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

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

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

HARDIN: Good morning, I'm Brian Hardin from District 48: Banner, Kimball, and Scotts Bluff Counties.

RIEPE: I'm Merv Riepe, Legislative District 12, which is southwest Omaha and the small town of Ralston.

HANSEN: Also assisting the committee is our research analyst Bryson Bartels, and our committee clerk Christina Campbell, and our committee page is Sophia and--

SOPHIA LOVELL: Ken is--

HANSEN: --Ken, right. OK. OK, looking for Ken. A few notes about the policy and procedures here. Please turn off or silence your cell phones. We will be hearing four bills this morning and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina when you come up to testify, or one of the pages. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying, which is right in front of you when you

testify. Each testifier will have five minutes to testify. When you begin, the light will turn green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask that you wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill and then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed until previously approved, and we have a strict no-prop policy in this committee. So with that, we will begin today's hearing with LB12 and welcome Senator Blood. Welcome.

BLOOD: Thank you. So good morning, Chair Hansen and to all the members of the Health and Human Services Committee. My name is Senator Carol Blood, spelled C-a-r-o-l B as in 'boy' -l-o-o-d as in 'dog,' and I represent District 3, which is the western half of Bellevue and southeastern part of Papillion, Nebraska. Thank you for the opportunity to bring forward LB12, which seeks a process that allows for greater access to human breast milk. Now I want to be very clear from the start, the purpose of this bill is not to create a breast milk grocery store, not to make breast milk a commodity, the purpose of this bill is to allow DHHS to establish standards for transporting, processing, distributing and-- for the safety of human breast milk. They have the ability to do this by forming a committee of subject matter experts to create the aforementioned standards and any needed programming. Now once a framework is crafted, a broader process will be more readily available in both rural and urban communities to better lift up our at-risk infants under six months of age. Now if you've had an opportunity to look also at LB13, you'll find a description of whom we hope to help. Now as I talk later in my introduction as to what other states have to offer, I believe that you'll have a greater understanding of whom we'd like to serve with this idea. If you read a recent story, which I've handed out, in our NCSL newsletter that is provided to all senators, you may have noted the story referring to breast milk as liquid gold. That is actually a really good description. And let me share with you why that is. The short-term benefits of exclusive breastfeeding include reduced risks of ear infections and stomach bugs, and the long-term benefits include reduced risk, reduced risk of sudden infant death syndrome, asthma, obesity, and Type 1 diabetes. But breast milk can be even more

important for our preterm infants who have an increased risk of necrotizing enterocolitis-- I've misspelled-- said that, but close enough, a gastrointestinal disorder that causes inflammation of intestinal tissue, which can lead to serious illness and sometimes death. Now breast milk has a protective effect against the disorder and promotes neurological development. The American Academy of Pediatrics recommends that very low-birth weight infants be given donor milk when a mother's milk is unavailable. However, not all preterm and seriously ill infants in neonatal intensive care units have access to donor milk. Not all hospitals prescribe donor milk or have it on-site. Hospitals bear the cost of storing, preparing and supplying the milk, even when the milk itself is covered by insurance. So let's be real. There is clearly scientific consensus that breast milk is an essential medicine for infants at risk or on the cusp of life or death when it comes to preventing infections or brain health. The irony is that the babies who need breast milk the most are also the most likely demographic who have trouble finding it, often because of income or lack of insurance. Mothers who deliver premature infants are often unable to produce enough breast milk. Sometimes that can be a combination of a premature infant's ability to suckle, stress, and separation when a child is in ICU or medical complications. In Nebraska, having a human breast milk bank allows us to not only help those babies, but will be accessible statewide giving all of our babies in Nebraska a fighting chance. So I'd like to walk you through-- excuse me, how other states utilize their breast milk banks to give you a grasp of what has being done to help infants. We aren't creating a type of grocery store for breast milk shopping. These banks usually have pasteurized donated human breast milk, which may include human milk fortifiers if indicated by a licensed medical practitioner and is covered either by Medicaid or insurance providers, depending on the state. Now as I previously noted, the eligible person is consistently an infant less than six months of age. A licensed medical practitioner prescribes the milk for the infant, and the milk is obtained from a human milk bank that meets quality guidelines usually established by the Human Milk Banking Association of North America or is licensed by the department in that state. The infant's mother is-- needs to be medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is, is insufficient because it has something wrong with it. The milk has been determined to be medically necessary for the infant, and one or more of the following applies: the infant's birth weight needs to be below 1,500 grams, which is almost three and a half pounds; the infant has a congenital or acquired condition that places the infant at high risk

for development of necrotizing enterocolitis; the infant has infant hypoglycemia; the infant has congenital heart disease; the infant has had or will have an organ transplant; the infant has sepsis or the infant has any other serious congenital or acquired condition for which the use of human breast milk is medically necessary and supports the treatment and recovery of the infant. Now there are more details I could share about how other states handle this issue, but those guidelines are pretty much the norm for most statewide human milk banks. So the secondary issue is how we consistently hear how we need to do more for Nebraska moms and infants as part of being a pro-life state. So now is the time for us to put our money where our mouth is. Our states-- other states have increased access to donor milk by requiring insurance coverage, both public and commercial, because they understand its importance. As of September, at least 17 states and the District of Columbia have enacted legislation requiring Medicaid coverage for donor milk. Indiana became the most recent state last August. Coverage varies based on the patient's length of time and settings. Coverage is required when donor milk is considered medically necessary. But again, states-- state definitions vary. For example, Illinois requires an infant to meet one of seven medical requirements ranging from low-birth weight to hypoglycemia. And you heard some of those in the previous paragraph. Louisiana considers donor milk medically necessary when several criteria are met, including infant health, caregiver ability, and source of donated milk. State laws also differ in coverage period. Kansas covers up to three months of donor milk; New Jersey up to 6 months; and Louisiana up to 12 months. But these laws are not about the mechanics of today's bill. They are just an example of how important this issue has become in healthcare. When we look to other states in reference to human milk banks, we note that in recent sessions, states also increased access to donor milk by creating, creating or regulating milk banks. Legislation for an Arkansas milk bank was brought forward after learning that the state was buying milk from neighboring states. During shortages, milk banks were prioritizing hospitals in their own states. With the high preterm birth rate and the high rate of Medicaid-covered babies, Arkansas was sending thousands of dollars to other states. Now Arkansas spends Medicaid dollars in the state, and Arkansas mothers have a place to donate their milk. Clearly, a step towards reducing the state's infant mortality rate because of the nutritional benefits of breast milk and a prompt for doctors to prescribe donor human milk. Pennsylvania requires the State Department of Health to license milk bank-- banks and man-- mandates that milk banks screen donors and pasteurize and test the milk. The law also creates licensing fees and prohibits the sale of human milk by unlicensed milk banks to ensure that donated

milk is safe for infants. States can statutorily regulate milk or, or, or change rules and guidelines after legislation processes begin-- after legislation passes. For example, Maryland regulates donor milk as a human tissue, and Texas requires that human donor milk banks follow guidelines set by the State Health Department. Selling breast milk is not illegal, by the way, but clearly unregulated in most instances. So how DHHS chooses to create Nebraska's human milk bank will depend on the experts that it brings to the table. There are tens of millions of federal funds available right now that are included in the Labor, HHS, and Agricultural appropriation bills, as well as other grant programming such as ACF grants and grants from healthcare networks that could be used. An existing human milk depot infrastructure could be utilized at a Nebraska hospital and we wouldn't have to reinvent the wheel. We know there are at least 28 accredited human milk banks in North America and a lot of legislation in play across the country to increase those numbers. Now it's time for Nebraska to do the same. What we decide to do in our own state is left up to the experts, of which we have many in both DHHS and across our state. This is more about the programming and how we can share resources than it is about creating something from scratch. With that, I encourage you to save any questions after today's testimony for-- from our supporters and possibly opposition, allow them to speak as, as you may have questions answered during their testimony. I'm always happy to answer your questions, but because I respect your time, I do ask that you save your questions for the test-- the people testifying, and then I'd be happy to come up at the end and answer any that may still be remaining. Thank you for your time.

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

BLOOD: All right.

HANSEN: I'll see you when you close. All right. With that, we'll take our first testifier in support of LB12. Good morning.

KATHY LEEPER: Good morning. My name is Kathy Leeper, K-a-t-h-y L-e-e-p-e-r, and I'm a physician and the medical director of MilkWorks testifying in support of LB12. Thank you, Senator Blood for calling attention to the importance of human milk. MilkWorks is a nonprofit community breastfeeding center that has served families throughout the state of Nebraska for 22 years this week. The mission of our organization is to create a healthier community by empowering families to meet their breastfeeding goals. MilkWorks provides individual clinical lactation support in person from board-certified

professionals, both in Lincoln and Omaha and via telehealth to the rest of Nebraska, as well as education in the form of support groups, classes, and via our website. We work very hard to help babies receive milk made specifically for them by their own mothers, but the lack of cultural support and sometimes medical issues prevent many mothers from being able to fully meet their own baby's needs. MilkWorks is a milk depot for the existing milk bank in Denver, meaning mothers in Nebraska with excess breast milk who have been screened for communicable disease and unsafe medications voluntarily bring frozen milk to us and we send it to Denver for processing. The Denver milk bank is accredited by HMBANA, which has been mentioned, which stands for the Human Milk Banking Association of North America. Founded in 1985, it has 31 accredited nonprofit milk banks in the U.S. and Canada and set international guidelines for pasteurized donor human milk. The mother's milk bank in Denver sends back bottles of the frozen, pooled and pasteurized milk at a cost of $4.75 per ounce, plus shipping and handling for an ultimate cost of about $25 for each four ounce bottle. We provide a family working with one of our lactation consultants with one bottle of this precious milk for newborns who have lost too much weight while waiting for their mother's own milk production to increase. Because supplementation is often only needed for one or two days and the volumes needed are small, some families who can afford it choose to purchase a few bottles, but the cost prohibits longer-term use. So most, so most pasteurized donor milk is used in the hospital setting in the neonatal intensive care unit, as you've heard, where it's been proven to greatly decrease death and illness in premature babies whom-- whose mothers cannot provide enough of their own milk. The closest HMBANA milk banks to us are in Denver and Iowa City, which are over 480 and 300 miles from here respectively. Having a milk bank in Nebraska would decrease the need to ship the milk so far from our population centers and presumably increase availability to our most vulnerable citizens. MilkWorks recommends that subject matter experts be consulted to finalize the wording and implementation of this bill, and that HMBANA's guidelines be utilized in creating Nebraska's human milk bank. I would welcome the opportunity to work with you and hope that this is the first step toward providing each one of Nebraska's babies with human milk for the recommended minimum of two years, ideally from their own mother but from other Nebraska mothers when this is not possible.

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

RIEPE: Thank you, Chairman Hansen. My question is, do we have any idea what the supply and demand within the state would be?

KATHY LEEPER: As far as what the hospital demand would be, I do not. I learned of this bill a week ago, and I have not had much time to consider that.

RIEPE: Do we have any hospitals in the state of Nebraska that provide this service?

KATHY LEEPER: Yes.

RIEPE: They are-- are they spread across the state or are they concentrated in urban areas?

KATHY LEEPER: I would assume they're concentrated in urban areas. Not even all the hospitals in urban areas are using it to my knowledge.

RIEPE: I've got another question if I may, Mr. Chairman?

HANSEN: Yep.

RIEPE: Is-- I assume there's a screening process to make sure that the product is--

KATHY LEEPER: Correct. That's why it's so expensive. Um-hum.

RIEPE: OK.

KATHY LEEPER: So each mother is screened with bloodwork and a questionnaire, and then there's random screening of the milk itself before and after processing.

RIEPE: Is there-- would there be an expiration date on the milk then?

KATHY LEEPER: That's a really good question. I don't know the answer to that question.

RIEPE: Oh, good, I've stumped the [INAUDIBLE].

KATHY LEEPER: We never have it sit around that long. I'm assuming-- I mean, it's generally recommended that you not use milk that's been frozen more than a year.

RIEPE: And the question always gets me, too, is the refrigeration standard in terms of any product that's mailed and--

KATHY LEEPER: Um-hum.

RIEPE: --I'm curious that in your thing you talk about Iowa City, which is way off balance from the center of Iowa,--

KATHY LEEPER: Yes. Um-hum.

RIEPE: --and I, I, I can only assume that that's associated with the medical school there.

KATHY LEEPER: Um-hum.

RIEPE: Is that right?

KATHY LEEPER: I would assume so, too. I do not know that for a fact. Um-hum.

RIEPE: OK. Thank you.

KATHY LEEPER: Yeah, it's shipped frozen.

RIEPE: Thank you for being here today.

KATHY LEEPER: Sure.

RIEPE: Thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? I have a couple.

KATHY LEEPER: OK.

HANSEN: So is MilkWorks, is that a private company?

KATHY LEEPER: It's a nonprofit entity.

HANSEN: OK.

KATHY LEEPER: Um-hum.

HANSEN: So right now, because we don't have this legislation in place, you can't open up here in Nebraska or you need-- do you need this to open up, like, open a distribution facility here in Nebraska?

KATHY LEEPER: No. I don't understand your question. We're a nonprofit breastfeeding support center that provides clinical support, five IBCLCs in Lincoln and in, in Omaha each.

HANSEN: OK.

KATHY LEEPER: And we have it available for the baby who's lost too much weight. The parents don't want to use formula to use in a three-day-old to bridge when the mother's milk is coming in.

HANSEN: OK. I'm just trying to figure out, like, what the business is. So you, you-- do, do you collect or, or does, does DHHS--

KATHY LEEPER: We're a, we're a milk depot. We're a milk depot so there are several points in the state where women can bring their frozen milk after the Denver milk bank has already screened them--

HANSEN: Gotcha. OK.

KATHY LEEPER: --and they have a number. And we don't even know their name, but they bring in milk number 51403 in baggies that are frozen. And we store it in a large deep freeze. And when we get enough, we ship it in big boxes that the milk bank provides us unprocessed to the milk bank that then pools the milk all together, pasteurizes it, packs it in little four ounce bottles and ships some of it back to us too.

HANSEN: OK, I was trying to figure out the--

KATHY LEEPER: So--

HANSEN: --the line of--

KATHY LEEPER: Yes.

HANSEN: --you know, it kind of makes sense now.

KATHY LEEPER: Yes. So we're-- right-- so we're not connected directly with the milk bank. We use a little milk and we work as a depot to collect a lot of milk to send to them.

HANSEN: OK.

KATHY LEEPER: Both in Lincoln and Omaha.

HANSEN: And does it require-- like, I think Senator Riepe was kind of touching on this-- does it-- breast milk, does it require special, special shipping since it's, like,--

KATHY LEEPER: No, it just--

HANSEN: --human, you know?

KATHY LEEPER: --it just needs to be frozen. There's no-- it's not a biohazard. The CDC does not consider breast milk a, a hazardous substance,--

HANSEN: Hope not.

KATHY LEEPER: --thus women can store it in their fridge at work and such, so.

HANSEN: OK.

KATHY LEEPER: Yeah.

HANSEN: Awesome. Cool.

KATHY LEEPER: Um-hum.

HANSEN: Thanks.

KATHY LEEPER: Oh.

HANSEN: Yes, Senator Hardin.

HARDIN: Thanks for being here.

KATHY LEEPER: Sure.

HARDIN: Is there payment, financial remuneration for ladies who provide the milk--

KATHY LEEPER: No, it's voluntary.

HARDIN: --or is it like donating blood, or?

KATHY LEEPER: Very good question. Yes,--

HARDIN: OK.

KATHY LEEPER: --it's just like that.

HARDIN: Very good.

KATHY LEEPER: It's donated out of the goodness of their heart.

HARDIN: Thanks.

HANSEN: Senator Walz.

RIEPE: Is it tax deductible? Excuse me.

KATHY LEEPER: Is purchasing milk tax deductible?

RIEPE: The donation tax deductible?

KATHY LEEPER: Oh, no, no, no. Huh-uh. No.

RIEPE: OK. Sorry, Senator.

HANSEN: Senator Walz.

WALZ: Thank you. So right now you're working with Denver, right?

KATHY LEEPER: Um-hum. Simply because--

WALZ: That's kind of where their main--

KATHY LEEPER: Simply because they existed before Iowa City so we--

WALZ: OK.

KATHY LEEPER: --established a relationship.

WALZ: Do you know if MilkWorks in Denver, is it-- does it have to be overseen by the Department of Health and Human Services there in Colorado?

KATHY LEEPER: MilkWorks in Denver or the milk bank?

WALZ: Oh, the milk bank, sorry.

KATHY LEEPER: The-- I do not know if-- I do not know the answer to that question.

WALZ: OK. All right. Thank you.

KATHY LEEPER: Um-hum.

HANSEN: OK. Any other questions? All right. Seeing none, thank you. We'll take our next testifier in support.

ANN SEACREST: Good morning,--

HANSEN: Welcome.

ANN SEACREST: --Chairperson Hansen and members of the committee. My name is Ann Seacrest, A-n-n S-e-a-c-r-e-s-t. And thank you for

allowing me to testify on LB12. I have been a Nebraska resident for over 40 years and I currently reside at 2309 Lake Street in Lincoln. As a registered nurse and an international board-certified lactation consultant, I have spent over 45 years committed to the well-being of mothers and their babies with a special focus on lactation as a clinician advocate and administrator. As a past president of the Lincoln-Lancaster County Board of Health, my commitment to infant nutrition really began based in public health and our need to improve the health of all citizens in the state of Nebraska. One of the things I'd like to mention, and I think that Senator Blood and Dr. Leeper have done an excellent job of providing lots of information, is that this is not a new concept. The idea of mothers sharing their milk with other mothers has been around since the beginning of time. We used to call them wet nurses. And this also is something that happens around the world with much greater frequency than it happens in our own country. So it's fascinating to look at what is, what is the standard around the world in, in this area. I also wanted to just mention that HMBANA, which is the accrediting organization, does not really set-- it sets-- it accredits human milk banks. It doesn't really deal with legislation regarding and it doesn't set legislation regarding them. So I'm testifying today in support of LB12, but I do have some concerns regarding the process and the wording behind the bill. So we have an infant nutrition crisis in our country and in our state. Only 33 percent of all Nebraska infants and 10 percent of low-income infants are exclusively breastfed for the recommended six months. So we've made some progress. Fifteen years ago, only 10 percent of Nebraska babies were breastfed for six months. But we have a long ways to go. Low breastfeeding rates, as you've heard, result in costly healthcare expenditures, unnecessary lifelong suffering. Infants who are fed formula, which is a processed cow's milk which is devoid of vital hormones, growth factors and antibodies are more likely, as you've heard, to die of SIDS and have lifelong chronic and acute health issues. So all mothers do not have the ability to make enough milk for their own babies, nor do we provide them with the necessary support. So banked milk from an accredited milk bank is one solution to increasing access. So while I encourage you to support a Nebraska milk bank, I have the following concerns. LB12 was apparently drafted without an interim hearing and without subject matter experts involved. Furthermore, the wording of the bill does not require that our health department involve subject matter experts. It says they may. The word "commercial" in Section 1 needs some clarification. HMBANA, which is the Milk Bank Association, the accreditation organization, is based on a not-for-profit distribution of human milk. The word commercial could be interpreted to address a for-profit milk

bank. No one should make money off the health and well-being of vulnerable mothers and babies in our state. So an accredited milk bank is a really important way to increase access to human milk. But it's really vital that we not ignore other avenues of support nor limit access to human milk in other ways. There are other states that are doing some innovative programs that are providing lower cost milk share programs that allow milk to be available for babies that are not vulnerable babies. So I really want to thank Senator Blood for bringing LB12 forward. This bill needs expert input and we need to make sure that it preserves the intent of milk banks. We all know that once legislation is enacted, it's really hard to reverse it. So we want a bill that's worded with the best intent and the best language. Thank you for your time and consideration.

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

M. CAVANAUGH: Thank you. Thank you so much for your testimony. This this is an issue near and dear to my heart. I have, of course, utilized MilkWorks' services-- so thank you for that-- and utilized milk from the hospital as well. And my question is-- and, and I apologize if you're not the right person to ask, but-- so our hospitals do-- some of them have access to human milk. Do you know what the process is for that? How do they have access? Do they send it to Denver or do they purchase it from Denver?

ANN SEACREST: So the hospitals would be purchasing it from an accredited milk bank.

M. CAVANAUGH: OK.

ANN SEACREST: I know that the two hospitals in Lincoln have access to it. I'm not sure how many in Omaha do, and I'm not sure if any of the smaller hospitals across the state are accessing bank milk. They typically use it under certain circumstances.

M. CAVANAUGH: It's a-- there's a form that you fill out and you check if you're willing to accept--

ANN SEACREST: Yes.

M. CAVANAUGH: --human milk when you're in the hospital with a newborn, which I've checked three times. This is-- it's just such a-- I appreciate the education from all of our, our introducer and our testifiers this morning because listening to some of the questions

that it does occur to me that perhaps this is an under-discussed issue.

ANN SEACREST: Correct. And that's why I, I think that sometimes if you mention this topic to people, they go, what, what, where on earth did that come from? And what are we even thinking about that? I mean, it's not so long ago in our state that if you mentioned donor milk to someone, it was, like, oh, no, oh, no. You know, am I going to get poisoned from it? Whatever. So this is something that should be-- and may be very, very new to all of you. But keep in mind, this is not something that's just started to happen. It's been happening since the beginning of time.

M. CAVANAUGH: Well, I appreciate your testimony and I think you buried the lead that you founded MilkWorks. But I know you're no longer with them, but appreciate your service and what you've done for mothers in Nebraska.

ANN SEACREST: OK. Thank you. And thank all-- thanks to all of you.

HANSEN: One, one second. Yeah.

ANN SEACREST: Yes.

HANSEN: Any other questions? Yes, Senator Riepe.

RIEPE: I'm inclined-- I have to look at the numbers as well. And my assumption is if it's-- as it's stated in a, a previous testifier from MilkWorks was that it would be $25 for each four ounce bottle.

ANN SEACREST: Yes.

RIEPE: So I'm saying, OK, if it's $25 times seven days a week, that's $175 per week--

ANN SEACREST: No.

RIEPE: --times six month-- let me finish, please--

ANN SEACREST: Yeah.

RIEPE: --six months, which means $4,200.

ANN SEACREST: It's going to be more than that.

RIEPE: Oh.

ANN SEACREST: Because what happens is when bank milk is used right now, particularly in a clinical setting like MilkWorks, it's used with a newborn baby that doesn't need that much milk. They might need a couple of ounces in that first week a day. So they might need $5 worth of milk a day to get-- as mom's milk supply is coming in. But a baby that's going to work their way up to about 30 ounces a day, so babies take about 20 to 30 ounces a day on average of milk in their first six months of life, so you're looking at up to 30 ounces a day at that price. So I had a conversation a number of years ago at a, a gathering in Washington, D.C., where they brought together nonprofits and kind of grassroots organizations from around the country, and I had a conversation with someone from the milk bank, and I really said, what can we do to bring the cost down? And she really said, it's about volume. It-- we really have to-- it's a, it's a volume-driven cost factor and we really need to get the volume going. And once we get the volume going, that will bring that cost down. But it's also when you add in the transportation, you add in a lot of issues like that, it just really does increase the cost. So the closer we can bring banked milk to the mom and to the donor mom and the recipient mom, we are going to bring that cost down. But yeah, you're talking a higher cost than what you're mentioning, Senator. That's why, that's why it's not available. That's why it's so strictly restricted.

HANSEN: You want one more?

RIEPE: Please. Thank you, Chairman. I guess my question gets to be is, is if commercial doesn't recognize it and Medicaid does recognize it, we've also set up a richer benefit for Medicaid than what commercial buyers are able to get on their private healthcare insurance. And so we spread that margin and make being on Medicaid more attractive than having private insurance. That's a concern. I, I know that's hard and cold--

ANN SEACREST: No.

RIEPE: --but it's the numbers.

ANN SEACREST: No, I think somewhat a little bit here we're venturing into unknown territory. I mean, insurance reimbursement for lactation support was unheard of even not that long ago. So now we're talking about insurance reimbursement for human milk. So I, I can't answer that. It's something I've not thought of before as we venture into this. I think what we do know is we need a better food product available for babies. We need a human milk product available for all babies, particularly vulnerable babies. And how are we going to go

about doing that? There's lots of ways to do that, like supporting moms in the workforce, having paid maternity leave so they can be home with their babies. So there's lots of ways we can do it. This is one avenue to try and provide it for the most vulnerable babies who cost all of us a lot of money when they end up with NEC, which I have difficulty pronouncing also, OK? So I call it by its shortened version. So all of those conditions where babies end up very sick in NICUs because of their prematurity and their other issues, they cost all of us a lot of money. I'd rather be spending that money on getting them human milk to prevent NEC. And I'm a taxpayer.

HANSEN: Yes, Senator Walz.

WALZ: Thank you. I'm just curious what, what is preventing us from creating a milk bank here in Nebraska right now?

ANN SEACREST: Well, I would say, you know, and I would turn it over to Senator Blood and what you found out. But I mean, I would say that, you know, what happens is there is-- generally in each state, there's an institution. It's usually a hospital, medical center, medical school or something like that, that believes in this concept and gets behind it. Generally, milk banks are not-- well, they're, they're not-for-profit if they're connected with HMBANA, which is the Human Milk Banking Association of North America-- they're not-for-profit. So they're a charitable-- they're a, they're a charitable organization that believes in this mission of improved health and well-being for babies and mothers.

WALZ: OK. So nothing really is stopping this from [INAUDIBLE].

ANN SEACREST: Not that I'm aware of.

WALZ: Thank you.

HANSEN: Can I ask some questions, too?

ANN SEACREST: Sure.

HANSEN: So right now, is it legal in the state of Nebraska-- just because I'm unfamiliar-- for you to just buy breast milk from somebody else like your neighbor?

ANN SEACREST: It is not regulated. It's not regulated by the FDA. There is federal legislation on making federal standards for all states right now-- for, for the country. But that has not passed yet. Senator Duckworth has been involved with that. So, yes, what's really

scary right now is that some moms will get milk off the internet from moms they do not know and do not really actually know it's milk. One of the best alternatives to a formal milk bank is a program in Wisconsin where what they do is they do an informal milk share in the community where they screen moms like we talked about with blood tests. The major issue with transfer-- with milk share is transferring the milk, making sure it's milk and transferring the milk in a clean manner. There's not a lot that will transfer from one mom's milk to another milk. HIV is probably the one we're most worried about. So, no, moms-- most moms will donate milk to other moms in the state right now. But are there some moms that are probably selling their milk? Probably. I mean, I don't know. I, I can't tell you personally anyone, but, yes, I would guess that it's happening.

HANSEN: OK. Good, because that's what we did for our daughter. I want to make sure I say that before it's illegal. [LAUGHTER] My daughter was born at four pounds and so I and my wife, we had some issues there. So we ended up, like, from people we knew, you know, personally, so.

ANN SEACREST: Yep. Yep.

HANSEN: And bringing home cooler-fulls of, of milk, you know, breast milk and then I made it myself. And so it just worked out really well, and so--

ANN SEACREST: And, and you could home-pasteurize it if you want to. So you could take mom [SIC] from another mom and pasteurize it, which is just a heat treatment that would then get rid of anything that possibly got into it during the transfer. But think of this, if you were a mom who your doctor, your midwife, the hospitals, everybody told you you need to breastfeed your baby. It is the best thing for your baby. And then for some circumstance, you don't have the milk. What are you going to feel like? You're going to feel further stressed; you're going to feel like a failure; you're going to feel like you're not doing your baby right. So you're going to get that milk wherever you can.

HANSEN: That's what we did. They didn't care. OK. Any other questions? All right. Thank you.

ANN SEACREST: Thank you so much.

HANSEN: Take our next testifier in support. All right.

LACIE BOLTE: Good morning.

HANSEN: Good morning.

LACIE BOLTE: Thank you, Chair Hansen. Good morning, members of the committee. I am Lacie Bolte, L-a-c-i-e B-o-l-t-e, and I work for Nebraska AIDS Project. We are a nonprofit organization serving individuals with HIV across the state. And I don't really want to take up a whole lot of your time, but just wanted to note that parents who are living with HIV, we have wonderful, wonderful medical resources where babies can be born HIV-negative, but mothers cannot breastfeed. And so having access to a milk bank would keep those babies healthy and those mothers protected. That's all I have. If there's any questions, I'd be happy to answer.

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

LACIE BOLTE: Thank you.

HANSEN: Appreciate it. Anybody else testifying in support? OK. Is there anybody who wishes to testify in opposition to LB12? Is there anybody who wishes to testify in a neutral capacity? Welcome.

ANN ANDERSON BERRY: Good morning. Good morning, Senator Hansen and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I am a UNMC faculty member and the medical director for the Nebraska Perinatal Quality Improvement Collaborative, NPQIC. However, today I am not speaking as a representative of the university. I'm here today to testify on behalf of NPQIC and in my role as a private citizen with professional expertise on the value of breast milk for babies. I'm a neonatologist by practice so I take care of these infants that have been referred to in the previous testimony in the neonatal ICU. Our group covers most of the state volume for these critically ill infants, and I also have a Ph.D. in medical nutrition, specifically around breast milk and feeding the sick preterm infant. I understand that there are ongoing conversations on how to enhance donor milk availability specifically to rural areas, and I would like to thank Senator Blood for introducing this bill. As a medical director of NPQIC, I coordinate collaboration with all of Nebraska's delivery hospitals, support perinatal clinicians and serve Nebraska communities. With other public health leaders and key stakeholders, we are committed to improving healthcare and outcomes for all Nebraska mothers and babies. Implementation of quality improvement initiatives to address perinatal health issues and reduce maternal and infant morbidity and mortality is a key part of this work. In fact, one of

our first collaborative initiatives was to increase exclusive breastfeeding in the first days of life across our Nebraska birthing hospitals. And we've made great improvements in this for Nebraska. Breast milk is the best source of nutrition for newborns, especially for those who are ill or premature. It provides all the necessary nutrients for growth and development and contains antibodies and other immune boosting factors that can protect against infection. According to a study published in the Journal of Pediatrics, premature infants who were fed breast milk had a lower risk of death and chronic lung disease compared to those that were fed formula. Donor milk is a product that is collected from mothers who have surplus supply after providing for their own infants' nutrition. It is typically collected in a plastic container, frozen, transported to a processing milk bank where it is thawed, put in an additional container, tested for substances and infectious agents such as viruses and bacteria, frozen, thawed, heat pasteurized, retested for bacterial contamination, placed into plastic containers, refrozen and then stored for weeks to months prior to shipping to hospitals where the milk is then stored frozen until it is needed for an ill infant. At this point, it is thawed and put into another plastic container to be delivered to the patient. This handling is important to understand as it "degradates" the nutrients present in the breast milk significantly. Plastic containers [INAUDIBLE] nutrients, antibodies and proteins are denatured and fat soluble vitamins, including A, E, and the carotenoids are present at levels of only 18 to 53 percent of mother's own milk. Donor milk is frequently used as a bridge to mother's own milk in a hospital intensive care setting, but not-- is not an ideal form of sole nutrition for a neonate. To best benefit moms in Nebraska and their babies, we need to ensure that we have appropriate lactation support, high quality breast pumps for women with state insurance, time at work to pump, and safe places in every workplace to express breast milk. Thank you, Senator Blood, for your steadfast advocacy for perinatal health. Support for breastfeeding in Nebraska is critically important as mothers strive to provide breast milk for their infants. LB12 provides an opportunity for us to discuss how to enhance the availability of donor milk in rural areas. Healthcare professionals like myself and the NPQIC would be pleased to work with DHHS to see how access to donor milk and breastfeeding rates could be improved here in Nebraska. Currently, all hospitalized NICU patients have access to donor milk or shelf-stable, commercialized donated milk. So it is not an issue of access across the state for neonates in intensive care units. What happens in some of the smaller rural communities for those infants that aren't in an ICU but may need a bridge to breast milk is the hospitals can't afford to buy it for

those families. And so that's where LB13 really is going to make a big impact. I'm not sure that LB12 in its current language is, is ready to move. I would agree with the other testifiers that it needs some significant language modifications and really the biggest bang for the Nebraska taxpayer's dollar is to support lactation, get more lactation specialists in the communities across the states, get more pumping availability, support the moms so that they can provide their own breast milk, which is nutritionally so much more important than donor milk. Thank you and I'd be happy to answer any questions.

HANSEN: Thank you. Are there any questions? I think you answered my question. I was just preparing to ask, like, what the nutritional value of breast milk is after you pasteurize it? I would assume it would break it down or, you know, alter it in some way.

