service.

JOHN TRAPP: Well, generally, these--

HANSEN: I find it hard to believe.

JOHN TRAPP: Yeah, generally, these events are-- seem to be very uncommon, first of all. I mean, these events that, that we identify where there's a conscious objection to a certain thing seem to be very uncommon, meaning that they're not happening on a daily basis. If I find that you've applied for a job, for example, in an abortion clinic, and now you have a conscience objection, I go, goodness, are we in the right role that, that you've applied to? We should look for a role that, that better aligns with your work in that situation. So I, I would try to find a better match for that person if this was a recurring theme that we saw in their role.

HANSEN: As an employer, do you ask an employee-- potential employees that when you hire them?

JOHN TRAPP: Ask--

HANSEN: Do you have any, do you have any, do you have any religious or conscious objections [INAUDBILE]?

JOHN TRAPP: I don't believe we can ask that question. I--

HANSEN: So what happens if they have that then?

JOHN TRAPP: Well, that, that would be for them to really update us. I mean, if that's really important for them, they should let us know. If they're applying for a position where this could be a potential conflict, I think they should let us know so that we can say, well, how do we accommodate for that?

HANSEN: That makes sense. OK. All right.

JOHN TRAPP: I mean, if someone can't lift more than 30 pounds and it's a job that requires them to lift 60 pounds, we should know that so we can say can we get a lift or something else to accommodate that for you to be successful in your job. There's a health care shortage. So we, we want employees right now.

HANSEN: Yeah. Yeah.

JOHN TRAPP: And we are looking for ways to keep them, not lose them.

HANSEN: And I think that-- if I can ask one more question?

HARDIN: Sure.

HANSEN: I think it goes back to a question I asked earlier of somebody is, wouldn't you want something like this? Because doesn't it protect you from possible litigation, because now you know ahead of time maybe what some conscious-- what they might want to deny ahead of time so then that, that--

JOHN TRAPP: This doesn't say that they have to let us know ahead of time anyway. This, this potential law does not do that.

HANSEN: If they did, would that be better if they put that in, in this bill?

JOHN TRAPP: To let us know ahead of time?

HANSEN: Yeah.

JOHN TRAPP: Again, that's a hard one for me to answer. We think that this is already addressed. And, and adding this is another layer that's unnecessary.

HANSEN: OK. All right.

HARDIN: Are the policies and procedures of Bryan identical throughout the state, throughout the various locations?

JOHN TRAPP: HR policies, yes.

HARDIN: OK. So Title VII would be exemplified in the same way throughout?

JOHN TRAPP: I would say, yes.

HARDIN: OK. Very good. If this were to pass, paint that picture for me. Can you give me a sense of what would the worst case scenario be?

JOHN TRAPP: I don't know how much this would change that, you know, in, in, in-- to a great degree. It depends on how people chose to apply this. I mean, if, if we saw increased statements for strongly held beliefs, I mean, that certainly could impact how we do work. Again, we feel like we already have lots of protections for our staff and employees and providers. We-- I, I don't know how much this actually adds. And you said what-- were it to pass, would it be a detriment? Hard to say.

HARDIN: I see. Senator Meyer.

MEYER: Thank you, Mr. Chairman. And, and this is probably right along the lines you were, you, you were asking-- and, and forgive me if I'm not totally understanding here, but we've had testimony today from, from medical students, we've had testimony from doctors that they feel this is very important to protect them. My question is, with the passage of this, how does that negatively affect you? I mean, we're looking at protecting people in the medical field and, and encouraging-- I believe we had some testimony about 20% won't practice here, because they don't feel that they have that protection. And, and that may, may not be totally accurate of what the testimony was. But were we to pass it for the protection of the, of the doctors and the medical students, does that negatively affect you in any way?

JOHN TRAPP: I mean, potentially it does. You know, we provide a service and, and let's say it's an OB clinic that provides oral

contraceptive pills. If, if patients are brought to this with the expectation that they're going to be allowed that service and one or two individuals opt out, we'd have to find ways to accommodate that. If more people would continue to do that, it would depend on call schedule, how we provide that call. Would they be able to take those calls or not? How do we deliver that service on a consistent basis? We, we do need to have some consistency in how we deliver the care and, and, and to meet the patient's expectations, caring for all patients.

MEYER: But, but for the delivery of your services and that type of thing, isn't that something-- don't you want to accommodate patients' needs. And, and each of them have some different needs. So knowing this ahead of time or, or having people involved with you know that someone is uncomfortable providing a particular service, that should be for your benefit. That should streamline the delivery of services so you don't have someone coming to you in the process of providing service saying, no, I can't do this. We got to find somebody else. We got to reschedule. I personally don't see how that negatively impacts you, sir. I, I-- it, it appears to me that we could provide a, a-- an area of comfort to those physicians and students that may be negatively affected without the burden of negatively affecting the delivery of services on your part. And, and, once again, that's, that's my perception of what this is. And, and, and hearing your explanation, I don't see where that's substantially negatively affecting the delivery of your services.

JOHN TRAPP: Nothing in this bill that says they have to tell us ahead of time what their objection is, so that objection could occur at 7:00 at night. And, and we may have already set the, the day's schedule up, or you may be the person on call and taking that phone call from the patient who says I need a, a refill of my medications for whatever reason. And, and then we have to say, and that person could say, well, I object, I can't do that. I'll have to get somebody else to take that call. So there's nothing in this bill that says that they have to let us know days or weeks ahead of what those objections may be. So it can impact our workflow.

MEYER: If the legislation provides a degree of protection for those people to feel more comfortable in providing services in the state of Nebraska, and perhaps encourage more people to provide those services, and it doesn't change the fact that at any particular given time someone can call you and say, no, I can't provide that service, it's not changing the negative effect on your business at all by passing

this bill. All it is, is providing a comfort level for doctors and, and students in order to feel more comfortable in, in the services they're providing and perhaps would encourage more to remain in the state, not having the fear of repercussions. And so what you've just told me is that it wouldn't negatively affect you in any way, shape, or form because it wouldn't change someone notifying you at 7:00 at night that I can't, I can't fill a prescription. It's putting a level of comfort and, and perhaps peace of mind and encourage more students to stay in the state and provide those services if that is a, is a concern, repercussions is a concern they have of not being able to provide the services that perhaps their employer would insist that they do. So I, I guess I don't see the negative impact on your business, sir.

JOHN TRAPP: Well, you know-- well, I heard medical students, students and residents having probably the gravest concern were they're meeting the attendance, the attendance, the residency requirements or looking for new positions, etcetera. I mean, if that's a problem, then that probably need to be solved within the, the residency and academic program. But for us, we don't know what's coming in our door at any one time, whether it's to the emergency room, through an urgent care, through a regular visit. So if, if people don't let us know what to expect ahead of time, we have a full cadre of clinics across the, the city and across the state. And so if a patient comes in and expects a service that we usually give, how do we know when that comes up and that, that, that impacts us. Now, if it's, if it's a critical nature, emergent-- in the emergency room, we should address that. Someone shouldn't have a, a conscious objection during an emergency. But for routine care, we don't know what comes in our door and what questions we may be asked and what, and what calls we may receive. So how do we anticipate those at all times, unless we have a provider that will do all things or we have a backup system. So a backup to our backup to address calls and issues that may come up on a routine basis.

MEYER: But by passing this legislation, it doesn't change that dynamic at all, whether this bill is passed or it's not.

JOHN TRAPP: Unless it escalates the number of conscious objections going up. And like I said, this is a really rare event. We don't see this as a problem today, and, and so adding another layer, we have concerns about adding more layers.

MEYER: OK. Well, I appreciate it. Thank you, Doctor.

JOHN TRAPP: Thank you.

FREDRICKSON: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I sense an organization like Bryan or a lot of other big hospitals, you can accommodate one, but when you multiply that times 1,000 individuals that make up your management or not your management team, but your health care delivery team, then it becomes a very big issue.

JOHN TRAPP: Correct. I mean, any business that would be difficult, whether it's a manufacturing plant or a hospital, we, we, we have work to do. And, and the vast majority of the time we can accommodate those rare events. But if it was a common event, we'd have a very difficult time. That's correct.

RIEPE: Plus, you're not an 8 to 5 kind of organization.

JOHN TRAPP: We're not, 24/7, 365, and, and, and then full.

RIEPE: That's right. Thank you very much.

JOHN TRAPP: Yes, thank you.

RIEPE: Thank you, Chairman.

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

JOHN TRAPP: Thank you very much.

FREDRICKSON: Next opponent for LB655. Hi, Josephine. Welcome.

JOSEPHINE LITWINOWICZ: Hi. My name is Josephine Litwinowicz, J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z, and I represent the Higher Power Church. And first of all, it's a ridiculous premise. I'm sorry, I'm mad, because of what's going on. The persecution of all sorts of folks. We're on our way from the Reichstag to 1936. Anyway, it's a ridiculous premise that somebody would go to a position that didn't-- wasn't comfortable or that didn't perform-- it's a ridiculous premise. I don't under-- I wouldn't, I wouldn't let my child if, if-- or, or, you know, I wouldn't let any of that. Oh, and by the way, Thomas Jefferson called religion a perversion, a perversion. And I'm not talking about the biblical Jesus because there's, there's nobody better. And my church, part of the temple are the first, are the four chapters of the Gospels, right? And I, I like to make the analogy of

Old Testament is 1.0 and, and the New Testament is 2.0. Now, just like in, in normal software, you know, if you, you make an improvement, you still have aspects of the old, like the Ten Commandments and so forth. But Jesus Christ, he never would do something like this because he didn't preach about it. He didn't persecute anyone. And it's just-- I think it's a ridiculous premise that anybody-- I mean, I would want somebody to actually talk to me, you know, like-- and I'm going to forget a whole bunch of stuff. It'd be nice if people asked questions, but I doubt it. The thing is, is that, you know, in our government right now, already, trans and fear have been erased. All traces. OK, there's statues going back to antiquity, marble clearly showing transgender people, and I, I don't see how you get away from just feeling morally superior now, you know, like we have to be depraved or something because the governor said it's a bunch of foolishness, so I'm, I'm a pile of foolishness. Well, he can foolishness this, because I am who I am, and just because I was given-- I was born with the wrong genitalia doesn't mean I don't feel that way inside. And so it's really annoying to-- of John Adams said religion, it'd be better if it didn't existed. And it's neat because a lot of the forefathers were deist, you know, which means that they thought God created the world and, and then, you know, that was it, kind of left it to our own devices. And so it's, you know, it's these claims that there was-- and what if the psychologist, what if a person came to the psychologist that spoke today and, and wanting to talk about, you know, is this really me or, or, or converting to-- because that would be the true definition of the word-- the conversion would be to go from what they are into what they aren't. And I just-- just because we are in a smaller club and it's been around since antiquity, and certain people just like to feel morally spiritual, I mean, morally superior when there's no basis on Jesus Christ as His Gospels. There's not. And I'm pissed because Trump--

FREDRICKSON: Josephine, you got your red light. I'm sorry, but if you could wrap up your thoughts.

JOSEPHINE LITWINOWICZ: I'll, I'll sum it up. The first lady-- had a little bit of time on there, and-- oh, hell, it doesn't take much to dislodge me and I, I basically-- I, I have so much stuff to say and it's relevant. Anyway. I wish I would have remembered what that was. So I would love any moral, philosophical questions. I would like that from anybody.

FREDRICKSON: Thank you.

JOSEPHINE LITWINOWICZ: Seriously. And--

FREDRICKSON: We'll see if there's questions from the committee. Any questions from the committee?

JOSEPHINE LITWINOWICZ: Because I dare you, because you ask other people, you won't touch me for some reason.

FREDRICKSON: All right.

JOSEPHINE LITWINOWICZ: Not with a 10-foot pole, you know.

FREDRICKSON: Thank you, Josephine.

JOSEPHINE LITWINOWICZ: I, I see your pole, but it doesn't-- it's only 10 feet. I'm a little further away right now. Anyway.

FREDRICKSON: Thank you for being here, Josephine. Next opponent to LB655. Welcome.

TIFFANY WEISS: Thank you. Members of the Health and Human Services Committee, my name is Tiffany Weiss, spelled T-i-f-f-a-n-y W-e-i-s-s, and I'm a constituent from Kearney, Nebraska, District 20 or 37. I'm here today in opposition of LB655. This bill is just discrimination written into law, especially because it does not include gender identity or sexual orientation as protected areas. As a mother of five kids, two of which are transgender, I feel like this bill, if this bill becomes a law, my already marginalized children will suffer even more. My trans son has a chronic kidney condition, and we have to drive 3 hours for every appointment to see the pediatric nephrologist and the pediatric urologist. Any services they provide have to take into account his transition, because it has to account for his testosterone that could affect his blood pressure, which also kidneys affect your blood pressure. So they're tied, he's one person. You can't just separate that from him. So what happens to my trans son if one of them decides that his identity is against their deeply held moral and religious beliefs? Who am I supposed to take him to then? Am I supposed to go out of state to find nonbiased care? And what happens if Children's physicians, as an entity, decide they're morally and religiously against transgender children? In my town, the only pediatricians work for Children's and all of my son's specialists are for Children's. Where, then, do we go for help? There've been many times I've had to take my son out of school to get his urine tested at the only pediatrician's office in Kearney. And what happens when the pediatrician on call does not treat trans people because it goes

against their beliefs? Does my child not get the right to health care because some people don't see his transgenderism as a piece of who he is, but rather as an affront to their God? There's one pediatrician at Kearney that we know is against transgender people, because he did a podcast stating that children can't know that they are trans and that being trans is a mental illness. And so we refused to see him. Yesterday, we had to take my son to the doctor for an allergic reaction that he was having on his hands. And because the only doctor who was available was that doctor, we had to take him to the emergency room to be seen. This is significantly more costly and takes way more time, and it also takes the service away from other people who need it. It wasn't an emergent case. He didn't need to see an emergent doctor. He wasn't bleeding out, but we couldn't go to a doctor who's not supportive of his transition either, because we're not going to take the chance that he's going to be referred to as the wrong pronouns or with the wrong name, because that is harmful for his mental health. The truth is, all people should be able to access health care that is appropriate and safe. Health care should not be-- should be provided equitably and not just to those who the doctor finds deserving. My trans son deserves the same respect and compassion as my cisgender children. Trans children see enough discrimination and they shouldn't have to deal with it at the doctor's office. Thank you for your time.

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

HANSEN: Thank you. I'm gonna throw a hypothetical out to you.

TIFFANY WEISS: I love it.

HANSEN: So the instance you gave of the Children's physician, if you knew they were morally and religiously against transgender children, would you see them?

TIFFANY WEISS: No.

HANSEN: So wouldn't this bill be a good thing if they were able to, without worrying about persecution, say that ahead of time so then you knew who you were going to see?

