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

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

RIEPE: That's me. I'm Merv Riepe. I represent Omaha and-- central Omaha, and I'm in District 12. And also the little town of Ralston.

HANSEN: Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton Counties.

HARDIN: Brian Hardin, District 48, "the real West." Banner, Kimball, Scotts Bluff Counties.

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

QUICK: Dan Quick, District 35, Grand Island.

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

FREDRICKSON: Also assisting the committee today, to my left is our research analyst, Bryson Bartels, and my far left is our committee clerk, Barb Dorn. Our pages for the committee today are Sydney Cochran and Tate Smith, both students at UNL. Today's agenda is posted outside the hearing room. With that, I'll turn it over to our chair.

HARDIN: For this, LB214, welcome, Senator Holdcroft. We do have two invited testifiers on this, is that correct?

HOLDCROFT: That's correct.

HARDIN: OK. We'll have those folks go first after you're done with your opening, and then proponents, opponents, those in the neutral. Will you stick around for the end?

HOLDCROFT: I will.

HARDIN: Wonderful. Take it away.

HOLDCROFT: Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. For the record, my name is Senator Rick Holdcroft, spelled R-i-c-k H-o-l-d-c-r-o-f-t, and I represent Legislative District 36, which includes west and south Sarpy County. I am here today to discuss LB214. This bill would amend Nebraska's new-- Newborn Safe Haven Act to add newborn safety devices-- affectionately referred to as "baby boxes"-- to the list of authorized drop-off

locations under the Newborn Safe Haven Act. LB214 simply gives an additional option for parents to surrender their newborn baby without fear of criminal prosecution. As most of you are aware, Nebraska's current safe haven legislation was initiated with the passage of LB157 in 2008. Despite language in drafts of the bill spec-- of the bill specifying age requirements for a surrendered trial-- child, the final bill was passed without such language. This led to children of all ages, and even from other states being surrendered under the new law. A special session with the sole purpose of providing a fix for the broad law was held later in 2008, and LB1 from that session added the words "30 days old or younger" to the statute language. Last year, through LB876, we were able to expand the list of approved drop-off locations under the Newborn Safe Haven Act to include fire stations, law enforcement agencies that are staffed 24 hours per day, seven days per week, as well as emergency medical service providers and emergency crews that respond to 911 calls. It also redefined newborn infant in state statute from 30 days old or younger to 90 days old or younger. We fell short last year in our attempt to approve newborn safety devices. This year, I have someone from the major manufacturer of baby boxes to testify as to their quality, safety, reliability, and spotless track record. The fiscal note for this bill is to provide funding for the installation of the receptacles. This is only after a local grassroots campaign has, has raised the funding for the receptacle and established a location for the device. An ongoing awareness campaign for the devices by the Nebraska Department of Health and Human Services will also, will also be funded. Chairman Hardin and members of the Health and Human Services Committee, thank you for giving your, your attention to LB214. I would appreciate it if the committee would give this bill timely consideration and advance it to the floor-- Legislature for debate. I would be happy to answer any questions you might have, but as I mentioned, I think the representative from the, from the Safe Haven Baby Boxes will be able to answer your questions in more, in more detail. Thank you.

HARDIN: Do we have questions for the senator this time around? Senator Riepe does.

RIEPE: Thank you, Chairman. Thank you, Senator Holdcroft, for being here. Last year, in 2024, you did, as you noted, introduce and, and were successful in the passing of LB876. My question is, during the past year, have there been any infants who have not been safely placed?

HOLDCROFT: Who have not been safe place?

RIEPE: Not safe-- been-- not been safely placed.

HOLDCROFT: What's your definition of not been safely placed? You mean in the nation?

RIEPE: In a-- any one that would have been injured if-- had they-- I mean, that would have been benefited by the boxes as opposed to going to the hospital. Obviously, I have a bias towards the hospital. It's 24/7.

HOLDCROFT: Well, not, not to my knowledge in Nebraska, but we can do some more research on that.

RIEPE: OK.

HOLDCROFT: I mean, certainly across the nation there have been a number, and I think the representative from the safety-- from the baby box company will have some statistics on that.

RIEPE: I'm also curious-- because I'm not a fan of the baby boxes. I think they're--

HOLDCROFT: Are you not a fan?

RIEPE: I'm not a fan, because I think-- maybe this is true, at least in an urban area. I worked for a, a Catholic hospital for 20 years and, quite frankly, we got more than our share. And I think that was because of the fact that we were a Catholic hospital. But I, I-- I'm concerned on the maintenance, the observation-- all we have to have this one get missed, just like a child that gets left on the school bus. And all we have to have is one of those, and it's a, a disaster. Hospitals are 24/7, they handle it well. Now, this might apply in smaller communities, but I don't see that many incidents in smaller communities.

HOLDCROFT: Well, in the installations they would be at either fire station or a hospital, which would be 24-by-7, so. I mean, it's-- I mean, the, the, the-- what, what this offers is an anonymous surrender, and the alt-- what's the alternative? A dump-- a dumpster, or maybe just leaving it alongside the road. So, what-- all we're, all we're trying to do here is save, save lives. And maybe that special case where it could make the difference of, of whether to deposit that live baby or do something else with it.

RIEPE: Well, I don't think it much is any kind of an argument to say that you would put it outside the door of a hospital. I mean, the

hospital is not going to-- you know, they might-- they'll call a social agency, but when we had them dropped, most of them didn't walk in the emergency and say, by the way, here. They would put it in a very public restroom, which, of course, would be a problem.

HOLDCROFT: No, I think the real advantage of this is, is at the, you know, the fire station, that's-- some of these small communities still have to be manned 24-by-7. But this is an opportunity where there's not a hospital nearby, so.

RIEPE: But, you know-- I, I don't-- I won't carry on here very-- any longer, but a fireman also sleep, and so they-- this baby might be in the cold for some-- and I know [INAUDIBLE].

HOLDCROFT: Well, it's not cold. They're climate-controlled, there's a silent alarm, and then there's an-- and there's an active alarm that goes off. I don't-- I am not aware of any situation- and again, our expert could probably amplify this-- where a baby was deposited and it was not-- it was not found in, in, you know, in a reasonable amount of time.

RIEPE: OK. I don't want to be-- I don't want to dominate the thing, so I would-- you know, I might come back, but thank you, Chairman. Thank you, Senator.

HARDIN: OK. Senator Fredrickson.

FREDRICKSON: Thank you, Chairman. Thank you, Senator Holdcroft, for being here. So, [INAUDIBLE] the bill we passed last year, we did pass a bill-- but do, do we currently have baby boxes in Nebraska? I've--

HOLDCROFT: No.

FREDRICKSON: --I don't, I don't remember.

HOLDCROFT: There are none.

FREDRICKSON: OK. So, the-- that was taken out. So, this would enable the baby boxes.

HOLDCROFT: Yes.

FREDRICKSON: A couple questions for you. I think you mentioned this. So, my understanding based on the bill is-- so, these would be only located at fire houses and then--

HOLDCROFT: Fire stations and hospitals.

FREDRICKSON: And hospitals. OK. And then, my other question is, this is more enabling legislation, so it wouldn't require these. So, let's say there's a rural area, for example, that said "Hey, we don't know if we can navigate this." They wouldn't be required to have a baby box. Is that right?

HOLDCROFT: Oh no, no, no. This is all voluntary. In fact, we're not, we're not purchasing the boxes; we expect that there will be pro-life organizations and community nonprofits who raise the funds and, and install-- want to install these in their communities.

FREDRICKSON: OK. So, so this-- so, this bill, the LB214, it's really about just enabling the ability to-- for these locations to have a baby box. [INAUDIBLE] Is that right?

HOLDCROFT: Well-- and, you know, they could do that today, frankly. What this bill really does is it forgives the parents from prosecution.

FREDRICKSON: OK.

HOLDCROFT: So-- I mean, there's nothing that stops a, you know, an organization from, from, from-- they can, they can go direct, have these installed. But what this really does is, is it really-- it-- there's no prosecution involved if the parents surrender their child.

FREDRICKSON: Got it. So, this, this is more protective for the surrenderer of the, of the child?

HOLDCROFT: Correct. That's correct.

FREDRICKSON: OK. OK. And my final question is, are there, are there multiple manufacturers of baby boxes? Or this is some-- like, how many [INAUDIBLE]

HOLDCROFT: Yes, and our expert can, can address that too. There's one major, and that's where she's from. But there are-- I think there's about four total--

FREDRICKSON: OK.

HOLDCROFT: --in the United States.

FREDRICKSON: OK. Thank you.

HARDIN: Other questions? We shall see you in a little while.

HOLDCROFT: OK.

HARDIN: We have two invited folks. And who are you? Raise your hands. Well, would you come up and let us, let us hear from you. We appreciate it. Welcome.

JESSI GETROST: Welcome. Jesse, J-e-s-s-i; Getrost, G-e-t-r-o-s-t.

HARDIN: Take it away.

JESSI GETROST: OK. Thank you, Chairman Hardin, and members of the Health and Human Services "Committittee." Thank you for the opportunity to speak in support of LB214. My name is Jessi Getrost, and I'm the executive assistant to Monica Kelsey, the CEO of Safe Haven Baby Boxes. After Monica started Safe Haven Baby Boxes, the vision became more precise; was based on statistics of where these babies were being dumped. A baby is thrown away like trash every 3 to 4 days in America, on average. On Monday this week, a baby was found dead in a dumpster in Modesto, California. Over the weekend, a newborn was found dead in Lynchburg, Virginia. This is shocking when you think about how much support we have from crisis pregnancy centers to govern a-- government assistance under the current safe haven law that's been placed-- in place since 1999. Yet, we still have babies being thrown away like garbage. And do you know the main reason why? Because women want anonymity, and they're telling us how important that is for them by where they're leaving them. Parents who surrender currently get confidentiality when they walk into a hospital and surrender their baby, but they don't get anonymity. This is very important to some parents who want to do the right thing but don't want to walk in and see a person or talk to them. This is why the baby box is so important, and has been successful in many states in America. Now, a parent can walk in still, and they can hand their baby to personnel inside the facility, and we don't want to change that. We just want to add an anonymous, anonymous option. Instead of taking a baby from a parent, you pull a baby from a box. The process after the baby is received will not change. How the state of Nebraska currently handles safe haven babies will not change after the baby is taken from the box. Since allowing newborn safety devices, we have passed in 21 states, and we currently have 320 active baby boxes across America. Our hotline has helped over 10,000 parents in crisis over the last ten years. We've walked alongside over 200 women and men who have successfully surrendered their infants. We hope that you will seed a need for this anonymous option in the state of Nebraska. We believe

it's better to have boxes and not need them than to need them and not have them.

HARDIN: Thank you.

JESSI GETROST: You're welcome.

HARDIN: Questions? Senator Meyer.

MEYER: Thank you, Chair Hardin. Do you know what the approximate cost of these boxes?

JESSI GETROST: So right now, we have-- the approximate cost is $15,000. This includes: the baby box; the signage; marketing materials; legal feels-- legal fees; contracts to the location; a $2 million policy on the baby boxes; 24/7 support for locations to contact us, and to-- if they need help with a mom at their facility or need help with the actual box; location listed on the website; blankets, beanie hats and mattress covers; in-person training of the staff. And keep in mind that this isn't a vendor bill. There are other companies out there that Nebraska location can contract through-- which I believe was a question earlier-- Banner Hospitals baby drawers, and Gems to Gems [SIC] cradles out of Canada.

MEYER: Do they need-- if I may, Chairman. Do they need internet connection or anything along those lines?

JESSI GETROST: A lot of these have the alarm hookup, so it depends on their area, what type of alarm system that they're going to use.

MEYER: And if I may, just, just one more brief question. And, and maybe you can't answer this, and, and I understand if you can't. What, what is Nebraska's liability now, if someone turns in a baby to a hospital in person?

JESSI GETROST: So-- excuse me.

MEYER: Essentially, that's baby abandonment, I would imagine. And what-- what are the ramifications?

JESSI GETROST: So, under the safe haven law, you have no liability. Under your law, it states that any parent who safely surrenders their infant, that protects whoever is taking that infant. So, there is no liability to the hospital, to the fire station, to EMTs, to the police officers, whoever would hand-surrender. Or in this case, if there was a box, to the box location.

MEYER: OK. Thank you.

JESSI GETROST: Mm-hmm.

HARDIN: Other questions? Senator Hansen.

HANSEN: Thanks. I don't know if you talked about a whole lot, but can you maybe explain a little bit more about, like, the safety aspects of these baby boxes?

JESSI GETROST: Yeah, sure. So, right now the records will speak for themselves. We do-- we've had 57 infants that have been surrendered in our box, and they've all been safely surrendered without a single box failing. We're currently working with Underwriters Laboratory [SIC] and we've been working with them for two years now, to get a UL testing on these boxes. Or, a UL certification, I'm sorry. They're tested every step of the way from the building process to the installation process. Weekly trained by the fire part-- or, weekly tested by firefighters, EMTs, police department, hospital staffs, on the box. Safe Haven tests the boxes at every step of the way throughout the process to ensure the safety and "constitity"-- consistency of our boxes. With the UL process, it's-- the policies, protocols, and procedures for the box, they've never had and never been able to do in American history. This is the first time that these boxes have been tested. So, they've had to put into protocol different things in order to make sure that they're doing it right. So, it has been a long process, and at the end of this summer, we're suspected to be able to be UL-certified. They're diligently working to add their certification just to make sure that there is an extra means of protection for these boxes.

HANSEN: OK, if I can ask one more question.

HARDIN: Sure.

HANSEN: Maybe you can answer this or maybe somebody behind your can, but-- or maybe it's just the law. I should ask a lawyer. What, what-- what's, what's, like, the rights of the father in all this?

JESSI GETROST: So, a father has the same right as the mother. If a baby is surrendered, they have the same right, and we would-- they go through-- like-- so, there's an exploited children's database, and that child will go into that. So, whether it's a father or a mother that would surrender the infant, that will go through that child database. They'll find out if there was anything that was suspicious about that child, if it was removed illegally from the home or from a

different parent. And there's also a fathers registry that they can sign up to, and if that baby was surrendered without them knowing, they have already signed up under that registry, and they'll be able to find their infant if it's turned-- once it's turned in.

HANSEN: There's a fathers registry?

JESSI GETROST: There is, yes.

HANSEN: I did not know that.

JESSI GETROST: Yeah.

HANSEN: How do you sign up for something like that? And I-- don't ever tell your wife. That'd be kind of a weird thing.

JESSI GETROST: Well, so, I mean, if you want to get technical with this--

HANSEN: No, that's all right. No. You answered my questions, so that's all. Appreciate it. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for taking the time to be here and to testify today. So, with the bill in front of us, are the facilities-- are they-- where these would be placed, would they be required to be kind of stationed or manned 24/7?

JESSI GETROST: Yes, they are.

FREDRICKSON: OK.

JESSI GETROST: Yes.

FREDRICKSON: So, if a fire station-- so, I know, for example, fire stations aren't always 24/7. So, the ones that were not 24/7 would not be eligible?

JESSI GETROST: That will depend on your state and what you decide for your state. In most of our states, they do have to be 24/7 manned, that way if there is an infant that's placed in one of these boxes, then they're always going to have somebody there that's able to process that, take it out, make sure that everything's OK. They do a check on it, call EMTs if they don't have manned EMS stations right out of their stations; some do.

FREDRICKSON: OK.

JESSI GETROST: And then, they'll transport them to the hospital.

FREDRICKSON: OK. The bill also requires kind of testing 1, 1 times a week. Who conducts that testing?

JESSI GETROST: So, when we do-- go into a location, when they first get their boxes, when they get ready to open that box, we do training for them. We come to their location, we train them on the safe haven law itself, because there's still a lot of locations in hospitals and fire stations that don't know the actual safe haven law. So, we make sure we walk alongside them through that. We do training on them on the box, to tell them how to train it, how to do the alarm testing, what-- if there's any things that would come up, any issues, we'd walk them through that as well. Plus, we have a 24/7 call number that, if they have any problems, they can always call us. But they're trained on that box, and that way, when they do their weekly testing, they know what they're looking for.