ANN ANDERSON BERRY: Yeah, it denatures the protein, it denatures the antibodies, it destroys many of the fat soluble micronutrients. The ones that I've listed and are in the graph on your sheet from my testimony are the fat soluble micronutrients that grow babies' brains and vision, particularly the carotenoids, luteins, the zeaxanthin, vitamin A. If we're feeding infants 18 to 50 percent of the intended concentrations of those, and we're proposing to do that for a, a six-month period, we're going to have infants that are malnourished in our own state. You know, formula is nowhere near as good as mother's own milk, but in many cases it is better than donor milk for the long term. We use donor milk as a bridge to mother's own milk and to protect our smallest, sickest infants from the, the things that you've heard about necrotizing enterocolitis or NEC, chronic lung disease, retinopathy of prematurity. Donor milk has a place, but it has a limited place. And our babies in Nebraska are getting that now. We have milk depots that send milk not only to the Colorado milk bank, but the Iowa milk bank. We have-- all of our hospitals have the ability to purchase milk from those banks, from milk bank of Austin, from commercial companies that provide a shelf-stable breast milk that's not-- doesn't require freezing. That's a great solution for our smaller rural hospitals because they can invest in that and know that they're not going to have to throw it away after a couple of months when it expires. So there are a lot of solutions in place right now for hospitalized infants. The cost is prohibitive for some of our smaller hospital systems, but I know because I work with them directly that all of our NICUs-- our level two NICUs in Kearney, Grant Island, North Platte, Hastings, Norfolk-- they're using donor milk. All of the units in Omaha and Lincoln are using donor milk. It's those critical-access hospitals who might take care of a moderately ill infant that could, could benefit from a supplement of donor milk that

really aren't getting that in right now because of cost. And, and so there is a role for it. I think LB13, which I'll be back to testify for next week, would solve a lot of those issues. It's expensive, to Senator Riepe's point. So, you know, we have to decide how are we going to invest. I would love to see more lactation support.

HANSEN: Do they have to pasteurize it? Like, if you're testing it already for viruses and bacteria beforehand, wouldn't that be adequate or is it more just kind of a--

ANN ANDERSON BERRY: It needs to be pasteurized or else it will go bad more quickly. And I think that no hospital from a medical legal risk standpoint would--

HANSEN: That's what I was wondering.

ANN ANDERSON BERRY: --administer a donor product--

HANSEN: Probably litigious issues, I'm sure.

ANN ANDERSON BERRY: --that wasn't pasteurized. Yeah, it-- it's a complicated--

HANSEN: I'm sure you'd probably, I'm sure you'd probably use it within a week or two probably, you know.

ANN ANDERSON BERRY: We try to keep a par, and, and rotate our stock so that ours does not go bad. We don't use the shelf-stable in the institutions that I practice in; other institutions use the shelf-stable and so they can order a year supply and, and it will be just fine. So it just depends on your practice and, you know, the costs are pretty equivalent. The other thing that is concerning to me is, you know, milk banks are incredibly expensive to open and to run. San Diego just opened a milk bank. The opening costs were $5 million. And then you've got to run it and you have to have someone who understands human milk food processing who can perform all these tests. And as one of the previous testifiers mentioned, it's a volume issue and we're a state of 2 million people. We have 25,000 deliveries at best each year. We've drifted as low as 20,000 deliveries. We don't have, in my professional opinion, the volume to support our own milk bank.

HANSEN: OK. All right. Well, you just ruined my dream of opening a milk bank. [LAUGHTER]

ANN ANDERSON BERRY: It would be expensive. If you, if you are independently rich, Senator Hansen, I would support you in that.

HANSEN: I'm a Nebraska state senator, that's not going to happen. I'm not rich.

ANN ANDERSON BERRY: Well noted.

HANSEN: Thank you for testifying. I appreciate it.

ANN ANDERSON BERRY: Thank you.

HANSEN: All right. Is there anybody else wishing to testify in a neutral capacity? All right. Seeing none, we welcome Senator Blood back up to close. And just for the record, if I could real quick, there were some letters, 12 letters of support for LB12 and 3 against. For the record.

BLOOD: So let's unpack some of what's been said today. So I agree the language is wonky. I don't know if you've noticed that there's been quite a few bills this year. We've got a lot of new Bill Drafters. No offense to Bill Drafting, but I understood what the intent was behind words like commercial. They know that if there's a cost involved that they thought the word commercial needed to be included in that. I don't agree with that. I, I agree "commercial" doesn't belong in this bill. And, and I have no issue with changing the language. In reference to not having an interim hearing, for those of us that have followed the Legislature for decades, you remember that prior to 2014-- and unless I go and I research the days, I can't tell you the exact dates-- but Nebraska was doing a really bad job of making sure that mothers were getting the help they needed for breastfeeding. We weren't in the, the front of the pack. We were in the back of the pack. And so some bills were passed, some initiatives were moved forward, DHHS got involved, and now we've move forward when it comes to that initiative. But statistically, we don't need more, more interim hearings, we don't need more data. We know the importance of breast milk in Nebraska. We know that we were previously at the back of the pack here in Nebraska, and we want to stay in the front of the pack. What else is wrong with this language and why I was so specific in my introduction is that we're going to get the subject matter experts together to decide. And then again, we may have to amend the bill as it's written. But the intent, the intent is to get these experts together to decide can we, how can we, and take advantage-- and if we can, and take advantage of the federal funds that are available right now. We have a window of opportunity to fund something

fantastic. But, you know, Colorado, Iowa-- I mean, state after state-- and read that article, by the way, that I gave to you-- they continue to, to be leaders. And although we may have the milk available for our infants in NICU, you saw what happened when we had the shortage when it came to formula. What were people doing? They were going online and they were buying breast milk. Like, I don't, I don't think we've expressed today the importance of breast milk. And not every mom has that benefit when their child is sick. My, my daughter, who will be 40 this year, my oldest, was three and a half pounds when she was born. She was two months premature and I was one of the lucky moms that I was able to still provide breast milk for my daughter. But that wasn't always the norm. And I remember seeing other moms crying and upset because they felt less-than, which, of course, it doesn't make you less-than, it just means you've got to find an alternative, right? I just feel like we can do better in Nebraska. I don't disagree with anything that's been said. I don't think the neutral is definitely neutral; I thought it was more in opposition, and that's OK. But we aren't ignoring the experts. I see the data that we've been given in Nebraska over and over and over again. It shows that we need to keep working forward when it comes to providing access to breast milk and educating people on breast milk. And the intent of the bill really was to put subject matter experts together to see if we can do better. And to be really frank, I think the language is a bit misleading in LB12. It's some wonky language, but we never really could get it to where we needed it. LB13 is not wonky. I'll warn you in advance that one's a good one. So-- but I also-- it's verbatim basically what I put in my bill request. So I do hope you consider this. We can work on an amendment. I, I don't see the issue with putting a bunch of subject matter experts together who say that they want to be involved to see how we can move forward with DHHS and make it more accessible and make it easier. And she is right, to build a breast bank, we're talking about millions of dollars. But again, there are millions of dollars available and so are there resources that we can utilize within our state to maybe create something, not necessarily a breast bank, but a way that we can make it more readily available to those most in need? Because not every child in need is in NICU, as we all know, if we've had premature infants. So with that, I hope that you will work with me on this one. I look forward to talking about LB13 with you in the future as well. And, and, Senator Riepe, I want to say that when we help our children that are most in need, we actually save Medicaid money, like considerable money. These infants that are prescribed, it isn't that-- again, we're not talking about a breast milk grocery store, these children are prescribed by doctors that, that they need this breast milk. And the fact that we're more willing to give a child

medication over breast milk, I think is kind of crazy and ultimately would probably even cost the state more. So I, I don't know, I think that nature has provided probably the best medicine that every child needs, and that's a mother's milk. I'm always surprised that there's still a weird stigma attached when we talk about it in rooms full of adults. You may have remembered my very-- one of my very first bills was that in Nebraska you could still be cited for breastfeeding in public. Which is crazy, right? We just have to keep moving forward. We have to do better for our moms. It wasn't that long ago that we were not doing well on the report card on breastfeeding for Nebraska. It was actually quite embarrassing. I know, I could talk all day about breastfeeding. So with that, I appreciate all the questions. I don't disagree that the language is wonky. I disagree about the interim study because we already had the data and we've had the data for a very long time and it's continually updated. We have subject matter experts willing to meet with DHHS. DHHS is willing to meet with them. You notice they're not here saying this is horrible. We've met with them. I think that there's just something that we could amend and do something with.

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

BLOOD: All right. Thank you for your time. I know you guys are going to have a long day today--

HANSEN: Um-hum.

BLOOD: --and God bless you all for doing it.

HANSEN: All right. Thank you.

BLOOD: Glad I'm not on this committee.

HANSEN: All right. And that will close the hearing on LB12. And we'll now open the hearing for LB181, which is my bill, and I'll be up there in two seconds to open.

HARDIN: Welcome, Senator Hansen.

HANSEN: Morning, Vice Chair Hardin and members of the HHS Committee. My name is Ben Hansen, that's B-e-n H-a-n-s-e-n. I'm opening today on LB181, a bill that would authorize pharmacists to fill prescriptions in specific situations. You will see I have included an amendment to exclude veterinarians from this legislation. They have their own set of standards to follow when it comes to prescription, and this

satisfies the concerns of all interested parties. But currently there are uncertainties on how a pharmacist is to proceed when the prescriber of a prescription is no longer practicing. Patients still rely on medications that have either been authorized for refills, are part of a continued subscription, or are qualified for a 90-day, one-time emergency refill. Are pharmacists free to dispense medication in these situations? Some assume that prescription-- prescriptions can still be filled, while others consider the lack of a valid prescriber and patient relationship the reason to halt the remaining refills and cancel prescriptions. Federal law is where we get the regulations for prescribers' authorization, but it is vague when talking about emergency refills. LB181 provides clarity on the issue and allows for continuation of care for patients. They have been diagnosed and have prescriptions that were legally written. Life brings unexpected changes though, and when a practitioner can no longer serve in such capacity it is important to have a plan in place and how to respond. LB181 trusts pharmacists in using the professional judgment to fill emergency refills until the expiration date or until therapy refills to maintain chronic medication. This prescription adaptation ensures patients can care until a new physician is able to provide an authorized prescription. It is my intent as a member of the HHS Committee to look for ways to eliminate over-burdensome regulations on healthcare workers, cut red tape, and foster an environment that helps providers in doing the jobs they love. I also put an emphasis on the patient and listening to their needs. In the case of LB181, a situation that prompts the necessity for emergency refills would respect the patient's healthcare in an effort to offer as much consistency as possible. It would rely on pharmacists' discretion backed by their experience, education, and professional judgment while recognizing the expertise of providers in the authorization process of prescribing subscriptions when emergencies are absent. I would appreciate your support of LB181 and thank you for your time and consideration this morning. There are testifiers following who can give further insight as to why this is necessary, but I'm willing to answer any questions you may have to the best of my ability. Thank you.

HARDIN: Questions, committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Hansen.

HANSEN: Um-hum.

M. CAVANAUGH: My question is about your amendment.

HANSEN: Yes.

M. CAVANAUGH: Why are-- just why, why veterinarians?

HANSEN: From my understanding, I think-- I don't know how many years ago, three, four or five years ago, they passed something very similar to this specific for veterinarians.

M. CAVANAUGH: OK.

HANSEN: So they-- they're already allowed to do this in just a different capacity that has to do with animals.

M. CAVANAUGH: So this is just ensuring that that isn't changed?

HANSEN: Yeah, we're just, we're just leaving them out so we don't--

M. CAVANAUGH: OK.

HANSEN: --mess with their stuff.

M. CAVANAUGH: Thank you.

HANSEN: Um-hum.

HARDIN: Any other questions? If not, will you be here to close?

HANSEN: I will be.

HARDIN: Wonderful. Are there any in the proponent category who would like to support LB181? Don't be shy.

MARCIA MUETING: Good morning.

HARDIN: Good morning. Thanks for joining us.

MARCIA MUETING: This room has me off my axis. Is anybody left handed? I feel left handed now and I'm not. Good morning. Senator Hansen, thank you for introducing this bill. My name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. I am a pharmacist and the CEO of the Nebraska Pharmacists Association. The intent of LB181 is to allow a pharmacist to fill a prescription issued or refills on a prescription if a prescriber is no longer in practice. As you may recall, this is like a bill passed recently regarding veterinary prescriptions. The idea for this bill came from a group of interested pharmacy students from the University of Nebraska Medical Center College of Pharmacy. They have assisted the NPA in developing this language, and two of

them are here to testify. And a whole group of young pharmacists, future pharmacists, are here to observe. The language for this bill was modeled after the state of Virginia's law. Texas and North Carolina have policies to specifically address the situation of how to handle prescriptions from deceased prescribers. So here's the scenario. A prescription is written today for a maintenance medication such as insulin with refills for a year. The prescriber is no longer in practice come April of this year. When the patient returns for a refill to Marcia's perfect pharmacy, should the pharmacist be allowed to utilize the previously authorized refills to prevent interruption in therapy? This bill does not allow a pharmacist to add refills to a prescription that has no refills remaining. Prescribers can-- right now today, prescribers can write multiple prescriptions for a controlled substance with notes that say do not, do not fill until a, a specified date. That's legal right now today. They can write three prescriptions dated today with instructions on when to fill the remaining prescriptions at a future date. This is a very common practice, especially for prescribing medications for ADHD. So the pharmacy has those prescriptions on file. So should the pharmacist turn away a patient who has valid prescriptions and refills because the prescriber is suddenly no longer in practice? There are practitioners across the state who don't accept new patients, new Medicaid patients or new Medicare patients, or they're booking appointments months-- for routine care, months in advance. If the patient can't access a supply of medication until a new prescriber is found or an appointment can be booked, the only option for the patient and the pharmacist is to go to the emergency room. And emergency care, we, we know it's costly and should be reserved for patients who are emergent. We've had multiple conversations with individuals who have expressed concerns about this bill, particularly regarding the provisions for providing a 90-day refill. Again, there are issues with finding a clinic who accepts new patients and how far in advance that routine office visit must be booked. I am committed to finding middle ground with the opponents of this bill. Currently, Nebraska law is silent on the validity of a prescription and the remaining refills once a prescriber is no longer in practice. I've been told that pharmacies are already filling prescriptions written by deceased prescribers. However, without enabling language, I'm concerned that pharmacists' license will be sanctioned. If a medication is covered by the patient-- their insurance-- that there's a likelihood that that, that pharmacy's reimbursement could be clawed back saying prescriber was deceased. I do want to bring to your attention the article that I submitted with the-- my testimony. Table one shows that 43 states have some provision for emergency continuation of therapy refills for

non-scheduled medications. Only seven states, including Nebraska, are either silent on emergency continuation of therapy refill provisions or do not allow it. Table five reflects another 36 states which have provisions regarding emergency continuation of therapy refills of scheduled medications. Nebraska is conspicuously absent from both tables since it has no provisions in the law to clarify a pharmacist's ability to dispense emergency or continuation of therapy refills. Thank you for the opportunity to testify in support of LB181. I'm grateful for the opportunity for pharmacy students to actively practice and participate in the legislative process. I ask the committee to advance LB181 and I would be happy to answer any questions.

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

MARCIA MUETING: Thank you.

HARDIN: Anyone else in support of LB181? Welcome.

LYDIA FRITSCHE: Good morning, members of the Health and Human Services Committee. My name is Lydia Fritsche, L-y-d-i-a F-r-i-t-s-c-h-e. I am representing the American Pharmacists Association Academy of Student Pharmacists chapter at the University of Nebraska Medical Center in supporting LB181. On behalf of myself and our chapter, I would like to thank Senator Hansen for introducing this bill. I and the other pharmacy students here today are all licensed pharmacist interns in the state of Nebraska and currently working in pharmacies. This bill matters to us because when patients need refills on a medication, they reach out to their pharmacies and they talk to us. If their provider is unavailable for whatever reason, that delays when the patient can receive care and can lead to a lack of adequate control over chronic conditions. Depending on the medication, missing doses can become a serious health concern when a patient forgets they were out of refills and the provider's office is closed for just a couple of days. When a patient is unexpectedly unable to continue their therapy under their usual provider, it can take much longer than that to find a new provider. Currently, they have three options if that happens. They can take the time to find a new provider immediately. In the best case scenario, they get transferred to another provider in the same office. And in the worst case, they get put on a waiting list, which can be months long. They could try emergency care. That is usually a last resort because it's expensive and not something we encourage because it takes time and resources from other patients in need of care. Then the last option would be to go without their medications while they find time to look for a new provider, which may not be the healthiest

option. When looking at LB181, we as pharmacy students are looking from a patient care standpoint specifically for Nebraskan patients. Some patients have enough flexibility and access to health services to find a new provider quickly. That is not the case for all of our patients. Some of the patients we see don't have reliable transportation to go to an appointment immediately. Some have no access to the Internet to find a new provider. Others may work long shifts and have trouble finding a provider who fits into their schedule. It's also very possible, considering which state we're in, that the patient is a farmer or a rancher with limited access to healthcare to begin with and unable to spend the amount of daylight hours it would take to go to a town that has a provider and reestablish a point of care. The patient is not at fault when their provider is suddenly unavailable. But they do have to bear the consequences. Pharmacists go to school to learn about the medications prescribed. They can understand the diagnosis, can see the patient's refill history, and the pharmacy is at least accessible enough that the patient can receive prescriptions from them regularly. This bill makes sense for Nebraska and makes sense to us. It would give patients a fourth option when they have no control over losing their provider to continue treating their chronic conditions while searching for a new provider. We have immense gratitude that our professors, state association, and policymakers have heard our concerns and made this bill a reality. We would continue to ask for this committee's consideration as it decides whether to move this bill to General File for further discussion. I'd be happy to answer any questions you have to the best of my ability.

HARDIN: Thank you. Committee, any questions? I have one.

LYDIA FRITSCHE: Yes.

HARDIN: What can you do to steal the gunpowder from the opponents? What would be the problem with this?

LYDIA FRITSCHE: I've heard a day supply may be a problem and that comes back to where we are. Just because I am actually from a rural area myself, so I've seen how hard it can be for a person working on a farm or ranch to actually be able to get to town. I mean, harvest season comes around and farmers will neglect their health if that becomes a problem. My issue isn't with forgetting, but when their prescriptions become canceled because the prescriber has passed away or retired, often they don't know about that until they come to the pharmacy. And then what do they do? So as far as day supplies is

concerned, I do believe it is reasonable that we have a three-month limit, but that is obviously up for consideration.

HARDIN: Very good. Well, thank you. Any other questions? Thank you. Anyone else who is a proponent for LB181.

MADALYNNE STUBBENDICK: All right. Good morning. My name is Madalynne Stubbendick, M-a-d-a-l-y-n-n-e S-t-u-b-b-e-n-d-i-c-k. Yes, I know it's a mouthful, but good morning. I am a third-year student at the University of Nebraska Medical Center's College of Pharmacy. Although today, I am speaking as a private citizen and as a member of a rural community. I support the adoption of LB181 as I think it will have a positive impact on communities across our state. I can attest through my professional experience so far as a pharmacist intern up in Omaha that losing your provider is a difficult situation for patients. In the last several years where I've been working, there have been quite a few practitioners in my area that have retired or passed suddenly. A few of the patients have come to the pharmacy and the only reason they know-- have knowledge of this is that we tell them that their provider has passed, and that's the issue with not getting a refill on their medication. Thankfully for my patient population, most of the providers up in Omaha have a partner or somebody that they work with in their office, which makes it considerably easier to get new authorizations on prescriptions, although it's not as lucky out in rural communities like where I am originally from. Forwarding that on does sound easy, but I do have to be on the lookout for the-- potentially a three-month period for any prescriptions that come in from that provider. Anything I don't catch and forward on to another provider results in a delay of care. There have been many times when I've been in a situation where I have to wonder what more can be done to help our patients. To me, it's frustrating because often I do have a refill on that prescription sitting here forever in kind of a limbo state with the presi-- provider no longer being a valid prescriber. This notion is troubling to me because there is or there was a valid patient provider relationship at the time of prescribing. In the course of us filling a prescription for the first time, we clarify any discrepancies, any problems with the prescriber. So typically the only time in the remaining life of the prescription that we usually have any communication from said provider is when they make a professional judgment and decide that an update to a prescription is necessary. For most of my prescriptions, you know, we get it, we fill it, it goes through. I'd like to run you all through a hypothetical situation, and this would be for a member of a rural community. Let's say you have two weeks worth of medication left when your longtime doctor has a heart attack and passes away suddenly. You are able, fortunately, to

spend the whole afternoon finding a new doctor who is only a county over, but is unwilling to prescribe you any medications until your appointment-- your initial appointment six weeks from now. There is no emergency department within an hour of your house, and your pharmacy is unable to fill your prescription because their provider number was deactivated. Under the current system, the only thing you can do in that situation is go a whole month without those medications so that when you do get to your new appointment, you're not assessing your current health. You're basically starting from square one. They-- your provider can't determine how your current therapy is working because at this time you have none. Under this bill, a pharmacist could provide you with enough medications to get to that appointment. The pharmacy is temporarily bridging the gap from your last provider to your new provider. This would allow them to have an accurate picture of your current state of health. From there, that doctor can use their clinical judgment to make or not make any changes that they deem necessary. To me, this bill represents an opportunity for, for pharmacists to help ease the transition of care from one provider to another. It also allows for reduced stress on the account of the patient who's faced with the daunting task of finding a new provider after their old one is no longer available. As healthcare providers, we strive to facilitate our patients good health, and I think that LB181 would achieve just that. I encourage this committee to consider advancing this bill towards General File. I'm happy to answer any questions that anyone may have. I thank you for your time.

HARDIN: Questions, committee? Seeing none, thank you so much.

MADALYNNE STUBBENDICK: All right.

HARDIN: Anyone else in support of LB181?

ROBERT J. HALLSTROM: Vice Chair Hardin, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today on behalf of the Nebraska Pharmacists Association in support of LB181. I would not typically get up to testify after Marcia Mueting has testified on-- excuse me-- behalf of the NPA, but Senator Hardin, your question spurred my ability to come up here and try to address your question about why the need for the bill based on the gunpowder of the opponents. And I think I'd just note for the record that we have had extensive discussions starting back in October with the Nebraska Medical Association, appreciated the actions of Amy Reynoldson and Paul Henderson in, in working with us. They had initially expressed some concerns over the provisions of the bill relating to suspension or revocation of the credential, the 90-day

supply for an emergency refill, and obviously caveated that by the fact that they had to visit with their members. I think since they've had some visitations with their members-- and you'll hear from their testimony later-- they may have other issues or concerns with the bill, and that's all fine and well. As Marcia Mueting indicated, we're open to amendments to address any legitimate concerns with the scope or breadth of the bill. But basically, I think the suggestions have been that pharmacists are already able to do this. And why do we need a law? The fact of the matter is Nebraska law is silent on this issue. Marcia Mueting referred to the tables attached to her testimony that indicated that 43 states have decided to proactively and affirmatively put into law or regulation what the rules of the road are. They have indicated in a few cases that pharmacists are not able to dispense under these circumstances. But in the vast majority of cases, 43 states for non-controlled medications, 36 states for controlled medications, that they do have specific provisions and they do differ in the length for emergency supplies and so forth. But some rules of the law will provide greater certainty or clarity in this area. And from the research that we did in putting the law together, the basic fundamental question was what can a pharmacist do after the physician/client/patient relationship is terminated or severed because of death or one of these other conditions addressed in LB181. And again, other states have chosen to be proactive. I assume the Legislature could choose to do nothing and leave the issue unresolved or, in our opinion, the better course of action would be to take action as proposed under LB181 and remove any uncertainty and provide that clarity that pharmacists and practitioners need. With that, I'd be happy to address any questions.

HARDIN: Thank you, Mr. Hallstrom. Questions from the committee? Seeing none, thank you.

ROBERT J. HALLSTROM: Thank you, Senator.

HARDIN: Anyone else in support of LB181? Seeing none of those-- or do we have one more?

MARK FRITSCHE: Yeah, one more.

HARDIN: Well, come on down.

MARK FRITSCHE: My name is Mark Fritsche, and I'm from southwest Nebraska, M-a-r-k F-r-i-t-s-c-h-e. I'd like to address the, the rural proponent of this. As a farmer and rancher where I live, it's 50 miles to the nearest pharmacy round trip, and the second closest is 100-mile

round trip. So as you can see, a lot of the, the-- when we renew prescriptions, it's usually on a, a, a parts run. So try to make the most of it. As far as putting in long hours, I mean, there are certain seasons when we do that and-- you know, like calving season, I can be fertilizing, spraying, planting, calving, feeding cows, moving pairs. As you can probably guess, it gets to be some pretty long days. And so with that, it is easy to, to, to miss your expiration date on your medication. And I guess it would be nice if we could go into a pharmacy with an expired prescription and walk out with that prescription under the circumstances of being, you know, so busy and, and, and there's no doubt about it, I have a great deal of respect for the Pharmacy Association. It's a profession that it is their job to know drugs, to know the reaction, to know drug interaction. So I, I think we're in very capable hands in, in allowing this to happen. Any questions?

HARDIN: Committee, any thoughts? Senator Riepe.

RIEPE: I'd only like to say thank you for coming in. Obviously, you took extra effort to do that. And not only that, but all the other testifiers as well. But thank you.

MARK FRITSCHE: Well, I appreciate that. Is that it?

HARDIN: I echo that. Anyone else?

MARK FRITSCHE: Thank you very much.

HARDIN: Thank you. Any other supporters of LB181? Seeing none, any in opposition to LB181? Welcome.

DANIEL ROSENQUIST: Thank you. Good morning, Vice Chair Hardin and members of the Health and Human Services Committee. My name is Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a family medicine physician in Columbus and the current president of the Nebraska Medical Association. I'm also here testifying-- I'm here testifying in opposition to LB181 on behalf of the Nebraska Medical Association, but also on behalf of the Nebraska Dental Association at their request. The NMA and the NDA appreciate the goal of this legislation, which we understand is to prevent disruption to patients receiving their prescription medications. We share that goal and value our pharmacy partners. However, we remain opposed to LB181. Our concern is twofold. First, the bill creates confusion regarding what we expect of pharmacists. In our conversations with the Board of Medicine and Surgery, there was a general puzzlement regarding the rationale behind

this legislation. Prescriptions that are valid when written remain valid until filled or expired. No regulatory board or agency expecting pharmacies to check the status of the prescriber's license, their location, or whether they are still living when they receive that valid prescription. These prescriptions are being filled. One of our members shared that in his two decades working in a busy emergency department that they have simply not seen this as an issue. Second, I would point you to the letter of opposition supported by the Board of Medicine and Surgery. As the, as the Board of Medicine points out in that letter, they are actively involved in contingency management plans in conjunction with the CDC and the Nebraska Department of Health and Human Services to ensure processes are in place to provide continuity of care when there is an abrupt disruption to the patient-- prescriber/patient relationship. There are a number of complications that factor into prescription authority and fulfillment, including state licensure, the department-- the Drug Enforcement Agency, the prescriber's enrollment with the relative payer. Whether this is a commercial insurer, Medicare or Medicaid, we understand the goal of LB181. However, we still feel that there are-- this may create as many problems rather than solving one that we're not certain that really exists. We value our partnership with the Nebraska Pharmacists Association and we appreciate them sharing this legislation with us before the, the session began. While we don't support the approach in LB181, we would welcome the opportunity to continue to work with them to ensure patients can safely and reliably receive their prescription medications. Thank you, and I'm here to answer questions.

HARDIN: Thank you for being here. Questions, committee? May I ask one?

DANIEL ROSENQUIST: Yes.

HARDIN: From 100,000 feet up. Clearly, we have two different perspectives here. Being a guy from out west, I have to ask the question. Has anyone from the AMA [SIC] ever been to western Nebraska that would be somewhere west of, I don't know, Kearney? It's-- the spaces are far and wide out yonder.

DANIEL ROSENQUIST: Yes, but I don't know, I don't know how long it's been.

HARDIN: OK. Do you get the sense of what I'm asking? Sometimes it's just difficult, as our previous testifier indicated, where it's difficult to somehow pour the barrel of the day into the thimble of reality. And so how do you get it done? And sometimes we're shocked and dismayed to learn that our provider is no longer our provider in

certain cases. And so anyway, is there any leeway for some, some help in those, in those extenuating circumstances?

DANIEL ROSENQUIST: I think it's always a collaboration and in cooperation with each other. I would tell you that as I approach that age, which I hope that I can voluntarily retire from practice, I'm very "cognizantly" aware of every prescription I write or send-- document right now as to when that expiration date is, because I want to know that I will still be in the office taking care of those patients if I am. And if not, I'm trying to make sure that those expirations are running out at the time when I think those people can need to be seen and need follow up. At my stage of my career, I'm mostly a geriatrician, which is pretty close, which is pretty much what I take with my, my-- I am myself, if you want to look at that and I recognize how often I need to see those people and I need to know when they need to come in and I need adjustments. There are certain reasons I prescribe only a 30 day. I prefer everything was a 90-day prescription. There are sometimes I, I need a 30 day because I need those people to come back. I think there are some potential concerns that I have in that situation that those peop-- my patients may not be getting that follow-up. Now, it's on me voluntarily-- I hope this is never involuntary-- that I retire or leave the practice, but I need to, you know, find a way to continue to manage my patients when I'm no longer there, like the last couple of weeks.

HARDIN: Understood. Any other questions? Thank you for being here.

DANIEL ROSENQUIST: Thank you.

HARDIN: Anyone else in opposition to LB181? Anyone in the neutral for LB181? If not, Senator Hansen, would you come up and close with us, please?

HANSEN: Well, I'll keep this short because I think they've pretty much explained both things. But I think when they talk about healthcare, you know, when we always talk about best practices, clarification and clarity is a part of that. And I think that's kind of the, the purpose of this bill, is to provide clarification for everyone involved that-- what their role is and what they're, what they're allowed to do and not allowed to do. I think because we do that in many instances in healthcare, and I think this is just one of them, along with what 43 other states have done. This is one way that we can provide clarifications. And I know a lot of medical doctors and health-- and healthcare practitioners always do, like the previous testifier said, they do what's in the best interest of their patient until something

happens. They-- like they pass away or they have a heart attack or they lose their license for some reason. And then who's looking out for the patient? I think this bill helps provide some clarification to allow them time to find a new provider, but also get their medications filled if they need to. So with that, I'll take any question as best I can.

HARDIN: Any questions from the committee? As a person who has insured lots of doctors and medical practices for the last few decades, I can tell you that doctors are not known themselves to have stellar health. And so sometimes the cobbler's children have no shoes. I just throw that out there because sometimes these things pop up where all of a sudden your doctor is no longer there. So I would also add that there have been six letters from proponents, two letters from opponents. And I thank you so much.

HANSEN: Thank you for your plethora of analogies, too. All right. Thank you. All right. All right. So with that, we will open up on LB245 and welcome Senator Walz to open.

WALZ: Good morning, committee members. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent Legislative District 15, which includes Dodge County and Valley. I'm here before you to introduce LB245 which is a simple change, so I'm going to keep my opening very short. The bill simply changes the per diem reimbursement rate for members of the Board of Barber Examiners. The board recently changed from having their meetings over the course of two days to meeting for one day. This per diem change reflects that. The reimbursement would change from the current rate of $75 to $150. The board members are completing the same amount of work and the bill allows them to receive the same amount of pay for the expenses they incur by doing their duties. This bill encourages government efficiency and helps ensure that those willing to serve are reimbursed fairly. Thank you for your consideration of LB245. I'd be happy to answer any questions, but Ken Allen from the barber board is here to testify and will be able to answer in greater detail. Thank you.

HANSEN: All right. Any questions from the committee? Seeing none, thank you. We'll take anybody wishing to testify in support of LB245. Welcome.

KEN ALLEN: Good morning, Chairperson Hansen and the committee. I thank you for your time on this bill and my chance to speak. I think Senator Walz and her group are crafting this bill. It's a very straightforward cleanup bill. What we do, as she explained, we currently pay our board

members $75 per day. OK, so-- and that was on a two day, one meeting, one-day meeting and one day for examinations. So we have condensed everything into one day now using our money wiser. But the main reason we did that, our examinees are required to bring a live or two live models to the exams. It's hard to find somebody to come in on a Monday. Our meetings were on Sunday, exams on Monday. To try to find somebody to come in on a Monday, working-class people. So our board members heard their cries, they voted July of 2021 to change it to a one-day meeting just to try it out. See how it worked. It worked amazing. So we were able to get the examinees, their models, if you will, live models to do their examination, complete their examination, and we were able to get the meeting in one day, and then they get to go home and spend the rest of the weekend-- Sunday, Monday is our weekend-- so they get to spend their Monday at home with their families. So this bill fulfills everything that was needed. Now-- so the board members were curious, why do we only get half the pay for doing the same work we used to do? So this was why this bill was crafted. And it's also hard to find board members. I don't know if you've ever worked in that department, but the board members don't just come and run at your door looking to be a board member. We have to do some recruiting. We try to screen the best members for the best job. That being said, if you look at the fiscal note, my side of the fiscal note shows a zero. However, budgeting wrote in there, if we have a fifth meeting or a sixth meeting, because currently we do four meetings per year, OK, so that's what we have to have. If we happen to have a fifth one, which I haven't seen since I've been here, and I've been here almost ten years, that is why that's in there. But like I said, I have never seen that fifth meeting; if I have, it wasn't an issue. It was a non-issue thing. So that being said, straightforward, we would reiterate, combine two days' pay into one day's work, and it's still the same duties. We would ask you to consider this bill, push it out to consent calendar, and I'd be happy to answer any questions you may have.