TIFFANY WEISS: So in this case, it's one doctor. But what happens when the entity decides as a whole? Because there's lots of doctors there that are pro trans. So my question back to you is, like, then who do I

go see because that's the only pediatricians in town? We can avoid one doctor, but I can't avoid the whole office. It's the only ones there are. And also, I don't take my child if I know someone's anti-transgender because I don't want them to be discriminated against in the office, like that makes good sense.

HANSEN: Yeah, you gave, you gave that example, and that makes sense--

TIFFANY WEISS: Yeah. Right. Exactly.

HANSEN: --through your perspective.

TIFFANY WEISS: Exactly.

HANSEN: So this might help give you a better idea of who you feel is right for your children to see, because now they have the ability to say, look, I feel like this is my moral and religious-- I feel like it's morally and religious against my ethics. And so they can state that ahead of time without worrying about being persecuted or maybe they may not now. Right? And that's what some of the examples of, I think, Bryan Health was saying. We don't see a whole lot of it. And maybe-- and that's the example I gave before, they're concerned that if they do-- you know, I mean, there might be some repercussions for their ability to share, like some of the medical doctors we heard earlier. They don't want to share some of their stuff or their, their morals because they're worried about being, you know, repercussions either from their employer or from, from a student. If you knew that ahead of time, wouldn't you want to know that ahead of time, like, what-- where, where they stood?

TIFFANY WEISS: I don't have a problem if someone's anti-transgender, if they don't treat my child in a way that is rude or discriminatory.

HANSEN: Sure.

TIFFANY WEISS: So when I go see his specialist, I've never asked his nephrologist, hey, do you support his transition? Are you on board with this? I've never had to ask that because he's never been discriminatory towards my child. Now, this doctor had done a podcast where he was discriminatory towards trans children. So that's why we don't go to him. But I see what you're saying, like, wouldn't I like to know? Well, yeah, I'd like to know if my nephrologist believes in my child's transition or not, but since he's the only pediatric nephrologist in all of the state, does it matter to me? Not if he's

not being discriminatory towards my child. As long as he's being OK with my child, like, I'm going to go to him.

HANSEN: OK.

TIFFANY WEISS: So I guess, like, yeah, it matters if they're going to discriminate. One doctor showed me he's going to discriminate, so I'm not going to go to him. But the other doctors I need to-- I still have to see a nephrologist. I still have to see an urologist.

HANSEN: OK. Thank you.

TIFFANY WEISS: Yeah.

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

TIFFANY WEISS: Thanks.

FREDRICKSON: Next opponent for LB655. Good afternoon.

LESLIE SPRY: Good afternoon, Chairman Hardin and members of the committee. My name is Dr. Leslie Spry, L-e-s-l-i-e, Spry, S-p-r-y. And I'm a nephrologist, which means kidney guy. Nobody knows what a nephrologist is, but, and a past president of the Nebraska Medical Association. I'm testifying in opposition to LB655 on behalf of the Nebraska Medical Association. The Nebraska Medical Association agrees with Senator Murman that a practitioner should be allowed to practice within the dictates of their conscience. However, we almost must recognize that the patients have rights here, too. And our duty to the patient requires that we facilitate or otherwise arrange for care of that patient. The AMA Code of Ethics provides in Opinion 1.1.7, regarding physician exercise of conscience, subsection (e): 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. Section-- subsection (f) of Opinion 1.1.7 provides: 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 the physician to decline to refer, the physician should offer impartial guidance to patients about how they could inform themselves regarding access to desired services. One of the difficulties of the legislation that has been introduced on this subject over the past several years, and I've been involved in this, I think, since 2008, is the 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 the care they feel best for them. LB655 does not provide adequate protections for patients in that regard. Section 3 of the bill provides that a health care provider has the right to opt out of participation in any health care service due to a conscience-based objection. Section 2 provides a broad definition of health care service, which specifically includes referral and medical services. Medical services presumably include counseling and/or advising patients regarding their medical care. The NMA does not feel this opt-out provision adheres to the patient's ethical duties to the patient. Specifically, when a practitioner has a long-standing patient-physician relationship, their duty to the patient is to discuss all potential options to the patient. I would add that many patients may have no idea what services they need or expect to hear from a trusted physician source. That should be the, the provision of the patient of the physician in that situation. We have a duty to educate the patient.

FREDRICKSON: And you're in the red light.

LESLIE SPRY: My time is up, I believe, so I'll-- I, I have a, a little more testimony in that since I've been involved in this--

FREDRICKSON: Feel free to continue. Yeah.

LESLIE SPRY: OK.

FREDRICKSON: Feel free to continue. Yeah.

LESLIE SPRY: I just, I just wanted to mention that I was involved with this, and we actually convened the task force at the end of May in 2013, where we got together with all concerned physicians on this particular issue. And it was our recommendation to this committee and to the senator who was putting forward the conscious-based objection bill, that all they had to do was that physician had to perhaps give the patient a resource such as the local medical society or the Nebraska State Medical Association would be happy to take those referrals and if the patient-- if the physician didn't feel comfortable referring to another physician or institution.

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

HANSEN: I'm trying to figure out the example you gave, subsection [SIC] 1.1.7: Physicians should refer a patient to another physician or institution to provide treatment if the physician declines to offer.

When a deeply held, well-considered religious belief, a personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients on how to inform themselves regarding access to desired services. Those two things seem in conflict with each other. If you're having someone who has a personal belief against something, but now you're saying you have to make sure they refer to somebody, but they don't have to.

LESLIE SPRY: Well, so that was that discussion that we had in our task force. It was exactly that discussion that I don't feel comfortable referring to another physician who may offer the services, i.e., abortion or whatever service you would like to choose from there. However, it's still my duty under AMA Code of Medical Ethics to provide as much information to my patient as I can.

HANSEN: Which would be nothing.

LESLIE SPRY: Which would-- well, the way they insist, it would be nothing, but I-- we would insist should be how can-- in other words, how would you seek a second opinion? My patients don't even know that. So in other words, all they have to do is give the potential patient or the patient a phone number for the local Lancaster County Medical Society or the phone number for the Nebraska Medical Association, and that can be sufficient. In other words, it's your duty as a physician. Now, I can't say about pharmacists. I, I-- in other words, don't know their code of ethics, our code of ethics, which is inscribed in Nebraska, a statute that says that the physician must provide as much information to that patient as they could if it's a strongly held belief that they don't want to refer to an individual or to another institution, then a general referral to make it to the Medical Society should be adequate. And we agreed on that.

HANSEN: OK. So it sounds like you're almost advocating for this bill, because now--

LESLIE SPRY: I would be happy with the bill and we said we would be happy with the bill back in 2013, if they would just include a provision that the patient has rights to be fully informed about their options.

HANSEN: OK. But what about the doctors' rights?

LESLIE SPRY: Doctors' rights remain. If, if your long, well-considered held belief is that you don't want to do a particular practice, or you

don't want to refer to another physician who may actually do that, then just make sure the position-- the, the patient knows how to make themselves available for a second opinion. In other words, my patients have no idea how to do that. I'm the only nephrology group in Lincoln, but we can certainly make arrangements for them to get other consultation.

HANSEN: It, it seemed like the best resolution to a situation like this was one of an example that a previous doctor gave earlier, was like, I just don't feel like this, I'm comfortable providing the service. The patient says I understand, they end the relationship. But you're saying they need to go a step farther and refer the patient to something, somewhere that's inevitably going to lead them to what they want but that--

LESLIE SPRY: OK, so I'm going to go--

HANSEN: --goes against the personal beliefs of the doctor. So you see, there's a little bit of a conflict here.

LESLIE SPRY: Well, no-- so I'm, I'm going to go back to the lawyer that was here. So it's different if this was a-- if this is my new patient, if this is a patient that comes to me for the first time and I haven't established a long-standing patient-physician relationship-- in other words, this is-- they're coming to me for this, then we can part ways immediately. That's, that's within the Code of Ethics. However, if I am somebody who has been seeing this patient all along and all of a sudden they come to me for advice because that's what I'm supposed to do. I'm supposed to educate them and give them advice. And if they're asking me now to do something I don't do, then in that situation I am compelled by my code to find a way to get that patient cared for.

HANSEN: OK.

LESLIE SPRY: That's my, that's my duty.

HANSEN: Isn't it also the duty of the patient, then, a responsibility to find somebody different?

LESLIE SPRY: Well, it-- yes, if they continue to want what, what-- in other words, they can't come in and ask for a smorgasbord of, of options of things that I don't offer. But if, if I've been caring for them all along and I have a trusted relationship with them already, in

that situation, I have a peculiar duty that I have to educate that patient on what to do next. In other words, I can't abandon them.

HANSEN: Yeah, I'm not talking about abandonment.

LESLIE SPRY: Well, but that would be-- in the AMA Code of Ethics, we differentiate from first visit. First visit is we're going to get to know you, and we're going to find out what you want from established relationship. Those two things, just like the lawyer said here previously and testified, are, are held differently in our code.

HANSEN: Yeah, I think that's the rub we're kind of running into here, isn't it? Like,--

LESLIE SPRY: Yeah. So we-- so--

HANSEN: --how do we not, how do we not, quote unquote, abandon a patient versus how do we respect the rights of the doctor?

LESLIE SPRY: Over the course that I've seen this bill, it's changed from being very prescriptive about what the patient-- what the, the physician could do, but not very descriptive about what the patient had rights of to being a lot more at the employed physicians, those physicians who work in systems and things like that, where they make their, their preferences known initially. And somebody who's been seeing somebody for quite some time, these things pop up and you don't know what that patient's going to ask for. In that situation, I have a particular duty to continue to care for that patient, even though I may disagree with their choices.

HANSEN: OK. All right. Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: I just want to follow up on that conversation. So, so if I understood you correctly-- thank you for being here, as always-- so if I understood you correctly, if there was some referral language than you would be, you would be comfortable with it and maybe the NMA would be comfortable with it?

LESLIE SPRY: We, we-- again, back in 2013, we made a commitment that we would if you put the language in there for referral, that the physician has a duty for referral, and we even define referral as doesn't have to be to another physician or institution, it can be to one of the medical societies. That was our statement.

BALLARD: OK. Or, or it could be just a list of providers in that area.

LESLIE SPRY: Yeah.

BALLARD: OK. OK. Thank you.

HARDIN: Other questions? This is one of those a million feet up in the air questions. Is that OK?

LESLIE SPRY: Sure.

HARDIN: OK. If the NMA and the Hospital Association are opposing this bill, how might providers, in general, regard that or feel about that? Does that kind of plant a flag and make them think, uh-oh?

LESLIE SPRY: Well, we, we respect the Catholic Conference and what they believe, and we respect the fact that they have feelings and they have ways in which they want to do things within a Catholic institution. I was the chief medical-- chief of staff for St. Elizabeth, St. Elizabeth Hospital here in town. So I'm intimately familiar with what they do and what they don't do. What I would say, though, is that I need to continue to remind those providers of their duty under the AMA Code of Ethics. I mean, that's just, yes, I know what your long-held conscious, you know, conscientious opinion is, but these are the things that the patient has a right to based upon the relationship you've established with them.

HARDIN: Sounds like there could be an amendment that could help fix some of this. Is that what I'm hearing?

LESLIE SPRY: I'm thinking.

HARDIN: OK. Thank you, sir. If there are not any other questions, thank you.

LESLIE SPRY: OK.

HARDIN: Opposition to LB655? Welcome.

ERIN FEICHTINGER: Happy to be here. I think this is my second Friday in a row with you all. This is great. Chairman Hardin, members of the Health and Human Services Committee, my name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r, and I'm the Policy Director for the Women's Fund of Omaha. Allowing health care practitioners to deny care based on their conscience would have devastating consequences for

many, including survivors of sexual assault. 1,592 survivors of sexual assault sought medical services after their assault from 2019 to 2020 in Nebraska, 83% of exams were performed on women, and 43% of exams were performed on victims ages 12 and under, and 21% were performed on the victims ages 13 to 17. Cases of sexual assault can be difficult to accurately measure, as they are frequently underreported, and many survivors choose not to seek care post assault because of the unique stigma and complex trauma associated with the crime. If we want to talk about folks who are scared to speak up and out, this is certainly one of those groups. We want survivors to seek treatment after a sexual assault, because this is often the first time that person will connect with a system that can further support them. We do not want victims to avoid health care or be forced to wait for care in an incredibly traumatic moment, so that the health care facility can find a provider who can provide the victim with a best practices trauma-informed response. Particularly for those survivors seeking care without disclosing the assault itself, which is their right, this bill would have a significant negative impact. Post-assault care includes treatment of injuries, testing for STIs, and providing emergency contraception to prevent an unintended pregnancy. If, for instance, a survivor needed emergency contraception but does not feel comfortable disclosing the assault that necessitated it, a health care practitioner could, as a result of this bill, deny necessary and basic standard of care for sexual assault victims based on their personal beliefs. Considering the time sensitivity around emergency contraception and its effectiveness, this denial of care could be devastating to the survivor. Additionally, many dating and domestic violence victims experience reproductive coercion by the person abusing them, and one common method of this is to attempt to force pregnancy on their victim. This could include birth control sabotage, all manner of things, which makes the victim's access to birth control options incredibly important. Similar to sexual assault, reproductive coercion is also underreported. A medical provider under this bill could refuse to provide access to birth control, and then a young victim of dating violence would not have that underlying issue addressed of reproductive coercion and intimate partner violence, and become pregnant against their wishes and their well. Over half of sexual assault exams in this state are performed on children under the age of 17, and there are victims of sexual assault who are minors and who have not sought care or had their cases reported. This bill will not only harm adult survivors of sexual assault, but children as well. And we would urge your opposition, and I'm happy to answer any questions to the best of my ability.

HARDIN: Thank you.

ERIN FEICHTINGER: You're welcome.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you very much. I, I just want to express, I very much appreciate the facts that you have, details. I like facts. I like--

ERIN FEICHTINGER: I was trained right.

RIEPE: You were.

ERIN FEICHTINGER: And we love citations.

RIEPE: Well, that's helpful for us, or, or for me, at least, from a committee standpoint, to see some of the actual statistics as to what the situation is.

ERIN FEICHTINGER: Yeah. And, as always, you all know where to find me. So if you need additional information, please don't hesitate to reach out.

RIEPE: Thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Dr. Feichtinger, for spending your time with us this Friday. I-- so can you walk me through a little bit-- so I guess what, what I'm hearing from your testimony is that this was [INAUDIBLE] I didn't even think about with this bill, to be honest with you. So can you walk us through a little bit more how should this pass into law, how a survivor of assault could be negatively impacted?