FREDRICKSON: OK. And then, we, we talked a little about temperature control--

JESSI GETROST: Yes.

FREDRICKSON: --for cold nights. What about warm nights, if the baby gets too hot?

JESSI GETROST: So, it goes the same way. We have a medical doctor that's on our, our staff, on our board, and they've told us that 75 to 82 degrees is the perfect temperature for infants. A lot of these infants are coming through with a low body core temperature. And that way, those body-- or those-- the box is registered for that temperature. There's holes in the front of the box, and that will regulate the air and rotate it in and out. If the box gets a little bit too warm, then it will pull from the outside and make that exact 75 to 82 temperature. If it gets a little bit to cool, then it will pull for the room also, and it'll warm it up as well. But that heater in there will constantly keep that temperature regulated.

FREDRICKSON: OK. And then, my last question is-- so, my understanding from safe haven law is that a, a parent or a person who's surrendering a child is exempt from prosecution the first 90 days of life. Is that your understanding?

JESSI GETROST: Long as the infant is not harmed or there's been no abuse. If there has been abuse or neglect, then that safe haven law does not protect that parent.

FREDRICKSON: OK, so the idea is that if you have abused or neglected your infant, you can safely put them in a baby box. Is that the--

JESSI GETROST: Correct.

FREDRICKSON: OK.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin. I'll try to be very brief, and, and it in all probability has absolutely nothing to do with this specific bill. But for my own personal education, which I need a great deal of, once a baby is delivered to a, a safe box, a safe baby box, what's the process for that baby after that? If you can be brief. Because I'm curious just what the steps are.

JESSI GETROST: Oh, sure. So, once that baby is surrendered in the, in, in the baby box, the firefighters will immediate pull-- immediately pull it out. They'll process it and make sure-- to see if there's any immediate medical help that we'll-- they'll have to do. If not, then they will transport that to the hospital, and at the hospital, child service departments in your state will take it over from there, and they go through the next process to adopt this infant.

MEYER: OK. Thank you, thank you. Appreciate that.

JESSI GETROST: You're welcome.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman. So, I'm going to guess they're hooked up to electricity somehow, the-- like, the utility department or something. But do they-- what happens if there's a power outage or something?

JESSI GETROST: So, all of our fire departments have backup generators. So, as soon as the power would go off, if that does happen, there was an alarm. So, if they would lose power, before that generator would kick in, then the alarm will notify them to let them know that that box is without power, but most of the cases that we've all had, it might be one to two seconds that that generator takes to kick in, but most of the time that doesn't even happen; it kicks on so fast that

automatically, it has that backup generator. So, it doesn't-- is is never without power.

QUICK: Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here and answering all our questions. Can you describe the signage on these baby boxes? What would that include?

JESSI GETROST: So, as far as-- so, from the moment that they will contact us, then we have a contract that we'll send out. And from, there the lawyers take over. If they want to agree to everything, then they'll sign the contract with us. If they have things that they want to discuss, then they can get lawyers involved and the lawyers will kind of handle things from there. We have our own set of lawyers, as will, usually, fire departments or the city or the hospitals. Is that what you're--

BALLARD: So, so you said the signage-- I think in the bill they said that signage approved by the department. So, the department would hire lawyers?

JESSI GETROST: I, I guess I'm not following what you exactly mean. So--

BALLARD: Oh, the-- so, you said the baby boxes would include signage on-- with the baby boxes.

JESSI GETROST: Oh, so that-- sorry. I thought you meant, like, from the very beginning stage when [INAUDIBLE] get ready to do contracts.

BALLARD: No, no, no.

JESSI GETROST: So, yeah. So, that would be-- outside, there's signs that say, you know, safe haven baby box. In your case, it would be Nebraska. There's going to be a Nebraska sign over the box, there's going to be a sign that says this is open for their use. Sometimes, the departments will have signs outside to let them know where it is. Especially a hospital, if you have a big campus, then there'll be signs that will be around posted to let them know and direct them to where the box is.

BALLARD: OK. And then one more question, if I may. And so, back to the 24/7 fire department.

JESSI GETROST: Yes.

BALLARD: So, what if-- is there a secondary alarm, just in case the firefighters are on a call?

JESSI GETROST: So, correct. Yes. So, a lot of times that happens, you know, you have firefighters that are out on a run, then what happens? So, from that they have the EMTs, you know, as your local EMS squad will come. And so, it will be the same way. They'll still have that 24/7 man there.

BALLARD: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you.

JESSI GETROST: Yes, sir.

RIEPE: I want to come at this from a little different approach.

JESSI GETROST: Sure.

RIEPE: Did you come in here for the hearing today from Indiana?

JESSI GETROST: I did.

RIEPE: So, do you represent the builders of baby box?

JESSI GETROST: For the Safe Haven Baby Boxes, yes.

RIEPE: So, you're here kind of as a salesperson, and with some conflict of interest.

JESSI GETROST: Nope. No, not a salesperson at all.

RIEPE: Well, of course you are. The cost-- the other question that I have is these-- once the boxes are placed, how is they maintenance-- say, if you spread them all across Nebraska, what's the process, once placed, to maintain them, to make sure--

JESSI GETROST: So, that's part of--

RIEPE: --routine checks? How frequently would those checks be?

JESSI GETROST: So, they do weekly checks on the boxes. They're walking by twice a day to make sure that the light is there. There's two lights--

RIEPE: Who, who walks by, please?

JESSI GETROST: The fire department or the hospital, whoever is the trained staff there.

RIEPE: So, the hospital would have to have someone walk by this box and check it?

JESSI GETROST: Twice a day. Correct.

RIEPE: OK.

JESSI GETROST: Because you want to make sure that that box works, correct? That that box has the lights that are still on, that there's not an infant in that box. So, it's being checked twice daily.

RIEPE: I also wanted to challenge a question that you talked about. You said that the women would have anonymity of taking-- you know what? We never questioned the mothers. We were very-- it's a very personal thing. We never challenged them, we didn't-- law enforcement never went after them.

JESSI GETROST: Sure. Is there--

RIEPE: And as a hospital-- former hospital administrator, I would not encourage my board to ever place one that had to a) tie into my hospital generator, or that I had to have someone on the staff walk around every day. One more task. But that's, that's [INAUDIBLE] position from a lot of years.

JESSI GETROST: But you also-- that's if a mother or a parent walks into your hospital and hands that baby to you. What if they don't? You had mentioned earlier that you had a lot of infants that were left outside. If they're left outside--

RIEPE: Who, who-- I never said that.

JESSI GETROST: If they're left outside, then that's considered an abandonment. It's not a safe abandonment.

RIEPE: I clearly understand that. I've been in the business a long time. I never had one that was left outside. Never.

JESSI GETROST: So, the boxes--

RIEPE: And I never said that.

JESSI GETROST: --are there to provide anonymity. Some parents don't want to walk into a facility and be able to be face-to-face with you. They want to be able to-- and that's why they're abandoning them. That's why they're leaving them outside fire stations and hospitals. They want to do the right thing, but they don't want to see anybody face-to-face. So, that's just another option. Just like you have tons of tools in your toolbox, are you going to use a hammer to screw in a screw? No, because you have a lot of tools in there. This is just another tool for women and, and men to use as a way to safely surrender their infant, other than the safe haven law. It's just an extension to that law.

HARDIN: Other questions? Thanks for being here.

JESSI GETROST: You're welcome.

HARDIN: Next. Welcome.

JUDY MANSISIDOR: Thank you. My name is Judy Mansisidor, J-u-d-y M-a-n-s-i-s-i-d-o-r. On October 7, 2023, around 5 a.m., a firefighter at Omaha Fire Station #21 opened the station door and found a box moving with a blue blanket in it. A newborn baby, alive, warm, and healthy was in the box. Following procedure, the firefighters took the baby to the hospital to be checked, which activated a response from DHHS in a child abandonment situation. The child was left lovingly wrapped in a blanket, and the mother rang the doorbell to alert the staff at the fire station. The child was left thoughtfully. All over the news, there are stories of babies safely surrendered at fire stations. The child was safely and quickly placed into the hands that provided a professional chain of care from the moment he was discovered. The mother of that child, however, was completely unprotected in her right to anonymously, legally surrender that infant. In fact, under Nebraska law, that mother was open to prosecution for abandonment, abuse, and neglect of that child. I called Attorney General [SIC] Kleine, and I said that he should not prosecute that mother. The baby was safe, and she did everything she could to make sure that child was discovered. He said, I have no intention-- I agree with you, I have no intention of prosecuting that woman. Under our current law, face-to-face surrender is demanded by our safe haven law. This is a strong barrier, as Jessi mentioned, for vulnerable women. With LB214, communities can build-- can build; are

not required to build-- can build a newborn safety device, a secure, alarmed, temperature-controlled device where a mom can safely and anonymously surrender her infant. This will help us receive more safe haven surrenders and have fewer abandonments. We can and must do better for Nebraska women. LB214 makes a way for a woman to safely and anonymously surrender her infant. DHHS already has procedures in place to care for children in abandonment situations and in safe haven surrenders. Allowing newborn safety devices in our communities will, one, give mothers an anonymous surrender choice; and two, save infants from dangerous abandonments and possible death; and three, allows for the immediate professional care of the child once the child is surrendered. Please give Nebraska women a safe and anonymous way to legally surrender their children, their newborn infants. Pass LB214 out of committee. Some other abandonments that have come up in the recent news: in 2022, in 16 degrees, a baby was abandoned on a sidewalk. In 2020, a woman was prosecuted for abandoning her newborn on a porch. And in 2018, a mom left twins in a hospital in Lincoln. It's a pertinent and pressing issue, and we can do better for women. Thank you.

HARDIN: Questions?

JUDY MANSISIDOR: Yes.

HARDIN: Seeing none. Thank you.

JUDY MANSISIDOR: Thank you.

HARDIN: Proponents, LB214. Welcome.

NATE GRASZ: Thank you. Good afternoon, Chairman Hardin, members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z. I'm the executive director for Nebraska Family Alliance, and I'm testifying in support of LB214 on behalf of the thousands of families we represent who share our desire to see every life cherished, protected, and given the opportunity to reach their full potential. At the heart of safe haven laws is a desire to love and protect both parents and their babies. LB214 improves our current law by providing a safe, proven, and anonymous way for parents in crisis to surrender a newborn baby. We don't want to see any child abandoned, but tragically, we know this does and has happened, and we want to instead provide a safe alternative that prevents abandonment, raises awareness of the option of anonymous surrender, and offers parents in need a last-resort option with the peace of mind that their child will be cared for physically, financially, and emotionally. Across the country, this

type of legislation has been used to help save lives. In Indiana, the first state to implement safe haven baby boxes, eight babies were safely surrendered just in 2022, and there has not been a single abandoned baby death in the state since the enactment of their safe haven law in 2016. If this bill can save one life here, it's worth it. Because we're better when no life is disposable; when every child is given a chance at life; and when instead of being abandoned with little or no hope of being rescued, a vulnerable child can be given an open door to a loving home. And I think the key here with this bill, again, is that this is voluntary. It's voluntary, and any of the hypotheticals or scenarios that we could come up with already exist right now. A parent could leave a child somewhere that is unsafe, outside when it's cold or hot, and no one might know. This is an option that eliminates those, those scenarios and problems by providing another option that, that is safe, that is effective, that has multiple alarm systems to ensure that the proper personnel and authorities can be notified. And it has been used to help save lives in other state, and we believe it's one more option, one more safety net that we can provide to vulnerable parents in our state. So, we appreciate Senator Holdcroft for bringing this bill to help protect parents and babies, and encourage the committee's support. Thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you. Welcome.

SANDY DANEK: Good afternoon. Thank you. Chairman Hardin and members of the committee, my name is Sandy Danek, S-a-n-d-y D-a-n-e-k, and I am executive director for Nebraska Right to Life. As a statewide grassroots organization, I'm here representing thousands of Nebraska pro-life households in support of LB214. Nebraska Right to Life has consistently supported safe haven laws in the past, and would like to further see the adoption of the safe haven baby boxes. We believe the boxes are a necessary resource for parents who are likely in a time of crisis, or facing emotional or practical challenges that could otherwise lead them to unsafe decisions. The safe haven law allows for the opportunity to surrender newborn infants 90 days of age or younger without fear of prosecution. The reality is babies are abandoned, and providing parents with a safe and anonymous option for child surrender likely gives that child a chance for a better life. Safe haven baby boxes have been used since 2016, and have been proven to be a secure option since they are located in hospitals, fire and police stations. These safety devices are a positive step that Nebraska Right to Life can support. They would help ensure that no child is left without care, and a parent could feel their option is a safe and secure one. No mother wants to be faced with such a difficult decision, placing her child because of her inability to provide. However, when there are

no other options and it is found to be in the best interest of the child, providing this positive resource can help to save lives. Every precious child is worthy of dignity and safety. We hope the advancement of LB214 will bring us closer to a place where children can be protected and cherished. Thank you.

HARDIN: Thank you. Questions? Seeing none.

SANDY DANEK: Thanks.

HARDIN: Thank you. Proponents, LB214. Welcome.

ADAM SCHWEND: Thank you. Thank you, Chair Hardin, members of the committee. For the record, my name is Adam Schwend, A-d-a-m S-c-h-w-e-n-d, and I am the western regional director for Susan B. Anthony Pro-Life America. Although I represent a national organization, I am a Nebraskan and a resident of Lincoln. Today, I am here to encourage the support for LB214, which would expand safe-- Nebraska's safe haven law to include the use of newborn safety devices, colloquially known as baby boxes. Although we regularly spar on the issue of abortion policy, it is heartening to be able to put aside ideological and partisan differences, which exist even in this hallowed nonpartisan institution, to work on legislation that crosses the political divide. Safe haven baby box legislation is just that sort of legislation. In fact, last year, Idaho passed safe haven baby box legislation with zero no-votes. Just last month, South Dakota passed the same legislation unanimously. For anyone attempting to make this bill about abortion, I challenge you to page through the digests of every single legislature in the United States and its territories and find a bill about abortion on either side of the issue that has passed unanimously. South Dakota's law was spurred by a tragic event which occurred in Sioux Falls. Last year, a full-term newborn baby boy was left dead in a recycling center. The details around the death of this little boy-- given the name Gabriel James by the community-- is still largely unknown. However, South Dakota state and local leaders have banded together to support the safe haven baby box law in an effort to ensure this never happens in their state again. LB214 brings Nebraska in line with more than 20 states across the political spectrum who have or are considering passing baby box legislation this year. While Nebraska's stave-- safe haven law is strong, it is still a reality that women who have a negative history with government entities such as the police may hesitate to exercise their legal options if having to personally communicate with an authority figure such as a police officer is required. LB214 gives mothers in crisis who feel they have no other option a chance to anonymously surrender

their baby. Mr. Chair, it is my sincere hope that we are able to get this legislation across the finish line without having to be prompted by a tragedy such as that occurred in South Dakota. I encourage the committee to advance LB214 as quickly as possible. Thank you very much, and happy to answer any questions.

HARDIN: And those questions are-- Senator Meyer.

MEYER: Thank you, Chair. Thank you for coming in today. In the past several years or, or historically, have-- how many babies have been abandoned in the state of Nebraska? Do you have any idea?

ADAM SCHWEND: I don't have that information at all in front of me, but I know there-- it has happened. In fact, there has been prosecutions of it happening. In 2004, there was a, a, a young woman who abandoned their baby who passed away, who was then prosecuted. This option, obviously, was not on the table for her, and perhaps she would have had a different outcome had this been an option. Certainly, this is not a requirement of any hospital, of any fire department. There's no requirement to do this. This is just another option, another arrow in the quiver to give communities, to give organizations, to give mothers an option if they find themselves in a crisis situation, that they're not leaving a baby in a recycling center; they're not leaving a baby to die in an alley; they're not leaving a baby just outside a hospital that maybe nobody notices.

MEYER: Thank you.

HARDIN: Other questions? Seeing none. Thank you.

ADAM SCHWEND: Thank you.