HANSEN: Are there any questions from the committee? All right. Seeing none, you're off the hook.

KEN ALLEN: Thank you, Senators.

HANSEN: Thank you. Anybody else wishing to, anybody else wishing to testify in support of LB245? OK. Is there anybody wishing to testify in opposition to LB245? Is there anybody wishing to testify in a neutral capacity? Seeing none, Senator Walz waives closing. And that will close the hearing for LB245. And last but not least, we'll open on LB261, and welcome Senator Riepe to open.

RIEPE: Thank you, Chairman Hansen and good afternoon, members of the Health and Human Services Committee. For the record, my name is Merv Riepe, it's M-e-r-v R-i-e-p-e, and I represent the 12th District, which consists of southwest Omaha and the city of Ralston. Before I begin, I'd like to comment that an actor likes to play in front of a full house, and obviously I don't have that today, but I appreciate the opportunity to be here. I have introduced LB261 on behalf of the Nebraska Funeral Directors Association. Prior to becoming a license in the field of mortuary science, a candidate must complete, among other requirements, a 12-month apprenticeship program. NE Revised Statute 38-1416 currently provides that a candidate may choose to complete the apprenticeship program requirement in two six-month blocks. This split approach allows a candidate to begin to work in the field immediately upon granted an apprenticeship license. While engaged in this first six months' apprenticeship period, the change in LB261 will clearly articulate the candidate is permitted to concurrently engage in the school of mortuary science coursework working towards completion of the coursework as one working works through the first six months' apprenticeship program. LB261 is intended to accomplish two primary goals. First, as with most other professions and industries in the state, there is a shortage of individuals engaged in and working through the funeral directing education process. It is becoming more difficult to find qualified, licensed individuals willing to remain in or move into rural parts of our state to provide what is a very necessary service to communities. Funeral directors from across the state, including the State Board of Funeral Directors and Embalming, view this legislation as another piece to removing unnecessary barriers to entry-- enter into the funeral directing profession. Second, the world modernizes and continues to move forward, providing more efficient, convenient ways of meeting every needs and requirements. In the world of education and training online courses, work has become more widely accepted and very popular. And as such, online mortuary science degrees are becoming much more common. The change provided for in LB261 is intended to expressly provide in statute an accommodation for concurrent work on both a mortuary science degree and completion of the required 12-month apprenticeship program. I would like to note there is no fiscal note associated with LB261 and I thank you for your time and attention. And I will be happy to the best of my ability to answer questions. I will-- also following me, will, will be a funeral director who will address specific questions relating to the practice of mortuary science. Thank you, Mr. Chairman.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you very much.

RIEPE: Thank you.

HANSEN: And we will take anyone who wishes to testify in support.

PAUL SEGER: Thank you, Senator Riepe.

HANSEN: Welcome.

PAUL SEGER: Committee, my name is Paul Seger, P-a-u-l S-e-g-e-r. Wanted to address the LB261. Usually the, the funeral service industry, we like to be behind times on everything. And with the online schooling we want to be kind of with it, and recognize that the online schooling is a major part of it now. I personally have three kids that are in online mortuary school that work with me every day. So I, I, I proctor them, teach them kind of the ways, and they go to school to learn how to take the test to pass the state-- the national board. Purpose of this bill today is that it gives us an opportunity to kind of weed out kids that maybe, you know, there are some kids that go to mortuary school that don't always-- had never experienced it and been in a funeral home. So this gives us an opportunity to let these people in. They can serve the apprenticeship their first six months after they have completed 20 hours per the state requirements of the 40 that were just redone. And then that gives them an opportunity to see if it's going to work out for them before they go through all the schooling. They go through everything, 12-month apprenticeship and it just doesn't work. Then that puts us behind on trying to fill positions on, on getting people-- workers that actually want to do funeral service, not, not everybody wants to work long hours, weekends, all that kind of stuff. So that gives us an opportunity to get these kids in and then it gives them a six-month head start once they have completed school. So then we can get them in the workforce sooner. So that was the main, the main point of, of this bill.

HANSEN: OK. Any questions from the committee? Yes, Senator Ballard.

BALLARD: Thank you, Chair Hansen. Thank you for being here. Do you have a hard time finding apprentice for, for funeral directors?

PAUL SEGER: Yes.

BALLARD: OK.

PAUL SEGER: It's, it's tough, you know, now I think the-- so I'm, I'm fortunate because I'm here in Lincoln that people want to be in the city. You know, we've heard all day people talking about western part of the state, further out west. I grew up in the north central part of the state. And to get somebody to say, like, OK, I want you to go here is very tough. I think you can all recognize that. This kind of we can, we can take this, we can get those homegrown kids that might may be interested, keep them home, working with that person there, do the online schooling if they so choose, or they can go to an outside school and do the same thing, and then get them back into those rural communities. We kind of feel this is, along with our examining board, we kind of feel this is the, the easier solution to get those people to go to the western parts of the state. If they're already there, they like it there; if they can do all the schooling and still work with the people and do-- be licensed and do everything they need to do, I just-- I think it's a good step in the right direction for that.

BALLARD: Thank you.

HANSEN: I discussed this with one of my really good friends, Darin Rapp,--

PAUL SEGER: Um-hum.

HANSEN: --who practice-- who's, you know--

PAUL SEGER: He's a good friend of mine--

HANSEN: Yeah.

PAUL SEGER: --as well. Yeah.

HANSEN: Yeah. Well, I'm sorry to hear that, so. But no, he's the same, the same thing that you just expressed, like, there is a, a big need for people in your profession and they're hard-- having a hard time finding people. And it's the same thing he said, sometimes you have people like to get in there and they take the schooling and they do the apprenticeship and they find out they don't like it.

PAUL SEGER: Right.

HANSEN: I had somebody in my class in chiropractor school that went through a year and a half of school and then they finally found out they don't like to touch people. And so you just, you just-- so they quit. And so you, and so you never know until you actually get

started. So I think it's a huge thing and getting them out there sooner, so.

PAUL SEGER: Yeah, I was in mortuary school with people that had never set foot in a funeral home before, and so they passed the national boards, they did all that, and then they went their first six months and they're like, I can't do this. And they were out and they spent all that time getting all that education to just turn around and go do something else.

HANSEN: Yeah.

PAUL SEGER: So.

HANSEN: And it makes it tough with people who are-- who currently are working because they think they might come work for them instead of someone else and then they're having--

PAUL SEGER: Correct, and they put all their time and energy into them and--

HANSEN: Yep, OK. Well, good. Well, thank you for your testimony.

PAUL SEGER: Thank you.

HANSEN: Appreciate it. Anybody else wishing to testify in support of LB261? All right. Anybody wishing to testify in opposition to LB261? Is there anybody wishing to testify in a neutral capacity? All right, seeing that, Senator Riepe, do you wish to close? He waives closing. And with that, that will close our hearing for LB261, and we'll close our hearings in the Health and Human Services Committee for the morning.

[BREAK]

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

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

DAY: Good afternoon. Senator Jen Day, Legislative District 49 and Sarpy County.

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

HARDIN: Brian Hardin, District 48: Banner, Kimball, Scotts Bluff Counties.

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

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

HANSEN: OK. Also assisting the committee is our legal counsel, legal counsel, Benson Wallace; and our committee clerk, Christina Campbell. And our committee pages for today are Delanie and Malcolm. So a few notes about the policy procedures about how the meeting is going to be run today. First of all, please turn off or silence your cell phones. We will be hearing one bill today and taken in the order listed on the agenda outside of the room, which is LB626. On each of the tables near the doors to the hearing rooms, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina or one of the pages when you come up to testify. This will help keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on the bill today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. I know we have staff and possibly even clerks handing out both of these. So, again, we're going to kind of get through as many people as we can to make sure everyone's voices are heard. But if we do not get to you or if you're not able to testify, make sure you fill that white sheet so at least your position is heard and on the record. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. So we will be using a light system for testifying today. Each testifier will have three minutes to testify. So when you begin, the light will turn green. When the light turns yellow, that means you have one minute left. And when the light turns red, it's time to end your testimony and wrap up your thoughts as soon as you

can. If we go a little bit past the red, I might have to stop you so we can kind of keep moving it, you know, make sure the courtesy is for everyone else who's testifying after you. So when you come up to testify, please begin by stating your name clearly into the microphone and please spell both your first and last names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill. So supporters of the bill will have three hours to testify total. Opponents, we'll extend the same courtesy to the opponents. The opponents will have three hours as well total, and then followed by those speaking in the neutral capacity. I will be a little bit stricter on neutral capacity this time than I typically am. So typically neutral capacity, if you're coming to testify in that aspect, is reserved for those who are in state agencies who actually talk about how this bill might affect different kinds of state agencies such as the judicial branch or the executive branch. If you are going to come up in a neutral capacity, it really does have to be clearly neutral. And if I start finding out that it's as a supporter, as an opponent, because you didn't have time to testify, we're going to stop you so we can kind of keep things moving along. And on a side note, the reading of testimony that is not your own is not allowed until previously approved. And lastly, we do have a-- we have a strict no-prop policy in this, in this hearing. So if you have any signs, if you have anything you want to kind of show everybody, well, just kind of keep it to yourself if you can. All right. So I appreciate everyone being here. With that, we will open up on LB626 and welcome Senator Albrecht, to open. Welcome.

ALBRECHT: Thank you. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. For the record, my name is Joni Albrecht, J-o-n-i, Albrecht, A-l-b-r-e-c-h-t, and I represent District 17, which includes Dakota, Thurston, Wayne, and portions of Dixon Counties in northeast Nebraska. I introduce to you today LB626, which is about one thing: protecting babies with beating hearts from elective abortion. Every parent remembers hearing their child's heartbeat for the first time. I know I do. I also know what it's like when the heartbeat isn't there anymore. These are moments that change all of us because a heartbeat is a universal sign of life. Sadly, abortion stops a beating heart. Under the Nebraska Heartbeat Act, before performing an abortion, a physician must perform an ultrasound to listen for a fetal heartbeat. If the heartbeat is detected, performing an abortion is unlawful except in cases of rape, incest, or to save the life of the mother. In addition to these exceptions, the Nebraska Heartbeat Act makes undeniably clear that a pregnant woman

can always receive care and treatment that they need. The bill clearly provides that treatment for ectopic pregnancies, miscarriage, and any emergency medical situation will remain unaffected. It also clearly provides that access to IVF will remain unaffected as well. Nothing in LB626 would change the standard of care for any woman who is facing a medical emergency. There are medical experts who will testify after me and they can tell you all about it. I'm very excited for you to hear from them. For any abortionist who violates the Nebraska Heartbeat Act, they will have their medical license subject to discipline by the Director of Public Health in consultation with their board of peers. Like any other instance of serious, unprofessional conduct, but no criminal or civil penalties. The bill is also clear that no woman who obtains or attempts to obtain an abortion may be held liable in any way. This bill is right for Nebraska and right for the medical profession. That's why it's supported by the majority of citizens across our state. A recent statewide poll found that 58 percent of Nebraska voters support a law that would protect pre-born children from abortion the moment their heartbeat can be detected, including nearly two-thirds of independents and nearly half of Democrats. I've had the privilege of introducing many bills in the Nebraska Legislature during my time here, and I'm proud of the work that our body has done to work together to make Nebraska a state and create-- a better state and create a brighter future for our children and grandchildren. This is the single most important issue that we will address as a Legislature, because this is about protecting our most vulnerable citizens, baby girls and baby boys who are living, moving, and have their own DNA and their own heartbeat, who are dependent upon us to give them the same right that was given to us to be born and allowed to live. That's why LB626 will be my personal priority bill. I believe, and I think we all believe, that every woman and every child deserves love and that our state will be at its best when every life counts. And that in Nebraska, we can love them both. We can protect and empower women. So let's start here in a place where we should all be able to agree: women deserve support and the babies with beating hearts should be protected. I thank you for your time and I'm happy to answer any questions you may have.

HANSEN: All right. Thank you for your opening. [APPLAUSE] OK. Also on a side note, we'll have no clapping that we can, please. If we, if we do have extensive noise from the crowd, the, the clerks will have to usher you out. Sorry. And one other thing-- sorry, Senator Albrecht-- when you are done testifying, if you can, we will have you exit out of that door after you are done testifying. Because as you exit, we're going to bring somebody else in. We're going to kind of keep shuffling

them in until we kind of get through ever-- as many people as we can. So thank you very much. And in case you don't know, there is an overflow room in 1013. So if you want to kind of continue watching the hearing, you can go over there as well. So with that, I will see if there are any questions from the committee. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. You looked at me first.

HANSEN: I could just feel your eyes on me there.

M. CAVANAUGH: Thank you. Thank you, Senator Albrecht, for being here today. So one of the questions I wanted to ask is, is this bill defining a medical practice?

ALBRECHT: Defining meaning-- like what type of medical practice are you talking about in particular? I mean, it defines that in vitro fertilization is an exception. It defines ectopic pregnancies. There are a lot of different type of procedures. What are you asking exactly?

M. CAVANAUGH: Well, what I'm asking really is if, if this were to pass and a doctor were in violation of this, would it be deemed an unacceptable medical practice?

ALBRECHT: I believe-- and there's people behind me that would know a lot more about it than I would in that respect, but it is my understanding clearly that what they're doing today should not make a difference in this bill.

M. CAVANAUGH: What they're doing today?

ALBRECHT: What the different medical practices that a doctor does today, as long as you're not taking an elective life by abortion.

M. CAVANAUGH: I'm sorry, I couldn't hear that last part.

ALBRECHT: If you have an elective abortion in the state of Nebraska and it has a beating heart, it would be a violation.

M. CAVANAUGH: OK. I'm sorry. It is very difficult to hear with the door opening, but I understand that there must be some concerns. I'll pause there because I'm trying to process what you said and I don't quite understand, but I don't know how to ask.

ALBRECHT: Probably because I'm not quite clear on what you're asking me. If it's a medical-- say that word again that you're asking.

M. CAVANAUGH: A medical practice. Are we defining a medical practice with this bill?

ALBRECHT: I can't answer exactly. Maybe someone behind me can. If you-- there are professionals that are in the field.

M. CAVANAUGH: So what is this bill, what is this bill seeking to do if not define a medical practice?

ALBRECHT: Well, it's-- they already know what they can and can't do in hospitals. So, again, I have professionals in the field that would-- that would be a good question to ask them.

M. CAVANAUGH: OK. I'm, I'm, I'm asking you as the introducer, though, what the intention of the bill is as far as medical practice.

ALBRECHT: The intent is, if an ultrasound is done and there is a beating heart, you would not abort the baby.

M. CAVANAUGH: So-- but I'm asking the intent as far as medical practice goes, because we are dealing with the medical practice of abortion.

ALBRECHT: And within the bill it does state all of the concerns, and we can certainly review it if you'd like.

M. CAVANAUGH: If you could point me to where.

ALBRECHT: OK.

M. CAVANAUGH: I'm sorry if I'm yelling. I'm talking loud-- loudly because of the noise. I'm not trying to yell at you. Just realized that maybe I'm talking very loudly.

ALBRECHT: So in Section 4,--

M. CAVANAUGH: OK.

ALBRECHT: --it defines abortion, includes-- it's including both surgical-performed and chemically-- abortions. It also makes clear that none of the following will be considered abortions under the Heartbeat Act. And you can certainly read for yourself.

M. CAVANAUGH: So it, it-- so in defining what is an abortion and what isn't abortion, you are defining a medical practice, it would appear.

ALBRECHT: And defining medical emergency, reasonable medical judgment.

M. CAVANAUGH: OK. So if a doctor does not follow this, then they are in violation of that medical practice.

ALBRECHT: Yes, they would be.

M. CAVANAUGH: OK. That's what I was asking. Thank you.

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

DAY: Thank you, Chairman Hansen, and good afternoon, Senator Albrecht. You mentioned some polling data in your intro. Can I ask who did that poll?

ALBRECHT: Sure. It would be the WPA Intelligence.

DAY: WPA Intelligence. And who managed that poll? Like, who sent--

ALBRECHT: The Susan B. Anthony--

DAY: OK.

ALBRECHT: --Pro-Life American organization.

DAY: OK. So it was organized by a pro-life organization?

ALBRECHT: Yes.

DAY: OK. I have some public opinion data that says the opposite of that. So that's why it's sort of confusing. We have data from Pew Research and also from Heart Research and Impact Research that says that the majority of Nebraskans oppose state senators applying more restrictions to abortion access. I also believe we had over 2,500 comments online today submitted for this bill, of which about 62 percent were in opposition to this bill. So I just wanted to clarify for the record that public opinion data leans towards opposing this type of bill. You talked about medical emergencies. And it also mentions in the bill under Section 3, "Medical emergency means any condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the termination of her pregnancy to avert her death or for which a delay in terminating her pregnancy will create a serious risk of substantial

and irreversible physical impairment of a major bodily function." My first question is what defines reasonable medical judgment?

ALBRECHT: That would be between the mother and the patient and-- the patient and the doctor, I should say. They'll determine if it is or if it is not.

DAY: OK. So I think maybe back to Senator Cavanaugh's question in defining acceptable or unacceptable medical practices. If, if a doctor's practice is seen as in violation of this bill, that would be deemed unacceptable medical practice. Is that correct?

ALBRECHT: You know, reasonable medical judgment in a medical emergency, I think they do those every day today and they know their boundaries. I'm, I'm quite certain they know of the standard medical care in a hospital. I don't think today they stop to ask questions. They take care of their patients. And that's exactly what is in the bill and that we're trying to portray.

DAY: OK. Sure. And I think that the reason they don't stop today to ask questions is because we don't have legislation like this in statute that is trying to do that for them. And so just my question is, what is reasonable medical judgment? How far-- how close to death does a woman have to be before--

ALBRECHT: I would certainly hope that the doctors in our state know exactly where they need to be and the amount of time that is there between a woman ending up in a critical care type situation. They know themselves. They're experienced. They understand if a woman is having trouble and they're going to be at her side and they're going to make those right decisions to save the life of the mother.

DAY: So if a woman is in critical care but she's not at risk of death, is that a state in which she would be allowed to terminate a pregnancy?

ALBRECHT: If it were to save the life of the mother, it's an exception.

DAY: But if she's in critical care and she's not at immediate risk of death?

ALBRECHT: Then I would believe that the doctor would make that decision for her.

DAY: But then would that doctor be in violation of this, of this legislation?

ALBRECHT: No, no. This legislation is about a beating heart that is not electively choosing to, to, to, to have an abortion. You're not, you're not talking about the woman who wants that baby. We're talking about those who don't want the baby, an elective abortion. They're having it because they want to, not because they have to.

DAY: OK. Thank you.

HANSEN: All right. Are there any other questions from the committee?

M. CAVANAUGH: Yes.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. That spurred a few more questions for me. So you said that reasonable judgment would be between the patient and the doctor.

ALBRECHT: Um-hum.

M. CAVANAUGH: Then why are we having this hearing today? Isn't that already-- I, I mean, why are-- why is there all this language in front of us?

ALBRECHT: Well, it needs to be so that the doctors know and understand. This is about elective abortions. They can't do those in our hospital today.

M. CAVANAUGH: I'm aware.

ALBRECHT: If they, if they have an abortion and they, they call, they call it an abortion if they're the doctors in this-- in the hospitals.

M. CAVANAUGH: It's not-- I mean, you just used air quotes, but it is an abortion.

ALBRECHT: Well, I've talked to several of them and they have told me that they, they can abort your appendix. The word abortion in the hospital means many things.

M. CAVANAUGH: Correct.

ALBRECHT: So my point is, for a woman who is wanting that baby, expecting to have that baby, that doctor has the care of both the woman and the baby at hand. They have to take care of both of them.

M. CAVANAUGH: So instead of this being a abortion, this, this is-- the intention of this is to prohibit elective abortions.

ALBRECHT: Yes, it is.

M. CAVANAUGH: And in the process, we're going to jeopardize patients' healthcare.

ALBRECHT: We're not going to jeopardize anyone's healthcare.

M. CAVANAUGH: So you, you said that doctors have been fearmongering over this bill. And I have to be honest here, I'm terrified by what you are telling me right now--

ALBRECHT: I'm sorry.

M. CAVANAUGH: --because I don't feel like you understand.

ALBRECHT: I think I fully understand. I've got to convince you that, that the doctors and what they're doing today in our hospitals, we have the utmost confidence in.

M. CAVANAUGH: But--

ALBRECHT: And to, to ask an in vitro patient to contact us and talk about the fact that they can't help them anymore, that is disingenuous.

M. CAVANAUGH: I'm not, I'm not talking about IVF at all.

ALBRECHT: Well, but you are, and, and any of the-- anyone that wants to have a baby--

M. CAVANAUGH: No, I'm talking about medi-- I'm talking about doctors and their patients. I'm not talking about IVF. I'm talking about a patient goes into their doctor's office and they are preeclampsia or septic or a million other things are going on. And to Senator Day's point, they are not actively dying. And, and what you are telling me and this committee is that you feel confident that they will act in the best interests of their patient, but you are restricting their ability to do that.

ALBRECHT: But, but we're not restricting it. If they have preeclampsia and they've had a history of it, that--

M. CAVANAUGH: Preeclampsia is not mentioned in here.

ALBRECHT: You just mentioned it.

M. CAVANAUGH: No, I mean-- but, but I'm saying it's not mentioned in here. There's not an exemption if you have preeclampsia.

ALBRECHT: But again, it's about a medical emergency. That would fall under a medical emergency, and that would be between the patient and the doctor to decide what they should be doing.

M. CAVANAUGH: So-- it's not, though. Because at the end of the day, when we enact this legislation and we say reasonable knowledge, it's-- or reasonable judgment, it's reasonable medical judgment left up to the Director of Public Health, who also doesn't necessarily have to have an M.D. And so we are actually leaving the reasonable medical judgment up to a third party that may or may not be involved in the situation at some point in time. So if somebody-- natural conclusion is to, to report this, somehow this gets reported that this abortion is, is, is conducted. And if someone believes that it wasn't conducted using reasonable medical judgment, you're not going to have doctors performing abortions on people with the risk of losing their lives, even if they think that it's reasonable.

ALBRECHT: Well, that's where we have to agree to disagree, because I think a doctor in the state of Nebraska--

M. CAVANAUGH: Well, I think when the doctors come in and tell us that.

ALBRECHT: Well, we'll, we'll, listen, and, and we'll figure it out. But in what this says is reasonable medical judgment and a medical emergency. There's a lot of problems that all of us have as health problems. They're going to deal with that based on her history.

M. CAVANAUGH: Yes.

ALBRECHT: And they can do today and tomorrow and after this bill is approved, the same type of work.

M. CAVANAUGH: But you are defining what is and isn't a medical emergency in this bill.

ALBRECHT: But I can't, I can't list every single thing that would be a medical emer--

M. CAVANAUGH: Well, apparently you could list that suicide is, is not a medical emergency. So--

ALBRECHT: I cannot list everything that could possibly be a medical emergency. The doctors know--

M. CAVANAUGH: But you don't trust the doctors' judgment enough to save their patient from suicide, only from other conditions.

ALBRECHT: I-- if the doctor deems that a medical condition--

M. CAVANAUGH: You, you specifically have it exempt as a medical condition. A doctor cannot, according to this, deem--

ALBRECHT: Does it say suicide in here anywhere?

M. CAVANAUGH: It says a-- "No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function."

ALBRECHT: But that doesn't say suicide.

M. CAVANAUGH: Well, that's--

ALBRECHT: Sorry.

M. CAVANAUGH: How would you define suicide medically, then?

ALBRECHT: I don't have a medical diagnosis for suicide.

M. CAVANAUGH: Well, then why is-- if you're not intending to exempt suicide, why is that in here?

ALBRECHT: There are many, many conditions, Senator Cavanaugh, that could be listed in here. But--

M. CAVANAUGH: But, but you've, you've specifically exempted this condition, but you are also telling me that it is not suicide. So I'm asking, why is this specific--

ALBRECHT: I didn't say it wasn't suicide. It's a medical emergency under whatever the doctor deems right for that patient.

M. CAVANAUGH: But you're exempting, you're saying this specific instance is-- I feel like this is a circular conversation in that--

ALBRECHT: It is.

M. CAVANAUGH: --you're not listening to my question. You are saying that this is not a medical emergency. You have defined in this bill that this is not a medical emergency. And my question is, why have you picked this? What is the reasoning behind this being deemed not a medical emergency?

ALBRECHT: All I'm saying-- I'm going right back to the bill. If it's a medical emergency, that's between the doctor and the patient.

M. CAVANAUGH: That's not my question.

ALBRECHT: I can't answer you any other way. Sorry.

M. CAVANAUGH: I'm asking you about specific-- page 2, line 30, 31, over to page 3, line 1 and 2. I am asking you why those lines are in the bill? What is the rationale? I'm asking you to tell me that. If you don't want to tell me that, then say you don't want to tell me that. But please stop saying the same thing to me over and over again.

ALBRECHT: I'm not telling you what you want to hear. And I can't help you with the questions that you have.

M. CAVANAUGH: You're not answering my question.

ALBRECHT: You're right. I'm not. Sorry.

M. CAVANAUGH: Then just say you don't want to answer.

ALBRECHT: I'm not going to answer your question at this time.

M. CAVANAUGH: OK.

ALBRECHT: I'll get back to you. Thank you.

M. CAVANAUGH: Thank you.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Senator Hansen. There was a concern brought up recently about lost lives of mothers, but I had heard recently that in Texas, and, and they've had a very restrictive abortion piece, that

they've had zero deaths of women since that new policy in Texas has been-- can you confirm that?

ALBRECHT: I have heard the same thing. I'm sure that those following me will be able to elaborate on it. Yes.

RIEPE: OK. Thank you.

HANSEN: Yes, Senator Day.

DAY: Thank you, Chairman Hansen. Related to Senator Riepe's question. I'm not sure whether or not that's cited or true. I would like to know that if you have any information on whether or not any women have died in any state in the country that has implemented a bill like this. But I do know that women have been put into seriously compromising medical conditions because of bills like this. And so women have been put into positions where they've become septic. Do you know what it means for a woman to become septic?

ALBRECHT: I certainly do.

DAY: Can you elaborate on that for me?

ALBRECHT: It would be a blood disorder; an infection from the--

DAY: Resulting from?

ALBRECHT: From an abortion that is possibly botched or possibly just coming in and having an issue with that. Maybe they've had it in their past.

DAY: So what I understand is happening in other states that have implemented bills like this is women are being forced to become septic because their doctors cannot perform a termination or an abortion at the time that they come in and have to wait until they get very, very ill and very sick before they can terminate because you specifically spell out the life of the mother has to be in danger before the doctor can legally perform the abortion.

ALBRECHT: Thank you for the question. I do have folks behind me that'll validate what would happen in that situation.

DAY: OK. I have another question.

HANSEN: Yep, go for it.

DAY: So relating to Senator Cavanaugh's question about a mother's mental health. So if a doctor-- if a woman has a history of mental illness, depression, suicidal ideation, and she comes in and says, I believe that I'm pregnant, if I have to carry this pregnancy to term, I will commit suicide or cause myself bodily harm, that would not be considered a medical emergency?

ALBRECHT: Again, I have specialists that deal with this every day. That would be an excellent question for them.

DAY: OK.

HANSEN: OK. Seeing no other questions, I'm assuming you're sticking around for closing.

ALBRECHT: Yes, sir.

HANSEN: OK. It should only be just a little bit. All right. So with that, we do have some invited testimony that we will go through first, and then after that, we will start taking people one at a time. And like I said, if you're done testifying, please exit out of that door so we kind of work some people in. So with that, we will take our first invited testimony, whoever would like to come up first. And again, when you do come up, please state your name clearly and spell it. First name and last name, please. Welcome.

ANGELA HIMMELBERG: Good afternoon, Senators. My name is Angela Himmelberg, A-n-g-e-l-a H-i-m-m-e-l-b-e-r-g. I've been performing ultrasounds for 20 years. I have a Bachelor of Science degree in diagnostic medical imaging from the University of Nebraska Medical Center. The past five years I've been teaching embryology to students and showing live fetal ultrasounds in classrooms across the country. In obstetrics, we use the fetal heart rate as the gold standard for verifying a living fetus. In obstetric ultrasound, we use-- if the length of the baby is seven millimeters or larger, we should always see movement of the fetal heart. If we don't, then we know that the pregnancy is not going to develop and is considered a fetal demise. However, when we have a fetal heart rate detected and the baby is then verified to be alive. Early in my career, I learned how impactful the fetal heart rate is to a mother. I had a patient come in for dating to see how far along she was. Upon doing the ultrasound, I realized she wasn't interested in looking at the screen, so I asked her if she wanted to see her baby. To which she replied, I'm having an abortion. And then she heard the fetal heart rate. And she said, what is that? And I said, that's your baby's heart. And she looked at me and said,

my doctor told me it was a mass of cells, and began to cry. I realized at that point she hadn't been given the full truth. I continued and finished the exam. I showed her her baby's arms and legs, and we both laughed as we watched her flip around. She ended up keeping her baby and I was able to do a second trimester ultrasound for fetal growth. In my experience, the most comforting sound a baby-- a mom can hear is her baby's heartbeat because she knows her baby is alive. So whether we want to call the baby an embryo, a fetus, a zygote, she's human. We know she's human because she has human parents. She has human DNA. And she deserves the same protection at any stage of life. So that's why I ask for a vote yes on LB626. Thank you.

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

ANGELA HIMMELBERG: Thank you.

HANSEN: All right. We'll take our next invited testimony. Welcome.

TARA SANDER LEE: Thank you. Thank you. To the Chair and other members of the committee, thank you. I am Dr. Tara Sander Lee, T-a-r-a, Sander, S-a-n-d-e-r, Lee, L-e-e. Please refer to my written testimony for my credentials. It is a scientific fact that human life begins at fertilization and abortion during any stage of pregnancy ends the life of a human being. It is also a scientific fact that there is a beating heart in every living human being. The heart is the first organ to form and function in the developing human embryo. It is a vital source of circulation of nutrients and oxygen carrying blood. About 22 days after fertilization, that's the sixth week gestation, the heart starts to beat or pump blood rhythmically. The heart beats around 110 beats per minute in the sixth week. By the end of the sixth week, the human heart will have already beat over one million times. Anyone who denies that an unborn child is alive and has a beating heart is blatantly ignoring the science. I have included quotes from top leading medical journals and embryology textbooks in my written testimony further confirming these scientific facts. Not only is the heart beating, but the heart can be detected as early as six weeks gestation by ultrasound. Ultrasound does not measure electrical activity. It measures pulses of high frequency sound reflected off solid objects. That is the heart beating and pumping blood. The heartbeat is a strong indicator of mark-- and marker of health. Researchers have shown that the heartbeat at six to eight weeks indicates that the unborn child has a very high chance of surviving to childbirth. Simply put, the heartbeat is a sign of life. The heart is vital to continued growth of the unborn child. Soon after the heart starts to beat, she will

already have arms, legs, fingers, toes, a face and eyelids. She will also bring her hands together, touch her face, and suck her thumb with a preference for her right or left hand. The early heart at six weeks gestation may not be a formed chambered heart yet, nor should it be at this stage. The prenatal heart organ is exactly the size it needs to be at this time of the child's unborn life. The heart is still moving, pumping blood, beating rhythmically, and circulating essential nutrients through the embryo. A human being does not suddenly stop developing once he or she is born. The brain continues to mature well into adulthood and does not complete until 25 years of age. Does the fact that a toddler or a teenager that the fact that they do not have a fully-formed brain mean that they are any less human? Of course not. So it is with the heart. The intrinsic worth of a human being is not governed by their developmental stage, abilities, organ function or capacity to do certain things. That's why this bill is so important. Nebraska will send a strong message that every human being is created with a purpose, has intrinsic value and worth. This law will protect children from the lethality of abortion, which ends the beating heart and life of a human being every time. Thank you. And I'd be happy to answer any questions.

HANSEN: All right. Thank you, Doctor. Are there any questions from the committee? Yes, Senator Hardin.

HARDIN: How much more dangerous are abortions that occur later; after a heartbeat? And then, maybe speak throughout that spectrum.

TARA SANDER LEE: So we will actually have an obstetrician that will be answering specifically those questions. But as the pregnancy, I can tell you from my experience, I mean, from reading the literature, I'm not an OB/GYN, but we will have an expert testify about that. But as you go through pregnancy, that the later in gestation that you go, the more dangerous abortion is for the mother.

HARDIN: Thank you.

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

RIEPE: You said-- I know you're a physician and you said you're not an OB/GYN. What-- do you have a specialty?

TARA SANDER LEE: I'm actually a Ph.D. scientist. I, I have 20 years of experience. I was, I, I was Harvard-trained in Boston, Massachusetts, at Children's Hospital. I specifically studied heart development. I

then ran a medical college research lab that studied heart development. I then directed a children's hospital clinical lab that did genetic testing in children that had congenital heart disease. So I have a lot of experience specifically in prenatal development and understanding pediatric disease as a Ph.D. scientist.

RIEPE: Very good. Thank you.

TARA SANDER LEE: Thank you.

RIEPE: Thank you, Mr. Chairman.

