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

MURMAN: Good, good afternoon. I'm Senator Dave Murman from District 38, from Glenvil, and I represent eight counties in the southern part of the state.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

M. CAVANAUGH: Machaela Cavanaugh from Omaha, Legislative District 6.

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill, our committee clerk, Geri Williams, and our committee pages, Morgan and Savana. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll be hearing two bills and one briefing. We will begin with the briefing by the Department of Health and Human Services, and then move to the bills in the order listed on the agenda posted outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. We will not follow this procedure as it relates to the briefing. This is just a-- that will just be a briefing. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. We do use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to enjoy testimony, and we will ask you to wrap up your final thoughts. If you wish to appear on the committee statement as having a position on one of the bills before us today, you need to testify. If you simply want to be part of the official record of the hearing, you may submit written comments for the record online via the Chamber Viewer page for each bill. However,

those comments need to be submitted prior to noon on the work day before the hearing in order to be included in the official record. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. And with that, we will begin today's briefing with a briefing by the Department of Health and Human Services. Welcome, Director Bagley, and you may proceed. Perhaps before you begin, I might make just one comment. I think it's-- I, I think, from the committee's perspective, and I know from your perspective as well, the topic of today is the, is the RFP, RFI. It's, it's the process of procuring the MCOs for the next, for the next round of contracts. It, it's just good to remember what we're really here for, and that is to provide good services to, to people that need the very, very badly. And so if we focus on the procurement, it's for that purpose, not for the purpose of procurement. So with that, please, please begin.

KEVIN BAGLEY: Thank you, Senator Arch. And I'm appreciative of the crowd that's gathered to hear about the RFP. I'm sure that's all they're here for.

ARCH: Sure.

KEVIN BAGLEY: Good afternoon, Chairman Arch, members of the committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y, and I'm the director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here today to provide a briefing on the status of Medicaid's reprocurement of managed care contracts. To begin, I'd like to provide a quick summary of what managed care is and how it works here in the state of Nebraska. Managed care is a system whereby state contracts and health insurance-- with health insurance companies-- are kind of set up to coordinate care for our Medicaid members. In Nebraska, managed care plans coordinate all of our physical health-- for example, doctor's visits, hospital stays-- behavioral health, and pharmacy benefits for all of our Medicaid members. In addition, we have another managed care entity that provides all of our dental benefits. In this system, Medicaid pays a per-member-per-month rate to the plan, called the capitation payment. The managed care plan is responsible for using the revenue from that payment to cover the cost of all the services that fall under their contract. And we, we refer to that as kind of a full risk scenario. So if the member costs less to serve during that time period or if they cost more, that payment is the same. And that payment also includes consideration for those plans' administrative costs. Our current managed care program, what we've called Heritage Health, began in

January 2017, with three managed care plans available statewide. We're nearing the end of our current contracts, and are now in the process of releasing a request for a proposal, or RFP, for new contracts. We expect to release the RFP in April, and intend to announce awards for those contracts in July. Once the awards are announced, we'll provide additional information on what that implementation time frame would be. I recognize that the procurement process has been a topic of interest during this legislative session. I'd like to take a moment to highlight what is different about these contracts, and what steps we are taking as a department to mitigate potential issues. One critical difference associated with our managed care procurement process is that the proposals will not be scored based on cost. Instead, capitation rates included in our contracts with the managed care plans are actuarially certified by a third-party actuary and approved by the Centers for Medicare and Medicaid Services. Rather than cost, our managed care vendor proposals are scored primarily on their ability to effectively deliver quality services to our Medicaid members. In addition, we've worked with multiple external vendors to help craft clearer expectations in the RFP and more effective evaluation criteria with which to score those proposals. Our hope is that, by including these experts in our process, we'll mitigate the risk of protests and select the best vendors for the state with the available bids. As you may be aware, my team and I traveled the state in January to hear directly from our Medicaid members and providers on what we could do to improve our managed care program. This was an invaluable experience. I was able to hear people's stories, better understand their experiences. We heard three common themes throughout those listening sessions related to areas of potential improvement. First was the member experience, next was the provider experience and, finally, the need for program and plan accountability. We heard stories of members not knowing to whom to turn with a question about their coverage or situations where our contracted care management fell short. We learned that access to care is really more than the number of clinicians within a certain radius. It really includes knowing how to access those services for our members, and whom to reach out to when they have questions. We heard from providers about the need to foster more consistency between our plans as it relates to provider credentialing and other activities. We also heard about struggles with reimbursement and the need to look at our existing quality and performance measures in greater detail. Finally, we heard from everyone the need for clearer reporting to stakeholders regarding how we hold ourselves and our plans accountable to important performance and quality outcomes. We're grateful for these perspectives and have

worked hard to incorporate those key lessons into our new RFP where possible. By next month, Medicaid will release its request for proposals, and we'll be able to share more details on the specific changes we're planning to implement in these new contracts. Until then, I'd like to thank the committee for your interest in the topic and for your support for the Medicaid Managed Payer, Managed Care Program over the years. Again, thank you for the opportunity to come and speak with the committee today. I'd be happy to take any questions you have.

ARCH: Thank you. Questions? I'm sure we have some.

WALZ: I thought you were going to ask one.

ARCH: Senator Walz.

WALZ: Thank you, Senator Arch. Sorry I was late. Yeah, you have heard a few stories, I'm sure.

KEVIN BAGLEY: Yes.

WALZ: As you know, I, introduced LB895 this session. It was in response to all the troubling differences and the lack of responsiveness by the current contracted Medi, managed care companies and how they deal with therapy providers: OT, PT, speech, chiropractic. And there have been, I would say, long-standing problems with prior authorizations for these services, and I know that you've heard this story. So my question to you is, can you tell me how you will address these multiple concerns related to utilization management for therapy services in your new request for the proposal?

KEVIN BAGLEY: Sure. I don't know that I'll be going-- to be able to go into a ton of detail on that as we haven't released it yet. We, we're trying to make sure we don't put any information out there that could create issues for the procurement process. That being said, we've, we've heard pretty loud and clear that too often our providers are seeing that prior authorization process as a means by which we restrict access to care; and that's not what it should be. And so part of what we've done to this point is have a lot of good conversations with our plans that are currently under contract to say, what are we doing to solve these issues? And I believe we're seeing some progress on that front. However, we've also included some provisions in the new RFP that speak to the need to improve our overall care management, and, and our prior authorization process is part of that. Prior

authorization should be about helping provide better care and more appropriate care to our members. It shouldn't be about restricting care. And so if, if we're focused on making, making that process work better for our members, then I think we'll find it's much more successful than it has been historically.

WALZ: Thank you. So what is, what is the goal or what is the intention or why do we have to rely on prior authorizations?

KEVIN BAGLEY: So really, the best way I think I could describe it is, when we have a health system where a lot of our providers may or may not have access to all of the data that is related to someone's care. So a physician, for example, may not know about a recent hospital stay, may not know about some of the other prescriptions that someone is on, may not know about previous therapies that have tried and failed. Our health plan typically does because those requests are coming in for reimbursement, and so they're able to see the broader picture that our clinicians may not. Now, prior authorization in the commercial world is frequently used as a way to deter that care, to control costs. In the Medicaid space, that really shouldn't be the case. What it should be is a mechanism by which we can see the broader picture of care and try to make sure that we're following the appropriate pathways. Recognizing that everyone's case is different, there also needs to be a mechanism by which they can share what's going on in their specific case. And so our plans will need to be in a position to take those calls from clinicians, from members, who can say this is what's going on here and why you need to think differently about it. So it's important that we have a standardized process, and prior authorization is part of that care management continuum. But it's also important that we recognize everyone's care is different. I don't know if that answers your question, Senator. I'm happy to try and clarify more if you'd like.

WALZ: No, that's okay. I'll think about it. Thank you.

ARCH: OK. Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. I'm going to kind of follow up on, on Senator Walz's question. So you said those who take the calls will then talk about what's maybe more appropriate care. What are the qualifications of the people that are taking the calls?

KEVIN BAGLEY: So generally, they should be at least in a similar specialty to the individual they're working with.

M. CAVANAUGH: So they're medical professionals?

KEVIN BAGLEY: I will, I will caveat that with, the person who actually picks up the phone may not be, but they will have folks on staff that can have that call, have that conversation with our medical professionals, our providers.

M. CAVANAUGH: And can you take through, like-- so prior authorization, I would say, is probably one of the biggest things that we've heard as a hurdle in all the different types of medical coverage. And so if-- and the time that it takes.

KEVIN BAGLEY: Yeah.

M. CAVANAUGH: So if somebody-- if a doctor thinks that their patient needs X, Y and Z, and they contact the managed care organization and they say they need X, Y and Z, and somebody answered that call, then how long will it take for them to get approval for that?

KEVIN BAGLEY: You know, and that varies by service.

M. CAVANAUGH: Right.

KEVIN BAGLEY: Some are going to be more emergent than others.

M. CAVANAUGH: So if they're emergent, is there going to be, sort of-- are they're going to be safeguards in place for when something is critical and needs to happen quickly, that they have to be responsive within a certain time?

KEVIN BAGLEY: Yes. And so part of what we are hoping to accomplish with this new RFP is to put more detailed accountability measures in place. There are a lot of those today that we look at. So we'll look at an overall average for time to respond to a prior authorization request. But there's a big difference between a prior authorization request-- and I'll pick on an easy example-- for pharmacy benefits for someone who has, you know, an SUD disorder versus, you know, an elective surgery, right? Those, those are going to be very different in terms of the timelines. Now that's an easy example for me to give. But I think what we've recognized in hearing from the individuals we've heard from, providers and members, is that if we're not paying attention to that in more detail, we're going to miss critical

elements of that, where the overall time frame meets our standards. But perhaps specific time frames do not, and we need to have a closer look. So that's something we're taking into account in the new RFPs.

M. CAVANAUGH: I have two more questions.

ARCH: Sure.

M. CAVANAUGH: I'll just ask them together and you can answer them how you like.

KEVIN BAGLEY: OK.

M. CAVANAUGH: So are you confident that what you're putting out in the RFP is going to appease, maybe not all, but a lot of the concerns that have been expressed by providers? And do you believe that this new RFP, once executed, will bring more providers on board to providing services to patients under this plan?

KEVIN BAGLEY: So let me try and answer the second one--

M. CAVANAUGH: Sure.

KEVIN BAGLEY: --first, because I think that's an easier one to answer.

M. CAVANAUGH: OK.

KEVIN BAGLEY: One of the big concerns we heard from folks from Scottsbluff to Kearney, to Norfolk, and even in Omaha, was this notion that we have access issues. In particular, we heard that on the dental front. That was an area that that we heard, I think, in nearly every single listening session we went to. And so as we went back and reviewed our changes to the RFP, we wanted to make sure that we were including provisions in that that would help alleviate and hold ourselves and our plans more accountable to those access standards. So yes, I'm confident we'll see an improvement in our access as a result of some of the changes. Do I feel like the new RFP will alleviate a lot of the concern that we heard from stakeholders? I will say, I feel like that might be a little bit of a loaded question.

M. CAVANAUGH: Oh, I didn't mean that.

KEVIN BAGLEY: And I don't--

M. CAVANAUGH: I'm sorry. I didn't mean it to be.

KEVIN BAGLEY: I don't mean to imply that you said it. Certainly, I don't mean to imply that.

M. CAVANAUGH: Let me, let me ask it differently then. So you do these listening sessions, and you kind of end up getting a synthesized list of what the concerns are. Do you feel like, if you look at the RFP and you look at the, sort of the general concerns, you've-- you feel confident that you've addressed them to the best of your ability?

KEVIN BAGLEY: Yes. And, and forgive me, I didn't mean to imply--

M. CAVANAUGH: No, that's OK.

KEVIN BAGLEY: --that there was any ill intent there.

M. CAVANAUGH: You never know.

KEVIN BAGLEY: I will assume there wasn't. You know, we went back and reviewed all of our notes that we took in those sessions, all of the notes that we took in our discussions with providers, and tried, as much as we could, to incorporate that. I think one thing I will say is, it may be that our stakeholders don't see specific language in that RFP that would appear to alleviate certain concerns. But that's not to say that they aren't being addressed. One of the things that is true about the RFP is there's a lot of general requirements, and those general requirements give our agency the flexibility to put specific reports and things in place as we identify those needs, moving forward. And so we've definitely done our best to put specific provisions in that. And I think, once it's released, the stakeholders will be able to see some very specific things we've done. And we're planning to share a document, once it's released, that outlines the feedback we heard and how we tried to incorporate it. I think we'll never satisfy everyone, and that's because there's always room for improvement. But I'm, I'm very confident that we're addressing a lot of the concerns we heard from our stakeholders.

M. CAVANAUGH: I, I asked the question 'cause I know so many people-- you've, you've spent a lot of time traveling and listening to people, and I think it's just important for them to know that, on the record, that the concerns are being taken seriously. So thank you for that.

KEVIN BAGLEY: Yeah. Thank you. And I'll say, you know, we heard some heartbreaking stories from some of our members where we dropped the ball, not because anyone had ill intent, but because there's just barriers in the system that we need to be able to overcome. And so,

taking inspiration from those stories, and doing some introspection to see what we can improve on, made a big difference. So I'm grateful to our stakeholders who were willing to share that experience with us.

ARCH: Thank you. Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Director Bagley, for being here. I'm the only one sitting in these chairs that was here in 2017, including you.

KEVIN BAGLEY: That's right.

WILLIAMS: And I just want to say thank you to the department, to you, your predecessors, when, when I look back and think of the monumental change that the implementation of Heritage Health, with thousands of members and, literally, thousands of providers coming together with a completely different system than they had been used to. I just have felt, during this whole time, it-- no, it was, it was never perfect and, just as you said, it never will be perfect. But, but your commitment, you're holding people accountable, and your communication, in particular with those of us that are dealing-- you know, we're, we're the ones that are getting some of those calls from providers-- I really appreciate that. A question: In your listening sessions, was there anything you learned that would lead us to believe that there are any geographical differences, that you heard things in one area, but not another?

KEVIN BAGLEY: Absolutely. And some of those weren't terribly surprising to us. You know, we-- one refrain I think we heard a few times was that we need to remember that the state of Nebraska is more than just the cities of Lincoln and Omaha. And I think, as we went around the state, one of the things that struck me was that there are different problems in different parts of the state, but some of those problems have the same root cause. There are just kind of different symptoms of that same root cause in different parts of the state. Access was one of them. Sometimes access, even in an urban area, can be difficult for our members. And so recognizing that, and trying to identify how we rectify that issue is important. We heard from a lot of members in the western part of the state. In Scottsbluff, they, the need to understand that sometimes the closest health care facilities for them are out of state. Going into Colorado or Wyoming is faster and easier, more accessible for them. And so making sure our plans contract with, with health care providers across those state lines is important as well.

WILLIAMS: And, and another follow-up. Did you, did you hear anything about, I'll say, large providers versus small providers, differences there?

KEVIN BAGLEY: Yeah. One of the things, I think, that's important for us, as an agency, to remember is that we sometimes, we sometimes hear the most from our largest providers. And so we need to make sure that we're also hearing from our more rural independent providers. We need to make sure we're getting out to our regional hospitals, to our local independent pharmacies, to really understand their experience in addition to, you know, just the broader associations that we may get to work with.

WILLIAMS: I understand, from your testimony and discussions that we have had previously, that there, there's some lack of detail in your testimony today that just needs to be there because of the system. If, if-- using your, your crystal ball, if, if we do, if you do make the announcement in July-- and I know there are some differences based on who they are, who your choices may be-- what do you think would be a reasonable time schedule to have the implementation?

KEVIN BAGLEY: So as I've shared with you previously, Senator, and I've shared with others, part of that will depend on the nature of our, our new awardees. If, if we have all three of the same plans that we do today who are awarded that contract, that may have a faster time frame than the example of having three completely new plans. So there is some flexibility we've built into that. Right now, our target date is July 2023, but we also recognize that we need to be flexible on that front. And so we haven't put a lot of detail out publicly at this point because we're waiting until we have a better sense of who those new awardees will be.

WILLIAMS: Thank you.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: Thank you. Thank you again for coming today. Going back to all the stories over the past few years, when you're establishing your policies, will you also be establishing-- and you kind of touched on it here-- but accountability for MCOs when they don't meet the requirements that you've established? And is there any way that you can tell me what that might look like?

KEVIN BAGLEY: Sure. There's a lot of levers that that we can include in our RFP that put additional accountability in place. The first one is, that's really to me, the foundational one, is putting together those performance indicators, and really making clear what those areas are that we want to monitor. Currently, with our three plans, we have a monthly call with each plan individually, to go through a dashboard of performance measures, from administrative-- you know, are you paying claims timely? Are you getting through your prior authorizations timely?-- to looking at some of the HEDIS measures that surround population health, trying, trying to identify, are they doing a good job caring for their patients? So our hope is that, over the course of the next year or so, we'll be able to put out some very clear measures, that for us are indications of how well we, as a program, are performing, and that we'll be able to break those down by plan so that we can start to share that more definitively and clearly with our stakeholders. Right now, part of the problem is there's tons of data, but that data is not meaningful to people who haven't been deeply entrenched in the process. And so we want to make sure that that's, that data is more democratized so that people can understand what's really going on. Once we've established those, there's a couple of other levers. So one is, we have quality improvement incentives that we include in the contract, whereby we take a portion of the money allocated to those plans and hold it in reserve to see if they meet those standards. And if they meet those standards, we can release that money. And if they don't, that money doesn't get released. And so that's another way we can provide those incentives. Ultimately, we also have the opportunity to put a corrective action plan in place whereby, you know, we put additional restrictions and, and requirements on the plan as a result of them not meeting standards outlined in the contract. So there's a number of ways we can do it. I think one of the things I heard pretty clearly in the stories and experiences of our members and providers was, they need to understand how to share with us the issues they're seeing. If we don't know that there's an issue, it's difficult for us to try and address it. And so while we try to monitor all of those things, sometimes those individual issues get lost in that data, and we need to make sure we're seeing that story and that experience as well.

WALZ: And that, that will be a process that you will be explaining to providers as well, so they know exactly what steps they need to take to file a complaint or--

KEVIN BAGLEY: Yeah. Right now, we've had a lot of outreach to simply say, please reach out and let us know where we're failing to meet your

expectations so that we can try and address it. And I would still say that's the best way we have, you know, some email addresses and other mechanisms by which they can reach out and let us know their experience. But we also plan to continue to have listening sessions after this, this RFP is released to understand people's experience, not just once every five years.

WALZ: All right, thank you.

ARCH: Thank you. Other questions? I have a couple.