HARDIN: LB214, proponents. LB214, opponents. Welcome.

SCOTT THOMAS: Good afternoon, Health and Human Services Committee. My name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s, from Village in Progress Nebraska and USIDHR, the U.S. Institute of Diplomacy and Human Rights. I'm opposing this bill because obviously, there's a number of human rights concerns, international treaty concerns with stuffing a baby in a metal box. To Senator Hansen's point, I don't know that 30 days or even 90 days is long enough time for a father to establish paternal rights and seek custodial rights. The first testifier, the invited testifier that spoke about a registry for fathers who have concerns of this nature, that's incorrect. The Missing and Exploited Center for Children [SIC] will not take reports from fathers. And so, before I had custody of my child in 2012, she was taken from the state by the

mother. I reported it, couldn't have the report accepted because I'm a father. In 2020, same, same child; mother took the child again. I had full custody from a district court in the state of Nebraska. Couldn't report it because I'm the father. So that, that information is incorrect. But my bigger concern is a baby is an image-bearer; bears the image of God, the image of our Lord and Savior, Jesus Christ, my Lord and Savior Jesus Christ. I won't speak for everybody, but he's your Lord and Savior as well. And what you're talking about is accommodating degeneracy; what you're talking about is-- people want to rob banks, and if there weren't guards in the bank with guns guarding the money, less people would get shot, so let's just put down the guns in the banks. Let's-- you know, I don't know how far you want to move the ball on this issue, but we heard testimony from the introducing senator that the alternative is a dumpster. We heard the testimony from the first invited testifier that anonymity is required on the part of the mothers abandoning their children. You know, they don't want everybody in their business. And so, this is a RINO bill. Vote for this is a RINO vote. You have people who are conservative in the Republican Party who are trying to stand on principle, and you have people who constantly undermine them. You know, accommodating degeneracy, making deals with the other side and, and undermining their own values, the things that we all believe in. We believe that life is valuable; we believe that life begins at conception. You don't undermine those values and principles by saying we can stuff the baby in a metal box when it's inconvenient, or what if you don't want to look somebody in the face when you're doing it? I'm, I'm just asking for, for you not to advance this bill out of committee. I would really appreciate it. God bless you all.

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

SCOTT THOMAS: Thank you, sir.

HARDIN: Opposition, LB214. Those in the neutral, LB214. Senator Holdcroft.

HOLDCROFT: OK.

HARDIN: Welcome back.

HOLDCROFT: Thank you, Chair Hardin. There is absolutely a Nebraska father's registry, which is maintained by the Department of Health and Human Services. If a father believes that his estranged wife is going to put their child up for adoption or abandon the child, then they can register. And when that occurs, then the Department of Health and

Human Services researches that database to determine if, if it fits. If the child's age, if the situation fits, then they will contact that father. It does require action on the part of the father to make that registration, but it does exist. Also, we added a few other things to the, to the bill under Section 6 to try and make sure that, you know, parents have an opportunity to ensure that their, their child, after surrender, is well taken care of. The department shall develop procedures which shells-- which shall be published in its website to allow an individual to, number one, anonymously provide any medical history information relating to a newborn infant. So-- that's been surrendered. So, that is one of the arguments about anonymous surrender, is that there's no, no medical history, there's no opportunity to take a medical history. But this provides for the medical history to be provided after the fact. Also, number two, if they want to reconsider surrender of the newborn infant under the act, they have that opportunity. I mean, it-- and then, and then-- and undergo a paternity testing for a newborn infant surrendered under the act. So, there's the opportunity for an individual to come forward and say, "I think that's my child," and there are processes and procedures within the bill and within DHHS to go ahead and check, check for paternity. Let's see what else I had here. The, the box-- the boxes can only be installed at hospitals and fire stations. Every fire station in the state of Nebraska is required to have a backup power supply. OK? We checked that out last year; every fire station in Nebraska has to have a backup power supply, and the bill requires that it would be manned 24-by-7, even with calls. So, they always have to leave somebody's back behind at the station if they have the box, to be there in case there is a, a, a surrender. You know, it's, it's really-- it's all volunteer. I mean, if you're really concerned about, you know, twice a day checks in your hospital, this is going to be an extra burden to the staff, then don't do it, OK? There are people out there in Nebraska who want to do this. Pro-life organizations, nonprofit organizations, community organizations that want to have these boxes in their community, and they're willing to put up the money for it and make the sacrifices to make sure that it's properly maintained. So, you know, the, the bill-- the $15,000 is to-- in the bill is just to help with insulation. It's a grant. But, but we are not-- the state is-- has no obligation to purchase these boxes, or main-- or provide funds to maintain them. It's up to the community, it's up to the fire chiefs, the police chiefs, the hospital administrators. If they want to do this, great. What we're providing in this bill is, is protection from prosecution for those parents who do surrender their child. And with that, I'll be happy to answer any questions.

HARDIN: Question for you. So, when we're dealing with a permanent scenario-- or, scenarios where we say that there are 24/7 manned fire stations, for example. Across the 93 counties, most of them are volunteer locations, so I'm assuming that volunteer locations do not qualify as manned.

HOLDCROFT: They do not qualify. There has to be a 24-by-7 operation.

HARDIN: OK.

HOLDCROFT: So, yeah. Volunteer fire departments will not be able to participate.

HARDIN: OK. Very well. Other questions? Seeing none. Let me point out that online, there were 128 proponents, 5 opponents, and 3 in the neutral. Thank you, sir.

HOLDCROFT: Thank you, Chairman.

HARDIN: This concludes the LB214 hearing for the day. Next up is going to be LB630 with Senator Hansen. We'll allow a few seconds for a reshuffle. Welcome, Senator Hansen.

HANSEN: Thank you, Chair. I think some members of the committee might be tired of seeing me. This, this is two of three times I've had to open up on a bill for some members here.

HARDIN: We could not be more glad that you are here.

HANSEN: That's nice to hear. And this is an easy bill. Shouldn't take very long at all. So, that's good.

HARDIN: That's what they all say.

HANSEN: Yep. All right. Good afternoon, Chair Hardin, and members of the HHS Committee. My name is Ben Hansen, that's B-e-n H-a-n-s-e-n, and I'd like to thank you for your time today. LB630 was brought to me by the Nebraska Occupational Therapy Association as they were finishing their 407 scope of practice update, with no opposition by the technical review committee. The green copy was introduced as a placeholder for the new language, as the OTs finished the 407 review process. Today, I bring you a white copy amended version of the bill, after changes were made per the final report from the technical review committee. Although we are waiting for the final vote from the Board of Health on March 17, we do not anticipate any concerns as their recommendations move to the attorney general and governor for

approval. The scope changes in the bill reflect the most current evidence-based occupational therapy service provisions across practice areas with varying populations. It includes clarifying the role of OTs, and providing interventions that support occupational performance, including additional training that may be needed; clarifies the use of dry needling; and promotes the ability of certified occupational therapy assistants to reflect current practice and modern entry-level education. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability and non-disability-related needs. The primary goal is to enable patients to participate in the activities of everyday life and engage in the occupations they want to, need to, or are expected to do, or by helping them modify the occupation or the environment to better support their life objectives. Prior to the submission of the OTs scope of practice 407 application, a great deal of work was done to reach out to other health professionals and institutions to receive feedback on the proposal, and changes were made even before the application was submitted to the department. This is a very clear and vetted proposal, which, as you know, is unusual for scope of practice changes. Additional details on the proposal will come with the testifiers today, but I am available for any questions. With that, I'd like, I'd like-- I like to-- I'd like your support for LB360-- or LB630. I was so close.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman. Just because I'm-- I don't know, but-- so, every time we do change the scope of practice, it has to go through the Legislature, then, to make it happen?

HANSEN: Depends on what you're going to do with that scope of practice. If you're looking to change the scope of practice or clarifying some things, but--

QUICK: OK.

HANSEN: Usually, for some occupations, they, they choose that route.

QUICK: OK. Can I ask one more question? So, do they ever do it through the, through the process too? It-- can they make changes like-- is it the 407 [INAUDIBLE] go through?

HANSEN: The 407 is almost an advisory--

QUICK: Advisory.

HANSEN: --role and recommendation role,--

QUICK: OK.

HANSEN: --to say, hey, look, we agree with the changes that you're making, or here are some recommendations that we would-- you know, we--

QUICK: OK.

HANSEN: --hope that you would use or change with the bill. So, that's kind of the purpose of the 407 process.

QUICK: OK. All right. All right. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hansen, for the bill. Just-- you mentioned there's a white copy amendment. Is that the one you-- I'm seeing AM529 that was-- it's posted on the legislative website. Is that the--

HANSEN: Yes.

FREDRICKSON: --the white copy? OK.

HANSEN: Yes.

FREDRICKSON: I just wanted to make sure I was reading the right one. Thank you.

HARDIN: And this would allow them to do things like dry needling?

HANSEN: Yes.

HARDIN: Wow.

HANSEN: Which is actually really great. I have, I have a, a chiropractor in one of my clinics in Omaha who does that, and it works very well, actually.

HARDIN: Yes. I have been an adherent. Questions? Will you stick around?

HANSEN: I will.

HARDIN: Great. Proponents for LB630. Hi.

MELISSA KIMMERLING: Well, hello. Good afternoon, Chairperson Hardin, and gentlemen of the Health and Human Services Committee. My name is Melissa Kimmerling, M-e-l-i-s-s-a K-i-m-m-e-r-l-i-n-g, and I'm here today to testify in strong support of LBC-- LB630. As an occupational therapist and the lead of the task force that went through Nebraska's credentialing review process, I would like to share our background, rationale, and answer any questions you may have about what occurred during that credentialing review process to provide further clarification and understanding of the bill. LB630 is a crucial step forward in addressing the outdated and limiting language present in the current statutes relating to the practice of occupational therapy. This bill is the result of our credentialing review, which we completed with unanimous approval from the technical review committee, who is reporting to the Board of Health on March 17. This bill presents updated language that reflects the current language of the profession, reflecting the American Occupational Therapy Association's Model Practice Act from 2022, as well as updated definitions of specific therapeutic procedures or modalities that have evolved in their breadth or use since the creation of the current statute. The language includes detail that is necessary for our often-misunderstood profession. Through the years, our profession has continued to run into challenges related to access to care and reimbursement for our services due to cross-disciplinary misunderstanding of our ability to contribute. The proposed language expands the detail of what occupational therapy professionals are concerned with, and reduces the barrier of potential misinterpretation due to our profession's unique language. The bill also clarifies the role of occupational therapy in providing interventions that support occupational performance that may require additional training for ethical delivery that is supported by the American Occupational Therapy Association's Policy E.18, published in 2023. This includes clarifying who and under what circumstances an occupational therapist can use the instrument-assisted modality of dry needling and physical agent modalities, and clarifying who and under what circumstances an occupational therapy assistant can use physical agent modalities. It also addresses feedback for various stakeholder groups that was provided during the credentialing review process. These changes not only addressed challenges encountered by occupational therapy professionals, but also create long-term positive outcomes for Nebraskans by settling-- setting our profession up for more detailed conversations with providers and payers about our ability to contribute to more positive outcomes and a values-based care environment. In addition, I also provided you a letter of support from the American Occupational Therapy Association who has been working alongside us throughout this process, and that is the

professional association that represents more than 213,000 occupational therapists across the United States. And with that, I'll take any questions you may have.

HARDIN: Long ago, there was a commercial on TV that said, "this is not your father's Oldsmobile." And I don't think today's modalities are our father's tools for doing PT or OT, and so on and so forth. There's quite an array of things that weren't here, really, even eight years ago.

MELISSA KIMMERLING: Absolutely. And our current statute, since-- since that was created, there are things that are in our current statute that require additional training per the current statute because they used to be new and exciting and innovative and not talked about in school that have been in school for more than 20 years, that are standard of care, something that everybody learns when they're going to occupational therapy school. Prior to 2007, occupational therapy was a mandatory bachelor's degree. It is now at least a mandatory master's, and most commonly a doctorate degree. So, you can only enter the profession at a master's or a doctorate degree to be an occupational therapist. And the bachelor's degree, now, is the occupational therapy assistant. So, we've seen significant increases in the amount of hours and time in school that we, we spend. We have more than 480 hours of on-site education at a clinical site prior to passing our licensure exam. We all must be licensed to practice, which-- not only do we graduate from accredited institutions, we also pass a national board examination demonstrating our understanding of entry-level practice for both the occupational therapists and the occupational therapy assistant. So, quite, quite a regulated profession; quite one that we have demonstrated our knowledge and understanding quite a few times before we are ever patient-facing.

HARDIN: Do these modalities actually hasten or even accomplish healing, or do they just help us feel better?

MELISSA KIMMERLING: You know, there is some value in just feeling better, but there is good data about many of these modalities, especially dry needling. Dry needling is new and exciting, and we are not proposing to be able to do that at entry level, but with the appropriate advanced training that we would need to work with the state board on determining exactly what that looked like. But we know in Nebraska we have an issue with opioid use, with chronic pain, and we believe that any health care professional that is able to address pain and the limitations that pain presents to an individual-- think about all the people who are on state incomes because of disability or

inability to return to work. If there is a modality that could be in our toolbox that we would be able to pursue advanced training in in order to address these concerns, we really want to contribute to the well-being of all Nebraskans by being able to do that.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I noted on your document here you have an EdD,--

MELISSA KIMMERLING: I do.

RIEPE: --which is commonly an educational doctorate.

MELISSA KIMMERLING: I do.

RIEPE: Is that different, though?

MELISSA KIMMERLING: Yes. No, I am full-time professor, so--

RIEPE: Oh, OK.

MELISSA KIMMERLING: --I've spent a lot of my career in higher education and academia. So, I entered the field when a master's degree was the minimum requirement of entry for an occupational therapist and have maintained my license, but I pursued my EdD when I became a college professor.

RIEPE: OK. I had second question, but-- oh, I know what it was. I wanted to ask you about going through the 407, if you will.

MELISSA KIMMERLING: Sure.

RIEPE: I mean, expanding scope of practice has always been rather resisted, and I think that that's been detrimental to rural health,--

MELISSA KIMMERLING: Yeah.

RIEPE: --and did you have any particular pushback that you thought was incredible-- I don't want names.

MELISSA KIMMERLING: Sure. No, that's good. Rural health had a lot to do with why we wanted to do that. You know, if I'm working in the city, if I'm working in Omaha and I'm not capable of doing something, there's 17 therapists on the floor that I would work on. I'm from Tekamah, Nebraska, a town of 1,500 people, and that would not be an option; if I was employed there, I would be the only individual. So,

we heard quite a bit about over and unnecessary regulation limiting access to care in our rural environments, and that had a lot to do with bringing this forward. But the credentialing review process was very positive. The intent would be to produce legislation that is, is clean and is without opposition, because any concern that any group had was addressed during the credentialing review process. We took feedback from the American Medical Assoc-- or, the Nebraska Medical Association to clarify when and in, in what situations an occupational therapist could diagnose. You will see a letter of support coming from them; I think it's in the letters that you have now. We worked with the Physical Therapy Association to make sure that it was very clear the difference between physical and occupational therapy, and they felt strong about our language. We worked with the physicians' association, the chiropractic association, who had specific feedback for us on clarifying where our work ends and their work begins as far as joint manipulation and things like that. So, the process helped us ensure that the draft language we are presenting you with today reflects the feedback from the constituent groups.

RIEPE: OK. I know Senator Hansen noted a chiropractor or--

MELISSA KIMMERLING: Yes.

RIEPE: --someone that he knows who does dry needling.

MELISSA KIMMERLING: Yes.

RIEPE: You mentioned dry needling.

MELISSA KIMMERLING: Yeah.

RIEPE: I think some physical therapists do dry needling, and--

MELISSA KIMMERLING: They do, and athletic trainers as well. Physical therapists--

RIEPE: Are there any hospital administrators that do dry needling? Or just needling people.