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

TARA SANDER LEE: Thank you so much.

HANSEN: All right. We'll take up our next invited testimony.

ELENA KRAUS: Good afternoon,--

HANSEN: Welcome.

ELENA KRAUS: --Senator Hansen and members of the Health and Human Services Committee. My name is Dr. Elena Kraus, E-l-e-n-a K-r-a-u-s. I'm a board-certified OB/GYN and I have a Ph.D. in healthcare ethics. Beyond this, I completed three additional years of training in obstetric ultrasound and the diagnosis and management of maternal and fetal health conditions to become a maternal fetal medicine specialist. Here in Lincoln, I care for both maternal and fetal patients at high risk for complications in pregnancy and delivery. Together with my husband, also a board-certified OB/GYN, we recently moved to Nebraska to work in women's healthcare. We have found Nebraska and Lincoln to be an excellent place to raise our family and to practice medicine. I support LB626. Others may argue that it will hinder lifesaving medical care in emergencies. This is not true. LB626 specifically empowers doctors to proceed with interventions, even direct abortions in the case of medical emergency. Whether a medical emergency exists is left to the reasonable medical judgment of the physician defined by the bill as, "a medical judgment that could be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." This gives broad latitude to physicians in many difficult and complex medical situations we encounter, whether it be an acute emergency, as in hemorrhage or sepsis, or a chronic medical condition that puts the mother at high risk for morbidity and even mortality in

pregnancy. I cannot think of a high-risk medical situation where this bill would restrict the available treatments to patients based on sound medical reasoning. Women's healthcare providers should feel comfortable with a level of deference this bill leaves to their professional judgment. You may also hear from opponents that LB626 will keep OB/GYNs from moving to Nebraska or discourage physicians in training from coming to complete residencies in OB/GYN. This is also not true. For many physicians and other healthcare providers, it is outside the scope of their conscience to participate in elective abortions. I'm here to tell you that excellent OB/GYN training and even board certification requirements do not mandate participation in elective abortions. I sought out training programs and subsequently my current job in places that supported this free-- freedom of conscience. I assure you I am in the company of many, albeit less vocal physicians who want to live in a state that values and stands for life-affirming medicine. The Dobbs decision has given individual states an opportunity to foster a healthcare culture that represents their constituents. This legislation represents a commitment to support and empower Nebraskans to say yes to children. One of our greatest treasures and indeed our very future. It furthermore enables women and their healthcare providers to make individualized decisions when challenged with pregnancy complications. My training has prepared me to provide excellent pregnancy care for both maternal and fetal patients and LB626 in no way compromises my ability to do that. I encourage you to vote it into law. And thank you, and I'll take any questions.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? OK. Seeing none, thank you. We'll take our next invited testimony. Welcome.

INGRID SKOP: Thank you, Chairman and members of the committee. I am Dr. Ingrid Skop, I-n-g-r-i-d S-k-o-p, a board-certified obstetrician gynecologist from Texas, testifying on behalf of the Charlotte Lozier Institute. The Nebraska Heartbeat Act requires that a human life be protected at the point of a detectable heartbeat. Death is usually diagnosed when cardiac activity has ceased. It is reasonable to conclude that life may be diagnosed and protected when a heartbeat has begun. There are many reasons to support these limitations. Almost all abortions are performed for social or financial reasons. Later abortions are also associated with coercion and indecision. This legislation does not prevent a woman from obtaining abortion. It just requires that she do so at an early gestational age when it is safer. CDC data documents that the risk of death from abortion increases by 38 percent per week. A chemical abortion is usually performed in early

pregnancy, but it sometimes fails, requiring surgery in 3 to 8 percent of women. But this number skyrockets to 38 percent if used in the second trimester. Most abortions beyond the early second trimester are performed by dilation and evacuation, also known as dismemberment abortion, which can be a dangerous surgical procedure. A woman is 76 times as likely to die from a D&E late in the second trimester compared to a first trimester abortion. Again, according to CDC data. Experts in the field of fetal pain acknowledge that pain perception may occur as early as 12 weeks and unborn children may experience excruciating pain as they are torn limb from limb in later abortions. Some women experience mental health complications after abortion. Those who are coerced and have later abortions are at much higher risk. In fact, Scandinavian studies tell us that a woman is six times more likely to die from suicide in the year following an abortion than term birth. Additionally, these studies tell us she is twice as likely to die from any cause, four times as likely to die from an accident, and 14 times as likely to be murdered. It's been discussed and you have heard that limiting abortion may threaten women's lives, but this is untrue, as the two senators brought up-- and it's a very good question-- this law specifically states a physician may use their reasonable medical judgment to determine when intervention is necessary in a medical emergency. Reasonable medical judgment is the standard that I use every day when I go to work. Obstetricians know what reasonable medical judgment means. There will not be confusion. In fact, the American College of Obstetrics and Gynecology, which is our professional organization, provides extensive information in situations where there is a threat to the woman's life on when we can intervene. I know my time's up, but I do want to let you know I practiced obstetrics in Texas for 30 years and my practice remains unchanged despite Texas abortion restrictions. Your women will be protected.

HANSEN: OK. Thank you for your testimony. Are there any questions? Yes, Senator Riepe.

RIEPE: Senator Hansen. I'm intrigued by your presentation. Do you have other thoughts you would like to continue and conclude with?

INGRID SKOP: Well, I think that doctors are sometimes-- and, and obviously even some of the senators are confused about the intent of this law. The intent is to allow physicians to continue to practice the way they always practiced. More than 90 percent of obstetricians do not perform elective abortions. However, all of us have had occasions where we have needed to intervene to save a woman's life. We've needed to separate a mother and her baby. The intent of that

action is not the death of the baby, which is a legal definition for abortion. The intent is to save the mother and save the baby, or at least one of them if we can't save them both.

RIEPE: Thank you. Thank you.

HANSEN: Any other questions? Yes, Senator Ballard.

BALLARD: Thank you for being here, Doctor. Thank you, Chairman Hansen. Thank you for being here. I want to go back to Senator Riepe's question. How long has Texas had similar legislation?

INGRID SKOP: We've had a law similar to yours for a year and a half.

BALLARD: Year and a half. And then how many mothers have died by not--

INGRID SKOP: No mothers have died as a result of our law.

BALLARD: And can you talk a little bit about the microscope that you-- you're under since that law was passed?

INGRID SKOP: Of course. I, I think that if, if, if a woman did suffer harm and died, the world would know about it. Because many people have criticized our law. The stories that you have heard of, perhaps a miscarriage, ectopic pregnancy, even preterm, previable rupture of membranes, which I think was brought up earlier, are all situations where doctors have not understood the law. Just like your law, our law specifically says intervention can occur in those situations. And just like your law, our law does not say that the risk of death must be immediate. We know because of our training, the situations-- maybe a complex cardiac condition that may lead to death at term, but we can intervene on presentation if we know she carries such a serious cardiac defect. So, I mean, again, ACOG has, has much guidance that's very clear. And obstetricians, if they don't know for sure, they can, they can consult ACOG's guidance or they can convene a multidisciplinary quality committee at their hospital where doctors can get together and decide the best course of action. And I, I would note also the-- your law, the people who are going to be deciding whether the doctor did the right thing are going to be other physicians and other medical professionals so they, they will understand when the intervention needs to be occurred. So doctors do not need to worry that they are going to be punished for taking care of women and practicing obstetrics the way they should.

BALLARD: Perfect. Thank you. Thank you for being here. Really appreciate it.

HANSEN: Senator Hardin.

HARDIN: What percentage of OB/GYNs who could be performing abortions do so?

INGRID SKOP: Polling tells us that 87 to 93 percent of OB/GYNs say they would decline to do an elective abortion if requested by a patient.

HARDIN: Can you speculate why that number is so overwhelming and maybe why ACOG and the AMA kind of presents that as though it's an overwhelming number that would be an opposite of that?

INGRID SKOP: Well, I went into obstetrics, and I think many of my peers did, because it is a challenge and a, and an honor to care for two patients at once. I do not want to kill one of my patients, and I believe that most obstetricians feel the same. Unfortunately, in many cases because it is such a politicized issue, the leadership of some of the organizations have a pro-abortion bias, but it's not because abortion is needed to save women's lives. Abortion actually has not-- the question was raised earlier about suicide. Abortion is never a treatment for suicide. There's so-- my husband's a psychiatrist, there's so many ways we can help people not to commit suicide other than allowing them to end the lives of their children. But it's, it's, it's politics, I think, that drives a lot of the professional recommendations. But on the ground, regardless of whether they consider themselves pro-choice or pro-life, 90 percent or more obstetricians do not do elective abortions.

HARDIN: Thank you.

INGRID SKOP: Thank you.

HANSEN: I would like to ask a question, if I could.

INGRID SKOP: Yes, sir.

HANSEN: I think one of the, and I'm assuming you're the person to best answer it. If not, maybe somebody else can expound on it later. Probably one of the biggest concerns I've heard and emails that I've seen is by a time there's a heartbeat, a woman doesn't know she's pregnant, or she may not know that she's pregnant. Can you discuss that a little bit? Like--

INGRID SKOP: Sure. At the time of fertilization, the embryo travels about five to seven days before implanting in the uterus. Upon

implantation, immediately beta-hCG, the pregnancy hormone is detectable in the blood within a day or so. Even over-the-counter testing is very sensitive. So women within, I would say seven to ten days of fertilization of the creation of that embryo can find out that they're pregnant. This legislation, the, the heartbeat is usually detectable about four weeks after fertilization. So this does allow, I would say, at least two weeks for a woman who is looking for evidence of pregnancy to find that she's pregnant and to procure an abortion. And a third of abortions nationally are obtained by this gestational age. So many women do discover they're pregnant and get abortions.

HANSEN: OK. And six, six weeks is about an average for a, for a heartbeat because, because people are saying this is a six-week ban. Right?

INGRID SKOP: Um-hum.

HANSEN: And so-- but it's called the heartbeat bill so--

INGRID SKOP: Right.

HANSEN: --I'm assuming a six week is more the average so it could be four weeks or it could be eight weeks.

INGRID SKOP: It's-- it-- that-- that's about the average. In my clinical practice, sometimes I don't see it until close to seven weeks. So, you know-- but again, it's when you see that heartbeat, you know you have a living human being that absent an outside intervention has a 98 percent likelihood of entering the world as a child.

HANSEN: OK. And what, if you know this statistic, too, unless somebody else mentioned it, I don't think they did, what percent-- percentage of abortions are done before a heartbeat is detected right now?

INGRID SKOP: About a third.

HANSEN: OK.

INGRID SKOP: Even now. And, you know, obviously, when limitations go into effect, organizations who feel that women may need abortions are going to be more proactive to reach out to offer free pregnancy testing. So, you know, it may be the case that even more women will be alert to that and abortions can still be obtained.

HANSEN: OK.

INGRID SKOP: But again, they get more dangerous as time goes on. So earlier is better if it, if it occurs.

HANSEN: OK. Thank you. Are there any other questions just to make sure? All right. Thank you for your testimony.

INGRID SKOP: Thank you.

HANSEN: All right. We'll take our next invited testimony. You can hand it to the page right there. Thank you. Welcome.

TERESA KENNEY: Thank you. My name is Teresa Kenney. That's T-e-r-e-s-a K-e-n-n-e-y. Thank you for letting me be here to testify. I'm a women's health nurse practitioner. I've been in practice for over 22 years in Omaha, Nebraska. I remember years ago listening to politicians discuss the issue of abortion. I remember specifically President Clinton back-- backing the pro-choice position as the need for a safe, legal and rare abortion. Times have changed and we do not refer to abortion as safe, legal and rare, but instead discuss it as just another common procedure in women's healthcare. I've often thought how through wordsmithing and changing terminology around pregnancy our culture has changed its view on abortion. It took years and a focused effort to dehumanize what we used to just simply refer to as a baby and instead call it tissue, contents of the uterus, or just the fetus. Objectively, the worth of any human being does not change. We are all equal. We all have 46 chromosomes given to us by two parents. We all grow the same. We have the same hands, feet, fingers, toes, and we all have the same beating heart. In medicine, the beating heart is seen as the pumping life force in each of us that sustains our lives until it stops and we take our last breath. At five-and-a-half to six-and-a-half weeks gestation, the beating heart of each baby can be seen on ultrasound. I've listened to hundreds and hundreds of beating hearts on ultrasounds of my patients. Two years ago, a young woman came to see me the day after being in an abortion clinic in Bellevue. She was pregnant, about eight weeks along, and a nurse. She had been given the first of two pills in the chemical abortion process. She was told this was her best option, her boyfriend was out of the country, and she could not imagine carrying this baby alone. She was searching for answers, searching for support. But the only answer she received at the abortion clinic that day was that it was OK to make the problem go away. She took the abortion pill, regretted it deeply, and through a sister who wanted to help her ended up in my clinic the next day. She desperately wanted her baby. And so with abortion pill rescue treatment administered by me in my clinic, her baby was saved. Her baby with a heartbeat was born eight months

later, healthy and happy. Abortion is always a failure of healthcare. It is a failure to save the life of two persons, the unique person in the womb and that of the mother herself. Abortion is a Band-Aid, a very poor Band-Aid to not addressing the healthcare needs of women, of their fathers, and of society's social, economic, and physical needs. Nebraska can be better. Our culture must do better. This bill is not just a bill to stop abortions after a beating heart. It is a call for all of us to step up and do the work that is required to take care of a woman in crisis and to provide any and all support needed to help her survive and thrive. For this reason, I stand in support of LB626, the heartbeat bill. Thank you.

HANSEN: Thank you. Like you guys almost have it timed down to three minutes exactly. OK. Thank you for your testimony. Are there any questions from the committee? OK. Seeing none, thank you.

TERESA KENNEY: Thank you so much.

HANSEN: Take our next invited testimony. Welcome.

ROBERT BONEBRAKE: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. Thank you for the opportunity to be here. My name is Dr. Robert Bonebrake, R-o-b-e-r-t B-o-n-e-b-r-a-k-e. I'm here on my behalf. I'm not here on behalf of my employer or my institution. I am board-certified in general OB/GYN and maternal fetal medicine. I practice in Omaha and have been taking care of women and babies in high-risk pregnancy situations for over 27 years. Every maternal fetal medicine specialist has at least two patients. The woman and her baby or babies. I have cared for approximately 15,000 to 20,000 different women over 27 years of MFM practice. Many, if not all of these women had immensely difficult challenges to deal with. That is why they see MFM specialists. In some cases, we know during the pregnancy that the baby will not survive outside the uterus, which is incredibly hard. But even in these most difficult of cases, we never have to forget the human dignity of the woman, the baby, or treat the baby as something less than our second patient. Over those 27 years of practicing maternal fetal medicine, I would dare to say that I have never had, nor have the groups I practiced in had a maternal death associated with a pregnancy complicated by a congenital anomaly or abnormal-- other abnormality of the baby. Maternal fetal specialists see a multitude of things in the many years they practice medicine and care for women and their babies. We care for essentially every complication of pregnancy that you can think of, whether that directly involves complications with the babies in utero; the women, due to underlying medical conditions; medical

conditions that arise during or due to the pregnancy; or a combination of the mentioned possibilities. The list is too extensive to try to describe. However, always the paramount concern is the health and safety of the women, yet with care and concern for the human dignity of babies. This is best medical practices. LB626 would change nothing for doctors in situations like these going forward. LB626 lays out a clear standard for protecting the woman's life and health. A physician can simply ask the question, could a reasonably prudent physician knowledgeable about the case and treatment possibilities with respect to the medical condition involved have come to the same conclusion that a medical emergency exists? Any physician providing best medical practices is safe under this framework, framework of LB626. Only those who would have reason for concern would be physicians whose conduct is so far outside the mainstream, so indifferent to human life that a well-informed physician could never have made the same decision. This is a very easy danger to avoid while providing comprehensive and appropriate medical care. LB6 [SIC--LB626] does what we all want. It allows for the best medical care while protecting the women of Nebraska and their unborn children. I support LB626 and ask you to do the same by voting yes. If there's any questions, I'm happy to try to answer them.

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

ROBERT BONEBRAKE: Thanks.

HANSEN: We'll take our next invited testimony. Welcome.

KATIE PATRICK: Good afternoon, Chairman Hansen, and members of the committee. My name is Katie Patrick. Katie, K-a-t-i-e, Patrick, P-a-t-r-i-c-k. I come before you today as a mother of three children. It was the morning of May 7, 2020, after weeks of rather intense morning sickness that I heard my oldest daughter's-- daughter Imogen's [PHONETIC] heartbeat for the very first time. She was due December 4, 2020, and being my first, hearing her little heart beating was an exciting moment. It was also a very relieving one because it affirmed the little life that was growing inside of me. My pregnancy with Imogen progressed without any major complications. It wasn't until Friday, November 6, when I went in for my regular 36-week checkup that my doctor was unable to find her heartbeat. There were no symptoms, no signs, no bleeding or pain. Everything seemed fine, but it wasn't. There was no heartbeat. There was no sign of life. My daughter Imogen had died. Several months after losing Imogen, my husband and I were expecting again, twin girls due on December 24, Christmas Eve. This

pregnancy had the same severity of morning sickness for which I was grateful for, and as, as I was thankful for the many doctor visits that I had to hear their heartbeats. Throughout my pregnancy with the twins, every day was a struggle. One afternoon in particular, I rushed to my doctor's office because I felt that something terrible had happened. It wasn't until I heard their heart beats on the monitor that I knew that everything was OK. When I was nearing my 20th week of pregnancy, my husband and I rushed again to the emergency room in the middle of the night because I hadn't felt them kicking as often as they usually did. Once I was hooked up to the monitor and heard their heartbeats, I knew that everything was OK. It was the day before Thanksgiving that I went into labor. And just before midnight, our daughters, Kira [PHONETIC] and Saoirse [PHONETIC] were born. They were perfectly healthy, relatively quiet, and curiously looking around the operating room. When I was handed both of them, at which point I held them to my chest and I felt that universal sign of life, the same sign of life that I heard throughout my pregnancy, two beating hearts against mine. My husband was unable to join me that day in May when I first heard Imogen's heartbeat. Thankfully, my doctor had allowed me to record it on my cell phone. It's the only record of her heartbeat that I have that I will ever have. Listening to her heartbeat now still gives me great consolation and joy amidst the sorrow having lost her. I respectfully ask that you advance LB626 from committee, and I also ask that each of you take the final step and pass this bill that will protect human life from the moment that a heartbeat is detectable. Thank you.

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

SEAN KENNEY: Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Sean Kenney. I'm a maternal-- board-certified maternal fetal medicine specialist and OB/GYN. I've been practicing maternal fetal medicine in Lincoln for the last 25 years. I care for people going out as far as Grant, Nebraska, and as far north, far north as Valentine, Nebraska. I was born in Nebraska. I've grown up in Nebraska. I've raised my kids in Nebraska. I'm going to be in Nebraska forever. I'm going to go off script a little bit, you have my written testimony. Some things Bonebrake-- Dr. Bonebrake said, and some things that have been brought up and not have been answered. When people talk about ruptured membranes, pre-viable, the risk of an infection to the mother, it's clear that when someone just has ruptured membranes with no evidence of infection, there's really no urgency to get someone delivered because there's no risk to mother.

Now, once infection is detected, we change our mind and then we do go ahead and deliver someone. And so once infection is detected, we'll go ahead and do someone. And the chance of someone getting sick in the meantime is very low because we caution the patient. If you have a fever, you call us, you come back; you have all the precautions, take your temperature, call us for over 100.4. And regardless of gestational age, we will go ahead and deliver them at that time. And so the chance of someone getting sick in those situations is extremely low. Everyone talks about that, but this is what we do. Patient in the hospital right now, same thing. She was infected. We got her delivered because we wanted to save her life. I'm very pro-life. It hurts my feelings to lose that baby. But I saved the mother. She's now pregnant again. And hopefully this time we have a better outcome. So when people say, well, I just don't know if I can do that. Well, we do it all the time. And when people say, I don't understand how I can do reasonable medical judgment, we do it all the time. Right now, we're doing it for-- compared to-- no offense-- lawyers, because we're worried about malpractice cases. And so reasonable medical judgment is reasonable medical judgment. And so we'll do that. (LB626) would not compromise the physician's ability to take care of these women. We will do whatever it takes to take care of women and provide lifesaving care. If the mother dies, the baby dies. So there's never a choice only pick the baby. We'll do chemotherapy if we need to do chemotherapy, that will help the mother, that will help with the baby if the baby survives. And so it's just not that issue. I support this bill. It recognizes doctors that specialize in treating people and the babies will survive. And I ask that you support it. Any questions?

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you. OK, still got some more invited testimony to go yet, so we'll bring up our next invited testimony.

MARION MINER: Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here to testify in support of LB626 on behalf of the Nebraska Catholic Conference. From the first moment of his or her existence, a new baby in the womb is and must be recognized as a fellow human being. Human beings have rights not to be asserted over and against other human beings, but to be recognized equally before the law as persons deserving of love and protection. As the late Father Richard John Neuhaus said in 2008, quote, The contention between the culture of life and the culture of death is not a battle of our own choosing. We are not the ones who imposed upon the nation the lethal logic that human beings have no rights we are bound to respect if they are too small, too weak, too dependent, or too

burdensome. We ask you today to contend for the culture of life. The U.S. Supreme Court's Dobbs decision in June overturned 49 years of the old Roe and Casey decisions, imposition of that lethal logic on the nation. Gone with Roe and Casey are the endless tangles of constitutional legal arguments about whether a pro-life law will be allowed to stand by the U.S. Supreme Court. The Dobbs decision set a new and very simple standard. Is there a rational basis for the law proposed? That is a very easy test to pass. It's the same test applied to any moral piece of state legislation. Four states bordering Nebraska-- Iowa, Missouri, South Dakota and Wyoming-- have laws in place right now that provide as much or better protection for unborn children than the Nebraska Heartbeat Act that we're proposing today would provide. So do several other states in the Midwest and Great Plains regions. The number of children lost annually to abortion in Nebraska after many years of decline has begun to increase again. It is imperative that we pass legislation similar to what has been acted in states around us to prevent Nebraska from becoming a regional elective abortion tourism or destination state. That is something I'm confident that not a single one of us wants to see. We urge you to contend for the culture of life. We urge you to contend to-- and to vote yes to advance LB626 to General File. Thank you.

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

MARION MINER: Thank you.

HANSEN: And we still have some more invited testimony to go, so I'll ask the next invited testimony to come up.

ANGELINA GILES: Thank you.

HANSEN: Welcome.

ANGELINA GILES: Thank you, Chairman Hansen and members of the Health and Human Services Committee. My name is Angelina Giles, A-n-g-e-l-i-n-a G-i-l-e-s. I'm a family nurse practitioner with a doctorate in nursing. I practice in a family medicine clinic in Omaha, Nebraska. Probably 14 years ago, I found myself in the same situation as many of the women that LB626 is designed to help. I moved out at midnight the day I turned 18, three and a half months before graduating high school to escape a very rough home life. I spent the next several months bouncing between spare rooms and couches of high school friends. Nonetheless, I managed to get very good grades and was awarded a full-ride scholarship to Creighton University to study

nursing. Before moving into college dorms, I was surprised to find out I was pregnant with my boyfriend of one year. Our society told me I had every reason in the world to abort my baby. I was broke. My scholarship would be at risk. I wouldn't have a place to stay, wasn't married. And how would I possibly be able to balance school, work, and being a mom? But for all these reasons pushing me to choose abortion, it was outweighed by one sole reason to choose life instead. That reason came when I went to a local at-risk pregnancy center, received a free ultrasound and heard my baby's heartbeat for the very first time. It was at that instant I made the connection that this is a baby within me, my baby within me, and not merely a clump of cells. Saying it was a difficult journey between then and now would be an understatement, yet I wouldn't trade my son Michael, my almost 13-year-old boy who gets straight A's and enjoys playing basketball more than anything. Professionally, I now have the opportunity to help mothers in the same predicament I was once in. These mothers are scared and believe abortion is their only way to escape their situation. And yet, in every one of these encounters, I witness these women, women allow their natural instincts of motherhood to overcome their fears and allow the, the love for their unborn child infiltrate every crack and crevice of the walls they put up to protect themselves. In my medical practice, I've encountered numerous women contemplating abortion, and when they see their baby on ultrasound and hear their baby's heartbeat for the first time, I get to witness the instant connection form right there in that exam room with that mother and her baby. The countless mothers I've served would, would without a doubt tell you it was hearing their baby's heartbeat on ultrasound that cemented in their minds that there is a living being within their heart-- within their womb. LB626 is more than protecting babies. It's protecting motherhood and allowing women the chance to be a mother to their unborn child. We can unequivocally state the heart begins to be around six weeks gestation, and scientifically speaking, anything with a beating heart is alive. Therefore, we can deduce a baby with a beating heartbeat is alive and we need to protect all living humans. For this reason, I stand in support of heartbeat bill, LB626, and hope that you will as well. Thank you.

HANSEN: Thank you. Are there any questions? There are none. Thank you. We'll take the next invited testimony. Welcome.

NATE GRASZ: Good afternoon, Chairman Hansen and members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z. I'm testifying in support of LB626 on behalf of Nebraska Family Alliance and the thousands of Nebraskans we represent who are working to help our state be a place where every life, born and unborn, is valued, cherished,

and protected. In the 50 years since Roe was decided, legalized abortion has caused tremendous harm to women, men, children, and society at large. It has pitted men against women, and parents against their own children. It has turned reproductive health into a euphemism for lethal violence against the most vulnerable members of society. It has undermined our shared understanding of the sanctity of human life, and it has ended the lives of nearly 200,000 children in our state; 10 percent of our population. Throughout this same time, we have also witnessed dramatic advances in science and technology and in the care and support that is available to women and families. We can see clearly in 3D and 4D ultrasounds that a pre-born child in the womb is not just a clump of cells or a disease to be cured, but a child deserving to be loved. Our laws recognize the intentional taking of a child's life in the womb as fetal homicide when they're wanted. But if that same life is ended in an abortion clinic, it's called reproductive care. Our state still allows elective abortion up to 20 weeks. This is noteworthy for two reasons: One, Nebraska's 20-week law that has existed for 13 years has the same medical emergency exception contained in this bill, and pregnant women have continued to receive appropriate medical care without any fear or confusion. This is a tried and true standard that we have operated under for over a decade without issue or the types of concerns you will hear raised by the opposition today. Second, there are only seven countries worldwide that allow elective abortion at 20 weeks, including China and North Korea. These are babies that are fully formed who can feel pain, suck their thumb, and have a heartbeat. Women and children in Nebraska deserve better. This is not about changing the way doctors care for their patients. This is about elective abortion and whether or not we will protect the lives of innocent and defenseless children who have heartbeats and are guilty of nothing other than existing. We are asking the committee to advance the Nebraska Heartbeat Act because women and families deserve love and support, and babies with heartbeats should be protected. Thank you.

HANSEN: Thank you for your testimony. Any questions from the committee? Yes, Senator Hardin.

HARDIN: Thanks for being here. Are you saying that in that respect, Nebraska is on a par with countries that have the worst human rights abuses on the globe?

NATE GRASZ: Thank you for the question, Senator. You know, Nebraska-- we were actually the first state in the country to pass our 20-week law, and many states have, have since followed that. But since that time, many states and many countries have continued to pass better and

stronger laws, recognizing the humanity of the unborn child and that we can care for that child and the mother without ending the child's life. And unfortunately, during that time, our, our law has stayed the same and we are now an outlier both nationally and internationally when it comes to abortion policy and the level of protection that we provide to both children and women.

HARDIN: Thank you.

NATE GRASZ: Thank you.

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

NATE GRASZ: Thank you.

HANSEN: Just a few more invited testimony left. We'll take the next one. Welcome.

CORI MOOBERRY: Thanks. Good afternoon, Chairman Hansen and members of the HHS committee. My name is Cori Mooberry, C-o-r-i M-o-o-b-e-r-r-y. Thank you for allowing me to testify today in support of LB626, the Heartbeat Act. My testimony is about our son, Abel William Mooberry. Roughly five years ago, on January 11, 2018, I gave birth to our son Abel. On the same day I watched him pass away in my arms, two and a half hours after his delivery, quietly, peacefully, and surrounded by loved ones. Abel suffered from a condition called Potter's sequence, a disorder where his kidneys never developed in utero, which doesn't allow for the necessary production of amniotic fluid vital to proper lung development. Plainly, he would not be able to breathe outside the womb. Potter's sequence is considered a fatal condition, one incompatible with life. But what I witnessed with the pregnancy, delivery, and ultimate passing of my son couldn't be farther from the statement. When my husband and I found out we were expecting baby number six, initially, we weren't overly excited. We already had five beautiful boys and had decided five was enough. When I went into our first ultrasound appointment sometime shortly after six weeks, I got to witness once again the miracle of a tiny baby's heartbeat. Strong heartbeat, just like the older brothers my doctor smiled. As I got into my car afterwards, I looked at the ultrasound pictures and the recorded heartbeat. Already, I could make out tiny nubs where arms, legs, torso, and head would be. Several weeks and months passed and eventually it was time for our 20-week ultrasound, the big one where all the vital organs are checked, measurements are taken, and gender could be revealed. It was at this appointment we were given the devastating news about Abel. Our world stopped. The earth fell out

from underneath us. We were heartbroken. After several days of crying, praying and a flurry of questions, we found out many babies like Abel and those with other fatal conditions are terminated shortly after their diagnosis. We decided we would carry him to term and allow him to pass away naturally. As the weeks and months trickled down to January 11, I was terrified. On that cold winter day in January at 3:08 p.m., roughly five years ago, Abel was delivered via C-section, alive and breathing, even cooing and opening his eyes. For two and a half hours, his brothers, parents, grandparents, aunts and uncles got to see, touch, and hold him. We witnessed the miracle of a four-pound baby boy convert the hearts of many during his short time on earth. Abel's life or Abel's time here on Earth was far from being incompatible. Instead, he lived the perfect life; one without sin, pain, suffering, or heartache. Was carrying a baby I knew I couldn't keep agonizing? Absolutely, without question. Do I miss and grieve my son every day? 100 percent. Do I ever wish I would have terminated his life early to spare myself that suffering? Never. I believe that LB626 will give Nebraska the opportunity to more truly value the gift of human life. And I humbly ask for your support. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? And your house is still standing with five boys?

CORI MOOBERRY: We actually have seven boys and one girl, so.

HANSEN: Seven, seven boys and one girl?

CORI MOOBERRY: And it's barely standing.

HANSEN: I know there's some Catholics in this room, you should get sainthood for that, so.

CORI MOOBERRY: We have a good contractor on, on speed dial, so. Thank you.

HANSEN: All right. We have three more invited testimony left, so we'll take the next one.

MICHELLE WITT: Good afternoon, Chairman Hansen and committee. It's a privilege to be here today and having a chance to speak to you in full support of LB626. My name is Michelle Witt. That's M-i-c-h-e-l-l-e W-i-t-t. I am a nurse and I'm the current director of health and wellness for Essential Pregnancy Services in Omaha. We're a pregnancy support organization that has provided life-affirming holistic support to women experiencing unexpected and under-supported pregnancy since 1973. We're going to be celebrating our 50th year of service to the

Omaha area this year. I've worked at EPS in different capacities for six years and have been a nurse for 39 years with experience in maternal newborn nursing and also in pediatric hospice nursing. So I've held newborns who have been born and I've held newborns who have been dying. EPS does provide pregnancy confirmation services for viability of pregnancy; we offer other services, but part of our testing services is pregnancy confirmation. We do see a lot of women who are contemplating abortion come through our services because all of our services are free. The reason why I'm sharing this with you, because many of the women that do come are wanting pregnancy verification to know that they have an intrauterine pregnancy. They want to know how far along they are because they are contemplating abortion. What distresses me the most and many of the women that I've scanned over the last six years as when they're coming in, they know they're pregnant. Some of them have made their appointments at the abortion clinics, have had a first appointment, yet they're coming to us for confirmation again or, or looking for their options. But in looking for options, when we're taking them in as clients and, and during our intakes, we're finding out that many women are misinformed about where they're at in their pregnancy and where, where they're going. And so what we do is we-- we're insuring women that they have all their options, that they understand what they're looking at before they're deciding for abortion or not. So we start with a pregnancy test. We hear that woman completely. And that is, if-- that is so important that we hear, we hear the concern, we hear where they're coming from, that they feel heard. And once we do that, we will offer ultrasounds. Some of our women will decline that ultrasound, but most of them will, will accept because they want to know how far they are in their pregnancy. So we'll do ultrasound and in ultrasound, this is where most women really don't understand where they're in their pregnancy because we talk about fetal development. And if they so choose to look at the ultrasound screen that's offered to them, most of them are very surprised in where they're at in their pregnancy and what they see. So at six weeks, we know that we can visualize a heartbeat.

HANSEN: Thank you for your testimony. Sorry to cut you off there.

MICHELLE WITT: OK.

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

MICHELLE WITT: Thank you.

HANSEN: All right. We will take our next invited testimony. Welcome.