KEVIN BAGLEY: Please.

ARCH: In any, in any patient population, it, it, the need is full gamut, right? So you, you have those that maybe need a once-a-year checkup and otherwise healthy, and you have those that have much higher needs. For those who have much higher needs-- perhaps they find themselves in a chronic medical condition, chronic mental illness, chronic lung condition, whatever it might be-- is there, is there-- how do you handle that when you're doing a capitation rate? Is it just actuarial? Do you have any, any special consideration for those who have those higher needs as it relates to the MCOs? Do they have any special programs as it relates to making sure that those, that those people, in particular, receive the care that they need?

KEVIN BAGLEY: Sure. From a rate perspective, that is definitely taken into account by the actuaries. Without diving into too much detail, those populations are broken down into what are typically called rate cells, but groups of individuals with kind of a similar level of need. And so those, each rate cell is assigned a different rate. So it's not just a single per member per month for everyone. That amount varies based on group. That being said, we also, in our RFP today, in the contract today and in the RFP in the future, are going to have some very specific language around what particular groups we see as having really high level of vulnerability, and making sure that there is care management services through the plan available, to help coordinate the services and care those individuals need. Like you mentioned, Senator, it's often chronic care needs. And that looks different than what we might see in a commercial plan where those needs are typically more acute. It's a post-surgical home health need versus a regular home health need. Therapies are another good example of that.

ARCH: Right, 'cause I mean, we-- I mean, we struggle with populations where the, the individuals, where the, where the state is the

guardian, and high needs, and, and acute, acute as well as chronic, and making sure that, that they are cared for. And I, I would imagine, as well, that one plan versus another plan doesn't have all of this population in their plan versus, you know, none in another plan that, that-- that particular population, I think, is, is, is of great interest to us in making sure that they have their needs cared for.

KEVIN BAGLEY: Yeah.

ARCH: Anything else you want to comment on that?

KEVIN BAGLEY: You know, I, I will add on that front, that group, in particular, is already called out in our contracts. One of the things we have started to do already is to work with our partners in child and family services to start having more regular coordination between our plans so that we all have a good picture of what care is being provided, and that we're coordinating our efforts across divisions. We plan to make significant improvement to that in the future as well.

ARCH: Good, good. Another question that's probably my last is, the-- we-- when we did our continuous glucose monitoring hearing--

KEVIN BAGLEY: Um-hum.

ARCH: --and recently advanced that bill, one of the, one of the things we discovered was that, well, one of the MCOS covers continuous glucose monitoring and the other two don't. OK, I'm not, I'm not going to use-- that's just an example. But I guess the question is, there are certain, there are certain requirements for every MCO. There are essential services that they must cover, and then, obviously, they have some flexibility as well to do other things that they believe would improve the health of the population, correct? I mean, that's, that's the thinking is that it would be for improvement of that, of the health of the population. How much, how much is essential and how much is, how much flexibility are, are built into these contracts?

KEVIN BAGLEY: So the, the floor, the essential piece is they have to cover the services that we outline as covered under our Medicaid state plan. So if we outline that a service is covered and so, for example, continuous glucose monitoring, if that bill were to pass, we would outline that as a covered service under our state plan. And so it would become mandatory for all of our plans to provide that. That flexibility comes with the notion that our plans are full risk. So if they identify-- and I'll, I'll pick on continuous glucose monitoring

again-- if they identify that that service for this individual might help reduce overall healthcare costs, they can provide that service, and it, and it is accounted for in the money that they've already been paid. So what happens is, they have the opportunity to innovate in terms of the care that's provided, and find ways to improve it. As we go forward, one of the things we do is to look at those experiences and say, with our actuaries, is this something that we could build into the rates in the future? And then we also have cases like this one, where we may say, hey, if, if the Legislature decides there should be a covered benefit, we'll work with our actuaries to identify what the potential financial impact would be to the rates.

ARCH: So there are dollars that are built into the per-member-per-month that provides them with some of that flexibility that they can, that they can innovate, as you say, and offer, offer services, believing that that will improve health, reduce cost.

KEVIN BAGLEY: Right. So those rates are based on kind of what the utilization of those state plan services is. But the plans have the flexibility, within that rate, to make adjustments and provide what are often termed value-add services.

ARCH: OK, very good. Are there other questions? Seeing none, thank you.

KEVIN BAGLEY: Thank you.

ARCH: And we all wish you well.

KEVIN BAGLEY: Thank you.

ARCH: It impacts all of us. And so thank you-- as Senator Williams says, thank you for the hard work you're doing on it. And look forward to staying in touch with you as we, as we continue this process.

KEVIN BAGLEY: Certainly.

ARCH: Thank you.

KEVIN BAGLEY: Thank you.

ARCH: That will conclude the briefing by the Department of Health and Human Services, and we will now open the hearing for LB859. Welcome, Senator Clements. You don't get a chance to come over here very often. They don't let you out of appropriations very often.

CLEMENTS: I think, in six years, this is my first time here.

ARCH: Six years, OK.

CLEMENTS: Thank you, Chairman Arch and members of the Health and Human Services Committee. I am Senator Rob Clements, R-o-b C-l-e-m-e-n-t-s. I represent Legislative District 2, and I'm here to introduce LB859. LB859 seeks to require all local public health departments to obtain approval from the Nebraska Department of Health and Human Services, DHHS, before implementing directed health measures, DHMs, pertaining to an epidemic or a pandemic. By doing so, this would bring continuity of DHMs across the state for citizens of Nebraska. In addition, the bill requires the Board of Health of such district to have a public hearing with a 10-day notice prior to enacting rules and regulations. This language was taken from Section 71-1631, which currently applies to all other health, health departments in the state. Currently, only a local health department organized under Section 71-1630, paragraph 4, as a city-county health department located in a county with a population greater than 200,000 people can implement DHMs without the approval of DHHS. This unique status was created by the Legislature with the passage of LB185 in 1997. Prior to 1997, I believe all health departments were subject to DHHS. To date, only the city of Lincoln and Lancaster County have established a city-county public health department pursuant to this subsection. It is my belief that no strong evidence or data supports allowing Lincoln and Lancaster County to create their own DHMs apart from the rest of the state. There is no apparent, apparent unique health risk in Lancaster County that would demand different treatment. This exception caused divisions among local communities located in their jurisdiction, and caused inconsistencies in DHMs implemented to address the COVID-19 pandemic across Nebraska. Many constituents that contacted my office believe that this unique power allowed overreaching DHMs arms to encroach upon their personal liberty, when residents in the rest of the state were free to make their own decisions regarding exposure to health risks. There are some school districts in Lancaster County, outside Lincoln, that were forced to follow a DHM that may not have fit their individual needs. Usually, I prefer keeping local decisions pertaining to local regulations as close as possible to those affected by them. While reflecting on the COVID-19 pandemic of the last two years, it's become clear to me that during a pandemic, pandemic of an airborne virus, it would be best dealt with on a statewide level when considering DHMs. Having consistent DHMs throughout the state benefits our citizens by leveling the economic playing field for businesses while treating our residents as equally and fairly as possible. As

always, I'm willing to work with the committee to improve the bill in any way. Thank you for your consideration. I will try to answer any questions.

ARCH: Thank you. Are there questions for Senator Clements? Seeing none, will you stay to close?

CLEMENTS: Yes.

ARCH: Thank you. We will take the first proponent for LB859 at this time.

DAVID KOHRELL: Good afternoon, Senators. I'm David Kohrell, K-o-h-r-e-l-l-- David spelled the normal David way, D-a-v-i-d. I live in District 27, 1311 Patterson Drive in Lincoln, Nebraska. I submitted some comments online in support of this bill. Appreciate Senator Clements introducing this, and just wanted to reflect on some things and share a couple more. So I support LB0859. The perspective I bring is a lifelong Nebraskan. I grew up in Lincoln, lived in Omaha. I had some extended stays in the Silicon Valley and Seattle in the late '90s, early 2000s-- wild times there with all the tech growth. But Nebraska is home. I'm a Spartan-- went to Lincoln East High School, graduated from UNL, undergrad, grad degree. Kiddos went to Northeast-- once a Rocket, always a Rocket, right? So I have some stake in the game, I guess, some table stakes. And so my perspective was, and has been, that there was a government overreach. It was particularly troublesome in Lincoln. For me personally, it doesn't really impact me. I'm in tech. I'm part of the Zoom economy right now. You know, I get up, log in. Did some great work in cybersecurity, a bursting field of recent. So I support this because it needs to bring, needs to be brought back in together. Let's remember the tell-- it was 14 days to flatten the curve; that was about 766 days ago. Now, fortunately-- and no coincidence with the State of the Union-- things have been relaxed very quickly. So our DHM ended in February, specifically on February 18, about 716 days into it. But for about 350 days of that, Lincoln-Lancaster's DHM was different from the rest of the state. So specifically, what Senator Clemens brought up, you know, I don't know if there's something different going on in Crete, Wahoo, Omaha, but somehow Lincoln-Lancaster was unique. It wasn't. We found even this fall that 90,000 people could gather for, most importantly, a concert and then football games, cheering on Nebraska. And believe me, I'm an optimist. And from the games I went to, there was no masking and clearly no social distancing. So what I'm asking you to do, and hope that you will support, is just to bring a credible check and

challenge. That's part of my livelihood; you look at something. And so I'd appreciate if you do it. It's going to keep us in line with the 92 other counties and keep that consistency and, also, hopefully, avoid what I call the "rules for thee but not for me." There was a little bit of recall effort against all odds, after some frustration and people trying to get their business done, trying to survive and, really, a brick wall of communication. There was a recall effort, actually pretty successful-- didn't hit the target, but over 350 petitioners came together and gathered just about 2,000 short for recall-- not funded, very spontaneous. But the stories that I heard in the people I met were people like Harry Watson, who owns Grata Bar, who was cited 33 times and just because he didn't feel like he needed to check the health information of his customers. And there were over 200 similar businesses in Lincoln. Understandably, people make decisions. And you know what? Lazlo's has been very stringent about the requirements. I respect that. And I can also make that intelligent choice. So I just want to wrap it up. And when I looked at the letter I shared back in September of '20, that I reviewed with friends, so collectively, there were about four of us with over 140 years of analytics modeling, risk management experience. You know, I come from IT, cyberspace. Had a professor at UNL, who will be unnamed, look at this, an oral surgeon who will be unnamed, the head of metrics and pharma, and say, what's going on here? Independent, dependent variables-- gosh. You know what? We would help the health department pro bono. We're not going at $150, $200 an hour. Something is really out of whack because the whole thing is, PCR tests were not really measuring the contagion. But that was turned down. So I speak from,-- again, let me just wrap. As a lifelong Nebraska-- you know, I already gave the Rocket callout and the Spartan callout, I won't go any further-- but someone who cares, but also someone who saw people suffer and even suffer medically, by deferring critical treatment. So thank you, Senators. Happy Ash Wednesday, and a blessing upon your day.

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

DAVID KOHRELL: Thank you.

ARCH: Welcome, Doctor.

GARY ANTHONE: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Dr. Gary Anthone, G-a-r-y A-n-t-h-o-n-e, and I'm the chief medical officer and the director of

public health here in the Department of Health and Human Services in the state of Nebraska. I'm here to testify in support of LB859, which will require city-county health departments to obtain approval for directed health measures. LB859 requires the Department of Health and Human Services to approve a directed health measure issued by a city-county health department prior to its implementation. With this change, all local health departments in the state would be required to have DHHS approval prior to implementing a directed health measure. Under current law, a local health department organized as a city-county health department, located in a county with a population greater than 200,000 people, can implement a directed health measure without the approval of DHHS. This bill would provide more continuity and consistency to directed health measures across the state in response to a pandemic or epidemic. Over the last two years, while responding to the coronavirus pandemic, we have seen that a cohesive response strategy is key to stopping the spread of the virus and keeping Nebraskans safe and healthy. The exception for a city-county health department and current law has caused confusion among people traveling between jurisdictions, and inconsistencies among counties in Nebraska. Viruses and infectious diseases like COVID-19 do not recognize county lines, which is why it is critical that we utilize a statewide approach to respond. LB859 would provide DHHS the ability to have a more coordinated and united effort to respond to any statewide health emergency, more effectively keeping Nebraskans safe and healthy. We respectively request that the committee support this legislation and move it to the floor for full debate. Thank you for the opportunity to testify today, today, and I'd be happy to answer any questions.

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

M. CAVANAUGH: Thank you. Thank you for being here. So I'm just looking at the language in this, and it looks like it does more than just that. It looks like it creates some additional requirements of departments to get approval from the Department of Health. Is that your understanding?

GARY ANTHONE: No, it is not.

M. CAVANAUGH: OK. So I'm looking at page 6, lines 21 through 24. Actually, it's more than 21 through 24, it's starting at lines 15: Community health services and health promotion and outreach, specifically includes policies related to the following: client services and fees; standing orders, supervision, screening, and

emergency and referral protocols and procedures; monitoring and reporting; and communicable disease investigation, immunization, vaccination, testing and prevention measures, including measures to arrest the progress of communicable diseases, subject to approval of the department. So all of those things would be subject to the approval of the department, including client services and fees and screening and emergency and referral procedures and protocols, monitoring and reporting? That's a lot more than a directed health measure.

GARY ANTHONE: My understanding is it is-- just was the part 4 there, the communicable disease investigation immunization. I think the rest was already part of the original bill.

M. CAVANAUGH: We'll probably have to get some legal counsel verification on that, so that's not your intention. It's just--

GARY ANTHONE: No.

M. CAVANAUGH: --to be that last part. Is there anything currently preventing the state from enacting directed health measures across the state?

GARY ANTHONE: No, we do that all the time.

M. CAVANAUGH: OK. Is there anything preventing the state from enacting directed health measures that are targeted to certain counties or municipalities?

GARY ANTHONE: No, we have done that, too.

M. CAVANAUGH: So the issue is just that counties and municipalities are doing it on their own,

GARY ANTHONE: Just one.

M. CAVANAUGH: Two.

GARY ANTHONE: Oh, two-- the city and county, yes.

M. CAVANAUGH: Yeah, but two cities have done it.

GARY ANTHONE: That's under litigation right now, as you know,

M. CAVANAUGH: Relitigation. But yes, thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Doctor, for being here. When we're talking about health emergencies, in the statistical analysis that you have seen and done, have you seen any different outcomes in Lincoln and Lancaster County than the rest of the state because of the DHMs that they implemented?

GARY ANTHONE: I'm not aware of any data to show that.

WILLIAMS: OK. One of my concerns with the bill is the requirement of a hearing and a 10-day hearing notice when there could be an emergency situation. Are you-- do you have a comment about that?

GARY ANTHONE: I thought that--

WILLIAMS: What about an emergency situation and all of a sudden you've got a 10-day notice period?

GARY ANTHONE: I thought that was related more to the City Council members, things of that nature, to implement their own mandates or measures.

WILLIAMS: OK, we'll take a look at that, too. I'm, I'm-- and I'm not being objectionable there, I'm just saying, you know, if you, if we have if there is an emergency situation that needs attention now. OK, I want to go down the line of getting something on the table that I think is probably on everybody's mind with this discussion. At the state level, when, when you're involved, on-- who, who is, what is the process, the line of decision-making for who issues a DHM from the state?

GARY ANTHONE: So we obviously put together a team, and the Governor's briefing team specifically, that we communicate with all the stakeholders, the local health departments, and then we use that information to make that decision. I'm the signer of the directed health measures in the final part.

WILLIAMS: I think the concern of, of some people, at least, is, is-- is the decision that is made, made on medical evidence or is it a politically motivated decision? And in your experience, I'd appreciate your answer for that.

GARY ANTHONE: Yes, it's, it's definitely based on medical evidence, not political, but what we think is best for the community.

WILLIAMS: So the people that are involved with the decision are all medical in nature, then, that are making the decision?

GARY ANTHONE: No, they are not.

WILLIAMS: OK, so we have elected officials that are, I will say, political in nature involved in that process of making that decision.

GARY ANTHONE: Yes, they are.

WILLIAMS: Thank you.

ARCH: Other questions? Senator Walz.

WALZ: Yeah, I'm just going to-- the question that he had about the 10 days. It says the Board of Health may enact rules, so on and so forth: having general circulation in the county at least 10 days prior to such hearing, and enforce the same for protection of public health. What is that? What does that process look like? Like, you're thinking it was a city council or--?

GARY ANTHONE: Yes, and the Board of Health. Yes.

WALZ: And the Board of Health, OK. And then: and investigate the existence of any contagious or infectious disease and adopt measures. So it does seem like it's taking some time, I guess, in my eyes, as, as what Senator Williams said.

GARY ANTHONE: I guess you could use, for example, when the city of Omaha did their mask mandate, that's the process they used as far as the mask mandate back in August 2021.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: So if we were to pass this, what would be the threshold that would guide implementing a directed health measure for the state? Because we did hear at briefings what the thresholds were going to be, but then those were moved. So what would be the guide rails for this,--

GARY ANTHONE: It would--

M. CAVANAUGH: --and how would, how would that be communicated and documented for the people?

GARY ANTHONE: You know, we did set up our certain thresholds for different levels of where our directed health measures would go, and that would be a fluid situation, depending on what the infectious disease was, what level of transmission there was, what level of hospitalizations there are, things of that nature.

M. CAVANAUGH: So in the instance in Omaha in Douglas County, they implemented a directed health measure for a mask mandate when the hospital capacity was at a critical rate, which I looked up. On January 5th, it was at 94 percent capacity, which is, I mean, horrific and terrifying for everyone, especially since Omaha serves so much of the state. And now the state is suing over that ability to enact a directed health measure, but the state could have enacted one. So I just-- like is it 99 percent? Is it 100 percent? When does the state enact a directed health measure? If you want to have this authority, we need the assurance that the people are going to get a health measure when they need it.

GARY ANTHONE: I think that's the reason, Senator, for keeping in constant communication with our hospitals, with our stakeholders, to see what those thresholds would be. That has been one of--

M. CAVANAUGH: But you did have a constant communication. I mean, they were on the news, they were on Twitter, they were on Facebook, they're on press calls. They were doing everything they possibly could, sending letters to you, to the Governor, to the media, begging for health measures to be enacted. That is constant communication, and it never happened. And now they're being, the county is being sued, the city is being sued. I just, I don't-- I'm not trying to be combative. I just really want to know what is-- if you want this, are you going to use this authority or is it going to be used for some sort of political reason that takes it out of the hands of medical professionals?

GARY ANTHONE: Just to get back to the issue about what capacity or threshold level is at a level where you need to issue a directed health measure as far as hospital capacity goes, we did some research and found that most hospitals are, are usually operating at about 90 to 95 percent capacity during peak times of the year at times. I have personal experience with that, working in hospitals and trauma centers.