MELISSA KIMMERLING: Do you need it, or you want to learn how to do it, right? I-- there-- there's a lot of people, and it's, it's just a tool. Right? So, any health care provider that works with somebody who's experiencing pain-- we might be working with them on different goals or different things that they need to accomplish, depending upon what our profession is, but it's a tool that can reduce that pain. So, for example, I was in a car accident in the year 2000. I broke 18

bones, five in my back; I have a total spinal fusion for my third thoracic vertebrae to my first lumbar vertebrae. And 25 years later, I'm just now receiving this intervention for problems that developed in my shoulder from the fact that my spine doesn't bend. And this modality, for me, is helping me go back to work, right? So, an occupational therapist would be doing that. But maybe for an athlete who's limited in their performance, athletic training, physical therapy, different reasons we're working with people. But it's something that, with the right training, could be in multiple rehabilitation professions' toolbox.

RIEPE: I very much like the idea that different disciplines might do the same procedure, because in some-- particularly rural markets,--

MELISSA KIMMERLING: Yes.

RIEPE: --we might not have an occupational therapist.

MELISSA KIMMERLING: Absolutely.

RIEPE: We may or may not have a physical therapist. We may have a, a chiropractor there.

MELISSA KIMMERLING: That's right. And I think that's why you see--

RIEPE: We've got-- I think, as part of the health--

MELISSA KIMMERLING: Yes.

RIEPE: Addressing rural health care, that's something we're going to have to look at.

MELISSA KIMMERLING: Yeah I think that's why you see the support from the Nebraska Chiropractors Association and the APTA Nebraska chapter, is that we recognize that in a values-based care environment, we need to get the client what they need in, in the way that they need it, right? And that the-- what used to be maybe turf war type things that used to exist in health care cannot exist anymore. We have to be able to provide the interventions that the client needs at the right time and in the right situation. And in a perfect world, we would have teams of all of us, you know, in deciding who should do what. But you're absolutely right. My home town only has a physical therapist, and I would want that person to be able to utilize those modalities if my dad needed to go there, for example. But I don't want the fact that that person can to prevent the profession of occupational therapy, too. So, that-- that's a huge piece of what came forward in this bill.

But like I said, the profession has all-- also updated many documents within the last three or four years, so it felt like a very good time to bring the entire language up to date while also addressing those things that have been brought forward to us by our membership.

RIEPE: I know we talk team, but I'm not sure we do teams very well.

MELISSA KIMMERLING: I know, I know. I think it's something, as an educator, that we are trying to work a lot harder on in school, trying to create more opportunities to-- for interdisciplinary experiences, to talk more about learning what the other people do so that you not only know what you do, but you know who, who else does what and when to refer, and helping people understand their referral responsibilities, as well.

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

MELISSA KIMMERLING: Thank you.

HARDIN: Can I ask?

MELISSA KIMMERLING: Sure.

HARDIN: How long did your 407 process take, essentially, start to finish?

MELISSA KIMMERLING: Letter of intent, we put in in February, but we didn't get a technical review committee assignment until September. But once we got assigned, we went through our meetings very quickly. We did a October, November, December-- or, a November, December, January meeting. We met three times through the technical review committee here at the Nebraska State Office Building.

HARDIN: Less than a year.

MELISSA KIMMERLING: Less than a year.

HARDIN: OK. Very good.

MELISSA KIMMERLING: Yep.

HARDIN: Does my heart good, just like Senator Riepe, to hear that the process was a good one, that it actually benefits all of Nebraska, including rural Nebraska, and we're working together on this. There are a couple of members of this committee, a couple of gentlemen who

are of lower moral character who have maybe questioned that committee process. I'm half of them.

MELISSA KIMMERLING: Oh, OK.

HARDIN: And so, a couple of us have bills coming up on the 407, and--

MELISSA KIMMERLING: Sure.

HARDIN: Well, that's--

MELISSA KIMMERLING: The only limitation I would say, is, you know, a lot of us speaking are in academia because our clinical practitioners often don't have the flexibility to just attend these types of meetings, and those of us in academia have a little bit more control of our own schedules and are able to do that. So, there is some of that, you know, thinking about health care, the logistics for health care providers. But we were able to identify individuals on our Nebraska OT association that would be able to support.

HARDIN: Glad to hear it, because that's what we need from our 407 is to, to think about outcomes. And it doesn't mean that everyone's going to turn out the way this one did; this makes a lot of sense, so. Great. Appreciate you being here.

MELISSA KIMMERLING: I appreciate it. Thank you. Any other questions?

RIEPE: Thank you.

MELISSA KIMMERLING: OK. Thank you.

HARDIN: All right. Proponents, LB630.

ERIN WESTOVER: Hello.

HARDIN: Welcome.

ERIN WESTOVER: Chairperson Hardin and members of the committee, my name is Erin Westover, E-r-i-n W-e-s-t-o-v-e-r. I'm an occupational therapist and occupational therapy educator, and president of the Nebraska Occupational Therapy Association, or NOTA. I'm here to testify in support of LB630 and to ask for your support of the bill. Occupational therapy is a vital profession, supporting Nebraskans to live their lives to the fullest. We serve Nebraska's youngest citizens with barriers to healthy development, our elders needing support to stay independent for as long as possible, and every other age and

stage in between. We bring a unique perspective for supporting the health and well-being of Nebraskans through considering the whole person-- mind, body and soul-- as well as the environment surrounding them-- their homes, school, workplace, community-- to create solutions for maximizing engagement in daily life. Despite the powerful impact we have on the lives of Nebraskans, our profession remains less understood than many. One of the goals of LB630 is to provide enhanced clarity about the role and skill-set of OT practitioners. NOTA has fielded questions and concerns for at least a decade about our current scope, and discrepancies exist across the state in how OT practitioners interpret that scope. The brevity of our current scope has also limited OT practitioners for practicing and getting fairly reimbursed in areas that we are well-trained for, such as mental health. LB630 also modernizes language to match the progression of OT education over the last 18 years. Entry-level education requirements have shifted from a bachelor's to a master's degree, and our educational standards are updated every five years. Due to these advancements, training on physical agent modalities, for example, is now updated-- or is now provided in entry-level education. NOTA has consistently heard from Nebraskans about the added burden, the additional licensure currently required for modalities, as well as the barriers for OT assistants to utilize modalities, even if they are trained. OT graduates are also required to develop strong foundations of ethics and clinical reasoning, making them well-prepared to safely determine the need for additional training. LB630 better describes pathways required for application of these advanced practice skills, such as dry needling. On behalf of the Nebraska Occupational Therapy Association, the occupational therapy practitioners we represent, and the Nebraskans we serve, I urge you to support LB630. Greater clarity about OTs' role, modern language matching advancements of OT education, and clear guidance about advanced practice skills are necessary to provide the high-quality occupational therapy care that all Nebraskans deserve. Thank you.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none. Thank you for being here.

ERIN WESTOVER: Thank you.

FREDRICKSON: Next proponent for LB630. Seeing none. Is there anyone here to testify in opposition to LB630? Seeing none. Anyone in the neutral capacity? Seeing none. Senator Hansen, you are invited to close. While you come up, we did have some online comments; we had 55 proponents, 2 opponents, and zero in the neutral, neutral capacity for LB630.

HANSEN: See? All the scope of practice bills I bring you are just smooth sailing. This is probably like my tenth one, I think. And so-- all right. Don't have much to close on. It just did want to clarify that, and update you that we are working with DHHS to bring some clarifying language, kind of a clean-- a little clean-up with duplicative language in there, so there might be an amendment either on the floor, or I might ask the committee about it later on, so just FYI. But nothing major. Otherwise, I'm here to answer any questions, if anybody has any.

FREDRICKSON: Great. Questions from the committee? Senator Meyer.

MEYER: I just has an ob-- an observation, as I was listening to the testimony, that it appeared from my perspective that dry needling and physical agent modalities should be something that should be avoided at all costs, but I was looking through the bill just to get an explanation of what that is, and-- we can talk later [INAUDIBLE].

HANSEN: OK. All right. I look forward to it.

FREDRICKSON: Great. Other questions from the committee? Seeing none. All right. Thank you, Senator Hansen. That will close our hearing for LB630. We will now move on to LB210. Senator Riepe.

RIEPE: Yes, sir.

FREDRICKSON: You're welcome to open.

RIEPE: Senator Hansen's was far too easy.

FREDRICKSON: It was.

RIEPE: You ready for me?

FREDRICKSON: We're ready for you if you're ready for us.

RIEPE: Acting Chair Fredrickson and members of the Health and Human Services Committee, good afternoon. My name is Merv Riepe, it's spelled M-e-r-v R-i-e-p-e, and I represent District 12, which is Omaha and the city of Ralston. I am introducing LB210 to refine and strengthen Nebraska's prescription drug monitoring program-- known as PDMP-- and health information exchange. This bill makes targeted updates to ensure the system remains efficient, transparent, and accessible while maintaining necessary oversight. LB210 updates requirements for access to the PDMP by defining good standing for participants, ensuring that users have met financial, documented, and

data submission requirements as determined by the Health Information Technology Board. This will help streamline access for authorized users while reinforcing the integrity of the system. Additionally, the bill establishes a reporting requirement, mandating the designated health information exchange and program operators submit an annual electronic report to the Health Information Technology Board. This report will assess utilization and impact, allowing for greater accountability and informed policy decisions. To help cover administrative costs, LB210 introduces a structured fee on pharmacy benefit managers-- PBMs. This fee will be set at a minimum of 10% of the total non-federal portion of funding required to secure federal participation, not to exceed $2 million annually. The Department of Health and Human Services will be responsible for identifying any PD-- PBM that fails to maintain good standing within 60 days of noncompliance. To further clarify oversight, the bill requires consultation between, between the program operator, hospitals, and health systems, ensuring the parameters of the program align with the needs and realities of Nebraska's health care infrastructure. It also adds provisions for birth and death certificate records, ensuring these documents are managed effect-- efficiently within the system. To improve the bill and reconcile the concerns with the language, I am offering an amendment that's being distributed that refines definitions, streamlines reporting, and strengthens enforcement mechanisms. Specifically, the amendment clarifies the definition of good standing for access to the PDMP, ensuring participants have met all necessary financial and documented requirements. Second, it mandates an annual report from the program operator and health information exchange to the Health Information Technology Board, assessing, assessing system performance. Ensures-- three, ensures collaboration between the program operator and health care stakeholders to evaluate the program's impact. Number four, outlines a clear process for identifying non-compliant entities, including PBMs and health plans, ensuring they are reporting-- reported to the relevant regulatory bodies within 60 days. These updates provide greater transparency, accountability and efficiency, and refor-- "reforce"-- it-- reinforcing Nebraska's commitment to responsible health care data management while supporting providers and patients alike. I will answer any questions within the scope of my knowledge, but I will defer any technical inquiries to representatives from CyncHealth and other groups who will be testifying in support of the bill and its amendment. Thank you for your time and consideration.

FREDRICKSON: Well, I'm assuming in the scope of your knowledge as it relates to the bill.

RIEPE: I'm sorry?

FREDRICKSON: I was giving you a hard time. I said, assuming scope of your knowledge as it relates to the bill, LB210.

RIEPE: It's very limited.

FREDRICKSON: Yes. All right. Questions from the committee? Senator Ballard.

BALLARD: Thank you, Vice Chair. So, does a-- so, is there a cap on the fee for that, that-- the-- CyncHealth can--

RIEPE: I think it's set at this 10% and that's the intent.

BALLARD: 10%? And then I know we've talked about--

RIEPE: And it's not indexed with an inflationary--

BALLARD: OK.

RIEPE: --that I'm aware of. Now, if I'm wrong, that should be clarified, but--

BALLARD: OK. And then, I know we talk about this a lot in the committee, and I think you, you have concerns about this. But with a federal match, what happens if those federal funds go away? Is there provisions in the amendment? Sorry, I haven't got a chance to look at the amendment. Is there provisions, if that-- if the federal funding goes away?

RIEPE: I think if the federal funds go away to the significant magnitude that we have heard that they may, everyone's going to be impacted, probably, to some degree.

BALLARD: OK.

RIEPE: Including, including this, but-- everyone, probably up and down the line.

BALLARD: OK. Thank you.

RIEPE: That's only speculation on my part, but it, it-- it's a significant number that's being floated out there that we definitely have to be concerned about.

BALLARD: OK. Thank you.

RIEPE: Thank you.

FREDRICKSON: Other questions? Seeing none. Will you [INAUDIBLE] to close?

RIEPE: Absolutely.

FREDRICKSON: All right.

RIEPE: Thank you, sir.

FREDRICKSON: We will see you then. We will now take proponents for LB210. Welcome.

JAIME BLAND: Good afternoon. HHS Committee members, my name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I am president CEO of CyncHealth, which operates Nebraska's health information exchange and prescription drug monitoring program. I'm here today to testify in support of LB210, which would create a sustainable funding model for the health information exchange and prescription monitoring program. As a statewide HIE and PDMP, we are an integrated solution into the care experience, with queries to the HIE exceeding 750,000 unique queries per month for the HIE, and over 200,000 queries per month for the PDMP. Additionally, the information shared at the point of care supports a number of private and public purposes when it comes to the accessing and sharing of health information. Currently, the infrastructure is funded by state match for federal funds. To date, Nebraska has funded the state's share of Medicaid and public health costs of operating these programs through General Fund appropriations. The LB210 statutory framework is an assessment levied on CyncHealth. The funds generated through the assessment would be coupled with fees contributed by pharmacy benefit managers and managed care organizations to replace the general funds as the primary source of the state's share of the match funds required to support the infrastructure costs of the HIE and PDMP. The bill authorizes CyncHealth to charge a user access fees to help pay the assessment, which would be levied by the Department of Health and Human Services on a quarterly basis. CyncHealth has worked with various stakeholder groups in an effort to alleviate concerns over the details of the user fees and the incentive programs. The bill is intentionally administrative-- administratively permissible, to allow for flexibility in the future years for different programing through CMS and HHS. Upon passage of LB210, CyncHealth will work with the Department of Health and Human Services to submit an advance planning document, or APD, to CMS. We have worked on APDs for a better part of

a decade with DHHS, and have started the process and are working with consultant experts to ensure the programs are presented to CMS that allows for flexibility, but also for the model to work for providers, CyncHealth, and the state. The overall goal is for data to be enhanced to working with providers to adopt the interoperability standards that are already outlined in federal regulations, and for all hospitals to have incentives applied based on what is outlined in the APD ultimately approved by CMS. We contend that LB210 provides an innovative and sustaining-- sustainable funding model for the valuable health information exchange and the prescription drug monitoring program infrastructure and operations. In addition to my testimony today, I am also submitting a letter of support from our board of directors, which represent a majority of major health care systems and other key stakeholders in Nebraska, and I'm happy to take any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Ballard.

BALLARD: [INAUDIBLE] Thank you. It's good to see you, Jaime. Can, can you-- the, the question I asked Senator Riepe about the-- so, it's a 10% cap with the, with the PBMs?

JAIME BLAND: With the PBMs.

BALLARD: Did I understand, understand that right?

JAIME BLAND: Yeah, as I think it's currently addressed in the bill.

BALLARD: OK.

JAIME BLAND: I-- that's what I believe.

BALLARD: So, there would be-- so, kind of ballpark, do you know what that would be per, per provider?

JAIME BLAND: I don't know what-- so, I don't believe that it's a per provider cost, but-- and I don't think there's a direction about charging individual providers. That's not the intent. The intent would be that the fees would actually-- the fees that are assessed on to CyncHealth would be-- and to PBMs-- would be derived out of the APD. That APD process, we have to go through complicated math on different cost allocations for different programing, and how that is attributed to the Medicaid population. That is anywhere from 90/10 to 75/ 25 to 50/50, as far as the, the allocations go. So, I don't have an exact

number until the budget is approved by CMS, and then DHHS would then assess the, the fees.

BALLARD: OK. So, I do have a little bit of concern because CyncHealth is codified in statute, correct?

JAIME BLAND: The health information exchange is.

BALLARD: The health information exchange is codified in statute.

JAIME BLAND: Yes.

