LATHROP: Good afternoon. Good afternoon. My name is Steve Lathrop. I am the state senator from District 12 in Douglas County, which is Ralston and parts of southwest Omaha. I'm also the Chair of the Judiciary Committee. And is our custom, I generally start out by giving sort of an overview of the process and kind of how we run-- run a committee hearing, just so you know what to expect, and if you want to testify, what's expected of you. We appreciate the fact that you're here and we know that there are a lot of people that want to be heard today. So let me start out with this. On the table inside the doors when you came in you'll find yellow testifier sheets. If you plan on testifying today, please fill one out and hand it to the page when you come up to testify. This helps us keep an accurate record of the hearing. There is also a white sheet on the table if you do not wish to testify but would like to record your position on a bill. Also for future reference, if you're not going to testify in person on a bill but would like to submit a letter for the official record, all committees have a deadline of 5:00 p.m. the day before the hearing to get letters included into the record. We begin bill testimony with the introducer's the opening statement. Following the opening we will hear from proponents of the bill, then opponents, and finally anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We ask that you begin your testimony by giving us your first and last name and spell the name for the record. We utilize an on-deck chair, actually an on-deck row, which is the front row here on my right and your left. Please keep the on-deck chair or the on-deck row filled with the next person or persons to testify, to keep the hearing moving along. If you have any handouts, bring at least 12 copies and give them to the page. If you don't have enough copies, the pages will help you by making more. We utilize a light system and this is going to be particularly important today because we have seven bills to be heard. And when I'm talking about the light system I'm referring to this box on my desk. When you begin your testimony the light will turn green. Yellow is your one-minute warning. When the light turns red we ask that you wrap up your final thought and stop. That's actually a three-minute time, so two minutes on the green, one minute on yellow, and then it turns red. If you are here and you brought prepared testimony, while you're sitting and awaiting your turn, if you have more than three minutes you may want to pare it down or decide what-- what you want to spend your three minutes relating to the committee. And you know, if it was up to us we wouldn't have a time limit, but we can't get through all

the committee hearings without having a time limit, I'm afraid. As a matter of committee policy, I'd like to remind everyone that the use of cell phones and other electronic devices is not allowed during public hearings, though senators may use them to take notes or stay in contact with staff. At this time, I'd ask everyone to look at their cell phones and make sure they're in the silent mode. Also, verbal outbursts or applause or things of that nature are not permitted in a hearing room. Such behavior may be cause to have you excused from the hearing room. You may notice committee members coming and going. That has nothing to do with how they regard the importance of the bill before the committee, but senators have other bills to introduce in other committees and sometimes have other meetings to attend to. We're holding our hearings in the Warner Chamber while our regular hearing room is being renovated. Please remember water bottles, soda cans, cups are not permitted on the desks and that's so that we avoid any water damage and rings and things like that on the desks. Assisting the committee today are Laurie Vollertsen, our committee clerk; Neal Erickson and Josh Henningsen are-- are our two legal counsel; and the committee pages are Alyssa Lund and Dana Mallett, both students at UNL. You're new. What's your name? Katherine. Katherine is standing in today. But they'll-- they're all very helpful. And that's Katherine, who you'll hand your testifier sheet to when you come up. If you have questions or you need something, they're here to help. And before we start, I'll have the senators introduce themselves and we'll begin with Senator Wayne to my right.

WAYNE: Justin Wayne, District 13, which is north Omaha and northeast Douglas County.

BRANDT: Tom Brandt, Fillmore, Thayer, Jefferson, Saline, and southwestern Lancaster Counties.

DeBOER: Hi. I'm Wendy DeBoer. I'm from District 10. That's Bennington and the surrounding areas in northwest Omaha.

LATHROP: We will no doubt be joined by other senators and some people have to come and go. Senator Slama, who's from the southeast corner of the state, is actually touring flood damage today and can't be with us. And with that, we will begin our hearing on LB209 and Senator Albrecht. Welcome to the Judiciary Committee.

ALBRECHT: Thank you. Good afternoon,--

LATHROP: Good afternoon.

ALBRECHT: --Chair-- Chairman Lathrop and members of the Judiciary Committee. My name is Joni Albrecht, and it's J-o-n-i A-l-b-r-e-c-h-t, and I represent Legislative District 17 which includes Wayne, Thurston, and Dakota Counties in northeast Nebraska. I am privileged this afternoon to present my personal priority bill to the committee. LB209 is a pro woman, pro information, pro-life, and pro-choice bill that will benefit all women who, after beginning the abortion pill process, want a second chance at choice. We all sometimes make decisions that we wish we could take back. It should not surprise us that this happens with abortion too. Fifty-five percent of abortions in the state of Nebraska are so-called medication abortions: those caused by two abortion-inducing drugs. The first pill, mifepristone, is taken at the abortion facility, Mifepristone blocks the natural hormone progesterone. Progesterone is crucial to the health of early pregnancy. The suppressant-- the suppression of progesterone causes separation of the placenta from the uterus, which leads to the death of the child. Twenty-four to forty-eight hours after taking mifepristone, the mother is directed to take the second pill and usually that's at home. Misoprostol causes the uterus to contract and expel the remains of the child. LB209 is for the women-- is for this-- those women, excuse me, who begin the medication abortion process and later change their minds. Recent evidence-based science has shown us that it is possible to greatly increase the chance that a woman can save her baby if she begins the abortion pill reversal process soon after taking the first abortion pill. The abortion pill reversal process begins when a woman is connected to a medical professional who is trained in it and mit-- and in administering it. The mother does not take the second abortion pill and begins the supplemental progesterone process within 48 hours of taking the first abortion pill. Progesterone is a natural hormone that supports healthy development for unborn babies in the womb and has been used for decades to sustain high-risk pregnancies. Reversal is already being offered successfully in Nebraska and across the country. LB209 would add a new section to our existing informed consent statutory framework simply requiring that when a woman goes in for an abortion she must be given all the information she needs to make a truly informed decision, including the information she needs to help find, excuse me, that she needs to help find if she changes-- should change her mind. The bill would amend the statute to say that consent to an abortion is voluntary and informed only if the physician or nurse tells the woman

that they may be-- it may be possible to reverse the effects of a medication abortion if she changes her mind, but at that time, that time is of the essence, and that information on the assistance with the reversing effects of the medication abortion are available and would be available on the Nebraska Department of Health and Human Services' Web site and in their printed materials. LB209 would also require that the Department of Health and Human Service review and update information regarding where to locate a qualified medical professional who can aid in the reversal of the medication abortion as necessary. Informed consent is the bedrock of good medical practice, whether in surgery, taking medication, or any other medical procedure. For abortion, Nebraska already has an informed consent framework in our law which lists a number of things an abortion provider must tell a pregnant woman so that she can make an informed and truly voluntary choice. For the woman who takes the choice, who, excuse me, who makes the choice to pursue the reversal, it gives her an opportunity to spare herself the pain and regret of a no long-- longer wanted abortion, as well as the pain and regret of losing a wanted child. In addition to the 24 senators who have already cosigned and sponsored LB209 with me, I'm proud to have the support of many doctors, nurses, and women and families across the state of Nebraska. Again, I want to stress to the committee that LB209 is about real choice and providing women with all the information they need to make a truly informed and voluntary decision. I would urge you to vote yes on LB209 and give the women a second chance at choice. If you should have-- I hope you've received the letter from an ob-gyn who has successfully administered the abortion pill reversal process right here in Lincoln. And I will be followed with testimony by another medical professional who administers this abortion pill reversal process. And you'll also hear from a mother who has benefited from receiving information on the abortion pill reversal and now has a healthy six-year-old baby boy. And I'd be happy to answer any questions you may have and try to answer those. And I thank you for your consideration.

LATHROP: Let's start with Senator DeBoer.

DeBOER: Senator Albrecht, for coming today. Do you know, what-- what is the current standard of care for abortion doctors when they're giving this medication, abortion in terms of informing their patients about the success rate of the process? I-- I don't know what the success rate is.

ALBRECHT: Uh-huh.

DeBOER: Do you have that information?

ALBRECHT: Actually in the bill it does state that they have 24 hours in the state of Nebraska to go over all of these things. They actually even talk about, you know, they-- they-- what do I want to say, they have the-- I'm going to screw this up. Sorry. Sorry. It's-- it's-- what am I trying to say, a-- they have to do an ultrasound. Sorry, I wasn't there. They have to do an ultrasound and they have to inform them about the pill. I'm sure there'll be people behind me to tell you what their process is. But it, within the bill, it basically states that they have 24 hours to talk to the-- to the-- to the woman about this, whether it be the nurse or the practitioner or the doctor who's going to administer the pill.

DeBOER: I guess I maybe have a slightly different question than that.

ALBRECHT: Sorry.

DeBOER: And maybe there's someone behind you who-- is there a Nebraska doctor who is coming after you--

ALBRECHT: Yes. Yes.

DeBOER: --that can tell the--

ALBRECHT: Uh-huh. They can talk. I don't know the people who actually do the actual abortion. Hopefully they're here today, which I believe they are, to let you know how-- what they do. I'm just asking that they inform the woman--

DeBOER: Right. I want to know--

ALBRECHT: --[INAUDIBLE] reversed.

DeBOER: So what-- I guess what I'm asking is what are the success rates of this procedure?

ALBRECHT: OK. I'm understanding that it's 65 to 68 percent ability to save that child if they go in within a 48-hour period.

DeBOER: OK. I'll maybe wait and ask my question later.

ALBRECHT: OK. Very good.

LATHROP: Senator Brandt.

BRANDT: Thank you, Chairman Lathrop. Thank you, Senator Albrecht, for bringing this bill.

ALBRECHT: Uh-huh.

BRANDT: And just to clarify in my mind, basically what we're doing is we're adding to the current informed consent.

ALBRECHT: Yes.

BRANDT: Is that correct?

ALBRECHT: Yes, sir.

BRANDT: And what we're adding is about the abortion bill removal or reversal process.

ALBRECHT: Correct.

BRANDT: And so this procedure can happen today. It's we're making sure that-- that individuals are informed about the procedure. Would that be--

ALBRECHT: Correct.

BRANDT: OK.

ALBRECHT: Uh-huh.

BRANDT: Thank you.

ALBRECHT: You bet.

LATHROP: I see no other questions. I assume you'll be around to close.

ALBRECHT: Yes, sir.

LATHROP: OK. Thank you, Senator Albrecht. First testifier, please, in support. Good afternoon.

REBEKAH HAGAN: Good afternoon. My name is Rebekah Hagan, R-e-b-e-k-a-h H-a-g-a-n, and I thank you so much for your time. I am here

representing first myself but also the many women who have changed their mind after starting a medication abortion and taking the first abortion pill called mifepristone, also known as RU486. I am here to tell you my story, to express my gratitude, and to ask for your support of LB209. In early 2013 I discovered that I was pregnant with my second child. I will never forget the day. I sat there in a grocery store bathroom staring at that positive pregnancy test and feeling devastated and ashamed. I was one month away from being 19 years old, a freshman at Sacramento State University, and a mother to an almost one-year-old child that I had my senior year of high school. I had just left the extremely abusive relationship I had been in most of my teenage years and I felt that raising two children at 19, while in college, was not just inconvenient. It was downright impossible. And because of that I felt alone and scared and desperate and hopeless. And so I sought out a medication abortion. I want to be clear that that was my choice and I don't put the blame on anyone else for me seeking that. On March 13 of 2013 I walked into my final appointment at a Planned Parenthood clinic close to my home. At this point I was just over seven weeks pregnant and I was called back into one of the last rooms where I sat with a staff member who had the abortion pill in a small Dixie Cup. She explained that once I started this there was no going back. There was no talk of if the abortion failed. With that, I took the abortion pill from her and I swallowed it. She explained that this first pill would end my pregnancy and then I was instructed to take a second set of pills called misoprostol the following evening, and I was told that this would, quote, expel the remnants of my pregnancy. I was then sent on my way with a brown paper bag full of medication. By the time I got to my car, which maybe took two minutes, I broke down. I began to feel intense sadness and regret and it was sort of like that fear and crisis and fog I was trying to operate through sifted and all I could think was, oh my gosh, what did I just do? There have been many times that a lot of us in this room, educated and-- and whatnot, can probably look back and wish that they had made a very different choice. And this was that moment in my life. I wanted so badly to take it all back and regretted this decision. I realized that the following day, March 14, was my son's first birthday and it was also going to be a day marked as one that I brought one child into this world and took another one out. I frantically searched for information on-line. And I wasn't the first. I read many stories from girls just like me, even back in 2013, and I was connected to a doctor through a hot line number and explained the reverse-- abortion reversal process. We followed the protocol which involved getting

progesterone back into my body. I was told that this would probably not be successful. My child could have abnormalities. I was told this by the abortion facility. And thankfully, I did carry to term because of the abortion pill reversal regimen, and I had a healthy baby boy who will be six later this year. So on behalf of all of the women who have gone through this, I thank you and I encourage you to support LB209.

LATHROP: Thank you.

REBEKAH HAGAN: Absolutely. And I stand for questions.

LATHROP: Senator Brandt.

BRANDT: Thank you, Chairman Lathrop. Thank you, Ms. Hagan, for appearing today. I take it what happened to you happened in California.

REBEKAH HAGAN: Sure. Yes.

BRANDT: And at that time did they have a law like what we're proposing here?

REBEKAH HAGAN: No. They didn't have a law and I actually had to frantically search for a while to find information. And the reason I'm so concerned is when you take the abortion pill you have a very limited time window to go through with the abortion pill reversal regimen before the abortion pill runs its course. And here I was sitting there wasting time, without any access to healthcare, without any access to information. So that's why this is so important so that girls are given that information before even making this decision.

BRANDT: And I don't know, have you had an opportunity to look at what we're proposing here in Nebraska?

REBEKAH HAGAN: I have. I actually have it with me.

BRANDT: OK. Do you feel that if that law had been in effect where you were at, would have addressed your situation?

REBEKAH HAGAN: Absolutely, because my main concern was Planned Parenthood, and I don't blame them. Again, this was my choice. But the woman had just told me there's no going back, and I looked at her and said OK and swallowed this pill. And she's going to think I'm crazy.

I'm indecisive I'm incompetent. I-- I could not go back in there and face her and she could not help me. So this absolutely would have given me access to information so that I could make an informed decision for myself.

BRANDT: OK. Thank you.

REBEKAH HAGAN: Absolutely.

LATHROP: I think it's the only questions.

REBEKAH HAGAN: OK.

LATHROP: Thank you.

REBEKAH HAGAN: Wonderful. Thank you.

LATHROP: Next testifier. Good afternoon.

TERESA KENNEY: Good afternoon. Thank you, members of the Judiciary Committee, for letting me speak today. My name is Teresa, T-e-r-e-s-a, Kenney, K-e-n-n-e-y, and I am a woman's health nurse practitioner who has 19 years of experience in women's health. I am representing those women who, like my patients, are seeking a second chance at choice. I am so grateful for that hot line number. This is what one of my patients said to me months ago after taking the first set of pills intended to cause her abortion. She regretted that choice to take the pill immediately after ingesting it and, therefore, looked on-line to try to figure out if there was a way to reverse the process. Thankfully, she found the abortion pill reversal hot line that put her in touch directly with me at Sancta Familia Medical, and I was able to see her in my office within 24 hours after she took the abortion pill. When I saw her, we talked about the events surrounding her pregnancy and her decision to terminate it, which was difficult and very conflicted. I discussed the protocol developed to reverse the effects of the pill she had just taken, and she was grateful to have that choice, a choice to save her pregnancy, a choice that she deserves. The emotional pain a woman goes through in deciding to have an abortion is real and it is no less painful and traumatic when she decides she made the wrong decision and wants a second chance. This patient, I am happy to say, because of abortion pill reversal is now in her third trimester with a very healthy pregnancy. The abortion pill reversal protocol is safe, based in science, and it is successful. The hormone called progesterone, the main hormone that

supports all pregnancies, is administered to the patient, effectively reversing the effect of the abortion pill medication called mifepristone. It is simply the exact antidote to the abortion medication process that starts after taking mifepristone. Progesterone has been used safely in pregnancy for over 50 years and is often used to sustain early pregnancy for artificial reproductive technologies and to prevent premature labor. Abortion pill reversal is great news for a woman caught in a situation where she changes her mind about abortion and wants to carry her baby. A recent peer reviewed study in 2018 shows the average success of the abortion pill reversal protocol is about 64 to 68 percent effective. This rate is significantly better than the 25 percent survival rate for the pregnancy if no treatment is offered. I have now had the opportunity to work with several patients who have had willingly participated in this treatment and all who have been very grateful. Most women are unaware of the information surrounding abortion pill reversal, and they should be informed while going through the process of education and informed consent regarding medical abortion before being in the midst of a crisis where time is short and they feel helpless about what to do next. Abortion pill reversal does not save every pregnancy but allows for a woman to do everything that she can to reverse a decision she deeply regrets. And it gives her support and so many other ways-- emotionally, physically, and socially-- which she would otherwise may not have received at a time when she feels unsupported, scared, and alone. Abortion pill reversal is important and all women should have the information they need to have access to it. I believe that women are strong and capable and I think that the state in Nebraska should stand behind and protect her right to receive this information as a part of all her options for reproductive care. And I'd be happy to take any questions that you have.

LATHROP: Senator DeBoer.

DeBOER: OK. So you're a nurse practitioner. Is that correct?

TERESA KENNEY: I'm a woman's health nurse practitioner. Correct.

DeBOER: And where do-- I think I've lost my-- OK, there, now I've found it. Where-- where do you practice?

TERESA KENNEY: Sancta Familia Medical Apostolate.

DeBOER: Which is where?

TERESA KENNEY: It's in Omaha, Nebraska.

DeBOER: OK. I just didn't know.

TERESA KENNEY: Uh-huh.

DeBOER: Even though I represent Omaha, I wasn't familiar with it. Sorry. So maybe you can help me then. Can you-- can you take me. I just don't know much about this process. So can you take me through the process? So a woman takes the mist--

TERESA KENNEY: Mifepristone.

DeBOER: --mifepristone, which is the progesterone blocker.

TERESA KENNEY: Correct.

DeBOER: How long does that take to get into her system?

TERESA KENNEY: It goes into her system within 12 to 24 hours. But the whole medication stays in her system about 72 hours. So that's where the window-- the woman has about 72 hours, basically, to be able to reverse that process or reverse the mifepristone process.

DeBOER: So the mifepristone goes into her system. She-- she takes it from the Dixie Cup and then 12 hours later it's sort of in her system. And then there's a window for the rest that 72 in which it's blocking the progesterone. Is that the-- the medicine of it?

TERESA KENNEY: Yes. I mean essentially if you know what-- I mean from a medical standpoint, it's about receptors. So the progesterone, you know, it normally is-- is-- is the-- the hormone that's actually in the system and protecting that baby in the womb of the uterus. The mifepristone is trying to remove that hormone from the process of being able to sustain that pregnancy. And so when we give progesterone, it's helping to outcompete that medication at the receptor level. So if we flood the system with progesterone, essentially again it's the antidote to the exact problem that the pregnancy is having.

DeBOER: And are there situations in which women normally, for some reason, have low levels of progesterone for, well, long periods of time or short periods of time or anything like that? Is this something that is sort of in flux in general or is it just a constant thing

during pregnancy that-- that all women have this constant flow of progesterone?