ERIN FEICHTINGER: Well, so any survivor of assault who chooses to seek health care is not always going to come through the health care system in the exact same way or interact with them. So for instance, you may be going through a child advocacy center, or you may be going into the ER, or you may be visiting, you know, wherever that point of contact is. Again, we're dealing with an incredibly traumatic situation, and that experience is not always going to look the same. So the idea that a sexual assault victim, let's say they choose not to disclose in this event, walks in and says I need emergency contraception. They could be

denied that. And again, like, further exacerbate that existing trauma. The other situation would be let's say someone does come in and disclose that they'd been the victim of a sexual assault. These are the things that we want. You know, obviously we want a rape kit. Obviously, we want evidence collection, obviously. We want testing and treatment for STIs. And they want emergency contraception. Now, time is of the essence in these moments, particularly not just related to the medication, but just in terms of providing a trauma-informed response to victims as they're experiencing this. And the idea that we would have to wait, you know, they might interact with the health care provider who says, I'm not-- I can't do that, and having to go find someone else, like, just adds to that trauma. That's not to say that they might not get that care eventually, but, again, being sensitive, I think, to the really unique, uniquely and devastatingly traumatic experience that this is. You know, having to interact in a health care system that may deny them the care they need is just a further erosion of their autonomy that's been taken away in an incredibly violent assault.

FREDRICKSON: Thank you.

ERIN FEICHTINGER: If that makes sense.

FREDRICKSON: It does. Thank you.

HARDIN: Other questions? Seeing none, thank you. Opponents, LB655? Welcome.

CHRISTINE NEWELL SNYDER: Hello. Good afternoon. My name is Christine Newell Snyder. Do you want me to spell it?

HARDIN: Yes.

CHRISTINE NEWELL SNYDER: C-h-r-i-s-t-i-n-e N-e-w-e-l-l S-n-y-d-e-r. I have a Bachelor of Science and nursing degree, and I have acted in my role as a registered nurse for the past 13 years. For the first provision of the American Nurses Association Code of Ethics for nurses: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person. Unique attributes. This is a core tenet of caring for individuals. It requires that I place my personal beliefs aside. It doesn't matter how that person comes into my care, they are here now, a human being worthy of being treated with dignity, respect, and compassion. Their age, disability, political party, immigration status, sexual

orientation, gender identity, class status, physical attributes and, in general, life choices, do not and should not affect my ability to see and treat them as equals and educate them regarding best practice to help aid in their autonomous decision-making. There are already federal conscience laws that allow health care providers/payors, which I will, will refer to as providers going forth, to make conscience-based decisions about the care they provide or cover related to assisted suicide, abortions, etcetera. So then why does LB655 need to exist? LB655 ensures providers be legally protected from discrimination for speaking and/or acting in a discriminating way against individuals based on anything that is not race, color, religion, sex, national origin. And you can see my list above for things that are not covered in that five-- those five. There is already an imbalance of power in the relationship between provider and patient. The patient is at the mercy of their guidance and financial coverage. LB655 posits that we exacerbate this imbalance. Providers must be held to higher standards than an average citizen. The weight of this responsibility forces them to deal in ethics, which go beyond their personal, religious, and/or strongly held beliefs. Ethics require we acknowledge and confront our own personal biases when caring for and guiding others. As providers, there are real-life consequences for choices. The important decision to weigh one's words carefully must be felt. LB655 allows providers to act with impunity, undermining ethical standards. The patient is the vulnerable one in this dynamic. The patient is the one without the special knowledge and education. The patient is the one who requires assistance navigating a convoluted and siloed system. The patient is the one in need of care. The patient is the one asking for help. The patient is the one seeking accurate, evidence-based information with, with which to make their personal health decisions. The patient is the one who relies on health insurance to pay for their medical coverage. The provider's role is not to ensure each patient lives a life exactly as they would. Their role ethically is to be forthright about their belief based limitations, and then to guide that patient to the provider or what the Medical Association suggested can best help them. As the saying goes, "your rights end where mine begin." I ask that you oppose LB655.

HARDIN: Thank you. Questions? Senator Meyer.

MEYER: Thank you, Mr. Chairman. So our, our previous doctor, his testimony was that there would be an opportunity to amend this to improve the bill. According to your last paragraph, you say essentially the same thing. If there would be an opportunity to amend

the bill so that the proper referral, referral process was, was provided for in the bill, you'd be OK with it?

CHRISTINE NEWELL SNYDER: No, I don't-- I wouldn't. There's other things in this bill that, especially after listening to all the other testimony, had I had a chance to rewrite my statement, I maybe would have changed some things. What this sounds like is the providers are afraid of people not liking the choices that they make. I would-- I respect that people have different opinions, you know, about-- based on their religious beliefs. And if they don't want to provide that care, I understand that. I, I think that what this bill is allowing for is it's, it's, it's giving the provider all the protections without providing coverage for the patient and what they need in the system. And it provides protection against the provider from discrimination while not providing protections against-- patient against discrimination. Did I say that right?

MEYER: May I, Mr. Chair?

HARDIN: Sure.

MEYER: In your professional experience, have you seen this happen with regard to people not being referred to, to get the proper care that they're seeking from someone that's not careful-- comfortable enough providing that care? Have you seen that in your professional experience?

CHRISTINE NEWELL SNYDER: I'm not usually in the room when that happens. I kind of-- I work in a hospital, so I'm not, like, in a health office.

MEYER: So the answer is no?

CHRISTINE NEWELL SNYDER: That they're not being referred on?

MEYER: That you haven't experienced that, you know of no situations where this happened.

CHRISTINE NEWELL SNYDER: That they're not-- I, I don't know. But this bill, you know, like not helping the patient get the care that they need, whether you can supply it or not. I mean, referring them to, I don't know, a list of providers, something like that. This just seems like it's all about protecting the providers and the payors and has no protections for patients.

MEYER: In our previous testimony from the proponents, I didn't hear anyone say that they were not willing to provide guidance as to where they could get help. In fact, one of our doctors mentioned that someone that had been coming to them for some time, she was not comfortable providing the care that they were seeking. The patient understood. She's still treating that patient, just not for whatever treatment that, that that individual was seeking. So, you know, in some cases, I, I, I, I hear-- in many cases, quite frankly, I hear that we're-- are we trying to fix a problem that doesn't exist? Does the problem exist? And from your experience, you're telling me no.

CHRISTINE NEWELL SNYDER: I don't-- I think that there-- it sounds like there are already policies in place that protect conscience objection. And what this seems to, like, codify is a provider's ability to-- it just like opens, opens wider what they're able to say. I don't, I don't know. It doesn't seem necessary. It seems like it's all about protecting the provider.

MEYER: So then what could that hurt?

CHRISTINE NEWELL SNYDER: What's that?

MEYER: If it's not necessary, then what could it hurt?

CHRISTINE NEWELL SNYDER: Well, because there's things in the bill that it allows for-- that prioritizes the provider over patient care.

MEYER: And, and, and I, I apologize to you. Whether I support this bill or not, I guess I was trying to look for a consistency of why you're protesting, why you're against-- opposed to the bill. And I, unfortunately, don't see a consistency in, in what your opposition is to it. And, and I'm probably being very unfair to you on this. And, and I apologize for that. But it, it appears that we're looking for some negativity regarding this bill where I haven't seen any expressed by any of our testifiers at this point in time, so.

CHRISTINE NEWELL SNYDER: Well, this says that it opposes-- sorry, I have trouble thinking on the fly sometimes. Section 7 indicates that health care providers can't be, like, just permeated against for posting on social media about their beliefs. To me, a lot of what this bill is trying to get at is that some of these viewpoints are largely considered kind of outdated. And, and the people who are for this are, like, feeling targeted, just feeling kind of like the pressure is on, you know, like maybe culture is moving on a little bit past where they

are. And that doesn't feel great. And I can understand that. I'm not opposed to them having their beliefs, but I also think that they have a role as a provider, and they're not the ones who need protection because there's already things in place that are protecting them.

MEYER: OK. Well, thank you. I appreciate that.

HARDIN: Other questions? Seeing none, thank you. LB655, those in opposition? Welcome.

SAM WHITT: Thank you. Honored members of the Health and Human Services Committee, my name is Sam Whitt, spelled S-a-m W-h-i-t-t, and I live in District 37. I come before you today as a trans man and opposed of LB655 and which, if passed, would lead to doctors being able to openly discriminate against transgender people. At its core, LB655 represents a dangerous and harmful step backwards. It threatens the fundamental rights of transgender individuals like myself to live authentically in dignity without fear of being discriminated. It is not just a law. It's a message. A message that tells transgender people that we are not worthy of the same rights and protections as other people in this society. First, I want to address the matter of the discrimination. LB655, if passed, sends a clear message that trans people, especially trans men like myself, are not to be trusted with our own lives and choices. As a trans man, the right to access gender-affirming care has been crucial to my mental and physical well-being. Hormone replacement therapy, for instance, is not just about looking the way I feel on the inside. It's about being, being able to live without the constant burden of gender dysphoria. LB655, by creating barriers to the essential care, would only serve to "expenite" the mental health strategies that so many of us face. When people like me are denied access to health care we need, it is not just a matter of inconvenience, it's a matter of survival. Denying transgender individuals the right to make decisions about their own bodies, their own health, and their own futures is a direct attack on our anatomy. The law should protect, not undermine, our ability to do so. We cannot afford to go backwards. The progress we made in creating a world where transgender people can live freely and openly is hard-won. But LB55 [SIC] threatens the progress. It threatens to undo years of work erasing, erasing the protections and rights that many of us have fought for. If passed, the bill could set the precedent that tells future generations of transgender people that their rights and their dignity are expendable. I stand here today because I believe that we are all worthy of the same rights and freedoms. Trans men, like, like all individuals, should be able to live authentically without fear of

discrimination, without barriers to the health care we need, and without laws that seek to undermine our humanity. So I ask you today, do not let LB55-- LB655 pass. Stand with us. Stand for fairness, stand for dignity, and stand for the right of people, transgender or not, to live freely and authentically in this world. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. Opposition to LB655? Welcome.

JESSYCA VANDERCOY: Thank you. Good afternoon. My name is Jessyca Vandercoy, J-e-s-s-y-c-a V-a-n-d-e-r-c-o-y, and I'm the Executive Director of the National Association of Social Workers, Nebraska Chapter. There are over 700,000 social workers in the United States, making us the largest provider of mental health services and services to veterans in our country. It is estimated that over 60% of the population will obtain services from a social worker sometime in their life. LB655 is not about protecting practitioners and their sincerely held beliefs. It's about creating a framework that justifies exclusion while hiding behind moral rhetoric, something this One Hundred Ninth Legislature has had on repeat all session long. A playbook that looks like-- that says manufacture an enemy, or in this case, a victim, create division, and hide behind moral rhetoric to protect an agenda that seeks to erase those that are different from you. Safeguards for practitioners are already in place through federal law and ethical codes. Medical providers and social workers alike have a, have a protection of good conscience, a safeguard recognizing that when they may not be the best person to provide services due to various reasons, including moral objections, good conscience upholds the dignity and worth of the client, keeps the client-- the patient's well-being as the priority, and allows practitioners to acknowledge their limitations while ensuring the client is connected to another provider who can serve them effectively. This is why practitioners undergo training on bias and education rooted in critical thinking, so they can indeed recognize when their own beliefs may impact service delivery. Ironically, the protection allowing a practitioner to decline services actually reinforces the need for diversity, equity, and inclusion efforts. Ensuring that clients receive care from someone who is better-- who is there to better serve them without bias or discomfort. Recognizing that because of who I am, this person may be better served elsewhere is an ethical stance, not an exclusionary one. LB655 is a be-careful-what-you-wish-for bill, not only because your way of life, values, and leadership may conflict with sincerely held beliefs from many practitioners, but also because you're prioritizing corporate interests over patient well-being, which could lead to

regional ban, treatment bans, denied coverage, and health care instability. Workforce shortages could deepen, costs would rise, and access to essential services, especially in rural areas, could deteriorate. Nebraska taxpayers would bear the cost through wrongful death lawsuits and investigations. I think you're grossly underestimating the savviness and the greed of payors and insurance companies to deny things that don't make money and, and, and claim it as a sincerely held belief. And we're in trouble if that happens regionally. Innovative treatments and medical breakthroughs also do not thrive in exclusionary, restrictive, and corporate-controlled environments. Young professionals, new science, and cutting-edge practices will bypass Nebraska. And as social workers, we are bound by a code of ethics that demands we center our clients, not corporations. We believe in the dignity and worth of every person, and ensuring access to care and holding systems accountable when they fail to-- fail the people they serve. LB655 does not strengthen protections for practitioners. It strips protections from patients. It does not improve health care, it destabilizes it, and it does not create freedom, it creates barriers. As Nebraskans, we deserve a health care system that serves everyone, not one that we pick and choose who is worthy. We vote no against LB655.

HARDIN: Thank you.

JESSYCA VANDERCOY: Yeah.

HARDIN: Questions? Seeing none, thank you.

JESSYCA VANDERCOY: Yeah.

HARDIN: Opposition to LB655? Welcome.

BRADEN FOREMAN-BLACK: I'm going to keep the social worker train going here. Hi, my name is Braden Foreman-Black. My-- spelled B-r-a-d-e-n F-o-r-e-m-a-n-Black, B-l-a-c-k. I'm a clinical social worker and mental health care provider here in the state of Nebraska. On a personal story, sometimes my husband and I will be out walking our dog in our neighborhood and we will hear words yelled out of cars such as fagot, queer, and homos. What I believe is happening with LB655 is that it seeks that same discrimination and brings that into the medical arena which will unjustly cause harm to individuals, families, groups, and communities, all under the guise of conscience-based objections to deeply held beliefs or I-- what I frame as legal discrimination. As a social worker, I am guided by the National

Association of Social Workers, or NASW, Code of Ethics, which has been developed through decades of research, best practices, revisions, and expertise. The NASW Code of Ethics is centered on the dignity and worth of every person, and states that social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection or understanding their bias, which is also deeply held belief and engaging in self-correction, recognizing clients as experts of their own culture, committing to lifelong learning, and holding institutions accountable for advancing cultural humility. LB655 allows mental health providers to disregard clinical training and counseling skills that are considered standard ethical practices. One in three LGBTQ adults say that they have experienced discrimination from a health care provider, which can seriously affect access to care. When people feel discriminated against by a medical provider, people refrain from accessing important health care needs and stop engaging in preventative health care practices. Furthermore, financial barriers such as being denied insurance coverage for important medical needs will negatively impact the overall physical and mental well-being of already marginalized populations. As a social worker, I'm ethically responsible for understanding my own biases so as not to cause harm to individuals in my care. Denying health care coverage will only devastate a system which is experiencing already grave access to care concerns. In my clinical training, I am required to meet the learning competencies as outlined by the social work accrediting body, the Council of Social Work Education, which also echo the NASW ethical standards of do no harm and engage in ethical social work practices. LB655 allows colleges and students who do not meet the standards of the profession to graduate and practice in the field, which will cause harm to the physical and mental well-being of all Nebraskans. LB655 effectively undermines CSWE-accredited social work programs and invalidates the necessary learning objectives that we are-- that are known to be proven that support growth and change among all populations. In doing so, LB655 could discredit the licensure requirements that are already necessary to practice putting an intense strain on our already under-- underfunded institution. Not everyone is able to be a social worker or provide mental health care. If you cannot put your biases aside to care for the individual in front of you, you should find a new job because harm will be done. LB655 is nothing more than legalized discrimination and bigotry in vulnerable health care settings, and discredits the very essence of providing ethical mental health care. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you.