BALLARD: So, I guess my concern is that we are giving-- I don't want to call it a blank check, but there's still some ambiguity in the language, in my opinion. So, we're giving a, a blank check, for lack of a better term, to a codified mono-- codified private company in statute. So, how'd you-- can you respond to that? I have a little bit concern.

JAIME BLAND: Sure. I-- we have a board of directors that represent our-- the users, stakeholders, and those that pay the fees to the organization, and will pay the assessment fee, essentially, to the organization. These folks are long-term representatives of health care across the, the state. They-- we have worked with consultants around different funding mechanisms and funding models, and this is the one that they approved. So, those that are paying the bill have approved this funding model as it relates to the fees that CyncHealth is, is charging. So, ultimately, they have to approve the whole thing, so it's not CyncHealth as a private organization saying this is, this is the fee. We have a representative board who I've-- was listed there. They approve the fees every year, we go through a detailed budget process, there's transparency for those that are, are paying the acce-- the fees. So, it, it is fairly robust in, in the process that we go through to identify what the fee structure is every year. And those are actually then put into the APD and ultimately, again, approved by CMS. If CMS doesn't approve it, we can't bill for it, right? We can't charge the fee for it, or we can't do the project. So ultimately, there are several checks and balances to the work that we do.

BALLARD: OK. Thank you. And then, so would this move you away-- if I might, vice chair. So, would this move you away from General Fund obligations.

JAIME BLAND: It would move us almost completely away from General Fund appropriations.

BALLARD: OK. And then, so what is your General Fund request-- or, [INAUDIBLE] request, but through the department, what is the General Fund request from the appropriation? Do you know, off the top of your head?

JAIME BLAND: I don't know,--

BALLARD: OK.

JAIME BLAND: --off the top of my head. It's a few million dollars.

BALLARD: OK. I think there was some back pay as well, a couple of years ago.

JAIME BLAND: There was.

BALLARD: Like $8 million dollars in back pay. OK. So, that's kind of the understanding, this would move you all from taxpayer-funded is to private--

JAIME BLAND: That is the intent.

BALLARD: --to provider funded.

JAIME BLAND: Yes.

BALLARD: OK. Thank you.

FREDRICKSON: Other questions? Senator Quick.

QUICK: Thank you, Vice Chair. Like, so, does the department-- who, who pays, like, the access fees and--

JAIME BLAND: Right now, mostly hospitals pay the access fees, and then the state also has matched contribution. So, we're [INAUDIBLE] the same in the state's contribution, and then we have some private fees; those private fees would now be paying the-- what the department currently funds, from an appropriations perspective.

QUICK: OK. And that's-- is that laid that-- is that laid out in the bill itself?

JAIME BLAND: It is. Yeah.

QUICK: OK. All right. Thank you.

FREDRICKSON: Other questions? Go ahead.

BALLARD: Go ahead.

FREDRICKSON: OK. I, I, I have one. As I'm, as I'm, I'm reading this, this is-- it's reminding me a little bit of-- Senator Jacobson had a bill last year, I think was about the hospital providers assessment. Is this similar to that?

JAIME BLAND: It-- it's similar in that it's an assessment or a, or a tax on CyncHealth, but the funding mechanisms and regulations for health information technology costs fall under a completely different regulation through CMS and HHS.

FREDRICKSON: OK. OK. And would this, would this require a Medicaid waiver, if we were to do this?

JAIME BLAND: It does not.

FREDRICKSON: It does not? OK.

JAIME BLAND: No. The APD, the advanced planning document process that we work on with the data and systems folks at CMS, that-- that's the approval process in lieu of the waiver.

FREDRICKSON: OK.

JAIME BLAND: Yeah.

FREDRICKSON: OK. Other questions? Yep, Senator Ballard.

BALLARD: Thank you. I'm sorry. So, back to the question I also asked Senator Riepe about the federal ambiguity on-- just any cuts. What would be-- what would be your reaction to-- would, would you go back to general funds if there was some federal, some federal cuts?

JAIME BLAND: Well, we would definitely work with CMS on any adjustments. I think there's also, within the administration, a desire for better data for the country. So, the work that we've done in Nebraska has been highlighted by the administration as one of the models to, to look at for different state infrastructure. And although there are definite changes coming, I, I don't see the matched contribution going away fully. But, you know, if there's adjustments we need, need to make, like everybody else in health care is contemplating making, we will make those adjustments.

BALLARD: OK. And then I have another question that's out-- a little bit outside of this scope, if you don't mind. So, on the-- when it comes to data, who owns the data at CyncHealth?

JAIME BLAND: So, the data is owned by the data suppliers. So, we have contractual agreements with everybody that shares data with us, so. But it's at the point of generation that the data is, is owned. We have data rights; we don't have data ownership.

BALLARD: OK. OK. Thank you.

JAIME BLAND: Yep.

FREDRICKSON: Other questions. Seeing none. Thank you for being here.

JAIME BLAND: Thank you.

FREDRICKSON: Other proponents for LB210? Seeing none. Is there anyone here to testify in opposition to LB210? Welcome.

JEREMY CAMPBELL: Thank you. Good afternoon. My name is Jeremy Campbell, J-e-r-e-m-y C-a-m-p-b-e-l-l. I'm a physician assistant, and testifying on behalf of the Nebraska Academy of Physicians Assistants and the Nebraska Medical Association in opposition to LB210. Our opposition stems from the potential fees that could be imposed on providers for accessing the prescription drug monitoring program, also known as the PDMP, a system that was designed as a crucial public health tool, not an unfunded mandate. The concerning language appears in Section 1 on page 2 of the bill, where it states that the PDMP shall include, but not be limited to, provisions that allow any prescriber or dispenser of prescription drugs to access the system upon payment of any access fees charged to such prescriber or dispenser. This replaces the original language, ensuring that all prescribers and dispensers could access the system at no cost. Nebraska's PDMP was created as a proactive response to the opioid crisis and other prescription related concerns, aiming to improve patient safety and prevent misuse without adding financial barriers to providers. Established through legislation in 2016, Nebraska's PDMP became the first system in the nation to require reporting of all prescriptions, not just controlled substances. This comprehensive approach ensures that prescribers have access to complete medication histories, enabling informed decisions and enhancing patient care. Importantly, it was designed to be a free and accessible tool for providers recognizing that effective monitoring benefits public health as a whole. By introducing the possibility of access fees with no cap,

LB210 could create a financial disincentive for providers to utilize the PDMP, consistently weakening a system that has been instrumental in curbing prescription drug misuse. For small or rural practices where resources are already stretched thin, such fees could disproportionately impact access to this vital tool. If providers face a cost barrier, participation in the PDMP may decline, undermining its effectiveness in tracking prescription drug trends, identifying potential abuse, and ensuring appropriate patient care. I urge the committee to reject this provision and uphold the original intent of Nebraska's PDMP to serve as a free, accessible, and effective public health resource for all prescribers. Thank you for your time and consideration. I'll take any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? My question is-- so, you, you-- from-- if I understood you correctly, one of your primary concerns with this is that providers themselves would be charged. Is that from a private practice perspective? Or if you're working presumably at, for example, like a Nebraska Medicine, CHI, or an organization, would-- is your concern that they would still charge individual providers? Or-- walk me through that a little bit more.

JEREMY CAMPBELL: Correct. Yeah. So, my concern would be, is that the providers would be charged a fee to access this information. When-- being a practicing provider for almost 18 years now, the last thing we want is charged or another barrier to access-- accessing this information. We already have a "bizinya"-- busy enough time making the medical decisions, and then adding this extra step of actually accessing the PDMP, but now we always-- now, do we even really want to access it? Because now we have to pay for it, so we may just not choose to do it completely.

FREDRICKSON: OK. How is that accessed currently? Is there-- are there fees for that currently?

JEREMY CAMPBELL: No.

FREDRICKSON: No. OK. Other questions? Seeing none. Thank you.

JEREMY CAMPBELL: Thank you.

FREDRICKSON: Next opponent. Welcome.

JESSIKA BENES: Thank you. Good afternoon. My name is Jessika Benes, J-e-s-s-i-k-a B-e-n-e-s. I am a veterinarian testifying on behalf of the Nebraska Veterinary Medical Association in opposition to LB210.

Our opposition to this bill is rooted in the financial burden it would create for veterinarians by imposing potential fees for reporting controlled substance prescriptions to the prescription drug monitoring program, or the PDMP. This system was established as a critical public health tool, not as a pay-to- participate requirement. Veterinarians interact with the PDMP in a fundamentally different way than human health care providers. In 2014, we made up just 10% of the total submitters, and unlike physicians or pharmacists, we only report prescriptions for controlled substances, not all medications. Additionally, our access is limited strictly to veterinary data. If I look up a client's name, I can only see prescriptions for their animals that were written by myself or another veterinarian. I have no visibility into human prescriptions or a patient's full medication history, making our role in this system much narrower. Nebraska implemented the PDMP in 2016 as a proactive major-- measure to address concerns surrounding prescription drug misuse. Veterinarians fully support responsible oversight of controlled substances and recognize the importance of monitoring their use. However, LB210 introduces the possibility of new fees without any cap, which would unfairly burden veterinary practices, many of which are small businesses. Unlike large health care systems that can automate reporting, many veterinary clinics enter prescription data manually, making this requirement more labor-intensive. Adding a financial cost on top of that would be an undue hardship, discouraging participation rather than strengthening the system. Veterinarians should not face financial penalties for complying with a system designed to serve the public good. I urge the committee to reject this provision and maintain the PDMP as a no-cost effective resource for all who contribute to it. Thank you for your time and consideration.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? I have a couple. So, you, you mentioned the manual entry component. That would be across the board, not just for veterinarians, but for other providers as well? Or that would be specifically for a veterinarians?

JESSIKA BENES: It's specifically for veterinarians. So, most small practices, someone actually has to log in to the PDMP website, and has to manually enter each time, like, the client's information, their address, the pet's information, it-- the system itself doesn't hold any of that data, so each time I prescribe for a patient, I have to-- someone-- I, I own my own practice, and I'm the only employee, so I get to enter that data. So I'm typing in all that information each time that I'm doing a controlled drug. So, for example, one of my clients is on phenobarbital- their, their dog is on phenobarbital--

for the prevention of seizures. So, they are getting that medication every month. So, every month, I have to log in, I have to enter the client's information, the pet's information, as well as the medication information by hand. There are a few veterinary clinics that will actually use their veterinary software to just automatically input that data, but I would say for the most part, especially in your more rural practices, it's someone designated in the practice that enters that at-- basically, at the end of every day.

FREDRICKSON: OK. And, and, and so the-- and you would be using this, so-- I, I wasn't aware that there was controlled substances for the-- for pets, but that makes a lot of sense. I mean, so this is for monitoring potential misuse of medication by, like, the owners, or by the pets themselves?

JESSIKA BENES: Well, it's definitely geared to monitor the patients themselves. We have no-- or, the owners themselves. We have no control of-- over whether a dog is given that phenobarbital. But the bigger challenge is that I can only see what a veterinarian prescribed to the dog, so I don't know if they saw their human dog or went to their human pharmacist yesterday. So, I'd say, quite honestly, veterinarians aren't pulling it very often if we're concerned about a substance abuse problem; I would say more often than not, we would prescribe that through a human pharmacy, because they're more likely to pull up that data. I literally only have veterinary information, so I don't know if you've gotten that prescription ten times or once.

FREDRICKSON: Right, right. Thank you. Other questions? Seeing none. Thank you for being here.

JESSIKA BENES: Thank you.

FREDRICKSON: Next opponent for LB210. Welcome.

RYAN McINTOSH: Good afternoon, Vice Chair Fredrickson, members of the committee. My name is Ryan McIntosh, M-c-I-n-t-o-s-h, and I appear before you today as registered lobbyist for the Nebraska Pharmacists Association. I am also testifying on behalf of Nebraska Retail Federation and the Nebraska Grocery Industry Association. First, we want to thank Senator Riepe and his office for their openness and willingness to discuss this issue, as we can hopefully find a path forward at some point; and also, to CyncHealth for the same reason, for being very open about discussions on this issue. As you've heard from previous testimony, particularly the, the physician's assistant that testified before me, the prescription drug monitoring program is

a very critical component for the, for the health of all Nebraska patients. Nebraska is one of the only, if not the only PDMPs that requires reporting of all prescription drugs. This allows pharmacists to be fully-informed and able to identify all drug-to-drug interactions before actually dispensing a prescription drug. Hospitals are able to have complete and accurate lists of all drugs that the patient is on once admitted, even if the patient cannot communicate that themselves. We wholly oppose any effort to pass this cost on to pharmacists and require pharmacists to pay for a program that is so necessary to benefit patient health. Unlike the PBMs and the health insurers, pharmacists are not able to simply pass this on to consumers. We have widely-mandated maximum dispensing fees and what we get reimbursed for-- what pharmacists get reimbursed for by insurance companies or Medicare or Medicaid. So, there is no avenue to pass those costs along. This would have a very detrimental effect toward independent pharmacies that are already struggling all across the state. We appreciate CyncHealth's proposing an amendment that does not put the cost on the pharmacists, however, we're concerned that the PBMs will just pass this cost along to the pharmacy, so we're back to square one. Thus, we have not reached an agreement yet on any sort of amendment to resolve this issue. In the meantime, we are left wondering why we are trying to fix a program that seems to work so well. Again, we thank Senator Riepe and the stakeholders for, for being-- and the proponents for engaging the stakeholders on these issues and attempting to find a path forward. However, in the meantime, we request the committee not advance the bill until that is complete. Thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none. Thank you for being here. Next opponent. Good afternoon.

ROBERT M. BELL: Good afternoon-- good afternoon, Vice Chairman Fredrickson. Losing my voice, so bear with me. My name is Robert M. Bell, last name is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation, appearing today in opposition to LB210. I'm not going to read my testimony because I can't talk, but I want you to know that if there are fees charged to PBMs, those are going to get passed on to health plans that are going to get passed on to consumers. One. Two, if you open the bill and you go to page 13, line 26 through 28, it talks about that if an insurance plan doesn't currently promptly pay the fees, that is, that is a condition of doing business in the state of Nebraska. And I do know there's an amendment that would involve the Department of Insurance, but do know that when you talk about licensure of an

insurance company, of any-- really, any kind of license in the state of Nebraska, there are due process rights that go along with that. And as we try to negotiate proper data safety and, you know, use of the data that is going to CyncHealth, we don't want the hammer of "you're going to lose your license in the state of Nebraska" without some sort of due process protections that would go, go into it. So-- yeah. Have those, have those concerns. We have expressed those concerns to Senator Riepe's office and to CyncHealth as well. Welcome to have further discussions. CyncHealth is important to health insurance, but we don't believe this is the answer. So, thank you for the opportunity to testify.

FREDRICKSON: Any questions from the committee? I think they're going to spare you having to speak more if you don't [INAUDIBLE].

ROBERT M. BELL: God bless you. And I, I apologize to the transcribers. Good luck.

FREDRICKSON: Thank you. Next opponent for LB210. Seeing none. Is anyone here to testify in the neutral capacity?