TERESA KENNEY: It is well known that progesterone is the main hormone that supports all pregnancies, particularly in early pregnancy. It is the main hormone that's supports and nourishes, basically, that baby and it gives it oxygen, you could say. It's at the point of about 11 weeks gestation that the placenta starts to take over the production of progesterone. But, yes, and certainly in cases where there is low progesterone, a deficiency, a pregnancy can be at risk for naturally being lost because of low progesterone. And so there are studies that confirm that giving progesterone in higher risk pregnancy situations actually help to support pregnancies and maintain them.

DeBOER: OK.

TERESA KENNEY: So it makes sense that the science of abortion pill reversal is very, very logical on that level.

DeBOER: OK. Do you-- can you tell me what the standard of care is? This is the question I was trying to ask earlier. First of all, this mist-- I am sorry, I had it in front of me, miss-- miff-- mifepristone, when the mifepristone is administered on its own, let's say, what is the likelihood of a pregnancy loss at that point?

TERESA KENNEY: If it's administered alone and she does not take this second set of pills the likelihood that she will lose her pregnancy is around 75 to 85 percent. So in the studies that I've reviewed, the average that a woman, if she just took the first set of pills and did nothing else, she has about a 12 to 25 percent chance of still maintaining that pregnancy.

DeBOER: OK. And if she then adds the progesterone back in, what's the difference there?

TERESA KENNEY: The difference is it increases her chance of carrying that pregnancy two to three times, or 64 to 68 percent comparatively to 12 to 25 percent, so it gives her--

DeBOER: OK.

TERESA KENNEY: --three times a chance higher of being able to successfully carry a pregnancy that she desires to carry at that point.

DeBOER: OK. And do you have studies that you can give to the committee so that we can see that?

TERESA KENNEY: Yes. Those studies should be provided to you today.

DeBOER: Great. Thank you.

TERESA KENNEY: Uh-huh.

LATHROP: I see no other questions. Thanks for being here.

TERESA KENNEY: Thank you so much for your time.

LATHROP: Appreciate your testimony. Good afternoon.

MARION MINER: Good afternoon, Chairman Lathrop and members of the Judiciary Committee. Excuse me. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here today to express the conference's support for LB209. LB209, as you've heard, makes an addition to Nebraska's existing informed consent-- consent statutory framework as it relates to abortion. Already under our existing law, a person performing an abortion has to inform the woman of several things before proceeding, including medical risks, the fact that no one can force her to have an abortion, and that she has the right to review information on alternatives. The U.S. Supreme Court has recognized in several cases that informed consent is critical, because women do in fact sometimes regret abortion, concluding that the medical, emotional, and psychological consequences of an abortion are serious and can be lasting, and that it is unexceptionable to conclude that some women come to regret abortion. LB209 would empower every woman with information so that she knows about all her options, including the option to change her mind and keep a wanted baby when she regrets her first decision. Abortion pill reversal, which is simply the administration of progesterone to overcome the effects of a-- of the abortion pill mifepristone, was only discovered in 2007. Rigorous studies have only been done on the process in the last few years. What they have found is both remarkable

and perfectly in accord with common sense. When women are given progesterone, which has been used safely to support pregnancies at risk of miscarriage for more than 50 years, it helps them to save pregnancies which have been put at risk by a drug, mifepristone, whose specific purpose is to suppress progesterone levels. Studies done by Doctors Mary Davenport and George Delgado in 2017 and '18 respectively have shown that when women are given a single dose of mifepristone in the current clinical practice, in the amount of the current clinical practice, there's approximately a 25 percent chance of embryo survival should the woman not receive progesterone treatment afterward. On the other hand, when the woman does receive progesterone, the chances that her baby will survive to term increase from 25 percent to 64 to 68 percent when the woman receives treatment through the most effective methods. LB209 is, in our view, a common-sense information bill that gives women a chance at a second choice when they regret their decision to start a medication abortion. Women in Nebraska deserve to have this information available to them. One can only imagine the devastation a woman might feel months or years later when she discovers it may have been possible to save her baby if only she had known about the resources available to her. This legislation is compassionate and would be justified even if it would only help a few women in Nebraska each year avoid a lifetime of regret. It does not place any restrictions on abortion. It only gives women the information they need to pursue every option available to them. The conference encourages you to advance LB209 to General File. And I will point out that in the handouts that I've provided, those studies by Doctors Davenport and Delgado that I referenced are included in that handout.

LATHROP: OK. I do not see any questions for you today, but thanks for being here.

MARION MINER: All right. Thank you very much.

LATHROP: Good afternoon.

KAREN BOWLING: Good afternoon. Good afternoon, Chair Lathrop and members of the Judiciary Committee. I'm Karen Bowling, K-a-r-e-n B-o-w-l-i-n-g, and I represent Nebraska Family Alliance in my testimony. The key to making important healthcare decisions is access to all relevant information. I want to thank Senator Albrecht for bringing this important legislation to ensure women have access to vital medical information prior to making important decisions about

her health. As with any medical procedure, women should have access to the highest quality and quantity of information possible. Abortion procedures should not be an exception. Women seeking an abortion should not be treated differently than other pregnant women when it comes to medical information. Time is of the essence. And I'll skip. This has been covered already on the process. Of note, one-third of all abortions in the U.S. are now done chemically with the abortion pill, according to the Guttmacher Institute. In Nebraska, 55 percent of abortions are chemical abortions and increased by 14 percent from 956 in 2016 to 1,086 in 2017, according to the Nebraska Department Health and Human Services. Twenty-nine states have abortion-specific informed consent laws that allows women to know about the risk and alternatives to abortion, including Nebraska. LB209 simply adds information to preexisting informed consent laws about the new option available to women. And you'll note there are five states that have adopted similar legislation already. I have also included for you testimony from Dr. Robert Plambeck. He was intended to be here but is not able to be here today. And he's a licensed physician and board-certified obstetrician/gynecologist and he practices here in Lincoln, Nebraska. Since 1991 he has delivered 4,000 babies, including some of my own family members, and also he has performed six APRs, and of those all six carried to term full nine-month-old babies born. And Mom and baby did well. He states progesterone has been used safely in pregnancy for over 50 years. Progesterone is used for many problems in pregnancy. For example, patients that are high-risk for miscarriage are often treated with progesterone throughout the first trimester of pregnancy, and is used during in vitro fertilization without harmful effect. Dr. Plambeck has been involved, as I stated before, in six of these APR procedures. The U.S. Supreme Court ruled the state has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns only after the event what she once did, in the case of Gonzalez versus Carhart. With more Nebraska women choosing chemical abortion, our state should protect her right to have access to all relevant information should she change her mind.

LATHROP: Ms. Bowling.

KAREN BOWLING: Thank you. I will field any questions.

LATHROP: I do not see any questions for you.

KAREN BOWLING: Thank you.

LATHROP: And just for people, for the benefit of those that are testifying, if someone is-- has a letter, you can testify about your own thoughts and your opinions and that sort of thing. But having people come up and read letters that have been submitted or could be submitted is not a good practice. OK?

KAREN BOWLING: Thank you.

LATHROP: Thanks. Next testifier, please. Good afternoon.

INGRID DURAN: Hi, everyone. Good afternoon. My name is Ingrid Duran, I-n-g-r-i-d D-u-r-a-n. Mr. Chairman, members of this committee, thank you so much for allowing me to have this opportunity to ask for your support on LB209, legislation requiring providing women informed information on the possibility of abortion pill reversal. My name is Ingrid Duran and I am the state legislative director for the National Right to Life Committee in Washington, D.C. I have worked in state legislation for the last 23 years. I assist our affiliates in passing protective pro-life legislation by drafting and analyzing legislation, research in policy issues and trends, and working closely with state legislators in all 50 states, State Attorney General's Offices, and we have been really successful in enacting effective pro-life protection-- protective laws like parental involvement, women's right to know, informed consent, partial-birth abortion bans, the Pain-Capable Unborn Child Protection Act, dismemberment abortion bans, and now abortion pill reversal. The legislation that is being considered today has the potential to save the lives of unborn children. It amends the current abortion informed consent law in Nebraska by requiring that the abortion facility orally inform the pregnant mother about the possibility of reversing the intended effects of a chemical abortion. It also directs the Department of Health and Human Services to update the informed consent materials, the printed materials and also the materials on the Web site, to provide information and resources on where mothers can go to get information on abortion pill reversal. So far this law has passed in five states: Arizona, Arkansas, Idaho, South Dakota, and Utah. By the end of this session hopefully four more states will pass it. It is on the Governor's desk in Arkansas, just amended their law in 2019, North Dakota, and there's one more state. I'm sorry. And I'm hoping that Nebraska will be added to that list by the end of 2019. Providing relevant information to abortion-minded women is nothing new. This

bill is constitutional. I base this conclusion on the fact that in 1992 the landmark Planned Parenthood versus Casey case the court held that a state has a legitimate state interest in protecting and making sure women are fully informed when they inserted that, quote, in attempting to ensure that a woman apprehend the full consequences of her decision, the state furthers the legitimate purpose of reducing the risk that a woman may elect to have an abortion only to discover later with devastating psychological consequences that her decision was not fully informed. If the information the state requires to be made available to women is truthful and not misleading, the requirement may be permissible. LB209 protects rights. It protects women. Contrary to what some would have you believe, it does not ban any for-- anything, therefore, it will pass the undue burden standard established by the Casey court, because it places no obstacles on women obtaining abortions. The law only serves to inform women about the possibility of abortion pill reversal. This possibility has so far saved over 500 babies and counting. Informed consent legislation is not an attack on personal freedom but a guarantee of it. It is constitutional. It safeguards a woman's right to choose and to know and make informed decisions. It is reasoned and compassionate response to the needs of concerned pregnant women, and it's good legislation. In conclusion, I urge you to support LB209, the abortion pill reversal information act. What Nebraska women don't know will hurt them, and this act tries to prevent that hurt and provide hope. Nebraska women deserve this, this second chance at life. Please support this legislation.

LATHROP: OK. I'm going to remind everybody we have a timer here. And I-- I appreciate you came a long ways to testify, but we got to observe that or people are not going to be able to testify or stay long enough to be heard today.

INGRID DURAN: OK. I apologize.

LATHROP: Anyone else have questions or concerns? OK. Thank you for your testimony.

INGRID DURAN: Thank you.

LATHROP: Good afternoon.

CHRISTINE GUENTHER: Good afternoon, Senators. My name is Christine Guenther and I am the executive director for an organization called

Nebraskans Embracing Life. I'm also a registered nurse. I'd like to start what I have to say by asking each of you, what is the downside of letting women know all of their options? I would also like to ask, do any of you know of anyone who has regretted a decision to have an abortion? Because I can tell you that in my current role this past year I have received numerous phone calls, numerous women who have come into my office. I've been involved in different speaking events where I have heard women come to me sobbing and telling me their stories about how they've had an abortion and how they regret that decision. They wish they had never done it. And there's no taking it back. Once you're the mother of a dead child, you are the mother of a dead child, and not everyone can live with that choice. So what would be the downside of informing them that, hey, maybe you made this decision in haste. You took this pill but there's another option within 24 hours. I can speak personally and firsthand to having an unplanned pregnancy and having people around me, significant others, family members, folks who really thought I should have had that abortion. And you know what? I can see how a woman can make that decision hastily. The thing is, when I see these women sobbing, I see myself and I say thank you, God, that I never made that choice. I ask you then to please consider this as a real viable choice for women under duress.

LATHROP: Thank you, Miss--

CHRISTINE GUENTHER: Guenther.

LATHROP: --Guenther.

CHRISTINE GUENTHER: Uh-huh.

LATHROP: I appreciate your testimony. I don't see any questions for you today.

CHRISTINE GUENTHER: Thank you.

LATHROP: Next proponent.

LAURIANNE MICHAEL: Good afternoon. My name-- my name's Laurianne Michael, L-a-u-r-i-a-n-n-e, last name Michael. I am a proponent of this LB209. I am a graduate of the University of Nebraska Medical Center College of Nursing. I've been a nurse for 16 years. The last 11 years have been in the emergency department. I'm kind of looking at this from a different angle in terms of we see a lot of patients who,

you know, come in and face end of life or just the possibility of losing their life. And I think about if a patient is-- has-- is maybe labeled a DNR or a DNI, a do not resuscitate or do not intubate. We always give them the option to change that to a full code if-- if needed. So we will always offer lifesaving measures to them if-- if they would happen to change their mind or if that opportunity presented. And so I just think that if a mother chooses to take a pill that would end her-- the life of her unborn child and she has a change of heart and a change of mind and has an opportunity, I-- I guess I just can't see why there would not be support or the ability for her to do that. And so I just wanted to present that today. Thank you.

LATHROP: OK. Thank you. Ms. Michael. I do not see any questions.

LAURIANNE MICHAEL: Thanks.

LATHROP: Thanks for being here today. Good afternoon.

CHARLENE EDMUNDSON: Good afternoon. My name is Charlene Edmundson, C-h-a-r-l-e-n-e E-d-m-u-n-d-s-o-n, and I'm here to speak as a proponent to LB209. We've heard lots of talk about the benefits for the mother and obviously for the baby. I'd like to address one last group. It looks like I'm the last. And that is the medical professionals who commit their lives to working by their Hippocratic Oath to do no harm. LB209 helps medical professionals to take positive action to fulfill the commitment that they made to their profession by sharing information with patients about oral progesterone capsules that can potentially save the preborn from a medication abortion. And thank you for listening to that last piece to the message. I appreciate that. I ask you to support LB209.

LATHROP: Very good. Thank you for your testimony. I do not see any questions. Anyone else here to testify as a proponent? Seeing none, we will next take opponent testimony. Can I see by a show of hands how many people intend to testify, just so that we can alert the next introducer. One. Are you moving to testify? Two, three, four, five, six, about six. OK. Anyone going to testify in a neutral capacity? OK. We're not taking neutral testimony at this point, just the opposition testimony. And if you're going to testify in opposition, if you wouldn't mind being in the front row so we can keep the chair filled and the hearing moving. OK. Good afternoon.

KELSEY WILSON: Hi. Hello. My name is Kelsey, K-e-l-s-e-y, Wilson, W-i-l-s-o-n, and I am a social work student at Nebraska Wesleyan University at the Omaha Campus, and I am currently completing my practicum placement at the National Association of Social Workers, Nebraska Chapter. I am actually here today to testify in opposition of LB209 on behalf of Sarah Hanify, who is a social worker and a member of the association who couldn't be here in person today.

LATHROP: But you're not going to read her letter, right?

KELSEY WILSON: Well, I was. I just have like a "chunket" of it, but.

LATHROP: If you can just tell us what your thoughts are and people have an opportunity to submit their own letters.

KELSEY WILSON: Yep. No, that's fine. So we adhere, NASW members, adhere to a strong code of ethics and our primary point within that code is a focus on self-determination of a client in independent decision making after reviewing all of their options. And so this statute would decrease an individual's ability to make a well-informed decision about their reproductive healthcare due to the inaccurate information being provided to them. If medical professionals are required to give inaccurate information to patients, that may cause the patient's faith in the profession and knowledge of their medical community to be greatly decreased and may cause them to seek less medical care in the future. So that's only part that I'm reading.

LATHROP: Yeah. No, I appreciate that.

KELSEY WILSON: No, you're fine.

LATHROP: You can understand.

KELSEY WILSON: No, I totally understand.

LATHROP: We accept letters, and when people come and read somebody else's--

KELSEY WILSON: Yep. No questions. OK. Thank you.

LATHROP: OK. I don't see any questions, but thanks for your testimony.

KELSEY WILSON: Thank you.

DONNA ROLLER: Good afternoon, members of the committee. My name's Donna Roller, D-o-n-n-a R-o-l-l-e-r. The American Medical Association says there is no credible medical evidence that abortion reversal works and the American Congress of obstruction-- obstet-- obstetricians and gynecologists insist there is no reliable research studies that prove any treatment can reverse the effect of medical abortion. In fact, if you decide after the first pill that you don't want to take the others, the second pill, 50 percent-- your pregnancy will continue by 50 percent. So I challenge the statistics that another testifier said that was for this bill. Medical abortion reversal is a medical myth and has led to several anti-women, anti-science laws, laws that promote junk science and force medical doctors to lie to women to under not-- undermine patients' rights. They are unethical and are condescending to grown women who have the ability and the right to make their informed decisions about their own health risk. The myth started with San Diego physician George Delgado, whose study was wildly flawed from both an ethical and scientific standpoint, and surveyed only seven will-- women. He was anti-abortion himself and his study was done in cooperation with Lifesaving-- savers Ministry. A religious conviction of a few should not be dictated by the rights of all women that may or may not have those beliefs. And I reviewed many articles on this subject and I find most of them are "ingree" with this. If they aren't they have some religious connection that are for this bill. So I don't really think this is necessary at all. And most women who make this very difficult decision, 95 percent of them are not sorry that they did that. So that's what I have read and I have read, gone through and read many, many articles. So they're all in agreement and I gave you a handout to that respect. Thank you.

LATHROP: I do not see any questions, but thank you for your testimony.

DONNA ROLLER: Thank you.

LATHROP: Sure, Ms. Roller, thank you. Next testifier, please. Good afternoon.

MICHAEL SAENZ: Good afternoon. My name's Michael Saenz, M-i-c-h-a-e-l S-a-e-n-z. I'm here on behalf of AbortionClinics.org, Doctor-- Offices of Dr. LeRoy Carhart. I first wanted to read some information about the American College of Obstetrics and Gynecologists. A 2012 case series reported on six women who took mifepristone and were then administered varying progesterone doses. Four continued their pregnancies. However, this is not scientific evidence that

progesterone resulted in the continuation of those pregnancies. This study was not supervised by an IRB institutional review board or an ethical review committee requite-- required to protect human research subjects, raising serious questions regarding the ethics and scientific validity of the results. Case series with no control groups are among the weakest forms of medical evidence and legislative mandates based on unproven, unethical research are dangerous to women's health. That is by the American College of Obstetrics and Gynecology. On my behalf, this is nothing more than an insidious attempt by antiabortion fanatics to further their agenda. This would force our physician to deceive his patients. This bill proposes that patients are treated on a hypothesis about administering progesterone to reverse the effects of mifepristone. And we, as a state, should consider the health of the public in every policy, not just politically driven ideology grounded in untested claims. Thank you.

LATHROP: Hang on a second if you don't mind. So the Catholic Conference, as part of their material, handed out a-- an article that's entitled Embryo Survival After meth-- Mifepristone: A Systematic Review of the Literature. Have you seen that article?

MICHAEL SAENZ: I have not.

LATHROP: I'm interested in knowing what the science is. You're telling me it's not there because there haven't been studies. And I just got this so I don't have an opportunity to read it before--

MICHAEL SAENZ: And who is it put forth by?

LATHROP: Mary Davenport, MD, and George Delgado, MD,--

MICHAEL SAENZ: OK.

LATHROP: --Matthew Harrison, MD.

MICHAEL SAENZ: I haven't heard about that.

LATHROP: OK.

MICHAEL SAENZ: Thanks.

LATHROP: I just thought if-- if you had a-- an opinion or a thought or-- or if you were familiar with it.

MICHAEL SAENZ: Not in regards to that.

LATHROP: One second. Senator DeBoer has a question for you.

DeBOER: This is something that I've just been thinking about as we're talking about the science of it, because we're sort of hearing a couple of different ideas here. And I'm wondering, how would you go about performing a test of this theory about progesterone? Like how would we even study that? I understand your ethical concerns about they didn't have an IOB or whatever. So how would you do this? I mean I can't imagine you'd be able to find a large enough group of people to study. So how would--

MICHAEL SAENZ: Right. And I -- I mean personally, I can't speak on behalf of people doing these studies but I-- I can't imagine any way in how you would approach this from an ethical standpoint, because, I mean you really are-- you're just kind of throwing stabs at something and you don't know what's going to work.