M. CAVANAUGH: What do you mean by peak times?

GARY ANTHONE: Peak times, like during, maybe, summer times when trauma is, is at a high level or flu seasons, things of that nature.

M. CAVANAUGH: Is there data to support this?

GARY ANTHONE: There is, that hospitals are used to working at that capacity, 99 percent capacity.

M. CAVANAUGH: If that's true, then why is their capacity at the start of the pandemic so significantly lower? And as infections went up, the capacity-- I mean, in the past two years, capacity has only been high, according to Omaha at least, when we've had high rates of infection.

GARY ANTHONE: Initially, when we set those directed health measures in place, we wanted to make sure we maintained that capacity because we did not know what was going to be necessary to take care of the patients. So that's why we held those capacities fairly low. And to get back to your other statement about hospitals begging for something to be done, in, in my recollection, it was not all the hospitals that were begging for that to be done.

M. CAVANAUGH: All the hospitals in Omaha were.

GARY ANTHONE: And that was not all the hospitals in Omaha, to my recollection.

M. CAVANAUGH: What hospital in Omaha wasn't?

GARY ANTHONE: The University of Nebraska Medical Center.

M. CAVANAUGH: I would argue that that is not accurate, but I'll leave it there. Thank you.

ARCH: Other questions? I have one, one last one. You used the term "best interest of the community" when it comes to issuing a DHM. Is that, that,-- that was the language that you used, is that correct?

GARY ANTHONE: That's correct.

ARCH: Is-- do-- as, even as a physician, do you view that, that that decision as a purely medical decision?

GARY ANTHONE: In the best interest? I do. Yes, I do.

ARCH: OK. All right. Thank you. Oh, we have one more question. Senator Murman.

MURMAN: I'm-- this is a little bit off the subject, but is a foodborne illness a-- would, would this be applicable to a, like a foodborne illness?

GARY ANTHONE: If it was communicable, yes.

MURMAN: OK. Would the 10-day notice period be a problem with something like that?

GARY ANTHONE: Yeah, if that's the way that the Board of Health or the City Council wanted to do that, that would be. But that's the reason for us doing directed health measures. We don't have to wait that 10-day period.

MURMAN: OK, thank you.

ARCH: OK. Thank you. Seeing no other questions, appreciate your testimony today. Thank you for coming. Next proponent for LB859?

DALE MICHELS: Thank you. Good afternoon, Senator. Senator Arch and members of the Health and Human Services Committee, I'm Dr. Dale Michels, D-a-l-e M-i-c-h-e-l-s. I'm a retired family physician who lives just outside the city limits of Lincoln, but I practiced in Lincoln for 44-plus years. I'm in favor of LB859. My question is a simple one: Why? Why is the Lincoln-Lancaster County Health Department, or LLCHDF, different from the rest of the state? I believe that the LLCHD is an excellent county health department and does many good things for Lincoln and Lancaster County. They coordinated and staffed a great series of vaccination clinics for COVID-19, among other things. I've supported them and participated in their activities when I was in practice. My concern is that the LLCHD is able to act independently of the state of the Nebraska Department of Health when it comes to certain directed health majors. I believe that, although there's been legislation that was enacted a number of years ago, that neither makes it in the best interests of our community, nor does it make sense. Are citizens who live in Lancaster County different than those who live in the rest of the state? I don't think so. Does the population of Lincoln require different public health measures than residents of Crete, Wahoo, Seward or other communities or school or count, count community or school governments close to Lincoln? My experience as a physician would not indicate that. I-- during the recent pandemic, it was, frankly, confusing to have different directed health measures, depending on where you were. When we visited our family in Milford, no masks were required, but when we came back to

Lincoln, we put our masks back on. Going to Omaha, which has a higher population, for the most part, didn't require masking. In addition, although I'm not sure of the actual statistics, I believe that there were not major differences in the rate-- Lincoln's rate of infection or hospitalization from COVID-19, despite the additional restrictions, when compared to the rest of the state. So why? Given the fact that Nebraskans are largely the same wherever they live, it just doesn't make sense to me. Therefore, I'm supporting LB859 as good, commonsense legislation, and I thank you for the opportunity to testify, and I would be happy to answer any questions.

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

DALE MICHELS: Thank you.

ARCH: Next proponent for LB859?

MARK BONKIEWICZ: Good afternoon, Senators, my name is Mark Bonkiewicz, M-a-r-k B-o-n-k-i-e-w-i-c-z. I am a former wheat farmer from Sidney, Nebraska. I live in Omaha now. I'm here to support LB859 from a business perspective. This bill will promote consistency in the application and enforcement of DHMs. This is of particular importance for adjacent counties, as has been spoken about earlier today, where the health risk within each county is virtually identical to neighboring counties. So I just want to share a couple of quick perspectives on the confusion that the current system allows. So it just increases confusion and irritation for employees that are doing business across county lines. So for example, think in terms of a UPS driver or a FedEx driver, OK? They're across all kinds of county lines in a typical route. So what do they have to do? And wear my mask, not wear my mask just causes a lot of confusion. So this bill would eliminate local DHM enforcement that can be politically motivated at the city or county level, and require them to rely on statewide data that is openly available to citizens to increase transparency. Transparency is a great thing. So please vote LB859 out of your HHS committee for floor debate. Thank you.

ARCH: Thank you. Are there any questions? Seeing none, thank you for testifying. Oh, did I miss one?

WALZ: No, that's all.

WILLIAMS: Sorry.

ARCH: OK, next proponent for LB859?

MILISSA WILES: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Milissa Wiles. I'm a parent of a middle school student, and here today to testify in support of LB859 as a parent.

ARCH: Could you please spell your name?

MILISSA WILES: Yes. Milissa, M-i-l-i-s-s-a, Wiles, W-i-l-e-s. I'm not here to talk about mask mandates, but rather share with you an experience that I had with another directed health measure by the Lincoln-Lancaster County Health Department. This had to do with the mandate to pause youth sports activities in November-December 2020. This mandate was eight months into the pandemic, began, and had no scientific basis, in my view, and was detrimental to our children. My husband and I have a 14-year-old son who was 13, 13 years of age at the time, and our number one goal was, and still is, to provide as much normalcy for him as possible. I know of children my son's same age, with no prior emotional problems, who committed suicide during the pandemic as a result of the mental effects of shutdowns and isolation. For us, the structure, socialization, and physical activity of youth sports was integral to our approach to provide normalcy for our child. The mandated pause of youth activities by the Lincoln-Lancaster County Health Department frustrated our efforts. I attempted to reach out to members of the Lincoln [INAUDIBLE] Council regarding these concerns, and got nowhere. If LB859, a law similar to L, LB859 had been in place, at least there would have been an upper-level review of such directed health measure before it may be instituted, and with the scientific expertise and knowledge that would behind, would be behind that directed health measure. So when asked that-- I would ask that you move LB859 to floor debate. We are fully in support of this measure. Thank you.

ARCH: Thank you. Are there any questions? Thank you for coming and sharing your testimony with us today-- very much.

MILISSA WILES: Thank you.

ARCH: Next proponent for LB859?

MARY HILTON: Good afternoon, Senators. My name is Mary Hilton, M-a-r [SIC] H-i-l-t-o-n. I am a citizen of Lincoln, a mother raising my children here, and I am a citizen of Nebraska and the United States,

and should be afforded due process under law to protect my constitutional rights. The Fifth Amendment and the 14th Amendment of the U.S. Constitution prohibits arbitrary deprivation of life, liberty, and property by the government, except as authorized by law. COVID-19 regulations and the due process in our law of Lincoln, Lancaster County, have certainly been arbitrary, over-reactionary, and we have been very slow to regain our freedoms. It does seem as though the residents of Lincoln, Lancaster County alone, by wearing masks and having other restrictions put in place were to, you know, eradicate COVID in America. And we have done so with we've had to endure these restrictions with no public hearing and no voice. I traveled widely over the last year to Virginia, Missouri, Iowa, Oklahoma, Texas, Illinois, Indiana, Ohio, Michigan, and Kansas, where I have experienced an incredible amount of freedom as compared to coming home to Lincoln, Nebraska. And I know that it was published that the-- at least as it goes for, for children in school, here, we in Lincoln, up until recently, have had to have our children in masks, and the number cited was that in Lincoln, we've had one tenth of 1 percent fewer cases of COVID with children. And at what cost? Phys-- at the cost of physical health, mental health, the loss of learning in school children, especially the young students, promotion of fear, paranoi, paranoia, condemnation. And these have come at the cost of us, as Americans, who are to be free and to have liberties. And this has happened because of an endless emergency powers and a health director appointed by and controlled by the mayor of Lincoln. We residents of Lincoln and of Lancaster County need to be rescued and treated like the rest of the citizens in Nebraska. LB859 will put us under the protection of the Department of Health and Human Services. Our health director will never again be able to go rogue, depriving last, Lancaster County residents of life and liberty. We need our rights protected by the state. We must never again be deprived of due process of law and treated unequally under the law of the state of Nebraska as the other citizens of this state enjoy. I ask you to please support LB859.

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

MARY HILTON: Thank you.

ARCH: Next proponent for LB859. OK, just take a seat up front. That'll be fine-- whichever one wants to go first.

JACK RIGGINS: Oh. All right, Jack Riggins, J-a-c-k R-i-g-g-i-n-s. I'm a citizen of Lincoln here. Senator Walz, I believe it's been about 30 years. I just want to say that I know you'd be an honorable and good woman, and it's good to see that you're serving in the state and the great county of Dodge.

WALZ: Thank you.

JACK RIGGINS: LB859, I ask that you support it. I'm a proponent. The questions have been interesting. It would be really easy to go down the mask versus mask. It would be very easy to just go down the science. I look at it as a governance issue and how we govern citizens in the state and in the case of Lincoln. If it were right or efficient governance for the state of Nebraska, all of the counties would have the individual organization that Lancaster County and Lincoln has, with regard to directed health mandates. Yet that's not the case. Only one county in our state has this arrangement. And it's more than likely it wouldn't even came to light if there wasn't COVID. So in that way, you and we, the people have a chance to see how it kind of works under pressure. And clearly it didn't work. It doesn't mean that anybody was right or wrong in a pandemic. It just means, how are we going to go forward in the best and most efficient way to govern under pandemics or epidemics or any such thing in the future? And I would go back to if, in all our collective wisdom, we thought the best way to do it was to have one individual county, then we would have that in the state; and we do not. We just have one. It happens to be the county in the city that I live in. It certainly brings into a lot-- a lot of questions to the citizens as well as other folks in governance, the checks and balances of said decisions. It brings in the political versus the science. I thought, Senator Cavanaugh, your questions were interesting and the reason is, is it's very difficult as a citizen to determine what is more important at any given one time. I thought that the answers by the current director were interesting. We should not fool ourselves that we can only make decisions in governance or leadership based on one thing, science, or politics. We have to think of the greater good of the people. I have failed multiple times trying to get leaders in this county, in this city, to understand the greater impacts of social development, mental health, economic development, and all of the things that go into a society that you are elected leaders for. But yet we in Lancaster County went with one: the science, the science of science. The question I would have back to you, Senator Cavanaugh, is: When Omaha instituted their last mandate and you made reference to it was because of the hospitals, how long did that mandate last? I think it was two to three weeks. So are you

to tell me that the three-week mask mandate changed the entire world for Omaha? Because here in Lincoln, Sandhills Global and myself did plenty of data analysis across the counties, and in no shape or form is there any empirical evidence that a mask mandate works to its stated goals. Historically, we have set ourselves up for a same situation when people in Nazi Germany were told to get on trains and just do it. Why? I have the power, do it. In other countries, in Africa, young women's clitorises are taken out because of a historical precedence that that's what's good for them. And so, as a free citizen of the United States of America in Nebraska, I'm supposed to trust one person with no checks and balances from my state leaders, when the rest of the counties have those checks and balances to make the best decision, both scientifically, health-wise, and for the greater health of the community? I don't buy it. Please support LB859. Bring trust and transparency back to Lancaster County. Thank you.

WILLIAMS: Thank you, Mr. Riggins. Are there questions? Seeing none, thank you for your testimony. Invite the next proponent? Good afternoon and welcome.

GRETCHEN HESS: Good afternoon. My name is Gretchen Hess, G-r-e-t-c-h-e-n H-e-s-s. I want to, first of all, apologize for my attire. I usually would dress up for the occasion, but I had a doctor's appointment out of town and didn't think I would be able to make it back for this. So since I did, I hurried on down here. So as well as I want to apologize that I have nothing prepared. So I'm going to speak from the heart and, if I get a little emotional, I'm sorry ahead of time. But back in 2020, my husband and I, you know, just like everybody, were super concerned about what was going on when COVID came. And we own a business. My husband works a full-time job as well as is part owner of a bar downtown Lincoln, and I stay at home and homeschool my four children-- our, our four children. And so we, you know, kept our eye on everything that was happening, and we have always tried to remain in compliance with our business as far as with the health department and everything that goes along with that, with the Police Department and those sort of things. So we, when this first shutdown happened, we complied with everything. And I am the type that likes to research a lot of things, so I started researching. And we got no, we got notice, the Police Department came around and said, you know, we're giving you a warning just to let you know you could be shut down if we decide that this is the route we're going to go, and you don't comply. They just kind of dropped something off but didn't tell us, didn't tell us there was an ordinance, didn't tell us anything. So a couple of months went by and one of the bars downtown,

our neighbors, got shut down. And they called us right away. We've always worked together, have a good rapport with all of the other business owners downtown. And they said, did you get shut down? And we said no. And so I started doing more research, like why? Why did this place get shut down? And so I went and took it to the City Council and asked. They later told us it was the compliance ordinance on, on file that was 8.18, I believe, if my recollection is right. And so I called. I made calls to the health department, I made calls to the State Capitol, I talked to the Governor's Office. I just wanted to know how that happens without prior notification, that a business can be shut down. And come to find out that the health department who shut these couple businesses down failed to give proper notice. They were supposed to hand deliver letters that said, if you're not in compliance. They did, they did undercover checks. They came into businesses just at the bars, not-- you know, they didn't go to Target and see if they were following their arbitrary rules that they put in place, just at bars. And so I found that odd, but I wanted to remain in compliance. So I said, can anybody tell me? Anyway, make a long story short, we went to have a meeting with the health department: Sorry, we forgot to give you the notice, but we did shut you down. And I said, that, that doesn't seem like that should be legal, you know, for a business to lose out on, on their revenue with no proper notification. It was, it was astonishing to me that that was allowed to go on. And so I brought it forth to the City Council and we had a meeting with the health department, and it just seemed like they were pulling out just arbitrary rules, and they were threatening. And it was, if you don't comply, we will shut you down. You need to follow these. And we, we just wanted to know what, what do we need to follow? Where is the data that supports this, these type of measures? What can, you know? And then it fast forwarded to, you know, just the bars were shut down and needed to be shut down at 11:00 or 10:00. And we were, we were on Zoom calls with the health director, and just-- it was, you know, we'd tell-- she'd tell us one thing and then something else would come out. And so we were just kind of left shaking our heads of what, what do we follow? You know, I call the Governor's Office: Can you do something? No, they have this ordinance on file, and, you know, that's, that's the best we can do. You need to follow it. And so we sat, closed down, and, and watched our business go to Omaha. We are law-abiding citizens, taxpayers. We have been open since 1935 in this, in this community, and we just felt like we were being punished. So we were the only industry that was shut down. We decided, look, you know, it's the lesser of two evils. We have to open up. I have children to feed, right? So nobody else-- I could go to Target or

anywhere-- a grocery store-- and lines of people. And we were following the procedures. It's just why was the 11:00 arbitrary time? Nobody could, could just tell us. So we decided--

ARCH: Your, your red light has, has come on--

GRETCHEN HESS: OK.

ARCH: --to-- and I would ask, if you have a summary, that you could close.

GRETCHEN HESS: I just-- we ended up having to go to court. We were fined. We had to settle with the city. So now we are, we are, in the, in the eyes of the law, we are, we are criminals.

ARCH: Yeah.

GRETCHEN HESS: And it's, it's not right. So thank you.

ARCH: Thank you. Wait, wait, wait. There might be questions.

GRETCHEN HESS: Sure.

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

GRETCHEN HESS: Thank you.

ARCH: Next proponent for LB859.

JANA VOLZKE: So bright up here. Hi, my name is Jana Volzke. First name is J-a-n-a; last name is V-- as in Victor-- o-l-z-k-e. Excuse the shaky voice; I really wasn't planning on talking today. I guess there's two sides of the science because I choose to listen to doctors that actually have protocols, that actually treat people early on instead of just getting a swab stuffed up your nose and sent home with a positive. And hey, come back when your lips are blue and we'll help you, put you on a ventilator and see how you fare. So I choose to listen to-- yes, they are doctors, they're scientists, world-renowned doctors that are actually preventing people from actually getting into the death centers, is what I now call them. So my dad was one of those people that spent four days in the hospital and was diagnosed with pneumonia, but wasn't even treated for the pneumonia because everything was COVID then. So my dad ended up dying with staph infection in his lungs because it wasn't treated for what he actually

had early on, because everything was COVID. So masks that are made to wear in hospitals now, I think this is hilarious. The blue with the light, you know, you have to put that went on to be in hospitals. Now your cloth, homemade ones won't work anymore. You at least have to wear those-- actually says on the back of the box that it won't stop the spread of COVID-19. So I'm just curious why we think that's effective. And just that the common sense is just gone. We wear them into a restaurant, and then we sit down and take them off and chitter chatter, chitter chatter. You know, it takes-- COVID is spread through aerosols, right? We figured that out; we learned that. It takes an aerosol or aerosols up to 50 days to actually come down out of the air so as people walk through and they get scattered again. So I just like, I don't know, it just makes zero sense that we wear them to get seated in some restaurants-- I don't go to those ones-- but once we sit down, we're safe? It's stupid, and it's just-- I don't know. The thought process behind these things, like we raise our kids to have common sense, to think for themselves and to not live in fear. Maybe it's, it's our faith in Jesus Christ. But this is just the fearmongering and the tyrannical thumb of an unelected bureaucrat that decides for all of us? That's just malarkey. It's just-- if people are that scared or if they're they have an immune deficiency or whatever, then stay home. Stay put. Fine by me. I'm not scared to go out. I've been living my life this entire time without doing any of this crap. How am I still here? Like you all promised me that I was going to die if I didn't follow these rules, These non-commonsense rules. Anyways, I have two beautiful daughters, a 19-year-old and a 16-year-old. Thank God my 19-year-old is no longer in the school system in this city. Actually, the whole state is a mess. But my 16-year-old is at Lincoln East. My 16-year-old tried to go to school the first two weeks of her freshman year, which was her first year in high school and year of all this stuff. She ended up coming home after the first two weeks, and doing all online. She went into a deep, dark depression. She isolated. She never came out of her room in the basement. She never saw her friends. And she started cutting her wrists because of the anxiety these masks gave her. She had doctors' notes, she had notes from her counselor, her therapist. And LPS: Oh yeah, we, we give mask exemptions-- da da da da. You know, we're told: Listen to the doctors, listen to the doctors. They're the experts, right? Well, apparently not at LPS. My kid had a doctor's note so she wouldn't have to wear a mask and have that anxiety, and we could help her. Nope, not good enough. We don't listen to the doctors then. Just it's infuriating. We have so many personal things that-- attached to this and why I'm here. People have no idea the hole that my now 16-- she was a 15-year-old--

had to work and climb out of, no idea how diligently she worked with her therapist. Would go into the school building after hours to work with her therapist and walk the halls so she could get comfortable with being in the hallway. Anyways, I just wanted to get up here and say that, so thank you for listening. Any questions?