BRADEN FOREMAN-BLACK: OK.

HARDIN: Opposition, LB655? Welcome.

MACKENZIE LONCKE: Thank you. Thank you, Senator Hardin and senators of the Health and Human Services Committee. My name is Mackenzie Loncke, M-a-c-k-e-n-z-i-e L-o-n-c-k-e, and I'm the policy fellow at OutNebraska, a statewide, nonpartisan nonprofit working to celebrate and empower LGBTQ+ Nebraskans. OutNebraska speaks today in opposition of LB655. No matter what we look like, where we come from, or how we express ourselves, we all want the freedom to be ourselves and to live healthy lives. This bill seeks to enshrine discrimination by health care providers and payors and endangers our health, our futures, and, and works to deny us the good life. Religious freedom and the right of our conscience are deeply held values that we do share. LB655 is not basic religious freedom, it goes far beyond a careful balance and endangers LGBTQ+ community among other marginalized communities. This law would allow employers to deny counseling for someone seeking to explore their 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. This bill is especially dangerous for people living in rural areas-- in the rural areas of our state, where access to health care providers is tenuous at best. With this bill, folks in rural Nebraska could quickly run out of medical providers that would provide necessary treatments just because those few providers hold their religious or moral beliefs above the health and well-being of their patient. All of this creates patient harm, something that the ethics of health care are supposed to protect against. For these reasons, OutNebraska asks that you not advance LB655. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you.

MACKENZIE LONCKE: Thanks.

HARDIN: Opposition to LB655? Welcome.

LACIE BOLTE: Thank you. Good evening. My name is Lacie Bolte, L-a-c-i-e B-o-l-t-e, and I'm here on behalf of Nebraska AIDS Project. We are in strong opposition to LB655. Since 1984, Nebraska AIDS Project, or NAP, has been dedicated to serving people impacted by HIV and AIDS, providing critical prevention, education, and advocacy to ensure access to health care for all Nebraskans, especially those who have historically faced stigma and discrimination. LB655 is dangerous.

While it claims to protect personal beliefs, in reality it puts up barriers to essential health care. This bill would allow providers and insurers to deny services like HIV testing, prevention medications like PrEP, and even lifesaving saving treatment simply because of their personal or religious beliefs. This means more people are at risk, more people are getting sick, and more lives cut short because someone in a position of power decided their beliefs mattered more than a patient's health. I'm going to go off script a little bit to talk a little bit more about what another testifier said, just to give an example about the money. So somebody living with HIV, it's going to cost over $3,000 a month to keep them alive. This sounds like a financial incentive for discrimination. Why would an insurance company want to pay for that? Right? If we want to prevent HIV, prevention-- HIV prevention medication costs $1,500 a month. Why would we want to pay for that? We're, we're, we're making a financial incentive to discriminate at this point. Going back. We know the communities most affected by HIV are LGBTQ+ people, people of color, low-income individuals who already struggle to access compassionate, stigma-free care. LB655 would make that harder, giving a legal shield to providers who refuse to treat people based on who they are or the health challenges they face. That's not health care, that's discrimination. At NAP, we believe that every person deserves access to care they need without fear of being turned away. Health care should be about science, compassion, and saving lives, not about personal or political agendas. We urge you to oppose LB655 and stand up for the right of every Nebraskan to receive the care they deserve. Thank you for your time.

HARDIN: Thank you. Questions? Seeing none,--

LACIE BOLTE: Thank you.

HARDIN: --thank you. Opposition to LB655? Welcome.

KAYLEY ANDERSON: Hi. Good afternoon, my name is Kayley Anderson. That's K-a-y-l-e-y A-n-d-e-r-s-o-n. Thanks for the opportunity to speak today. I'm a fourth-year medical student currently working on my master's in public health, and I also happen to be a queer woman born and raised in Nebraska. I speak today as a private citizen and not on behalf of any organization. I'm deeply troubled by LB655. This bill would grant health care providers the right to deny care based on a sincerely held moral belief. Who gets to decide if a belief is sincere or moral enough? As health care providers, we take a solemn oath to care, heal, and help patients. The idea that doctors would be allowed

to turn sick people away based on our own subjective beliefs is in direct contradiction to the values of this oath and the ideals of our profession. I chose to pursue a medical degree. People do not often choose to be patients. Service providers can and already do opt out of providing birth control, abortion services, and gender-affirming care. The vagueness of this bill allows any service to be denied based on any sincerely held belief if the patient is not in one of the protected classes listed. As mentioned earlier, sexual orientation is not a protected class. I do not fall under protected class. When I transitioned to health-- to adult care from, from my pediatrician, it took me three doctors before I was able to find somebody willing to manage my care. The reasons for which I'm happy to get into if there are questions, but boiled down to my lifestyle choices. They did not refer me to someone else. They did not tell me where I could find other care. My story is not unique. Fear of discrimination by providers is one of the number one reasons that people who identify as LGBTQ avoid seeking care. It was said earlier that this bill does not greenlight discrimination, but it does not, in the language of the bill, specify any services that are exempt. I have seen students opt out of things they feel are against their beliefs, without repercussions and with faculty support. We are not taught or exposed to abortion. No one is forcing us to learn about these things. This bill is not necessary to protect against that. This bill would make this discrimination not only acceptable, but legal. It is a way to avoid accountability. It does not erase the queer community from our state. We are your neighbors, your friends, your family members, your senators, and your doctors. We have always been here and we will continue to be here. We are still Nebraskans and we still deserve care. Thank you for your time and consideration. I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your willingness to testify. It's always-- I mean, we've been talking a lot about medical students. I don't know if you were here for the proponents of the bill as well,--

KAYLEY ANDERSON: Yeah.

FREDRICKSON: --but there's a lot of discussion around that. And, you know, again, I, I, I kind of-- this was sort of a bit of ah-hah moment for me as I listened to a lot of the testimony and just in my, in my own experience as a clinician, but I'm curious to hear your thoughts

on this as well. It sounds to me like folks-- it, it-- there, there almost is a lack-- there, there-- for folks who want to deny providing certain services or care, to me, it almost sounds like this is an interpersonal issue that they need to work on communicating that they are not going to provide this care. Is that your sense as well?

KAYLEY ANDERSON: I would say so. I would also point to earlier testimony that no one was able to identify an actual repercussion that they faced as a result of wanting to deny care, but I, as a patient, who was denied care, faced repercussions.

FREDRICKSON: Yeah.

KAYLEY ANDERSON: They-- the providers don't need the protection, the patient does, as someone else earlier said.

FREDRICKSON: Well, because my, my, my other thought is I can understand because I-- because of what I'm hearing is that there might be a fear that if you were to say I don't want to do this, you might be punished or penalized around that. I'm also thinking that these are folks who are in positions that are providers, and that is a huge responsibility. And the thinking that if you're going to be being a provider, having those difficult conversations seems to be a prerequisite to, to that level of responsibility.

KAYLEY ANDERSON: Yeah. I mean, we receive training on that. So, yeah.

FREDRICKSON: Great. Thank you.

HARDIN: Other questions? Seeing none, thank you.

KAYLEY ANDERSON: Thank you.

HARDIN: Opposition to LB655? Welcome.

BRITTA TOLLEFSRUD: Hello, everyone. Good afternoon, my name is Britta Tollefsrud, and I come before you as a lifelong Nebraskan, a licensed mental health practitioner working in Lincoln, and I oppose this bill on merit as a Nebraskan, mental health clinician, and a human. Turning to history as a guide, measures similar to this bill have kept people of color, women, and other underrepresented groups of fellow humans from obtaining care. Interestingly, this bill does not condone limiting services to a patient due to race, color, religion, sex, or national origin-- you can turn to Section 3(2)(c)-- which acknowledge-- which acknowledges the historical harms of racism,

sexism, and other forms of oppression on a person for simply living in a body different from the majority. What is loudly left off this list of protections includes queer-identified Nebraskans. So it begs the question who truly receives protections from this bill? On the surface, it feels like a standoff, two parties requesting to be respected as individuals in a manufactured contradiction. So let's look at the roles and who bears responsibility to think of the collective above the ego. Anyone with a license to provide medical care is in a position of authority with, with regards to their respective field and, thus, has a duty to protect all. We don't allow police officers to only protect citizens they share identities with. They are ostensibly charged to protect and serve every Nebraskan. We don't allow teachers to pick and choose which students they teach because of preconceived notions of what an acceptable student is based on their own personal beliefs, they are taught and tasked to teach every student equally. Similarly, a doctor's role is not to decide whose life they save. Like many Nebraskans, I come from a background of faith. My grandfathers were both Lutheran pastors. Quite the family business. In their role as faith leaders, my grandfathers instilled in me the importance of caring for others because they are human. Roles matter and roles carry duties. This bill allows people to abstain from their earthly duty to provide care. My grandfathers would counsel that it is not upon you to act as judge and jury to enact what you foresee as a religious conviction. Your role as a fellow human is to provide care. Can I then, under this bill, as a clinician who works with predominantly queer-identified clinicians-- clients abstain from providing care to heterosexual clients because I oppose the perpetuation of heteronormative standards of love. That would be problematic and unethical, going against my role. To denounce the fact that conscience is not used to masquerade religious convictions is a facade. Therefore, if religious convictions are in fact the primary catalyst for this bill, then I say turn back, turn back to Romans 14:13: Therefore let us not pass judgments on one another any longer, but rather decide never to put a stumbling block or hindrance in the way of a sibling. I have the greatest fortune to continue family's work of providing care to all, welcoming them as they are, celebrating our unique differences. And in doing so, I often learn from them more than they learn from me. I hope you are charged with doing the same. Thank you.

HARDIN: Thank you.

BRITTA TOLLEFSRUD: Yeah.

HARDIN: Questions? Seeing none, thank you.

BRITTA TOLLEFSRUD: Thank you.

HARDIN: Opposition to LB655? Welcome.

ALEX DWORAK: We're not done with professors yet.

HARDIN: Hi.

ALEX DWORAK: Good afternoon, Senators, Chair Hardin. My name is Dr. Alex Dworak, A-l-e-x D-w-o-r-a-k. It is a, an honor today to testify in strong opposition to LB655. I am also speaking on behalf of OutNebraska, of which I'm a proud member. I'm also a past board member of Nebraska AIDS Project and an NMA member, as well. This bill is about discrimination, pure and simple. Its aim is to take away health care from disfavored Nebraskans and protect medical providers who wish to express discriminatory beliefs. I say that because there is no protection for conscientious providers of services like me, who are already burdened by state laws restricting my freedom of conscience and, and sincerely held moral, ethical, and religious belief. In our current context, it's just another brick in the wall of an onslaught of culture war bills telling marginalized Nebraskans that we don't deserve health care, and that our own elected representatives don't want us here in this great state. I can personally attest that there are already workarounds for conscience. I have clinic and hospital partners who follow them as we speak, and I'd be glad to expand on that. I can also assure that no patient wants to force a clinician to do something that they don't agree with, because they know that clinician probably isn't going to do it well under duress. I echo others in saying this bill solves a nonexistent problem, even as it causes more problems. I'll move ahead and say that the emergency clause is in there, but I have several examples, both nationally and internationally of people have died in emergency settings. So I do not believe that that will protect people. The bill also sets up a vague and exceptionally abusable system. Where are the exemptions going to stop? I can give examples again in question time if the committee would like, both from statistics of which I have even more that are in that folder I gave you of exhibits, and from the personal experiences of my own patients. I'm sad to say I've had patients who've gone through this, and I can lift up their experiences by speaking for them, including one who's dead and can't speak for herself anymore. I will note that all ethics papers on this topic-- again, I spared you all the 82-page Harvard Law Review article that I read, but I've got

it here if anyone would like. These papers mandate a duty of referral to balance provider and patient rights. This was reviewed in previous discussion, but it's not in the bill. LB65-- LB655 pointedly does not mandate referral, and explicitly permits a complete refusal to refer a patient on, counsel them that other options exist, or even to send records to a new provider the patient might find on their own, because it would be participating in something that I disagree with, with total protection for the provider and no recourse for the patient. And I'll close, echoing again someone else by pointing out that allowing payors, not just individual practitioners, to decline services is an open invitation for abusive practices. Insurance companies are notorious for denying care constantly and harming patients as it is. This would be another way for them to find religion and decide that, say, chemotherapy is against their sincerely held beliefs because it's really expensive. This bill will not be a disaster just for women and the, and the queer people that I think it's clearly aimed at, but all Nebraskans, and especially rural Nebraskans. I have multiple exhibits here, even more if you would like, and I strongly urge you not to advance this bill out of committee. I think we can and should want to aim higher than Florida and Mississippi. And I appreciate the chance to be here, again. There is nothing-- well, the only thing I would love more than to take your questions right now is for Senator Hansen to come back because I'll be sad if I miss out on the chance for him to ask me questions. Thank you.

HARDIN: Thank you. Well, we're lacking Senator Hansen at the moment. Questions?

BALLARD: I'll ask one.

HARDIN: Senator Ballard.

BALLARD: Just because you came all the way down from District 12.

ALEX DWORAK: The best district. Thank you, Senator.

BALLARD: Yes, of course. It's good to see you again. Can you expand on this insurance, this idea that insurance is going to benefit from LB655? I'm struggling with that.

ALEX DWORAK: So I have not-- so specifically, I deal with prior authorizations constantly as it is. I am-- I can speak to a situation and I spoke with Senator Dungan about this. I had a patient living with HIV who had what's called a reference-based insurance plan, which

was not something I'd ever heard of. And they were denied the first-line care for HIV, which, as we've discussed, will kill you if it's not treated. So I called and said, OK, well, instead of Biktarvy, what about Triumeq? No. OK, what about Symtuza or another [INAUDIBLE]? No. What about older ones like Atripla or, or, or [INAUDIBLE]-based regimen? No, no, no. And I finally asked the person on the phone who obviously was not a clinician, what do you cover? And there was nothing. And I-- they had a commercial plan. They were working. They had a job. They were doing what they were supposed to do and, literally, nothing was covered. And we actually had to talk to our friends at NAP and use federal Ryan White funding to make sure that they didn't have their viral load shoot-up, which has devastating consequences for their physical health, their mental health, because they know they're not sick. They know that they're not treating a deadly disease and has public health implications because infectious diseases are infectious. That's happening without something like this. And so I'm, I'm thinking that insurance companies being profit driven, this seems-- I mean, if I were wanting to play devil's advocate and I wanted to make more money, this is a great way to deny care. And there are different philosophical traditions with regard to a blood transfusion, which was mentioned, our Catholic friends, not all Catholics agree with them, but who disagree with reproductive care and abortion. And I don't see any limitations in here of how this couldn't be expanded further and further to say we don't agree with that, we don't agree with this, we don't agree with that. And I worry that the things that we happen to-- the payors happen to disagree with will be the most expensive ones.