SANDY DANEK: Good afternoon, Chairman Hansen, members of the committee. My name, my name is Sandy Danek, S-a-n-d-y D-a-n-e-k, and I am the executive director of Nebraska Right to Life. I know you hear often that Nebraska is a pro-life state, but I'm here today to reiterate that in a recent WPA Intelligence survey of registers voters found that 58 percent of Nebraskans support a bill protecting pre-born babies once a heartbeat is detected. Whether they are pro-life, pro-choice, including nearly two-thirds of independents and half of Democrats, Nebraskans who support protection for pre-born babies and those who believe that the Heartbeat Act is not strong enough polled over 60 percent. Well, this is good news for women and their pre-born babies. It's not surprising. It's certainly what we see in this state. So Nebraska Right to Life is the largest grassroots, longest running statewide organization. And in that capacity, for example, our outreach efforts provide a double booth at the Nebraska State Fair every year. And it gives us an opportunity to see a multitude of Nebraskans, general public, not, not just those who are under our umbrella as being pro-life. And most recently, we had our annual Nebraska Walk for Life at the State Capitol, where we had 4,000 to 5,000 people who were there in support of life this year. We had a keynote speaker who was an OB/GYN, former abortionist that brought 500 people to our first ever gala event and spoke on the issue the night before the Walk for Life. So there's a recurring theme within our state that people want pre-born life to be protected, and the Nebraska Heartbeat Act offers that protection. Additionally, in the WPA Intelligence survey, 57 percent of likely voters are even more willing to support a heartbeat bill after they were introduced-- they were introduced to the scientific evidence that the presence of a child's heartbeat in the womb indicates a very high likelihood of survival to childbirth. So when I'm traveling the state, I'm encountering those who are in the grassroots pro-life movement, and they tell me that advancing policies like the Nebraska Heartbeat Act is consistent with Nebraska values. So, Senators, I ask you to advance the Nebraska Heartbeat Act legislation out of this committee so it can hear a full debate. Thank you.

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

SANDY DANEK: Thank you.

HANSEN: And one more invited testimony. Welcome.

JESS MEETH: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Jess Meeth, J-e-s-s, Meeth, M-e-e-t-h, and I'm the national communications director for Democrats for Life of America. Our organization represents Democrats around the country who are committed to protect-- protecting human life throughout all its stages from the moment of fertilization. We believe that legally protecting the pre-born is the beginning of our whole life mission. We also advocate for legislation that will provide pregnancy and parenting support. I stand before you today in support of LB626. As Democrats, we stand with the most vulnerable and speak for those who cannot speak for themselves. Pre-born children are among the most vulnerable in our society and they, and they deserve to be protected. Imagine, imagine a world where every human life is protected, is protected from violence. The right to life is for every human life, regardless of age, race, gender, disability, condition of dependency, or stage of development. A heartbeat is a sign of life and that life is worth saving. By passing LB626, we will be protecting human life from the violence of abortion. Abortion ends a human life through suffocation, lethal injection, or dismemberment. This cannot be healthcare. Healthcare must save human life, not end it. Abortion perpetuates violence in our society, and our society has failed to protect vulnerable pre-born children. Preventing violence inside the womb is a critical step in preventing violence outside of it. Human life at all its stages should never be discarded nor disposed of. We must not only value all human life, we must protect it. We have a duty to protect all human life. That is why I ask the committee to favorably recommend LB626 to the full Legislature to take steps in protect-- in protecting all human life. Thank you for your time and consideration.

HANSEN: Thank you very much for your testimony. Are there any questions from the committee? All right. Seeing none, thank you. Appreciate it. All right. So now we'll move on to all else who wish to testify. And again, as we are done, we'll kind of exit out that door and then as, as spots open up more towards the front, and if everybody wants to kind of scoot their way up, you know, if they can, that would be helpful. So we can kind of, kind of get things going, make sure you have those green sheets filled out. Helpful reminder--

MARTIN CANNON: I have mine. Where does it go?

HANSEN: Yep. And then when you come up, you can hand your green sheet to the page or to Christina. All right. We'll give them one minute here just to kind of settle down. OK. All right. And if we can, we'll try to keep it down. I know it's kind of loud out there so if we can

make sure we speak up in the microphone, too, and so I appreciate it. All right. Welcome to the Health and Human Services Committee.

MARTIN CANNON: Good afternoon, ladies and gentlemen. My name is Martin Cannon, M-a-r-t-i-n, last name Cannon, C-a-n-n-o-n. I am senior trial counsel with the Thomas More Society. On behalf of Iowa's Governor Kim Reynolds and the people of Iowa, I defended Iowa's heartbeat bill. I'm here to assure you that this bill is on very solid footing legally. What Roe took, Dobbs has restored. And not in some small technical way, but in a big way. Rational basis is highly deferential. It allows you to regulate abortion like you regulate practically everything else. The law is well-written and should pass any rational basis challenge. I'd like to address, I believe it was Senator Day's concern about threats of death or serious bodily injury. The bill does exempt from its provisions such threats, but it is rational to exclude from that a threat made by the mother herself. There are two reasons for that: number one, it is intended to avoid the, the overbroad, overused, and undefined health of the mother exception that was forced upon us by the Supreme Court. Secondly, a person who is truly suicidal is legally incompetent and is not able to make any serious decision. I'd like to talk maybe about Senator Cavanaugh's concerns about reasonable medical judgment. I've had a lengthy litigation career, 35 or more years in this area. I can tell you the entire medical industry governs itself by that standard. It is not only highly workable, but I submit you cannot find or come up with a better one. Law affects behavior. Roe gave us abortion on demand. Abortion mushroomed; it gave us sex without regard to its obvious purpose and likely consequence. Roe, because it affects behavior, did not free women. It freed men to treat women like playthings, and it deprived other men of a say in protecting their own children. This bill will restore the social sense of purpose and constraint and start to repair the corrosion wrought by Roe. I'd like to also remind this body of the way-- the place this body was when Roe came down. Prior to Roe, Nebraska was a very pro-life state. After Roe, this Legislature passed some amendments to statutes that still stand today and contain a lot about what they felt at the time. Section 28-325 says the Legislature finds and declares "the following provisions were motivated by the legislative intrusion of the U.S. Supreme Court by virtue of its decision removing the protection afforded to the unborn." And then they go on a little farther to say that "the members of the Legislature expressly deplore the destruction of the unborn human lives which has and will occur in Nebraska as a consequence" of that decision. That's the law today. That is the express declaration of the Legislature today.

HANSEN: Mr. Cannon, if I, if I can interrupt for a second. Christina, was that three minutes? That was three minutes? OK. All right.

MARTIN CANNON: Very quickly.

HANSEN: Well, if you can wrap up your thoughts really quickly here.

MARTIN CANNON: Yes. Yes. Thomas More Society supports this bill. And for those that might be concerned, we will also defend the bill with great resources free of charge to the people of Iowa or assist the AG in his own efforts to do so. Thank you.

HANSEN: Thank you, sir. All right. Take the next testifier, whoever wants to go next. All right. Welcome.

NICOLE SHASSERRE: Good afternoon. My name is Nicole Shasserre, N-i-c-o-l-e S-h-a-s-s-e-r-r-e. I am the mother of seven children. Yes, seven. And today I am here to briefly share their stories. We met our oldest daughter when she was a seven-year-old little girl in foster care. Because the system is one focused on reunification and kinship placements, we were told adoption was out of the question. Ultimately, it was her father who asked to sign relinquishment papers at his request that we adopt her. I never had the privilege of hearing her unborn heartbeats, but did hear the sound of her son's. When she found herself in an unexpected pregnancy this past year, everything changed the moment she heard his little heartbeats. The more people she told, the more she was embraced by us, her family, her college, and community. Her son is very loved. We met the birth parents of our oldest son a week before we got the call that his heroic mother needed to be induced. She was in her senior year of high school completing classes from her hospital bed due to preeclampsia. Every day, listening to the sound of her unborn baby's heartbeat as she was monitored, it was the sound of that heartbeat, a heartbeat she would do anything to protect that gave her strength. We have a beautiful, open adoption. Later, I would find myself in my own high-risk pregnancy. We stared at the screen in awe as we saw our daughter's little heart beating around six weeks. It was the sound of her heart that calmed my fears at each closely-monitored appointment. Today, she is known for her tender heart. Thriving in school, her IEP allows her to receive the special help that she needs. The same little heart I see racing at Husker Games today is the same heart I saw on the frequent ultrasounds of our second son. After so many ultrasounds, I became accustomed to our children's heartbeats being the first thing we would hear at each appointment until the day we didn't. At the 25-week appointment of our third son, the ultrasound technician was

unusually quiet. I'm so sorry. I can't find his heartbeat. Our world stopped. I delivered Simon [PHONETIC] that night by C-section. Family and friends gathered with us in the hospital. We held this perfectly-formed little body. His siblings counted his fingers and toes, gave him a million kisses. The nurses weighed him, swaddled him, made castings of his little hands and feet. We had the funeral. We were allowed to grieve. My husband lowered that little casket into the ground. At 25 weeks, he was so very loved. A little over a year later, we found ourselves again at the same office where we had heard I can't find a heartbeat. I didn't want to look. Tears fell as I feared the worst. All signs were pointing to early miscarriage. Look, you have to look. The ultrasound's [SIC] voice squealed with excitement as she pointed to not one, but two beating hearts. Twins. You're having twins. And I promise, I'm wrapping up.

HANSEN: Yep.

NICOLE SHASSERRE: I'm here today to ask each of you to look, to not be afraid to look. I often think if our society-- I think our society is afraid to look, to acknowledge that universal sign of life, because we would have to face what we have allowed to happen. The intentional stopping of beating hearts.

HANSEN: Thank you.

NICOLE SHASSERRE: Please look at their unique, unrepeatable hearts.

HANSEN: Thank you for your testimony. Appreciate it.

NICOLE SHASSERRE: Thank you.

HANSEN: Sorry for cutting you off there.

NICOLE SHASSERRE: I'm sorry. Any questions?

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

NICOLE SHASSERRE: Thank you.

HANSEN: Welcome.

JULIE SYKES: Hello, and thank you for inviting me to do this. I'm Julie Sykes. J-u-l-i-e S-y-k-e-s. I'm here to support LB626, Nebraska heartbeat bill. I was 18 years old. I had to make the hardest decision of my life. I had no clue it would change me forever. I felt alone at

the clinic because I wasn't allowed to bring anyone back with me to the room before the abortion. Some of the feelings I felt inside after waking up was alone, scared, empty I felt inside in pain. What you don't understand is I had a medical abortion due to my disability. Even though I wanted this baby, I was told I could not carry to full term. The effects of this choice I made just got worse. Now I had to deal with an abuse from a baby's father because of his pain from the abortion. The pain didn't stop there. The whole new problem, social-- suicidal thoughts, waking up in tears, deep depression, alcohol abuse. The truth is, I was scarred physically, emotionally, and spiritually from this choice. It took me a long, long time. But finally I started to do things that helped-- would help me cope with my past abortion and deal with the guilt. But the best healing is when I got connected to a group that helped me to learn about forgiveness. I came to understand that God has forgiven me and that one day I will-- in heaven, I will see my baby again. Therefore, I choose not to be silent anymore. I please ask to support the LB626 bill.

HANSEN: Thank you very much. Are there any questions from the committee? Seeing none, thank you very much.

JULIE SYKES: You're welcome.

HANSEN: Welcome.

JENNIFER ROUSH: Welcome. Thank you for the opportunity, Chairman Hansen and members of the committee. My name is Jennifer Roush. That is J-e-n-n-i-f-e-r R-o-u-s-h. I have a background as a registered nurse and nurse sonographer, and as a director of medical services for a network of pregnancy centers. I am currently the executive director of the SperaVita Institute. We are based in Omaha and we provide training and equipping for pregnancy centers across the United States. Pregnancy centers are committed not only to educating and empowering women with factual information they need when faced with an unplanned pregnancy, but also ensuring that they have the resources they need during their pregnancy and after their baby is born. There are 27 pregnancy help organizations in Nebraska committed to this and ready to serve more women. In my career, I have cared for and performed ultrasounds on hundreds of women facing unplanned pregnancies. An ultrasound ultimately shows a woman the truth, the truth of what is happening inside her womb, her baby with its own separate organs and movement, its own unique DNA, often a different gender than its mother. After seeing the heartbeat, I've heard women say things like, I'm not going to stop that beating heart, or this changes everything. I've seen patients who felt abortion was their only option, but after

receiving services from the pregnancy center and seeing their baby via ultrasound, not only have they chosen life and expressed thanks, but they have gone on to pursue sonography as a career so that they can give women the same help and information that empowered them to choose life. I have a recent testimony from one of our centers in Nebraska, and there are many like this. A young woman called the center recently to make an appointment looking for information to help her make a decision about her pregnancy. When she arrived in the office for her appointment with her boyfriend, she stated their intention was to abort due to financial struggles and not feeling ready. During her appointment, she was given an ultrasound, measuring six weeks, two days. When she saw and heard the heartbeat, she was overwhelmed with emotion. She came for a follow-up appointment and just reiterated how that heartbeat was information that she did not previously have, and it was critical to their decision to choose to parent. They left that time not only hearing the heartbeat again, but with pictures. The center has followed up to ensure that her needs are met. She is receiving prenatal care with an OB feeling good and excitedly waiting to meet her baby boy. I believe this bill is good for women and good for the state of Nebraska and I urge you to please advance LB626.

HANSEN: Thank you. Is there any questions from the committee? Thank you very much for your testimony. What we're probably going to do from now on is we're going to go from one side of the room to the next and we'll kind of alternate so that way everyone can kind of get an idea of who wants to go next, because I can already see what's going on. So that way you can go next and then, yep-- so--

HAILE KUCERA: I was about to rock-paper-scissors someone for it.

HANSEN: Yep, it's not, it's not uncommon because sometimes people don't know who can go up. So the next time we'll just kind of take somebody from this side of the room and then back and forth, if we can, please. OK? All right? All right. Welcome.

HAILE KUCERA: Thank you, Senator Hansen and HHS Committee. My name is Haile Kucera, H-a-i-l-e, last name is K-u-c-e-r-a. OK. So in September of 2014, I lost a baby. As a scared 20-year-old, I laid on my bathroom floor alone, bleeding and hopeless, that-- thinking about the decision that had led me here today to testify to you guys. I want to take you back to that day in early September of 2014. I walked into a cold, gray, and unwelcoming doctor's office at a Planned Parenthood. I handed over a check through a glass window and was promptly placed into a room with a TV. A man that I had never seen before popped up on the screen and told me that what I would be going through the next few

hours and coming weeks. He assured me that all my problems would be solved that day. In the next 45 minutes, I would be on my way with a pill in my hand, seeing as I had already taken one earlier at the clinic, with reassurance from the nurse that everything would be just fine. That afternoon, in the privacy of my home, I swallowed the lone pill without any clue as to what I had just done. Within hours, I was kneeling in the bathroom with blood clots the size of large marbles falling out of me. I was crying profusely because the pain was too much to bear and I was all alone. I was laying on the cold bathroom floor thinking that this could just be the end for me. I would eventually lay in the bathtub so that anything that came out of me could just rush down the drain without having to flush the toilet, clean anything up, or even more. I bled for weeks after this experience, clots of my insides were soaking through my clothes. My cramps sent me home from work on multiple occasions, and the once bright future I had ahead of me was now wrapped up in a deep depression and my lack of judgment continued to get worse. I became closed off, cold, and would end up making choices that still have consequences nine years later. I never received a call from Planned Parenthood after that experience. When I left the clinic that day, that was the last time I would ever hear from them. I was all alone from the people who said everything would be just fine. It took years of therapy, a hard rock bottom, and climbed my way through suicidal thoughts to be able to sit here today. I grew up in a Christian household with wonderful parents that taught me right from wrong and instilled in me that every human life matters. As I grew older, I heard conflicting narrative. If I had sex, it didn't matter because places like Planned Parenthood could help me out and I could go on living my life if I did wind up pregnant. Unfortunately, the voices of influence of-- I'm sorry. Unfortunately, the voices of the latter took hold of my judgment. I saw celebrities talk about it. TV was promoting it. Politicians were giving rally cries and it became the norm. The message slowly turned into women can do anything except be a mother. I sit here today as a 29-year-old woman who remembers that day like it happened yesterday. I still feel, feel tears swell up in my eyes when I think about what a terrific mom I would have been and would now be a nine-year-old little girl or boy. I will never have the opportunity to watch them be in sports or to watch them graduate kindergarten. I will never be able to teach them how to drive or take pictures with them on prom night. While I can't turn back the clock, I can look forward to supporting the Nebraska Heartbeat Act. No woman should have to be put through what I went through that week. No woman should have to sit, sit and lay on a cold, hard floor, scared and alone. Instead, I look

forward to the work Nebraska will put into supporting young mothers and adoption centers. Thank you for supporting this bill, Senators.

HANSEN: Thank you for your testimony. OK, is there anybody-- do we have any questions from the committee? All right. Seeing none, thank you.

HAILE KUCERA: Thank you.

HANSEN: Those are the shiniest shoes I've ever seen in my entire life.

HAILE KUCERA: I like to make a statement. Oh, so sorry. Oh, this way.

HANSEN: Welcome.

DALE MICHELS: Good afternoon, Senator Hansen. Senator Hansen and members of the Health and Human Services Committee, my name is Dr. Dale Michels, D-a-l-e M-i-c-h-e-l-s. I'm a retired family physician who practiced in Lincoln for 44 years and delivered babies for about 30 of those years. I'm testifying today as the Nebraska representative of the American Academy of Medical Ethics and not any other medical organization. I strongly support LB626 and encourage you to bring this long overdue bill to the floor of the Legislature. It will protect babies while dealing with the complications of a pregnancy that have been used as reasons to not pass this legislation. I would like to preview some of the arguments that you'll hear later from opponents and address why their arguments are lies or misunderstanding of the issues. Opponents say this bill will hurt a woman's personal right to choose. But what about the personal choice of the baby girl or, for that matter, the baby boy who is developing in the uterus? Their human rights are equally important and you can see that on page two of my testimony. Opponents claim this bill will hurt healthcare, but the simple fact is abortion is not healthcare. Abortion kills a human being. During my 44 years of providing healthcare to patients, never did patients ask me to consider killing them as a part of providing their healthcare. Good hippocratic medicine is built on doing no harm to the patient, and this includes a patient who is a living unborn child. Opponents claim that pre-born babies are just a blob of tissue, but the developing baby is a unique genetic individual human being, and there will never be another individual with the same genetic makeup unless, of course, the baby is an identical twin. Opponents claim this will criminalize physicians, but this is not true. If a physician breaks the law of this bill, they will only face disciplinary measures on their license. Discipline on this issue is the same as for any other disciplinary action, which means there are

no criminal penalties involved. Opponents will claim this bill restricts their ability to practice medicine, but it's important to note that this bill in no way restricts physicians or nurse midwives from dealing with the complications of a pregnancy in any way, nor does it affect normal deliveries or cesarean sections. Opponents will claim that this is intrusive government interference in the exam room. But it's important to remember that most of this legislation is preexisting law, which already governs physician misconduct. This bill is not an onerous addition to the current responsibilities of the Board of Medicine and Surgery. LB626 is an important bill for Nebraska. It recognizes, it recognizes what all of us physicians know that the pre-born baby in the womb is a human being. Please support LB626 and protect the most vulnerable humans who can't yet speak for themselves.

HARDIN: Thank you, Dr. Michels. Questions? Thank you for being with us. Someone from this side of the room. Welcome.

DANIELLE PIMENTEL: Good afternoon. I would say good afternoon to Chairman Hansen, but I see that he's left the room briefly. But thank you, members of the committee. My name is Danielle Pimentel, and I serve as policy counsel at Americans United for Life, which is a national law and policy nonprofit organization--

HARDIN: Would you mind spelling your name, please, for the record.

DANIELLE PIMENTEL: Yes, Danielle Pimentel, P-i-m-e-n-t-e-l.

HARDIN: Thank you.

DANIELLE PIMENTEL: As I stated before, I am from Americans United for Life, which is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. I've examined LB626, and I urge your support for the following reasons. First, this bill protects the health and safety of pregnant women and pre-born children, which is a legitimate interest for the state of Nebraska. In Dobbs, the Supreme Court recognize that states have an interest in preserving prenatal life, protecting maternal health and safety, and "migitting"-- mitigating fetal pain. However, Nebraska currently allows abortions up to 20 weeks gestation, which subjects women and unborn children to life-threatening health risks such as blood clots, hemorrhages, incomplete abortions, infection, et cetera. And scientists have found evidence that unborn children can feel pain as early as 12 weeks gestation. Additionally, this bill also requires that a physician must perform an ultrasound before an

abortion. Ultrasound requirements serve as an essential medical purpose because it is the only method of diagnosing ectopic pregnancies which, if left undiagnosed, can result in "infiterd"-- infertility or fatal blood loss. Thus, by enacting this bill, the Legislature is protecting not only unborn children, but also greatly reducing the risks women face when seeking an abortion. The second reason why this bill should be passed is because it recognizes that women deserve better than abortion. Despite the cultural narrative that abortions are necessary for women's health and equality in American society, women are increasingly rejecting abortion, recognizing the humanity of their unborn children, and taking advantage of the resources available to them to help parent or adopt. As a result, the current abortion rate is nearly half of what it was at the high point in the 1980s. And pregnancy resource centers play a essential role in empowering women to choose life. And Nebraska has many pregnancy resource centers; we heard people today testify from them, and they stand ready to assist women upon passage of this bill as they've done so in the past. My last point, which I'll make very briefly, is that this bill is consistent with numerous other states that have enacted strong pro-life limits. There are at least 18 states have laws that completely abolish abortion at any gestational stage, and three laws that-- or three states have laws that abolish abortion after six weeks gestation. Nebraska should join these states that have enacted laws to protect some of their most vulnerable citizens. For these reasons, I urge the committee to support LB626. Thank you very much.

HARDIN: Thank you. Questions, committee? Seeing none, appreciate it.

DANIELLE PIMENTEL: Thank you.

HARDIN: Thanks. Welcome.

ORRIN PETSKA: Thank you. My name is Orrin Petska, O-r-r-i-n P-e-t-s-k-a. And thank you guys for letting me speak here today. I'm the father of two kids and representing myself as a conservative Christian, advocating for life. I support LB626, as I believe it's a step in the right direction to protecting the sanctity of life. It is a fair and reasonable-- and I believe it's-- as I believe, it's very hard to legislate morals. But our morals and convictions have brought many of us here today. As I think back in my experience as a father, one thing's very clear to me. They all have a personality and they all have a purpose. Rewinding back, my wife and I were expecting our first child. Excited as most parents would be, but anxious to see what was in store for us. We went to our first ultrasound at around what we

thought was about eight weeks. It turned out it was probably closer to 12. What we saw on the 3D image literally shocked us. It was a fully-formed baby. He had every appendage and clear features as though he would be able to reach out of the womb and hold your hand. We were shocked because we were both bought the lie that our baby was a fetus or a cluster of cells and we were just unsure of what to expect. That moment changed our lives and we were so sorry for how blinded we had been. The thought rolled through our heads, how could anybody think that this wasn't a life? I think the debate with abortion is that we confuse our life with life styles. The idea that a mother and a father can willing take the life of their child with no emotion or physical repercussions is just ludicrous. The fight to end abortion is not just for children, but also for adults. This is a fight to bring respect back to human life. This is a fight for human rights in all capacities that all may know and respect the gift of life. Knowing that a heartbeat is usually detected about six weeks and that this will eliminate about 85 percent of abortions is a win in secular terms. But these exceptions still allow for life to be taken. I'm willing to take this as a step, but I strongly advise for stricter regulations to eliminate abortions altogether, with exceptions already stated in this bill for things such as ectopic pregnancies. It is said that when a sperm cell penetrates the egg, there is a literal spark that occurs in the womb. Science implies that a big bang theory occurred 12 or 14 billion years ago, where an explosion created all of this life or my preference when God said: Let there be light. And there was. So if a flash of light created all of us on earth, do you think it's plausible to assume that all it takes to form a perfect being with the personality and a purpose is just a spark? Thank you for your time and consideration. Please support this bill.

HARDIN: Thank you. Questions, committee?

WALZ: I have one.

HARDIN: We have one.

ORRIN PETSKA: Yes, ma'am.

WALZ: Thanks for-- thanks for being here. You, you mentioned in your testimony that it would eliminate-- six weeks would eliminate about 85 percent of abortions--

ORRIN PETSKA: Right.

WALZ: --if this law was passed, can you just kind of tell me where you get that information from?

ORRIN PETSKA: I guess it was kind of hearsay or whatever in conversations that I've been having with, I guess, people bringing opinions for this bill, so.

WALZ: OK. All right. Thank you.

ORRIN PETSKA: No good answer. Thank you.

HARDIN: Any other questions? None. Thank you, Mr. Petska. Welcome.

GARY NELSON: Afternoon, committee members. My name's Gary Nelson, G-a-r-y, Nelson, N-e-l-s-o-n. Thanks for the opportunity to share today. My experiences come back to several things. One, I'm a teacher of 24 years. I worked for the Nebraska Children's Home for 15 and a half years. And of course, I'm a dad. I am a man of faith, but I'm also a sap. So forgive me. One of my things I remember is a young lady by Deb. She was short, not a good basketball player, but we-- at the end of the game, last game of the year, she hadn't scored. So I said, our offense is get Deb the ball and Deb's going to shoot it. By jove, Deb made two points. You thought she'd won a gold medal because life matters. Amy [PHONETIC], another girl I had in class, test anxiety. Two times three, she would come up with five and I'd go, Amy, look at that. She'd look at it. And to this day, whenever I've seen Deb, she gives me a hug, and Amy gives, gives me a hug. They matter. As a planned giving manager for the Nebraska Children's Home, I traveled the state; I visited with probably 10,000 to 15,000 people. And never once, when I went into a home to visit with them, did they say they wish they had not adopted that child. No. They brought out the photo albums. They bought out the coffee. They looked at the big picture on the wall of their family and how important they were too. And I never visited with an adoptee that said, gosh, I wish I had never been adopted. No. The Children's Home placed 108 children the year that my daughter was adopted. Last year, they did 16. There's a solution for us right there, but we don't want to think about that. The Nebraska Children's Home's motto was: Do what is best for the child. I'm not sure that this practice is what's going to be best for that child. Parenting is one of those areas. Adoption is another one of those areas. So for 25 years with my daughter, I have been blessed exceedingly, abundantly beyond my wildest possible dream. They said we couldn't have pictures here or any displays. I would love for you to see the picture of my daughter and I when she's a baby and I've got her in my arms. And for some reason I decided to put my nose on her

nose and my wife got a picture of that. So when did my daughter become mine? When she was in my arms. And I have another picture of her a couple of years ago when we were at a football game. Great picture. I am blessed to be a father because her birth mom decided to choose life. Who decides whether life is important or not important? Moses? Pharaoh? Martin Luther King, or the KKK? Zelenskyy, Putin? God, or Planned Parenthood. One of the verses I love in the Bible says-- John 17:24: God knew you before there was a before at the time when the father loved the son before the foundations of the earth. Matthew 10:26 talks about no sparrow shall fall to the ground without the father knowing. The numbers of the hair on my head and your head is counted already. Does God make mistakes with these children? No.

HANSEN: OK, sir, the red light went off, so we're going--

GARY NELSON: Oh, shoot.

HANSEN: I know, it goes, it goes fast so--

GARY NELSON: And one second.

HANSEN: You've got, like--

GARY NELSON: In Esther in the Bible 14:4 [SIC] in the saving of the Israelites from Exertia [SIC], the King at that time, she said-- Mordecai said to Esther: You were born for such a time as this. And that's what you're at. You're born for such a time as this.

HANSEN: Thank you, sir.

GARY NELSON: And I pray God will give you wisdom beyond your wildest dreams. It was a pleasure.

HANSEN: Thank you very much.

GARY NELSON: Thank you.

HANSEN: All right. Oh, man, forgot to ask if anybody had any questions. All right. And just for, just for everyone to know, in about 15 minutes, we're going to move to two-minute testimony. We have a huge line out there, and I'm trying to get as many people as I can to at least get their voice heard. So just FYI, we'll start with moving to two-minute testimony in about 15 minutes. So welcome.

COURTNEY MILLER: Welcome. Thank you.

HANSEN: We're going to be done at 4:45. That'll be three hours from when we started.

COURTNEY MILLER: Good afternoon, Chairman Hansen and committee members. My name is Dr. Courtney Miller, C-o-u-r-t-n-e-y M-i-l-l-e-r. I am a licensed psychologist in the state of Nebraska and vice president of Clinical Services with the Immaculate Heart of Mary Counseling Center. I am speaking on the behalf of post-abortion healing ministry as our agency as a call center for the state of Nebraska for Project Rachel, a post-abortion healing ministry of the Catholic Church. Statistically, we know one out of four women have had an abortion by the age of 45, and 50 percent of women seeking abortion have had a prior abortion. Women seeking abortion are often misinformed or under-informed when making their decision to have an abortion. Most women feel they have no choice but to have an abortion. Women may feel that this is their best choice, although they often have not been fully given all the information to make their best-informed decision. Women are often told by Planned Parenthood and abortion providers that there will be minimal after-effects from an abortion. Contrarily, we see, through the post-abortion healing ministry, women who are suffering immensely and often now feel isolated and alone. Women who have suffered an abortion have experienced a traumatic event. This trauma bears with it physical, psychological, emotional and spiritual effects. Long-term physical effects are often most related to future childbearing issues, including miscarriages, stillbirth and infertility. Psychologically and emotionally, a woman often experiences feelings of guilt, shame, depression, grief, sexual problems, eating disorders, alcohol or drug addictions; problems bonding with subsequent children and sleep disturbances are also common. Spiritually, many women report feeling punished by God. There is a great woundedness that comes from having an abortion and a deep-residing pain that, if not healed, will repeat itself. We see generational cycles of abortions within families, as well, meaning a woman whose mother has had an abortion is likely more-- is more likely to have an abortion as well. Women deserve to be comprehensively cared for when under the care of a physician. The requirement to check the baby's heartbeat as confirmation for first functioning organ is imperative to quality healthcare. This act offers a chance for confirmation inside the woman of this heartbeat. The doctor-- it holds doctors accountable to more fully care for each woman in this life-changing choice. This act recognizes the human nature of the beating heart and protects both baby and mother from the undeniable traumatic effects of an abortion. We need to meet women where they're at with love and compassion. For more ma-- more

information on post-supportive healing, you can visit our website at immaculateheartcounseling.org. Thank you for your time and considering this testimony on post-abortion healing ministry.

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

COURTNEY MILLER: Thank you.

HANSEN: We'll take one from this side of the room.

DAWN LIPHARDT: Hello.

HANSEN: Hello.

DAWN LIPHARDT: I'm Dawn Liphardt, D-a-w-n L-i-p-h-a-r-d-t. I'm a lifelong, hardworking Nebraskan. I'm here today to tell you a story. It's a true story of love and commitment. It's also a story of strength and courage. In 2001, after a year-long wait, my husband and I received a phone call that a birth mother had chosen us to be the parents of her beautiful young daughter. We were elated and anxious at the thought of being new parents. We were also thankful and blessed to have this mother choose us to care for her child. This birth mother was 17 years old when we met her and five days later our daughter was born. This was in 2001. But you know the most important part of all of this? That year was the beginning for all of us. We have always fostered our daughter's relationship with her birth mother. In the beginning, she would visit regularly each week. To this day, they have regular contact with-- by phone, texts and visits. We are our daughter's parents, but our daughter's relationship with her birth mother is an important part of who she is. What is most important to me as her parent is the incredible courage and strength her birth mother had throughout this process. Yet, to this day, whenever talking to my daughter's birth mother, she always tells me she has never regretted her decision to make that choice. Because we had such a positive experience, we began the journey to adopt a second child. This is also a beautiful story and one of strength and courage. Our son was born nearly three years after our daughter. We currently have relationships with both the birth mother and the birth father. Together this young couple made the choice to choose the parents they wanted to raise their son. They are beautiful people with loving hearts. In fact, every Christmas, our son's birth mother-- mother joins me and my entire family to celebrate my son's birthday and Jesus's birthday. Whenever I speak with my children about their birth parents, I stress to them the incredible strength and love that each of them had for them. They chose life and they chose us to parent

them. They deserve the utmost respect and honor for this incredibly difficult decision. Today, my daughter is about to graduate college after receiving a ball-- volleyball scholarship to play at an Iowa college. She has been on the president's list nearly every semester. She has applied to graduate school and is hoping for an acceptance letter very soon. This is the positive impact her birth mother had. Without this decision, the world would never know our beautiful daughter. My son is halfway through his freshman year at the University of Nebraska. He has good grades and is very involved in activities at school and through his fraternity. He is an-- emerging as an outstanding young leader within his house. Today, both children are thriving, wonderful young adults in college. I'm--

HANSEN: I'm gonna have to cut-- I'm gonna have to cut you off there.

DAWN LIPHARDT: I'm asking all of you to support LB626. Thanks for your time.

HANSEN: It goes fast. Yep. Thank you very much. Appreciate it. And we'll take the next testifier. Welcome.