DeBOER: OK. Thank you.

LATHROP: Thank you. Good afternoon.

DEBORAH TURNER: Good afternoon. My name is Deborah, D-e-b-o-r-a-h, Turner, T-u-r-n-e-r. I am the associate medical director for Planned Parenthood of the Heartland. I am here to testify in opposition to the additions to LB209 as it cuts across the core values of medicine: the physician-patient relationship and science. Briefly, my background is I completed my residency in obstetrics and gynecology at the University of Iowa, followed by a fellowship in gynecologic oncology at MD Anderson Cancer Institute. I am certified by the American Board of Obstetrics and Gynecology. I have served as assistant professor of gynecologic oncology at University of Nebraska Medical Center and the VA Hospital in Omaha, as associate medical director at University of Iowa and the Medical College of Wisconsin. I retired from the practice of gynecologic oncology as director of "medico" of-- at Mercy Medical Center in Des Moines, and I have spent over 35 years, including in basically growing and building my expertise in gynecology, gynecology, gyne oncology, and abortion care. I spend much-- most of my life dealing with women who are dealing with serious issues in their life and making serious decisions. There are several misconceptions about medical abortion and the so-called medical abortion reversal process that I will address here. Medical abortion is a healthcare service

that is available to patients who have been pregnant for fewer than or equal to 70 days or 10 weeks. The patient is given two pills or two medications. The first is mifepristone and then a second is misoprostol. The misoprostol is administered either 6 to 48 hours later, depending on the avenue, be it vaginal, buccal, or oral. The patient is given the misoprostol because in order to empty the uterus after the Mifeprex has worked. And how Mifeprex works is it an antiprogesterone, basically, or it's a synthetic steroid, as we would call it. It essentially attaches to progesterone receptors and by doing so it stops the growth of the pregnancy. It softens and starts the breakdown of the uterine lining. So that is the mechanism of it. Medical abortion is a safe procedure that has been studied and approved by the U.S. Food and Drug Administration, in contrast to the idea that the process can be reversed by administrating reversal doses of progesterone, which has not been studied, evaluated, or approved by the FDA. The literature purporting, as has been discussed earlier, proposing and promoting this procedure is uncontrolled, mostly case studies, and mostly by one individual. One of the biggest things about the LB209 that I have concerns about is that not only that the research regarding reversal so is inappropriate, or incomplete I should say, but the fact that the physician-patient relationship is critical. When we talk to patients about their options, whether it be for abortion or whatever the medical procedure is, we are required as physicians to give honest, factual, science-based information. If you talk to-- if we are telling physicians like I that we have to tell our patients information that has not been shown to be proven, is untrue, and could potentially give harm, we are destroying the patient-physician relationship and it would cause me simply to lie to my patients, so.

LATHROP: Doctor, let's see if there's any questions for you. Senator DeBoer.

DeBOER: Thank you for testifying today. Can you tell me what the standard of care is? This is my question.

DEBORAH TURNER: OK.

DeBOER: Still, still don't know the answer to. What is the standard of care for someone who's coming in to have a medica-- medication abortion about the efficacy of the procedure and about-- so the

efficacy of the first half, if they don't take the second one? What do you tell them now?

DEBORAH TURNER: Basically, what we tell them, first of all, we go through the process of what will be done. We talk to them. We give them all the options, ask them for sure. They have to do a decision regarding do they want an abortion. We talk to them about parenting. We talk to them about adoption. And then we talk about their abortion, if that's what we choose. Then we tell them about how the pill works. We explain to them that the first pill is the one that actually stops the pregnancy growth and they understand that that may not be 100 percent effective. And we usually give them percentages. We tell them that the second pill, which is some-- the misoprostol, is one that empties the uterus and causes to uterus to contract. So by the time they've gone through our first initial discussion with our ultrasonographer who goes over their background and that and then spends time with our educator who goes over all the facts, talks about the medication, talks about the process, talks about the side effects and makes sure that they have their decision to go through for the abortion is clear. And then they come to the provider, who is me in this case, in our clinic, and I sit down and I go through all the options again with them but I also discuss with them the possibility that it may not be effective and explain to them what our recommendations would be if it's not effective. They understand that if they take the one pill and they don't take the second pill there is a large possibility that they may not-- or about a 50 percent, I guess I should say, possibility that they might not abort the pregnancy. How many of those will continue on for a viable pregnancy you can't be absolutely sure about. Depends on what you read in the literature. It could be anywhere to 25 to 50 percent. And they understand that if they take the second pill where thereby we recommend that they continue with the completion of the pregnancy at that time and they usually come back, get an ultrasound, and then determine whether they want to go through with a surgical abortion, if there's still tissue left, or if they want to try a second dose of the misoprostol. So they have multiple chances to hear everything and they have multiple decisions, times to make the decision and make sure that this is what they want to do.

DeBOER: So, OK, I have a number of questions.

DEBORAH TURNER: Oh, OK, I'll try to answer them.

DeBOER: So what are the-- so medication abortion in general, about what percentage of the time is it successful in terminating pregnancy?

DEBORAH TURNER: If we do the medication abortion which we consider the Mifeprex and the misoprostol, if you are at under nine weeks of gestation, it's roughly around 98 percent. You'll see some studies that will tell you 95 percent, but it's closer to 98 percent. If you are 9 to 10 weeks, which is to 10 weeks is the upper limit, you are-- we will tell patients that they have about a 92 percent chance. So in other words, when we're talking to patients, I'll say 2 out of 100 women, if you're at seven weeks for example, may not be have a complete abortion, may need something further or-- and if you're at 10 weeks I'll say 8 out of 100 women may need further.

DeBOER: OK. So you're-- so particularly with the 10 weeks,--

DEBORAH TURNER: Uh-huh.

DeBOER: -- you're telling them that they're-- this may not be effective. You may need additional.

DEBORAH TURNER: Right. Yes. So they have a 92 percent chance of it being effective, but there are going to be 8 out of 100 women that may need something further. That doesn't mean that it'll be ongoing pregnancy. It may mean that they don't completely expel all the products of conception.

DeBOER: OK. So then is that the-- the process? I know that-- that some of the process that you described for informed consent is-- is part of our statute.

DEBORAH TURNER: Uh-huh. Yes.

DeBOER: But it-- it doesn't sound like all of what you describe to them is statutory. You also have other things you say to them. Or am I getting that wrong?

DEBORAH TURNER: I guess I'm not understanding your question exactly. I'm sorry.

DeBOER: Yeah, yeah, yeah. Do you just tell them what's required by statute or do you add additional instructions, information beyond what's just required by statute?

DEBORAH TURNER: I can say that in our clinic the things that-- I guess I'd have to look at see exactly what we say. We tell everything that's in the statute. But you know we're going to give them further information that if you have this problem you can call us at this time, if you have this concern you can call us at this time. And you know we do things like ask them to make sure they're going to have somebody with them, do they feel comfortable, those kind of things that maybe I guess is what you're talking about?

DeBOER: For example, like--

DEBORAH TURNER: I'm curious.

DeBOER: --the question about whether or not after taking the first pill they might still be pregnant. That it doesn't seem like is required statutorily or for I don't know why we're all here. So that doesn't seem like that's required. So where does that-- you said that that's something that you tell them. Is that a Planned Parenthood? You work--

DEBORAH TURNER: Any-- I guess the quest-- I think the question you're trying to get at is that if they take the first pill and then decide not to take the second pill? Is that what--

DeBOER: Yes.

DEBORAH TURNER: --you're asking me?

DeBOER: You said that there was some information that you give them about--

DEBORAH TURNER: We explain to them that the first pill, what it does is it stops the pregnancy growth, and the second pill empty the uterus. We explain to them that if they do not take the second pill, you know, they may not potentially empty the uterus so they may not have a complete, completion of the-- of the abortion, if that's what you're asking me.

DeBOER: Yeah.

DEBORAH TURNER: Yeah.

DeBOER: And where does that--

DEBORAH TURNER: They-- they long-- basically, basically what we tell them along the way is that there are no absolute positive guarantees that any step of the way that it will all be completed.

DeBOER: And where do-- so what makes you tell them that?

DEBORAH TURNER: Because physicians speak honestly to their patients. Like if I tell someone they're going to have a hysterectomy, you know, chances are very good they're going to survive, but I tell them they could die.

DeBOER: Sure.

DEBORAH TURNER: OK? So it's the kind of same thing, that the outcome may not be. And I tell them they might have injury to the bowel, bladder, or whatever. So the statute may not say that I need to say that when I get informed consent for a hysterectomy, it may or may not, but you try to give women as much information as they need to make the decision in a informed way, but also not giving them information that is incomplete or inaccurate.

DeBOER: So it's part of just the standard of care that you would have as a doctor to offer--

DEBORAH TURNER: Right, inform your patient, uh-huh.

DeBOER: --as much information as possible, including this information about the effectiveness of each of the individual pills?

DEBORAH TURNER: Yes, we talk about the effectiveness. Yes.

DeBOER: OK. That's fine.

DEBORAH TURNER: OK. I'm sorry I [INAUDIBLE].

DeBOER: No, I [INAUDIBLE].

DEBORAH TURNER: I was trying to figure out what you were asking me. I apologize.

DeBOER: I'm trying to figure out what people know and when they know it and why they know it.

DEBORAH TURNER: Sure. Uh-huh.

DeBOER: So thank you for-- for that. I had another one for you. Let me look through. Oh, how many-- how would-- how would you study this? So the-- the progesterone issue, how would you study? You know that's--

DEBORAH TURNER: That would be a very difficult, honestly, study to setup, OK? And there are, you know, I'm honestly not a researcher and I don't design all research studies, but when you're looking at a research study, first you look at the question you want. Then you figure out how many people you would need to prove it one way or another. That's kind of where you would start. And the trick would be how many-- how you could get women. I doubt you're going to get a group of women that are going to a controlled study to say, yes, I will take it and see what happens as opposed to I take it and I want the abortion, particularly since most women who come in for abortion have already decided that's what they wanted. Very few of them change their mind. That's a very small number and there are plenty of studies out there that show that. So it would take you years and years and years probably to figure how to design a study and that would actually prove that this was the case, would be my guess. But I'd start out by looking at what it is you want to answer and then how many patients or women you would need to actually have the power enough to prove that. And two or three or four or five or six is not enough.

DeBOER: And then my last question, I promise, what-- are there-- are there any risks of taking the progesterone at any level after taking the mifepristone?

DEBORAH TURNER: As far as the risk of, you know, anytime you take a hormone, be it a small dose or a large dose, there are always some concerns about the risk. So you would have to look at the dose that you're taking and you'd have to look at studies that show what progesterone does or does not do to a woman who is pregnant or nonpregnant. Because the-- the complications may be something other than related to the pregnancy. And you'd all-- we all know that taking hormones during pregnancy can have some effects on the fetus. And we just have to look at those [INAUDIBLE] and determine that. And there's data out there and there's studies out there that actually look at progesterone supposedly in the nonpregnant and pregnant woman.

DeBOER: OK. So that data is available somewhere.

DEBORAH TURNER: Uh-huh. Yes.

DeBOER: OK. All right. Thank you.

DEBORAH TURNER: Uh-huh.

LATHROP: Did you have any questions? Senator Pansing Brooks.

PANSING BROOKS: Thank you for coming,--

DEBORAH TURNER: Uh-huh.

PANSING BROOKS: --Ms. Turner-- or Dr. Turner. Yeah.

DEBORAH TURNER: No, that's OK.

PANSING BROOKS: I guess I was-- I'm just interested in the study that has been referenced and I think that you-- you also referenced that it would be very difficult to have-- have a group of people come in pregnant, take the first pill, and then-- and then not take the other, and then be able to prove that this works. So do you have anything else to say about the study from your understanding as a medical professional?

DEBORAH TURNER: Well, other than the fact that, yes, it would be difficult, but when you design a study, you try to compare apples to apples, as oranges to oranges. So one of the difficulties with the study that is out there, and there's a really great review and we can certainly get to the reference that was in the New England Journal of Medicine and I believe it was October of 2018 that review. Saw the information, It's an excellent article so we can get to the reference. I apologize I didn't bring that today. But so if you're going to study women who are going to take progesterone in this sense or whatever sense it may be, first of all you would have to look at the same gestation. You'd have to make sure they were taking the same dose. You would have to make sure they were taken in the same regimen. You would have to determine whether you were giving it, whether someone already has an ongoing viable pregnancy or someone has a pregnancy that's, oh, if the-- how you're going to determine if it's a viable pregnancy or not. Because there's good data that shows that if indeed you take the Mifeprex and you have an ongoing pregnancy at about-- a viable pregnancy after, I believe, it's 72 hours. And I'd look at that for sure but I think it's 72 hours. The chances of you going on to have-- continuing the pregnancy are probably at least 50 percent, which is basically kind of the same numbers that you're seeing in the studies.

So it's like you really have to fine-tune it to very specific data and comparing apples to apples and oranges to oranges.

PANSING BROOKS: OK. Thank you.

DEBORAH TURNER: Uh-huh.

LATHROP: I have a question. In the bill it says that-- that somebody that wants to have this done must be told 24 hours in advance and there's a series of things as you--

DEBORAH TURNER: Uh-huh.

LATHROP: --probably well know. This would add the following: that it may be possible to reverse the effects of a medication abortion if she changes her mind but that time is of the essence. Is that a true statement? If we made you say that to a patient would it be a true statement?

DEBORAH TURNER: No, it would not. There's no data or information that would-- that I could tell a patient that that would be an honest statement. So if you told me I had to tell the patient that, medically or ethically, I would either have to say I can't tell them or I have to tell them, you know, basically this is not a proven or true statement that I'm going to tell you, if you're an honest physician.

LATHROP: And we-- we talked to physicians about the efficacy of medications when we had medical marijuana here--

DEBORAH TURNER: Uh-huh.

LATHROP: --a month ago or so. And your opinion that you just gave is a function of the fact that there are no studies that would show the efficacy of the progesterone treatment that's been described. Is that my understanding?

DEBORAH TURNER: Yes.

LATHROP: And is it possible, I think maybe in answering pan-- Senator Pansing Brooks's question, it doesn't sound like it's possible to do such a study because you can't get a control group.

DEBORAH TURNER: I didn't say it's not possible. I'm saying that in order to try and do it, you would really have to design a well-designed study, and that has not been done.

LATHROP: OK. It's not-- that's something that's possible; it just hasn't been done. So from a scientific point of view, you don't have the information.

DEBORAH TURNER: Right. And we try not to give patients information that is not scientific or proven. And it's very unethical to do that, and as physicians, we try to be as ethical as possible.

LATHROP: OK. And I want to try to understand one more thing that you testified to, to make sure I understand what your testimony is. And you tell me if I got this wrong. If somebody takes the first medication of the two-medication regimen and they change their mind and stop, they have a 50 percent chance that the child will go-- the development will continue. The child will ultimately be born.

DEBORAH TURNER: And in the-- if you look at the literature, there's anywhere from some studies will say 25 percent, some will say 50 percent. We say there's about a 50 percent efficacy with mifepristone alone without the misoprostol.

LATHROP: OK. And the fact that some of those people who took the first one but not the second one went on to have a successful pregnancy suggests that some of the information that's been put out by some of the folks that have case studies, it may just be a function not of the progesterone but the fact that they're in the 25 to 50 percent of the people that would go on to have a successful pregnancy just by virtue of not taking the second drug.

DEBORAH TURNER: Yes.

LATHROP: I think I get it.

DEBORAH TURNER: OK.

LATHROP: Senator Morfeld.

MORFELD: Thank you for your testimony.

DEBORAH TURNER: Uh-huh.

MORFELD: [INAUDIBLE] a copy of your testimony?

DEBORAH TURNER: Yes.

MORFELD: That would be useful. Thank you.

LATHROP: I do not see any other questions.

DEBORAH TURNER: OK.

LATHROP: Thank you for your testimony--

DEBORAH TURNER: You're welcome.

LATHROP: --and your sharing what you know about this subject.

SOPHIA JAWED-WESSEL: Hello. Good afternoon to the committee--

LATHROP: Good afternoon.

SOFIA JAWED-WESSEL: --and to Senator Lathrop. My name is Dr. Sofia Jawed-Wessel, S-o-f-i-a J-a-w-e as in elephant-d as in dog hyphen Wessel, W-e-s-s-e-l. I'm an associate professor in public health at UNO, but my testimony today does not represent anything from the university. As a public health practitioner, one of my duties is to undo some of the damage that previous generations of public health practitioners in the medical field have done either intentionally or unintentionally that has led to pretty significant mistrust of the medical field. It's-- mistrust in our line of work is-- is common. It's something that we have to deal with on a regular basis. And while it might seem like this bill on its surface would increase trust, because LB209 is-- it is actually harmful to public health and makes my job a little bit harder because it forces providers to essentially mislead their patients instead of giving them accurate information. So I wanted to discuss the Delgado study, if that was all right with you all, and answer some of the questions that I've heard. So I've read this study and there's two others actually as well. And if you were to take a kind of in-depth dive into the methods used behind the studies, there are some significant scientific problems with this. So one of the issues that I have is not so much even that there isn't a control group. It's-- it's the methods that they use in terms of how they selected their patients, right? So in their methods you'll find that they conducted an ultrasound prior to administering the progesterone to see if the pregnancy was still viable after taking that first

medication, right? So those who did not have a viable pregnancy anymore were not enrolled. OK? So that creates a biased result right from the git-go, right? So likely there-- that just that half, yes, part of it is due to the fact that we don't know what would be going on with the control if they hadn't taken the progesterone. But even within the sample, they're working with a group of patients who had shown to likely continue their pregnancy. I'll also say that this study did not get proper ethics review, so every scientific study that is done has to be reviewed by an IRB. And while they state in there, in their study, that they received IRB approval, the study has actually been yanked from the scientific journal to confirm this because the university itself is investigating this study because they found out that women were enrolled in the study without being told that this was an experimental study, that the progesterone was not yet a approved-- approved way to maintain the pregnancy after "mife" had been given to them. So there's a difference between somebody having a spontaneous miscarriage and being given progesterone to try and hold on to that pregnancy versus somebody taking mifepristone and taking progesterone. That has not been studied in terms of its safety and its efficacy. The Delgado study starts to do that, but I'll stop there.

LATHROP: I wanted-- I wanted to ask you because this was handed out to the members by Mr. Miner and it appears one of the people is Dr. Delgado.

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: It's entitled "A Case Series Detailing the Successful Reversal of the Effects of--

SOFIA JAWED-WESSEL: Yes.

LATHROP: --Mifepristone." That's what you're talking about.

SOFIA JAWED-WESSEL: That's what I'm talking about. Uh-huh.

LATHROP: This is apparently reported in Issues in the Law and Medicine, Volume 33, number 1.

SOFIA JAWED-WESSEL: Yes. And it's-- so it was published and now the Journal that published it is-- is removing it. OK? So they-- they've issued a retraction of that study.

LATHROP: The representations you made about the flaws in the study,--

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: --which is to say that the-- according, I don't know this,--

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: --but your testimony is that-- that the folks that did this study did an ultrasound of people after--

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: --the first pill.

SOFIA JAWED-WESSEL: Uh-huh,--

LATHROP: If the--

SOFIA JAWED-WESSEL: --to ensure that it was--

LATHROP: --not viable any longer,--

SOFIA JAWED-WESSEL: Yes.