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your testimony. Next proponent for LB859. Seeing none,--

ROBERT BORER: Yes. I'll, I'll take a seat, please. Can I fill this out afterwards?

ARCH: Yes.

ROBERT BORER: I was grabbed out in the hallway by a friend. Ah, excuse me. Committee and Chair, my name is Robert Borer, R-o-b-er-t B-o-r-e-r. I'm going to shock you. I knew, from day one of the "plandemic," "scamdemic"-- whatever you want to call it-- and it was a total hoax. And I queried our local health department for the science to back up their alleged claims of a novel contagion. They responded that they had nothing, and referred me to the corrupt CDC. Of course, the CDC doesn't have anything either, so I took it up higher to the Department of Health and Human Services, with the same request. This would be for both formal public records requests. I outlined the science that it took. I know the scientific method to prove a novel deadly contagion. I got the same response from the DHHS. I proceeded from day one of this narrative that was designed-- well, I'll say that, from day one, I ignored all of the tyrannical mandates. I haven't worn, I haven't touched a mask in this county. And furthermore, I traveled far and wide, starting in June of 2020: Florida, Texas, Missouri, Wisconsin, South Dakota, Colorado, many of those places a couple of times, and always sought to immerse myself in the community where we went. Fellowship with-- face-to-face with tens of thousands of fellow patriots, never wore a mask, never, never followed any of the alleged precautions, just lived my life normally. And my wife and I never got sick once, once. Where's this novel deadly bogeyman at? No, I ran into a couple of health guys. Where's your bogeyman? How do you explain the fact that you got this novel deadly contagion floating around everywhere, and I can't seem to catch it? And it's not that I'm not-- it's not that I'm avoiding anybody. I didn't avoid anyone. I don't care if they were even sick. I even took, I even set the challenge to as many news and media outlets and newspapers and radio as I could, saying: Hey, come on. Somebody, somebody want to do a real story and do some real science? Bring me

your sickest, alleged COVID patient. Now, I'm not saying that people haven't died, but the reason-- it's the cause of the deaths that is, is the issue. And the cause has, has been hijacked by nefarious forces, by incentivized harmful medical protocols. Our local health department had no idea what they were talking about. They were following. They were taking orders from a deep state cabal that's seeking to implement a new world order. And call me a conspiracy theorist, but it's true. How much time do I get, five minutes?

ARCH: Five minutes.

ROBERT BORER: Any questions? I'm still living my life with-- I did put on a mask once because before we launched into this goofy pandemic, we had plane tickets to Florida. So I put a John Wayne bandana around my neck, and when I got on the plane, I just put it up and blew my nose, just so I could get on the plane. That's the only time. Otherwise I wasn't afraid to get close to anybody. We'd go down to Missouri, to Branson, and right outside the city limits-- in the city, you got a mask mandate right outside the city, you got cheeky, Crazy Craig's Cheeky Monkey Bar, which is a great place to meet people and have fun. They, they really treat you well. So we go in there and here's this place that's packed to the hilt, I mean, literally packed to the hilt. A nice three-person band off in the corner, singing some great, you know, old-fashioned rock and roll, playing. You know, these are old guys and, and just having the best time. And so I talked to the owner who happens to be from Nebraska. He owns a bar in Branson, and he's never had a drink. And he was a, a fraternity president while he was at Peru State. But I said, how long have you guys been operating like this? You guys haven't taken any of the precautions. Oh, well, from the beginning, they never shut down. So these so-called health missions in this city and in this state, they can't seem to look up above the fence of their own blindness and look at what other places are doing. And like, why aren't you guys up-- a case is defined as nothing more than a person who test positive. The test does not test for a contagion, I mean, so--

ARCH: I see your red light has come on now--

ROBERT BORER: Yeah.

ARCH: --five minutes.

ROBERT BORER: Thank you.

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

ROBERT BORER: OK.

ARCH: Next proponent for LB859? OK, seeing none, first opponent for LB859?

JOEY LITWINOWICZ: I'm sorry, I always come up first. I try to remember, so thank you. Hello, Chairman Arch and members of the committee. I hope you get outside today-- barbecue some vegetables-- just vegetables. Anyway, I, I'm, I'm really sorry for anyone that, you know, suffered losses of any kind.

ARCH: Excuse me, before you begin,--

JOEY LITWINOWICZ: Oh, oh-- I will be--

ARCH: -- name, name and spell the name, please.

JOEY LITWINOWICZ: Joey Litwinowicz, J-o-e-y L-i-t-w-i-n-o-w-i-c-z.

ARCH: Thank you.

JOEY LITWINOWICZ: And I just-- I'm listening to certain things. I'm not jiving you or anything, but as far as the legislation in the past, I wasn't as smart in the past either, not in 1997. All right. You know, I have a problem with arguments like that. And the farther I got into studying science and that-- I mean, making sure our mandates, but, you know-- but earlier on, too. The more you know, the more you don't know. And I don't see how any other field, like cyberspace or-- even qualifies you for anything because you learn just how--I don't even I didn't even know what my group, my group mates were doing, you know? What the hell is that? So I have a problem with not trusting expertise and, you know, being swayed. There is a political motivation. And you know, the guy who did it suggested injecting cleaning chemicals. And, and so it's really-- it's just hard to deal with. My 92-year-old mother is waiting. She's in New Orleans, where I'm from. She's waiting to, you know, come out, you know, to-- when they, there's a better antiviral or, you know-- yeah, or even a vaccine. So the health mandates-- getting back, getting to the point-- I think, are essential because nobody, nobody here understands the science, including me. But I do understand that there was no conspiracy theories, and that Fauci was fine, you know? And yet the, the scientific method is one thing, but-- anyway, I'm going to, I'm

going to get off of that, because "Captain Hindsight" is always 100 percent, and it turns out that this virus-- I can remember back in the, at the time it was occurring, we didn't know what was going on or what really, you know? And in a sense, you know, what about the next one? And as far as masks are not working, you can compare unbiased communities, unbiased with respect to previous COVID-like infections. And there's a lot of empirical science and observation that has been done and, and even two masks work better. I wish there was no incentivization for studying all of these kinds of things like you could model, you know, a mask. Like, maybe I don't look at it, but I, I've talked and nobody has-- no doctor has brought it up. Like you, you, you could model things like exhalation and droplets. You know, there is a fluid-- I took fluid-- yeah, anyway, of course. So the whole thing, as far as the airborne stuff, it's actually interesting 'cause I have a background to understand some of that, as a material scientist. And I, you know, but I knew nothing, right? Because first of all, I, I, I like that my lab partner who's doing it, you know, he's, he's, he's so [INAUDIBLE]. He's doing it so much, so much, something so much different under the same advisor. You know, even when I go-- you have the group, weekly group meetings. You know, I don't know. I mean, I'm asking questions. And that's even if you have a-- well, anyway, I don't want to get off the point. I think I was doing pretty good today. The thing is, as far as big government goes, you know, you can either have big government or a big head. And, you know, for as far as Governor Ricketts, all right, he doesn't-- he shook hands with President, President Trump last June. And you know, if you look at a shotgun-toting Tuberville, you know, we had--that's, nothing's going to change. I want to live in my bubble, you know. And we have the other guy who's still out. I think the last time I checked, he had-- endorsed by Trump, my guy. He's supporting Russia and Putin's got him by the balls. I don't know. But let's listen, just trust expertise. Please, can we do that again? I hope so, because I'd like my 92, your 92-year-old mother to live, too, and wearing a mask is an act of love. It's like buying a war bond. Just do it. It was hard for me to breathe through-- quit whining unless you can't, OK, if you can't, you know. But I mean, it's World War II, you know. What are we going to win? The lives of some people at the expense of what? What are we going to buy? A little inconvenience and wearing a mask I don't know. It's an act of love. I grew up. My dad was a World War II--

ARCH: Your red light has, has come on.

JOEY LITWINOWICZ: Oh, OK. And you just don't bitch, in a sense. So do you have any questions?

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

JOEY LITWINOWICZ: Thanks. I really-- it really means a lot to me.

ARCH: Next opponent for LB859?

ABBIE FOUGERON: Hello, my name is Abbie Fougeron, A-b-b-i-e F-o-u-g-e-r-o-n. I'm the administrator for Nebraska Pulmonary Specialties in Lincoln, and going to read a statement on behalf of physicians, nurse practitioners, and physician assistants from both Nebraska Pulmonary, Inpatient Physician Associates, and Nephrology that couldn't be here today to read it for themselves. So Chairman Arch and members of the Health and Human Services Committee, we write this letter in opposition to Senator Clements' LB859, which seeks to require city-county health departments to obtain approval for directed health measures and removes the Lincoln-Lancaster County Health Department's authority to issue directed health measures independently. In the setting of a public health emergency, efficiency in the decision-making process is imperative in assuring that hasty action can be taken to protect the health of the public. Many weaknesses in our public health response to the COVID-19 pandemic have been identified, but this bill would weaken the health departments' ability to accomplish their mission. Certainly, through the state of Nebraska, most public health departments were hindered by such restrictions. It's clear to us that introduction of this bill was motivated by the uniqueness of Lincoln-Lancaster Health Department to enact directed health measures without going through a bureaucratic and politicized process. Such processes hinder responses aimed to protect the public. Below, we've outlined reasons for the opposition. First, health and-- health departments and health directors need to be able to operate outside of political influence. In the setting of a public health emergency, although there are often competing interests, critical decisions must be made to protect the health of the public, including the most vulnerable members of our community. Unfortunately, these are not always popular decisions. Everyone focuses on the mask mandates in this current pandemic, but there may be other potential directed health measures for different public health emergencies in the future. Unfortunately, politicians are sometimes more likely to make decisions that are popular rather than right, which absolutely weakens a response and puts the public's health at risk. As healthcare workers, we are the best advocates for the public's health and medical welfare. It only makes sense that medical decision-making should be made by people with a medical background. Secondly, local public

health departments are going to have a better handle on what measures would be most effective and easy to operationalize. As a state, we do not want to have to get approval from the federal government for critical actions. Similarly, it does not make sense to add a layer of bureaucracy for our local health departments to wade through. Passing this bill ensures that the already complex task of protecting Lancaster County will become even more difficult and that potentially lifesaving measures become delayed. Third, in Lancaster County, we had tremendous collaboration with numerous members of our local health department, including the current director. Decisions were not and are not currently being made by a single individual without collaboration with multiple other entities. One must look at the data comparing Lancaster County mortality rates to the rest of the state, and I have updated numbers that are not reflected there, but I'll read them here: 132 per 100,000 Lancaster County residents versus 187 per 100,000 Douglas County residents versus 205 per 100,000 greater Nebraska residents. There are probably several explanations for this discrepancy and why Lancaster County did better. But we believe part of it was the ability for our health department to enact directed health measures that other health departments could not. We have often supported high percentages of hospitalized patients here in Lancaster County who were transferred in from external counties who had not enacted good nonpharmaceutical interventions, such as indoor mask mandating. The other health department directors knew these nonpharmaceutical interventions would help protect and flatten the curve, but were mostly powerless to enact and enforce them. Fourth, we saw no abuse of authority by our health department director in the decision-making process for directed health measures. We continue to experience excellent collaboration between our local health department, numerous members of the healthcare community, spanning multiple hospital and healthcare systems, various school boards, and other appropriate public and private entities. Such collaboration facilitated continued careful and timely review of available medical data, allowing directed health measures to be enacted and rescinded at the right time. The ability to operate collaboratively with limited societal disruption provided a layer for protection for Nebraskans in our community even very early on in this pandemic. Again, this response would be hindered by requiring approval from a politically influenced individual. These are just some of the compelling reasons we would not support LB859. In thinking of our arguments for the benefits of this bill, it's difficult to come up with any other than centralized control. Sometimes centralized control is important and valuable, but this is not one of those situations. Putting the right

person in place as director, as well as the appropriate guardrails, allowing them to operate and make collaborative and rapid decisions, is much more efficient than doing what this bill intends. We realize that directed health measures are often unpopular, and certainly mask mandates are an example. Although mask mandates are the impetus behind the introduction of LB859, the public health impact of this, this bill goes beyond this. On behalf of the frontline Lancaster County healthcare providers signing below, we ask that, as a minimum, this bill not be moved out of committee. In fact, we would encourage a reevaluation of the current structure and governance of our public health departments across the state, and would favor allowing other counties the right to more effectively operate independently in a public health emergency. Lincoln-Lancaster County has been a model for organized successful pandemic response and has shown how the public health department, healthcare organizations and providers, school boards, as well as other organizations, can respond to a complex healthcare crisis appropriately and free of political influence. Please let me know if you have any questions. Sorry about the time. Yes, go ahead.

ARCH: Thank you. We typically don't ask questions because this is not your personal testimony.

ABBIE FOUGERON: Perfect.

ARCH: I see there is one question. No?

DAY: We don't have to. Yeah.

ARCH: OK.

ABBIE FOUGERON: I can try.

ARCH: OK. So yeah, and so thank you.

ABBIE FOUGERON: Yes.

ARCH: I would, I would simply mention that if, if there's anybody else out here that, that wants to come up and read a letter into testimony, we would ask that you submit that letter to the clerk, and not, and not-- because we, because it's not your personal testimony, we don't have a chance to ask you questions. So with that, thank you very much.

ABBIE FOUGERON: Absolutely.

ARCH: Next opponent for LB859?

_________________: I do have a letter to submit from the Medical Society. Just submit it and not read it?

ARCH: Is it, is it the Medical Society's position?

_________________: Yes.

ARCH: Did they submit that previously?

_________________: Yes-- no, no, no; they have not.

ARCH: You may submit that to the clerk and they will make copies for all of us.

_________________: Well, I made copies actually.

ARCH: Oh, OK. Fine.

_________________: So you need me to read it to you?

ARCH: No, thank you.

_________________: Thank you.

ARCH: Next opponent for LB859?

PATRICIA LOPEZ: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. I'm Patricia Lopez, P-a-t-r-i-c-i-a L-o-p-e-z. I'm the director of Lincoln-Lancaster County Health Department, and I'm here to speak in opposition to LB859. It is critical that local public health officials have the ability to take actions to reduce the impact of infectious diseases, authority that our department has used judiciously for over 100 years. In 1868, the Nebraska Legislature authorized cities to establish local boards, a help to "secure the city and the inhabitants thereof from the evils of contagious, malignant, and infectious diseases." Examples of this, after our health department was formed in 1873, include: in 1912, the local health director took actions to stop a typhoid fever outbreak by shutting down a well contaminated with sewage; in 1925, the local director stopped a smallpox outbreak at UNL with a mass vaccination clinic. During my career, Lancaster County has faced infectious disease health threats, not just COVID-19, but also anthrax, Ebola, Hepatitis A, H1N1 pandemic influenza, measles,

monkeypox, tuberculosis, tularemia, and West Nile virus, to name a few. You probably did not hear about most of these diseases. It-- because they were able to be taken care of with rapid action due to our ability to respond at the local level. Each disease posed a unique threat, and the local health director took specific local actions. This included temporarily closing a restaurant, halting the spread of hepatitis A, ordering mosquito spraying to stop West Nile virus and holding mass vaccination clinics in 2008, for H1N1 influenza. With COVID-19, we had a small amount of lead time before it arrived in Lincoln. Our health department, with expertise from epidemiology, infectious disease, public health, nursing, and environmental health continuously assessed the spread of the COVID-19 virus. We activated our pandemic response plan. Partners, including local medical providers, education system, and business and industry were brought together, and a multi-agency unified command system was activated to constantly monitor and respond to the emergency. We have established ongoing two-way communication with our partners and community throughout this pandemic. We relied on evidence-based practices advocated by CDC, the American Academy of Pediatrics, and other public health agencies. Our goals were not to just save the hospital system, but also reduce illness and death and lessen the impact on our schools and colleges, healthcare system, businesses, and government operations. As an example, we have, and continue to provide consultation to the Unicameral and state and federal courts on how to safely continue operations during this trying time. Our actions were informed by consultation with local medical providers, businesses, elected officials, the state epidemiologists, and experts at UNMC Global Center for Health Security, and the John [SIC] Hopkins Bloomberg School of Public Health. The rapidly changing local outbreak required our department to make adjustments to our community response, including implementing directed health measures. This is similar to how we have addressed infectious disease outbreaks throughout our history. Local directed health measures had a clear and measurable impact of slowing the spread of the virus, resulting in fewer people becoming ill and fewer people dying. Sadly, in our community, there have been 40 to 424 deaths. They're not just deaths. These are grandparents, parents, siblings from Lancaster County who have died due to COVID-19. If we have the same day, death rate as Nebraska, 230 more people would have died. John [SIC] Hopkins University analyzed over 700 counties with similar demographics to ours, and found that Lancaster County was in the lowest 10 percent for death rate in the nation. Such data is strong evidence for the positive impact of local directed health measures. There will always be new and emerging

infectious disease threats. Having the ability to address them locally and rapidly, implement protective measures based on local conditions, is critical to protecting the public's health for Lincoln and Lancaster County. I urge you not to advance LB859. Thank you.

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

M. CAVANAUGH: Thank you. Thank you for being here. So you-- a lot of what you testified to, in addition to the health measures, is the ability to investigate in, infectious diseases. And I think that's something that maybe has been overlooked that is in this bill. And so I just wanted to highlight that since you brought it up. On page 8, lines 8-10 is where investigate the existence of any contagious or infectious disease and adopt measures to address [SIC] the progress of the disease are subject to approval of the Department of Health. So that would limit when all these other diseases have come up,--

PATRICIA LOPEZ: Correct.