BEN STANGL: Thank you, Chairman Hansen and members of the committee. My name is Ben Stangl, B-e-n S-t-a-n-g-l. And thank you to all who are paying attention to the testimony. I commend you. Appreciate that. I'll start with some reference material initially from Psalm 139. "You have searched me, Lord, and you know me. You know when I sit and when I rise; you perceive my thoughts from afar. You discern my going out and my lying down; you are familiar with all my ways. Before a word is on my tongue, you, Lord, know it completely. You hem me in behind and before, and you lay your hand upon me. Such knowledge is too wonderful for me, too lofty for me to attain." "For you created my inmost being; you knit me together in my mother's womb. I will praise you because I'm fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be. How precious to me are your thoughts, God! How vast is the sum of them! Were I to count them, they would outnumber the grains of sand. When I awake, I am still with you." If I didn't care about you, I wouldn't warn you that the following verses after that are-- are a judgment, and it's because I care about you that I share this with you and warn you. And there are many who have found forgiveness for-- for bloodshed. Please look into the mantra of Planned Parenthood advocates. Their mantra is: No bans. Not now, not ever. There's no compromise with those that want

to kill pre-born babies, and there should be no compromise from those who support pre-born babies. It's incumbent upon every senator who supports the heartbeat bill to bring an amendment for a total abortion ban or something that approaches a total ban without precluding saving a mother from death. So I support prohibiting killing babies. I apologize if I'm confused about being a proponent or an opponent of this bill, but I'm not neutral. I support prohibiting killing babies, and I want to see a total-ban-on-abortion bill every year. And so I challenge you, do not compromise. There's no compromise from the opposition. You can read my paragraph about Mars. We'd be ecstatic to find life in an uninhabitable place, and yet we find any excuse to deny that life exists in the most habitable place: a woman's womb. Abortion does end a beating heart; that is true, but it's a compromise. It stops short of telling the whole story. Abortion kills a human life, no ifs, ands or buts about it. So don't call it abortion. Call it killing a pre-born human, because that's exactly what it is. Ban it totally, and ban it now. Thank you.

HANSEN: Thank you. Any questions? Seeing none, thank you very much. And we'll take the next testifier. After this one, we will move to two minutes.

SHERRY JONES: Good afternoon. I'm Sherry Jones, S-h-e-r-r-y J-o-n-e-s. I wholeheartedly-- yes, pun intended-- support the Nebraska Heartbeat Act. A heartbeat is a universal sign of life, a marker which can be easily established using an ultrasound machine-- not complicated nor ambiguous. I recently heard a statement that has lingered in my mind since hearing it. It was said: Every abortion takes the life and wounds a woman. Every abortion takes a life and wounds a woman. Abortion wounds a woman in a number of ways. The long-term effects on a woman's health are outlined in a documentary entitled "Hush," which was, ironically, directed by a woman who refers to herself as pro-- as pro-choice. These effects include increased breast cancer, difficulty getting pregnant, future miscarriages, future premature birth, sterility and psychological harm. I'm encouraging-- I'd encourage those on both sides of the abortion aisle to view this eye-opening documentary. Abortion is not a friend to women, and of course we know what it does to a developing baby. The Nebraska Heartbeat Act is one of common sense, compassion, and, to use a buzzword of the past few years, follows the- the science. For the sake of children, women and our society, I sincerely ask you to advance this bill. Thank you. And I have a copy of the DVD "Hush" that I would gladly give to this committee if any of you would choose to watch it. I have it in my bag. Is anyone interested? I will give it to you.

HANSEN: Probably the best way to do it is to give it to our office.

SHERRY JONES: I will do that, Ben-- or Senator Hansen.

HANSEN: Yes. All right.

SHERRY JONES: Thank you.

HANSEN: All right. Any questions from the committee? All right. Thank you very much. Now, I know two minutes seems like a short time, and you might have been-- planned for three. So just kind of concentrate your minds, the important parts of what you want to say, so that-- and I'll try not to cut you off too harshly if I can, but everyone's kind of wanting to be heard, so. Welcome.

GEORGE BOLL: Thank you, Senator. My name's George Boll. G-e-o-r-g-e B-o-l-l. I'm thankful that our Supreme Court has given us the opportunity in our state to illustrate great concern for our pre-born children. Our state can live up to being the good life state. Thank you, Senator Albrecht and all the other cosignees of this bill. I wanted to point out the fact that almost every woman, and man also, in this state is glad that their mothers chose to carry them to full term. Some people will say that this is kind of a women's rights issue, so I want to actually take the time to address specifically the three women in this committee room. And one of you-- Senator Cavanaugh, you are my senator, so I might have a special right to address you. But I have experienced-- I have five children. I have experienced one who actually's [SIC] heartbeat did come to an end at age 18, a very depressing time in my life. And it was probably one of-- it's been-- and there's been other depressing times-- and I'm, sure you can all relate-- that there's been times where I felt like, you know, I think I want to end it all myself, and you might call that a moment of temporary insanity because, in reality, 99.9999 percent of the time, I am 100 percent pro-life for myself. And I'll bet you, all of you are, too; 99.9 percent or 100 percent pro-life for yourself, and I'm going to be willing to bet you that that started when your heart started beating. And I'm asking you to be responsible enough to say, I might change my position and actually defend those people's, whose life are beating hearts. Fifty percent are women and 50 percent are men, and it is a women's issue that I pray that you will consider supporting and actually showing your responsibility as senators to our great state. Thank you.

HANSEN: Thank you for your testimony. Any questions? Making sure. All right. Welcome.

CAROL WATSON: Thank you, Senator Hansen and members of the committee. My name is Carol Watson, C-a-r-o-l W-a-t-s-o-n. I'm a citizen of the 43rd District in Arnold, Nebraska, Custer County, and I'm here to support LB626, the Heartbeat Act. Let me share with you quickly: 1984, rural Custer County, a mom is expecting her third baby. She's lying in bed on bed rest due to the fact that nine weeks she was shown an ultrasound, which in 1984 was not a common thing. This was the first one she had had. And in that ultrasound she saw the movement on the screen. She said to her doctor-- Holtmeier [PHONETIC] in Broken Bow, Nebraska-- what is that? And he said, that's the heartbeat. Twenty-six weeks later, she is in the car. Her husband's driving, 2:00 a.m., in the morning, to the hospital, hard contractions. Baby is delivered in the car. He is 26 weeks. It's a boy. His name is Evan [PHONETIC]. He's less than two pounds. He's 14.5 inches long, which is good for his development at 26 weeks. He is one of two babies that were born. The older, other one was 24 weeks and survived. And I, as a person of pro-life, remember this very well in our community. Today I'm going to fast-forward. Evan is, in 2023, he is a dad. He graduated from the Arnold High School in 2003. He was the homecoming king. He was a pole vaulter at the state. He now is a contributor to Nebraska's food source. He's a five-generation farmer and he helps hundreds of people have food. If Evan had not been given that chance to live at that heartbeat stage, look what we would have missed. Thank you for hearing--

HANSEN: Thank you. Appreciate it.

CAROL WATSON: --this testimony that's true, and I pray that you will--

HANSEN: OK, thank you.

CAROL WATSON: --move--

HANSEN: OK.

CAROL WATSON: --on LB626. Thank you.

HANSEN: Appreciate it. Thank you very much. All right, we'll take the next testifier from this side of the room.

LISA McINERNEY: Hello, Chairman Hansen and the committee. My name is Lisa McInerney, L-i-s-a M-c-I-n-e-r-n-e-y. I'm the program director for Sidewalk Advocates for Life here in Lincoln. Sidewalk advocates are trained to offer loving, life-affirming alternatives to all present at the abortion facility in Lincoln. There are also teams of volunteers at abortion facilities in Omaha and Bellevue, and at 236

other locations in the U.S. and beyond. We use a peaceful, prayerful and law-abiding approach that focuses on first showing love and compassion to the women entering abortion facilities and then being a gateway from the abortion facility to pregnancy help organizations, which include pregnancy help centers, maternity homes, adoption agencies, and life-affirming social service agencies. And you've already heard that there's about 27 of those PHOs here in Nebraska. We believe that when a woman experiences an unplanned pregnancy and considers abortion, that the baby is not really the problem. But the baby is shining a light into the other areas of the woman's life where she needs help and support. Besides the PHOs in Nebraska, there are also four Embrace Grace chapters at churches in Nebraska that provide support, encouragement, a baby shower, and more to pregnant single mothers. I had the privilege of attending my church's recent Embrace Grace baby shower. Four single mothers were lavished with tables full of gifts that had been donated by members of my church. The mothers were accompanied by family and friends and-- and were provided a meal plus leftovers to take home late-- for later. I witnessed the bonds that had formed between the four mothers and the leaders of the Embrace Grace group. A couple of weeks after the baby shower, the mothers were also invited to have their hair and makeup done for free, along with a free maternity photo session. The photos were so precious and the mothers were grateful. They deserve to be encouraged to-- to know how strong they can be, to be told the truth about the lives growing inside of them, and to be told the truth about all the help that is available to them. I respectfully ask that your committee advance LB626 to legislative debate. Thank you.

HANSEN: Thank you. All right. So with that, we'll take our next testifier from this side of the room. You guys are doing great. We're getting there.

DAVID ZEBOLSKY: It's going fast now.

HANSEN: Welcome.

DAVID ZEBOLSKY: Hi. Hello. Thank you. Thank you for allowing me the privilege to be here today. My name is David Zebolsky. David Z, like "zebra," e-b-o-l-s-k-y. It's Nebraskans Embracing Life where I serve as chairman of the board of directors. I would like to say that we represent thousands of life-from-conception Nebraskans in support of this lifesaving legislation for children in the womb. Each of us was once this age. Our pregnant mothers knew that they were with child for each of us. Nebraska is now a destination state for abortion, as our sidewalk advocates have reported an increase in out-of-state license

plates and a sharp increase in surgical and prescribed chemical RU-486 abortions as more abortion-minded mothers come to Nebraska from other states. This heartbeat legislation will save Nebraska lives. There are already literally thousands of counselors, medical professionals, mentors, clergy and volunteers ready to support mothers and walk with them through their pregnancy, with dozens of pregnancy resource centers in every area of the state ready to help mothers with virtually every need that they may have, whether it's adoption referral or material needs of any kind, continuing education, parenting classes or counseling of any kind. We must defend these youngest Nebraskans. If you have any doubt at all about life in the womb, please watch a fetal development video. If you really advocate for abortion, please watch an abortion. And if you can watch an abortion and support it, you're-- you're supporting the destruction of sacred human life in the womb. You can watch these videos on our website, nebraskansembracinglife.org. I'd like to say that Jesus Christ himself said, I am the way, the truth, and the life; whatsoever you do to the least of these, you do unto me. Each of us will have to stand before God and give an account of our lives. To Senator Lynne's-- Walz's question, if I may?

HANSEN: Briefly, yes, go ahead.

DAVID ZEBOLSKY: She was asking about the 2,000 number. So the Nebraska Department of Health and Human Services has reported approximately 2,400 abortions in Nebraska annually, so this bill would address those surgical and prescribed RU-486 abortions. That's where they get that number from.

HANSEN: Thank you.

DAVID ZEBOLSKY: OK. God bless.

HANSEN: Yes, thank you. We'll take the next testifier.

JENNIFER BUTCHER: Thank you, Chairman Hansen and committee, for having me. I'm Jennifer Butcher, J-e-n-n-i-f-e-r B-u-t-c-h-e-r. I have seven children, seven grandchildren, four born, two in their mother's womb currently, and one in heaven. Each of these lives was precious before they had their first heartbeat. I could speak today about their beating hearts, but today I speak on behalf of the almost thousand people-- men and women-- who have called my hotline that I answer as a volunteer. It's a post-abortion hotline. I've been doing this for over 20 years. I'm here to speak about the suicide of a young woman, 24 years old, who tried to get the help from multiple counselors and

psychiatrists. We surrounded her with love and gave her everything we could to help her heal, but in the end she could not live with the fact that she had killed three of her own children. She ended up taking all the medications that she had been prescribed by multiple doctors. I speak on behalf of the grandmother who came to me distraught that her daughter had not come to her when in crisis. Her daughter thought her parents would kick her out, so she secretly had the abortion. This grandma later told her daughter that they would have been upset, but they would have helped her-- a life ended because it was legal and convenient. Imagine if she'd been supported at a pregnancy center instead and told that she was doing-- that she would be doing the right thing by having an abortion like they tell her at the abortion clinic. I speak on behalf of the woman who was traumatized by her roommate's RU-486 abortion, not even her own, but she witnessed it in their apartment. You heard someone earlier talking about what that's like. Imagine delivering your own dead child in your home or being the roommate who witnessed that and have to live in that home after you've done that. I speak on behalf of the abortion clinic worker who couldn't get the feeling of the baby parts off of her hands because she was the one who had to count the parts every time there was an abortion. She had to make sure the hands were there, and the legs; she had to make sure they had come out during the abortion. Imagine those people. I'm speaking on their behalf. I speak on behalf of the men who grieve their children, whether they encouraged it, whether they were silent or whether they had no say. They grieve and we need to help them. I don't understand why we tell women they can do anything except parent. I don't understand why we can't help them and provide resources. I'd love to see all abortions eliminated, but I know that LB626 is a good step in helping women and children to enjoy the good life of Nebraska that you and I get to enjoy. We can do this. Please advance this. Thank you.

HANSEN: Thank you for your testimony.

JENNIFER BUTCHER: Any questions?

HANSEN: No, we're good, actually. Yeah.

JENNIFER BUTCHER: Thank you.

HANSEN: And for the people who just kind of came in as well, we are doing two-minute testimonies, so just kind of try to get your thoughts in-- in a condensed manner and we'll try to get as many people in as we can so their voices are heard. And we have till 4:45 yet, so.

MELISSA HUME: My name is Melissa Hume, M-e-l-i-s-s-a H-u-m-e. Abortion is an unnatural act that separates a mother from her child, which is the most beautiful, loving, powerful bond of all humanity. I have counseled women outside of abortion clinics, offering them alternatives. I have counseled at pregnancy centers. I've had friends who've had abortions. Most of the women going into the abortion clinic do not want the abortion. They feel they have no choice. They're under stress. They don't feel support. And they're being pressured by the people in their life, by the fathers who don't want to financially support the baby or by the parents or friends or teachers. These women that I've talked to at pregnancy centers and friends that have had abortions, they have suffered deeply. They all regret their abortions. Abortion hurts women, emotionally, mentally, physically, often spiritually. Abortion hurts women. Beau-- abortion destroys beautiful children created in the image of God with a beating heart. Abortion destroys the bond between a mother and a child. Women deserve more. They deserve compassionate, loving alternatives to abortion. Please protect this bill-- please pass this bill and advance this bill to protect unborn children and women from the harm of abortion. Thank you.

HANSEN: Thank you for your testimony. Thank you. We'll take the next testifier from this side of the room. Oops, looks like you get the "reserved" sign stuck down there. Welcome.

RICK EBERHARDT: Good aft-- good afternoon, Senator Hansen, members of the committee. My name is Rick Eberhardt, R-i-c-k E-b-e-r-h-a-r-d-t. I'm from Pierce, Nebraska, and by profession I'm a law enforcement officer. In the 40 years I've been doing this business, I've seen a lot of bad things. I've-- I've had to do some things and-- that were troubling. And during my time I got to teach DARE for 14 years and I taught a lot of kids. And I always told my kids, I said, if you ever get-- find yourself in trouble at any time in life, I'm just a phone call away. So one day the phone rings and I had to go do a welfare check and I pulled up at a house and a young woman came out where a young girl had once stood and she was crying. And I said, what's going on? And she explained to me that she had been pregnant and that she had went to a provider and had been given the medication to terminate her pregnancy. And she described how she had delivered the baby in the house. And she was crying. And she had the baby in a jar and she didn't know what to do. She didn't know what to do. So there are gonna-- people that are-- here are going to testify today and they're going to-- they're going to call a baby a mistake or an inconvenience. Some of them will even call them a parasite. What was in that-- but what was in that jar that day was not a mistake. It wasn't an

inconvenience. It was a baby. That's what she called it. She told me she had been informed by the provider that it was going to be a clump of cells or something like that. She's the one that called-- it's a baby. She bawled and I-- she sobbed and I held her. My-- my question is, what would you guys have done? What would you have done? What would you have said? There was nobody there from Planned Parenthood. There was two human beings. Thank you.

HANSEN: Thank you for your testimony. We'll take the next testifier from this side of the room. Welcome.

BRANDI BURKETTE: Hi. This is my first time. My name's Brandi Burkette, B-r-a-n-d-i B-u-r-k-e-t-t-e. I'm from Legislative District 4 in Omaha. Thank you, Senator Hansen, for sitting here and listening to all of us. I know it's gotta be a long day for you. There's a couple other senators in this room that I wish would quit looking at their phones all the time, and their computers, and actually listen. So in my view, a lot of Americans have lost responsibility, accountability and common sense these days. People need to be held accountable for their actions and they need to take responsibility for their choices. I am not a parent. I don't know what it's like to be a parent. But I would like to be someday. Someday I really would. This country was founded on Christianity and "In God We Trust" is written on our money. So if you don't believe in that, then, I'm sorry, but you can also move. There's-- there's other countries to live by. God knows that you are-- you are in the womb and he knows who you are when you're there. So you are wanted. You're wanted by a lot of people. If you don't know what Nebraskans want, take a drive down some highways in Nebraska. On my way to Wahoo, I see two pro-life billboards. On my drive to Fremont, I see a pro-life billboard. These signs are respected and have never been destroyed. So I think-- I think that goes to say what-- what Nebraskans want. Thank you.

HANSEN: You did good for your first time. All right. We'll take the next testifier in support.

DAN BUHRDORF: Dear esteemed members of this committee, my name is Dan Buhrdorf; common spelling of Dan; B-u-h-r-d-o-r-f is my last name. I'm a proud member of the Lancaster County Republican Party and a strong advocate for the sanctity of life. I'm here today to express my strong support for LB626, the Heartbeat Act. As a member of the party that upholds care of life and the sanctity of life, I believe that every human life is precious and deserving of protection. The Heartbeat Act aligns with this belief by requiring medical professionals to detect the heartbeat of a fetus before performing an abortion. If a heartbeat

is detected, it means that the fetus is alive and should be protected under the law. This bill will provide much-needed protection for the unborn, who are often the most vulnerable and defenseless members of our society. It will also serve as a deterrent to those who seek to end the lives of the unborn for selfish or irresponsible reasons, at the same time keeping procedures in place when two lives are at risk. The Heartbeat Act will ensure that the value of life is upheld in Nebraska and that the rights of the unborn are protected. This bill ends the denial of the humanity of one group just to support the hierarchy of another. The Heartbeat Act will also send a powerful message to the rest of the country about the importance of protecting life. As a state, we have a responsibility to set a positive example for the rest of the nation and to lead the charge in the fight for the sanctity and care of life. In conclusion, I strongly support-- I strongly urge you to support the Heartbeat Act and to make it a law in Nebraska. This bill is a crucial step in the direction of ensuring that every human life is valued and protected, and I am confident that it will make a positive impact on our state and the lives of countless unborn children. Thank you very much.

HANSEN: Thank you for your testimony. Appreciate it. And we'll take the next testifier from this side of the room. Welcome.

JAEHNE MOEBIUS LAMM: Well, thank you. Good afternoon, Senators and committee members. My name is Jaehne Moebius, J-a-e-h-n-e M-o-e-b, like "boy," i-u-s, and Lamm is the married name. I'm from Garfield County; just wanted to mention. The constitution guarantees the right to life, liberty and the pursuit of happiness. Maybe somebody wants to inform our vice president of this fact. The right to life is just that. It's a right. We need representatives who will stand up for life. If there's a heartbeat, there is life. The Supreme Court correctly overturned Roe v. Wade. It was an erroneous court decision. No right to abortion has ever existed in the constitution, period, period, period. We need representatives who will attest to this and not be swayed by representatives who have-- who are deluded of this fact, having been born well after Roe v. Wade was passed and that's the only world they know. Please support this LB626 and pass. Thank you.

HANSEN: Thank you. Appreciate it. We'll take our next testifiers from this side of the room.

JEANNE GREISEN: Thank you. My name is Jeanne Greisen, J-e-a-n-n-e G-r-e-i-s-e-n, and I'm here representing Nebraskans for Founders Values. And I would like to take a 40,000 few-- foot view on this

issue. So on one end, we have the moms maybe not wanting their baby or can't handle their baby, so they turn to medicine to give them the-- the result that they want and a quick fix. On the other end, we have all the moms and dads that are wanting a baby so much that they go to fertility. And so they would do anything to have a baby and we've got about-- millions, 2 million families that are wanting babies on the other end and paying astronomical amounts of money. So they turn to medicine to get that baby. So what is the common denominator in both of these situations, on both ends? It's medicine. And so what does LB626 do? That can bring both of these groups together. So you have no babies on one end, but people wanting babies on the other end. It can bridge that gap and getting medicine out of the way so then you can actually have families working together to give babies an amazing life, as what was intended for them. And as I-- and on another note, for eligible-- every eligible adoption baby, there is an invisible queue of 36 couples waiting. That's all I want to end with. But I do want to say I testified for a pro-life bill last year, and my husband and I were there, and there was only two rows of people and we said, where is everybody? I'm glad a year brought them all out. This is amazing. Thank you, Senator Joni Albrecht.

HANSEN: Thank you. We'll take the next testifier.

JOHN SCIARA: My name is John Sciara, J-o-h-n S-c-i-a-r-a. I-- didn't need the address, OK. Thank you very much for giving us the opportunity here. When we were children playing games with others, if we made a move that didn't-- we-- that we didn't like, we'd yell, "Do over!" and take the move back. There were very little consequences of our choices back then as children. The state of Nebraska requires us to be adults before we can get married and decide to have a family. We are no longer able to call for a do-over since we are now an adult. Abortion should not be used as a do-over. You'll hear opponents claim that, as a man, I shouldn't be able to speak on the subject since I don't know what I'm talking about. That claim is only used since the opponents don't have a valid argument and they can't debate the issue that they want and they want to silence their opponents. I have three sons and I was involved with the bringing of two of them into the world. I was there when they were conceived. I do think that means I know what I'm talking about. You'll hear opponents claim that six weeks is not enough time to know that you are pregnant. Something has to have happened for you to get pregnant. You need to have an intimate relationship with your spouse or significant other. I'm not sure how opponents claim that six weeks isn't enough time. How long does it take for you to know that you'd had an intimate relationship with a significant other? My one son was conceived on November 16, 1989. I

know that because I was there also. It didn't take long for me-- it didn't take me six weeks to know that I'd had an intimate relationship with my spouse. If you oppose the bill, try to come up with a valid argument for opposition of the bill. Don't rely on wanting to do-- say "do-over" or that you believe that women are not-- ignore-- intelligent enough to know when they've had an intimate relationship.

HANSEN: Thank you for your testimony.

JOHN SCIARA: Please protect this bill like you would a child's life.

HANSEN: Thank you. Appreciate it. We'll go to the next testifier in support.

WARD GREISEN: Good afternoon, everybody. My name is Ward Greisen, W-a-r-d G-r-e-i-s-e-n. And I'll start off by saying western civilizations, specifically the United States, are all built on the idea that there is intrinsic value or sacred value in everybody. No matter your background, your past, or your origins, our laws are built to protect that value. Our government and nonprofit organizations spent countless time and money on this idea. Whether it's protecting the elderly, the homeless, the handicapped, the mentally ill, or the children, the U.S. works hard to protect them all. As a country, we don't always agree on how that protection should work or look; however, the idea it is needed is almost universal. So why would we treat the unborn child any differently? There is need for protection. It's need-- there-- need protection-- our protection, as much, if not more, than all the others mentioned. There are some who frown on the words "unborn child." Instead, they like to use other terms like "fetus" and-- and many others, but they do that just to dehumanize the child or-- and it's the same that other cultures, you know, that did mass genocide did as well. They tried to dehumanize the victims. We can't let that happen. Calling it something else other than what it is, is wrong. We need to call it a child. We need to realize that what we're doing is killing an unborn baby. So I ask that you all support this bill. Advance it to the floor. Thank you.

HANSEN: Thank you, appreciate it. We'll take our next testifier in support.

GREG EPP: My name is Greg Epp, G-r-e-g E-p-p. You know, abortion is such a polarizing issue, and but even the National Cancer Institute is equally polarized by the-- by this. They say there is no risk and no long-term effects from an abortion and I wonder, are they really being objective? They point to a conference that they supported in 2003 in

which they gave only a 20-minute presentation on the subject. They squelched the one opposition to it and then they called it conclusive evidence. And I ask, what information am I missing in this? Dr. Ian Geltz [SIC], the author of the book "Complications," he looked at 108 independent studies done all over the world, and he found 73 percent of these studies had a correlation between abortion and breast cancer, and then he found that 50 percent of them had a very strong correlation between abortion and breast cancer. And then I look at China, which has had a three- to four-decade stint of forced abortions, and I gave you the study from the Huang meta analysis. It's a study of 36 studies accumulated by the-- by the-- this Chinese group, and they-- they point to a 44 percent increase in breast cancer from one abortion, 76 percent increase in breast cancer from two abortions, and an 89 percent increase from three abortions. And I think we can't ignore some of this data. And I just-- hey, please support LB626. Thank you.

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

HEIDI GILLILAND: Thank you, Senators. My name is Heidi Gilliland, H-e-i-d-i G-i-l-l-i-l-a-n-d. There's a lot written down and I'm going to shorten it if I can and respect to your time like you've respected mine. My first pregnancy, when I was 19 years old, I was a pretty broke college student in a good relationship, but certainly not married and, to be honest, not wanting to be a mother yet and, to be honest, considered abortion. But because I knew better, like I think we all here know better, that baby was separate from my own body. And no matter what I wanted, there has to be some level of understanding, appreciating for all life. And so I continued with that pregnancy and chose life and at 36 weeks, I delivered my son stillborn. And if you were to ask me to do it over again, I would, because his life was precious and I grew resilient and because I found that there is help. There is so much help in our state and in our city. And again, at 35, I found myself pregnant, unexpectedly but married, and carried that child even though he passed away. And I had severe complications in that pregnancy, as well, and I would still do it again. We have pitted our life, liberty and pursuit of happiness against one another, and that at heart is the abortion discussion. We've pitted women against their babies, mothers against their children, and these three fundamental rights against one another. I ask you to please think about your own children. And when did they earn their humanity? When did you earn yours? That is what I ask you to consider. That is at the heart of this bill. Thank you.

HANSEN: Thank you. Appreciate the testimony. We'll take a testifier from this side of the room in support. Welcome.

SETH BRAUNING: Thank you very much. My name is Seth Brauning, and that's S-e-t-h; last name is B-r-a-u-n-i-n-g. Thank you, Chairman Hansen and the senators of the Health and Human Services Committee. I'd like to ask you a question here today. Where would you say is the most dangerous place to live in America? Would you say it's Chicago, St. Louis, or perhaps Los Angeles? No, I'm here to talk about the last stand of about 62 times the American deaths and all the U.S. wars combined. Yes, I am talking about the womb in the United States. I'd like to talk about two things here today. I'd like to go over just a couple objections that might be brought up against LB626, and I'd like to go over a very quick biblical case for the humanity of the unborn. So first, if we look at LB626, two objections might be raised with this bill. An objection might be raised that the life of the mother is not protected. However, Section 3(1)(a), the abortion definition, protects the life of the mother. Another objection might say that this bill would punish pregnant women. Section 6 says exactly the opposite. Now, let's quickly look at a biblical case. We're all made in the image of God. Genesis 1:27: "So God created man in his own image, in the image of God, he created him; male and female, he created them." The unborn are also human. Jeremiah 1:5: Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations." So we see here that a couple objections may be raised against this bill, but those objections do not have standing. We saw a biblical case that all people are created in the image of God. And over 63 million babies have been killed since 1973. Just to put that in perspective, that's just 3 million shy of the entire population of Texas and California combined. The American womb is clearly the most dangerous place to live in America, and I would urge you to make the womb a safer place in Nebraska with your support with LB626. Thank you so much.

HANSEN: Thank you for your testimony. We'll take the next testifier from this side of the room.

AMY CODR: Good afternoon.

HANSEN: Welcome.

AMY CODR: My name is Amy Codr, A-m-y C-o-d-r. Rick Green is a constitutional coach and founder of Patriot Academy; I'm not sure if any of you are familiar with him. He talks about the fact that historically most civilizations fall after 250 years. And how to save

a civilization, it is crucial to get back to its foundation. America is now 246 years old. That's just four years from that 250 mark. By this logic, it is prudent that America get back to its roots, the roots and foundation that our forefathers put in place, and that foundation is one of Judeo-Christian principles. And included in those principles is the sanctity of life. Now, whether you choose to believe them or practice them in your own lives or not, the fact of the matter is that these principles state that there is one true God, and he is the author of life. They say that he knit us together in our mother's womb and that he has a plan and purpose for each and every person he creates. You've heard these scriptures today, but these principles also tell us that Satan is the enemy and that it is the enemy that comes to steal, kill and destroy. By giving in to the hand of the enemy and allowing his works to continue, allowing the continuous murder of the unborn, we are allowing this country to fall farther and farther from the foundational principles of our forefathers. We are allowing our civilization to fall. It is time to right the wrongs we have continued to partake in and take steps to save our country. Other states have begun to do that. Let's join them here in Nebraska and see this bill passed. Thank you.

HANSEN: Thank you for your testimony. We'll take the next testifier from this side of the room. Looks like you made it up here after all, huh?

SARAH LOUISE PETERSON: I did. Thank you, Senator.

HANSEN: I saw her out in the hallway when I went there last time. She was way in the back.

SARAH LOUISE PETERSON: Thank you.

HANSEN: Welcome.

SARAH LOUISE PETERSON: Thank you. Hello. My name is Sarah Louise Peterson, S-a-r-a-h L-o-u-i-s-e P-e-t-e-r-s-o-n. Thank you, Senator Hansen and all the senators here listening today. Life-- if I had to pick one word to describe why we are all here today, it would be that word: life. Life begins at conception. A baby in the womb of his or her mother is alive when his or her heart beats. A baby in the womb has the evidence-- when the heart beats, we can hear the evidence of that life. Hearing that heartbeat at around six weeks or earlier of gestation is proven scientific evidence that the baby in utero is alive, is its own person that is separate from the mother, and who has his or own-- his or her own unique DNA. There never has and will never

be another person like that baby. My husband and I have been blessed with three amazing daughters. Because I experienced three high-risk pregnancies, I had early ultrasounds for all three. I will never forget having those ultrasounds for my girls done in the early weeks of pregnancy. The sure cla-- sorry, the sure, clear and fast sound of the heartbeat of each girl was music to my ears. There was no mistaking that heartbeat. Babies have very fast ones. I loved hearing them. And of course, this was a sign of each of their lives growing inside of me. So I wish you would think through-- and you're so great. I can't imagine sitting here for six hours. That is amazing. We thank you for your service. And I would ask you to please advance LB626 and then pass it to save these babies. I do have an answer for Senator Walz's earlier question about the 85 percent.

HANSEN: Very briefly.

SARAH LOUISE PETERSON: OK. In the-- Nebraskans [SIC] Right to Life put out the literature and they had that statistic that they had looked up that 85 percent, up to or about that amount, could be saved by this heartbeat bill. The Washington Post has their statistic that 90 percent of abortions happen in the first 12 weeks. 95 percent of abortions in the fifth-- first 15 weeks, so that statistic. And then Nebraskans [SIC] Right to Life, their materials said that that's why 85 percent of the abortions could be saved or stopped, 85 percent stopped by this bill because we have that approximate six weeks of gestation with the heartbeat.

HANSEN: Thank you. Appreciate your testimony.

WALZ: Oh, can I just clarify--

HANSEN: Yes.

WALZ: I'm so sorry.

SARAH LOUISE PETERSON: No, it's OK.

WALZ: You said 90 percent and then 95 percent on the--

SARAH LOUISE PETERSON: OK. So The Washington Post had statistics out around this last year or last year when the Roe v. Wade got overturned, and their statistics state that 90 percent of abortions performed happen in the first 12 weeks of pregnancy.

WALZ: OK.

SARAH LOUISE PETERSON: And 95 of them that are performed happen in the first 15 weeks.

WALZ: OK. Thank you.

SARAH LOUISE PETERSON: Thank you. Thank you all.

HANSEN: Thank you for your testimony, appreciate it. We'll take the next testifier from this side of the room.

SARAH LOUISE PETERSON: Thank you.

HANSEN: Welcome.

MIKE DAVIS: My-- my name is Mike Davis. I'm a retired educator. I was, four different school districts, a high school teacher, elementary principal and superintendent of schools. And my wife and I have-- my-- my name's Mike Davis, M-i-k-e D-a-v-i-s. My wife and I of 50 years-- we were married in 1973-- have 5 children and 16 grandchildren and 1 great grandson, and I'm very passionate about abortion in Nebraska, kills children. My wife and I feel that they're a gift from God and that I also want to let you know I'm president of the Nebraska-- or, no, the Lincoln Right to Life chapter under the Nebraska Right to Life, and I spend-- I've spent five years now in front of Planned Parenthood praying for the end of abortion. And I pray [SI(C] on my phone, on my sound system, the heartbeat, and those working there, the escorts have no idea what that is, but it is very powerful. Thank you.