LATHROP: --they were taken out of the study.

SOFIA JAWED-WESSEL: Yes.

LATHROP: Is that evident in the study or is this some information that's available to you or you believe for--

SOFIA JAWED-WESSEL: It's evident in the study.

LATHROP: OK.

SOFIA JAWED-WESSEL: Uh-huh. So especially if you go in and look at the tables. So they don't actually come right out and say it in their methods section, but you see it in the results. So if somebody who is lay who doesn't necessarily understand statistical analysis and some of that work might not pick up on it. And that was one of the reasons why it missed, when it was initially peer reviewed it was missed. But as people are-- have been reading it more thoroughly, it's-- it's definitely in there.

LATHROP: And so who's telling them-- who's trying to pull this? I don't under [INAUDIBLE].

SOFIA JAWED-WESSEL: So the university that-- that Dr. Delgado works for, and I can't remember what the university is.

LATHROP: San Diego.

SOFIA JAWED-WESSEL: Yeah, San Diego. USD is the one that their IRB had been notified that there was incorrect informed consent. Right? So some of the women were not told that the progesterone injection they were going to get was part of an experimental study. Right? So that was the first big red flag.

LATHROP: That may be unethical but doesn't affect [INAUDIBLE].

SOFIA JAWED-WESSEL: Yes. So once that happened, their methods were being reviewed. So you-- an IRB, they look through the-- the ethics of whether-- of a study, but they also look to see if there's scientific merit too. You know, is the study going to create biased results? So after going back through it and seeing that they were going to be only doing-- they were only going to be working with those who have viable pregnancies and that they weren't coming out right in that article to talk about it as a limitation, it's-- it's disingenuous. Right? So the IRB would-- would not approve, normally, a study like that. Does that make sense?

LATHROP: It does.

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: Is there anybody else that's done a study that's come to the same results as this [INAUDIBLE]?

SOFIA JAWED-WESSEL: No, not that I know of.

LATHROP: OK. Senator DeBoer.

DeBOER: How would you design a study to test this?

SOFIA JAWED-WESSEL: I was actually thinking about that as you've been asking this. So it would be difficult. You wouldn't be able to do a randomized control trial, not that I can imagine, because you can't force pregnant women to, like, potentially lose their pregnancies or not, you know? So the-- that would just be off the table. But you

could still do like a pseudo experimental study where you have women who are pregnant who don't want to be who approach their doctors and say I want to try and continue the pregnancy and stop the abortion. And you would have to give them an option that, like, we can try to do nothing and then we'll put you in the control group, or we can give you this progesterone injection if that's what you want to test. And you would have to have a large enough sample in both groups but you would have to give women the choice whether they want to be in the experimental group or whether they want to continue and see, without taking any other medication, and seeing what happens. But once again, you'd have to match both groups so that there's equal numbers of women with similar demographics as well as how far they are in their gestational age. It would be tough but you could theoretically do it. It would take you a long time, like Dr. Turner said, because there's so few women that go to their doctor saying that they want to stop the abortion, but that would give you a bit of-- kind of a control group.

DeBOER: So are there other pieces of public health where--

SOFIA JAWED-WESSEL: Uh-huh.

DeBOER: --where you're similarly sort of constrained and not really very able to--

SOFIA JAWED-WESSEL: Yeah, absolutely. Most of my research is with pregnant women and there's plenty of things that I would love to like know like hard and true whether this is safe or not safe, but I can't ethically ask pregnant women to do something that might be dangerous for their pregnancy. So-- and there's plenty of workarounds and we don't always have to have a randomized control study to get a pretty good picture of whether something is safe or not. It's never-- it's not going to be 100 percent like a randomized control trial would be, but that's OK. That's not always what you have to have.

DeBOER: OK. Thank you.

SOFIA JAWED-WESSEL: Does that answer your question?

DeBOER: Yeah.

SOFIA JAWED-WESSEL: OK.

LATHROP: I don't see any more questions for you.

SOFIA JAWED-WESSEL: Thank you.

LATHROP: Thank you for your testimony,--

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: --Doctor. Good afternoon.

SCOUT RICHTERS: Good afternoon. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in strong opposition to LB209. I am circulating written testimony and will just briefly summarize here. LB209 is-- is an unnecessary and dangerous, dangerous intrusion into the patient-provider relationship. It compromises care and it is also constitutionally suspect. So this idea of reversal is not grounded, as we've heard, in credible science. It's not supported by the FDA, the ACOG, or the AMA. But LB209 is constitutionally suspect on First Amendment grounds. Free speech means that we're protected in our speech and we're also protected from being compelled to speak. And LB209 is an example of compelled speech. It's-- it's constitutionally suspect, especially in light of the 2018 Supreme Court decision, NIFLA v. Becerra. And in that case the court considered a California state law requiring mandatory disclosures at crisis pregnancy centers, and the court, on First Amendment grounds, ruled in favor of the centers and held that disclosures can't be unjustified or unduly burdensome and also that the disclosures need to remedy some kind of harm that is potentially real and not hypothetical. And so here, with LB209, you're requiring disclosure of something that's not based on reputable science, which is certainly unjustified and obviously not remedying any type of actual harm. So LB209 is constitutionally sus-- suspect and does have the potential to bring about litigation, which we did see in Arizona after this same reversal language was adopted. And the reversal language was repealed, as a result of that litigation in Arizona, and the state was left with $550,000 in legal fees. LB209 forces doctors to give patients inaccurate, misleading information about unproven and experimental treatments. This compromises care as well as trust between a patient and her provider. And we need to trust patients and support doctors in providing medically accurate care. Thank you. And I'm happy to answer any questions.

LATHROP: Did I hear you say that there was-- that this provision or a similar provision was tested in litigation in Arizona?

SCOUT RICHTERS: Yes. And it was repealed as a result of that litigation.

LATHROP: So did-- did-- did the litigation lead to a judgment or was the litigation pending and the Arizona legislature says, we take it back?

SCOUT RICHTERS: That is my understanding, the second one.

LATHROP: So we don't have an order from a court in-- interpreting this provision relative to the Supreme Court Opinion on commercial speech?

SCOUT RICHTERS: Correct. That's my understanding. But I can clarify that and get that information to you.

LATHROP: I'd appreciate it if you would. I do not see any other questions. Thanks,--

SCOUT RICHTERS: Thank you.

LATHROP: --Ms. Richters. Anyone else here in opposition to LB209? Anyone in a neutral capacity?

KELLEE KUCERA-MORENO: Good afternoon, Senators. Kellee Kucera Moreno, K-e-l-l-e-e K-u-c-e-r-a-hyphen-M-o-r-e-n-o. Thank you for bringing this, this bill to the Judiciary Committee. I-- this is definitely my opinion. I have not studied this. I think what's important, too, is that we start trust-- trusting the Judiciary Committee to check into things and that we, too, have full disclo-- disclosure on options. It-- it just sounds like a way of bridging the gap between the people who are pro-life and pro-choice. You know, if pro-lifers are feeling like all the information is not available to someone who is choosing an abortion, they're going to have a hard time trusting. I do owe Planned Parenthood my-- my life. They've been there in supporting me through-- through my-- my situation. And I don't know, it just kind of surprised me here. So I just want to encourage others to testify. Your opinions do matter. But I would hope that the Legislature would at least check, you know, look into this and make sure that we are giving women all the options.

LATHROP: OK.

KELLEE KUCERA-MORENO: And-- and to show them that we may or may not have the proof. We're going to have to trust other laws, such as the

marijuana laws and judi-- prison reform laws that we might not be able to get true facts about, but we're just gonna have to take it. Thank you.

LATHROP: Thank you. Anyone else here to testify in a neutral capacity? Seeing none, Senator Albrecht, you're free to close. We do have 26 letters that have been received and will be made part of the record in support, 4 letters in opposition, none in neutral.

ALBRECHT: Great. Thank you. Again, thank you for taking the time. And I think this was good conversation. Based on the information given to me about that study, that it was repealed, but it is now back out there. Where it's at I'd like to find out so that I can provide it to you. But I-- when-- when the opposition was up before to say that-- that there's no way that-- that you could possibly check to see what a good study would be, if that study was over a four-year period that was provided to you and these were women from the hot line that called in across the country, I would think that that would give a good number of people within a study to know whether it's working or not. So I would implore you to look into that study. I will get you more information so that you can make a decision that's right for you. But I can't emphasize enough the importance of women having all the options in front of them to decide to pursue-- to pursue the Medicaid [SIC] abortion reversal. Physicians have an ethical and professional responsibility to provide patients this information. And it's a woman's right to have complete medical information regarding medical abortion process. I have three beautiful grandbabies at home, because my daughter-in-law could not carry her first one and they realized it was a progesterone problem. And if this has been studied over 50 years, that that's what it takes for any-- anybody that's high risk that needs progesterone to make that baby viable full term, I do believe that if-- if somebody is going to make that decision to reverse it, they should have all the information to do so. And with this information given to them by the-- whoever decides to perform that abortion, I guess my bigger question to the opposition would be, do you-- what do you do when they say they want to reverse it? Where do you send them? Do you-- can they can they reverse themselves or they're just convinced that they can't and they don't want to? But the abortion pill reversal is safe. I believe it is proven. It's important that we give all women the information they need to make that informed choice. And LB209 could be life changing for those women. And it is a-- a second chance at choice. So I was very much moved by Rebekah's story about her son and, quite frankly, to come back a second time to

Nebraska to share that story with us I think is compelling. You know, she-- she does this throughout the country and goes to all the states to tell her story. That's just one-- one life that was saved. But if there, in fact, is over 500, I think it's great that those women did have a choice. But LB209, again, a real choice by providing women with all the information to make that truly informed voluntary decision. I mean nobody's going to-- told them to, anything else, but women deserve to hear that. And I would implore you to look that study over that was given to you, because if it was, in fact, republished again and whatever information in the beginning was taken out, that would be your scientific question that should answered. But thank you for your time. I'll try to answer any other questions.

LATHROP: I don't see any.

ALBRECHT: Thank you.

LATHROP: Thank you for bringing this before the committee. It certainly sparked a-- an interesting discussion.

ALBRECHT: Yes. Hope we didn't take too much of your time.

LATHROP: Well, that happens--

ALBRECHT: I know.

LATHROP: --even when it happens. So thank you, Senator Albrecht. That'll close our hearing on LB209, and bring us to Senator Hunt and LB503. Senator Hunt. How many people are here to testify on this bill? Keep your hands up. Hold them up high so I can get an idea. The reason I ask is that we try to tell the next testifier or the next senator to introduce a bill. So probably eight, nine people. OK. Senator Hunt, you're clear to open on LB503.

HUNT: Thank you, Chairman Lathrop and members of the Judiciary Committee. I'm Senator Megan Hunt, M-e-g-a-n H-u-n-t, and I represent District 8 in midtown Omaha. Today I'm presenting LB503, a bill to allow telemedicine for medical abortion. Telemedicine is when a physician consults with a patient through telecommunication services, such as videoconferencing, to make a diagnosis, provide treatment, and prescribe medication when necessary. Telemedicine is revolutionizing the way we receive care in our country, bringing down costs, and expanding the reach of quality care for those restricted by geographic barriers. Its prevalence is rapidly increasing with ophthalmologists,

dermatologists, psychiatrists, and cardiologists most frequently utilizing this tool. Under current statute, all treatments and consultations that do not involve a physical procedure can be performed through telemedicine, except for medical abortion. This means that patients seeking an early term abortion must be in the same room as a physician just to swallow a pill. This leaves many economically disadvantaged women and women in rural counties without access to safe and necessary care. I want to make sure we're clear on terms here, because I've seen some misinformation promulgated in the press. So let me explain what it means when we talk about a medical abortion. Medical abortion is a nonsurgical way to terminate a pregnancy in the first ten weeks. It's done through medication, two pills, that must be provided by a trained healthcare professional. That doesn't necessarily have to mean a physician. In states where telemedicine for medical abortions are allowed a registered nurse or physician's assistant is present with the patient throughout the entire process. There's a growing body of research that demonstrates that virtual consultation with a physician for medical abortion is perfectly safe. We don't have to look farther than our neighbors in Iowa to see how this policy can play out. In 2008 Iowa legalized telemedicine for abortion to increase access to this care for rural patients. A scientific peer reviewed study, not revoked by the university who sponsored it, published in the Journal of Obstetricians and Gynecologists, took a look at patient outcomes for women who visited one of several telemedicine abortion providers in Iowa between 2008 and 2015. Those patients were evaluated by clinic staff who took their health history and an ultrasound. An off-site doctor then looked at their information and consulted with the patients through videoconference to determine if they were good candidates for medical abortion. If the physician says they are a candidate for medical abortion, they are prescribed medication, a regimen of mifepristone and misoprostol, two drugs that together are sometimes called the abortion pill. I'm not going to belabor what all that is because you have heard about that already, but these patients take the first dose in the healthcare facility and then they take the second dose at home, and receive subsequent counseling and follow-up care. Patient outcomes for those who receive video counseling, video care from physicians, were compared with those who took the medication in the presence of a doctor. There were actually fewer complications among telemedicine patients than in in-person patients. This study just adds to a growing body of research that demonstrates that this method is just as safe and effective as meeting with a physician in person. Physicians and

other medical providers who have years of education and experience treating patients should decide the proper medical course for their patients, not Legislatures. Facts matter and evidence-based science and medical treatments are imperative to providing the best care for patients. This holds true whether we're treating the flu, cancer, premature infants, or terminating a pregnancy. The Legislature rightly does not try to regulate treatments provided by cancer centers in the state. They have no business interfering with women's health either. Medical professionals have an obligation to provide their patients with the best care science has to offer. To single out a noninvasive treatment and deny access to necessary care for patients that do not have the means to find childcare and travel to another town, take time off work, it's unethical and it puts an undue burden on women who are seeking safe and legal healthcare. And with that, I'll answer any questions.

LATHROP: I do not see any questions, Senator Hunt.

HUNT: Thank you.

LATHROP: Are you going to stick around to close?

HUNT: Yes. Thank you.

LATHROP: Very good. All right. With that introduction, we will first start out with proponents of LB503. And if you're going to testify as a proponent, if you can come up to the front row that will help us keep things moving. Good afternoon.

REBECCA WELLS: Good afternoon. My name is Rebecca Wells, R-e-b-e-c-c-a W-e-l-l-s. Good afternoon, members of the Legislative Council here.

LATHROP: It's close enough.

REBECCA WELLS: In Nebraska, currently abortion has been singled out as the only medical care where telemedicine is prohibited by law, and this is wrong. There's no purpose in the current law except to favor the religious beliefs of some of the population who believe that abortion is a moral-- is morally wrong. Medical abortion is a safe procedure, and for women with a pregnancy, who for health or other reasons, want to end it, the earlier it's done the safer it's done-- it is. Pregnancy is not without risk to a woman's health. Here in the United States, as we've been seeing in the news, maternal mortality has been going up instead of down and it's one of the worst in the

world. So when women feel that they want to make a decision that involves their health, they should be able to make it without the infringement by those who would limit their choices based on their religious beliefs. Nebraska is a large state and there's a big rural underserved population where there is not always adequate healthcare provider access, and abortion in many areas of the state is limited or nonexistent. Passage of this bill would work to bring healthcare equity to all women in this state, and this is an access to healthcare bill. I am hoping that you will advance this bill. I am hoping that each of you can support it even if you personally do not believe abortion would ever be a choice for you or your family. Again, there should be a strong separation between a-- religion and state and I think this bill needs to be passed. Thank you. Any questions?

LATHROP: I don't see any questions--

REBECCA WELLS: OK. Thank you.

LATHROP: --but thanks, Ms. Wells. Good afternoon.

LIZABETH GREEN: Good afternoon. My name is Lizabeth Green, L-i-z-a-b-e-t-h, Green like the color. I am the regional director of Health Services for Planned Parenthood. My territory includes health centers in Nebraska, Iowa, South Dakota, and Minnesota. I am here today on behalf of Planned Parenthood to offer strong support of LB503 and answer any questions the committee may have regarding the nuts and bolts of telehealth related to abortion services. Planned Parenthood of the Heartland has served as an innovator in healthcare delivery, including ending early pregnancies through dispensing medication via telehealth. We have been delivering telehealth medication abortions in Iowa for more than a decade. Our system is very similar to that used to deliver other types of healthcare, like mental health services. The medical community at large has supported these efforts, including the American College of Obstetricians and Gynecologists. Briefly in 2012 an Iowa restriction similar to the one here in Nebraska, in Nebraska's law, was challenged and we won. Planned Parenthood believes abortion must always be a matter of personal choice and that the patient, in consultation with the physician, has the right to obtain an abortion under safe, legal, and dignified conditions, and at a reasonable cost. We also recognize and accept our responsibility to guard against coercion or denial regarding a patient's decision about continuing a pregnancy. Options counseling and coercion screen-- screening are still very much part of the telehealth abortion process. In our

Council Bluffs, Iowa, health center, for example, the process for a telehealth abortion is the same as a medication abortion performed in the health center. The only difference is the physician is on the computer through a system what we call true clinic, where the patient can see and talk to our physician just as if they were physically in the room with them. This telehealth process available to people who are less than ten weeks from their last missed period is extremely safe. In fact, two medications are taken and even when the process starts in the health center, as it does now in Nebraska, the second pill is ingested off-site, typically at home. We already know the two medications. We've talked about it heavily so I won't go into detail with that. When this service is offered through telehealth, one of our physicians connects into the health center room with the patient as present via videoconference. The physician goes over the process of the medication abortion, including what medication is being administered in the office as well as what medication is being sent home with the patient. The physician unlocks the medication remotely after educating the patient. The patient takes the first set of medication, mifepristone, while on the videoconference with the physician. During the visit the physician goes over the educational information provided to the patient from our staff in the health center, which includes what to expect after taking the second medication, misoprostol, as well as who to contact should they have any additional questions after leaving the health center. We have an on-call licensed healthcare provider available to all of our patients 24 hours a day, seven days a week. The risk and side effects of medication abortion are relatively low and mild-- mild and low, excuse me, including cramping, bleeding, nausea, and dizziness. Antibiotics are also prescribed, regardless of whether the service is offered in person or through telehealth, in order to help protect the person against side effects. We also send people with all information they need in case there are a larger side effects. We do require an in-person checkup one to two weeks after the medication is ingested to perform either an ultrasound or HCG level assessment to ensure the medication abortion was completed and successful. During this follow-up visit, we take the opportunity to answer any additional questions the patient may have. I just want to thank Senator Hunt and all the cosponsors for supporting this legislation and access to healthcare for Nebraskans. We urge the committee to support LB503.

LATHROP: Thank you. I-- Senator DeBoer.

DeBOER: I just kind of heard a little bit at the end, you were talking about the side effects of the medication abortion. It looks like cramping, bleeding, nausea, dizziness. When do those come up?

LIZABETH GREEN: When do the-- when does the patient?

DeBOER: Yeah. When do those-- when does the patient experience--

LIZABETH GREEN: After taking the second dose at home, so 24 hours after taking the first medication.

DeBOER: They don't have any side effects just from the first medication?

LIZABETH GREEN: They can have slight nausea and a slight dizziness, yes, they could have after the first, but the-- it really has-- really, really experience after the second.

DeBOER: And in the-- the last discussion we heard that the-- the medication mifis-- mifepristone, there we go,--

LIZABETH GREEN: Yes.

DeBOER: --sort of go-- gets into the blood about 12 hours later. Is that your--

LIZABETH GREEN: Correct.