BALLARD: OK. So your, your concern is that they'll-- insurers will use providers as--

ALEX DWORAK: Well, it, it says payors can deny care. So even without regard-- recourse to who they choose to hire and setting hospital policies and, again, I have some great friends at Creighton, but that hospital system is discriminatory. There are certain services that I know from personal fact are not allowed there because of the institution's beliefs. But this is regardless of what a provider like me does. I can-- and I can be trying to get a patient something that, in my judgment, with my extensive training, I know they need and the insurance company can practice medicine by telling me how to do it. Maybe a clinical pharmacist looks at it, maybe I can get a peer to peer with another doctor, maybe not. And so, again, the payor side of this is another aspect that I think it's, it's rife for possible abuse. And I think the insurance companies are obviously rapacious.

And I think that if we open this door that I worry about them walking through that and harming the health of Nebraskans, in addition to all my other concerns with it as written.

BALLARD: OK. Thank you for being here. Always good to see you.

ALEX DWORAK: Thanks, Senator Ballard.

HARDIN: Other questions? Seeing none, thank you.

ALEX DWORAK: Thank you.

HARDIN: Those in opposition to LB655? Welcome.

JESSI HITCHINS: Thank you. I'm Dr. Jessi Hitchins, J-e-s-s-i H-i-t-c-h-i-n-s. I was not planning to speak on this bill. However, there were some really great conversations being had, and I think that I could relay some information that does relate to the bill that's really crucial. So prior to being a Nebraskan for the past 10 years, I was an Illinoian for most of my life. So starting my life in 1983 in rural Illinois, because most of us are not Chicagoans as, as people think. So, for me, I was a rural Illinoian. And now where my parents are still residing, which is again in rural Illinois, my father was a farmer for most of his life, as well as working in the industry of the picking industry. The only options that were available was the ones that were associated for my family was with our insurance that we were able to offer. That was specific now to my area where my, my family still resides. That conversation about one in seven facilities are CHI. In my parents district, that is the only facility that has available to my parents at this point. And that is incredibly harmful for if we were to be their two daughters again, if we were to roll back time having access to reproductive health care. So having options related to us, and that was one of the things that my mom was very, very terrified of was, like, what would happen if I need to have my uterus removed? She would have to go and drive another 2 hours to go and get the care that she needed if needed in an emergency. This is the problem that will arise. So I think it was really interesting that was talked about, about, like, Illinois has the, the strongest association with this. There has been problems, and what hasn't been talked about was the fact that this is the result of it is that my parents are in a district, they will have to drive 2 hours, and that is-- and that would be a-- there's some areas within Illinois that it would probably be 4 to 5 hours. Luckily, they would be able to drive to a Chicagoland area within that time frame. But, again,

understanding the repercussions of what this could look like could be incredibly harmful knowing that one of the, the conversation was around access for care, specifically around rural support. And one of the positions I support in my current role is supporting rural Nebraskans with their health care. And I'm actually going to talk about that a little bit later. But for this one, I really want us to make sure that we're taking care of rural Nebraskans, because as a former rural kid, it's really critical to make sure that we do keep the people in the state and have good health care providers that are available to them that can provide all options. Thank you. I'm happy to take questions.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thank you. You alluded that there might be some-- you said there's problems with Illinois, Illinois, their, their rule that they have. You said there's problems, but you didn't expand on that.

JESSI HITCHINS: Well, so what I was saying--

HANSEN: I'm curious to know your thoughts on that.

JESSI HITCHINS: Absolutely. Thank you, Senator Hansen, for asking a question. So the issue is related to the fact that if my mother would need some reproductive health care at this time, she would have to be driven in a private vehicle to a hospital that would provide health care for her. Because right now, all the health care within my, my parents' county is only CHI. And so they will not have health care that could be potentially lifesaving, as my mom does have a history of reproductive-related issues. And so one of the things is if she needs a hysterectomy, what would that look like? She, she might not make it. And my mom could pass away. And let me tell you, my mom was my favorite person in the whole entire world. And so just the idea of what that look like, if that was your mother? Right? So this is the really true impact of when we put expectations in this, of how it could look like in the long run. This is part of that conversation.

HANSEN: OK. Thank you.

JESSI HITCHINS: Thank you.

HARDIN: Thank you. Other questions? Seeing none, thank you.

JESSI HITCHINS: Thank you.

HARDIN: Opposition to LB655? Hi.

MARIEL HARDING: Hi. Good afternoon-- good evening, Chairperson Hardin and members of the committee. 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 the Reproductive Health Collaborative of Nebraska. And I'm here to express opposition to LB55 [SIC] on behalf of Reproductive Health Collaborative and our board. So we are a nonprofit organization that ensures Nebraskans have equitable access to high-quality sexual and reproductive health care. We do this through funding health centers across the state, educating our communities about sexual and reproductive health with unbiased, medically accurate information, and advocating to enhance and expand sexual and reproductive well-being and equity in our state. We're opposed to this bill because we think it has the potential to have negative impacts on health across the state. While the impacts on the health care system writ large could be grave, impacts to sexual and reproductive health will be particularly significant. This is evidenced by the testimony that we have heard here today, which has included outdated misinformation about emergency contraception. I'd like to share a few statistics about sexual and reproductive health with you that indicate that Nebraska already faces challenges in sexual and reproductive health and access to care. So, for example, chlamydia cases have been rising steadily for many years. In 2022, there were over 9,500 cases in the state. That's the highest number documented at any time since 2011. Syphilis is climbing. I know you all know that in this committee. 10 years ago, there were 45 cases of primary and secondary syphilis in Nebraska. In 2022, that number was 215. According to the CDC, in 2019, 75% of all women in Nebraska ages 18 to 24 had an ongoing or potential need for contraceptive services. And a study published in 2023 found that 99.2% of women who had ever had intercourse with a man had used contraception at some point in their life. So I share these statistics to paint a picture of the sexual and reproductive health needs in the state. We are already struggling to achieve healthy outcomes in sexual and reproductive health. This bill could worsen those outcomes by creating additional barriers to care. The bill could have more pronounced impacts in rural areas due to the lack of providers. According to a recent report by UNMC on the rural health care workforce, 79 of Nebraska's 93 counties are without an ob/gyn and 21 are without a primary care physician. In these counties, health care consumers do not have many options for care. The ability for health care providers to deny care based on personal beliefs presents the potential for deteriorated access for health care for rural patients. We share the concerns about

discrimination on the basis of sexual orientation and gender identity. I think that's been covered today. I would also flag pregnancy status is not included in the bill. We believe that professional health care providers' ethical, religious or moral preferences should not limit another person's access to health care. These broad exemptions will harm patients, and we at Reproductive Health Collaborative stand in support of our fellow Nebraskans' right to equitable, quality, and accessible health care. We ask that you not advance this bill out of committee. Thank you so much for your time and I'm happy to answer any questions.

HARDIN: Thank you. Questions? I have one. How come, in some of those categories that you just listed, are, are we seeing exponential rises in STDs? What's going on?

MARIEL HARDING: It's tough, isn't it? I think there's a lot of things at play in sexual reproductive health. One is, of course, access to care. Another is stigma. People are embarrassed to talk about their sexual health. And that makes it-- there are kind of pushback on seeking health care when there's stigma. So I think something that has occurred to me as I've been listening to the testimony today is that people don't always know what they're going to talk to their provider about when they schedule an appointment, particularly when it comes to sexual and reproductive health care. I think we see this often with adolescent patients who schedule something and then have a moment to say, actually, I also need an STI test. They wouldn't have had the opportunity for the provider to decline that ahead of the appointment. It would be in that moment that they would be disclosing that they need that care. I think the reproductive coercion component that the Women's Fund raised is also aligned to this issue, where people are living in a complex personal community and political situation as it pertains to their sexual health care. And that can limit their access to care. We-- DHHS, in Nebraska, published a report a couple of years ago about the rise of HIV, and they found that it was particularly rising among white rural men and that they were coming in getting tested with higher viral loads, meaning that they were waiting longer to be tested. I think that's an indication of the stigma and the lack of access to care. People are just not seeking those services.

HARDIN: OK. Understood. Thank you. Other questions? Seeing none,--

MARIEL HARDING: Thank you so much.

HARDIN: --thank you. Those in opposition to LB655? Welcome.

SCOUT RICHTERS: Good afternoon. Thank you. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s. I'm here on behalf of the ACLU of Nebraska in opposition to LB655. LB655 would allow health care professionals and payors, including insurance providers and employers, to refuse to provide patients with care or pay for care based on conscious objections. While the majority of states, including Nebraska, have rules allowing providers to decline to provide abortion care, LB655 sweeps much more broadly and reaches literally any kind of care that someone might object to on moral or religious grounds. It's also important to recognize that, as other testifiers have said, federal and state law already prevent discrimination on the basis of an employee's religion. LB655 could create staffing challenges because employers would have to accommodate any refusal of care, and could not take any steps to adjust work obligations or assignments in response to a refusal to do basic duties of an employee's job. Further, if enacted, LB655 will be felt more severely in rural areas where patients have more limited choice of medical providers. Our government should never make it more difficult for individuals to access health care, and that's exactly what LB655 does. We urge the committee to indefinitely postpone this bill.

HARDIN: Questions? Senator Hansen.

SCOUT RICHTERS: Hi. Good to see you.

HANSEN: Hey, I want to ask you an ACLU question.

SCOUT RICHTERS: Yeah.

HANSEN: I know you're out representing and, and concern for the civil liberties of the patient. What about the civil liberties of the doctor?

SCOUT RICHTERS: Right. So from our perspective, the-- an employee's religious rights are already protected under both Title VII as well as the Nebraska Fair Employment Practices Act. So there's already a great deal of protection for individuals' religions and their individual religious beliefs. We, we just find it problematic when religion is used as a license to discriminate or the basis to deny someone care.

HANSEN: Yeah. I think-- if l can-- it seems like the bill spells it out as one of the things they worked on, I think, from time is to make sure we're not talking about the discrimination of the patient, but just the comfortability of the doctor performing a procedure. I know

it's spelled out, particularly in the bill, even though some people may not feel that way. However, I'm going to pose another kind of hypothetical to you.

SCOUT RICHTERS: Yeah.

HANSEN: So say the doctor decides they do not want to perform a procedure on a patient, whether it's providing a pill or procedure or whatever, the patient gets upset. They go online. They complain about it.

SCOUT RICHTERS: Yep.

HANSEN: It becomes viral. The hospital then terminates the employment of the doctor. Would the ACLU come out and stand up for the doctor?

SCOUT RICHTERS: I think I'm-- I'm having a little trouble following the hypothetical.

HANSEN: So, so the doctor got fired because they decided not to perform a service for a religious or moral reason.

SCOUT RICHTERS: Um-hum.

HANSEN: Would the ACU-- ACLU then come out and support the doctor?

SCOUT RICHTERS: I think that, definitely, number one, probably need more details. And number two, I think that it's also important to remember that medical, medical science and research should guide medical care rather than an individual's beliefs. I think that, that that can be separated.

HANSEN: OK. All right. Thanks.

SCOUT RICHTERS: Thanks.

HARDIN: Other questions? Seeing none, thank you.

SCOUT RICHTERS: Thank you.

HARDIN: Those in opposition to LB655? Those in the neutral to LB655? Welcome.

TRACY AKSAMIT: Thank you. Good afternoon, Senators. I'm Tracy Aksamit, T-r-a-c-y Aksamit, representing myself. I'm a licensed architect, and I research and write about the local impact of global agendas. I

question the effectiveness of this bill to meet its perceived intent to protect provider speech. And I oppose its reinforcement of payor protections, which further alienate the provider from the patient. First, the bill generally refers to both providers and payors together, yet Section 3 requires only providers to give written notice of an objection to their administrator, and to document the same in the patient's file. There is no requirement to notify the patient unless the patient is specifically seeking the objected-to-service. If tables were turned and we lived in a healing world instead of a sickness world, this would be like asking a provider believing in eugenics and overpopulation to disclose their objection to early, effective lifesaving treatment for a 90-year-old, or to providing preconception, nutrient-dense diet education to a couple preparing for pregnancy. How often might that really happen in practice? Second, page 4 of the bill limits objections to a specific health care service and does not waive the duty to provide informed consent. My own personal history and experience of the last 5 years demonstrates to me that legislating informed consent does not work. For over 150 years, corporate medicine has effectively shut down informed consent so that most avenues of unpatentable, traditional, and new healing methods are suppressed. This is very well documented, including this book-- in this book, Dissolving Illusions: Disease, Vaccines, and the Forgotten History. I am providing you with the graphic that I created for home, my own informed consent, listing just a few of the available treatments compared to the current paradigm, as I see it, where early effective outpatient treatment is not promoted by corporate medicine. Third, the bill is generally concerned with the ability to decline service, and on page 5 and 6, it constrains the provider's free speech to that which doesn't violate a law or simply a rule. As this bill appears to only strengthen payor protections with little patient benefit and the proven difficulty with further legislating free speech and informed consent, I'm asking for a cultural shift to personal responsibility and a mutual respect for all truly healing modalities. Please remove regulations that hamstring innovative healing practitioners. Thank you for your time.

HARDIN: Thank you. Questions? Seeing none, thank you.

TRACY AKSAMIT: Thank you.

HARDIN: Anyone else in the neutral to LB655? If none, Senator Murman. We had online: 63 proponents, 280 opponents, zero in the neutral.

MURMAN: OK, well, I appreciate everybody hanging in here on Friday afternoon, and I don't mind getting up twice there. It was good exercise after sitting so long, but appreciate it. It was spoken a lot about emergency situations and under this bill services will be provided, whatever's needed in, in emergency situations. And that's covered, of course, under federal law. And then I think it was-- well, one of the testifiers talked about under sexual assault getting the care at the hospital. And that is also covered under federal law. So that would always be done. Another testifier talked about CHI services not being available in rural areas. I think she's referring to Illinois, but we do have CHI in Nebraska. And I did Google in Nebraska that hysterectomies are provided in several locations in Nebraska by CHI. But the whole-- the-- one of the big goals of the bill is to provide more medical providers, not less. And I think in rural Nebraska, especially a bill like this, you know, when we're talking about medical students especially, would open up the, the gates more for more providers to be-- to take their schooling here in Nebraska. And then the Hospital Association, early in the testimony they said that situations were very rare that they couldn't accommodate. So, so in other words, it isn't a problem. But then later in the testimony, they said it would be hard to accommodate certain situations under this bill. So conflicting testimony there. And then with the NMA, the code of ethics only requires impartial guidance to the patients. It doesn't require referral. Actually, there's two different standards. And this bill requires that there must be an informed consent to the patient even if the doctor opts out of a procedure or service. But I am willing to have further discussions with the NMA or, or any provider that we can work out language that would, would fit their, their objection in a better way. And I want to emphasize that the bill does protect patients. It's not just about doctor protection. It still requires providing informed consent to the patient, even if a doctor or medical provider objects to providing a service. It also requires to provide all other care that would be provided to that patient, and only the objectionable procedure or service would not be provided, and it still provides for the professions for them to follow their code of ethics and to help offer guidance or referral to the patients. And it still, of course, provides-- protects emergency care as I said earlier. And we definitely don't want a patient to force a, a certain procedure, whatever the procedure is, for the health care provider to provide that, that procedure. Section 3 of the bill was mentioned several, several times, and Section 3 specifically says that: written notice of a conscientious objection has to be given to the employer or the supervisor as soon as practicable. So that would cover the-- a

large hospital, or something like that, to, to provide that information as soon as, as practicable. So likely when the provider is asking for employment. And I guess with that, I will answer any questions that weren't answered this afternoon.