M. CAVANAUGH: --doing contact tracing--

PATRICIA LOPEZ: Correct.

M. CAVANAUGH: --and rapid response--

PATRICIA LOPEZ: Correct.

M. CAVANAUGH: to like a, just a food--

PATRICIA LOPEZ: Correct.

M. CAVANAUGH: --contamination?

PATRICIA LOPEZ: Correct.

M. CAVANAUGH: OK.

PATRICIA LOPEZ: That's our understanding.

M. CAVANAUGH: That's my understanding, as well. I just wanted to make sure that that, that was what you were testifying about. And then at the bottom on page, of page 8, lines 25 through the remainder onto the next page, is that creating new authority for the Board of Health?

PATRICIA LOPEZ: We currently, I think it-- in Lancaster County, our Board of Health, due to the legislative change that was brought by our

current mayor-- the mayor at the time, Mike Johanns, who became our Governor, that was done at his request, just to give a little bit of history there. And what was in close, included in that legislation was some change about some of the management and selection of the health director. But then it rolled over all the other responsibilities the health department already currently had. So this would be-- and it moved our Board of Health to an advisory board, which is different than some of the other areas of the state. And so this would be-- before we enact things, we do take them to our board of health, and they review them. And most of our statutory changes go to the City Council and the county board.

M. CAVANAUGH: But you wouldn't wait to have a meeting with the board of health to start contact tracing.

PATRICIA LOPEZ: Well, if we did have a meeting with the board of health, and we had to give 10-days' notice for the meeting to occur, I think we can all understand what that would mean.

M. CAVANAUGH: OK, thank you.

ARCH: Thank you. Well, there are the questions that are Williams.

WILLIAMS: Thank you, Chairman Arch. And first of all, Miss Lopez, thank you for all your work during the last several years. It has not gone unnoticed. I asked one of the proponents early on if he had seen any difference in outcomes between Lancaster, Lincoln-Lancaster versus the rest of the state. Your testimony would seem to point out that there has been a fairly significant difference. Would you like to expound on that?

PATRICIA LOPEZ: Well, I think that the data that we use and the other data that was mentioned in the first testifier's information comes directly from CDC. So that is information that's been provided to them. And we calculate that. Then we do have trained epidemiologists on staff. We review this data. We work with them. And as I mentioned, that's what the data is telling us, and we've been very transparent about that. We've shared that in our briefings previously and we feel confident that that's the correct information.

WILLIAMS: So you're confident that the directed health measures that you issued have saved lives in Lincoln, Nebraska?

PATRICIA LOPEZ: Yes.

WILLIAMS: I asked some questions earlier about the difference between medical advice and political advice. One of the proponents-- I've used the term that you were controlled by the mayor. Can you tell me the relationship that the mayor of Lincoln has had in this process, and, and how that has worked with the decisions that have been made and the decisions to implement corrective health measures?

PATRICIA LOPEZ: Sure. I'd be happy to clarify that and share that. The mayor has been a remarkable supporter of our health department and our health team, as well as our city council and our county board members, our board of health. And you heard many others. The mayor is informed about what's happening. She's provided information just as we provide information to our city council and county board. The mayor makes no decisions about a directed health measure; that's solely from the health team. We also work with our legal team at the city in reviewing all the measures that we take. So the mayor does not provide any input or sway into what the decision is for the directed health measure.

WILLIAMS: Has the mayor ever directed you to do anything in your role as the head of this?

PATRICIA LOPEZ: Absolutely not.

WILLIAMS: OK, so saying that you are controlled by the mayor, you would take strong opposition to that?

PATRICIA LOPEZ: I would. It would be, you know, if I were able to say that, it would take a lot of weight--

WILLIAMS: Well, you can here if you want to.

PATRICIA LOPEZ: It would take a lot of weight off, and all the sleepless nights and the constant worry about all the ramifications of actions that you're taking. You know, our goal always, during the entire time, was to keep our students and school, which we did, and was to keep our businesses moving forward when the appropriate time was. Our business, we raised a lot of money in the community. Grants were given. Our businesses have received some economic dividend back to assist them-- constantly look at ways to change that and support them. There were a lot of moving parts in this whole pandemic, much more than you probably have time to hear. But the millions of supplies that PPE sent out, to dealing with people who couldn't speak the language and having them get access to care, taking-- getting somebody to go out and do tests at home for people, assisting people with

developmental disabilities to access what they needed, creating [INAUDIBLE] quarantine packets, organizing clinics that, so that we can serve those who are most in need for vaccine. So this pandemic isn't just one thing about the directed health measure, but the directed health measure was always, only, solely to prevent illness and death.

WILLIAMS: Thank you.

ARCH: Other questions? I, I have a, I have a question. You used examples of your 40-year career, yeah, about, about some of the other infectious diseases.

PATRICIA LOPEZ: I don't want to tell, tell you how long my career has been.

ARCH: I won't ask? I won't ask.

PATRICIA LOPEZ: Yes, which one?

ARCH: So, so were those, were those local?

PATRICIA LOPEZ: Yeah.

ARCH: Those were local issues specific to your county, not, I mean-- I don't recall,--

PATRICIA LOPEZ: Well,--

ARCH: I don't recall monkeypox spreading across the, the state, but--

PATRICIA LOPEZ: You know, I can't say about other counties impacted. But multiple times, those things that we're talking about, they are in other counties.

ARCH: OK.

PATRICIA LOPEZ: And, and so that's why it's really important. They may be in our community, they may be one of our sister health departments community-- in another community, but they're not in all the other counties in the state. So we have to be able to respond to what's occurring locally.

ARCH: And were, were DHMs issued for those, for those infectious--?

PATRICIA LOPEZ: Some of those were, yes. Um-hum.

ARCH: So DHMs can, can be very local?

PATRICIA LOPEZ: Yes.

ARCH: It can be very specific.

PATRICIA LOPEZ: Um-hum.

ARCH: Do you ever recall when a DHM was issued on a local basis that it conflicted with a, a statewide DHM? I mean, we, we're kind of living COVID right now, and everything's COVID, but we've had-- you have other examples here. Has there ever been a conflict between a local DHM and a statewide directive?

PATRICIA LOPEZ: Not to my knowledge,

ARCH: Until we, until we've come to COVID.

PATRICIA LOPEZ: Right. And I think that, when we look at this, and I think Dr. Anthone even shared that across regions, when I hear people, there were different DHMs for different locations in our state. And so I think that's an important thing to remember, based on--

ARCH: As, as, as approved by the state.

PATRICIA LOPEZ: Right,--

ARCH: Right.

PATRICIA LOPEZ: --based on the local conditions that were occurring there. And our DHMs always aligned clearly with the state DHM. There may have been, at times, added measures, but we always aligned with the state DHMS as closely as possible.

ARCH: OK. Thank you. Other questions? Seeing none, thank you for your testimony.

PATRICIA LOPEZ: Thank you. Thank you for all you do.

ARCH: Next opponent for LB859? Good afternoon.

RICK VEST: Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Rick Vest, spelled R-i-c-k V-e-s-t. I am appearing before the committee in my capacity as a member of the Lancaster County Board of Commissioners. I'm here to testify, on behalf of the board, in opposition to LB859. The Lancaster

County Board believes in local control of public health. We believe in local control not merely out of some ideological stance, but because the practical results show that it works in Lancaster County. Previous testimony has established that Lancaster County outperformed peer counties, and the state as a whole, when it comes to mortality rates during this pandemic. Simply put, when faced with the monumental task of responding to this public health emergency, the Lincoln-Lancaster County Health Department admirably executed its mission and saved lives. LB859 mistakenly treats the Lincoln-Lancaster County Health Department as an exception that needs to be corrected, whereas the results show that our health department is a model to be emulated. Public health is not a one-size-fits-all. By attempting to regulate public health at the state level, LB859 ignores the fact that local public health departments are best positioned to determine the facts, on the ground, in their communities. These are the same local public health departments that do the work of public health at the local level, day in and day out, not just when a pandemic erupts. Nebraska is a diverse state, and no county necessarily shares the public health realities of its neighbors. Whereas one county may find that a directed health measure is unnecessary at any given time, another differently situated county may find that an immediately implemented, implemented directed health measure will save countless lives. By undermining the ability of local public health departments to choose the health measures that fit each county's needs, LB859 ultimately denies communities, like Lancaster County, the power to ensure that their local public health departments have the local control necessary to do what's best for their communities' well-being. We all should be proud of what the Lincoln-Lancaster County Health Department accomplished for our community during this pandemic. As an integral member of the Lancaster County, the Lancaster County community, this Legislature relied on guidance from its local health department to ensure that the work of the people could be accomplished during the challenges of the pandemic. So too, our counties, cities, villages, schools, universities, and businesses all turned to our local public health officials for guidance in a dynamic and emergent situation. This work was not easy. It was not without challenges, and oftentimes it probably seemed to be an insurmountable task. Nevertheless, as it has since it was originally formed in 1947, the Lincoln-Lancaster County Health Department stepped up to serve the public in its time of need, and we ask that this committee, to ensure that our health department will retain its ability to function as a leader in the field of public health for generations to come. Thank you for this opportunity to testify. I would be happy to answer any questions.

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

B. HANSEN: Thank you, Chairman. Sorry, I'm just getting into it. I just got-- I was in a bunch of other hearings, and so I hope I'm not repeating any questions. So what's your biggest concern if this does, if you do have to report to DHHS first for approval for certain things?

RICK VEST: Well, there have been a number of issues covered throughout the hearing, but a few, some of the highlights would be: one, that delayed that it would cause with the ten-day hearing, that there are times when that could be a very heavy, heavy lift on the local community; number two, I think the biggest one is, Lancaster County has its own dynamics, Senator, as Pat Lopez testified. We, we have an enormous amount of languages, different groups immigrate into this city and are a part of our community. We feel that the local control, the ability to make those decisions locally, with the understanding of the unique nature of our community, is in everyone's best interest.

B. HANSEN: OK. Thanks.

RICK VEST: Very good.

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

RICK VEST: Thank you, Senator Arch. On, on behalf of my-- I'm meeting my mother tomorrow, and she will ask me if I thanked you all for your service to the great people of the state of Nebraska [LAUGHTER].

ARCH: Oh, she's a good mother.

RICK VEST: She did the best she could.

ARCH: Thank you for your testimony. Next opponent for LB859?

DEXTER SCHRODT: Chairman Arch, members of the committee, I'm glad to be here with you on-- I think it's your last hearing day. No? Tomorrow? That's okay, I'm sorry-- the last one that we are following. My name is Dexter Schrodt, D-e-x-t-e-r S-c-h-r-o-d-t, vice president of advocacy for the Nebraska Medical Association, testifying in opposition to this bill. I'm going to be very brief because I think Director Lopez did a great job, as did Ms. Fougeron, as she wrote a brilliant letter from our local physicians here in Lincoln. I just want to give you the perspective of the NMA, as a statewide organization. Obviously, being the physician organization and COVID

starting, we were heavily in the weeds in countless things. We repeatedly had citizens, other physicians, other health providers, the media, sometimes elected officials asking the NMA to take a position in asking-- in-- to ask the Governor for a statewide mask mandate. And repeatedly, our board had the opinion that it was a local matter because what's going on in Omaha and Lincoln is not relevant to what's going on in the Panhandle, and, therefore, a statewide DHM mask mandate would be inappropriate. And I think that essentially sums up our opposition to this bill, because it would remove that differentiation. And we do agree with the letter that Miss Fougeron read, that it would perhaps be better if, if each public health department had their own authority to react to items in their community. So that's just a little behind the scenes. I think we had three or four board meetings. Each spike, each wave, you know, we'd get a flood of calls, emails, so we'd gather our board, and it was always the same answer. So with that, I will wrap up.

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

MURMAN: Thank you, Chair Arch, and thank you for your testimony. I've seen so many studies that show that masks are-- or most of the masks that are worn anyway, have, you know-- don't protect from the smaller particles from the virus. And then I've seen studies, both ways, that masks do stop the spread to some degree, and then, probably, more that show that they don't. Just-- how can you explain the difference between the particle size and, and what most of the commonly worn masks do and, also, the difference in the studies?

DEXTER SCHRODT: Well, Senator, I don't think I'm going to be able to answer that one. As you know, I literally have no science background, but what I can do is, I can get you some data and have one of our physicians reach out to your office and talk that through with you if you'd like.

MURMAN: That'd be great; thanks.

DEXTER SCHRODT: Thank you.

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

DEXTER SCHRODT: Thank you.

ARCH: Next opponent for LB859?

CHRISTY ABRAHAM: Good afternoon, Senator Arch and members of the Health Committee. My name is Christy Abraham, C-h-r-i-s-t-y A-b-r-a-h-a-m. I'm here representing the League of Nebraska Municipalities. I thought Mr. Vest, from the Lancaster County Commissioners, did a great job of explaining, sort of, our concerns, as well. The League, as you know, we really feel that decisions are best made locally by the people who are closest to their community and know what's best for their community. And because this bill does take away that control and requires that a state agency have some approval over those local decisions, we, unfortunately and respectfully, have to oppose this bill. So I'm happy to answer any questions.

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

CHRISTY ABRAHAM: Thank you so much.

ARCH: Next opponent for LB859?

RICHARD HALVORSEN: Good afternoone. My name is Richard Halvorsen, R-i-c-h-a-r-d H-a-l-v-o-r-s-e-n. Now as I was sitting here, I was struck, between the exchange from Doctor-- or Senator Cavanaugh and the doctor. And she said, well, in Lincoln-- there are Omaha hospitals, right-- and-- but 97 percent capacity. And he said, well, yeah, but during the summer, they're the same thing almost. And, and I thought, well, yeah, during the summer, they were not putting off elective surgeries. You know, there were people who could get right in. It reminded me of a story of a guy was hiring for an accountant. He asks the first accountant, what's two plus two? The guy says, four. He asked the second accountant, what's two plus two? The guy says, float two square. He asks the third account, what's two plus two? And the guy says, what do you want to be? So you can look at facts from different angles, so to speak. You know, you can-- depends on which facts you put forth to support your cause. Well, I'm in the office, partly because one might say-- they talked about confusion about masks. Well, so what? Nobody I know has got tickets. So a guy goes to another county and he's not wearing a mask. What's the worst that's going to happen? You know, police officer might say, please put on your mask or a store will say, put on your mask. I went to other counties. If they wanted the mask, they would post it on the store: please wear a mask. So the confusion doesn't have-- should have no matter in the say. And I'll admit, during this past few years, there have been some pretty-- where-- I don't know where the rules-- you know, bars got to close at 10:00, et cetera, like that. You know, you got to wipe down the surfaces. But we were learning, or the health

professors were learning. This was a new variant, and they learned, as things went on, that, yeah, you know, you don't have-- you know, it's not really transmissible [INAUDIBLE] such. So I'm sure the Health Department did not put these measures in effect maliciously. They just thought-- they used, at the time, what knowledge they had at the time, and decided to err on the side of caution. But the main issue I have against this bill would be the ten-day waiting period for a hearing. And like I said, I'm going to-- this-- the political is going to play into this. But if you wait ten days, again, this-- we're talking-- this bill is a response to history-- COVID, basically. And we have no idea what's coming down the road. Like Senator-- or Ms. Lopez pointed out all sorts of diseases in the past, which we didn't know existed because of measures-- well, we knew they existed, but we didn't know we had a problem 'cause they had the ability to put measures in effect [INAUDIBLE]. There might be a disease coming along that's more deadly and more transmissible. And you may not have-- and the ten-day hearing period, you may not have time for a ten-day hearing period to curb the spread of disease. So again, that may be my main opposition to this bill. Thank you for your time.

ARCH: Thank you. Are there any questions? Seeing none, thank you. Next opponent for LB859? Seeing none, is there anyone like to testify at a neutral capacity? Seeing none, Senator Clements,--

JACK RIGGINS: Well, I've been motivated to change to neutral. Is it OK if I give my [INAUDIBLE]--

ARCH: I'm sorry.

JACK RIGGINS: -- on neutral?

WILLIAMS: He already testified.

ARCH: No, you--

JACK RIGGINS: You can't do that?

ARCH: Yeah, you've already tes, you've already testified.

JACK RIGGINS: I can't testify if I change to neutral--

ARCH: No, not--

JACK RIGGINS: --'cause I've been motivated?

ARCH: You-- did you, did you previously testify?

JACK RIGGINS: I testified as a proponent.

ARCH: You've taken a position, so--

JACK RIGGINS: Thank you.

ARCH: Yes, thank you. Senator, Senator Clements, you're welcome to close. As you're coming up, I would, I would mention that there are-- we received 77 letters as proponents, 21 in opposition, and 0 letters in neutral.

CLEMENTS: Thank you, Mr. Chairman. I have a couple of comments to make regarding Senator Cavanaugh's question. On page 6, line 21, my interpretation is, the items above the Roman numerals I, II, and III don't have the subject-to-approval language. Only item IV, which is the communicable, communicable disease part, is subject to approval by the department. Then on page 8, line 8, we were talking about the investigation of contagious disease. I did-- should've given you a copy of another section, 7-- Section 71-1630(1), item (10) on the second page. This is what all the other health departments have to follow. I didn't copy it because it's not, not, not being changed. But it's-- one of the items in there is, investigate the existence of contagious or infectious disease "with the approval of the Department of Health and Human Services." So it's not singling out Lincoln-Lancaster from what the others are. Then Senator Williams was talking about the ten-day notice. And the ten-day notice is also in 71-1630(1), with the other boards of health, down at the bottom, item (7), "to enact rules and regulations, subject to public hearing held after due public notice at least ten days prior to such hearing," so we did not add these, those clauses in to single out Lincoln-Lancaster. They were just mimicking what the other health departments are required to follow now. Any, any questions? I'd be glad to respond.

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

M. CAVANAUGH: Thank you. Thank you, Senator Clements. OK, so when you say that this isn't singling out Lincoln-Lancaster, and the other health departments have to follow this, I, I'm a little confused because this sounds like it's applied to health departments across the state or public health officials across the state. So isn't this-- this is just new to Lancaster? Like it doesn't-- anywhere in here does

it say that it's including Lancaster and existing. It looks like it's adding to everyone's. Maybe I'm--

CLEMENTS: No.

M. CAVANAUGH: --really confused. It's late in the day, but--

CLEMENTS: The-- yeah, the bill, yeah, is only dealing with the, the one special section that was put in to carve out Lincoln-Lancaster, or Douglas County could do it, if they wanted, with their city, but, you know, counties over 200,000, and their--

M. CAVANAUGH: Can you tell-- show me where that is, that it's--?

CLEMENTS: In 71-1630(1),--

M. CAVANAUGH: OK, so--

CLEMENTS: --there is an item, number (7).