JEREMY NORDQUIST: Good afternoon, Vice Chairman Frederickson, Chairman Hardin, members of the Health and Human Services Committee. I'm Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t. I'm the president of the Nebraska Hospital Association, here today representing our 92 member hospitals and 50,000 individuals that they employ across the state. Nebraska hospitals appreciate the vital role that CyncHealth plays in our health care ecosystem. There is no question that secure and timely exchange of health care information by providers can save lives and make our state healthier. We also appreciate the thought that CyncHealth is put into this concept. Appropriately funding this critical health care infrastructure is-- appropriately funding it is an expensive endeavor, and we need to look for ways that this does not become an unfunded mandate on providers. The NHA is testifying neutral today because our, our board just is not comfortable with the lack of clarity in the green copy of the bill or, or the proposed amendment that we have seen, have seen up till now. We understand that CyncHealth's reservations about it, including some specifics in the legislation, we-- as with a ten last year-- or, LB1087 last year, we know what we have to do. It's, it's a, it's a fine line to walk, sometimes, for CMS approval. But our members do not want to move forward without certainty in key areas. Is this mandatory participation if the-- mentioning the language that Robert Bell mentioned, the same is for providers about a condition of, of-- condition of doing business in the state of Nebraska. That's a, that's

a very heavy hammer. What are the upfront costs? What are the goals and specific projects to be funded? What are the timelines? How do hospitals receive reimbursement for the fees they pay? And if they receive reimbursement, how is that going to be determined? Our members have received a presentation by CyncHealth that generally covered these topics, and we've had many conversations, but we certainly need more clarity. Our members were told that no hospital would be required to participate, but again, not, not spelled out in the green copy of the bill. It's our understanding that CyncHealth, under this, would determine whether hospitals achieve data quality standards, which they establish under federal law and regulation, and then determine at which rate the hospitals will receive reimbursement. We've asked in January for clarity on some items and have not received those, to date; we remain hopeful that we can get those written details so all of our members have assurances that they'll be able to comply with the law and the parameters that would be set out under this bill. One of those items is the PDMP access fee, which remains unclear. We would want that to remain no-cost. Secondly, our members have asked that all NHA members have a voice in the process, not just a handful of members on the CyncHealth board. We would ask the committee to use language that's been in sever-- several recent bills; that's a-- that encourages them to consult with a statewide association representing a majority of hospitals or health systems. We believe this ang-- language should be included and ensure all hospitals have a voice. Finally, finally, we're committed to collaborating with the committee, DHHS, and CyncHealth to advance this concept. We have proposed working with CyncHealth and DHHS on an MOU outside of the legislation because there's only so much detail you can put into the bill, and certain items change. I have a red light here. I'll just finish up with-- an MOU would help all the partners understand what their roles and responsibilities are. We would ask that the committee hold action on the bill until we can get to terms on an MOU like that, and all hospitals have a clear understanding of what's expected of them. Thank you.

HARDIN: Thank you. Questions? Senator Ballard.

BALLARD: Thank you, Mr. Nordquist, for being here. And I appreciate the conversations we've had in the past regarding CyncHealth. Can you outline-- and I again appreciate kind of the tightrope you walk as well in., in testifying in the neutral. Can you testify kind of those conversations that went in with your members regarding this bill? I know you have some, some members that love CyncHealth and some members that struggle--

JEREMY NORDQUIST: Yeah.

BALLARD: --with CyncHealth. Can you kind of elaborate?

JEREMY NORDQUIST: Yeah, I think there's unanimous support for the need for PDMP, certainly HIE. You know, right now, yes, I-- we think-- yeah, I think membership thinks there's a need for that and needs to maintain that. There's certainly longer-term questions about how that plays out. There's bigger players with Epic and Cerner-- which is Oracle-- and how much they're gobbling up, that eventually that might be the HIE. But with entities like that there come big costs because, because they're big entities and they can demand those big costs. Certainly, we have, as you said, hospitals that, that deeply appreciate and are 100% on, on board with all the work CyncHealth's doing. Many of them are, are on their board and, and are very plugged in, and it is a number of our larger health systems. And then, again, there's a smattering of hospitals that question, you know, some of the-- some of the practices. I think ultimately, this comes back to-- and, and Speaker Arch came and spoke to our board a year and a half ago, and we had a really good conversation about it. And hopefully he doesn't mind me saying, but he kind of posed it as-- and I, I kind of agree-- that when we started with CyncHealth-- and I, I actually made the motion in the Appropriations Committee to get them their first $500,000 back when it was knee-high, back-- I believe it was 2011-ish. So, I personally have been a big proponent of this. But since that point, the, the relationship of CyncHealth to the state, to the people that, that it serves, has kind of not been as clearly defined, I think, as it should have. Obviously, it's not a state agency. From the beginning, we said it's-- the state can't do this work. Doesn't have the expertise to do it, can't pay people what's needed to pay them to do this work, so it's not a state function. We've also said it-- you know, this isn't a vendor because they're clearly defined in statute, identified in statute, so it's not a-- any private sector entity can come and compete for the business; it's something in between. And I don't know if you want to call that quasi-governmental or, or what it is, but when you're in that space, when you have the power of being in law and, and now, potentially, the power-- enshrined power to collect fees, you better have some pretty good guardrails and clarity in place in that situation to build trust from everyone who's doing it-- or, the-- for everyone that's participating. So, I think-- and, and Speaker Arch, again, talked to our board a lot about that, and that kind of said that's still not defined. And I think it doesn't necessarily need to be defined for LB210 to move forward, but I do think longer term, for everyone to feel comfortable with what this is, there probably needs to be more thought put into that.

BALLARD: OK. And-- excuse me. You said there a smattering-- do those members have-- do they have options when it comes to PDMP support?

JEREMY NORDQUIST: Not, not for, not for PDMP, no.

BALLARD: So, it's, it's kind of like a statutory-- I mean, lack of better-- a statutory monopoly--

JEREMY NORDQUIST: Yeah.

BALLARD: --on this, for this business.

JEREMY NORDQUIST: Yeah. And for the HIE, they would, they would have the ability-- so all, all hospitals have to submit data that was passed under-- I believe it was LB411 during COVID. But you-- right now, you don't have to pay to extract. That-- that's the question that's kind of left that, that isn't as clear here that we would like it to be clear, because we do have-- I mean, we have one of our four largest health systems in the state that doesn't right now pay, and they would prefer to keep it that way. They have other ways to get the HIE information from their health informa-- from their electronic medical record, and, and they would like to keep it that way. So, I think that's, that's the clarity that do-- at least on the HIE, that we would want to make sure that it isn't mandatory.

BALLARD: OK. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

JEREMY NORDQUIST: Thank you.

HARDIN: Neutral testifiers, LB210. Welcome.

JED HANSEN: Thank you, Senator Hardin. Well, thank you for the opportunity to provide testimony on LB210. My name is Jed Hansen, spelled J-e-d H-a-n-s-e-n, and I serve as executive director for the, for the Nebraska Rural Health Association, and I'm submitting testimony in a neutral capacity today. I spent a significant amount of time on LB210 over the past month, speaking with the CyncHealth team, many of our rural providers, state agencies, and other associations. And while there are still some ans-- unanswered questions, there's a little bit of what I do know. Support for CyncHealth is, is mixed. Most of our rural health care teams highly value the prescription drug monitor program. Some have found value or continue to find value in the health information exchange, and as Mr. Nordquist pointed out, some are very much in favor of the HIE. And many believe that there

are things that could be done better. LB210 is a response to the budgetary challenges that you all are facing. Cync needs a funding vehicle to cond-- to continue operating, and I believe that their leadership team is working in good faith to find a solution, and I especially appreciate their effort to reduce HIE fees for critical-access hospitals. The bill, as written, needs some work. The good standing criteria, along with others, including federal funding and the mandatory fees for PDMP, are all concerning from a rural perspective, especially with-- on federal funding "reliancy." I think that if there's anything that we know over the last, last six weeks that we never know where, where those dollars will come, and if they'll continue. I also know that we may not have a better alternative. While I do believe that there are PDMP alternatives that exist, the same cannot-- can't be said quite as much on the HIE side. National data exchanges do cover most of our hospital care in the state, but again, as Mr. Norquist [SIC] had pointed out, for-profit EHR vendors like Epic and Cerner are probably the most likely substitute. And with increasing AI integration, I think there's-- are serious concerns on what an out-of-state for-profit entity would have access to, and their abilities with Nebraska data. Cync as the in-state partner is likely the best option. Some of our hospitals would be left out without an HIE, as previously mentioned, and without both-- alternatives to both the PDMP and the HIE, and also a transitioning to, to a new entity would likely cause some interface fees and potential other hidden costs. And so, just kind of in summation, LB210 really needs to balance some of that funding relief that CyncHealth is needing, along with some of the help-- the, the funding, really, for our rural hospitals. We do need some clear oversight; we need some accountability and safety mechanisms in place to protect against some of these federal funding shifts. And additionally, PDMP funding models really do need to be reevaluated. We need to ensure that all of our providers have access to this, with concern that mandates-- with costs would, would include attacks.

HARDIN: You're in the red, but keep going.

JED HANSEN: And then really, we need to, to continue to look for sustainable solutions and looking forward to working with the Cync team on potential MOUs, so. Thank you, and, and happy to answer any questions.

HARDIN: Questions? Senator Ballard.

BALLARD: Both you and Mr. Nordquist mentioned the MOUs. Can you describe kind of what, what would be-- what'd be included in those?

JED HANSEN: Yeah. So, some of the concern with doing a complete rewrite of the bill and including specific guardrails would be that we could get into language so specific that it would-- wouldn't really be good legislation. An MOU between Cync and our hospitals, pharmacists, and providers could provide a means outside of-- a, a, a non-binding but, but certainly official means for us to be able to provide some of the clarity that this bill lacks at this time; making sure that in the case that if that federal funding match were to go away, that our hospitals would have an ability to, to, to shift out of, of this legislation so that they're not being taxed at an increasingly higher rate; making sure that we're understanding, from a, from an oversight standpoint with, with Cync, where, as it had been mentioned, we kind of have a, a quasi-government entity enshrined in statute, but then also has kind of the power of the purse as well. And so, making sure that there are guardrails in place there, I think, is a, a-- and I think-- I believe the Cync team has signaled that they've had some willingness, or that they're wanting to, to go this route as well.

BALLARD: OK. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

JED HANSEN: Thank you, Senator. Thank you all.

HARDIN: Neutral testimony, LB210. Senator Riepe. While Senator Riepe is coming back up, online, we had 1 proponent, 5 opponents, and 1 in the neutral.

RIEPE: Thank you, Mr. Chairman, for the opportunity to respond as well. I would first of all like to thank everyone that testified, regardless of the side. I believe that's the real beauty of democracy, and I, I appreciate and respect that always. I also, on another point, wanted to note that you, Chair Harding [SIC], and I both serve on the Banking and Commerce and Insurance Committee, and we have never experienced Mr. Bell not being able to speak, and I would-- I'm going to hang on to this moment for-- at least for the time being. My third point would be, is CyncHealth is a-- and more serious-- CyncHealth is a recent essential add to the management and-- of confidential information and data of health care delivery. I would also point out that Governor Pillen has priorit-- or provided for CyncHealth in his budget list of priorities, for the financial support of CyncHealth, which is a non-direct embrace of the function and of this particular bill in my, in my interpretation. I also wanted to point out to Senator Fredrickson that the hospital association ran a similar bill to generate more revenue. And by the way, it was-- I was reprimanded

when I called it a tax; they said, no, it's an assessment. So, the last speaker referred to it as a tax, and I would kindly ask him to consider it an assessment. Also, because it was such a lucrative piece, the Nebraska nursing homes also had a bill also-- all of these have been with Senator Jacobson-- and, and interestingly enough, the medical association had a similar bill to enhance its revenue. So, I find it a bit rich that the medical association would now oppose anyone else using the same vehicle to try to capture some revenue, because the bottom line is this: if the revenue doesn't come from the assessments of the users, then the, the cost of doing this business is going to fall to the, the General Fund or to the general government. And I think that's their interest, is-- we want the service, but we don't want to pay for it. I also, in response with the veterinarians, I-- it just happened to me because I've been around long enough, I guess. I was chair of this committee in 2016, and recall specifically in working with the veterinarians and their lobbyist to make special accommodations for the veterinarians at that time, to get them to, to sign on and join us. So, I think some of those concessions are quickly forgotten, and I just wanted to bring that back. It's one of the problems of having had someone around for that period of time and having that memory. So, with that, that's all I have.

HARDIN: Questions? My sense of CyncHealth is that we cannot live with them and we cannot live without them. So, my sense of them is that--

RIEPE: That's what-- that's what some wives will tell you about men, but, you know.

HARDIN: That's correct. And those wives are, are also very, very accurate. My understanding is that they have approximately a $100 million budget; $50 million of that comes from the federal government, $25 million of it comes from the state government, $25 million of it comes from private funds, if you will, those hospitals that participate in that situation. They're in an-- at one time, on one side of the coin, they have a very admirable and covetable kind of arrangement because, as we said with one of the earlier testifiers, they enjoy not being government, they enjoy not being a vendor; they kind of have a quasi-developed, evolved sort of state. And yet, I, I-- and these are just my own reflections. I promise there might be a question at some point at the end of this. It's just to kind of, I guess, regurgitate some of what I understand about CyncHealth, as the chair of this committee. And that is, the way things are, from, oh, I don't know, 20,000 feet up, it is not a settled situation, so I really appreciate any bill that says, let's take a look at this and see what we can do to better improve how things go. Certainly, there are those

hospitals-- as was pointed out by Mr. Hansen-- that very much cherish and relish their relationship; there are some that feel the opposite of that. When it comes to getting data, I have also humbly learned that we, in the Legislature, since the early 1990s, have contributed statutes. And I actually asked Mr. Faustman [PHONETIC] for some of those; he provided me with two of those statutes I have on another document that, frankly, kind of get in the way of CyncHealth being able to do their job. We didn't mean for that to happen, but it happened. Unintended consequences of legislation going clear back to the early 1990s, well before 2011. And so, it is a difficult situation, and we have a number of us-- and there's probably enough blame to go around, maybe not quite enough credit to go around the whole circle on this, but I, I definitely appreciate the fact that we're talking about this. As my psychology friends say to me, the three elements of dysfunction are "don't talk about it, don't think about it, and don't feel." Any hybrid of those will also do. And so I think we need to talk about it, we need to think about it, and we need to feel our, our way through it. And so, I appreciate very much the bill coming and, and I'm sorry I, I missed some of what was discussed earlier. But I think it's also important to know that we are working on this at a number of different levels and trying to say, how do we create the best, healthiest situation? I don't think there's anybody out there that will say, "hey, we have all of the data we need when we need it." No one says that. Who has contributed to that? I think we have plenty of blame to go around, I have humbly learned on this. And so, thanks for bringing a bill.

RIEPE: May I comment? I also wanted to point out that I think Senator Hansen was chair of HHS when we made the divide between separating-- or the decision to separate CyncHealth from DHHS. Is that correct? You were chair?

HANSEN: Depends if you're blaming me for something.

RIEPE: No, I'm not blame-- I'm not blaming you. I'm just saying this is the recent-- it's very recent, in terms of the challenges that we had. And we did that, as one of the testifiers-- I think it was former Senator Nordmeyer [SIC] from, from the Nebraska-- or Nordstrom [SIC] from the-- Jeremy from the Nebraska Hospital Association said we really couldn't afford to keep them and get the talent that we would have to have if we did it through DHHS. It was just-- but it was a-- quite frankly, a very contested issue, and it took some real leadership to get us through that. I also wanted to point out in the success of CyncHealth, the state of Iowa ran into a crisis-- I, I don't know all of the details, but with one of its hospitals-- and

they were closed down for, I think, a week or two weeks. It was one of the major hospitals, and I think it was in Des Moines. And CyncHealth went in there, and they now have an agreement to provide this service in Iowa. And to me, Iowa didn't have it, Nebraska did have it, and Nebraska was called in and-- to, quite frankly, bail them out. And then, because they were so good, they kept them on under contract. And I think that is-- bodes well for them. I think it's a, it's a program that we have to maintain. It's simply a matter of who's going to pay.

HARDIN: Questions?

RIEPE: And nobody, nobody wants to pay, but somebody's got to pay.

HARDIN: Senator Ballard is smiling while he raises his hand.

BALLARD: I, I-- a couple of testifiers mentioned guardrails. Do you agree there needs to be some guardrails?

RIEPE: I think there needs to be guardrails on everything.

BALLARD: OK.

RIEPE: Everything. Up and down, I don't care what piece of legislation it is. You got to-- yeah, you have to have boundaries, you have to have a lot of communication, and you have to have all of that. But the core piece is, you know, is it a-- is it a program you want to walk away from? I would say, oh, heck no. So, if you don't want to do that, do you have any alternatives? The answer is, probably not. So then, the question gets to be, is you want it, you like what they do, they've done-- been successful at doing it. Who's going to pay? That's the bottom line, in my opinion.

HARDIN: Other questions? Seeing none. Thank you.

RIEPE: Thank you. Thank you, gentlemen.