HARDIN: Questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. My one question that kind of come up during the testimony some on the payor side. So I know, and nothing against insurance companies, but I know myself, sometimes you're-- we're-- we've-- I've been declined, declined insurance payment for a certain procedure. So I think at some point, they, they don't even-- they're, they're just looking for reasons to not pay maybe a claim. So I don't know if this is something we're going to need to address in this bill, but I could see this becoming an issue or opening up that Pandora's box on something like that.

MURMAN: Yeah, I know what you're saying. It's, it's difficult sometimes to work with insurance companies. And, yeah, it does seem like, well, sometimes at least that they're just trying to get out of paying for whatever the service is.

QUICK: I just don't want any unintended consequences--

MURMAN: Yes.

QUICK: --from a bill like this.

MURMAN: And, and I can say that an insurance, an insurance company came in originally opposed to this bill. So they were actually opposed, just like a lot of other, other providers that we heard. But we just made a minor tweak in the language and they're not opposed. But, but they, they're not for-- they didn't come in pro either, so. That's what I can say about that.

QUICK: Can, can I ask one more?

HARDIN: Sure.

QUICK: It wasn't that you added payor in there, was it?

MURMAN: No, payor was always in there.

QUICK: OK.

MURMAN: So--

QUICK: Just a question.

MURMAN: Yeah, it-- they were originally opposed at least.

QUICK: All right. Thank you.

HARDIN: OK. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Murman, for sticking it out for this hearing. So the, the, the two-- kind of piggybacking a little bit off of Senator Quick's question. You know, two of the primary concerns I heard today were-- and I don't want to misspeak for any of the testifiers, but one was looking at potentially an amendment about something like continuity of care or, or providing a referral should this be something that you are unable to or unwilling to provide. Do you have any thoughts or response to, to that?

MURMAN: Yeah, we'll certainly work to address that concern. We've, we've discussed that in the past and we'll continue to look at that.

FREDRICKSON: And my second concern was-- or the second concern I heard a lot about and what I share as well was, was kind of related with Senator Quick was asking with the payor piece, specifically, kind of like the slippery slope nature of this, where, you know, again, not to assign nefarious intent to an insurance company, but this idea that we don't want to cover X procedure regardless of what it is, right, because it's expensive. Right? And we are now saying we have this deeply held belief as a company or as an organization that, you know, preventative mastectomy should not be covered or-- I, I'm just kind of thinking out loud here. But that to me is concerning with the payor piece. And so do you have any thoughts on working or kind of massaging that a little bit to ensure that we don't have abuses of denial of, of care for the purposes of simply saving money for the insurance companies.

MURMAN: Yeah, you know, insurance companies, it's always difficult to figure out exactly what's covered and what's not. And, and it's hard to read all the fine print sometimes. But, yeah, I'm, I'm willing to work with the insurance companies. Well--

FREDRICKSON: Well, they might, they might like this.

MURMAN: Yeah. Well--

FREDRICKSON: [INAUDIBLE]

MURMAN: Like I said, they came in opposed originally and we didn't hardly change anything but I'll work with what-- whatever the situation is to address the, the-- an issue that could be possible with payors.

FREDRICKSON: That's helpful. Thank you.

MURMAN: Yeah. Thank you.

HARDIN: Other questions? So just to re-emphasize, no health insurance carriers came in support of this?

MURMAN: Correct.

HARDIN: OK.

MURMAN: Or opposed.

HARDIN: Or opposed. OK. Very well.

MURMAN: Or neutral as far as that goes.

HARDIN: Thank you.

MURMAN: Yeah. Thank you.

HARDIN: Appreciate it.

MURMAN: Thanks, everybody, for sticking this out.

HARDIN: This ends our testimony on the hearing for LB655. We're moving on to LB515 and Senator Quick. Welcome.

QUICK: Thank you, Chairman Hardin and members of the committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35 in Grand Island. I'm here today to introduce LB515. LB515, as introduced, would allow a pharmacist who receives a request to refill a prescription for maintenance medication where no refill-- no refills remain, and the pharmacist is unable to readily obtain authorization from the prescribing practitioner to dispense a refill, refill within the following limitations. The refill is lesser of 30 days, or the amount dispensed on the most recent refill. The refill is not a

controlled substance, and in the pharmacists professional judgment, the interruption of taking the prescription will produce undesirable consequences or may be detrimental to the patient's welfare and cause physical or mental discomfort. AM227 is a white copy amendment that represents the work in agreements between the NPA and the Nebraska Medical Association. The amendment contains compromise and input from both the prescribers and the pharmacists. These changes bring the bill into alignment with limitations and protections found in other states and, and addresses the concerns raised by the Nebraska Medical Association. Notably, with AM227, it is important to the pharmacist that deliver be-- delivery be allowed, as many patients rely on pharmacy delivery services for their maintenance medication. The NPA has asked some pharmacists to repre-- to, to be present to testify in support of this bill. I am also aware of several pharmacists who have already submitted online comments in support of LB515. Thank you and I appreciate the committee's vote to advance this bill out of committee, and I'll take any questions that I can try to answer.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for holding out.

QUICK: Yeah.

RIEPE: My question is, who has the greater liability with this action, the pharmacist or the physician?

QUICK: They might have to answer that.

RIEPE: You're, you're an attorney, aren't you?

QUICK: Yeah. Actually, a welder. But, you know, it's close to an attorney, maybe. I don't know.

RIEPE: OK.

QUICK: I don't know if I can answer it, but I'm, I'm going to guess that maybe they can. I don't know who would be more liable.

RIEPE: OK. Obviously, I didn't either. So thank you. Thank you.

QUICK: Yeah.

RIEPE: I'm done.

HARDIN: Other questions? Will you stick around?

QUICK: I will.

HARDIN: Great. Proponents, LB515? Welcome.

HALEY PERTZBORN: Hi, guys. Chairperson Hardin and members of the Health and Human Services Committee, my name is Haley Pertzborn, H-a-l-e-y P-e-r-t-z-b-o-r-n. I'm a licensed pharmacist, the CEO of the Nebraska Pharmacists Association, and a registered lobbyist. And it is just me today. Sorry. We had some work scheduling conference, conference or conflicts. So just, just me. Thank you to Senator Quick for introducing LB515. Pharmacists play a crucial role in ensuring patients have continuous, continuous access to essential medications. However, when a patient runs out of refills and cannot immediately see their provider, they face potential health risks. An example of this is a patient on blood pressure lowering medications comes to me on a Friday evening at 7 p.m., needing a refill, and is completely out. Monday is a holiday and her doctor's office is closed as I try to get ahold of an on-call physician, but no luck. The patient does the same and tries to reach out. As a pharmacist, seeing her dosage of blood pressure medications and knowing her history, I, I know it will put her in extreme risk if she goes 3-plus days without her medication. And that is assuming the office gets back to us right away on Tuesday. LB515 provides legal protection for pharmacists who dispense a limited emergency supply of medications, allowing, allowing patients to safely continue their treatment until their next appointment or their next refill is sent in. By passing this bill, Nebraska would join other states in prioritizing patient safety and supporting pharmacists in their critical role. The NPA also worked with the NMA on the language in AM227, which we support and thank the NMA for their collaboration. I'd be answer-- I'd be happy to answer any questions.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your testimony. So what, what happens currently if someone comes in and needs an emergency refill?

HALEY PERTZBORN: Well, off the record, a lot of times it does happen, but there's no protections for the pharmacist on it.

FREDRICKSON: Got it. And, and, and so-- and from what I understand, this would be a less than 30-day refill?

HALEY PERTZBORN: Um-hum.

FREDRICKSON: So this is--

HALEY PERTZBORN: Yes. The amendment is 7 days--

FREDRICKSON: 7 days. Got it.

HALEY PERTZBORN: --max.

FREDRICKSON: OK.

HALEY PERTZBORN: Yeah. Or-- I guess, or if there's, like, an inhaler, that package size can't be changed to 7 days. So there's that exception, too.

FREDRICKSON: OK. Great.

HALEY PERTZBORN: Yeah.

FREDRICKSON: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Do Walgreens and CVS, bigger pharmacies, have specific policies so that the pharmacist, although I've had it happen on my own that they will fill it to give you a carry over,--

HALEY PERTZBORN: Yeah.

RIEPE: --but are they not only exposing themselves and the company to liability, but maybe exposing their, their jobs?

HALEY PERTZBORN: Yeah. I'm not sure on their policy.

RIEPE: I'm not tattling on them.

HALEY PERTZBORN: Yeah. I'm not sure on their policy, honestly.

RIEPE: Oh, OK.

HALEY PERTZBORN: I'd have to get back to you on that. Yeah.

RIEPE: I could see--

HALEY PERTZBORN: Yeah.

RIEPE: --some need for protection on it--

HALEY PERTZBORN: Yeah.

RIEPE: --if the company doesn't get them. Thank you.

HALEY PERTZBORN: Yeah.

RIEPE: Thank you, Chairman.

HALEY PERTZBORN: Oh, and to answer your question, too, on who has liability, it would be the pharmacists. It's on their judgment, professional judgment. I mean, I'm not gonna-- I'm not a lawyer so don't take me--

RIEPE: So I assume most of the pharmacists, if not all, carry personal liability--

HALEY PERTZBORN: Yeah.

RIEPE: --up to a million bucks or something like that.

HALEY PERTZBORN: There is professional liability insurance. Yes.

RIEPE: OK. And is that provided through the Pharmacy Association?

HALEY PERTZBORN: No.

RIEPE: OK. Thank you, Chairman.

HARDIN: So I'm going to speak in some hyperbole just to make a point.

HALEY PERTZBORN: OK.

HARDIN: You're a pharmacist--

HALEY PERTZBORN: Yes.

HARDIN: --not a doctor--

HALEY PERTZBORN: Yes.

HARDIN: --medical doctor. And I know that with my own medical doctor, if I'm going to set up a time for a physical, they schedule that about 7 years from now. If I'm sick, they'll schedule that 2 months from now. If I need a refill on my script, am I able to get in relatively

quickly, say, within your example if I need to get in before that long weekend and I'm out, can I-- will they actually respond and, and send that in? Is it just a phone call that I'm just too lazy to make to my doctor or am I hung up? In other words, do we really need this bill?

HALEY PERTZBORN: It is-- it depends, obviously, on the situation. But, again, like this is happening, the patients are coming and needing an emergency supply to get them through. Patients do their best with their health care and, oftentimes, they're like, oh, my gosh, it's my last day of my blood pressure medication. Had no idea. So this is happening, and pharmacists don't have protection for doing the right thing in protecting patients right now.

HARDIN: OK.

HALEY PERTZBORN: So I think so.

HARDIN: Thank you.

HALEY PERTZBORN: Yeah.

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

HALEY PERTZBORN: Thank you.

HARDIN: LB515 proponents? LB515 opponents? Opponents? LB515 neutral?

LESLIE SPRY: Back again.

HARDIN: Welcome back.

LESLIE SPRY: Stuck it out on a Friday here. This is good, so. Good afternoon, Chairman Hardin and members of the committee. As I said, my name is Dr. Leslie Spry, L-e-s-l-i-e, Spry, S-p-r-y. I'm a kidney guy and past president of the Nebraska Medical Association. I'm testifying on behalf of the NMA regarding LB515 in a neutral capacity. However, we do, do support the amendment, which Senator Quick mentioned, and we do support AM227 in its current form. The NMA appreciates Senator Quick and Nebraska Pharmacists Association for bringing an amendment to the LB515 to address the issue in a way that minimizes fragmented care and ensures prompt notice to the prescriber. Physicians understand that emergency situations occur where a patient may suddenly not have access to necessary medication. As the physicians, we do our best to ensure that we are accessible to authorized refills in urgent situations, working with our partners and staff to provide

coverage to fill the requests. However, we recognize that despite these measures, there may be times when a prescriber's authorization cannot be obtained as quickly as necessary. That said, even the maintenance medications, where there can be variability and ongoing monitoring that is needed to be completed by treating physicians and other prescribers. It is common for dosages to require adjustments. Sometimes we may prescribe medication with the intention of limiting it to a strict window of time, or often that there needs to be adjustments in medications, either up or down over time. And sometimes our contracts with the payors require seeing patients within certain intervals. That's also true. Outside of some health system pharmacies, a pharmacist won't have access to my patient's medical record. The pharmacist can use their best professional judgment based upon pharmacy records and the patient's input when it comes to complex care. The amendment provides several components that make the bill more workable from the prescriber perspective and to help ensure optimal care of the patient. First, notice to the prescriber within 72 hours will allow the prescriber to review the patient's medical record and ensure that appropriate follow up is, is available. By limiting emergency refills to a 7-day supply, unless packaging requires something greater, and limiting the refill to once in a 6-month period, the amendment ensures patients are following up with their practitioner appropriately. The Nebraska Medical Association appreciates Senator Quick and the Nebraska Pharmacists Association for their collaboration in this legislation, and we encourage your support for the amendment.

HARDIN: Thank you. Questions? The amendment makes it OK?

LESLIE SPRY: Well-- and the question was who has the liability? The last-- the amendment actually spells that out. Section [SIC] (4) says: The prescriber of a drug shall not be liable or subject to disciplinary acting-- action for an act of or omission in connection with dispensing a refill pursuant to section [SIC] (2) of this, of this section. So that answers that.

HARDIN: OK. Thank you.

LESLIE SPRY: And, and, and, you know, in my business, I do kidney, I take care of kidney patients. And I also take care of many patients who are on complex medications. And they can't always remember to refill their medications either. And-- but in many cases, my medicines have two edges of a sword. They can hurt as well as help. And so I need to be monitoring their drug levels on many occasions. Same way

for neurology and seizure disorder. So there's a whole bunch of prescribers out there who walk a fine line in certain medications where we don't want the patient to use this as an excuse to get a large prescription. But if they suddenly realize they don't have any, we don't want him skipping any days either, so we can certainly arrange for things to happen more quickly. And I hope you could get in sooner than 7 years. I mean, that's-- that seems like a--

HARDIN: Not all, not all drugs or all patients are created equal.

LESLIE SPRY: That's right.

HARDIN: Right? OK.