M. CAVANAUGH: 71--

CLEMENTS: Dash--

M. CAVANAUGH: 16--

CLEMENTS: 1630(1), local boards of health.

M. CAVANAUGH: 1630(1), OK. So this bill-- I'm sorry, 'cause I didn't see that in the actual language, but it's in the statute.

CLEMENTS: Yes.

M. CAVANAUGH: OK.

CLEMENTS: It's in the other, the red, the statute that applies to everyone else. And the only thing we put revisions or-- revisions in, was to add the language in the section regarding specifically Lincoln-Lancaster, putting in the phrase "subject to approval by the Department of Health."

M. CAVANAUGH: So this would also apply to Douglas County and, and Omaha.

CLEMENTS: No, they don't have a city-county. They have not adopted a city-county health department.

M. CAVANAUGH: OK.

CLEMENTS: This is-- yeah, they've made it very--

M. CAVANAUGH: So does this--

CLEMENTS: --specific-- city-county health department with 200,000 or more in the county.

M. CAVANAUGH: So when there's some sort of like E. coli outbreak in Omaha, they have to get the approval of the state-- of the Department of Health and Human Services to start contact tracing?

CLEMENTS: It appears that that's true, and I think it's good that we've pointed out this ten-day rule could be something that should be addressed. But it's the language that we're trying to match for Lincoln-Lancaster is what's in the other statute.

M. CAVANAUGH: Thank you. That helps clear things up for me.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Thank you. On page eight, line 25, did you dress the "may" part, the Board of Health "may" then enact these rules, so if they decide not to, they don't have to? So if there is something that is an imminent danger that needs to be addressed quickly, can they skip the ten-day?

CLEMENTS: We put "shall" in there and Bill Drafters changed it to "may."

B. HANSEN: Oh, I must have-- sorry.

CLEMENTS: And I pondered whether to change it back to "shall" but, with their higher knowledge of the law, we-- I've got it circled in red here.

B. HANSEN: OK.

CLEMENTS: That's what the words say, and I'm not sure that that allows for more leeway or not.

B. HANSEN: Well, I think that would take care of the ten-day notice then, so if there's something that is-- has to be addressed quickly, like an E. coli outbreak or something else, then they can say, OK, we don't have time for the ten-day hearing because it's something of

imminent danger as opposed to, let's discuss whether we should do mandated masks or mandated vaccines. We should have a hearing and hear from the public, which I think is what the public kind of-- essentially wants, then they can choose to do that [INAUDIBLE].

CLEMENTS: Could be that's why Bill Drafting changed that, but I, I wasn't sure.

B. HANSEN: I'm not going to say anything bad about Bill Drafting ever, because then my bills will turn out horrible after that, so-- they do a great job, and I give them donuts every year, except this year I forgot.

ARCH: Any other questions for Senator Clements? Seeing none, thank you.

CLEMENTS: Thank you, Mr. Chairman.

ARCH: This will close the hearing for LB859, and before we open the hearing for LB963, we're going to take a ten-minute break, so we'll start at 5:04.

[BREAK]

ARCH: And we are prepared to open on LB693 [SIC-- LB963]. Senator Murman, you're welcome to proceed.

MURMAN: Good afternoon, Chair Arch and fellow members of the Health and Human Services Committee. For the record, my name is Dave Murman, D-a-v-e M-u-r-m-a-n, and I represent the 38th District, which includes the counties of Clay, Nuckolls, Webster, Franklin, Harlan, Furnas, Red Willow, and part of Phelps County. I've got a long opening, but before I open, I'd like to say thank you to all the healthcare workers. That's the reason I wore a white shirt today-- no, not really. But I did wear, I did wear a white ribbon today to celebrate Healthcare Workers Appreciation Week, and I appreciate everything healthcare workers have done, especially in the last couple of years. I'm here today to introduce LB963, which adopts the Medical Ethics and Diversity Act, MED Act, to protect the right of conscience for medical practitioners, healthcare institutions, and healthcare payers by providing that no medical practitioner, healthcare institution or healthcare payer should be compelled to participate in or pay for any medical procedure, or prescribe or pay for any medication with which such person or entity objects to on the basis of conscience. I have several handouts that I'd like to provide. I first became aware of

this issue through my son-in-law, Grant Hewitt, who is southeast regional director of Christian Medical and Dental Association, an organization which, among other things, addresses healthcare policy and issues such as right of conscience. I learned that, during a time where there is an ever increasing need for healthcare professionals, many young people are concerned about entering a field where they may have to participate in a procedure or therapy that would violate their moral beliefs. One of my handouts shows that 20 percent of those surveyed decided not to pursue a particular medical specialty because of hostility toward their beliefs in that area of practice. The purpose of the MED Act is to protect medical practitioners, healthcare institutions, and healthcare payers from discrimination, punishment or retaliation because of an instance of conscientious medical objection. The term "conscience" is defined in Section 3 of the MED Act as the ethical, moral or religious beliefs or principles held by any medical practitioner, healthcare provider, healthcare institution or healthcare payer. If we're talking about an entity rather than an individual, conscience is determined by the entities governing documents, for example: mission statements, constitutions, articles of incorporation or bylaws. The term "medical practitioner" is also defined, in Section 3, to include anyone who may be or is asked to participate in any way in any healthcare service. This would include: doctors, physicians' assistants, nurses, nursing home employees, pharmacists, medical, medical school faculty and students, medical researchers, psychologists, and mental health professionals, among others. Section 4 of LB963 provides that a medical practitioner, healthcare institution or healthcare payer has the right not to participate in or pay for any healthcare service which violates such person's or entity's conscience. This section goes on to say, however, that the exercise of this right of conscience is limited to conscience-based objections to a particular healthcare service. It does not waive or modify any duty that any individual or entity may have to provide other medical services that do not violate such person's or entity's conscience. This is procedure-specific and not patient-specific. Other provisions in LB963 state that, by exercising this right of conscience, an individual or entity shall not be civilly, criminally or administratively liable, shall not be discriminated against, and shall not have the right to make employment, staffing, contracting, and admitting privilege decisions consistent with its religious beliefs. No person may be scheduled for, assigned to perform, facilitate or participate in an abortion unless they affirmatively consent, in writing, to do so. Nothing in the MED Act, however, would override the requirement to provide emergency

medical treatment pursuant to federal law. A civil action may be brought by a medical practitioner, healthcare institution or healthcare payer for any violation of the MED Act. Please note that four other states have passed similar laws: Illinois, way back in 1977; Mississippi in 2005; and Ohio and Arkansas last year, in 2021. There have been no legal challenges to any of these laws because states have the right to protect the conscience rights of their residents. The parade of horribles envisioned by those opposing this bill has not occurred in the states that have passed this law. Rather, the Illinois law has been successfully used a few time-- has been successfully used a few times, including a recent case where a nurse who was punished by her employer for not wanting to participate in abortions. Contrary to what those opposing this bill say, this is not a green light to discriminate. Federal law prohibits providers who participate in Medicaid, Medicare or other federal programs from discrimination on the basis of race, color or national origin. This bill would not supersede those protections or provide any other reason to dismiss a patient from his or her practice. It simply protects providers from being forced to perform a specific medical procedure, if it would violate their conscience. If a pro, provider offers a certain procedure to others, they couldn't simply refuse a specific procedure to an individual. That would be discrimination. Furthermore, this bill doesn't override the requirement, in federal law, to provide emergency medical treatment to all patients. The Emergency Medical Treatment and Active Labor Act mandates treatment or appropriate transfers of emergency situations. Rather than emergency situations, the current conscience issues involve objections to lifestyle and elective procedures and treatments. For example, assisted suicide, gene editing or abortion procedures. I have proposed Amendment 2060 that I'd like to offer. Oh, they've got that, OK. This amendment clarifies the procedure a medical practitioner shall follow when they have a conscience-based objection. They must notify their supervisor if applicable and, if the patient requests, assist in the patient's transfer of care by promptly releasing the medical records to the patient. HIPAA gives practitioners 30 days to transfer or release medical records. The prompt release of records would be a substantial benefit to patients. Provided the patient consents, the medical practitioner remains responsible for continuing to provide all other medically necessary healthcare services other than the service which they have conscience-based objection. As I previously mentioned, the object of this bill is to protect the diversity of belief within the medical field. A person can live out their faith in what they do and not be compelled to go against their beliefs. I believe that this will

bolster the supply of much needed professionals within Nebraska's healthcare system. You don't want to push people with a conscience out of medical, nursing or pharmacy schools. Additionally, I believe that this will benefit patients, as they will be working with healthcare professionals that fully believe in what they're doing. Chairman Arch and committee members, thank you for your consideration. I'd be happy to take any questions, but there are people behind me that can probably answer better than I can.

ARCH: That's a nice disclaimer there. Any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Murman. I do actually have several questions that are specifically for you, as the introducer, so bear with me. First, in your amendment, the-- lines 2 through 4. So this sounds like when we had the emergency contraception conversation about requiring that a person basically excuse themselves. So this would allow-- this would actually enact that, that if somebody did not agree with providing emergency contraception in the emergency room at a hospital to a victim of assault, that they are required, then, to excuse themselves from caring for that patient. Correct?

MURMAN: If the medical proviser-- provider doesn't normally provide that service, they wouldn't be mandated to do so, but in a emergency situation, of course, they would comply with federal law.

M. CAVANAUGH: So but-- so in the emergency room, if the nurse practitioner doesn't agree with the emergency contraception, they-- he or she would go to their supervisor and say, I don't agree with this, and that's the standard of care for this situation is to offer it, so I have to recuse myself, and then a different medical provider would then take over.

MURMAN: Yes, a different medical provider could take over.

M. CAVANAUGH: OK. Well, that's a part I, I appreciate. I also would like a clarification of, what are objections to lifestyle?

MURMAN: That is something that this does not cover. It would only be-- it, it only covers procedures so if there's a procedure, it would be covered by this; if not, it wouldn't be.

M. CAVANAUGH: OK. So it covers medical procedure, prescription, therapies, and treatments. So if you have a patient that comes in for

hormone therapy, you could deny them that because it conflicts with your beliefs.

MURMAN: No. If you normally provide hormone therapy,--

M. CAVANAUGH: Then you could not deny them that.

MURMAN: Correct.

M. CAVANAUGH: Even if it was because-- I mean, I am getting very close to that wonderful age of menopause.

WALZ: [INAUDIBLE].

M. CAVANAUGH: What? I didn't look at you. So hormone therapy is one of the therapies that is used. So if I go to a doctor and they recommend hormone therapy to me, and then somebody who is wishing hormone therapy for a different reason, they couldn't be refused that hormone therapy because that is the service that that doctor provides typically.

MURMAN: Maybe someone behind me could--

M. CAVANAUGH: OK.

MURMAN: --answer that better, but the way I-- I believe it would be if you, if the doc, if the medical provider normally provided that hormone, they would provide it.

M. CAVANAUGH: They would continue to provide it.

MURMAN: Yeah.

M. CAVANAUGH: OK, thank you. That's very helpful. I guess I didn't have that many questions.

ARCH: Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator Murman. And maybe this will be somebody else, but on page 7, starting at line 29, this is under what I would call the, the damages section for a civil action. It says: any party aggrieved by any violation of the act may commence a civil action and shall be entitled, upon finding of a violation, to recover the party's actual damages sustained, but in no case shall recover less than $5,000, along with costs and things like that. I don't understand. That sounds a whole lot more like a penalty

to me than it does-- why should a person ever be able to receive more than their actual cost of damage?

MURMAN: To be honest, I'm not sure why it says less than $5,000 there, but maybe someone behind me can answer that better.

WILLIAMS: OK.

ARCH: Other questions? Seeing none, thank you. First proponent for LB963?

MATT SHARP: Good afternoon, Mr. Chairman and members of the committee. I'm Matt Sharp, M-a-t-t S-h-a-r-p, and I'm senior counsel with Alliance Defending Freedom. I'd like a second opinion. These words are synonymous with our healthcare system, which gives individuals the freedom to consult with multiple doctors and clinics to find one that best meets their healthcare needs. Some doctors may be willing to do a controversial procedure. Others may find it unethical. This diversity is one of the greatest features of our system, gives a person numerous choices for medical services while allowing healthcare professionals to practice consistent with their own values and beliefs. But we're seeing a disturbing trend as nurses and doctors are disciplined and even fired when they express a conscientious objection to a specific medical procedure. Consider the position that one of my firm's clients, Dr. Leslee Cochrane, a physician in California, has provided compassionate hospice care to numerous patients over the years. Unfortunately, the state is now mandating that Dr. Cochrane participate in the process of assisted suicide, including referring patients to someone willing to perform the assisted suicide. LB963, the Medical Ethics and Diversity Act, would ensure that what's happening to Dr. Cochrane doesn't happen to nurses and doctors in Nebraska. It protects them from being fired or disciplined because they decline to participate in, for example, the sterilization of a person with a mental disability or a medical school student who-- from being expelled for declining to experiment on a human embryo, Protecting healthcare professionals and healthcare students from discrimination because of their ethical or religious beliefs means there will be more nurses and doctors on the job at a time of critical need and projected shortages. As I'm sure this committee is aware, the nat-- Nebraska Hospital Association recently predicted a shortage of over 5,000 nurses by 2025. Sadly, the lack of protections for medical conscience are leading some medical personnel to consider leaving the profession altogether. In fact, 91 percent of physicians who are religious would rather leave the profession than be forced to violate

their conscience. Protecting medical conscience also benefits patients, 80 percent of whom want a doctor who shares their beliefs. This is vital for expectant mothers, especially those facing a high-risk pregnancy. Pro-Life OB-GYNs can be difficult to find, and a mother should have access to a doctor that shares her beliefs and will work tirelessly to save both mother and child. The MED Act gives doctors, nurses, and medical students a legal remedy if they're forced to participate in, for example, an assisted suicide or genetic experimentation. And to answer Senator Williams' question about that amount, one of the things the courts often look at is how do you put a price on violating constitutional rights? How do you put a price on violating someone's right to free speech, exercise of religion or conscience? And so part of that is to try and provide some meaningful remedy to those who have their conscience rights violated. The bill ensures that, even as a doctor or health clinic may decline to perform an ethically problematic procedure, they will still serve the patient in all other healthcare she seeks. There is no right in this bill to refuse to serve a person. The bill also aligns with the American Medical Association's Code of Ethics, specifically Section 1.1.7, which says: Preserving opportunities for physicians to act or to refrain from acting 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 the patients and publics rely. Thus, physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities, end quote. The MED Act preserves options, both for physicians and patients, who will continue to have the freedom to seek a particular service from another medical professional, to get a second opinion. The bill preserves a free market for healthcare, respecting the values and preferences of both patients and physicians. Thank you, and I'm happy to answer any questions you have.

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

M. CAVANAUGH: Thank you. Thank you. I'm sorry, I didn't catch the name of your-- I got "Alliance."

MATT SHARP: I'm sorry. Alliance Defending Freedom.

M. CAVANAUGH: Defending Freedom, OK. I'm not familiar with your organization, but you said somebody that's associated with your firm. Are you a law firm?

MATT SHARP: We are. So we are a law firm and we have, for example, represented physicians, nurses, and others that have had their conscience rights violated, including Dr. Cochrane, that I was mentioning in my testimony.

M. CAVANAUGH: All right. OK, thank you. That's helpful. So you mentioned the sterilization of a person with an intellectual disability. Where is that legal in this country?

MATT SHARP: Well, again, it's, it's generally not. I know, in a lot of states--

M. CAVANAUGH: Is it, is it, is there a state that you're aware of that it is legal?

MATT SHARP: Well, I don't, I don't know that states have actually outlawed it. I know what happened is a lot of states have created a legal process that you have to go through for individuals before anyone can be sterilized. And so a lot of times it requires a court appearance for a court-appointed guardian to be appointed to the individual to make sure that their best interest-- because you never want a family member, something, one like that, pressuring an individual to go through all that.

M. CAVANAUGH: Sure, but that just--

MATT SHARP: So what we're concerned about is just making sure again, and we're trying to give examples. That's why we want to broadly protect conscience rights.

M. CAVANAUGH: Well, as far as I'm aware, that's not legal in the state of Nebraska.

MATT SHARP: I, I hope not.

M. CAVANAUGH: So I guess I just-- it's an interesting choice. But then my next question is, you said having an OB-GYN in who is pro-life, that's your value. So I don't, I don't know if you physically have given birth. I have three times, and I've never asked my healthcare providers their stance on reproductive health, and I've always received very high quality of care. And if I were to venture a guess, I would say that, of the group of midwives that I've gone to see, that at least three-fourths of them are pro-life. So I don't, I guess I don't know how-- how does one find a pro-life OB-GYN?

MATT SHARP: Yeah, great question. So I know I've had conversations. I have children myself, but for a lot of women, that that is questions when they are first shopping around for an OB-GYN. They have those conversations, and want to know that they share those values with them about pro-life, just because, again, as complications arise, they want to make sure that the person helping them through that process shares those beliefs. So again, it's just something that gives women the option, something that they can have those conversations with.

M. CAVANAUGH: I have very severe complications in pregnancy, and I still don't know how those women feel about my reproductive rights. But thank you.

ARCH: Other questions? Senator Walz.

WALZ: I just have a question about the disclosure part of the bill. Can you explain? I've been trying to read through it, what, what it means by the disclosure portion of the bill. Like what is that pertaining to, that you're disclosing ahead of time, that, you know, this is something that you don't agree with? Or what's the disclosure for? Do you know?

MATT SHARP: Sure. So part of this is also a whistleblower protection so that if a doctor or nurse or other medical practitioner witnesses something, maybe in their practice in a research firm that they believe is unethical, and they raise concerns about that to the appropriate body, so they disclose this, that they're protected from that retaliation. They're protected from being dismissed, punished in any way by their employer because they blew the whistle on something that they witnessed that was unethical. And so those disclosures get to what they're allowed to disclose as part of that sort of whistleblowing process.

WALZ: OK. That's all.

ARCH: OK. Other questions? Seeing none, thank you for your testimony.

MATT SHARP: Thank you, Mr. Chairman.

ARCH: Next proponent for LB963?