HANSEN: Thank you for your testimony. Take the next testifier in support from this side of the room.

ELIZABETH DAVIS: Elizabeth Davids, E-l-i-z-a-b-e-t-h D-a-v-i-d-s. Twenty years ago this month, I learned I was pregnant with my first child. I remember from Febru-- February 7, 2003, vividly. I was not ready. I was scared. I cried. This wasn't my plan. There was no way this was going to work. The opponents of this bill have women like me in mind, who are facing an unplanned pregnancy and need support. They're scared. They don't know how this could possibly work, to carry a baby to term that they hadn't planned on and aren't ready for it. But it can work. In my situation, I had a support system of friends and family that helped me in many ways, and I'm grateful for their support, but not everyone has that personal network, which is why I'm also glad there are pregnancy centers all across our state that serve women in need for free. I'm glad Medicaid is available to women with unplanned pregnancies. I'm glad for the WIC program. The truth is, even if I didn't have supportive friends and family, my child still

deserved to live. Even if no one encouraged me and I hadn't felt I could keep my child, that child still deserved to live. And today, that child is a strapping 19-year-old young man who is loved by many, growing in life preparedness and serving his community. That child has changed my world, of course. He has changed his father's world. He deserved to live because he hadn't done anything wrong. Our world is better because he is here and our world will be better because of the lives of those who will be saved by passing this bill into law. This month is also Black History Month, and I would like to honor Dr. Milfred [SIC--Mildred] Jefferson, who was the first black woman to graduate from Harvard Medical School in 1951. She received 28 honorary degrees during her lifetime and dedicated herself to caring for the sick and poor while she publicly and passionately spoke out against the violence of abortion. She was quoted in Ebony magazine in 1978 saying, I would guess that the abortionists have done more to get rid of generations and cripple others than all of the years of slavery and lynchings. And again, in 1978, she spoke these words in a public speech: I became a physician in order to help save lives. I am at once a physician, a citizen and a woman, and I am not willing to stand aside and allow this concept of expendable human lives to turn this great land of ours into just another exclusive reservation where only the perfect, the privileged and the planned have the right to live. We can love both women in need and their unborn children. We can honor the sacred life-giving nature of women and their children in the womb. We can honor black and brown women whose children deserve to live just as much as any other.

HANSEN: Thank you for your testimony. Appreciate it. And we'll take the next testifier from this side of the room.

KATHLEEN HORSLEY: Hello.

HANSEN: Welcome.

KATHLEEN HORSLEY: My name is Kathleen Horsley, K-a-t-h-l-e-e-n H-o-r-s-l-e-y, and I'm here in support of the heartbeat bill, LB626. I've been a Nebraska registered nurse for 30 years, but I'm here-- I'm here representing myself as an adopted child born in Lincoln in 1962. I met my birth mother when I was 24 years old. She told me that had abortion been legal in 1962, that I would not be here. I was an inconvenience for her. I have three grown sons, all productive members of society. One is a naval officer. I have ten-- ten-- ten grandchildren. I'm so sorry. This is so--

HANSEN: You're doing good.

KATHLEEN HORSLEY: --emotional for me. We are erasing our next generations with abortion. We need the heartbeat bill to mitigate this travesty. Thank you so much.

HANSEN: Thank you for your testimony. We'll take the next testifier in support from this side of the room. And again, we've got about 15 minutes left and we're doing two-minute testimony. So in case we do-- are unable to get to today, make sure you filled the white sheet so at least you'll be on record as being here and your opinion being heard on the record, too, so just in case.

ISAAC DAVIDS: Hello. My name is Isaac Davids, I-s-a-a-c--

HANSEN: Can you scooch up for me here, bud? All right. There we go.

ISAAC DAVIDS: My name is Isaac Davids, I-s-a-a-c D-a-v-i-d-s, and I'm glad that I'm alive. Thank you for your time.

HANSEN: All right, Good. Thanks for coming. Take our next testifier in support. Welcome.

CHRISTINA ST. HILAIRE: Hi. My name is Christina St. Hilaire. I'm a resident of the town of Dwight. Please, for a minute, imagine a scenario with me. Imagine--

HANSEN: Hey, Christina, can I just-- sorry, can I interrupt you?

CHRISTINA ST. HILAIRE: Oh.

HANSEN: Can you spell your name for me real quick?

CHRISTINA ST. HILAIRE: I didn't spell my name, did I?

HANSEN: Yeah. You're fine.

CHRISTINA ST. HILAIRE: C-h-r-i-s-t-i-n-a S-t. H-i-l-a-i-r-e, St. Hilaire. Imagine you have a friend who is a single mom of a six-month-old infant. She is working long hours to provide for her child but is still struggling. One day she calls you, crying, to inform you that she lost her job, the one thing keeping her off the street. She can no longer pay rent, afford medical bills, or even buy formula. She is afraid, frantic and seemingly helpless. In a moment of utter desperation, she asks you if maybe it would be better for her and her child if he were dead, so that he would not have to experience the potential years of suffering ahead of him. She asks you if there is any way to quietly, humanely and perhaps legally kill him. Knowing

your friend is not in the right frame of mind, you tell her no. Then you tell her that you will make sure that she and her baby will be taken care of. You assure her that there are programs to help women just like her with employment, financial assistance, housing and baby supplies. Notice how saying to your friend you can't kill your baby even though you are both suffering is not the same as saying I don't care about you and your suffering. It's quite the opposite. It's saying I care about you so much and I know killing your baby is wrong and would only hurt you more, and I can't let you do that. This same treatment towards unborn babies with detectable heartbeats in the state of Nebraska is what we're considering today. I am asking that we give pregnant mothers with unborn children the same nonviolent assistance that we would give the mother with a six-month-old. Science tells us that unborn babies are genetically distinct human beings like each one of us here. They are underdeveloped and vulnerable, but being underdeveloped and vulnerable is not a grounds to be killed. On the contrary, the less developed and the more vulnerable someone is, the more protection they receive. Why is it different with unborn humans?

HANSEN: Ma'am, I'm going to have to-- your red light went on, so.

CHRISTINA ST. HILAIRE: Is that all?

HANSEN: Your red light, yeah.

CHRISTINA ST. HILAIRE: OK, thank you.

HANSEN: So I'm sorry to cut you off. I apologize, but we're going to have to--

CHRISTINA ST. HILAIRE: That's fine.

HANSEN: --try to get to some more people, so thank you.

CHRISTINA ST. HILAIRE: Thank you.

HANSEN: Thank you for your testimony. I appreciate it. All right. We'll take our next testifier from this side of the room.

MARY DOHER: This is my first time doing this, so. My name is Mary Doher, D-o-h-e-r, and I felt compelled to come here today because I strongly support this bill. I have four boys. My youngest is severely autistic. He is now 25, and I wouldn't give his life up for anything. He has brought so much to our family. And I can remember my first OB/GYN appointment for each one of my boys. And hearing the heartbeat, just like everyone else has said, was so important to know that

there's life there. So I don't know how we can say that we hear a heartbeat, but yet there's no baby. So anyway, I'm here in support for LB626. Thank you.

HANSEN: Thank you for coming. All right. With that, we'll take our next testifier from this side of the room. Welcome.

KATHERINE YOHMAN: Hello there. My name is Hannah H-a-n-n-a-h, but I go by Katherine, K-a-t-h-e-r-i-ne, and my last name is Yohman, Y-o-h-m-a-n. I'm a resident of Lancaster County in Nebraska and today I'm here in-- to speak in favor of the 2023 Nebraska legislative bill LB626, the Heartbeat Act. As a proud member of the Lancaster County Republican Party, I am deeply committed to the sanctity of life. Our platform, which can be found on our website at lcrpne.org, clearly states that we believe in the inherent value of every human life and that the right to life is the most basic and fundamental right of every human being. The Heartbeat Act is a critical piece of legislation that aligns perfectly with our platform. This bill would protect the lives of the most vulnerable members of our society, the unborn. By prohibiting abortions once a heartbeat is detected, the Heartbeat Act sends a clear message that we value and respect the lives of the unborn and will do everything in our power to protect them. I'd like to address a comment or a question made by Senator Day about mental health. I knew two women who had abortions in their twenties. One took that guilt with her to the grave, but unfortunately she was far enough along that she knew it was a boy. The other now suffers greatly from bipolar and has vivid nightmares still in her sixties, two children that we don't know the genders of. I urge the Nebraska Legislature to pass this critical piece of legislation. It's a win for Nebraskans who believe in the inherent value of every human life and it's time for our state to stand up for the sanctity of life and pass the Heartbeat Act. Thank you.

HANSEN: Thank you. We'll take the next testifier from this side of the room.

ANNA OLSON: Hello, Senators. My name is Anna Olson, and I'm 19 years old. As a 19-year-old girl in today's day and age, I am a prime target to be told that abortion is a woman's right and it is morally wrong for the state to limit that right.

HANSEN: OK, can I have you spell your name for me real quick?

ANNA OLSON: Yes. A-n-n-a O-l-s-o-n.

HANSEN: OK. Thank you.

ANNA OLSON: However, I disagree. I work as-- both as a nanny and as a caretaker for the elderly, and I have seen firsthand how life is valuable in all ages, from a newborn baby to a 97-year-old woman. We are all valuable and precious in the eyes of God. The heartbeat is the universal sign of life, and any parent in this room will and can tell you that hearing their child's heartbeat for the first time is an emotional and amazing experience. Abortion stops a child's beating heart. And even if that child is unwanted, that does not mean they deserve to die. The first constitutional right we are granted is the right to life. I appeal to you all today to do your duty and protect the lives of our-- of our most vulnerable citizens by passing this bill. They cannot speak for themselves. Please be their voice. We stand with both for the child and the mother today, offering help, resources and comfort to those who might make life-altering-- life altering decisions out of fear. We stand with those who regret decisions they made in the past, and we are all here today to stand with the unborn children who need our voices. In the end, these babies are not choices, they are children; children who are worthy of protection. Please support this bill. Thank you.

HANSEN: Thank you very much. Take the next testifier from this side of the room.

ALEX STEPHENS: I thank the committee for their time. My name's Alex Stephens, A-l-e-x S-t-e-p-h-e-n-s. I am from LD27 in west Lincoln. Human life has value outside of what any one person ascribes to it. This remains true irregardless of some of the characteristics often used to make the claim that fetal life is somehow less valuable than all other varieties of human life. Let's go over these and how they are in fact fallacies. All people from conception are a group of cells that work together fully, a human in the eyes of embryology and in the eyes of most philosophies the world over. You never stop being a clump of cells. You are from the beginning until you die. There is no distinction, therefore, from that perspective, between before and after birth. Brain and heart activity, the basis of life and thought and science, do not begin after you exit the womb. They happen well before. Place does not matter either. Reliance on another is something we all do. Many of us come with families with people with special needs. They are dependent on others their whole lives. They cannot survive without others, but through being given even a semblance of the grace of God, we treat them with all the humanity and respect that they deserve. And that is in fact already enshrined in our laws, that they have a right to life and their own humanity. This bill does the

same for yet another group of humans. All laws tease out moral questions. One fallacy is that abortion is-- should not be legislated because it is a moral question. All laws are moral. All have-- talk about questions of whether something is moral, evil, and thus should be ended and whether it is good for society. This law does something similar. To claim that those who are blessed with the gifts of intelligence are somehow-- those who are not blessed with the gift of intelligence, as those who are in the womb still aren't, are somehow deserving of death-- death, is a reprehensible moral travesty worthy of the fullest condemnation of the law. Mental faculty also has no bearing on whether someone is or is not human. This law places abortion, which is at its heart an economic decision to murder for profit, back into its rightful place as something condemned by society. Thank you.

HANSEN: That was good. Thank you. All right, we'll take our next testifier in support from this side.

NORMAN HAAS: Good afternoon, Senators. Thank you for the opportunity to testify. My name is Norman Haas, N-o-r-m-a-n H-a-a-s. So I haven't prepared a statement, but I'm just going to give you a little bit about what I think is going on. So there's sort of a darkness that's coming across America and I don't want to see it come and envelop Nebraska. And there's a worldview that is anti-Christian that is taking over or is trying to take over the world, and we need to resist that. Now, about 45 years ago, I was married to a woman who had an extramarital affair with someone else, and her decision was to abort the baby. Now I didn't participate in that. I disagreed with it, but I wasn't sure because I was very young. I was in my twenties back then. And the doctor and her did not have the right to end the legacy of my family. This is my legacy that has been destroyed by abortion. And so I urge you and I charge you, as-- as-- as a Christian man who represents the church, that you would resist our opponents, resist the works of the devil, because if you do that, he'll flee from you. Amen. Thank you.

HANSEN: Thank you. Take the next testifier on this side of the room in support.

TAYLOR HICKEY: Hi, my name is Taylor Hickey, T-a-y-l-o-r H-i-c-k-e-y, and I'm here in support of LB626, the Nebraska heartbeat bill. I'm a former president of Students for Life at UNL and a member of the UNL Honors Program. I am a senior biology major currently. I have done abortion dialoguing on campus and have volunteered with the Women's Care Center here in Lincoln and have previously written a speech for

my communications class at UNL, and I'm going to share part of it with you today. So to begin with, abor-- Nebraskans need to know why abortion is a problem. As a student at UNL, I have seen a common misconception as the point at which life begins. In the textbook Essentials of Human Embryology, Keith L. Moore said in 1988 that human development begins after the union of male and female gametes in the process known as fertilization, otherwise known as conception. This is not just a matter of belief, but a matter of science. I would also argue that abortion hurts women. The Linacre Quarterly, the longest running bioethics journal the United States published long-term physical and psychological health consequences of induced abortion, a peer review, and found that abortion was linked to increased rates of suicide, depression, self-harm, regret and substance abuse. Does this really sound so liberating for women? Abortion does not set women free. Sure, maybe she can travel the world or chase down her dream career, but she can never outrun the trauma that has been inflicted on her. Women will have to carry this for the rest of their life. I once encountered a woman outside of a Planned Parenthood in Michigan when I was staying there for the summer and I was praying with some friends and she came up and started yelling. I calmly got up and started talking with her, asking what was wrong. As we talked, her defenses came down and she apologized. But what I-- but she asked if I would ever want to be unwanted. I explained to her that every child is desired by God. She began to cry. She'd suffered the trauma of abortion and had asked forgiveness, but hadn't been able to express to another the depth of her sorrow. According to what our society preaches, there was no reason abortion-- abortion should make her feel enslaved, yet she did. Fathers are no longer required to parent after having sex with a woman. Is this truly empowerment to be used and left like a box on the side of the road? Should we not instead be served by men as we were created for? As-- at-- for my days dialoguing on UNL's campus, I have seen that most pro-choice students only support abortion in the case of rape. However, USA Today found on May 24, 2019, that only 1 percent of abortions are due to rape. No woman should ever have to undergo the horrific experience of rape. I have more to say, but in conclusion I would just say that these abortion services do not serve women, but corporate CEOs. And true feminism is celebrating that you can be a boss woman and a supermom. So finally, I believe America will once again be the land of the free, thanks to women who know their body is worth more than a single choice. Thank you.

HANSEN: That's good. Thank you very much. OK. We'll take our next testimony from this side of the room. You got about room for one more person after him from this side of the room.

MERLYN BARTELS: Good afternoon, Senators. My name's Merlyn Bartels, M-e-r-l-y-n B-a-r-t-e-l-s. I'm here today to urge you to support this and to move this out of committee and put it into law, because we are all here today because of some woman that made the right choice. Let's make that right choice again and move this out of committee and put it into law and protect the unborn. Everyone that's for abortion has been born. They still have a voice in this. But I think about this and I wonder, is their life so terrible that they wish they weren't here or what, and is that why they want to force this onto somebody else? So thank you for your time. Please move this out of committee and make Nebraska a safe place. Thank you.

HANSEN: Thank you for your testimony. We'll take one more person.

KYLE POEN: Thank you all for being here. Thanks for the opportunity to speak today. Kyle Poen with Students for Life and Students for Life Action here in support of the Nebraska Heartbeat Act as filed. Students for Life has 1,300 chapters in middle schools, high schools, colleges and medical and law schools across all 50 states in America. We have more than two dozen-- two dozen chapters in Nebraska alone. We know that every successful abortion ends a human life, shown by Steve Jacobs in his diss-- dissertation for his Ph.D. at the University of Chicago. And 96 percent of biologists globally agree that life begins at fertilization. At this conception, a distinct human life is created with its own unique DNA, just as you and I have our own. As previously stated by Students for Life Action, one conflict of interest in current abortion practice is that we allow the person who will profit off of the death of an infant to counsel women on whether or not to buy an abortion. This shows the practices of abortion in Nebraska are misleading, making women and families vulnerable to coercion. Millennial-- millennials and Generation Z make up one third of the current electorate, according to the democratic data firm Catalyst. Students for Life Action ask-- Action asked a series of questions surrounding the reality of a heartbeat act. Millennials and Gen Z, by 47 percent to 38 percent, supported such a ban, and by an even larger margin, 60 percent to 25 percent, supported requiring doctors to check for a heartbeat before offering to commit an abortion. The Nebraska Heartbeat Act is a step towards protecting innocent lives of the baby and the health and lives of the mother. Enacting an ultrasound requirement to check for a fetal heartbeat before the decision of an abortion is made will ensure that the mother is more informed about

the state of her pregnancy. If you, the distinguished senators, or I, or anyone in this room was in a medical emergency, we would all come together and do everything we could for that person in order to keep their heart beating. We would not poison and dismember anyone in this room. It is beyond time to come together in that principled stance and to pass these protections for the pre-born as well as for the mothers here in the state of Nebraska. Thank you all.

HANSEN: Thank you. All right, so that will have to end our testimony for the proponents. We went actually about five minutes over. I got a whole host of people out there. We'll be ready to go at 4:45. So I want to make sure, everybody-- hey, if you filled out your white sheet, your opinion will at least be on the record that you were here and that your voice is heard the best you could. And if you want to even have your voice heard even more, make sure you try to email all of us on the committee too. And I know all of us read our emails as well, so. Again, sorry. Yeah, we'll take a break for about ten minutes as they shuffle other people in.

[BREAK]

HANSEN: OK. All right. Well, good-- I think it's good evening. Good afternoon and welcome to the Health and Human Services Committee. Some of you might have heard me go through this already once in the overflow room, but I'm going to go through some of this stuff again. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming and parts of Stanton Counties, and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my left with Senator Day.

DAY: Thank you, Senator Hansen. Good evening, everyone. My name is Senator Jen Day, and I represent Legislative District 49 in Sarpy County.

WALZ: Hello, my name is Lynne Walz. I represent Legislative District-- I can't even remember anymore-- 15, which is Dodge County and Valley.

HARDIN: Senator Brian Hardin, District 48, Banner Kimball and Scotts Bluff County.

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

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

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

HANSEN: All right. Also assisting the committee is our legal counsel, Benson Wallace, and our committee clerk, Christina Campbell. And our committee pages-- if they're still there-- Ethan and Delanie? OK. All right. They're over there. So just a few notes about our policy procedures for tonight. Please turn off or silence your cell phones. We will be hearing one bill and taking the order list outside. On each of the tables near the doors to the hearing room, or you might have-- already have already, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Christina or one of the pages when you come to testify. This will help keep an accurate record of the hearing. If you are not testifying at the microphone but still want to go on record as having a position on the bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note, if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will be included as part of the record as exhibits. We would ask, if you do have any handouts, that you please bring ten copies and give them to the page. We do use a light system for testifying. And for the next-- when I'm done here, for one-- for the next three hours we'll be hearing opponent testimony only. OK, so there shouldn't be any proponent testimony in the room. So for the next three hours, we'll be hearing opponent testimony. I'll be extending the same courtesy that we did for proponents. We'll go three hours. The-- we'll do three minutes per testimony for the first two hours, and then the last hour we're going to do two-minute testimony so we can kind of gets people through as much as we possibly can, so, trying to get the people heard. Now we do use the light system for testifying. Each testifier will have three minutes to testify, like I mentioned, or two minutes at the end. When you begin, the light will turn green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask that you wrap up your final thoughts very quickly, if you can. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on the-- well, we already went through the opening statement for the-- for the test-- for the introducer, so we don't have to worry about that. On a side note, the reading of testimony that is not your own is not allowed unless previously approved, and we do have a strict

no-prop policy in here. So if you have any props, any pictures, anything else, well kind of just keep them to yourselves, if you can, please. All right. I think-- oh, one more thing. When you do come up to testify, we'll have you exit out that door right there so we can kind of bring people in, so we can kind of keep funneling people in as we go. We do have invited testimony here, just like we did for the proponents. We will start with them first, and then as they-- as they kind of move out, then we will start moving and shuffling people around here a little bit, so it's-- yeah, I'll-- I'll try to take care of that. So with that, we will start with our first invited testimony, and so whoever would like to come up first with the invited testimony in the reserved seating. Thank you.

MEGAN WILCOX: Good afternoon, or evening, I guess now. My name is Megan Wilcox, M-e-g-a-n W-i-l-c-o-x, and I am here today to tell you why I am opposed to LB626. When my husband and I decided to try for a second child, it didn't take long for us to see those two little pink lines on the pregnancy tests and we were absolutely over the moon. We couldn't wait for the 13-week ultrasound, which is typically a joyous pregnancy milestone, as you finally get to see your little one taking shape. I will never forget that day, not because it was Halloween 2017, but because we heard the one word no one wants to hear: abnormalities. My OB told us that she detected abnormalities on the ultrasound concerning for a chromosomal defect, so she referred us for further testing in consultation with the maternal fetal medicine specialist at the Olson Center for Women's Health at Nebraska Medicine at 14 weeks. One week later, on November 7, we saw Dr. Carl Smith, who did another ultrasound, and we also met with a genetic counselor who talked us through the possible diagnoses we were facing: trisomy 13, trisomy 18 and trisomy 21. Dr. Smith informed us that the ultrasound was showing fetal cystic hygroma, a congenital malformation of the lymphatic system. And we were told in layman's terms that our little one's body was essentially swollen with lymph fluid, including the heart and lungs. There was no nasal bone and his intestines were growing outside of his body. Dr. Smith suspected trisomy 18 and recommended an amniocentesis for definitive diagnostic testing. Sixteen weeks: On November 22, an amniocentesis was performed for further chromosomal testing and a definitive diagnosis. The baby had not grown since the 13-week ultrasound. Seventeen weeks: On December 1, we received the news we didn't want to hear: full trisomy 18. Dr. Smith told us that full trisomy 18 was incompatible with life and he would support termination of pregnancy. We decided to make one more appointment to weigh our options, but at this point my husband and I were leaning towards termination. Eighteen weeks: on December 5, my

husband and I met with Dr. Ramzy Nakad, and he echoed Dr. Smith's recommendations. Because state law requires a 24-hour waiting period prior to performing an abortion, I went on December 7 to start the two-day procedure that my husband and I chose to do. My husband and I feel that religious and spiritual beliefs are deeply personal, and my intent is not to drag religion into this debate, but we don't subscribe to the belief that it's in God's hands. We didn't want the baby to suffer. We named him Bodhi [PHONETIC], which means enlightenment or awakening, and is a Buddhist concept-- concept synonymous with the state of nirvana, or being freed from suffering. It's been five years and I still can't describe the ache and longing I feel when I think about Bodhi [PHONETIC] and what we went through. But I have no regrets and I know we made the choice that was right for us and our family, a choice that we wouldn't have been able to make if LB626 had been law. Thank you for your time.

HANSEN: Thank you for your testimony. Are there any-- can I stop you for one second real quick? Are there any questions from the committee? Yes, Senator Day.

DAY: Thank you, Senator Hansen. And thank you, Mrs. Wilcox, for being here. I really appreciate it. I just wanted to mention my sister also lost a baby at 22 weeks of trisomy 18. I was also pregnant at the time and I remember going through that process with her when she was asked what she wanted to do and the absolute heartbreaking process that is. And from that day forward, I vouched that I would never force anyone to do anything against their will if they're in that situation, and I greatly appreciate you being here to share your story today.

MEGAN WILCOX: Thank you.

DAY: Thank you.

HANSEN: Is there any questions? Oops, stop one second. Sorry. [LAUGHTER]

MEGAN WILCOX: Sorry.

HANSEN: Yeah, it's-- especially with invited testimonies, we might have a few more questions for people, just in case. Are there any questions? Yes, Senator Cavanaugh.

M. CAVANAUGH: I just wanted to say, first of all, thank you for sharing your story and for being here. But I was asked to let people know that there are comfort buddies out in the hallway if anybody

needs that. So if you need that, I just wanted to make sure you knew that was available.

MEGAN WILCOX: Thank you.

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

MEGAN WILCOX: Thank you.

HANSEN: All right. We'll take our next invite in testimony. Hello. Welcome.

LIBBY CROCKETT: Thank you. Dear Chairperson Senator Hansen and the other members of the committee, thank you for allowing me to speak today. My name is Dr. Libby, L-i-b-b-y, Crockett, C-r-o-c-k-e-t-t. I live in Grand Island, Nebraska, and I am a board-certified obstetrician/gynecologist. I have lived in Nebraska my entire life, and I have practiced medicine here for the past 14 years. I am here today to state my opposition to LB626, which would effectively ban abortions in Nebraska. My personal experiences with abortion have been through my medical education and professional career, and these patient encounters have deeply shaped my views on abortion. I have the honor and responsibility to be with people in their most private moments. They share with me the most private and personal details of their lives. Therefore, my opinions on abortion come from working with real people and from their real tragedies. These professional experiences have made it clear to me that abortion is healthcare and needs to remain accessible, legal and safe in Nebraska. I feel comfortable speaking on behalf of my coll-- my physician colleagues that are here with me today and many who were not able to come in saying that we would all love to live in a world and a state where abortion was not necessary; a Nebraska where every pregnancy was planned and healthy; where every child was born into a loving, financially and emotionally stable home; where access to medical care, especially mental health services, was equitable and easy; and where every individual understood the science of how their bodies work, especially with regards to reproduction; where contraception was easily obtainable and never failed; and a state where rape and incest did not exist, or even if they did, justice and protection for victims through the criminal and legal systems would be easy to navigate, effective, safe for the victims, and not trauma-inducing; where trusted adults never took advantage of their power and where women and children could always find their beds at night to be places of comfort and safety and not places of torture and sexual abuse. But Nebraska is

not this utopia. In my professional experience, many people facing a decision about pregnancy actually do choose to continue their pregnancies, but some do not. But it is the option of choice that provides humanity, dignity and compassion for people in crisis. I do not want to practice in a state where I cannot have an open and honest conversation with patients about their care, and where comprehensive healthcare is not available to them. What we need in Nebraska is more compassion and support for each other as humans, particularly for those that are most vulnerable in our communities. LB626 will never achieve that goal. I ask for you all to oppose LB626 and not advance this bill from committee hearing. Thank you.

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

M. CAVANAUGH: Do you--

RIEPE: Please.

M. CAVANAUGH: Thank you. Thank you, Dr. Crockett. One of the things you mentioned here, first of all, that you practice in Grand Island, which-- I know Grand Island is not a rural town, it's a city, but you are in a more rural part of the state. And how would this bill impact access to reproductive healthcare if enacted?

LIBBY CROCKETT: So currently, most available abortion resources for patients are in the eastern part of the state, and so it is difficult already for patients that live out of-- out-state Nebraska to access those care services. We actually see quite a few people who present late to care, who did not know they were pregnant, and I'm actually participating with kind of a-- a study right now looking at how does that happen and why and how can we improve that. But all of those-- you know, distance is a huge barrier. And then when you can't afford access to entry care early or even be able to have the ways to even identify that you're pregnant or how to access care or how to navigate that, I think that that's higher and more significant in western Nebraska.

M. CAVANAUGH: Thank you. I have an--

RIEPE: Go ahead.

M. CAVANAUGH: OK, go at it. You mentioned in here rape and incest. If a patient comes to you and says that they are a victim of rape or incest, what are the protocols that you have to go through?

LIBBY CROCKETT: So if they're an adult, they-- it's up to them how they would proceed. And in general, the way that those patients present to me are typically well after the event has occurred. Many come and are requesting STD testing, pregnancy testing because they either were too scared to present to the emergency room and report it, or they tried to and it was just a very stressful event. I have found in practice over the years that even as people tell me their, you know, their gynecologic and obstetrical and, you know, histories, that just a lot of women do not report their sexual assaults. And so-- if it's a minor, that's different; there are required legal reporting avenues that we have to follow through with that. But as an adult, it's up to them what-- how they would wish to proceed.

M. CAVANAUGH: And in this bill, do you view it that it would be your responsibility to report that they were a victim of rape in order to provide that care?

LIBBY CROCKETT: I think what would happen with this bill is because of the gestational age being so low, very few abort-- people would be able to make it for abortion care and the people that are providing abortions in the state would be gone. So even people presenting with rape and incest who-- it's not clear how-- I mean, in the bill, it kind of says you could write that that happened. But I think as a practicing physician, that would be a place of discomfort where we would-- wouldn't be comfortable, like do we need a conviction to refer? You know, there's a lot of ambiguity there. And I think what would, you know, essentially happen is that people who were victims of rape would actually still have to travel out of state to obtain abortion.

M. CAVANAUGH: With this bill?

LIBBY CROCKETT: With this bill.

M. CAVANAUGH: Thank you.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. I think I heard you said "we," so I assume that you don't practice solo, that you practice in a group.

LIBBY CROCKETT: Um-hum.

RIEPE: My question along that line would be, is, have you or your group performed elective abortions?

LIBBY CROCKETT: We do not perform elective abortions in our practice, no. You'll find that most general OB/GYNs in the state often don't, and most of the places in the state where people get abortions are located in a couple of small clinics. That has a lot to do with employer requirements, politics within, you know, medical provider groups. It's also probably a lot of legal infrastructure for people to kind of navigate whether or not they're providing elective terminations to patients. And then also-- also, you know, many of us in this room, just because we're here saying we oppose this bill, we all fall into different spectrums of values and many would be comfortable performing elective terminations and many would not be. And so, you know, I think that that's important to recognize. We are all human beings and fall in this value system. But I think, you know, speaking for myself and having had many conversations with other physicians that I know are in this room, we really feel like that's still-- it shouldn't be a political issue, but a healthcare issue that a patient has access to this care.

RIEPE: A follow-up question, if I may, Chairman?

HANSEN: Yes.

RIEPE: Thank you. In Grand Island, where is the closest opportunity for someone to have an abortion. Is it within--

LIBBY CROCKETT: Lincoln.

RIEPE: Lincoln? That's it?

LIBBY CROCKETT: Um-hum.

RIEPE: OK. That's what I wanted to know. I appreciate it. Thank you for being here.

LIBBY CROCKETT: As far as I know.

HANSEN: Any other questions in the committee. Seeing none, thank you very much for your testimony.

LIBBY CROCKETT: Thank you.

HANSEN: All right. We'll take the next invited testimony. Welcome.

EMILY PATEL: Thank you. Good evening. Chairperson Hansen and members of the Health and Human Services Committee, my name is Dr. Emily Patel, E-m-i-l-y P-a-t-e-l. I'm here today in opposition to LB626. I'm

a Nebraska native, a mother, a wife, and a physician. I completed my higher education and medical training through the University of Nebraska system, UNL and UNMC. I'm double board-certified in obstetrics and gynecology and maternal fetal medicine. I spent over a decade of my life in medical training to become an expert in high-risk pregnancy care. My responsibility is to take every woman and fetus through pregnancy and help ensure a healthy outcome for both. However, this is not always the reality of the work that I do. Maternal morbidity and mortality is a public health crisis in the United States. Among industrialized nations, the U.S. ranks last and sees three times more maternal deaths than the next industrialized country. Preliminary data indicates that states with bans like LB626 will exacerbate the existing maternal health crisis. Multiple studies have shown the negative impacts of restrictive abortion laws. For example, in 2021, Texas passed a six-week ban similar to LB626. One study examined what happens when the amniotic sac breaks prematurely. After the Texas law passed, it was illegal to offer termination in this situation, and the maternal morbidity nearly doubled from 33 to 57 percent. Women experienced hemorrhage, ICU admission, need for surgery, and even hysterectomy due to overwhelming infection. Restri-- restrictive bans such as LB626 will have negative impacts on individuals and will continue to worsen our public health crisis. Despite doctors sounding the alarm, some legislators are set on taking medical decisions away from the patient and physician. I recently took care of a patient I will call Jane. She was a mother of two and hoped for a third child. However, Jane had significant medical complications such that her life was at risk should she continue the pregnancy. During one of our first visits, we discussed those risks and her options. Jane was terrified for her health, worried to leave her children without a mother and anxious about her potential outcome. She looked at me and asked, if there is an abortion ban here, who will take priority, me or the fetus? I felt like I couldn't give her a straight answer due to the ambiguous nature of this proposed law. Why should patients worry they will not receive appropriate healthcare, that best practices will not apply because of a law that's not based in medical science? This law will ask physicians to discount their training and act in harmful ways at-- at the expense of a patient's health and well-being. My testimony today highlights the complexities of pregnancy care. Compounding those complexities is LB626. Ultimately, I care for mothers and fetuses and want to ensure healthy outcomes for both. But as I have demonstrated today, a successful pregnancy is never guaranteed. I want to continue to be able to care for patients in the best way I know how and without interference from the government. Thank you for your time.