DeBOER: --understanding as well?

LIZABETH GREEN: Correct.

DeBOER: OK. So thank you.

LIZABETH GREEN: You're welcome.

LATHROP: I see no other questions. Thanks for your testimony today, Ms. Green. Good afternoon.

ELENA SALISBURY: Good afternoon. My name is Elena Salisbury, E-l-e-n-a S-a-l-i-s-b-u-r-y. I'm here to testify in support of LB503. Currently in Nebraska the only clinics that provide abortions are in Lincoln, Omaha, and Bellevue. For people living in the western half of the state, this means traveling up to 450 miles for an appointment, in addition to paying for gas and lodging. This places an unfair burden

on patients. I speak to the impact of barriers to abortion access based on my own abortion when I was 19. I just moved to North Carolina for college and didn't have a support system. I was scared and alone but certain of my decision. The law mandated a 72-hour waiting period between the initial consultation and the actual procedure, required the doctor to give me biased information about the risks, and required me to undergo a transvaginal ultrasound. I was able to return from my appointment three days later because I lived in the same city as the clinic and I had transportation. Not everyone is so lucky. It's difficult to put into words the feeling of being forced to go home and think about a decision that I'd already put an extensive amount of thought into, a decision I had made about what was best for my body and my life. The lasting negative effects of my experience are not from the procedure itself but from state legislation enacted with the goal of shaming and coercing me into changing my mind. Enforcing barriers to abortion will not stop them from happening, but it will stop them from happening safely. Research has shown that laws banning telemedicine abortion limit the options of patients seeking care with particularly severe impacts in rural areas. Patients are forced to travel greater distances and take time off work, which increases the financial burden. A recent study showed that the number of clinics providing abortions has declined by 22 percent in the Midwest. In addition, the total costs for abortion services and travel were equivalent to more than a third of monthly income for over half of participants. Difficulty paying for travel can force patients to delay the procedure, which results in even higher costs. The ability to provide medical abortions via telemedicine would change the landscape of abortion access in Nebraska for the better. It would remove barriers to access for many patients in the rural part of the state and reduce their financial stress. Numerous medical associations have affirmed the safety of medical abortions and advocated for the repeal of telemedicine bans. Research has shown that medical abortion can be safely and effectively administered via telemedicine and the mortality rate associated with medical abortion continues to be lower than the mortality rate associated with childbirth. The issue here is not whether abortion is safe or legal, because we know it is both. This is about equity and about access. Telemedicine bans disproportionately affect rural and low-income patients. No one should face additional hurdles when seeking healthcare because they live in rural areas. Yet, patients all over our state must overcome barriers to abortion access. I volunteer as a clinic escort in Bellevue and I see firsthand the intimidation and scare tactics that protesters use in an attempt to

discourage patients from following through on their decision. Patients who have traveled for hours and spent the night at hotels are greeted with harassment and bullying. There is no place for shame and coercion in healthcare of any kind. Lifting the ban on telemedicine medical abortions in Nebraska would help put healthcare decisions back in the hands of patients and their trusted healthcare providers. Thank you.

LATHROP: Thank you. I don't see any questions. Thanks for your testimony. Next proponent. Good afternoon.

ALEX ALCALA: Good afternoon. My name is Alex Alcala, that's A-l-e-x A-l-c-a-l-a, and I'm here representing myself. I am very thankful for telemedicine because it made it possible for me to have my abortion back in 2015. I was just beginning my second year in college at UNO when I found out that I was pregnant. I remember going to the store to purchase a pregnancy test and immediately running to the public rest room in hopes that this was just a scare. I waited, went to my car and looked at the test and, sure enough, I was pregnant. My entire body just kind of sunk into the car seat. I started panicking, crying. Just everything, I don't know, sucked. And my first thoughts were just like how do I end it all for myself. Choosing to have an abortion didn't come to mind because I grew up Catholic and I just didn't see it as being an option for me at the time and I definitely did not want to deliver a baby, let alone carry it full-- to full term to just, you know, give it away. And I don't think the way that I was feeling is how anyone should feel when they find out that they're pregnant. I went home and began talking with my partner about our options. After talking and taking into consideration the futures that we wanted, I decided I wanted to have an abortion. I called Planned Parenthood and they were able to help me set up an appointment. The only downside was that I had to travel to Iowa in order to make my appointment. However, I have the opportunity to get there because I had the means to get there, however, not everyone does. During my appointment I was asked if I was there on my own free will and if anyone was forcing me to be there, and I told them I was there because I needed to be and that no one was forcing me. Telemedicine in Iowa made my abortion possible and I couldn't be more thankful for the staff at Planned Parenthood for being there for me. I don't regret my decision whatsoever and I'm very proud of that decision and I hope you all support LB503 to make telemedicine and abortion more accessible for people here in Nebraska. Thank you.

LATHROP: Thank you for your testimony. Good afternoon.

CHELSEA SOUDER: Hello. My name is Chelsea Souder, it's C-h-e-l-s-e-a, Souder, S-o-u-d-e-r. I'm the director of clinical services at AbortionClinics.org, which is the offices of Dr. LeRoy Carhart in Bellevue, Nebraska. And I'm here to talk about this bill today. As many people know, decisions about pregnancy are extremely time-sensitive, whatever decisions are being made. It is essential that pregnant people and their families have timely and accurate information when going over their options. However we feel about abortion, once a person decides to end their pregnancy they should be able to access care without barriers. That includes forced delays, harmful unbiased-- or, excuse me, unproven politics or harassment. We work with every person who calls our clinic to ensure that they can access the care that they have chosen and that they need. Unfortunately, there are many barriers that prevent women from accessing care that they need, including waiting periods, arranging childcare, time off work, financial barriers, and unfortunately here in Nebraska traveling. We serve hundreds of women a year that come from outside of the metropolitan area, some of them traveling anywhere from four to five hundred miles just to access a procedure that they need to be in a clinic for two hours. Unfortunately for these-- for these people that are accessing this care that have to travel, coordinating that travel, lodging expenses, all the things I went over are just further barriers to access. And for many of them it's not something that's feasible. Ensuring people seeking abortion can do so safely, under the direction of medical professionals using evidence-based practices is vital in truly ensuring the well-being of pregnant people in this country, giving them the autonomy and self-determination to thrive in their own lives. Thank you.

LATHROP: Thank you, Ms. Souder. I don't see any questions today.

CHELSEA SOUDER: Thanks.

LATHROP: Appreciate your testimony. Afternoon again.

SCOUT RICHTERS: Hi again. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in strong support of LB503. We'd like to thank Senator Hunt for bringing this legislation. Allowing for medication abortion via telemedicine is consistent with Nebraska's tradition of leadership in telehealth. It upholds constitutional principles and it ensures safe access to care

for all Nebraskans, including rural and low-income Nebraskans. As you've heard, the provision of telemedicine for medication abortion, it would have particular impact in a geographically large state such as Nebraska where 97 percent of Nebraska counties have no clinics that provide abortions and 41 percent of Nebraska women live in those counties. The Supreme Court has recognized that a woman has a fundamental right to terminate a pregnancy and pre-viability restrictions cannot serve as an undue burden on that right. And now with the whole women's health that was decided in 2016, we must weigh the extent of the burden on a woman seeking an abortion against the state's justification for the restriction. And we can look to Iowa in that undue burden analysis with respect to medication abortion through telemedicine. And the burden placed on women, especially low-income women, to travel to a clinic is not justified by having a same-room requirement, as there were very few health benefits to such a requirement. Litigation in several other states, including Kansas and Idaho, have resulted in telemedicine continuing to be used for medication abortions under this same undue burden analysis. Nebraska has long been a leader in telemedicine and it's time we remove this unnecessary restriction on telemedicine being used for medication abortion given all that we know about the safety of medication abortion. We thank Senator Hunt, as well as all the cosponsors of the bill, offer our full support. And I am happy to answer any questions.

LATHROP: I don't see any questions today but thanks for your testimony.

SCOUT RICHTERS: Thank you.

SOFIA JAWED-WESSEL: Hello. Thank you to the committee for your time. My name is Dr. Sofia Jawed-Wessel, S-o-f-i-a J-a-w-e-d-hyphen-W-e-s-s-e-l. I reside in LD8. I am an associate professor in Public Health at UNO, and I come before you as an expert in public health, maternal and child health, and reproductive health. I'm going to skip good chunks, lots of chunks of my testimony, since they've been spoken already. I want to emphasize that both medication abortion and surgical abortions are practices that are very heavily monitored for their safety and adverse effects, as they should be. Multiple studies have proven that abortion delivered through telehealth is as safe as when the pills are-- are administered in person by a physician. We have both global and local studies that show this. So globally we've seen rigorous studies that examine telemedicine logs from a site called Women Help Women. Here we find

that almost all of the women who use this service confirmed that their abortion was successful, and most reported side effects that were tolerable and comparable to their menstrual period. Another large scale study in Thailand found telehealth distribution of "mife" and "miso" to be safe, effective, and acceptable to both providers as well as the patients. Women in both studies were able to determine for themselves that they were pregnant and didn't want to be, that they were eligible, based off of their gestational age, whether they had any contraindications that should leave them out of this pool of folks that take these medications, and if they need follow-up care. The in-clinic pregnancy tests, ultrasounds, and clinical examinations were not and are not necessary for medication abortions that happen correctly. Closer to home, from Iowa we have seven years of data comparing the prevalence of clinically significant adverse effects between telehealth administered medication abortions and in-clinic, in-person patients. Close to 9,000 telehealth medic-- medical abortions and over 10,000 in-person medical abortions were performed during that-- that seven-year period and there was no significant difference in the adverse effects that were documented. And in fact, there were less than 1 percent that documented any kind of adverse effect. I think that particularly keeping in mind once again rural Nebraskans, 41 percent of our-- the women that live in Nebraska are in rural counties where there are no abortion clinics. We can trust telehealth for providing quality care. We can trust women. We can trust the scientific evidence that supports the safety of this method of provision. Thank you.

LATHROP: I don't see any questions, but thank you--

SOFIA JAWED-WESSEL: Uh-huh.

LATHROP: --so much for your testimony. Good afternoon.

MICHAEL SAENZ: Good afternoon. My name's Michael Saenz, M-i-c-h-a-e-l S-a-e-n-z, here from AbortionClinics.org, the offices of Dr. LeRoy Carhart. I just have some anecdotal experiences to speak on. So right now, as somebody mentioned earlier, we only have two counties in Nebraska that have abortion clinics, unfortunately, and the rest of the women in Nebraska don't have access to care. Some of the logical conclusions that I've come to is that because of so many insurmountable barriers that women face, whether it's traveling, getting a lot-- care for their children in place, or finding-- finding the financial means to access an abortion is part of the reason why

they have to have delays to get their care. So not only does having access to early abortion help in terms of safety but also in delaying access to care to later abortions. So if people have to wait to get abortions later on in their pregnancy, you know, it makes it harder for them to get care in the state. So I would just like to say that I support this bill. Thank you.

LATHROP: Very good. Thank you for your testimony. Any other proponents of LB503? Anyone here to testify in opposition? If you don't mind coming forward, obviously somebody can get the chair, but if you don't mind filling up the front row so we can keep the hearing moving along since we have seven of them today. Good afternoon.

JULIE SCHMIT-ALBIN: Good afternoon, Mr. Chairman and members of the committee. My name is Julie Schmit-Albin, J-u-l-i-e S-c-h-m-i-t-hyphen-A-l-b-i-n. I'm executive director of Nebraska Right to Life, the state affiliate of the National Right to Life Committee. I appear today in opposition to LB503. And the U.S. Supreme Court has held that abortion can be treated differently than other medical procedures in Harris versus McRae. Abortion is not the same as following up on gallbladder surgery, diabetes treatment, or a broken leg. Telemedicine is about sustaining life and health. Abortion takes the life of an innocent living human being. In 2011 the Legislature inserted language into statute that would not allow the introduction of webcam chemical abortions across Nebraska. This language states that, quote, physician must be physically present in the same room, end quote, for any abortion and of course that includes not just surgical but also the chemical RU46 abortion pill regimen. At the time Planned Parenthood of the Heartland was conducting webcam chemical abortions at 16 satellite sites around Iowa up to seven weeks gestation. Planned Parenthood of the Heartland is now down to eight clinics across Iowa. Five of those conduct webcam abortions up to ten weeks gestation. In 2011 Planned Parenthood of the Heartland also announced that they wanted to expand to six Nebraska college towns with remote sites: Hastings, Grand Island, Kearney, North Platte, Norfolk, and Fremont. Opposition from pro-lifers ensued. LB521 was passed and Planned Parenthood never opened their remote sites. We are concerned that by LB503 taking this protective language out of the statute that it will give rise to Planned Parenthood's webcam abortion outreach again in these rural communities. Chemical abortions dispensed via computer addressed two problems for the abortion industry. The fact that they have a dwindling number of abortionists as well as the fact that they can't afford to put circuit rider

abortionists in rural areas to reach the counties that they would like to do with surgical abortions. Chemical abortion numbers have been rising and now make up half of all abortions done in Nebraska. We feel that removing this protective language will cause abortion numbers to rise here. The RU46 regimen also has that potential for more women to experience complications that they may not be able to discuss openly in an emergency room. The abortionists who initiated the action can be hundreds of miles away: so much for the patient-physician relationship. Any complications become the problem of the local ER in those rural communities. They may not be told that a chemical abortifacient is responsible for hemorrhaging. Additionally, young women who have told no one that they are pregnant are delivering their unborn babies alone and may not be equipped to deal with the trauma that ensues. Anecdotes of Iowa, out of Iowa, mention girls who have put their aborted babies in the freezer, not knowing what to do with them. Planned Parenthood Federation of America aborted over 327,000 babies last year and took in $500 million in tax dollars. Their affiliate in Iowa and Nebraska has now been merged with Minnesota, North Dakota, and South Dakota. They want to bring more chemical abortions to rural America where they have no presence now. Please vote against LB503. Thank you.

LATHROP: OK. I do not see any questions. Thank you.

JULIE SCHMIT-ALBIN: Thank you.

LATHROP: Good afternoon.

DARRELL KLEIN: Good afternoon, Chairman Lathrop and members of the Judiciary Committee. My name is Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I am deputy director of the Division of Public Health for the Department of Health and Human Services. I'm here to testify in opposition to LB503. As you know, LB503 strikes the language in Nebraska Revised Statute 28-335(2) that requires a physician to be physically present in the same room with the patient during the performance of an abortion. Violation of this requirement is currently a Class IV felony. The bill removes the physical-- physical presence requirement and the penalty for violating that requirement. The physical presence of the physician helps assure patient safety. The department opposes the bill because the lack of a trained physician in the room when the procedure is being performed diminishes patient safety and increases the chance of injury, illness, or death to the

patient, thereby causing increased risk to the public. I'd be happy to address any questions.

LATHROP: Senator DeBoer.

DeBOER: Can you tell me, I don't know how this all works very well. You've heard that. What does the doctor do, right, like-- because it seems to me like handing the-- the pills is not something the doctor needs to be present for.

DARRELL KLEIN: The department's opposition is because the lack of the physician being present diminishes what that doctor could do to help out if there's anything that goes wrong. So we're not really addressing what the doctor does in terms of-- of the administration of the drug. We're talking about the fact that there is some diminution of safety by having the physician no longer being required to be present.

DeBOER: Because of possible side effects or something?

DARRELL KLEIN: Yes.

DeBOER: OK.

LATHROP: I see no other questions. Thank you, Mr. Klein.

DARRELL KLEIN: Thank you.

LATHROP: Next opponent.

MARION MINER: Good afternoon again, Chairman Lathrop, members of the Judiciary Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, testifying on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here today to express the conference's opposition to LB503. LB503 would eliminate the requirement that a physician be present when an abortion, whether surgical or via the prescription of abortion-inducing drugs, is performed. In practice, this would mean the legalization of so-called "telemed" abortions. The conference opposes this change for several reasons. First, "telemed" abortions present significantly increased health risks to women because it would mean a physician need not ever meet with a woman who is seeking an

abortion in person. Since it was approved for use in-- in the U.S. in 2000, mifepristone has been linked by the FDA to 22 deaths, 97 undiagnosed ectopic pregnancies which can be fatal themselves, and 4,185 total adverse events as of December 2017. And I have attached in the handout those statistics from the FDA. That a physician should perform needed tests on a pregnant women that can only be done in person, such as to diagnose an ectopic pregnancy, and that a doctor should be readily available in the event of significant complications is a common-sense requirement before prescription of a drug whose use may result in serious health complications. Second, the people of Nebraska have made clear time and again that they do not want to see a liberalization of the state's abortion laws. Nebraska was the very first state to allow-- to disallow abortion after 20 weeks and enacted the physician presence requirement in 2011. We have enshrined in statute a recognition that it is the will of the people of the state of Nebraska to provide protection for the life of the unborn child whenever possible. Countless other examples abound. Third, the elimination of the physician presence requirement is likely only the first step in a series of reforms that have been pushed in other states in recent years, including pushes to eliminate the requirement that only physicians perform abortions. These, quote, reforms are enacted at the behest of an abortion industry that recognizes it can realize greater profits where there are less restrictions, including laws which require the personal presence of a physician. Fourth, it's difficult to ascertain how the requirements Nebraska has for informed consent can all be satisfied if the physician and the patient never meet in person. Finally and most fundamentally, abortion is simply a terrible and tragic evil that should not be expanded. Efforts to help vulnerable women who feel they have no other choice exist but they need to be promoted and expanded. Many women seek abortion in desperation because they feel they have no other place to turn, and that is a travesty. The toll on mothers and on unborn human life has been devastating. More than 60 million children have been aborted in the United States since 1973. And I'll wrap up just by saying that we should be intent on reducing those numbers and helping women to know that they have another place to turn.

LATHROP: OK. I don't see questions. I do want to ask you a question while I have you here, and this is pretty unusual, I'll admit, but when you testified on the last bill you handed out two things, both of which appeared to have this Dr. Delgado as one of the authors.

MARION MINER: Right.

LATHROP: And the-- the one I think that you wanted us to take a look at, well, you want us to read both of them.

MARION MINER: Right.

LATHROP: The one that seems to have caused the concern is this one entitled "A Case Study Detailing the Successful Reversal."

MARION MINER: Uh-huh.

LATHROP: Right?

MARION MINER: Right.

LATHROP: And so after you testified, I didn't know about this and you and I didn't talk about this in advance,--

MARION MINER: Right.

LATHROP: --after you testified we heard that they've been asked, the people that published this, have been asked to pull it. And then Senator Albrecht suggested that maybe that's not the case.

MARION MINER: Right. Thank you for giving me an opportunity to address that.

LATHROP: I'll give you-- I'll give you, let's say, a minute.

MARION MINER: Sure. Sure. I'll-- I'll do that as quickly as I can.

LATHROP: [INAUDIBLE] what's the status of the study.

MARION MINER: Right, the status, yeah, the status of the study is good. It's been republished. It's been republished for several months. So--

LATHROP: Where?

MARION MINER: Where? In the same journal, Issues In Life [SIC] and Medicine. What I-- what I handed out to you is the republished study. So the first study came out. There were some issues with regarding the time line for the data analysis that was presented to the institutional review board. And the review board pointed out, after

the study was published, that the time line established for when these data analyses are taking place was not quite consistent with-- with the-- with the time line established for the study. So it was a technical error based on the time line. So they said, we're going to have to pull this study and you're going to need to republish it after you make those corrections. So they corrected the data time line to-- to line up with what they had.