HARDIN: This concludes our hearing for LB210. We are up to LB632 and Senator Hansen. We're going to transition the room a moment. Well, Senator Hansen, that is perhaps the, the fastest transition of a room I've seen. You're up.

HANSEN: Good thing I put deodorant on this morning, I guess. All right. Good afternoon, Chairman Hardin, and members of the HHS Committee. My name is Ben Hansen. Again, that's B-e-n H-a-n-s-e-n, and I represent Legislative District 16. Today, I'm presenting LB632, a bill to require that health care facilities who perform elective

abortions provide for the dignified and safe disposition of the remains of those deceased unborn children. Nebraska Law, in Section 71-20 [SIC] already requires, with exceptions only for elective abortions, that every hospital in the state have a policy for the proper disposition of the remains of any baby at any stage of gestation who has died in utero. This policy is not only after 20 weeks or 12 weeks, or 6 weeks; it is required for any baby at any stage of gestation. Any baby that is miscarried or stillborn in a Nebraska hospital must have its body cared for and have its final disposition properly arranged. In my bill, LB632, the law would require that any health care facility in Nebraska that performs elective abortions has a responsibility to arrange for the disposition of the aborted baby's remains by burial or cremation. There are at least two important reasons for existing law and for this bill. The first reason is public health. Failure to provide for proper and safe disposition of human tissue and blood presents risks to the natural environment and the health of the general public by contamination of air, soil, and water. Existing law is in place partly because of the need to protect against these dangers. On the contamination of water particularly, the World Health Organization states that improper disposal of so-called health care waste, including human tissue, poses health risks through the release of pathogens and toxic pollutants into the environment, including through the contamination of drinking, surface, and groundwater. Where chemical disinfectants or drugs are present in tissue and blood, as in-- as is common in an abortion situation, the presence of these elements presents its own environmental issues if not properly disposed of. And where air, soil, or water is contaminated, it is self-evidently a public health risk. The second reasons for existing state law on the proper disposition of fetal remains is the fact that these are human bodies, and as such, they deserve to be treated with some measure of human respect. All of us understand the need and the desire to treat dead bodies, including the bodies of miscarried or stillborn children, with dignity. All of us understand the horror that is felt when a human body has been subjected to indignity, desecration, or neglect. Both reasons-- public and environmental health and the basic respect due to the bodies of the dead-- are as applicable to the tissue and blood of children who have died by elective abortion as to babies who have died from natural causes. On average, there are more than 2,000 abortions in Nebraska per year. Though not all elective abortions are completed inside a licensed facility, some of them are. In those circumstances, it makes sense to require that these bodies are cremated or buried to protect against environmental and public health risks. It is just as important, or even more, that their dignity is recognized and their

bodies are treated with some measure of human respect. The alternative is to be content with the possibility that bodies of these children will be treated as common garbage. This is a horrific possibility that has to be taken seriously, because such stories are unfortunately and revoltingly common in the United States. I'd like to give a few examples, and I apologize for those listening if this disturbs some people. In 2012, abortion clinics in Texas were cited for contracting with a medical waste company to drive to landfills and dump aborted bodies in with common trash. In 2014, horrified public officials in Oregon demanded that an incinerator immediately stop burning medical waste to produce energy for residential use after it was found that the bodies of-- and body parts of aborted children were being mixed in with the material for burning. In 2015, again in Michigan, abortion clinic directors admitted to disposing of aborted bodies by the use of garbage disposal and by storing body parts or whole bodies for months in freezers. In 2019, the preserved remains a more than 2,400 aborted babies were found in the garage of deceased abortionist Ulrich Klopfer in Illinois. Infamous abortionist George Tiller was known to personally burn the babies he aborted via a personal crematorium he kept in his own clinic. Infamous abortionist Kermit Gosnell, now in federal prison for various crimes, was known to keep baby body parts in jars and freezers on location in his clinic in Philadelphia. Finally, medical waste disposal companies such as Stericycle, which specializes in taking care of human tissue disposal for abortion facilities, have been found at various times over the years to have engaged in dehumanizing and illegal disposal of abortion remains. A couple examples are Stericycle being fined $72,000 in Washington state for illegal disposal that could potentially leach into groundwater, and in 2014, a $2.3 million settlement with the state of Utah for emissions violations in its disposal practices. There are many more examples. I think the ones I have listed illustrate the point. This never needs to happen in Nebraska. LB632 provides a simple, inexpensive preventative solution to this problem. I hope these terrible and horrifying things are not happening here, but we don't have to take it on trust. We can do something about it, as at least 15 other states have already. One final point, LB632 does not impose any duties or liabilities on the parents of aborted children. It is, it is also simply not applicable in a situation where an abortion is completed in the home. The only duties imposed by current statute is on the health care facilities to create safe and dignified policies. LB632 follows this process, and applies to only the health care facility at which the abortion is performed and completed. We can all agree that human bodies deserve to be treated with human respect. We can all agree on the importance of safe and effective practices to

public health. That's what LB632 is all about, and I hope you will join me in voting to advance this important piece of legislation. I just want to renumerate that-- because I-- from the emails that I have gotten, maybe it's-- I wouldn't say misinformation, but maybe misunderstanding of the bill-- that this does not affect hospitals, only those facilities who decide to do elective abortions. And since hospitals do not do that, they already have their own policy in place-- very similar to what we're introducing here-- already in place to dispose of human, human-- yeah, miscarriages and stillborn babies. So, this does not affect them since they do-- don't do-- perform elective abortions. It does not require or force the clinic or provider to discuss any disposal information to the mother unless the mother asks. So, we're not forcing them to do anything or, or give them any traumatizing information. Many other states already have this policy in place, like I mentioned earlier, and the one we actually kind of mirrored this policy after was actually Minnesota. You want to-- if, if-- many of you know Minnesota and their philosophy and policy on abortion is very "insimilar" to what Nebraska is, but they still had a good policy in place for this kind of issue. And again, no birth certificates are needed or issued or forced for the facility to do anything like that, so. I'll do my best to answer any questions, and there are some people behind me who can answer questions as well.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin. Does-- what's outlined in the bill, does that somewhat coincide with what hospitals are currently doing?

HANSEN: Yes. Nebraska law already requires every hospital to have a policy for disposal of the remains of any baby who died in utero by any cause other than elective abortion. So, this is very similar to what many hospitals already have in place.

MEYER: I have received some emails also, which I find problematic for me, frankly. I don't view this as medical waste. So, I appreciate you bringing this. Thank you.

HANSEN: Yep.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I'm going to brag a little bit on Bergan Mercy, because on any stillborn that they had, they held religious services and we had a cemetery-- a Catholic cemetery-- across. And they had--they invited the family, if the family didn't want to take

the stillborn. But it's-- you covered it in your last comment, I think, about-- this policy doesn't necessarily extend to hospitals.

HANSEN: No, it should not, because none of them are currently doing elective abortions.

RIEPE: As long as they have a policy.

HANSEN: Yep.

RIEPE: Yeah. So, I think it makes sense.

HARDIN: Other questions? Will you stick around?

HANSEN: I definitely will.

HARDIN: Thank you.

HANSEN: Thank you.

HARDIN: Proponents, LB632. Welcome.

MARILYN KLEIN: Hi, thank you. My name is Marilyn Klein, M-a-r-i-l-y-n K-l-e-i-n. I've never done this before, and I wasn't really pumped about going first, but I gotta go get my kids, so, here I am. I have five living children. This is my youngest, Veronica. You may have heard her squawking in the back; she's by far our loudest. And my husband and I also had two miscarriages in 2022. Our first miscarried baby, we named Gianna Elizabeth [PHONETIC]; she was miscarried at eight weeks. It was really important to us that we buried our baby. We buried her in Calvary Cemetery, and we buried our second miscarriage there as well. We were able to see her body, her hands, her feet. She was a person, and she was important to our family. She's important to us now, still. My kids talk about her and her brother. We don't know if they were a boy or a girl. And we have had friends who didn't know that they could bury their babies and have regretted that choice. And we have-- we've never met anyone who has regretted burying their child. So, I'm, I'm excited that this bill would bring awareness to all women in Nebraska that they would be able to bury their baby, and also to provide dignity to the smallest and most helpless among us. Practically speaking, it seems to impose no great hardship on these clinics, and so I just would like to offer my support for this bill. Thank you.

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

MARILYN KLEIN: Thanks.

HARDIN: Proponents, LB632. Welcome.

ANN SUYKER: You're welcome. Thank you. Good afternoon. My name is Ann Suyker, A-n-n S-u-y-k-e-r. I am a wife and mother. I am married to Doctor Andrew Suyker. We are the parents of six children: four living and two deceased. I am here today in support of LB632 due to my strongly-held beliefs regarding the value of each and every human person, and also because of my personal experience. My husband and I have the sorrow of losing two of our children in early pregnancy. John Chloe [PHONETIC]-- "J.C."-- was miscarried at 11 weeks. Our baby, Elijah Patrick [PHONETIC] was born at rest at 19 weeks. We had two very different experiences with our two babies. With J.C., due to different circumstances, we miscarried at home, and to my great sorrow, the body of our baby was lost down the toilet into the sewer system. To consider this reality is quite difficult even to this day, six years later. To truly ponder that the body of J.C. was in our sewer system is quite unsettling. It's a sadness not knowing his final resting place. Our baby Elijah was delivered at a hospital with great reverence. All the persons involved with his delivery and subsequent care handled his tiny body with greatest respect. We were able to hold him and look at his tiny face and hands and feet. We had a burial service for him with our family and he is now buried in a cemetery near our home. Our grieving full-- for Elijah has been easier knowing his body was treated properly and with the dignity he deserved. The value of a child is without measure, and regardless of how the life of a child is lost-- be it through abortion or miscarriage-- the body of that child is deserving of the utmost respect, and it is our duty as a human family to treat their remains properly. To treat the remains of the smallest members of our human family as medical waste is frankly appalling, and this bill hopes to address this disservice. This bill will ensure that the remains of the babies lost through abortion will not be treated as medical waste, possibly going through a decontamination, decontamination process, being incinerated, and maybe ending up in a landfill. We cannot treat our unborn babies this way. Therefore, I strongly support this bill. Thank you.

HARDIN: Thanks for being here. Questions? Seeing none. Thank you. Proponents, LB632. Welcome back.

SANDY DANEK: Thank you. Good afternoon again. 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. Years ago, when my husband and I suffered the loss of our baby in utero, our doctor scheduled me for a DNC where the body of our

baby was removed. I later learned his body was incinerated with the rest of the hospital's medical waste. To this day, I am still unsettled at the thought that my baby was denied the dignity of a humane burial or cremation. It just wasn't common practice to take the remains of your deceased pre-born child as it is today. Later on, when we had the same tragic experience with our daughter, we knew we wanted to take charge and have our baby buried. Medical technology has given us a window in the womb for the pre-born baby. This is a tiny human life worthy of respect and dignity, yet we determine the worth of a baby in the womb by whether it is wanted or unwanted. If a mom suffers the tragedy of the death of her wanted child during pregnancy, most are sympathetic and understanding of the family's need to bury or cremate the remains, laying the child to rest. However, if the baby is labeled as unwanted, then we callously define its body as garbage or medical waste. This protocol practiced by the abortion facilities in our state reflects a dehumanizing effect. LB632 seeks to provide the dignity and worth for an aborted child's remains; it encourages society to recognize the humanity of the pre-born baby. Perhaps it brings us closer to a culture where abortion is unthinkable. Without this regulation, abortion facilities are free to dispose of these remains in any way that is cost-effective, likely a third-party disposal company that incinerates the remains with other medical matter. I respectfully ask you to advance LB632 from the committee. Thank you.

HARDIN: Thank you. Questions? Senator Riepe?

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

SANDY DANEK: Mm-hmm.

RIEPE: I think there's about 2,000 or 16-- I think the state-- didn't we pass a law that was for miscarriages, for acknowledgment?

SANDY DANEK: Yeah, it was a certificate that would acknowledge--

RIEPE: Certificate of something?

SANDY DANEK: It acknowledged the death.

RIEPE: Is that still being utilized?

SANDY DANEK: Mm-hmm.

RIEPE: Is it some?

SANDY DANEK: Yes.

RIEPE: And how is that distributed? Do the institutions--r

SANDY DANEK: Through the hospitals.

RIEPE: The-- are they using them?

SANDY DANEK: I'm sorry?

RIEPE: Do you know if they're using it?

SANDY DANEK: I believe so, yes.

RIEPE: Are they? OK.

SANDY DANEK: It's my understanding that yes. That's true.

RIEPE: It's a different subject than this, but that's--

SANDY DANEK: Well, it isn't because the--

RIEPE: Well--

SANDY DANEK: You know, I think it-- what it does is it acknowledges the humanity of the child. And while, while a woman might be in the circumstances where she chooses to not continue the life of her child, it's still a human life that we should be paying respect to as a state.

RIEPE: OK. Fair enough. I was just--

SANDY DANEK: Yeah.

RIEPE: OK. Thank you.

SANDY DANEK: Mm-hmm.

RIEPE: Thanks for being here.

SANDY DANEK: You bet.

HARDIN: Other questions? Seeing none.

SANDY DANEK: Thank you.

HARDIN: Thank you. Proponents, LB632. Welcome back.

NATE GRASZ: Chair Hardin, members of the committee, my name is Nate Grasz, N-a-t-e G-r-a-s-z. I'm testifying in support of LB632 on behalf of the Nebraska Family Alliance to uphold basic human dignity, and because no child should ever be treated like medical waste. In elective abortion, after the pieces of an aborted child's body have been reassembled to ensure that no part of the child has been left in the mother, that child's body is then callously treated as medical waste. This is the tragic reality of the dehumanizing logic of abortion. If a baby at that same age were, were miscarried in a hospital, they would be provided humane disposition through burial or cremation. But in Nebraska, aborted babies are denied this basic human dignity, and the remains can be treated as medical waste and discarded in dumpsters, landfills, flushed down toilets, or worse. Planned Parenthood says that requiring fetal remains to be buried or cremated is unnecessary, even inappropriate. Remember those words. In 2010, authorities discovered the remains of 47 aborted babies-- including one frozen inside a water bottle and jars of severed baby feet-- stacked inside refrigerators at an abortion clinic in Philadelphia. In 2014, NBC news reported that aborted babies in Oregon were being routinely burned at an incinerator to generate electricity. In 2015, authorities in Ohio brought attention to Planned Parenthood's practice of steam-cooking human remains before dumping them in landfills. In 2016, leaked footage from the National Abortion Federation conference showed a Michigan abortionist stating many abortion clinics were using garbage disposals to dispose of human remains. And in 2019, authorities in Illinois discovered the remains of more than 2,000 aborted babies in the garage of an abortion doctor's home. Boxes and bags stuffed with the hands, fingers, toes, and heads of aborted babies. So, what is unnecessary? What is inappropriate? Requiring human remains to be treated with the basic human dignity, or to be labeled as medical waste and treated like garbage. At least a dozen states have passed legislation to prevent such callous and inhumane treatment from happening, and we must now confront the grim realities of the abortion industry in Nebraska. While these babies have been denied dignity and life, their lives were not without value, and they have not been forgotten. We urge the committee to advance LB632 to provide hope for a future where every person is seen as deserving of love, protection, and human dignity. Thank you.

HARDIN: Fundamentally, why does that laundry list of things that you just give us a sample of take place?

NATE GRASZ: Thank you for the question, Senator. You know, that list sadly didn't take very long to compile. There's many more examples, and I think it strikes at, again, the, the dehumanizing nature of the

way that unborn children are, are viewed or not viewed and treated, and sort of the inconsistency in how these lives are viewed and treated, depending on if they are lost or miscarried in a hospital, as Senator Riepe mentioned, and, and the honor and respect and care that has shown for the families and for that child versus if a child at that same age is, is aborted in an abortion clinic and then discarded as, as trash. And as was mentioned earlier, I think as a culture, as a society, regardless of how people approach the issue of abortion, I think as, as a society, as a state, we can do better.

HARDIN: Other questions? Thanks for being here.