LESLIE SPRY: I would hope not.

HARDIN: Well, thank you. Appreciate your help with that. Any other one-- anyone else in the neutral on LB515? Seeing none, Senator Quick. We had online: nine proponents, zero opponents, one in the neutral.

QUICK: Yeah, thank you, Chairman Hardin and members of the committee. And I think you heard from the testimony, I think this bill is important. I know myself, I've forgotten to refill my blood pressure medicine. And I'm very fortunate, I'm married to a nurse and she has every doctors' phone number in the-- and-- but I'm fortunate that way. So we-- she could call the doctor and we could call the-- he could call it in for us. But there are a lot of people, especially some of the elderly, who maybe, for whatever reason, maybe would forget. And then it's a weekend and you can't get a hold of a doctor in a weekend most times. So, you know, unless they have their-- we're given their personal numbers. So I think it's really important that we get this passed, and just for those emergency situations. And, you know, we can-- you know, it's a 5 day or is it 5 or 7 days? I don't remember on the amendment. But, you know, you could have a long weekend where there's a holiday in there, too. So that would help maybe cover that, that emergency situation. And then they could get ahold of their doctor and, and get that refill back on-- online, so. So thank you.

HARDIN: Questions? Senator Hansen.

HANSEN: They brought the point about the liability issue. The prescriber of a drug shall not be liable if there's a disciplinary action. So would the, would the pharmacist then be liable?

QUICK: I think that's what she said when she was up here that--

HANSEN: I might have missed that part. OK. All right.

QUICK: Yeah. I think she-- Senator Riepe had asked me that at the start, and then she kind of said that they would be liable.

HANSEN: OK. All right.

QUICK: Or they have liability insurance as well.

HANSEN: Sure. Cool. Thanks.

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

QUICK: Yeah, thank you.

HARDIN: This concludes our hearing for LB515. We'll be turning our attention to LB555. Senator Riepe.

RIEPE: Yes, sir. In the interest of time, I made a dash for the table here.

HARDIN: Please, dash away.

RIEPE: I want to, I want to address a happy, happy hearing, a board, if you will. Are you ready for me, sir?

HARDIN: Yes, sir.

RIEPE: OK. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. For the record, my name is Merv Riepe. It's M-e-r-v R-i-e-p-e, and I represent District 12. Today, I am presenting LB555, a bill that seeks to amend the Funeral Directing and Embalming Practice Act to establish and regulate the role of assistant funeral directors in Nebraska. Under current law, only fully licensed funeral directors and embalmers may perform tasks related to funeral home operations. However, the demand for funeral homes continues to grow, and many struggle to find sufficient licensed staff to meet those needs. LB555 creates a structured pathway for individuals to assist licensed funeral directors in nontechnical aspects of funeral service, such as arranging interments, coordinating services, and supporting grieving families. To ensure oversight and accountability, this bill requires assistant funeral directors to be employed by a licensed funeral director and to work under a formal collaborative agreement. They would not be allowed to engage in embalming or other technical procedures, and any violation of this

restriction would result in immediate termination of their collaborative agreement. LB555 also outlines disciplinary measures and recordkeeping requirements to uphold the professionalism and integrity of funeral services in Nebraska. This bill is a response to workforce challenges within the funeral service industry, and aims to provide funeral homes with additional support while maintaining high standards of care. Additionally, LB555 includes an emergency clause to allow for timely implementation. However, experts will be testifying after me. I ask that the committee advance LB555, and I am happy to answer questions that I might be qualified for. Thank you, Chairman.

HARDIN: Questions? Will you stick around?

RIEPE: Oh, I wouldn't miss it. Thank you, sir.

HARDIN: Thank you. Proponents, LB555? Welcome.

CHRIS KLINGLER: Good afternoon. Good afternoon, members of Health and Human Services Committee. My name is Chris Klingler. For the record, my name is spelled C-h-r-i-s, last name Klingler, K-l-i-n-g-l-e-r. I am testifying on behalf of the Nebraska Funeral Directors Association as cochair of the legislative committee in support of LB555. This bill has been a work in progress over the last 4 years as we've traveled across the state of Nebraska and hear our members with concerns about the decline of funeral directors entering our profession, like every other profession that we're having this issue with. Allowing a licensed funeral director to assign tasks to an assistant funeral director, excluding embalming, would allow us to delegate responsibilities we are currently legally required to perform by statute. This legislation would also authorize a licensed funeral director to train, manage, and oversee an assistant funeral director to run day-to-day operations. This would also-- this would be allowable under the supervising funeral director's license. In rural areas, funeral directors cover large service areas. Under this legislation, it would allow for the funeral director to either stay at the funeral home to see a family or to go on that graveside service 60-- 60 miles away. Allowing an assistant funeral director to help complete these duties ensures families are being served in the respect and manner they deserve. LB555 would allow funeral directors as a profession to self-govern and supervise assistant funeral directors with the accountability factor held under the supervising funeral director's license. This ensures accountability for their action through a collaborative agreement between the assistant and the licensee. I believe this legislation will have a positive impact on

the current-- currently diminishing funeral industry workforce and the families we serve without creating a fiscal impact on the Nebraska Department of Health and Human Services. Thank you for your time and attention to this matter, and I would be happy to answer any questions.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your, for your testimony. So just, just kind of more of a point of clarification. So the role of the assistant funeral, funeral director-- so when you say embalming is that, is that-- that's essentially anything that involves direct contact with the, with the body. Is that--

CHRIS KLINGLER: Correct.

FREDRICKSON: --correct? OK.

CHRIS KLINGLER: Correct. Yeah, they would not be involved in the embalming.

FREDRICKSON: [INAUDIBLE]

CHRIS KLINGLER: Now, there's nothing that says a person can't assist dress someone, a decedent.

FREDRICKSON: OK.

CHRIS KLINGLER: You know, there are people that can do that. But this would be probably someone that would help with that, too, but didn't have to and more on it.

FREDRICKSON: And where does cremation fall in this or, or does it fall all on--

CHRIS KLINGLER: Really wouldn't fall under that. This would, this would allow them to, to see families or, or do services.

FREDRICKSON: OK.

CHRIS KLINGLER: But--

FREDRICKSON: Great.

CHRIS KLINGLER: --as far as the cremation side of things, no.

FREDRICKSON: Thank you.

CHRIS KLINGLER: Yeah.

HARDIN: Senator Hansen.

HANSEN: I like this bill because this is something I've heard from constituents and other people in the state of Nebraska, funeral directors in particular, saying we need help. I mean-- and so I think this is a good creative way to kind of help them out. I mean, without any hopefully burdensome government regulation. So I think it's good. One question I did have was about the 25 embalmings performed by an apprentice. That's required before they become an apprentice or like-- but they're-- but they can't do embalmings?

CHRIS KLINGLER: So that's, that's part of-- that's separate from this part of it. That, that is-- well, no, they added that, the, the terminology for apprentice in there.

HANSEN: Yeah.

CHRIS KLINGLER: So say that again, Senator Hansen. I apologize. The--

HANSEN: Well, if, if they're not allowed to do embalmings, why are they required to do 25-- assist in 25 [INAUDIBLE]--

CHRIS KLINGLER: Oh, OK. So that's for an apprentice, an actual funeral director that's going to become a funeral director.

HANSEN: Oh, gotcha. OK.

CHRIS KLINGLER: That's, that's adding some more wordage to that bill to clarify that.

HANSEN: All right.

CHRIS KLINGLER: Yep.

HANSEN: Makes sense.

CHRIS KLINGLER: Yep.

HANSEN: Thanks.

HARDIN: OK. Other questions? Seeing none, thank you.

CHRIS KLINGLER: Thank you.

HARDIN: Proponents, LB555? Welcome.

PAUL SEGER: Good afternoon, members of the committee. My name is Paul Seger, P-a-u-l S-e-g-e-r. I'm, I'm here to express our strong support for LB555. This bill addresses a critical need within the funeral service industry by fostering workforce development. In recent years, we've had a steady decline in individuals pursuing funeral service as a profession. By enabling licensed funeral directors to assign ordinary tasks, excluding embalming, to an assistant funeral director, this would allow us to delegate some of the responsibilities we are legally required to perform. LB555 would authorize licensed funeral directors to oversee an assistant funeral director under their license, facilitating greater operational efficiency. Furthermore, it would grant us the authority to self-govern the assistant, holding us accountable for their actions through a collaborative agreement between the assistant and the licensee. In rural communities, funeral directors often cover vast distances. Funeral directing is a demanding around-the-clock profession. If a funeral director is unable in the time of need, the public is forced to wait for their return, especially in the smaller communities in the western part of the state. I believe the LB555 would have a positive impact on the funeral service industry and the communities we, we serve. I respectfully request the support for this legislation. Any questions?

HARDIN: Any questions? Seeing none, thank you.

PAUL SEGER: Thank you.

HARDIN: Proponents to LB555? Opponents, LB555? Those in the neutral, LB555? Senator Riepe.

RIEPE: Thank you, Chairman. First of all, I'd like to thank both of the testifiers for coming in and staying. I will say this in one sentence. I think LB555 is a workforce issue, as Senator Hansen pointed out, and we are under, under-- and we are understanding with the compromise of-- without the compromise of quality and service. I had a little hard time getting that out.

HARDIN: Well, that was well done.

RIEPE: One sentence.

HARDIN: Yes.

RIEPE: OK.

HARDIN: We--

RIEPE: Questions?

HARDIN: Online, we did have five proponents, zero opponents, one in the neutral. Any questions for Senator Riepe? Well, thank you.

RIEPE: Thank you, sir.

HARDIN: You bet.

RIEPE: Gentlemen.

HARDIN: This concludes LB555. We're going to move on to LB697, and Senator Strommen arrived just in time.

STROMMEN: I thought I'd, I thought I'd take my time.

HARDIN: Just on time.

STROMMEN: I was told that you guys were thinking you wanted to be here a little longer, so.

HARDIN: You know, nothing scares us.

STROMMEN: I hope you have your questions ready. Lots of them.

HARDIN: We do.

STROMMEN: All right.

HARDIN: And we have a lot of angst on this one, so.

STROMMEN: All right, Senator Hardin-- Chairman Hardin, HHS Committee. Paul Strommen, P-a-u-l S-t-r-o-m-m-e-n. LB697 was brought to me by the Nebraska Pharmacists Association. This bill has three parts that we believe are relatively noncontroversial so we can proceed. First, it would add a pharmacy technician to the Nebraska Board of Pharmacy. Second, it would further clarify that compounding for office use, office use only and not for resale may be done by an outsourcing facility operated pursuant to federal law. Third, for delegated dispensing permits for public health clinics, the bill would allow dispensing pursuant to a prescription written by a practitioner licensed in Nebraska, working in affiliation with a public health

clinic. Section 1 deals with the Nebraska Board of Pharmacy. The Board of Pharmacy oversees the minimum standards of proficiency and competency for the practice of pharmacy, makes recommendations related to the issuance or denial of credentials and disciplinary action, and makes recommendations regarding regulations to the Department of Health and Human Services. The current makeup of the Board of Pharmacy is four pharmacists, one lay member, also known as a public member. LB697 would incorporate representation by a pharmacy technician. It would add one pharmacy technician, one additional pharmacist, and one additional lay member. By adding the three members, the Board of Pharmacy will incorporate pharmacy technician representation-- say that three times fast-- while also maintaining the current balance of pharmacists and lay members. The NPA believes it is important that pharmacy technicians have a voice and representation on the Board of Pharmacy. Section 2 of the bill-- this is the complex part-- will-- deals with compounding of drugs for office use only. This is a technical measure aimed at ensuring Section 38-2867.01 of the Nebraska statutes is consistent with federal law. The current statute states that compounding may occur for office use only and not for resale. LB697 will limit this to compounding by an outsourcing facility operating pursuant to Chapter 21 of the United States Code, Section 353b, this section of federal law deals with what is commonly referred to as a 503B facility under the Federal Food, Drug, and Cosmetic Act. Only 503B facilities are authorized to do such compounding. A 503A pharmacy is a traditional compounding pharmacy that creates patient-specific medications based on individual prescriptions. In contrast, a 503B pharmacy, also called an outsourcing facility, produces large batches of medication for health care providers to use on multiple patients, often without specific prescriptions, and is subject to stricter Food and Drug Administration regulations compared to a 503A pharmacy. The additional language in LB697 clarifies 503A facilities are not authorized to compound for office use only, which ensures the facilities do not run afoul of federal law. While this clarification may not seem necessary, we believe that it will provide needed clarification. To be clear, this does not expand the authority to compound drugs. Third, Section 3 of LB697 deals with delegated dispensing permits for public health clinics. A delegated dispensing permit allows a public health clinic to dispense prescription drugs and devices in Nebraska. The permit is required by any entity that operates a public health clinic in this state. The clinic must have a delegated dispensing agreement and only dispense drugs and devices from an approved formulary. The delegating pharmacist is responsible for training clinic staff and for the security, inventory, and

recordkeeping of all drugs and devices. Under current law, specifically Nebraska Revised Statute 38-2884, drugs and devices may only be dispensed pursuant to a prescription written onsite by a practitioner. Practitioners include medical doctors, physician assistants, advanced practice registered nurses, or other individuals authorized to write prescriptions. LB697 would expand this to allow these prescriptions to be written via telehealth. However, the practitioner will still be required to be licensed in Nebraska. This prevents out-of-state practitioners from writing such prescriptions. Nebraska pharmacists know these prescriptions can be safely transmitted via telehealth, which allows for greater access to quality health care, especially in rural Nebraska. The prescriptions written and dispensed at these public health clinics are generally related to contraception and treatment of sexually transmitted diseases. These-- this-- in discussing this issue with members of Health and Human Services Committee, it was asked whether this would cover Plan B, also known as the morning after pill, Plan B is an over-the-counter medication and would not be covered under LB697, which only deals with prescription drugs. Questions?

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Strommen,--

STROMMEN: Yes.

FREDRICKSON: --for being here today. Can you review the entire Section 2 again?

STROMMEN: Sure.

FREDRICKSON: I, I-- I'm joking, I'm-- no, joking. But to just to clarify that, that, that piece is, is really just aligning our state statute with the federal law that's already in place.

STROMMEN: That is correct. Yes. We're just-- we, we just want to make sure that the state is-- our, our folks in the state are compliant with federal law. And this just sort of the codifies that

FREDRICKSON: Codifies it. Great. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I have a very simple question. I have sort of a hang-up over even number of board members, and you're going from five to eight. Was there a reason they didn't go to seven or nine?

STROMMEN: That's actually an extremely good question. That would be something that maybe something sitting behind me might have the answer for you for it.

RIEPE: It's a math question.

STROMMEN: It is a math question. And I'm not-- as, as someone on Appropriations, I'm not really qualified to answer those math questions.

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

HARDIN: Other questions? Senator Hansen.

HANSEN: Thank you. You said 503A, getting rid of that does not expand the authority to compound drugs. Does it restrict the, the ability to compound drugs, then?