LATHROP: And it hasn't been criticized since?

MARION MINER: I mean it's-- it's been criticized by people who-- who aren't interested in finding out what the-- what the results are. But as far as the-- as far as the criticism that it's not-- it wasn't ethically done or that it was based on that women weren't consenting to the-- to-- to-- to the study being performed, that's false, and I think that that's actually addressed in the study.

LATHROP: We'll take a-- we, of course, the committee, will take a look at it. OK?

MARION MINER: Sure.

LATHROP: Not that we give people an opportunity for rebuttal, but I was trying to sort that out and we'll continue to try to sort that out.

MARION MINER: Right. Thanks a lot.

LATHROP: Hang on one second.

MARION MINER: Uh-huh.

LATHROP: Senator Brandt.

BRANDT: Thank you, Chairman Lathrop. Thank you, Mr. Miner, for testifying. Just so I'm clear on your position, the Catholic Conference is not against telehealth?

MARION MINER: The con-- the conference isn't against telehealth in gen-- well, we-- we haven't really taken a position on telehealth one way or the other. So I know that there have been concerns about whether it's necessarily the best practice in all cases but there are disagreements about that and we just have never had a position on it in general. With regard to abortion, we have always opposed that not

only for-- not only because we don't believe it's in the best interest of anybody to expand abortion but also because there are significant concerns with-- significant concerns with the health of the woman should complications arise.

BRANDT: All right. Thank you.

LATHROP: OK. I don't see any other questions. Thank you, Mr. Miner.

MARION MINER: Thanks a lot.

LATHROP: Good afternoon once again.

CHRISTINE GUENTHER: Good afternoon again. I'm Christine Guenther, G-u-e-n-t-h-e-r. I am the executive director for Nebraskans Embracing Life. I'd like to start by saying that one thing the opposition said here today is that not every woman regrets their decision to have an abortion. This is true. But what concerns me is the many women who do regret their decisions. And I'd like to start by saying specifically on this bill, if this is just an easy to swallow pill, why isn't it available over the counter? Why do we-- why do we need a physician to prescribe it to begin with? I'd like to relate something that happened when I was working at Creighton Hospital one time when one of my colleague nurses administered a medication to a patient and I was asked to go in that room and assist with that patient. The patient had a very serious allergic reaction called an anaphylactic reaction. At that point we had to call a code and thank God that that patient was in the hospital and able to be immediately transferred to ICU. We are here concerned about the so many women who live in the rural areas because they don't have access to this medical care. My question to this legislative senators is what happens if something like that happens out in these rural areas where these patients are being seen by a "telemonitor" and they need a physician to reverse that, not just some nurse? Who is going to take care of these patients? How are they going to be transmitted to the hospital? Does anybody have the numbers on that or the amount of time that it's going to take to get them to that hospital? The CDC reports that 431 deaths have occurred as a result of these medical abortions. These aren't my numbers. These are from the CDC. How about the assessment of a patient who's suffering from severe anxiety? Can you tell that by just being over a "telemonitor"? Because as a nurse, I've assessed many patients and sometimes you need to be right with them. You need to be able to look into their eyes. And when they have a full-blown anxiety attack, how

are they going to get immediate help? And my question to you is, do you want to be responsible for making a decision like this on a medication that is not even available over the counter? It's not as simple as swallowing a pill. The other thing I'd like to say in wrapping up is we are always accused of being the ones who don't care about women, but we are the ones who are there each and every time to clean up the mess after the providers get their money and are long gone. Thank you for hearing me today.

LATHROP: Senator Brandt has a question for you.

BRANDT: Thank you, Ms. Guenther, for testifying. I'm from a rural area. OK? It sounds like you're really anti telehealth. You know, a lot of people rural areas live hours from Omaha and Lincoln. It's not very convenient to go to a top-notch hospital all of the time for any procedure. And it just sort of sounds like to cover the hospitals or the doctors, cover all the bases, we need to be in the hospital. Do you not see any value to telehealth?

CHRISTINE GUENTHER: Maybe there's a value to it. I suppose there might be. But in this particular case, when a medication that can't even be purchased over the counter is given to a patient and there is-- could be a risk to anaphylactic reaction, I would like to know how those patients are going to get to a hospital fast enough.

BRANDT: In my experience I had a neighbor that did telehealth for the V.A. She's a psych nurse and she would do that with-- out of the hospital here in Lincoln to a nursing home in Iowa. In Iowa there would be a qualified medical individual on the other end of the telehealth to help with the diagnosis. I would envision this would probably work the same way.

CHRISTINE GUENTHER: It might for psych, not for an anaphylactic reaction where a patient would need immediate, and I mean immediate, help.

BRANDT: Thank you.

CHRISTINE GUENTHER: Thank you.

LATHROP: Thank you.

CHRISTINE GUENTHER: Thank you.

KAREN BOWLING: Good afternoon,--

LATHROP: Good afternoon.

KAREN BOWLING: --Chair Lathrop and members of the Judiciary Committee. My name is Karen Bowling, K-a-r-e-n B-o-w-l-i-n-g. I serve as the executive director of Nebraska Family Alliance and am testifying on their behalf. NFA is a nonprofit policy research and education organization that advocates for marriage and the family, life, and religious liberty. We represent a diverse statewide network of thousands of individuals, families, and faith leaders. We oppose LB503 telemedicine abortions because it eliminates requiring a physician's physical presence in the same room when performing, prescribing, or inducing an abortion. Women deserve the best standard of care with the presence of a physician when pursuing medicated abortion. When complications arrive, care should include a physician present who can examine, evaluate, and provide care as needed, particularly when complications occur. Medication abortions include risk factors. According to a 2017 report, FDA Mifepristone Post-Marketing Adverse Events Summary, the abortion pill masked symptoms of ectopic pregnancy, such as vaginal bleeding, pelvic pain, and sharp abdominal cramping. Diagnosis can be missed without a pelvic exam. In fact, it oftentimes it does require a pelvic exam and even an ultrasound cannot detect that. Efficient-- a physician must be present. Patient safety can be compromised. In closing, one of NFA's core values is to reaffirm the unique value and dignity of individual human life in all stages of growth and development, from fertilization onward. Senator Lathrop and committee members, we ask that you not advance LB503. And I'll take any questions.

LATHROP: OK. Thank you, Ms. Bowling.

KAREN BOWLING: Thank you.

LATHROP: Good afternoon.

JOHN DOCKERY: Good afternoon. Thank you for letting me testify. My name is John Dockery, that's J-o-h-n D-o-c-k-e-r-y, and I'm from Omaha. I'm opposed to LB503 eliminating the requirement that a physician be present in the same room when a medical abortion is performed. A 2015 study in Finland found there is a much higher complication rate with medical abortions than with surgical abortions. Every patient considering these procedures has the right to a physical

exam and personally seeing a physician before making such a decision. In a recent interview with Donna Harrison, executive director of American Association of Obstetrics and Gynecology, she talked about the health risks and dangers of medical abortions. Both drugs, mifepristone and misoprostol, are immune suppressant drugs. Infection is one of the most serious complications in a medical abortion. Holly Patterson of California died within two weeks of taking these drugs. She was perfectly healthy. And there are many more, as it was testified today, who have died also. Dr. Harrison said that medical abortions can be very painful with side effects that can last much longer than indicated: intense cramping that can even require narcotics, bleeding which can last for weeks. You cannot predict when the baby and the placenta will pass. You could be in the office, you could be in an elevator, or even driving your own car. Over 95 percent of doctors surveyed do not want to be involved in these procedures, which is one of the abortion industry's biggest problems. Isolating women from a physician at this critical time is more about profit than the safety and health of mothers. Dr. Harrison says when most physicians see a pregnant woman in the office they see two patients. Please vote against this bill.

LATHROP: You know I'm just going to say something. When you started your testimony and you thanked us for the opportunity, that's what we're here for. We appreciate you came down here today to share your thoughts.

JOHN DOCKERY: Thank you very much.

LATHROP: Anyone else here in opposition to LB503?

JOHN DOCKERY: Can I make one comment?

LATHROP: I think you had a little bit of time left on the lights.

JOHN DOCKERY: Yeah. Well, I'd like to compliment you also, because I was here, you know, a few weeks ago when we had all those testifiers and you held everybody to the three minutes that we have. And I've testified here years prior to that where people, Chairmen disregarded that and just let people go on and on. But anyway, so that particular day, even though it was very, very long, it went, I thought, very, very well.

LATHROP: Yeah. Thank you. I appreciate that.

JOHN DOCKERY: Sure. Thank you.

LATHROP: Committee tries to be fair with everybody that testifies. Anyone in the neutral capacity? Are you here for neutral?

KELSEY LEINEN: I'm a proponent. I was a little late.

LATHROP: OK. Go-- go ahead. No, that's all right. If you were late, we'll let you-- as long as it's not rebuttal testimony.

KELSEY LEINEN: No.

LATHROP: OK. We don't allow that. But go ahead.

KELSEY LEINEN: Well, hello. My name is Kelsey Leinen, it's K-e-l-s-e-y L-e-i-n-e-n, if that matters.

LATHROP: Just a little bit louder if you don't mind.

KELSEY LEINEN: Oh.

LATHROP: You're good.

KELSEY LEINEN: I-- sorry. I'm very nervous. I want to start by saying that today I have a wonderful job that I enjoy. I have a partner that I love who supports me. I have a savings and a safe home. But getting to this point has been somewhat messy. So prior to today I have had two abortions in this state, one because I was very young and very stupid, and the other because I was unaware of medication I was taking could compromise my birth control. In these I was very lucky. I was able to make an appointment and pay immediately. And both abortions were performed prior to eight weeks. They were done very quickly, very easily, and the pain was almost entirely due to a sense of shame and secrecy, which I obviously now reject. At that time, because of that sense of shame and secrecy, I would say that I was suicidal. I would have done anything to-- to not, you know, be in that position, including, as I said, to hurt myself. So what I'm getting at is that I understand that not everyone in this state has the resources that I have had. They don't have the luck or the clinics nearby that I had access to. And so I'm coming here to tell you this today because I would like everyone, particularly in a rural communities like where I grew up, to have the opportunities that I have had to get to a place

where, you know, hopefully I do get to start a family when I'm ready. And that's all I have for you. Thank you.

LATHROP: OK. I don't see any questions but thanks for coming down. And to be clear, you were a proponent of LB503,--

KELSEY LEINEN: Proponent.

LATHROP: --out of order. Yeah.

KELSEY LEINEN: Yeah. Sorry.

LATHROP: We-- we keep a transcript and I just want to make sure the transcript reflects what your position was. Anyone else? Thank you so much. Thank-- anyone else here as an opponent or anyone here in a neutral capacity? Seeing none, Senator Hunt, you are free to close. And as you approach the testifier's chair, I'm just going to note for the record that we have 2 letters in support, it looks like 25 letters in opposition, and 1 letter in the neutral capacity, part of the record. And with that, you may close.

HUNT: Thank you, Chairman Lathrop and members of the Judiciary Committee. And thank you to everybody who came out to testify today, both for and against. One thing that I talk about a lot is that we have to engage with our local elected officials, and I just want to thank everybody for taking the time to do that. In Nebraska we really have a first-class medical community. On a daily basis our healthcare professionals determine when any healthcare delivery method is safe, including telemedicine, for many, many areas of care, including birth, including cancer treatment, including literally everything except abortion. Telemedicine for medical abortion should not be any different. Telemedicine in this case just allows a physician to prescribe and dispense medication by video. This has been proven to be perfectly safe and cost effective. It's not administered while you're sitting on a couch at home. It's-- it's nothing done in any unethical way. It's administered in a clinic under the supervision of a PA or a nurse or another medical professional, and it's a way to get access to people, especially in rural areas who really need it. I respectfully, since Senator Lathrop brought it up, I want to again address I would be very careful to use anything that's published that's been under review or investigation by a university that sponsored it. Because in Dr. Delgado's case, the numerous concerns about his methods and his lack of scientific, ethical procedures, and the scientific community

has raised a lot of concerns about his practices and findings, and these are not findings that we can trust. And since I got another turn on the mike, I wanted to say that for the record. As more and more women's healthcare clinics are closing under the weight of governmental restrictions all over the country, especially in Nebraska, telemedicine is an increasingly crucial option for low-income and rural patients. In all medical contexts except abortion, Nebraska authorizes physicians to use telemedicine to provide treatment and prescribe medication. To not offer telemedicine for abortion is to create an undue burden for Nebraska women. Thank you.

LATHROP: I do not see any other questions. Thanks for introducing LB503. That was a good hearing.

HUNT: You're so welcome. My pleasure.

LATHROP: Good. Good.

HUNT: Thanks, Senator.

LATHROP: That will close our hearing on LB503. I think we're gonna take five minutes because the chair needs to stretch. So we'll be back in five minutes to take up the last few bills.

[BREAK]

LATHROP: All right. You ready to go back?

WAYNE: [RECORDER MALFUNCTION]-- but with the issue of what I believe is our prison population, figure out a way to not get people in the door. LB91 is something that is similar to the rest of the country. Actually, 37 states right now do what's called deferred judgment. We are one of the states who don't. And if you look across the river at Iowa, they also do it. And what we'll hear is that there are some issues and procedurally that we could change to probably get there. But in fairness to this committee, we spent this year working on the witness tampering bill that came before us and we just never got around to negotiating how we can make this work for all the parties. But I think we can get there over the summer. With that being said, this bill would provide an alternative to sentencing, particularly for the first offender-- offenders of minor charges. Participants would likely be required to complete some type of rehabilitative programming, such as on probation or alcohol treatment, similar things

that are-- are a part of those programs as opposed to a traditional punishment as jail or prison. Like I said, other states have had this. And the reason why this is important is because even if you are charged with a felony drug court and you go to drug court and you do all the things to stay clean for a year and-- and graduate from drug court, oftentimes you go from a Class III or Class II to a Class IV. But it's still considered a felony and that felony still gives the social ills that follow that for the rest of your life. This is a way to remove some of that. And this is actually an easier way than proposing to remove Class IV felonies altogether, which is where I would like this committee one day to go. But this is just a way to lessen the population, I think, in our prison and to make sure that we provide opportunities for those who make mistakes one or two times, particularly the first time, to not have a felony around them, holding them back for the rest of their life. And with that, I will answer any questions.

LATHROP: I see none. I'm-- I'm gonna ask one quick one. Did I hear you say that there-- that you already understand there's some opposition to the procedure?

WAYNE: Yes. There's a little bit of opposition but it's procedural stuff that we can sit down and figure out. Again, we just didn't get to it this year because we were working on the other bill that came out of this committee.

LATHROP: OK. Perfect. Thanks,--

WAYNE: Thanks.

LATHROP: --Senator Wayne. First proponent of LB91. Welcome.

JOE NIGRO: Afternoon. Senator Lathrop, members of the committee, I'm Joe Nigro, J-o-e N-i-g-r-o. I'm the Lancaster County Public Defender and I appear in support of LB91. I want to thank Senator Wayne for introducing this needed legislation. I became aware of the concept of deferred judgment probation a few years ago when I became frustrated when applicants for drug court were turned down because their drug problem wasn't severe enough. These people were told that they could seek to be placed on probation. The problem is that drug court graduates get their case dismissed; people who complete probation still have a felony on their record. They can try years later to have it set aside, but that doesn't happen easily. In at least 37 states

deferred judgment exists for a variety of offenses. Iowa is one of those states. Under Nebraska law, once sentence is pronounced by the court, the case is final. With deferred judgment probation the court keeps control of the case and can dismiss it after probation has been successfully completed. This helps to restore people completely to society. They can say no when asked on a job application if they've been convicted of a felony. It could impact eligibility for federal student loans and federal housing. All of these things can help someone to be more likely to be successful and less likely to reoffend. This dismissal isn't a gift. People have to earn it by successfully completing probation. Judges decide who even gets the opportunity. They don't have to place people on deferred judgment probation. It's unlikely that deferred judgment will be granted for a number of offenses or for people who have significant criminal records. It will motivate some defendants to seek probation instead of just doing time, and it will motivate defendants to successfully complete probation. This concept is similar to other steps the Legislature has taken, such as ban the box, to restore people fully to society after they have served their sentence. If people are fully restored they are more likely to be successful in life, benefiting us all. I urge you to advance LB91. Thank you.

LATHROP: OK. Is this like diversion?

JOE NIGRO: Well, generally, diversion happens at the very beginning of a case and--

LATHROP: This happens after a conviction.

JOE NIGRO: This happens after somebody pleads but what happens is, instead of the conviction being final, the court basically delays it. It would be similar to when somebody comes to drug court and they plead to the charge but they're not sentenced. The sentencing is delayed. And then if they complete drug court their case gets dismissed. And in this situation the court still maintains jurisdiction. And so if the person can complete probation successfully, do a specific type of probation, at the end the court can dismiss it. Some states require a hearing. Some just do it automatically. Some limit it to certain types of offenses. But it's really something that we should be doing here in Nebraska. I mean when it's in 37 states, this isn't some radical concept.

LATHROP: OK. We don't always jump on board with what other states are doing, especially this committee.

JOE NIGRO: [LAUGH] Well, better late than never but--

LATHROP: I don't see any other questions, Joe. Thanks.

JOE NIGRO: All right. Thank you.

LATHROP: Any other proponents? Anyone here in opposition?

JEFF LUX: Good afternoon, members of the committee. My name is Jeff Lux, first name Jeff, J-e-f-f, last name Lux, L-u-x. I'm a deputy Douglas County Attorney and here representing the Nebraska County Attorneys Association. I guess opposed as introduced I guess is the right way to kind of describe where we're at. We-- we've-- we've talked with Senator Wayne in terms of, you know, this is a concept that other states use, a bunch of states use. We're not opposed to having this type of concept in Nebraska. We'd just like to work through it with him and-- and the defense bar on, you know, what would work here in Nebraska. I mean the concept of deferred judgments could be beneficial for the jurisdictions who don't have the number of cases or the resources to set up their own drug court or Veterans Treatment Court or diversion like-- like we do in Douglas County, so it would allow those jurisdictions to be able to offer those defendants something very similar, which would be, OK, you can go through some type of programming through probation instead of a problem-solving court type of scenario, and then if you make it through the case is dismissed, sealed, how-- however, you know, you want to set it up. It would allow those type of options for different jurisdictions, which I think is-- is something to look into. For jurisdictions that do have those types of courts, those like we do in Douglas County, we do have kind of a gap that was mentioned by the previous where, you know, it's best practice for those courts to take high-risk, high-need. And so we do have situations where, well, you're high-risk but low-need or you're medium, medium or whatever. And so if it's still a little too serious for us to put in a diversion program then, yeah, you're stuck with, well, some type of plea and they've got a conviction and you're-- you're off doing probation with a conviction. So it could kind of work in conjunction with drug courts or problem-solving courts to kind of fill that gap. I would be afraid that-- I wouldn't want it set up in such a way that would undermine our problem-solving courts, like, well, I don't want to do drug court; I rather do, you know, I'd

rather do a deferred judgment type of scenario. But you know we've talked with Senator Wayne. I-- I think we can get in a room and work some options out that we could, you know, present in a future session. So you know there's-- there's-- there's different issues we've talked to the senator about. He's willing to-- to sit down and-- and at least, you know, work through those with us. So I think that just the concept of deferred judgments could be beneficial in certain ways, so.

LATHROP: Well, sounds like Senator Wayne is amenable to that and we appreciate the county attorneys' interest in trying to work through the language. I don't see any other questions for you, Mr. Lux, but thanks for being here,--

JEFF LUX: Thank you.