NATE GRASZ: Thank you.

HARDIN: Proponents, LB632. Welcome.

MARION MINER: Thank-- excuse me. Thank you, and good afternoon, Chairman Hardin, and members of the HHS Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advancing the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. The conference supports LB632, which would require that a licensed health care facility that performs an elective abortion make provision for the burial or cremation of the aborted child's remains. Nebraska law, since 2003, as Senator Hansen stated, has already required that every hospital in the state have a written policy, and the only exception to this requirement is for children who die by elective abortion. Where a child has died by elective abortion, there is no provision in Nebraska law that imposes any duty on a health care facility for the disposition of the child's bodies. Abortion facilities are the only licensed entities in the state, to our knowledge, that perform elective abortions. What they presently do with the body parts of dead, unborn children in Nebraska is anyone's guess, and in the eyes of the law as it currently exists, it does not matter. It should matter. I'm going to go ahead and skip in, in my-- forward in my prepared testimony, because much of what I have prepared has already been said, so I, I won't belabor the point with many of these details. But I think it's, it's worth re-emphasizing one thing in particular, which is that even where these abortion facilities have contracted with others, like Stericycle, for example, to, to take care of, to facilitate the removal and the disposal of these remains-- even in those circumstances, there have been atrocities and abuses that have been found to, to, to be committed. Senator Hansen mentioned two cases in particular, one in Washington state, which has very few

abortion laws at all, but has some regulation with regard to the disposal-- disposition of fetal remains. The state of Washington fining Stericycle for disposal practices that could have leached into groundwater, and then the state of Utah extracting a $2.3 million settlement from that same company contact-- contracted with by many abortion providers for emissions violations, meaning they were using incinerators to, to dispose of children's remains, and that they were not working properly and so were polluting the air. So, even where the abortion facilities say, listen, we have people who take care of this for us, the fact is that anybody who's connected with this industry, that the history has been that they don't tend to view-- because of the way that they tend to view these little persons, which is as not people but simply as byproducts of a procedure that makes money for them, they don't tend to be very careful about how this is done. So, I'll wrap up there. We think LB632 is a very simple, very direct, and very common-sense requirement, both for public health reasons, but from our point of view, more importantly for the dignity of these unborn children.

HARDIN: Thank you. Questions? Seeing none.

MARION MINER: Thank you.

HARDIN: Proponents, LB632. Welcome.

LEONARD STOHLMANN: Thank you. Members of the committee, thank you for letting me speak. My name is Leonard Stohlmann, L-e-o-n-a-r-d S-t-o-h-l-m-a-n-n. I'm from Manley, Nebraska. I'm here to represent myself. I'd just like you to consider this bill, LB632, and advance it. It's just the right thing to do. Thank you.

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

LEONARD STOHLMANN: You're welcome.

HARDIN: Proponents, LB632. Welcome.

SCOTT THOMAS: Thank you, HHS Committee. My name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s, from Village in Progress Nebraska and USIDHR. I support the bill. Would urge the committee to advance it out of committee. And I wish that every bill was this easy for me to support. This bill protects the broader dignity of humanity. I think we've already heard a couple of testifiers speak to that; the senator spoke to that when he introduced it. The, the theory of social contracting posits something like because every law is underpinned by force doctrine, the government has an objective duty to act-- or, has a duty

to act from a position of objective morality, so. Doing things that protect the dignity of humanity, like I said, I, I don't see anything objectionable about this bill at all. So, that's all I have.

HARDIN: Thank you.

SCOTT THOMAS: Unless you guys have any questions, appreciate it.

HARDIN: Any questions? Seeing none. Thank you. Proponents, LB632. Opponents, LB632. Welcome.

SPIKE EICKHOLT: Good afternoon, Chair Hardin, and members of the committee. My name is Spike Eickholt, S-p-i-k-e E-i-c-k-h-o-l-t. I'm appearing on behalf of the ACLU of Nebraska in opposition to LB632. I apologize, I didn't tell Senator Hansen I was going to testify in opposition. He probably expected our opposition, but I normally like to check in beforehand. The concern the ACLU has with this bill is the impact that this bill is going to have on health care providers and abortion care. I understand that there apparently is a law now that requires hospitals to have some sort of policy regarding disposal of still-- stillborn babies or other deaths, but this bill does not amend whatever statute that is. Instead, this is a, a brand new section in law that has some terms and some impact that's going to impact abortion care. If you look at the bill itself, the term uses the-- the bill uses the term "health care facilities." That's not defined. It's not necessarily limited to hospitals. It could be doctor's offices, it could be a Planned Parenthood. There's a definition of health care facilities that's very broad in Section 30-603(9). That would include a healthcare facility that's licensed or any facility that provides health care. The voters recently-- last fall-- did affirm or at least put in our constitution a 12-week ban, if you will, at least some sort of accommodation and recognition that people have a right to get an abortion up to 12 weeks in certain circumstances. 82% of the abortions in the state were medication abortions. And the way that-- and we heard some of the testimony for referring to surgical abortions, but the majority of abortions in the state are medication abortions, and the way that it works is that the patient goes to the health care facility where they are given the first of the two pills. They take that at the facility. In other words, that is where-- if the term "performed" means that, that is where the abortion service is performed. The second pill that's, that's required by the two-pill medication procedure is taken at home. In other words, this bill does not accommodate what happens in those situations with the remains, if you will, of the abortion process. It's not happening at the facility; it's happening at the patient's home or some other place like that.

That's one issue that we have. The concern that we have as well is that the impact this bill might have on the health care facility or even doctor's offices may deter physicians from prescribing what would be normally prescribed as far as an abortion. The term "elective abortion" is used, but that's not defined. That could be a medically-advised abortion. That is something that a patient has who necessarily was not looking to terminate a pregnancy, but was advised to do so for medical purposes. So, for those reasons, we'd encourage the committee to not advance the bill. I'll answer any questions if you have any.

HARDIN: Questions? So, your thinking, Mr. Eickholt, would be that if those two things could in some way receive greater definition, that you would have no other challenges with this particular bill.

SPIKE EICKHOLT: I think that if we would-- if we could refer to what we mean by elective abortion-- and the proponents are talking about surgical DNC procedure is what it sounds like to me-- that are actually done at a hospital or a facility where they would have the remains, that would be one thing, right? But what you have here, there's just no real reference to that. And as I said before, the majority of terminated pregnancies, abortions, are not that. 80% are the medication abortion.

HARDIN: And we're doing about how many abortions a year in Nebraska right now?

SPIKE EICKHOLT: I think a couple of thousand, if I remember. DHHS does-- I'm not sure of the number. I think somebody might know. I think a couple thousand a year.

HARDIN: A couple thousand?

SPIKE EICKHOLT: I'm not certain of that. I know DHHS keeps the numbers. I normally would look that up when I come testify on something like this, but I just had to jump from another committee hearing.

HARDIN: So, as written, this may apply to the other 18%.

SPIKE EICKHOLT: It might, right.

HARDIN: I see. OK. Any other questions? Senator Meyer?

MEYER: Thank you, Chair Hardin. My definition of elective would be someone that's choosing to do something, which I would think a chemical abortion would fall under the same category.

SPIKE EICKHOLT: It could.

MEYER: It certainly could.

SPIKE EICKHOLT: OK.

MEYER: Thank you.

HARDIN: Other questions? Seeing none. Thank you. Opponents, LB632. Welcome.

ANDI CURRY GRUBB: Good afternoon, Chairperson Hardin, and members of the Health and Human Services Committee. My name is Andi Curry Grubb; that's A-n-d-i C-u-r-r-y G-r-u-b-b. I'm the state executive director of-- in Nebraska for Planned Parenthood North Central States. Our mission is to advance and protect sexual and reproductive health care for all, and we do this through our health centers, public education, and community engagement. I'm here on behalf of PPNCS to oppose LB632. This bill is vague and unworkable, and it does nothing other than burden abortion providers and patients, shame and stigmatize care, and further remove patients' control over their own health care. I would respectfully ask the committee to consider what the purpose of this bill is. It has absolutely no impact on the health and safety of Nebraskans. Instead, as with most of the anti-abortion legislation we are seeing this year, the bill is nothing more than an attempt to put abortion care further out of reach for Nebraskans. While we broadly oppose any attempt to stigmatize and unnecessarily restrict abortion care, I will highlight some of the specific concerns we have with this bill. The term "elective abortion" is not a medical term. At Planned Parenthood, we see patients that are seeking abortion for a whole host of reasons. Some are victims of rape or incest; some are sent by their OB-GYNs because there is a threat to their health; some, like a woman that testified here a couple weeks ago, have medical conditions that make pregnancy life- threatening; some have received a heartbreaking diagnosis for their pregnancy. Using a vague and non-medical term to determine how and when this bill is implemented is unworkable. Number two-- and I believe Senator Hansen attempted to clear this up, but I would, I would argue that is still incredibly vague in the bill-- as a result of the 12-week abortion ban in our state, the majority of patients here choose medication abortion. Patients seek medication abortion for a range of reasons, one of which is because they can

complete the process in the privacy of their homes and with the company of loved ones, and at a time of their choosing. There is no clarity in this bill regarding how to implement the disposition restrictions in those situations. Number three, by mandating that every health care provider offering abortions buries or cremates any pregnancy tissue resulting from abortion, the bill is effectively imposing a funeral requirement after abortion at any stage of pregnancy. This is shortsighted and disrespectful. Abortion providers like Planned Parenthood already work with patients on a case-by-case basis to answer any questions they may have regarding the disposition of fetal tissue, including honoring any specific requests they may have in accordance with state law. However, the bill applies a one-size-fits-all approach that is inappropriate for medical care and for personal choices like this one. In addition, by requiring either burial or cremation, the state would be imposing religious and spiritual views on any person who has an abortion, regardless of how they feel or what they believe. Mandating these decisions for a patient is wrong and insulting. All of these issues highlight that this bill is unserious and simply a political statement. As with other health care, decisions about abortion should be left to patients, their families and their health care providers, and we should respect a person's ability and right to make these deeply personal decisions for themselves, without shame and without unnecessary interference from the state Legislature. For these reasons, we respectfully request the committee not advance LB632 out of committee. Happy to take any questions.

HARDIN: Questions? I have a question. What do you do with remains now?

ANDI CURRY GRUBB: Sure.

HARDIN: Planned Parenthood, for example.

ANDI CURRY GRUBB: So, I, I would love to clarify a little bit that what we do currently is completely in line with what most other health care providers who deal-- who manage fetal tissue do. I would argue I, I think there's a lack of clarity about what the existing law is in regard to managing fetal tissue. The law says you have to have a policy. It doesn't say that the policy has to be to cremate or bury. So providers, OB-GYNs who manage miscarriages, things like that, they have a policy in place. That policy does not require them to bury or cremate fetal tissue.

HARDIN: Which would be different than, evidently, what Senator Riepe referred to as, you know, the approach of their hospital.

ANDI CURRY GRUBB: Exactly. There are quite a few-- I would argue, actually, that any facility that is not religiously-based likely has a policy that is fairly generic and allows for, for the, the disposition of fetal remains in very similar ways. There are many religiously-based hospital systems, particularly here in Nebraska, that have a policy that is very specific to their religious basis that does require a certain type of disposition that aligns with the religious beliefs of that particular institution. Other health care facilities that do not have that basis in a religious view, they do not use those same types of policies.

HARDIN: OK.

ANDI CURRY GRUBB: Our policy aligns with OB-GYNs across the state.

HARDIN: OK. Are these human remains?

ANDI CURRY GRUBB: This is fetal tissue.

HARDIN: And so how do you know they're not human remains?

ANDI CURRY GRUBB: I mean, if that's-- is that-- if you're asking a question about life and when it begins and things like that, I think that's--

HARDIN: How do you-- how do you know they're not human remains?

ANDI CURRY GRUBB: I think that's a question that has been debated for millennium. And I'm, I'm not sure that my personal opinion on that is, is particularly relevant.

HARDIN: Since you're here, I think it's very relevant.

ANDI CURRY GRUBB: I, I disagree. Respectfully.

HARDIN: As a testifier, I see that you're not willing to own your testimony,--

ANDI CURRY GRUBB: That's--

HARDIN: --and I think that's a problem.

ANDI CURRY GRUBB: I--

HARDIN: Any other questions? Seeing none.

ANDI CURRY GRUBB: Thank you.

HARDIN: Opponents, LB632? Those in the neutral? Senator Hansen. Once again, Senator Hansen is breaking records on line. Proponents, 141; opponents, 124; neutral, 5.

HANSEN: I think I broke the record for the amount of babies testifying this year, too, maybe.

HARDIN: That's probably the case.

HANSEN: With mothers carrying babies, this--

HARDIN: The midwifery bills. And thank you; had it not been for you, I would never have learned to pronounce the term "midwifery."

HANSEN: We're learning.

HARDIN: Yes.

HANSEN: Again, I, I-- when I look through a lot of the online comments in opposition, I just want to clarify some of the-- some of the opposition that I've heard, that this does not affect women who are having abortions at home. Spike-- Mr. Eickholt from the ACLU-- I-- I'm more than willing to work with them if we need to maybe clarify some language to be more specific with some things, if we need to. Not totally against that so long as it doesn't take away from, like, what we're trying to accomplish with the bill to make sure things are done in a safe and, you know, safe manner. This does not require mothers to bury the babies themselves or any of that kind of [INAUDIBLE]. This is just some of the comments that I've heard online. Just making sure I clarify some things. They say policies are already in place; they are not. And so, this is actually putting a policy in place. And I would think-- I wouldn't think this would be a controversial issue. I know some of us are-- have different opinions on a woman's right to an abortion and varying degrees. I think something like this, it-- I wouldn't feel it would be a controversial issue, because it deals with the respectful disposition of human remains, just like we do with funeral homes; we have policies in place for them to make sure it's done in a safe manner and respectful manner. We require hospitals, yes, to have a policy in place. And so, I wouldn't-- this is something that's not uncommon, it's something we've done before in legislation. And this does not increase or decrease a woman's right to an abortion. I want to clarify that. And if we don't bury or cremate them, then what do we do with them? Nobody's really answered that, and I haven't seen a whole-- I-- no-- I-- this-- that's the clarifying kind of question that I would like to hear, and I've never heard a testifier

grasp at so many straws as I had heard from Planned Parenthood. The arguments she gave, I think I spelled that, you know, succinctly in my opening about the term elective abortion. I know Senator Eick-- Mr. Eickholt brought that up, too. That's something we can kind of look at, too, if we need to define that in, in the, in the bill. And the whole idea that most patients use medication abortion doesn't pertain to this bill. We're not talking about that, again. When they-- when they're at home when they're having an abortion, that does not pertain to this. Whenever somebody-- especially testifiers-- call you disrespectful and insulting, that usually means you're winning the argument, and they can't think of other arguments to use besides call you names, which the testifier from Planned Parenthood used twice. And I-- I'm still trying to grasp the idea that this is imposing religious or spiritual views on people, because, again, this has nothing to do with that whatsoever. So, with that, I will-- I'll take any questions if senators have any, and I hope that we can vote this out of committee and onto the floor.

HARDIN: Thank you. Questions? The numbers. If, if there are around 2,000 abortions that happen, and if 82% of them are chemical and 18% are remaining, just to use that as a notion of a number, that would be about 360 a year that this would be pertaining to, to Mr. Eickholt's point. And to your point, you're willing to have that discussion with him. Is that right?

HANSEN: Yeah. And I appreciate him coming in clarifying, like, his opposition in a respectful way, you know, and actually willing to say, hey, look, this is maybe some things you can kind of work on.

HARDIN: Right.

HANSEN: And so, I always appreciate bring-- people bringing solutions--

HARDIN: Right.

HANSEN: --if they can.

HARDIN: Right. Right. He does that. Yes.

HANSEN: He-- he's an all right guy.

HARDIN: He's an all right guy.

HANSEN: Most of the time.

HARDIN: Yes. Any other questions? Seeing none.

HANSEN: Thank you.

HARDIN: Thank you. This concludes our testimony today on the hearing for LB632 and our work for the day. Thank you.