STROMMEN: My understanding is that it does not restrict-- it is-- does not restrict their ability to compound drugs.

HANSEN: OK.

STROMMEN: It's just-- like as, as we just said it, it's just, it, it's just-- we're, we're, we're making sure that our language and the state statutes comply with federal language.

HANSEN: OK. And--

STROMMEN: So it's, it's neither expanding nor diminishing their ability to do what they are currently able to do.

HANSEN: OK. And on Section 3, because I know I'm going to be asked this, you're now-- looks like allowing public health clinics to dispense medications. Would those include abortifacient medications such as Mifepristone?

STROMMEN: That is not a-- I cannot answer that. That-- maybe the technical folks sitting behind me might be able to answer them.

HANSEN: OK.

STROMMEN: I, I know that it, it did not cover Plan B. My understanding is that it covers STDs, some medications related to contraception, and then like Erythromycin, those, those sort of antibiotics.

HANSEN: OK. All right. Thank you.

HARDIN: Other questions? Will you be sticking around?

STROMMEN: I, I will be. Yeah, most definitely.

HARDIN: Wonderful.

STROMMEN: Yeah, yeah, I'm, I'm-- I've, I've got--

HARDIN: Proponents?

STROMMEN: --no where to go.

HARDIN: LB697, proponents? Welcome back.

HALEY PERTZBORN: Thanks. Chairperson Hardin and members of the Health and Human Services Committee, my name is Haley Pertzborn, H-a-l-e-y P-e-r-t-z-b-o-r-n, licensed pharmacist, CEO of the Nebraska Pharmacists Association, and registered lobbyist. Thank you to Senator Strommen for introducing LB697. As he mentioned, there's three provisions within it. Section 1 would add a pharmacy technician, a pharmacist, and a public member to the Board of Pharmacy. There are 14 other states that have a pharmacy technician on their board. These states are reported having a technician on their board provides valuable insight to the decisions made by the board, and helps to ensure there's a specific focus on the pharmacy technician, also helps to promote pharmacy technicians as a serious career path. To answer the question, the, the even number on the board of pharmacy was brought up. However, the-- I believe the medical board also has an even number and the Board of Pharmacy talked to them and they don't-- they didn't have any concerns or anything with it on kind of how they operate, so. That was brought up, but. Section 2 aligns our state law with federal law. There are two types of compounding, as Senator Strommen did such a good job explaining, 503A pharmacies are-- can compound only to pursuant to a prescription, so they need a prescription for Haley to compound for me; 503B facilities can compound for office use or office stocks over inventory. This change was brought to us by some of our compounding pharmacists, who saw a discrepancy in that statute as allowing any person authorized a compound to compound for office use when that isn't allowed federally.

The fix ensures that 503B pharmacies and hospitals are the only pharmacies allowed to compound for office use or office stock. Within the last week, though, we have heard from some stakeholders about the language and we are working on an amendment to clear up some of the language for office use and just making sure it cleared up issues in there. Section 3 enables telehealth services for a prescriber to occur more readily via a public health clinic with a delegated dispensing permit. This fix would allow a physician to cover multiple public health clinics by seeing patients via telehealth, and then send a prescription to that public health clinic, The current statute states that the prescriber has to write the prescription onsite. I also want to note that Nebraska Revised Statute 38-2881, those clinics can only dispense medications for contraception, STDs, and vaginal infections per statute. Happy to answer any questions.

HARDIN: Thank you.

HALEY PERTZBORN: I can answer your question. I'm ready.

HANSEN: Can I ask a question that she can answer?

HARDIN: Yes.

HANSEN: Can you answer my question?

HALEY PERTZBORN: Yes. No, medication abortion is not covered at all in these clinics per statute already.

HANSEN: Because it's not contraception?

HALEY PERTZBORN: Yes.

HANSEN: OK.

HALEY PERTZBORN: Yeah, Mifepristone, that is not contraception.

HANSEN: OK.

HALEY PERTZBORN: Yeah.

HANSEN: OK. We're just talking about birth control pills and stuff like that?

HALEY PERTZBORN: Yeah. Yeah, 100%.

HANSEN: Just making sure, because I know I'll get emails about it, so.

HALEY PERTZBORN: Yes. We were prepped for that, too.

HANSEN: And Senator Strommen mentioned in his opening, LB697 would expand this to allow these prescriptions to be written via telehealth. I'm trying to find in the bill where it says that.

HALEY PERTZBORN: So-- yeah, so-- and I know they have a physician behind me, too, that can kind of answer more of the operational side of it. But physician A might be covering public health clinic A and B, so if they're at A, they're-- but they see you or talk to a patient or, no, they just need a refill on their birth control, they would have to travel to site B right now to write that prescription, even if they've already made contact via a video chat, telehealth, whatever that is. Even if they know that that's a legitimate prescription, they would still have to travel however distance that is to-- just for that one patient maybe. So it enables telehealth to occur in that scenario and whatnot. So they don't have to actually be onsite--

HANSEN: OK.

HALEY PERTZBORN: --at the public health clinic. Does that make sense?

HANSEN: OK. I think that sort of answered my question. We'll see--

HALEY PERTZBORN: OK.

HANSEN: --we'll see what Senator Strommen says here, too.

HALEY PERTZBORN: Yeah. OK.

HARDIN: Other questions? Seeing none, thank you.

HALEY PERTZBORN: Thank you, guys.

HARDIN: Proponents, LB697? Welcome.

MARIEL HARDING: Make sure I have the right one open. OK. Hi. Hello, again. So, again, I am Mariel Harding, M-a-r-i-e-l H-a-r-d-i-n-g. I am the Senior Director of Programs and Initiatives for Reproductive Health Collaborative Nebraska, as I mentioned. And I'm here to express my support of LB697 on behalf of our organization and our board. Thank you to Senator Strommen for introducing it. My testimony does only pertain to that third section about delegated dispensing, and we see the proposed additions to the statute as updating Nebraska's laws to reflect the reality of health care in the post COVID-19 world, a

reality in which telehealth is a common part of health care practice. As I mentioned, we are a nonprofit organization that ensures all Nebraskans have equitable access to high-quality sexual and reproductive health care. One of the central ways that we do this is by administering federal and private funding to support health centers across the state to deliver sexually productive health care for free or on a sliding-fee scale. We work with 10 nonprofit health care agencies from Omaha to Scottsbluff, Norfolk to Chadron. This network of providers delivers care and education at 30 clinics. Nearly 20,000 Nebraskans access health care at these clinics annually to receive cancer screenings, HIV and STI testing and treatment, basic infertility services, and receive contraception and pregnancy counseling. The health centers that we work with are eligible for delegated dispensing because they are public health clinics. So I'm sure that you are all familiar with telehealth and how it has become central to health care delivery since COVID-19. I wanted to share some statistics with you about its growth. So across the country, there has been a 63-fold increase in Medicare fee for service beneficiary telehealth visits since 2020. Over 20% of adult patients had a telehealth visit in 2022, and 96% of ERISA-funded health centers used telehealth to provide care in 2023. So these are national statistics from the federal government, and I share them to demonstrate how commonplace and important telehealth has become to the delivery of health care in this country. Adding the clarification that the drug or device can be dispensed pursuant to a prescription written by a practitioner licensed in Nebraska, working in affiliation with a public health clinic pursuant to a delegated dispensing permit-- it's many words-- but it helps clarify that health centers can operate-- that operate with a delegated dispensing permit can utilize telehealth and delivery-- in the delivery of their care. For our rural state, this is particularly important. There are a couple of scenarios that I can share with you. You know, as we've talked about, our state faces a health care shortage, 83% of all health diagnosing and treating practitioners are concentrated in metropolitan areas, whereas only 65% of the population resides in these areas. So that creates a challenge of recruitment for rural health care providers. This is particularly marked for our partners, who may not even be able to offer benefits to their staff. So telehealth can be an important tool that we have to leverage the health care talent that we have in our state for the greatest good, either through connecting distant partners and maybe urban parts of the state to rural clinics or rural clinics through site to site, which I talked about, or by connecting directly to patients in their home. And they may not have to travel to the clinic.

As I mentioned, we provide funding to 10 agencies with 30 sites. You'll note that there are 3 times more sites than there are agencies. They often operate by having a primary site and then satellite sites. And this is great for access to care, particularly in rural communities. However,--

HARDIN: If I can encourage you to wrap up your thoughts, please.

MARIEL HARDING: Oh, sorry. So like she mentioned, it means that they have to drive. The provider has to drive. That takes provider time and resources that may not be the best use of resources. So that's just another way that telehealth can help expand access to care. And this provision is just a great way to clarify that telehealth is, is an important and common practice for delegated dispensing. So thank you.

HARDIN: Thank you.

MARIEL HARDING: Happy to answer any questions.

HARDIN: Questions? Senator Hansen.

HANSEN: I hate to ask questions. I know we're ready to go, but--

MARIEL HARDING: it's Friday.

HANSEN: So you're pretty familiar with public health clinics, then. I, I-- I'm confused, and maybe this is just for clarification.

MARIEL HARDING: Yeah.

HANSEN: They said: Under a delegated dispensing permit for a public health clinic, approved formulary drugs and devices may be dispensed by a public health care worker or nurse, licensed practical nurse, or physician assistant. So we're, we're saying a public health care worker has the same, I would say prescriptive ability, but their ability to dispense of medications is the same as a nurse, licensed practical nurse, or physician assistant. So can you define what public health care worker-- like, maybe it just-- it maybe just looks funny to me.

MARIEL HARDING: Are, are you-- so that, I think, is in the statute currently.

HANSEN: Yes.

MARIEL HARDING: Yes. I think-- I, I could try, but I want to make sure that I give you the right answer. I think when I read that, I read that there are certain folks who can provide prescriptions, and then there are other folks who can hand out the medications, and those folks that hand out the medications or dispense can be the health care workers, like nurses. So, for example, a provider, a nurse practitioner would see the patient write the prescription, and then the nurse might hand the patient their prescription.

HANSEN: OK. OK.

MARIEL HARDING: Does that make sense?

HANSEN: I think so.

MARIEL HARDING: So that's how I understand that. We do have another partner following me who might be able to answer even in more detail about how it works in operations.

HANSEN: OK, [INAUDIBLE] just more for clarification, so.

MARIEL HARDING: Yeah.

HANSEN: Thanks.

MARIEL HARDING: Yeah. Absolutely.

HARDIN: Any other questions?

MARIEL HARDING: Thank you so much.

HARDIN: Seeing none, thank you. Proponents, LB697? Welcome back.

JESSI HITCHINS: Thank you. Chairman and members of the committee, my name is Jessi Hitchins, J-e-s-s-i H-i-t-c-h-i-n-s. I'm the Executive Director for Family Health Services, federally funded Title X, sub-recipient of the Reproductive Health Collaborative. We've been functioning since 1973. Our agency proudly serves 10 southeastern counties of Nebraska, including Gage, Jefferson, Johnson, Nemaha, Otoe, Pawnee, Richardson, Saline, Seward, and Thayer. While we maintain our urban presence, the vast majority of our service area is rural, where access to health care remains a persistent challenge. I'm here today to support LB697, specifically in the proposed language. This update is not just a linguistic clarification, it is a practical and necessary adjustment that directly impacts our ability to provide

timely and essential reproductive health care across Nebraska. Across-- sorry-- access to reproductive health care in rural areas is uniquely challenging. Research consistently demonstrates that individuals living in rural communities experience lower rates of contraceptive use due to geographic, economic, and provider shortages, shortages. According to the American College of Obstetrics and Gynecologist, rural communities have significant fewer health care providers trained in reproductive health, which leads to longer wait times, higher travel burdens, and gaps in continuous care. Delegated dispensing permits are a best practice in states with large rural populations because they allow qualified providers in public health clinics like FHSI to efficiently dispense prescribed medications and contraceptive methods without requiring patients to travel long distances and face unnecessary delays. The CDC and the Guttman [SIC] Institute both recognize the expanding direct dispensing practice improves contraceptive adherence, and reduces barriers to essential care. For the communities we serve, LB697 is not just a policy, it is a lifeline. Our clinics provide low- to no-cost services to individuals who otherwise face financial and logistical barriers to care. Many of our patients have limited transportation options and cannot afford to take time off work to visit multiple providers just to receive necessary medications. To ensure the public health clinics can dispense medications prescribed by affiliated Nebraska-licensed practitioners under the delegated dispense permit, we can increase access, improve health outcomes, uphold our mission to provide equitable health care and Nebraskans who need it most. This is particularly critical for those in rural communities, where access to prescribed-- prescribing practitioners can be dozens, if not hundreds of miles away. LB697 represents the necessary step towards modernizing Nebraska's health care policies to reflect the best practices in public health, particularly in underserved regions. As one of the few Title X sub-recipients in the state, FHSI is uniquely positioned to provide essential reproductive health care and the language change will allow us to do some-- will allow us to do, do so more effectively. Any questions?

HARDIN: Questions? Senator Hansen.

JESSI HITCHINS: Yes.

HANSEN: Can you have-- you said, said in your opening, by ensuring that public health clinics can dispense medications prescribed by affiliated Nebraska-licensed practitioners, which we have in here, health care practitioners, but then we also include public health care

worker or public health clinic worker. I don't know what that means. Does that mean, like, the administrative assistant there can hand out drugs?

JESSI HITCHINS: If they go through the proper training, yes.

HANSEN: Do you think we should specify that in the bill?

JESSI HITCHINS: I would refer that to the bill writers.

HANSEN: OK. All right.

JESSI HITCHINS: Yes.

HANSEN: Thanks.

HARDIN: Other questions? Seeing none, thank you.

JESSI HITCHINS: Thank you.

HARDIN: Proponents, LB697? Opponents, LB697? Those in the neutral? If not, if you'll come back, Senator Strommen. We had online: four proponents, one opponent, two neutral.

STROMMEN: All right. Well, it sounds like we might need some clarifying language.

HANSEN: We'll look into it together.

STROMMEN: OK. If you'd like, we would be more than happy to ensure that that is clearer. So just to reiterate, three parts: Board of Pharmacy, add a technician, two other folks; compounding, codify the law so that we are in line with federal statutes; delegated dispensing helps our rural health clinics provide access to individuals that may otherwise not have access to medications. I think that pretty much sums it up.

HARDIN: OK. Questions for Senator Strommen?

STROMMEN: I think Glen might be ready to go.

MEYER: Well, I have a question. I, I wanted to ask him [INAUDIBLE]--

STROMMEN: Don't, don't.

MEYER: --he read that so well, I wondered if he wrote his opening, quite frankly, because he-- it was so professionally done, and he read it so well, that I thought perhaps you had a hand in writing that.

STROMMEN: Thank you. I appreciate that.

MEYER: OK.

HARDIN: If there are no other questions, thank you. And this will conclude LB697, this hearing, and our hearings for today.

STROMMEN: Thank you. You, guys, have a great night.