LATHROP: --for your testimony today. Anyone else here in opposition to LB91? Anyone in a neutral capacity? Seeing none, Senator Wayne, would you care to close? He waives closing. Before we close the hearing, though, we do have a letter of support from Spike Eickholt with the ACLU, and four letters in opposition from Nancy Carr, Ron and Lynette Nash, Kathy Wilmot, and Lester Unruh, U-n-r-u-h. No neutral testimony. With that, we'll close the hearing on LB91. That will bring us to, for those of you that are here today, we're going to have Senator Wayne introduce both LB89 and LB652 since they are similar and on the same subject. And with that, Senator Wayne, you are good to open on LB89 and LB652.

WAYNE: Thank you. Good afternoon, Chairman Lathrop and members of the Judiciary. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent Legislative District 13, which is north Omaha and northeast Douglas County. First, I want to talk a little bit about LB89, but both bills' overall concept is dealing with the issue of these arbitrary numbers and placements on marijuana that allows-- has helped create, I believe, the overpopulation of our prisons and at the county level the overpopulation of our counties. So I'll start with LB60-- LB652. This bill will correct the abuse and injustices within the system. Right now there's no basic distinction and no protection from prosecutors from someone simply caught with a pipe that has residue versus someone caught with actual measurable amounts. Why is that important is because residue is what residue sounds like. You can't get high. It's not unusable. But there is enough for a dog to sniff or enough that maybe in some instances could be tested. But the reality is this is a Class IV felony. What this bill does is try to make it--

well, it does make it a Class I misdemeanor for somebody in possession of residential-- residue. The bill defines residues as drugs customarily sold by weight, amounts less than .1 gram or less; the-- for drugs not customarily sold by weight, amounts less than one dosage unit; ashes, resins, and other remains of controlled substances that have already been consumed but not-- is-- but is not a usable amount. I just want to remind this committee that this bill, and the identical amended version is this bill right here, was LB971. I introduced it last year and this was voted out unanimously 8-0. We just ran out of time. As we shift to LB89, the continuation of what I believe are the injustices in our marijuana law, LB89 reduces the penalties for possession with intent for those who are caught with a certain amount under a certain weight. This actually is very ironic that today we're having this hearing because this is actually the issue we were debating on the floor today. What does it mean to be a distributor versus a nondistributor? We have arbitrary numbers in the marijuana statutes that make the presumption that you are a distributor and this actually raises it to a point where most people would agree if you're over this threshold you may be a distributor and that burden of proof would rely on-- would fall on you in some instances. And what I mean by that, this law distinguishes between is simply being caught with a lot of marijuana versus being caught with a significant amount that would incite trafficking levels. Our-- our law needs to be nuanced because, if not, we are doing what we're currently doing which is prosecuting people who simply may have a habit, although illegal, but are not considered drug manufacturers or distributors. This law would change if you were caught with the intent to deliver with five pounds or less, the crime is lowered to a Class IV felony. If you are caught with five pounds or more this changes nothing and it remains a Class IIA felony. For simple possession, this bill would lower the amount to a Class I misdemeanor. Anything more than a pound, this raises the floor that is once charged from someone who has an ounce: Class III misdemeanor for possession from three ounces to a pound, and a Class IV felony is a simple possession of five pounds or more. In short, this bill addresses the amounts for the charges, the amounts that were completely and, let me stress, arbitrary to begin with. I am attempting to adjust these penalties to modernize and moderate-- modernize our marijuana laws to match not only what's going across nationally but the "unjustice" we've seen done here with individuals being charged as drug trafficking when that is not at all the case. With that, there will be a couple people who could answer some other questions that deals with this issue. And I won't get into, but if we

have to get into, the historical context of the war on drugs and how it hurts and "hurted"-- and hurt the African-American community and it's this distinguish between these laws and arbitrary numbers that were part of that overall war on drugs or war on my community. And with that, I'll answer any questions.

LATHROP: I do not see any questions. I think your opening was pretty clear. I appreciate that, too, and your willingness to do both hearings at one time. If you are going to testify as an opponent or a proponent, please indicate which bill you're referencing with your testimony so that we can keep a clear record. Please, first proponent.

SPIKE EICKHOLT: Thank you, Chairman Lathrop 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 testifying as a proponent for both LB652 and LB89. I'm also appearing on behalf of both the ACLU of Nebraska and the Nebraska Criminal Defense Attorneys Association. We support both bills. Senator Wayne gave a-- a very good explanation of the-- what both bills do. I just wanted to add to that a bit. LB89 adjusts the penalties with respect to marijuana. I just ask the committee to keep in mind that right now there is no minimum weight for proving up the charge of possession with intent or even distributing. In other words, you can have a relatively small amount. And I've seen cases where people have had less than an ounce of total marijuana. But the facts support the charge that the person with possessing less than that ounce with intent to sell or distribute that. And that's a felony, zero to 20 years. That's the same penalty for someone who's caught on I-80 with 500 pounds of marijuana. There's no distinction. And prosecutors do charge and, in my opinion, overcharge those kind of cases. An ounce is an arbitrary amount. The other parts of the statute talk in terms of grams and that kind of thing. And the federal system is penalized based on gram weight and-- and that way of measuring it. But to keep in mind, a gram is a paperclip weight. So kind of shifting to LB652, that's the residue bill. Senator Wayne is right. This is the identical version as was amended by the committee last year. And you see residue cases on what's commonly considered the hard drugs or someone is caught with a pipe or someone's caught with an empty baggie or a baggie they think is empty and is charged as a felony. These are in fact charged as felonies. The opposition I think last year asserted that they were not. They are. And I will tell you they are because one of your colleagues actually sat on a jury that I had a couple of years ago where my client was charged with a possession of a pipe. It was a residue amount. That colleague is now Senator Anna Wishart. You can

ask her. She served on the jury. Not only was it charged as a felony; it went to jury trial. The issue in the case was whether my client knew or intentionally knew that the discoloration on the pipe that she had in her purse was in fact methamphetamine. An expert from the state lab had to come testify to that because you can't really know for sure that that stain still tests positive for the presence of methamphetamine. My client was convicted. My client received a maximum sentence and she went to prison. I had another case last fall. It admittedly involved a gun charge. Another person you might know was on that jury as well. There was a drug car-- charge and a gun charge. It was another lobbyist, Rochelle Mallett. She was on the jury panel. She was not chosen. But that was another case. And I know it's not fair perhaps to argue by anecdote, but I mention this to you that these in fact are charged as felonies and people do go to prison for them. And this brings a right amount of distinction because when you're talking about a residual amount, a part you can't even hardly see with the naked eye let alone measure or consume, people are charged with that equivalent to having a measurable amount of a hard drug. So I think these are very good bills. At least get the consideration of moderating some of these penalties that we now have under current law. I'll answer any questions you have.

LATHROP: I do not see any questions but thank you for your testimony, Mr. Eickholt.

JOE NIGRO: I'm going to testify on both bills. I'll speak first on LB89 because I wrote separate testimony. Senator Lathrop, members of the committee, I'm Joe Nigro, J-o-e N-i-g-r-o. I'm the Lancaster County Public Defender and I appear in support of LB89. I want to thank Senator Wayne for introducing this bill. This bill would reduce the penalty for possession or delivery of up to five pounds of marijuana. Legalization of marijuana across the country is inevitable. The war on drugs hasn't worked any better than Prohibition. Use of marijuana runs across racial and socioeconomic lines, yet African-Americans are four times as likely to be arrested and charged for marijuana offenses. Just last week the Hennepin County, Minnesota, County Attorney, that's Minneapolis, announced that they would no longer prosecute people for possession or sale of up to 100 grams of marijuana. Other prosecutors are also reevaluating how they handle these cases in light of the disparate impact of marijuana laws on people of color and the reality that marijuana is now legal in several states and Canada. When a conviction has a more devastating impact than the use of the drug, it's time to reevaluate the policy. This

bill would be a small step in the right direction. I urge you to advance this bill. Regarding LB652, OK, can I? Regarding LB652, Senator Lathrop, members of committee, I'm Joe Nigro, J-o-e N-i-g-r-o. I'm the Lancaster County Public Defender. I appear in support of LB652. I want to thank Senator Wayne for introducing this bill. The crime rate has been going down since 1992. This is true in Lancaster County. It's true across the country. But felony filings here have significantly increased the last four years, in the time that I've been the elected Public Defender. It's been driven by an increase in filings of possession of small amounts of a controlled substance, especially residue cases. I'm talking about substances other than marijuana. Residue is what is left after the substance has been used. By definition, you cannot get high from it and there usually isn't enough to weigh. I don't believe drug use has increased. It appears that more items are being sent in for testing. These cases burden the system. The crime lab takes three, four months to test items. Filed as felonies, these cases clog county and then district court. Our office has workload standards. Each month when we reach our limit, we file overload motions. When half of our felonies are drug cases, 70 percent of our drug cases are possession cases, and at least 39 percent of those possession cases are residue cases and would be reduced to misdemeanors under this bill. Outside attorneys who bill by the hour when we overload cost thousands of dollars. Some of these people charged sit in jail, unable to make bond. Most of these cases are resolved with a plea to a misdemeanor, resulting in a large fine which people ultimately sit out in jail or a jail sentence, few receive probation. It would be one thing if all of this was reducing drug use and making our communities safer. It isn't. This is a classic example of the failed war on drugs. Who does this hurt? It hurts the-- the poor and people of color. Last year Senator Wayne introduced a similar bill that included making up to 1 gram or 10 pills a misdemeanor. The Douglas County Deputy Attorney and law enforcement people who testified were opposed to those amounts but they basically testified they didn't care about residue. They didn't see that as an issue. The bill was amended to only residue in committee which-- because that wasn't controversial and it was advanced out of committee. So I urge you to again advance this bill because it would solve what's become a huge problem here in Lancaster County certainly. Thank you.

LATHROP: Senator Brandt.

JOE NIGRO: Yes.

BRANDT: Thank you for testifying today. How much would this reduce your overall load if-- if the new law was in effect?

JOE NIGRO: Well, it would be, trying to think, I mean it-- it-- it could wind up-- it's my feeling that if residue was only a misdemeanor, I think that it's likely that many of these items would never be sent in for testing. I mean I think they get sent in for testing because the officers know it's going to result in a felony arrest. I think it could wind up being the caseload of a couple of attorneys. And right now, based on our workload standards, we could probably hire about eight more attorneys and save the county money. When we get to a certain tipping point, around 100 cases, it's cheaper for the county to hire, give us more staff than to appoint outside attorneys who bill by the hour and-- and so it's significant. I mean when it, you know, you're talking about 70 per-- 50 percent of our felonies are drug cases and 70 percent of those are possession and, you know, a pretty big percentage of those are just residue. So we're talking a tenth of a gram. I mean it's almost nothing. It's usually you're talking about scraping the ashes out of a pipe. And so it-- I see a significant-- and you're talking about a lot of people who wind up sitting in jail, unable to make bond. Not very many wind up going to prison, but there's still some. I've seen it happen over time. So there's a cost to the-- the system at every stage.

BRANDT: But you don't have any idea how much you could reduce your jail population?

JOE NIGRO: I think that by the numbers I saw in last year, I think it was about 45 people. Now you know those people, you know, if you're talking about people in jail, it's $100 a day to keep somebody in jail. And if the cases drag on at all, you know, again you're talking about thousands of dollars. But I haven't looked at those cases. And I mean I did figure out how many were unable to make bond and it's-- it's mid-40s I think.

BRANDT: All right.

JOE NIGRO: But I can't tell you how long each of those cases took to be resolved. And then if they get sentenced to jail there's an additional time.

BRANDT: So it would be a significant reduction.

JOE NIGRO: I believe that it would be a huge savings for the county.

BRANDT: All right. Thank you.

JOE NIGRO: You're welcome.

LATHROP: I do not see any other questions for you,--

JOE NIGRO: All right.

LATHROP: --Mr. Nigro.

JOE NIGRO: Thank you very much.

LATHROP: Thank you. Anyone else here as a proponent of either LB89 or LB652? Good afternoon.

BILL HAWKINS: Good afternoon, Senator Lathrop and members of the Judiciary Committee. My name is Bill Hawkins. B-i-l-l H-a-w-k-i-n-s. I'm here on behalf of a lot of people in the state of Nebraska. I've lived 45 years with this war on drugs in the front lines and it's been a long war. I think I remember watching our President Nixon sign that declaration on TV. Senator Wayne and his staff have worked hard to bring some reform that is greatly needed as this country and the world progresses to end this war on drugs. I'm here speaking on both issues because I knew-- I know clusters of mothers who their connection is their kids went to high school and now they are homeless meth addicts and they revolve in and out of prison, possibly just for that residue in this pipe we're talking about. Right now it is a disgrace on this state the state of our prisons. I've been in here about five or six years and I've watched this committee's hearings and everything about reforming, and we still aren't getting anywhere. And if these criminals would do things like that, they would be in prison. And so we have some real issues here. Senator Wayne's bill on reducing the amounts of cannabis possession is greatly needed. Usually I don't like baby steps but this is a big step and so it would greatly reduce that prison population. Right now, just as a estimate, there are approximately probably 32,000 cannabis consumers here in the Lancaster County area. They consume approximately one ounce a month. That is 6--2,000 pounds of cannabis is being consumed every month. The entrepreneur or business people who choose to supply that demand are working to supply that demand. And yet, because they're choosing that product, they're criminals. And so every month that amount of cannabis is being consumed here in this area. It's not going away. And so any

type of reform you will have the Attorney General come in and state how dangerous it is, how much psychosis it is causing across the world, and it's really not so. So look at the facts. And I appreciate your time and I'll answer any questions you have.

LATHROP: I do not see any questions, Mr. Hawkins.

BILL HAWKINS: Thank you very much and I appreciate you being in here.

LATHROP: Thank you. Anyone else here as a proponent of LB89 or LB652?

KELLEE KUCERA-MORENO: Good afternoon. Kellee Kucera-Moreno again, K-e-l-l-e-e K-u-c-e-r-a M-o-r-e-n-o. I'm here without my statistics. I'm here with personal experience. I've been in recovery since 1986 from drugs and alcohol. I met and married a man who was reformed and in recovery in 2000-- well, I met him in 2014, 2013 we got married. When he was imprisoned in 2005, he knew he was a drug addict, a drug dealer, a bad person. In 2005 he became-- worked on his reform and recovery. He worked on the programming that was offered to him in the corrections system and he makes the system look good. There were things that were offered to him. He did do what he was expected. However, there is this revolving door they call recidivism. It's recidivism because people keep getting sent back and it's not because they necessarily reoffend. It's based on if you-- if you violate a rule, if you relapse. You know, you don't have to have-- make-- do something horrible to end up back in prison. What nobody is talking about really across the nation is what it does to the families. The first day that you-- you put somebody-- you incarcerate somebody, they have a chance of losing their children, their job, their home, everything, and that's without even being charged with anything. You know, if you're picked up on something and you are not able to bond out, you sit in jail. I'm talking to an expert here. I-- I don't even know if I'm talking to the right people here. But the fact is that this war on drugs is it's over. You know right now we need to be working on reform, recovery, rehabilitation of families. This is costing a lot of money and it's not helping anybody. I'm ready to lose my house. I've already lost my truck. I've lost my husband. We are losing so many things because of this war on drugs that-- that's-- it-- it's over. We need to take care of our people. You know today I sat in the balcony and I heard somebody trying to figure out who we were going to give food stamps to, who was going to be the deserving people that would get to have food stamps. The Judiciary Committee knows what they need to do. You've already been given a road map and a

blueprint. I'm starting to get upset with that you guys do know what to do. You know people, the Oversight Committee has-- has researched this. I don't know what we need to do as constituents to make that happen. But there are a lot bigger things going on than sending somebody to prison for residue for a small amount of marijuana and destroying our families.

LATHROP: OK.

KELLEE KUCERA-MORENO: Thank you.

LATHROP: Thank you for your testimony. Anyone else here in support of LB89 or LB652? Seeing no further testifiers in support, anyone in opposition? Good afternoon once again [INAUDIBLE].

JEFF LUX: Hello once again.

LATHROP: Can just make sure that you're clear on which one you oppose--

JEFF LUX: Yes.

LATHROP: --or both.

JEFF LUX: I'm here on one. So I'm Jeff Lux, first name Jeff, J-e-f-f, last name Lux, L-u-x. I'm a deputy Douglas County Attorney here representing the Nebraska County Attorneys Association in opposition to LB652. As previous testifiers have testified kind of the history that the-- this bill kind of last year was negotiated out of a-- a previous bill and did basically cover residue. I guess that kind of some issue-- and it made it out of this committee I believe unanimously. There's some issues obviously with the con-- with consuming drugs and especially with the opiate epidemic that's been happening over the last few years and where we've been seeing an influx in-- in heroin use and fentanyl. And people are using fentanyl, carfentanyl, any other types of analogues from the fentanyl family in order to try and-- and-- and get that high because they've been using opioids for so long and then heroin for so long. And so we've even had some of the biggest seizures in the country of fentanyl right here in Nebraska. And the problem when you start using these other drugs is that the amount is so small. And so when we're-- we've been seeing now with the influx in heroin use and fentanyl use is that the-- the amounts that you can use are these .1 gram amounts which could be considered a user amount for heroin. That's a point of heroin. That's

a $40 amount of heroin. And the way that the-- the weight is currently written here that we'd be saying that a user amount, a point of heroin, would be considered residue. And-- and-- and same with fentanyl. I mean we've had cases where people have made drugs with fentanyl in it where they've used, you know, a gram like per pound with cut. And so when you knock that down, I mean you're talking grains of fentanyl that will make a bunch of drugs. And you know they'll make it in such a way that they'll put it in a solution so that it will hopefully get distributed throughout the entire solution and use food coloring. And when they spin it around enough and the food coloring has covered everything, they assume then that the fentanyl has gone everywhere. And they'll cut it with some type of sugar, dextrose, whatever, and they'll have it in there with, you know, grain alcohol. The grain alcohol then gets evaporated. You're left with a powder that has minuscule amounts of fentanyl in it but it's enough that can-- that can get you high. And so I guess our concern is with the-- the way the weight is written on here that opioids like heroin, the fentanyls, the carfentanyls, the other analogue fentanyls that people are making up, you know, like they used to K2, that a low, very low amount, even less than .1 grams we'd be having issues with in terms of, yeah, those are user amounts. They might even be possession with intent to deliver user amounts with the fentanyl family. So we've-- we've mentioned that to Senator Wayne. I think he's amenable to maybe addressing those concerns. There's-- with the-- I see my time's up, so.

LATHROP: Yeah. So is your, to be clear, is your opposition to LB652 and not LB89?

JEFF LUX: Yes. I'm only here on LB652.

LATHROP: Not on-- not on LB89. Don't have a position either way.

JEFF LUX: The County Attorneys Association didn't take a position one way or the other on that this year.

LATHROP: Thank you. I do not see any other questions. But thanks for your testimony.

JEFF LUX: Thank you.