DALE MICHELS: Well, good afternoon again-- different this time. Senator Arch and members of the Health and Human Services Committee, my name is Dr. Dale Michels, D-a-l-e M-i-c-h-e-l-s. I'm a retired family physician and the Nebraska representative of the American

Academy of Medical Ethics, or AAME. I am speaking as an individual and on behalf of the AAME. I'm also a past president of the Nebraska Medical Association, although I'm not testifying on their behalf. I'm here today to testify in favor of LB963. Let me begin again with a question. How many of you have ever said or thought, I can or cannot do this with a clear conscience? Or I can or cannot do something in good conscience? If you have done certain things with a clear conscience, don't you think that healthcare professionals should be able to do the same? Do you want those who help care for you doing what they do with a clear conscience? Or are you OK with making them do something if they don't believe in it or believe it is wrong? If it's OK for you to say that you don't do certain things based on your own conscience, but healthcare professionals cannot use that as a reason to not provide certain services, is that correct? Healthcare professionals may be required to provide services because of a third party payer or the organization that employs it, employs them, makes them provide services even when they think it is wrong. By being required to provide a service which goes against their own deep personal convictions, they are no longer serving you in the best way they can, but serving someone who may not have your best interest as a part of their purpose. After Senator Murman's introduction of LB963, a newspaper article claimed it will allow healthcare professionals to deny care to patients. This is in error. LB963 doesn't restrict care in any way. The bill will allow a healthcare professional to not provide the service based on his or her conscience, but it does not restrict the patient in any way from seeking that care from someone else. This is too often used as a smokescreen to make the conscience issue appear to deny care. This is not the case at all. Let me give you just a quick example. During my 44 years in practice, I chose and had a clear conscience about performing mastectomies or male sterilization. However, some of my colleagues did not feel that was appropriate and wouldn't perform the procedure, based on their own conscience. Did that mean the care was wrong, or those men who wanted the procedure done were not able to have it performed based on the decision of their doctor? Not at all. In addition, an argument against LB63 [SIC-- LB963] is that it does not allow the so-called warm handoff, quote unquote, if the healthcare professional can't provide the service based on their conscience. The problem with this is moral complicity in having someone else provide the service. I would be happy to explain this in further detail, but I don't think I can provide an adequate explanation in the five minutes of time allotted for testimony. I'm aware of AM2060 that Senator Murman has presented and believe it is at least a good start at attempting to deal with the

issue. Several of us who have concerns are ready to help improve the language to meet the concerns of both sides if we need to. I know that there are many who have a different opinion about the issue of conscience, including the Nebraska Medical Association. However, in good conscience, I feel I must strongly support the right of the use of conscience in an appropriate way for my fellow healthcare professionals. To do otherwise would be a violation of my personal conscience in this manner. Therefore, I urge you to pass LB963 with the amendment AM2060 out of the committee. I'd be happy to answer any questions.

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

DALE MICHELS: OK.

ARCH: Next proponent for LB963?

SANDY DANEK: Good afternoon. My name is Sandy Danek, S-a-n-d-y D-a-n-e-k, and I'm the executive director for Nebraska Right to Life, a statewide grassroots organization representing thousands of Nebraska pro-life households. I come before you in support of LB963. It is increasingly evident that there are efforts to force medical providers to either perform actions against their personal conscience or leave the profession completely. Faith-based professionals are being especially targeted, sometimes being driven out of the medical field. The most frequently cited reasons for conflicts of conscience in healthcare settings are abortion and euthanasia. The right to freedom of conscience is an internationally recognized human right, guaranteed in many international treaties, starting with the International Covenant on Civil and Political Rights. Jonathan Imbody, vice president of government relations at the Christian Medical Association, says his organization has dozens of examples on its website of healthcare providers who say they were punished because of their religious or conscious objections, including an anesthesiologist who refused to participate in an abortion and objected to referring a patient seeking one to another doctor when he refused to participate. Everyone, without exception, is called to educate his or her conscience well, and to follow the clear judgments of conscience. Medical workers, however, are in a profession that is especially significant because of the many grave moral dilemmas that routinely occur. Frequently, life-and-death decisions have to be made, and physicians are often called to help make these choices and to carry them out. Healthcare professionals who respect human life should not

be driven from the medical field. Most doctors enter the obstetrics field because they care about saving life, nurturing, and healing. If they find abortion to be in opposition to their medical practice, that is their right, and our laws need to protect their right to practice only life-affirming, life-protecting medicine. LB963 would protect medical practice, practitioners and healthcare professionals from discrimination or punishment as a result of any conscientious medical objection like abortion. We ask you to advance this legislation.

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

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

SANDY DANEK: Um-hum.

M. CAVANAUGH: I, I guess I don't know the answer to this, so I'm asking. Are abortions frequently happening outside of specific settings in the state of Nebraska? It's my understanding that there's only specific settings in which an abortion could be.

SANDY DANEK: Sure. Well, you, you probably could check with the medical professionals, but, but an abortion can be performed in any medical facility. Are you saying-- are--

M. CAVANAUGH: Could.

SANDY DANEK: --standalone facilities like Planned Parenthood?

M. CAVANAUGH: Planned Parenthood doesn't perform abortions. They have to refer you to a different facility in Nebraska.

SANDY DANEK: No, that's not true. We have an abortion facility right here in Lincoln on 48th and Old Cheney Road. They perform abortions there.

M. CAVANAUGH: OK. Well, I guess I'm-- I think my question is more complicated, so I'll, I'll hold it for later.

SANDY DANEK: OK.

M. CAVANAUGH: Thank you.

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

SANDY DANEK: Thank you.

ARCH: Next proponent for LB963?

NATE GRASZ: All right. Good afternoon, Chairman Arch and members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-c-z. I'm testifying in support of LB963 on behalf of the Nebraska Family Alliance. Nebraska Family Alliance represents a statewide network of thousands of parents, families, and faith leaders who support protecting the conscience rights of all Nebraskans, including our doctors, nurses, and medical providers, because no medical professional should be forced to violate their oath to do no harm. LB933 [SIC-- LB963] protects diversity of belief within the medical profession, and ensures that medical providers are never forced to participate in procedures or treatments that conflict with their ethical, moral or religious beliefs. Federal law and professional code of ethics rightfully require medical providers to provide examinations and treatments to anyone with an emergency medical condition. This bill does not change that. It simply protects providers from being required to perform a specific medical procedure if doing so would violate their conscience, such as assisted suicide, genetic manipulation of children in utero, and abortion procedures. It is unsurprising that in a diverse and pluralistic society like ours, that there are differing opinions and beliefs on these issues, including in the medical field. But I think we all can agree that medical providers should not be forced to choose between their ethical, moral or religious values and their life's calling to practice medicine. So we encourage the committee to advance LB963 so that the public policy of the state of Nebraska is to protect the right of conscience for our medical providers. Thank you.

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

NATE GRASZ: Thank you.

ARCH: --your testimony. Next proponent for LB963?

MARION MINER: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here testifying on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. The conference supports LB963. This bill would protect doctors, nurses, pharmacists, and other people in the medical field from unjust discrimination and retaliation if they refuse to act in a

way that would violate their consciences. Moral conscience present at the heart of every person, at the heart of the person, requires him or her at the appropriate moment to do good and avoid evil. Persons have a responsibility to form their conscience, as well, so that they may reliably make such distinctions. They have the corresponding right, as well, not to be forced to act contrary to conscience and violate the sense of their own moral integrity. The rapid development of medical science in our age comes with exhilarating possibilities for the preservation of life, the treatment of disease, and the relief of many kinds of physical suffering-- all great goods. It also brings medical ethical problems, some quite complex and often hotly debated in the political arena. Doctors, nurses, physicians, and medical researchers are people we hope are dedicated to the highest moral and ethical standards because it is to them-- because it is to them that we entrust our lives, health, and the lives and health of those we care about. It is imperative, therefore, that we not drive away from this profession those very people who take their ethical duties seriously and refuse to violate their own consciences and their best judgment about what is in the best interests of patients in the course of their work. Doctors, nurses, pharmacists, and researchers are people, not mere utilities to achieve outcomes. They deserve to have their rights of conscience protected. Their patients and the general public are also greatly benefited where people in these professions can be confident in their ability to serve free from the threat of moral coercion. The conference respectfully urges your support for LB963.

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

MARION MINER: Thank you.

ARCH: Next proponent for LB963? Seeing none, we'll now accept the first opponent for LB963.

SEAN FIGY: Chairman Arch and members of the committee, my name is Dr. Sean Figy, S-e-a-n F-i-g-y. I'm an assistant professor of surgery in the Division of Plastic and Reconstructive Surgery at the University of Nebraska Medical Center. However, I'd like to make it very clear that I'm here speaking on behalf of myself and on behalf of the Nebraska Medical Association, in opposition to LB963. Thank you for the opportunity to speak today. Medical ethics and the role of physicians in society has been a topic of discussion, discussion since the profession first came to be. More than half of medical schools use an oath unique to their own school, however, when doing their, their

medical oath. The majority of oaths taken by the medical students today are not the Hippocratic Oath. However, most contain the four fundamental components of the original oath of Hippocrates, and those are: respecting patient confidentiality; avoiding harm; respecting teachers, interestingly enough; and upholding the integrity of the profession. The American Medical Association, which is the largest, largest organization of physicians in the country, has a well-developed and well-vetted code of medical ethics that is discussed twice a year at our House of Delegates meetings in both June and in November. Interestingly, in some states, including one that I trained in, in Ohio, the Code of Medical Ethics has been codified into law. So the discussions we have at those meetings are [INAUDIBLE] in those states. According to the AMA Code of Medical Ethics, the freedom to act according to conscience is not unlimited. That is very clearly stated. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, respect basic civil liberties, and not discriminate against patients with whom they have a patient-physician relationship. That's all language from the code. The AMA code, specifically, as previously mentioned, ethical opinion 1.1.7 gives specific considerations that physicians should consider when considering abstinence from delivery of care. It should also be noted that, when discussing the physician's right of conscience, this can be impinged upon by other circumstances as well, including when a, when a "patient is not reasonably able to access needed treatment from another qualified physician." And that is a direct quote, when a "patient is not reasonably able to access needed treatment from another qualified physician." The code does give a series of recommendations, however, when a person-- when a physician follows conscience. Several of them have been discussed, however, I'd like to point out several that I think are important to highlight. Things that should be discussed include: taking care that the actions do not discriminate against or unduly burden, unduly burden individuals or populations of patients and do not adversely affect patient and public trust-- that's number 3 of 7 that I specifically called out; be mindful of the burden the actions place on fellow professionals; and should uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects. That is clearly delineated in the AMA Code of Medical Ethics, Opinion 1.1.7, point number 5. In general, it goes on to say that physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held or well considered personal belief leads a physician to also decline to refer, the

physician should offer impartial guidance to patients about how to inform themselves regarding desired services, and they should continue to provide other ongoing care for patients or formally terminate patient-physician relationship, in keeping with ethical guidance. One of the concepts that's been discussed is the right to get a second opinion. Sometimes this is not an option. We see this in areas where we have inadequate access to care. Access has to become part of the discussion. Also, sometimes patients don't know that a second opinion is needed because they don't have the basic information to understand what their options may be. One of our primary roles as a physician, outside of that of being a healer, is being an educator. We must educate our patients about what the options are so that they can make a decision for themselves. Refusal to give adequate education does remove patients' rights by removing their ability to make a self-determination, by removing their options based on not, based on not knowing. On a separate but related note, the patient-physician, patient-physician relationship is based on trust and honesty. The physician patient-relationship that is based on trust and honesty is paramount to good outcomes. In order to best take care of patients, they must trust that they will be met with caring and nonjudgmental attitude. If the thought that a patient might not be cared for because they have a religion, sexual orientation, gender identity or ideology that might cause a physician to no longer care for them, they'll be less likely to be forthcoming with information that could be an important in their care. They'll be less likely to be forthcoming with medical, with information in their medical interview, and they may not give us the information that we need to best take care of them.

ARCH: Oh, your red light has come on.

SEAN FIGY: Oh, I apologize.

ARCH: Ask you to, if you have a closing statement, you can make that.

SEAN FIGY: LB963 is a bill that does more harm than good, and there are lots of unintended consequences with how it's written. Without proper safeguards-- and I appreciate the amendment that was brought. However, I just don't think it goes far enough. With those things discussed, I do respectfully request that this bill not be advanced.

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

B. HANSEN: Thank you. It sounds like when you're reading off the Code of Ethics-- maybe I'm wrong-- it sounds a lot like what Senator Murman is trying to propose.

SEAN FIGY: I think there's-- I don't think that-- I haven't seen the language because I just found out about it today, to be quite frank with you. But I think that there are some components of it that don't necessarily go far enough, in terms of what needs to be done in order to protect patient safeguards. So without having looked at it and just having heard of it, I don't think it does quite enough. And I think some of the unintended consequences haven't thoroughly been thought through. So I think that this bill, at its current juncture, given our time constraints and where we are, doesn't really meet muster to be passed forward.

B. HANSEN: OK, thanks.

SEAN FIGY: Of course.

ARCH: Other questions? I have one.

SEAN FIGY: Of course, Senator.

ARCH: Code of ethics.

SEAN FIGY: Yes.

ARCH: So that's to the individual physician, correct?

SEAN FIGY: Yes, Senator.

ARCH: So is the individual physician, or in the case of other code of ethics of other professions, is that physician the one who needs to make the decision concerning the guidelines? In other words, where does the, where does the authority and responsibility lie to determine whether or not the physician is following that code of ethics?

SEAN FIGY: That's, that's a great question, Senator. So the Council on Ethical and Judicial Affairs is an organize, is a council within the American Medical Association, which does actually take referrals for ethical discussions. So if there's a concept that may, that a person may have violated those codes, they can be referred to the Board of Medical Ethics. However, there are some states like Ohio, where it is-- the, the code is law in that state. So in terms of how is the

code used, it varies based on the state. It is also used-- it's based on the state and also based on the reporting of that, as well.

ARCH: OK, thank you. You know, the question came to my mind, is it-- is it the individual professional's responsibility or is it, in some cases, is it the employer? The employer looks at the physician or the professional and says, I do not believe that you are following the Code of Ethics.

SEAN FIGY: Um-hum.

ARCH: The physician says, I believe I am following the Code of Ethics, right?

SEAN FIGY: Yeah.

ARCH: And so, so there, there is the rub. And so at that point, then, who determines? And I know the Code of Ethics isn't the, the--

SEAN FIGY: Yeah.

ARCH: --the determination of all of these issues. But, but I mean, I think, I think what I wrestle with is, is, is it the, is it the employer's right to make that call or is it the individual? Is it the individual professional's right to make that call? And in a lot of cases, I'm sure they work it out. You know, it's not, it's not an automatic--

SEAN FIGY: Yeah.

ARCH: --conflict, but--

SEAN FIGY: So I think that that is an area of employment law that they-- I might have skipped that class in med school, so I apologize. I'm not a lawyer. Dexter and I had opposite classes when we were in training, so I don't quite know that. What I can tell you is on personal experience. I do work in a field that oftentimes does have a lot of morally-- a lot of discussions on moral and ethical components of that. So I'm very well versed in these discussions. I'm very well versed in the discussions between our staff, other physicians at the Med Center. In my own personal practice, we have never once forced a person to do anything. We've been very conscientious about people's deeply held moral and religious beliefs in, in our discussions regarding what we do. So I think the decision comes down to the person because, at the end of the day, the person is-- it's an individual

decision to do certain things. But those safeguards do exist. And I, I hear people saying that these things happen, but I personally haven't really seen anybody forced to hold a scalpel or write a prescription--

ARCH: Against their conscience.

SEAN FIGY: --against their conscience. I haven't seen that. So I think that--

ARCH: Well, good.

SEAN FIGY: I haven't been-- exactly, I love that.

ARCH: Yeah.

SEAN FIGY: So--

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

SEAN FIGY: Thank you very much. Have a great day.

ARCH: Next opponent for LB963?

JULIA KEOWN: Good evening, members of the committee. I guess it is kind of evening now, isn't it? My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am here on behalf of the Nebraska Nurses Association. I'm representing them in my testimony today. I'm a registered nurse. I do critical care and, also, I do sexual assault forensic nurse examinations. So we, as the Nebraska Nurses Association, are opposed to LB963. Supporters of LB963 claim that it will protect a lengthy list of healthcare workers and institutions who object to procedures or prescriptions on, quote, moral, ethical or religious grounds, unquote, from discrimination, retaliation or punishment. The Nebraska Nurses Association seeks to support the delivery of safe, cost-effective care for Nebraskans, and we recognize the need to provide healthcare services without discrimination. If passed, LB963 would remove fundamental protections against discrimination, on a broad basis, for our patients. LB963 will allow healthcare providers to selectively exclude populations from their care and further marginalize disadvantaged groups. Healthcare providers are already able to decline to provide services based on their competencies and training, which I would actually back up what the physician said. I have seen, you know, a few situations where other healthcare workers have said that a certain procedure or taking certain patients would be

against their conscience for whatever reason. And they were, you know, it was very much allowed and encouraged for them to do that, which is another reason why this bill is not needed. So no patient should ever be obstructed from receiving legal healthcare, based solely on a provider's personal biases. Conscience bills such as this one lead to dysfunctional healthcare delivery and compromise the quality of care by creating barriers to meet our patients' needs. Conscience legis, legislation such as LB963 also complicates the healthcare system, and compromises any united standard of care. The strain would put-- this-- the strain this would put on minimally staffed healthcare facilities and patients in rural areas with sparse access to care-- think you're critical-access hospitals-- is unreasonable and unconscionable. The NNA opposes violating patients' autonomy in choosing the type of healthcare services they deem most appropriate to their own needs. The NNA opposes legislation such as LB963 that regresses healthcare into a paternalistic system where the provider is the ultimate decision maker, rather than the patient. Nurses across Nebraska trust you, that you will join us in our opposition to this bill. I'm happy to take any questions.

ARCH: Thank you.

JULIA KEOWN: Yeah.

ARCH: Are there any questions? Senator Hansen.

B. HANSEN: Thank you.

JULIA KEOWN: Yes.

B. HANSEN: Thanks for coming to testify.

JULIA KEOWN: Thank you.

B. HANSEN: I, I just kind of, in conjunction with what they were talking about, the AMA Code of Ethics, it sounds like they already have the ability, the provider, to deny care or maybe refuse to do something because of their conscious beliefs. That's what it said when, when he was reading the AMA--

JULIA KEOWN: Yep.

B. HANSEN: --Code of Ethics.

JULIA KEOWN: Yep.

B. HANSEN: And you were saying here, no patient should ever be obstructed from receiving legal healthcare based solely on the provider's personal biases?

JULIA KEOWN: Um-hum.