COREY O'BRIEN: Good afternoon, Chairman Lathrop, members of the Judiciary Committee. My name is Corey O'Brien, that's C-o-r-e-y O-'-B-r-i-e-n, and I'm appearing on behalf of the Nebraska Attorney

General's Office in opposition specifically to LB89. We do not take a position as to LB, I think, LB652. The reason we have an issue with LB89 is really threefold. One, it eliminates any penalty or distinction from somebody that distributes less than a pound of marijuana. There are situations where people are possessing 8-9 ounces of marijuana and they're going to be treated the "zit"-- the same exact as somebody that just simply possesses and not selling an ounce and a half of marijuana. Additionally, we believe that it's wrong for Nebraska at a time when law enforcement agencies and-- and prosecutors are combating an ever-growing tide of marijuana trafficking, even more importantly the often violent and deadly by-products of this trade. Furthermore, it sends the wrong message to our youth who are increasing their use of marijuana across the board at a time when the marijuana available contains THC concentrations that produce effects that rival powerful hallucinogens like ecstasy and LSD. There can be no doubt that the black market manufacture and sale of high-grade and THC-potent marijuana is thriving throughout Nebraska. As a result, the profit margins are huge and the comp-- comp-- and competition especially fierce. Not as a coincidence, the incidence of robbery, violent assault, and murder have flourished in and around those involved in this lucrative trade. As an example, across this state I was able to find no fewer than six homicides, an untold number of home invasion style robberies, and traditional robberies that have occurred in the last six months here in Nebraska directly tied to the marijuana trade. Many of the people that are involved in the marijuana trade are part of international cartels and they bring in a nefarious element that poses great risks to our population. Make most-- make no mistake that the people that have amounts exceeding one pound are absolutely involved in drug trafficking. To exemplify this, you can conceivably get about 40 joints from an ounce of marijuana. That's about 640 per pound. With five pounds it's about 3,200 joints. In my 20 years as a prosecutor I've never seen a mere user of marijuana have more than two ounces. From the moment you cut marijuana, it begins to degrade, as does the THC potency. As a result, marijuana users do not buy in bulk but instead want the freshest and most potent marijuana available. At a time when we should be doing more to dissuade those from participating in the manufacture, trafficking, and the use of marijuana, LB89 would potentially be doing the opposite and potentially create an environment that will further proliferate it and all the ancillary side effects. As a result, the Nebraska Attorney General's Office is opposed to LB89. Thank you.

LATHROP: And to be clear, you don't have a position on LB652?

COREY O'BRIEN: Not one way or another. No, sir.

LATHROP: OK. Senator Brandt.

BRANDT: Thank you, Chairman Lathrop. Thank you, Mr. O'Brien, for testifying today.

COREY O'BRIEN: Yes, Chairman.

BRANDT: What you said is right. The THC content has gone up dramatically over the years and yet we don't address that in the law. So I mean some kid chops up a bunch of ditch weed, got five pounds of it. He's gonna get the same sentence as some high-grade product out of Colorado. Should this not include THC numbers in addition to pounds to quantify the scope of this?

COREY O'BRIEN: As I understand it, and I'm not a chemist but I talk to the chemists quite frequently, the ability to touch-- to test the potency at our crime labs doesn't exist at this point in time. So I don't know what equipment they need in order to test the potency. The Department of Agriculture, as I understand it, is developing a program so that they can test for the potency of the THC. But our crime labs themselves do not have that capability and I think would require a significant investment in order to do that. We are obviously concerned about the potency because the potency of-- of today's marijuana rivals nothing of my grandfather's marijuana. And that obviously is a huge concern of ours. Just this morning I was reading an article that was issued this morning saying that there's a direct correlation between the development of marijuana-induced psychosis, and I can get that article to the committee, and the high potency use of marijuana-- high-- use of high-potency marijuana. It was released from Europe. There were-- there were 940 cases of such psychosis.

BRANDT: OK. You're correct. Well, there is a hemp bill being proposed here in the Legislature.

COREY O'BRIEN: Correct.

BRANDT: And part of that is a cost to have a machine to test the THC.

COREY O'BRIEN: Correct.

BRANDT: And really, in my mind, if we can test the THC in industrial hemp we can certainly test it in high-grade hemp. I would think the same machine could do the job for both. And you could probably pay for the machine with less people in prison if you could quantify, tie the THC to the pounds and-- and have a sliding scale of some sort. Do other states do anything like that? Are you aware of-- of any other program that-- that attacks this THC component?

COREY O'BRIEN: I'm not. I don't know of any other state that does that. It's possible but I've never heard of it in any conference I've ever gone to or anything like that. And again, I'm not saying it's not possible to test the potency. I'm just saying that our existing crime labs that do that testing, they do not have the equipment. And I don't want to speak for them but I assume that they would need some additional monies in order to do that.

BRANDT: But it-- it just seems, as the Attorney General to come in here and make an argument that the potency is higher than it was 10 years ago, and I think we all agree with that statement, but without being able to measure it, it-- we should have had a machine here a long time ago. I mean why doesn't our State Patrol have a machine to measure this?

COREY O'BRIEN: Because we don't have to prove that in any cases. I mean all you have to prove is whether it's marijuana or not and-- and not the potency because is it-- is it a public health risk? Yeah. I mean I think perhaps HHS would be somebody that would want to know more so than maybe law enforcement. But we-- we do know based upon some of the products that are coming in here because they're marked out of Colorado and things like that with their potency, that the potency is higher. But we do not have any need at this juncture, from a criminal standpoint, to prove what the potency is.

BRANDT: At least not yet. All right.

COREY O'BRIEN: At least not yet.

LATHROP: I don't see any other questions, Mr. O'Brien. Thank you for your--

COREY O'BRIEN: Thank you.

LATHROP: --testimony. Anyone else here in opposition to LB89 or LB652? Anyone here in a neutral capacity on either bill? Seeing none, Senator

Wayne to close. And as you approach I have no letters of support on LB89, three in opposition from Ron and Lynette Nash, Kathy Wilmot, and Lester Unruh. And on LB652 I have letters-- none, no letters on LB652. Senator Wayne to close.

WAYNE: Senator Brandt, that's exactly the conversation that needs to happen. And to say that we don't distinguish between drugs or makeups of drugs, we did this years ago, and we did it federally, where we distinguish between crack and cocaine because the potency between crack and cocaine was crack was supposedly more addictive. And we-- we just-- we went around the country and changed our laws to figure out ways to test it, to figure out ways to charge people with it. So that's not new. I did hear the Attorney General say that he's never seen anybody over two ounces so maybe we need to amend it at two ounces and he'll be OK with it based off his testimony, because right now it's just one ounce and I was going to three ounces. So we can have a common ground to go two ounces and we'll be willing to move forward with that. As it relates to the county attorneys, I'm willing to remove fentanyl and heroin to move this bill out of committee and move it forward if those are the issues that they still want to have residue. Where I'm concerned is the residue in the ashtray from marijuana and-- and-- and pretty much cocaine or crack that you can't get made, can't perform testing on, and we're still sending people for 20 years in prison off of residue is just unbelievable. But this goes off to a bigger conversation that I know, Chairman Lathrop, we're talking about "execing" more and talking about the issues. We charge the exact same person with 4 pounds of marijuana than 200 pounds of marijuana, and we are treating them the same. And that's just unbelievable to me. We are charging people with residue as the same as less than five pounds of marijuana. That's unbelievable. We have to start distinguishing between our laws and making them more equitable across the country, and that's what these two bills are trying to do. And with that, I'll answer any questions.

LATHROP: I do not see any questions, Senator Wayne.

WAYNE: Thank you.

LATHROP: That will close our hearing on LB-- LBs, LB89 and LB652, and bring us to another combined hearing also with Senator Wayne. Again, we're going to combine LB90 and LB684. They're very similar bills dealing with the same subject matter. We'll have Senator Wayne

introduce LB90 first and then I'll introduce LB684, and we'll let Senator Pansing Brooks chair that combined hearing.

WAYNE: Thank you. My name is Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I represent the "Mighty 13th" District, which is north Omaha and northeast Douglas County. This bill is a bill that, in practice, I've been frustrated with the entire time. For a Class IV felony you have to have posts-- post supervised release if you spend one day in jail. What that means is-- and I want to walk through what a judge actually has to find here and you'll see why this is absurd in practice. I think in reality when they first tried it, there was a good intention. But we have so many people in Douglas County who have to wait so long on a Class IV felony that it makes no sense to put him on supervised release. I think the bill was intended for the broader, our original bill, broader state of Nebraska. But we just have so many felonies in Lancaster County, Sarpy County, and Douglas County that it just is not working the way it should. And what that means is somebody charged with a Class IV felony, they sit in jail for 30 days, 60 days. And the judge has to find, after all the information comes in and he's found guilty or she's found guilty, they have to find that this person is not suitable for probation because a Class IV felony is a presumption of probation or a maximum imprisonment of two, two years. So the judge has to find on the record you are not suitable. But let's say that judge only wants to give him 30 days in jail. So he's already sat for 30 days. The judge says you are found guilty; we sentence you to 30 days; have a good day. That's how it used to work. Well, now it says, no, not have a good day. You are not eligible for-- for probation because I have to send you to jail; you're not suitable but I'm going to put you on post-supervised release, which is essentially probation, for the next nine months. Makes no sense. So in one determination he says not good enough to be on probation or the factors don't warrant probation; we give you time served; but we essentially put you on probation. It makes no sense. And so what we are finding is that people, including myself, and I think Prosecutor Lux will testify 'cause one of our cases, my clients are actually pleading up to higher charges. They're pleading up to a Class III, and the judge and everybody knows this person, if we put him on probation, may violate or he doesn't even live here. He's actually got caught doing something driving through. He's going back to Colorado or California or New York. Think the case we have were New York and so we pleaded them up with a harder penalty so the judge can give him time served without being placed on post-supervised release so he can go back to New York

and be with his family. That's the craziness that we're trying to navigate through our system because of this post-supervised release that's mandatory. So all my bill does, and where it's little bit different than Senator Lathrop's bill, is this says it's discretionary all the way through. And my bill clarifies, why there's some more language in there, that this is not retroactive. It doesn't apply to current cases. It's only applied after this bill goes into effect, because there are people who are pending right now, are caught in this situation. So my bill just gives complete discretion through the whole process. And Senator Lathrop's bill is slightly different but it deals with the same issue. And we're talking about Class IV felonies, which they-- the presumption is no prison time. And the only way you get prison time is by finding that they're not suitable for probation. And by the way, most of them, actually all of them, never go to D&E. Time served is in your county jail. So there's a process that occurs. You get sentenced, time's served. They process you through D&E. I had one guy go down to D&E and get a-- had to catch a bus back to Omaha the next day because his time was already served. I'm trying to avoid that situation again. And with that, I'll answer any questions.

PANSING BROOKS: Thank you, Senator Wayne. Any questions for Senator Wayne? No. Seeing none, thank you.

WAYNE: Thank you.

PANSING BROOKS: Now we all have Senator Lathrop on LB684. Welcome.

LATHROP: Good afternoon, Chair-- Vice Chair Pansing Brooks and members of the Judiciary Committee. My name is Steve Lathrop, L-a-t-h-r-o-p, and I'm the state senator from District 12 here today to introduce LB684. I brought this bill as a result of discussions with the Office of Probation Administration. As you know, LB605 in 2015 established flat sentences for people convicted of lower level felonies, followed by a mandatory period of post-release supervision overseen by the Office of Probation. Since then we've learned of some small changes that could ensure we're not using post-release supervision-- ensure that we use it efficiently as well as encourage better engagement by participants. First, with the lowest level cases we want to give judges discretion in who they sentence to post-release supervision. For example, we have people who are getting sentenced to just the time they've already served in county jail, as Senator Wayne just talked about, and they're ready to reenter the community. And now the judge is required under state law to put them on nine months of post-release

supervision. So LB684 would give judges discretion in requiring post-release supervision for Class IV felony cases when the person goes to county jail rather than to the Department of Corrections. The other change in LB684 is designed to give judges a more significant hammer when a person violates the terms of their post-release supervision. Currently a person's post-release supervision can be revoked only for the time they have left on their original term. This means, especially for a person who is nearing the end of their supervision term, there's very little incentive to comply. LB684 would allow judges to revoke a person's post-release supervision and order them in prison for a period as long as their original post-release supervision term. I'll add the end goal here is not to see more people spending time in jail or prison for violating their supervision terms. While that might be what happens in limited cases, the goal of LB684 is to encourage participation in the program that is proven effective in preventing people from continuing future crimes that result in them returning to jail or prison. I will say this. I think you'll hear that this is something that needs to be done. Whether we take elements of Senator Wayne's bill or mine, how we-- how we work that in, too, I expect this is an issue that we'll probably try to work into our corrections priority bill. And so with that, I would include-- encourage your support of LB684, some element of LB684 or Senator Wayne's bill. Thank you.

PANSING BROOKS: Thank you, Senator Lathrop. Any questions for Senator Lathrop? Seeing none, we will take proponents. And as happened before, if you could please indicate if you're supporting one bill or both bills, and we would appreciate it. Thank you.

SPIKE EICKHOLT: Thank you.

PANSING BROOKS: Welcome.

SPIKE EICKHOLT: Madam Vice Chair, members of the committee, my name is Spike Eickholt, S-p-i-k-e E-i-c-k-h-o-l-t, appearing on behalf of the Nebraska Criminal Defense Attorneys Association in support of both bills. We have some concerns with one portion of LB684, but on the whole we do support both bills. We talked this year or this session about LB605. This post-release supervision was something that was recommended to the state from the Council for State Governments and it was to address the problem that we had with flat sentences where people would go to jail or prison for a relatively short period of time and then get out, where they go from custody, on the street. And

the concept of post-release supervision was developed based on that where a person does not simply go from custody automatically to be free. They need to be transitioned and supervised for a while. So the law now requires that if a person is sentenced to any time of in custody, whether it's jail or prison, for any amount, even one day as Senator Wayne explained, there needs to be a minimum term of at least 9 months' of probation, if you will, for Class IV felonies, up to 12 months. In theory, that does work. The problem that we see, and it's related to a couple of things, but the problem we see is in practice it's very difficult for some people to do that. And by "some people," I mean people who could not make their bond on the original charge and sit in custody for sometimes six, eight, ten months. The charge is a Class IV felony. That's the-- the convicted charge. So a person can sit in custody on a much higher charge and, part of the plea process, ends up getting found guilty of a Class IV felony. As Senator Wayne explained, the process used to be that person would just be done, where the case would just be over and they go back to their lives. Now the judges are required to place that person on probation. If a person has been in custody for eight, ten months, they have just lost a lot. They've lost where they live. They probably lost a job. They simply cannot keep up with the conditions of post-release supervision of probation. If they fail on that there is a process and it's delineated in 29-2266 and 29-2267, sort of the sanctions process where a person is reprimanded, if you will, for missing drug tests or not having a job, missing, violating curfew, or some similar thing like that. And then eventually if the person is incarcerated for what they call custodial sanctions for a total of 90 days then their post-release supervision is revoked and then they must serve the balance of the time. The concern that we have is with respect to LB684, the part that Senator Lathrop described as a hammer. We would prefer keeping the approach that Senator Wayne has in his bill where a person is sentenced up to the remaining time they have on post-release supervision, because for some of those people who simply are struggling and are trying to comply with post-release supervision, they do several months, they slip up, eventually they just come to the point where they can't do it any more. It's our position that that would be somewhat unfair to expose them to up to the original time again as a sentence if they were to ever violate those terms of post-release supervision. The judges can still order it. It's discretionary under both bills. So if a person is suitable for that and they can hopefully comply with that, the courts will hopefully do the right thing and only impose that transition, post-release

supervision in those types of cases. So other than the concern we have with respect to LB684, we would support both bills.

PANSING BROOKS: Thank you, Mr. Eickholt. Any questions for Mr. Eickholt? No. Thank you for coming. Next proponent. Welcome.

JEFF LUX: Thank you. Again, my name is Jeff Lux, first name Jeff, J-e-f-f, last name Lux, L-u-x. I'm a deputy Douglas County Attorney representing the Nebraska County Attorneys Association in support of both bills, LB90 and LB684. As has been said, you know, we found situations where in cases where everyone is in agreement, the prosecutor, the defense attorney, the defendant, the judge, that you know, hey, a time and cost is an appropriate outcome to this case or some type of county jail sentence is an appropriate outcome for this case, and then it should be done. But in the way the law is currently written, for those Class IVs we've got to at least add on that nine-month post-release supervision. And we do find ourselves sometimes in like weird situations where I have people that are either charged with a Class IIA, like a possession with intent to deliver marijuana, and normally you know maybe we would work that down to a Class IV or something. That never happens now because nobody wants to go down to a Class IV because that's post-release supervision and they'll stay at a IIA, where it's a zero to 20, no post-release supervision, and you can, in essence, get a time and cost but it's at a higher felony level. It just ended up giving kind of a goofy quirk of how the law ended up working. Either one of these bills kind of takes care of that kind of scenario. Senator Lathrop's bill would definitely cover that time and cost type of scenario for Class IVs. Senator Wayne's bill would also cover a situation where-- and this happens in Douglas County some, I'm sure in other areas-- whether it-- say you-- you get-- you're in drug court and you wash out at drug court and then you're going to get sentenced. OK, well, we're going to sentence you on a Class IV possession. You were just in something that was even more intense than probation. We're going to sentence you to a year in prison and, oh, yeah, by the way, we got to put you on nine months of post-supervised release again when you just washed out of drug court which was even on top of you more than probation or post-supervised release would have been. It doesn't make sense. It'd be good, hey, let's just do that one year. A lot of times they've already got two, three months already in so they only have to do another two and a half months anyway and then they're on nine-month post-release supervision. The same thing can happen with violations of probation. We, you know, you start out that case, they get convicted

of a Class IV felony, presumption probation, do the probation. They mess that up. We go to violate it. Oh, you're gonna do a year and, oh, by the way, we've got to put you on nine months of post-supervised release when we just violated you for not doing your probation. So it's those kinds of situations that these bills address. I think they make sense. When-- when you've got, you know, everybody in the room, the defense attorney, the defendant, the judge, and the prosecutor, it's like that everyone's in agreement, that doesn't happen very often. [LAUGH] So I'd take any questions if there are any. Thank you.

PANSING BROOKS: Thank you, Mr. Lux. Any questions for Mr. Lux on this kumbaya moment?

JEFF LUX: [LAUGH] Yeah.

PANSING BROOKS: Thank you for coming.

JEFF LUX: Thank you very much.

PANSING BROOKS: Any further proponents? Proponents? OK, any opponents? Opponents? Anybody in the neutral?

DEB MINARDI: Good long afternoon to you. Thank you, Judiciary Committee. My name is Deb Minardi, D-e-b M-i-n-a-r-d-i, and I'm employed by the Nebraska Supreme Court as the Probation Administrator with the Administrative Office of the Courts and Probation. And I'm here today to testify in a neutral capacity for LB684. In 2015 the courts and probation successfully implemented the legislative changes set out by this body, commonly referred to as justice reinvestment or LB605. In particular, this involved the creation of what's now referred to as post-release supervision. Post-release supervision includes individuals convicted of a Class III, IIIA, or IV felony. A little over three years later there are 1,380 individuals under the authority of a judge and being supervised by probation officers in every judicial district across the state. Reentry efforts, including reentry courts, assist individuals in getting on the right track and target necessary services. Should the Legislature pass LB8-- LB684, we are equally confident that we will implement any changes effectively, efficiently, and within a short period of time. I'd be happy to answer any questions on behalf of probation and the courts.

PANSING BROOKS: Thank you. Any questions for Ms. Minardi? No. Seeing none, thank you for coming today. Any additional neutral testifiers? Seeing none, Senator Wayne, would you like to close? Senator Wayne

waives and so does Senator Lathrop. Both waive closing. And that closes the hearings, the combined hearings on LB684 and LB90. Thank you.