B. HANSEN: More of a philosophical question. Then aren't we discriminating against the provider?

JULIA KEOWN: No, because--

B. HANSEN: [INAUDIBLE] have to do something?

JULIA KEOWN: Oh, God. No. As a provider, anyone who goes into medical school, nursing school, NP school, you know what you are getting into. And then, even after you go into school, you do your clinicals. You know what your job is going to entail, just as any engineer knows what their job is going to entail. So I would say, no, it's not.

B. HANSEN: OK.

JULIA KEOWN: These, these providers, when you accept a position, that's part of that position unless, like if, you know, if you want to be involved in abortions or something like that, you would go to an abortion clinic to provide care there. That doesn't happen in other places.

B. HANSEN: OK. Thank you.

JULIA KEOWN: Um-hum.

ARCH: Other questions? I, I, I have one. It's a follow up to what Senator Hansen asked here.

JULIA KEOWN: Yeah.

ARCH: First of all, it sounds as though we're talking about not a lot of these incidences happening.

JULIA KEOWN: No.

ARCH: From previous testimony, it doesn't sound like this conflict occurs a lot of times.

JULIA KEOWN: Um-hum.

ARCH: But when it does, you, you used that term "personal biases" in your, in your testimony.

JULIA KEOWN: Um-hum.

ARCH: Do you draw a distinction between personal biases and sincerely held religious beliefs?

JULIA KEOWN: That's a fantastic question.

ARCH: Is that different than a personal bias? And I didn't mean to--

JULIA KEOWN: You--

ARCH: --put you--

JULIA KEOWN: Yeah, it's--

ARCH: --on the spot here or anything.

JULIA KEOWN: --it's-- no, that's OK, that's OK. It's, it's always good to question semantics, isn't it? You could, I suppose, switch that to "personally," you know, per--

ARCH: Sincerely held--

JULIA KEOWN: --very fervent beliefs.

ARCH: --religious beliefs.

JULIA KEOWN: Absolutely.

ARCH: Yeah.

JULIA KEOWN: Absolutely.

ARCH: OK.

JULIA KEOWN: But there again, in those situations where someone has a very firm religious belief, there's already a kind of framework on how to deal with that. You either don't choose a job that would put you in those positions or you, you know, you can talk to your coworkers. You know, for instance, I have worked with several patients who were serial child rapists on, in my work as a critical care nurse, and so I chose to work with those patients because I knew I could provide good care for them, and I knew it would take that stress off of my

coworkers who would not necessarily be able to deal with that stress, and who maybe would not be able to provide as good care due to their personally held beliefs.

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

JULIA KEOWN: Thank you.

ARCH: Next opponent on LB963.

ABBI SWATSWORTH: Good evening, Senator Arch and committee members. Thank you for the opportunity to provide testimony for the committee record. My name is Abbi Swatsworth, A-b-b-i S-w-a-t-s-w-o-r-t-h. I'm the executive director of OutNebraska, a statewide nonprofit working to celebrate and empower lesbian, gay, bisexual, transgender, and queer/questioning Nebraskans. OutNebraska is here today in strong opposition to LB963. No matter what we look like, where we come from or how we express our genders, we all want the freedom to be ourselves and to live healthy lives. Certain Nebraska senators want to enshrine discrimination by healthcare providers and endanger our health, our futures, and deny us the good life. We see it in the introduction of LB963, the so-called Medical Ethics and Diversity Act, which would allow any health provider the ability to deny any specific healthcare service to anyone. The law is exceedingly broad in its definitions, which could mean an individual staff member in a larger hospital or insurance system could make a referral of a service already approved by a doctor or insurance payer. For example, were there an accountant in a healthcare system that did not believe in emergency contraception or contraception in general, although that was being provided by the hospital pharmacy, could refuse to pay for that because they don't agree with it. The, the line in the law seems written very broadly that that could happen, and that's a concern. We believe the law would and might allow employers to deny counseling for someone exploring their gender identity, perhaps blood transfusions for individuals recovering from COVID, IFV [SIC] for a family that struggles with infertility, or HIV prevention medications for sexually active adults. I understand there's been an amendment that does allow or require a referral, so I've changed my testimony slightly to take out the next part about referrals. In regards to getting a second opinion, I think it has been mentioned that this is a really tough situation for lots of rural patients in areas where access is already at a premium. If there are no other providers available, perhaps in an instance of emergency contraception, and a pharmacy-- and a pharmacist does not

believe in that, and there is no other pharmacist in town, is it reasonable to require that patient to drive an hour or more to receive that care? We don't believe that it is. Religious freedom is a deeply held value in our communities, and LB963 is not basic religious freedom. It goes far beyond what is already a careful balance being struck by existing law. We believe it endangers the LGBTQ+ community along with other marginalized communities. All of this creates patient harm, something that the ethics of healthcare is supposed to protect against. For these reasons OutNebraska asks that you not advance LB963. And I am happy to answer questions.

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

ABBI SWATSWORTH: Thank you.

ARCH: Next opponent for LB963?

SARAH MARESH: Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Sarah Maresh, and that's S-a-r-a-h M-a-r-e-s-h, and I am the healthcare access program director at Nebraska Appleseed, testifying in opposition to LB963 on behalf of Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans, and one of our core priorities is working to ensure that all Nebraskans have access to quality, affordable healthcare. Ensuring equitable access to healthcare is a crucial part of that mission. Because this bill effectively restricts access to healthcare services and disproportionately impacts communities that have been marginalized, Nebraska Appleseed opposes this bill. First, LB963 is harmfully broad. The bill very vaguely defines which types of healthcare services can be denied, and provides that the healthcare services means medical research or medical care provided to any patient at any time over the entire course of treatment, and then goes on to list some wide-ranging, nonexclusive examples like testing, administering medications, and referrals, which I understand there's an existing amendment on that. But what will this look like in practice? It's difficult to imagine a healthcare service that could not be permissibly refused under this bill. Furthermore, this bill applies to more than just providers. Entire institutions and even payers can broadly deny providing or paying for critical services. Not only is this bill overly broad, LB963 will also have negative impacts on Nebraskans and our health. Communities that have been continuously marginalized, including those with low incomes, people of color, and

members of the LGBTQ+ community already disproportionately face barriers to healthcare for a variety of reasons. LB963 will create additional barriers to further exasperate deep health disparities and inequities. When providers can deny nearly any type of care, based on their broadly defined conscience, Nebraskans will have to scramble and expend extra time, money, and resources to find appropriate care, and that's if Nebraskans are even aware that they are being denied care options, based on their provider's beliefs. LB963 also lacks guardrails to protect patients. There aren't requirements to inform patients that their care is being limited by their provider's personal beliefs. Data shows that patients are unaware of limits of care posed by referrals, like refusals like those permitted in LB963. And many providers whose conscience limits the scope of care they provide don't believe it's necessary to disclose their objections and the resulting limits on care to patients. The result is that Nebraskans will not know if and when their care will be denied or how their care is impacted by their provider's beliefs. This bill could also have a chilling effect on the provider and patient relationships. It could prevent patients from sharing relevant medical information about their health with providers for fear that they may be denied a service which will prevent administration of the most appropriate care. Provisions. Like those in LB963 can easily lead to discriminatory practices that will most certainly negatively impact Nebraskans' health and their well-being. LB963 is also not needed. Healthcare providers and entities already have existing protections under current law and legal remedies. Federal laws permit providers to refuse certain healthcare services on religious and moral grounds, and Nebraskans' own state laws already provide protections as well, and many protections involve procedures that proponents testified about earlier today. Nebraska Appleseed is committed to ensuring that all Nebraskans have access to equitable healthcare services, and, therefore, opposes this bill. Thank you for your time, and I'd be happy to take any questions.

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

B. HANSEN: Thank you. Just a couple examples, if you can provide them. Abbi gave some good testimony and made some good points about her concerns about the possibility that some people might be denied care because of gender reassignment surgery, I'm assuming, and other medical care that might be important to the LGBTQ+ community. Oh, you mentioned also, in here, too, that communities that have been particularly marginalized, including those of low incomes and people of color. What kinds of care would be denied to those people?

SARAH MARESH: Yeah, I think-- thank you for your question first. And I think what-- and I'm referring to when we're talking about that in our testimony that the resulting impacts of this bill have disproportionate effects on low-income folks and people of color. If you imagine, kind of like the example of Ms. Swatsworth's testimony, that someone would have to drive an extra hour or two to try to find a provider who can, you know, provide those prescriptions. So they're already facing-- those communities statistically already face disparities and barriers. And so this is just kind of adding another large barrier to the pile that they're already facing, which will deepen inequity.

B. HANSEN: OK. That makes sense. Thank you; appreciate it.

SARAH MARESH: Yeah.

ARCH: Any other questions? Seeing none, thank you--

SARAH MARESH: Thank you.

ARCH: --for your, for your testimony. Next opponent for LB963?

SARA RIPS: Hi, my name is Sarah Rips, S-a-r-a R-i-p-s. I am the LGBTQ legal and policy counsel for the ACLU of Nebraska. Thank you to the Health and Human Services Committee for your time today, and I'm here to speak in opposition to LB963. This bill would provide an unbridled license to discriminate to healthcare professionals against their patients for almost any reason, refuse to provide them with care, and limit any professional accountability for those acts of discrimination. This measure contains many vague and undefined terms. It would be impossible to implement and would have a chilling effect for the health of all Nebraskans, but most specifically, our most vulnerable in their times of medical need. This license to discriminate will be felt most severely in rural areas, where patients already have a limited choice of medical providers. As a Jewish person, I'm deeply concerned that I might be denied medical care because of someone's conscience, because of their deeply held philosophical beliefs. This fear is not unfounded. A few years ago, a medical student in Ohio tweeted that she would go out of her way to not provide quality care to Jewish people. Fortunately, laws like this were not in place, and so she is not allowed to practice today. This bill would empower people and institutions to refuse care because they dislike Jews, Muslims or even Christians, so long as their conscience tells them to not treat unvaccinated Christians, that is their right

to refuse care. As a gay person, I am deeply concerned that I might be denied medical care because someone is uncomfortable about who I am. Again, this fear is not unfounded. Across the country and within this state, politicians have worked relentlessly and maliciously to curtail and deny lifesaving care and treatment to LGBTQ people. Our government should never make it more difficult for individuals to access healthcare. This bill legitimizes unequal treatment or the denial of treatment of patients by healthcare providers, organizations, and insurers. LB963 provides extreme religious exemptions under the guise of conscience, which is both reckless and unnecessary. The rights of conscience are already specially protected in the Nebraska Constitution, throughout our statutes in certain instances, and under existing law. Our Legislature has already balanced the rights of conscience with long-standing nondiscrimination laws to ensure people can honor their beliefs but not weaponize those beliefs to harm others. The broad exemptions would allow people and institutions to engage in behavior that harms others with total impunity. For example, a nurse could refuse to assist in providing chemotherapy to a child with cancer because the child's parents are a lesbian couple. A pharmacist could refuse to administer COVID-19 vaccinations because they are morally or ethically opposed to vaccination. On the flip side, this bill would also allow healthcare providers to reject providing treatments to patients that are unvaccinated. A doctor could refuse to examine a patient in the ER for wearing a T-shirt promoting a particular political candidate, because it would violate the doctor's moral, ethical or philosophical beliefs. A surgeon could refuse to operate or choose to ration care on a physically or mentally disabled person, based on their philosophical belief that such people are less deserving of care. We must do what we can to ensure that all Nebraskans, regardless of background, circumstances or location, have access to the best possible healthcare. Thank you, senators, for your time today, and I am happy to answer any questions you may have.

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

SARA RIPS: Thank you, Senator Arch.

ARCH: Next opponent for LB963.

LACIE BOLTE: Good evening.

ARCH: Good evening.

LACIE BOLTE: My name is Lacie Bolte; that's L-a-c-i-e B-o-l-t-e. And I am a representative of Nebraska AIDS Project. We're a nonprofit organization that serves the entire state of Nebraska. We support people living with HIV, as well as provide advocacy and education services. I'm providing my testimony to you. I know it's getting late into the evening, so I'm going to keep it really short. I'd encourage you, though, to read that full testimony. Essentially, we're really fearful about the broad language used in this bill, especially thinking about employers or pharmacists being able to deny coverage for people living with HIV's lifesaving essential treatment. I think it's especially important to think about the cost of living with HIV. A lot of the folks that we work with have medication prescriptions that cost over $3,000 a month. And so for an employer to maybe not want to provide that specifically to that population is extremely concerning to me. So we do oppose LB963. And if you have any questions, I'd be happy to answer those.

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

LACIE BOLTE: Thank you.

ARCH: Very helpful to provide it in writing.

LACIE BOLTE: Yes.

ARCH: Thank you. Next opponent for LB963? Is there anyone who'd like to testify in a neutral capacity on LB963? Seeing none, Senator Murman, you're welcome to close. As you are coming up, I would mention that we received 29 letters as proponents and 27 letters as opponents, no neutral.

MURMAN: Thank you for-- all of you-- for the consideration of this bill. There's been a lot of misunderstanding about this bill. We talked a lot about-- or it's been talked a lot about Ohio, that they do-- they have adopted the AMA guidelines, but Ohio has actually passed this MED Act-- MED Act, exactly as it's written, in 2021, so there's no conflict there. And the whole-- well, not the purpose, but the effect of the bill is that it, it never allows a medical provider to refuse a patient. The only thing the medical provider could refuse is a procedure that that medical provider never does or doesn't allow in their practice. So there's absolutely no discrimination because of lifestyle or race or anything like that. And then there was a lot of talk about limiting healthcare in rural areas. Illinois has passed the

bill, Mississippi has passed the bill and a couple of other states, but those two, in particular, have a lot of rural areas, and there's never been a problem with the effects of this bill in rural areas. And it was mentioned that an institution may not pay for a procedure or care that's already been provided. That can't be done because the insurer could only refuse to pay for something if it is in their bylaws or their statement of beliefs or, or those kinds of things; it wouldn't be done by a secular insurer. And of course, the purpose of this bill is to improve healthcare. So healthcare would be provided by a person that totally agrees with the procedure they're providing. And you know, their purpose for being in the profession is to provide good quality care. So that would be assured-- more assurance with this bill. And also talked about it'd limit the number of-- some have talked about it would limit the number of medical providers in the state. Actually, this bill, as shown by the handouts that I provided at the start, would encourage more students to go into healthcare, because students right now are hesitant to go into healthcare because they're afraid they'll be forced to do something that's against their beliefs. So as I've stated, LB963 is to protect the diversity of belief in the medical field so the, that a person can live out their faith in what they do and not be compelled to go against their beliefs. I ask your support of this bill and to move it forward out of committee, and I'm open to any questions you might have.

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

M. CAVANAUGH: Thank you. Thanks, Senator Murman. On page 6, there's two different parts on page 6: (4) and (5), so lines 8 through 15 that I've got a question about, and then lines 16 through 19. So on lines 8 through 15, it seems like this is additionally going so far as to create some new-- I don't even know how you'd call it-- like statute or standing in employment law in Nebraska. So it's saying that you can have your religious beliefs, have the right to make employment, staffing, contracting, and admitting privileges decisions consistent with its religious beliefs. I mean, we already have religious exemptions in the state. I used to work for a religious order, and so I, I'm familiar with that. But this seems to be going even further than the current religious exemptions. Is that your intention?

MURMAN: No, I don't-- that's not the intention at all. I think it maybe just makes it more clear that this will be allowed under this bill.

M. CAVANAUGH: Well, so currently, there's-- you know, certain religious entities have certain exemptions, like such as the Catholic Church's health insurance. When I worked for a religious order, they didn't cover birth control, and so that would be because of a religious exemption. So they had that exemption out of their Blue Cross plan, that that wasn't covered. And as any, everyone has pointed out today, I went, engaged in that employment and understood that that was the beliefs of my employer, and accepted that. That was the situation, but this seems to be expanding religious exemptions beyond religious institutions into its-- I guess I would just-- maybe just-- It's late, so maybe we can have further conversation about this and talk to the employee, the employment department with our Chair of Business and Labor.

MURMAN: Yes.

M. CAVANAUGH: Yes. OK. And then the next question; I'm sorry, I know we're all tired. There's been a lot of testimony today about, about this bill and abortion, and I guess I just feel like I don't really understand. It's not clear to me if you understand how women access abortion in the state. You don't-- like I couldn't just go to my providers that delivered my children. If I went to them and wanted an abortion, they would be like, we-- that's not-- we don't do that. It doesn't matter if they're like walking in every rally for abortion in the country. They would say, that's not what we do. It's, I mean, you have to go to a specific clinic. And so to nurse Julia-- I'm going misspell,pronounce her last name, so I'm not going to say it-- boy, like you would not take a job at an abortion clinic if you were fundamentally opposed to abortion.

MURMAN: That's true.

M. CAVANAUGH: So what is the concern? I guess I'm not-- I'm trying to figure out what the problem is that that, that part of it is trying to address, because I certainly don't think any practitioner should have to perform a, an, a medical procedure such as abortion against their will; that would be a horrible thing to have to do. But I don't-- I also don't think that people are rampantly going around to their medical provider, demanding an abortion. Is that--

MURMAN: No. That, this bill makes it clear that exactly what you said, if you didn't agree with the procedure, you would not have to provide it. But I agree with you, and the vast majority of abortions are done in abortion clinics.

M. CAVANAUGH: I think like all.

MURMAN: Not-- well, not all, but--

M. CAVANAUGH: Well, maybe not all,--

MURMAN: --the vast majority.

M. CAVANAUGH: --but a-- yes.

MURMAN: Yeah.

M. CAVANAUGH: Most are done-- you want to be in the-- just like any other procedure that you would have done, you'd want to go to a professional who's an expert in that. But--

MURMAN: True.

M. CAVANAUGH: OK, I just-- sorry. I just needed more clarification on that because that kept coming up. But thank you very much.

MURMAN: Yeah, and another example might be in a, a, a medical school, if a, a medical student, student is required to perform an abortion or--

M. CAVANAUGH: Let's follow up with our medical schools,--

MURMAN: Yeah, that's a--

M. CAVANAUGH: --to ask them about that 'cause I feel like--

MURMAN: Yeah.

M. CAVANAUGH: --we're not giving them that chance to answer. I don't know that--

MURMAN: Yeah.

M. CAVANAUGH: --that's a common practice procedure to learn.

MURMAN: Well, I'm familiar with medical schools and-- with family connections-- and that can be required to be part of the procedure. You can have pressure on you from the administration to do things that you don't agree with in medical school.

ARCH: Are there other questions? Seeing none,--

MURMAN: Thanks a lot for lasting late into the afternoon, and in a--

ARCH: Thank you, Senator Murman.

MURMAN: --warm building.

ARCH: Thank you, Senator Murman. This will close the hearing for LB963 and the hearings for the committee for the day.