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

DAY: Thank you, Chairman Hansen. And thank you, Dr. Patel, for being here today. So you mentioned in your testimony, after the Texas law passed, it was illegal to offer a termination in this situation, referring to the amniotic sac break, and maternal morbidity nearly doubled from 33 percent to 57 percent. It was cited earlier that no women have died since any of these laws have passed in other states. So can you clarify that for me, please?

EMILY PATEL: Yeah. Yeah, no, I'd be happy to speak about that. So maternal mortality data does not come out instantaneously. That usually takes time. For example, Nebraska's data for-- that ended in 2020 just came out in 2022, so we will not have definitive data on maternal mortality for years at this point. It just takes time to compile that data and to actually research it appropriately. So that is not information that we have of yet, but we do have data that's indicating higher morbidity. And while we talk a lot about mortality and death, because that is alarming, of course, I don't think that we should discount the fact that women will experience morbidity as a result of these bans as well. This can lead to, as I mentioned, things like surgeries and hysterectomies and loss of the ability to have children, and infertility-- there are a lot of consequences. So while death is a big one and the ultimate consequence, there are a lot of other consequences that we will see.

DAY: Thank you.

HANSEN: Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Dr. Patel, for being here and for clarifying that information about the data. You are a specialist in sort of high-risk pregnancies. Correct?

EMILY PATEL: That is correct.

M. CAVANAUGH: So could you talk a little bit and explain to the committee what are fetal anoma-- anomalies or what are some typical fetal anomalies?

EMILY PATEL: Yeah, so--

M. CAVANAUGH: Probably not typical.

EMILY PATEL: Yeah. So a fetal anomaly is an unexpected condition that arises in the fetus. That is kind of a general definition. It can range from things like an absent bone in the nose to something like a congenital heart defect to absent kidneys. There is a huge spectrum of congenital fetal anomalies that can exist. And that is part of my job every day, is to help make those diagnoses.

M. CAVANAUGH: So if a fetus has no kidneys, what is the probability of survival outside of the womb?

EMILY PATEL: We consider that a lethal fetal anomaly, meaning that the baby would not be able to survive after birth with that particular anomaly without-- with absence of the kidneys. Obviously, the kidneys are needed for blood filtration. And additionally, they will never have any amniotic fluid surrounding them in the amniotic sac, and that means that the lungs will never develop properly.

M. CAVANAUGH: So in this bill, do you feel like it accounts for that type of fetal anomaly?

EMILY PATEL: No, I see no exception for fetal anomalies. And I think that this-- I think that that's against standard of care. And it's unethical to be able to allow-- to not allow patients to be able to make a choice with regard to a situation like that, like a serious fetal anomaly, and that should be allowed.

M. CAVANAUGH: Ask one more question? Oh, sorry.

HANSEN: Senator Riepe.

RIEPE: [INAUDIBLE]

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: OK. The standard of care, you just mentioned standard of care. Could you tell us what that means?

EMILY PATEL: Yeah. So our national organizations, American College of Obstetricians and Gynecologists, my personal society, Society for Maternal Fetal Medicine, that maternal fetal medicine physicians are part of, have national guidelines to help guide our practice, day in and day out. And as part of that national-- those nat-- national guidelines, abortion care is considered standard-of-care medicine. When we-- when I counsel patients every day, I'm taking care of patients that may have fetal anomalies. I'm also taking care of patients that might have maternal complications. Part of what I do

every day is counseling them about those conditions and telling them what their pregnancy may look like moving forward. Sometimes what it may look like could be very dangerous for the mother; it could be lethal for the fetus. There are a lot of different scenarios that I encounter every day. Part of what I do every day is counseling them about those outcomes, but also talking about options that they may have moving forward. Abortion is an option that women need to have in these circumstances.

M. CAVANAUGH: Thank you.

HANSEN: Senator Riepe.

RIEPE: I have two questions. One of them is, you used the term-- it says bans LB626 will exacerbate-- I don't know if it was-- is that a 5 percent increase, 10? I'm-- I'm just trying to-- is that-- "exacerbate" is kind of an open term.

EMILY PATEL: Sure. Sure. So I-- all I can do right now is point to some data that we have, which I outlined in my testimony today. So going back to that Texas ban, we already have some preliminary data that showed a doubling of morbidity--

RIEPE: Doubling huh?

EMILY PATEL: --of-- of poor outcomes related to that ban. And so I can guarantee that there will be worse outcomes in terms of morbidity. And I would stand here in testimony today and say that there will be deaths as a result of abortion bans.

RIEPE: So instead of exacerbate, it might be more.

EMILY PATEL: Correct. There will be-- there will be worse outcomes and there will be more of them.

RIEPE: May I take a second question?

HANSEN: Yes.

RIEPE: More and more we read-- I-- I'm a former hospital administrator, so I follow some of this stuff. I'm certainly not an expert. You are. But they're talking about some corrective surgeries while the infant-- prior to birth and as an expert, what's the status of that? What does it look like--

EMILY PATEL: Sure.

RIEPE: --projected forward a few years down?

EMILY PATEL: Yeah.

RIEPE: I'm not saying to be able to go in and--

EMILY PATEL: Yeah--

RIEPE: --do a kidney transplant.

EMILY PATEL: Sure. Yeah. No, there are-- thank you for that question. There are definitely situations in which fetal surgery is an option, but those are few and far between. An example would be spina bifida. But that being said, that is not always-- there-- people have to meet criteria to be able to be candidates for that, and the fetus does also. So, again, these are very rare scenarios that we were talking about, and things like renal agenesis or absence of the kidneys would not be a situation in which we could offer any kind of a fetal care.

RIEPE: OK. Thank you. Thank you for your expertise.

EMILY PATEL: Thank you.

EMILY PATEL: Any other questions from the committee? I'm a-- oh, yes, Senator Day.

DAY: Sorry, I have-- just have one more. So I mentioned to the introducer in the opening about the-- the bill references reasonable medical judgment, and a handful of testifiers said that that provided a lot of leeway for the doctor to make the decision between themselves and the patient. How does that affect-- if it only says "reasonable medical judgment" and provides, you know, exceptions for the life of the mother, rape, incest, how does that affect your ability to practice medicine, like do you have to consult an attorney before you make those decisions? Or how--

EMILY PATEL: Yeah.

DAY: --what does that look like in, in application?

EMILY PATEL: So not having a ban here now, I don't know how this is going to technically work in application, but I can tell you from my conversations with people in other states where these bans have taken effect, they in many circumstances are turning to hospital attorneys to get advice on how to proceed with regard to medical care. And I went through over a decade of training to become an expert in my

field, and we need to continue to allow physicians who are experts in this field to make decisions with patients together and not include the Legislature and not include lawyers in that decision making. So, yes, I think there are a lot of hospitals where-- where these bans have taken effect that lawyers are now having to intervene and get involved and decide whether or not certain cases can move forward--

DAY: OK.

EMILY PATEL: --or there are questions about it, which can lead to delay of care.

DAY: OK, yes.

EMILY PATEL: That would be another point that I would say.

DAY: And that would be my next question. I said I had one question, but I think I had two. When there is a delay of care, particularly when there's an emergency, a medical emergency-type situation-- maybe she is in critical care, she could potentially be put into critical care, maybe she's going to go into sepsis, she's already septic. What does that mean for the-- the person who's pregnant, the patient? If they're-- I mean, is--

EMILY PATEL: Right.

DAY: --there a timeline where it becomes-- is there any amount of time that it's safe for you to take to, to, to talk to an attorney, or what does that look like?

EMILY PATEL: Yes. So the reality is that in real time, these decisions can be split-second decisions. Additionally, I could have a patient who is well, sitting in front of me right now, but in 15 or 30 minutes is critically ill or getting sick very fast. A good example of that would be a hemorrhage. They could start off with some light bleeding, but before we know it, we could be having a hemorrhage that's going on. So that's one example, but sepsis or infection is another example where oftentimes people are well until they hit a point and now they are not well anymore. We do not want to have our hands tied and waiting till they hit that point where we're sure that we're not going to be held liable or be going against a law. We do not want to wait until that point where they're critically ill to make those decisions. Their outcomes absolutely will be worse for that.

DAY: OK. Thank you.

HANSEN: Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you.

RIEPE: She always beats me.

M. CAVANAUGH: Thank you. That spurred some more questions for me. So one of the concerns that I have with this legislation is that even though it does make exceptions that in the medical, in the-- when you're in the moment, are doctors going to feel confident in making these judgment calls and not be concerned that they're going to lose their license or even suffer some criminal penalties? So can you speak to the way that this is written currently? Do you feel that you-- do you feel confident that this accounts for your ability to use your medical judgment without retribution?

EMILY PATEL: No, I don't think that it can possibly account for every scenario that I may face. There may be some that to everybody is very clear cut. And we know, OK, we need to act now. But there are so many shades of gray and this bill cannot account for all of those. If you trust us as physicians to be able to do our job and do it competently and with our expertise, then we should not be having bills like this because it's really hindering our ability to take care of patients the best way we know how.

M. CAVANAUGH: Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you. I have such an appreciation for your training that I, I want to quiz you while I have you here. I think that LB626 does not try to invade into the art side of it because they think if art--

EMILY PATEL: And to-- can you say that one--

RIEPE: In the language of the bill, there's allows for physician, quote unquote, reasonable judgment-- professional judgment. So to me, that's kind of a-- well, it's an expanding term and I don't think that-- that's always been the art of medicine.

EMILY PATEL: Sure.

RIEPE: That you have to make a decision, you have to make it on the site. So then it's interpretation of how harsh would the interpretation of--

EMILY PATEL: I--

RIEPE: --LB626 be?

EMILY PATEL: And I think, I think that our testimony today actually highlights this point great because if we're talking about, you know, expert opinion or best medical judgment, we had physicians who were supporting this bill earlier in the day. So you can see that there's going to be a wide differing of opinions and who is making that decision ultimately and who, who is right in making that decision. But what I want to point out is that our personal beliefs should not be interfering with what we're doing as physicians. We've taken an oath to care for patients regardless of their ethnicity, their religion, their race, their personal views. And so my personal views should not get in the way of me taking care of patients. And if abortion is an option for that patient, they should be offered that. It is up to them to decide if that is in line with their personal beliefs and views and that's how it needs to remain, I think.

RIEPE: I appreciate it. As you were talking, I saw some white coats there and their heads were bopping, so. OK, thank you so much. Thank you, Chairman.

HANSEN: Can I ask a couple of questions?

RIEPE: You're the Chairman.

HANSEN: Thank you. I do have a few questions; one pertaining to your testimony, particularly the second paragraph when you were talking about what happened with Texas when it went to the, the six-week ban similar to this. That maternal morbidity nearly doubled 33 to 57 percent. I'm trying to think of the statistical-- a little statistical analysis here.

EMILY PATEL: Um-hum.

HANSEN: The majority of abortions-- is there an income or a health disparity that you typically see?

EMILY PATEL: I don't think that I could answer that question accurately right now on the spot.

HANSEN: That's fine.

EMILY PATEL: Yeah.

HANSEN: I was just-- and maybe somebody else can.

EMILY PATEL: Yeah, I'm sure that somebody can.

HANSEN: There might be a correlation between those who maybe would have gotten an abortion if there's a health and income disparity and they carry that to term, that might end up leading to some more maternal morbidity based on those factors, right?

EMILY PATEL: I think that what I can explain with regard to this a little bit more clearly since I have a little bit more time, is just that this study in particular is studying specifically when the amniotic sac breaks early before a baby can survive on the outside. So, for example, somebody whose water breaks at 18 weeks, that would be an example of that. Pre, pre-Texas law, pre-ban, people were allowed to then have an abortion in that circumstance because of the risk to the mother being infection, hemorrhage, hysterectomy, sepsis, et cetera. After the ban, because it is a heartbeat ban similar to this one, they were not allowed to proceed with an abortion. They'd have to continue on with what we call expectant management, meaning just waiting for them to either get sick or continue the pregnancy. So when they compared those two groups of people who had the ability to have a termination or an abortion versus those that did not, that's where they saw the discrepancy in the morbidity and that there was higher risks for those patients.

HANSEN: Gotcha.

EMILY PATEL: That, that--

HANSEN: OK, that makes sense. And when you were leading-- the way you were leading the paragraph kind of led me to believe some differently.

EMILY PATEL: OK.

HANSEN: But the way you explained it makes sense now. One other question-- when it comes to the lethal fetal anomaly, when are they typically detected? Is it before 10 weeks, before 20 weeks?

EMILY PATEL: The vast majority of fetal anomalies are going to be diagnosed at a 20-week anatomy ultrasound. That's something that I do on a daily basis and read those ultrasounds. That's part of my day-to-day job. So most of them are going to be at 20 weeks or thereabout. There are very rare scenarios in which we might diagnose conditions or have suspicions for conditions in the end of the first

trimester, 10 to 12 weeks. But certainly, we're not detecting fetal anomalies by six weeks.

HANSEN: I think the ones that are probably detected later aren't as severe or, you know, life-threatening, maybe?

EMILY PATEL: No, not necessarily, actually.

HANSEN: OK. I don't know because, like--

EMILY PATEL: Yeah.

HANSEN: I didn't really, I--

EMILY PATEL: Yeah, no.

HANSEN: --didn't really know for sure and, like, if--

EMILY PATEL: That's-- yeah. No, that's a fair question.

HANSEN: --maybe it might seem easy. The earlier you see it, the worse it is but, but that must not be the case.

EMILY PATEL: Not, not-- so we can't see a lot of the fetal anatomy in detail early on.

HANSEN: OK.

EMILY PATEL: So that's why we wait until 20 weeks where we can see all of the structures of the fetus very clearly at that point in time.

HANSEN: Gotcha. OK. Thank you. And I want to-- one last question. I just want to pose the same question that I did earlier. One of the biggest concerns that I hear with this bill and the emails that I get is the concern that the woman may not know they're pregnant by six weeks. I was hoping you can expound on that a little bit and what your thoughts are about that and how--

EMILY PATEL: Sure and to be--

HANSEN: --how difficult it is or not.

EMILY PATEL: --to be fair, I know that there is somebody who is going to be speaking about that specifically, but I'm also happy to kind of touch on that. So when we date a pregnancy, we date it by last menstrual period. Two weeks after the first day of the last menstrual period, a woman typically will ovulate, OK? So now we're two weeks in.

That is on average, but there is a lot of variation in that depending on the person. About-- almost ten, ten days or so after that would be the very first time that you might be able to detect a pregnancy on a pregnancy test, OK? So now we're up to about four, four weeks in at this point in time. And that's if somebody is trying to get pregnant, they are checking, they're making sure, and-- but the first missed period that they would have would happen at about four to five weeks after, after the last menstrual period. So we're typically-- most people are not going to have any clue until they're at least four to five weeks in, most people. And that's if they're really tracking, they have very normal cycles and there is no other abnormalities. And that's not how the, the body works. It's not always the case, and usually not actually. So that is under the very best circumstances. So then we're leaving about one to two weeks or so.

HANSEN: OK. The fetal heartbeat is typically detected after conception about four weeks or is it at six weeks?

EMILY PATEL: It's, it's somewhere between about five-and-a-half to six weeks.

HANSEN: So five-and-a-half to six weeks after conception, not from the, from the first period?

EMILY PATEL: Five weeks after the first, first day of the last menstrual period.

HANSEN: OK, so-- OK, got you. All right.

EMILY PATEL: Yeah.

HANSEN: Thank you. Any other questions from the committee?

RIEPE: Thank you.

HANSEN: OK. Yeah, thank you for your testimony.

EMILY PATEL: Thank you.

HANSEN: All right, we will take our next invited testifier. Welcome.

MARY KINYOUN: Thank you. Chairman Hansen, members of the Health and Human Services Committee, thank you for allowing me to speak with you today. My name is Dr. Mary Kinyoun, M-a-r-y K-i-n-y-o-u-n. I'm here today independent of my employer and speaking on behalf of the Nebraska section of the American College of Obstetricians and

Gynecologists, representing 227 practicing OB/GYNs who care for women and families in our state, asking you to oppose LB626. We are concerned about the unintended serious health consequences that will befall our patients should this bill become law. Exceptions to this bill for medical emergencies are vague and despite what proponent Dr. Skop stated, ACOG, or the American College of OB/GYN, does not in fact have strict guidelines about what constitutes a medical emergency. ACOG affirms that delays in abortion care can lead to complications such as life-threatening infections, hemorrhage, need for hysterectomy and even death. Women in states like Texas are already sharing stories about waiting to become sick enough to receive their abortion and even being denied miscarriage care due to provider fear and confusion regarding these unclear laws. Maternal morbidity and mortality in the United States is already unacceptably high and LB626 will augment these statistics in Nebraska. LB626 seeks to punish physicians who engage in what would be considered an illegal abortion with revocation of their medical license. The vast majority of rural counties in Nebraska are already considered maternity care deserts, which means there are no obstetric providers and/or hospitals that provide OB care. Restricting physicians' ability to practice evidence-based OB/GYN care and threatening medical licenses will weaken the already tenuous supply of obstetric providers, particularly in rural Nebraska. To be an accredited OB/GYN residency program, programs must provide surgical training and abortion care as regulated by the Accreditation Council of Graduate Medical Education. Restrictive abortion laws make obtaining this training nearly impossible and programs could lose accreditation. All OB/GYN physicians must have the capability to safely evacuate a uterus from-- in life-threatening scenarios such as hemorrhage or infection. Without this training, patients will suffer. Finally, most resident physicians stay near the location where they trained. If there are accreditation issues for residency programs or applicants deem Nebraska to have inadequate abortion curriculum, we will likely see a decrease in our already-threatened workforce. Again, particularly, particularly could be in rural areas. In conclusion, as physicians who provide expertise in women's health in our state, we, the Nebraska section of the American College of OB/GYN, urge you to oppose LB626. If this bill becomes law, it will cause real and measurable harm to people in our state and the practice of medicine. Thank you for allowing me to testify today and I'm happy to field any questions.

HANSEN: Thank you for your testimony. I'm sorry for the noise, but this is how it's been like since we started. This is-- things echo in here, so I apologize-- when they open the doors. And one other thing,

when we do kind of shuffle around and stand up, that seat usually smacks against the back all the time and I just-- so if you can maybe hold on to it so it cuts down the noise a little bit. All right, thank you for your testimony. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your testimony and for being here today. You touched on-- towards the bottom of your testimony-- about the accreditation residency program. And I had asked Dr. Patel about standard of care and if, if this would conflict with what is the standard of care. And she mentioned that it would with national guidelines. Can you explain to us if-- how or if-- if this bill were enacted, would it impact-- you, you kind of touched on it here, but one of my concerns has been how does this impact the education of doctors in our state? Because we have such a great-- multiple great medical facilities and schools in the state, how or does it not impact that?

MARY KINYOUN: So the ACGME, or the Accreditation Council of Graduate Medical Education, which is the governing body of all residency programs, not just OB/GYN. So just for clarity, you graduate medical school and then you complete a residency program in whatever you specialize in, family medicine, OB, surgery, whatever it is. The ACGME governs that and creates standards for which programs have to comply in order to have an accredited residency program. For OB/GYN, there must be curriculum and training provided for surgical termination of pregnancy. They also have, like-- have to have curriculum as far as didactic education regarding that too. So if this bill became law and essentially we have no more abortion providers left in the state of Nebraska, it becomes a real challenge to provide-- to say that we have this curriculum and to maintain accreditation. So there are programs that are sending their residents halfway across the country. Who pays for that? How do we, how do we ensure that, you know, these resident-- these OB/GYN residency programs that we have in the state are, are not losing the ability to keep this training so they can have their accreditation?

M. CAVANAUGH: So-- I'm sorry. Can I follow up?

HANSEN: Yep.

M. CAVANAUGH: OK. So in order-- if this were enacted, as it has been in Texas. So Texas, in order-- any medical schools there, they have to send their students out of state to maintain accreditation?

MARY KINYOUN: Not necessarily medical students. This applies to OB/GYN residency--

M. CAVANAUGH: Sorry, yes.

MARY KINYOUN: --programs. And so, for clarity, not every OB/GYN resident has to perform abortions. You can opt out of that training. That being said, you don't have to perform the tr-- you don't have to perform that procedure. But all OB/GYN programs must have pathways for residents to complete that surgical training.

M. CAVANAUGH: OK. Thank you.

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

DAY: Thank you, Chairman Hansen, and thank you for being here and I appreciate your testimony. So related to the question of training and accreditation, I was reading about doctors in Tex-- or to-be doctors in Texas, Texas, excuse me, having to train abortion procedures on papayas because under the law, they couldn't perform that on patients. Can you help me understand that a little bit better and how it would relate to--

MARY KINYOUN: Sure.

DAY: --a bill like this?

MARY KINYOUN: Yes. Thank you for that question. So a lot of medical education is simulation, right? And I think it's important to note that the procedure to perform an abortion, an elective abortion, is the same procedure to perform an abortion that's threatening the life of the mother, right? OK, so you have to know how to do that to be an OB/GYN to be able to save that patient's life when she is coming in with her medical exception, like bleeding or hemorrhage. So in order to try to get some sort of, you know, training, with numbers for these procedures being far less because elective terminations aren't being performed and things of that nature, we do result-- we do do simulations like the papaya lab. That's a pretty common early first step. That's great for, you know, an intern-level resident. That's great for a medical student interested in OB/GYN, wanting to kind of get familiar with the tools, but it's not sufficient. There's no, there's no papaya that can mimic a hemorrhaging uterus and how you manage that in the operating room in real time.

DAY: OK. Thank you. So essentially, a doctor who in, in-- if LB626 were to pass and a woman's life was in danger, and that doctor needed

to be able to provide an abortion to be able to save her life, potentially the only other time that doctor would have had any training in that situation would have been on a papaya.

MARY KINYOUN: Not necessarily.

DAY: OK.

MARY KINYOUN: So this is still the procedure that we do for miscarriage management. This is still the procedure that we need to do for threats to maternal life. But the problem is, is that you need people that are really comfortable with this procedure teaching residents. And so there are-- we have people that are more specialized in performing this procedure than others and feel more comfortable than others. And if those folks leave our state due to these restrictive laws, I, I worry about the capability to have, you know, the best training for our resident physicians.

DAY: OK, understood. Thank you.

HANSEN: Yes, Senator Cavanaugh.

M. CAVANAUGH: Sorry, I-- were you going to go?

RIEPE: Not until you get done.

M. CAVANAUGH: Thank you, Senator. I have three children so you'd think I would know the answer to this question, but I do not recall. At what point do you have your first ultrasound?

MARY KINYOUN: That is incredibly variable. I would say that the vast majority of women, and the standard practice in many of the OB/GYN clinics in our area, eight weeks is the first time you see a doctor or a nurse midwife or a nurse practitioner. You may or may not get an ultrasound at that visit, so--

M. CAVANAUGH: Yes.

MARY KINYOUN: --it is incredibly variable. But usually the earliest people have a-- like, a regular, healthy patient that's not having symptoms, we try to get them seen for their new OB visit between eight to ten weeks, but certainly there-- that's someone that has good health insurance, is well-connected. There are so many barriers to obtaining healthcare, unfortunately, so it's not uncommon that I see people at 18 weeks, 20 weeks for their new OB because of different barriers for care--

M. CAVANAUGH: OK.

MARY KINYOUN: --unfortunately.

M. CAVANAUGH: I'm now remembering those ultra-- when those ultrasounds happened.

MARY KINYOUN: Yes.

M. CAVANAUGH: Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Because I have so much expertise in the room, I want to take advantage of that.

MARY KINYOUN: Sure.

RIEPE: I'm assuming that as a OB/GYN and also at the hospital that you practice at, that you have-- you talked about hemorrhaging and so, do you have a protocol that would address that? I'm sure you have to type and crossmatch, and I don't know how long that takes. But if you have a delivering mom and you have massive hemorrhaging, how fast can you respond? I'm sure you can respond to it, it's just a matter of how fast.

MARY KINYOUN: And it depends where you are. So I'm lucky to practice in Omaha at a large hospital where there is blood on tap. You know, we can get a blood bank-- to the blood bank really easily. We can get-- we have trauma blood that's not cross-matched and we can give-- or not-- that's O-negative so it would be able to go to anybody. That's not the case in other places throughout the state so it's incredibly variable based on where you live, unfortunately.

RIEPE: OK. But in Omaha, how many minutes would that take?

MARY KINYOUN: I think that we can get blood to our operating rooms within minutes.

RIEPE: OK, OK. It relates back to another bill that we talked about.

HANSEN: OK.

RIEPE: Just trying to get cheap-- trying to get some cheap advice so if it seemed off--

MARY KINYOUN: Happy to provide.

RIEPE: --scale from this, I apologize, Mr. Chairman.

HANSEN: We don't get paid a lot as senators so we got to do anything we can to--

MARY KINYOUN: Sure.

HANSEN: Any other questions from the committee? All right, seeing none, thank you--

MARY KINYOUN: Thank you.

HANSEN: --for your testimony. We'll take our next invited testimony, please. Welcome.

CHRISTON MacTAGGART: Thank you. Good evening, Senator Hansen, members of the committee. My name is Christon MacTaggart, spelled C-h-r-i-s-t-o-n, last name is M-a-c-T-a-g-g-a-r-t. I am the executive director of the Nebraska Coalition to End Sexual and Domestic Violence. I'm here to testify on behalf of the coalition and our network of 20 direct-service programs who collectively provide services at all 93 counties to survivors of domestic violence, sexual violence, sex trafficking and stalking. Honoring survivor choices and navigating trauma and healing is the very foundation of how we do all of our work, and so it's with this grounding philosophy that we oppose LB626. The 2020 Nebraska Statewide Intimate Partner in Sexual Violence survey found that over 50 percent of Nebraska women experience rape in their lifetime, and more than 50,000 Nebraskans have experienced unwanted pregnancy due to rape. While LB626 includes an exception for survivors of sexual assault and incest, it also requires a survivor bear their trauma in order to access that care. It requires sexual assault be made part of their medical record and suggests medical professionals must report to law enforcement, even though only a small percentage of survivors ever make that choice. Sexual assault survivors don't owe us their trauma and it should not be a mandate for them in order to access healthcare and take control of their bodies back. Additionally, this bill will have a devastating impact on domestic violence survivors due to high rates of birth control sabotage, pregnancy coercion and force in abusive relationships. It's not surprising that when intimate partner violence is present, the chance of an unintended pregnancy doubles. This issue is called reproductive coercion. It's a common tactic for abusers to engage in to maintain control over the survivor and the relationship. And our programs have thousands of stories of what this looks like and the narrative they hear from survivors every day in every county. This,

too, is sexual violence and this bill would provide no options for survivors when a forced pregnancy occurs. Since nearly half of Nebraska women experience physical violence at the hands of their partner during their lifetime, the impact of that can't be ignored. Survivors of domestic and sexual violence experience severe violations of their body. Regaining control over their bodies and lives is essential to their healing. Our work as advocates is supporting victims in that journey. If a survivor of any form of violence decides they cannot go through with a pregnancy resulting from those violations, they deserve access to care that is not conditioned on their willingness to share the traumatic details of their victimization. And we ask you to consider the harm that LB626 would cause survivors and not vote this bill out of committee. I am happy to answer any questions that you might have.

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

M. CAVANAUGH: Thank you. Thank you for being here, Ms. MacTaggart. You're the first person in I don't know how many hours to talk about this specific issue. So, first of all, thank you for that. This has been something that's been of a great concern to me is how are we re-victimizing and traumatizing victims of assault? It's my understanding in reading this bill-- and I don't know how familiar you are with the ins and outs of the bill-- but that this does require involving-- police involvement if you are to receive abortion care in the instance of rape and incest. Is that your interpretation?

CHRISTON MacTAGGART: I-- my sense from reading it is that it's not entirely clear, but it suggests that the medical provider may need to contact law enforcement.

M. CAVANAUGH: And because of your background-- and I don't actually know the answer to this. Is it-- when a victim of sexual assault goes in for abortion care, it is not automatic that, that would be put in some sort of medical record currently.

CHRISTON MacTAGGART: I mean, I assume that it would-- the sexual assault would not necessarily be part of the medical record--

M. CAVANAUGH: Right.

CHRISTON MacTAGGART: --unless-- I mean, I also don't know that that's my expertise because I'm not a medical professional.

M. CAVANAUGH: OK. That's OK.

CHRISTON MacTAGGART: But I would say generally right now it doesn't-- a sexual assault survivor isn't required to disclose that to access abortion care. But under this bill, they would be required to access abortion care so I think that's a difference.

M. CAVANAUGH: And it would be required to be put in their record as the reason, right?

CHRISTON MacTAGGART: The-- my, my reading of the bill states that it is required to be put in the record.

M. CAVANAUGH: And I just, for the room, want to remind people because I see some people-- this has been a difficult testimony specifically-- that there are comfort buddies out in the hallways if anyone needs that.

HANSEN: Any other questions from the committee? All right, seeing none, thank you very much. And we will take our next invited testimony in favor of LB626-- opposed, excuse me, opposed to LB626.

M. CAVANAUGH: It's a long day.

HANSEN: Yeah. Good-- welcome.

DEYANNA BOSTON: Good afternoon. Good afternoon and thank you, Chairperson Hansen and the HHS Committee for your time today. My name is Deyanna Boston, D-e-y-a-n-n-a B-o-s-t-o-n. I am a family physician that provides obstetrics care here in Nebraska. I stopped seeing patients early today because I thought it was important to speak in opposition to LB626. It is my opinion as a physician that cares for pregnant women, newborns and their families that the relationship any patient has with their physician is a sacred one. It is a private one. We build meaningful and long-lasting relationships with individuals and families. My female patients come from all walks of life, ranging from the most affluent and educated to recent refugees that don't speak any English and have only heard about America on the news in their respective home countries. Each of those women have a story. They have hopes and dreams for their futures and families. Their ideals and beliefs may not be in alignment with yours or mine, but they should have the ability to make the most informed decisions they can when faced with tough choices. I have treated patients that were married, working mothers that are barely scraping by and cried in my office because they were on birth control but got pregnant. I have treated young women on the way to college that got pregnant and did not want their dreams derailed. I have treated patients who have

already had four children and can't financially support any more. I've also treated a 14-year-old that wished she had the option to defer a pregnancy, but financially it wasn't feasible for her family and she ended up with medically complex twins. There is no one-size-fits-all. The discussions that occur in the privacy of a physician's office with patients and their families should be held in confidence. Men and women alike deserve to make informed decisions about their healthcare in concert with their doctors without the undue influence of government. Specifically with regard to LB626, I do not believe that a woman should be limited in the decisions that they can make about any aspect of their healthcare, including their reproductive options. Women should have a choice in their healthcare. Women must be the final decision-makers in regards to their reproductive care. Moving forward with this bill would deprive a woman of some of the options currently available to her with regards to how she wishes to proceed with a pregnancy before she might even realize that she was pregnant. As physicians, we owe it to our patients to give them all options available to them. It is not our job to judge patients, but to guide and support them to make the best decisions for their families. As legislators, it is your job to protect the fundamental rights of Nebraskans and women who are included in those protections, or at least we should be. There are many businesses, organizations and institutions already limiting contraceptive coverage. Funding for social supports are often inadequate. Where will that leave women in our state? As a physician and as a woman here in the state of Nebraska, the choices we make are between us and our doctors and there should be no legislation impacting or influencing that sacred relationship.

HANSEN: Hey, Doctor--

DEYANNA BOSTON: Please do not advance this bill.

HANSEN: Oh, there we go. Good call. Sorry, didn't mean to interrupt you, but I kind of had to.

DEYANNA BOSTON: Thanks.

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

RIEPE: Dr. Boston--

DEYANNA BOSTON: Yes, sir.

RIEPE: --thank you for being here.

DEYANNA BOSTON: Thanks.

RIEPE: And I think that maybe you and the soon-to-speak president of the Nebraska Medical Center are the only ones that are not in white coats here today, so. I hope that you have some someplace.

DEYANNA BOSTON: I do. But some of the work that I do, I don't want anything to get on my white coat.

RIEPE: Good enough.

HANSEN: Politics is a dirty job. Any other questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. I thought you were going to ask my question.

RIEPE: Probably not.

M. CAVANAUGH: But possibly. Where do you practice?

DEYANNA BOSTON: In Omaha.

M. CAVANAUGH: OK.

DEYANNA BOSTON: I'm actually a-- you're my representative.

M. CAVANAUGH: Oh, well, welcome.

DEYANNA BOSTON: Yes.

M. CAVANAUGH: Is that-- so where you practice, how long does it take to get blood in those emergency situations?

DEYANNA BOSTON: So I work in an outpatient office a lot of the time, but in a hospital situation, if I am there for a delivery in an emergency situation, we do have access to blood very quickly.

M. CAVANAUGH: OK, because you're in Omaha.

DEYANNA BOSTON: I'm in Omaha.

M. CAVANAUGH: In possibly the greatest legislative district.

DEYANNA BOSTON: Agreed.

HANSEN: I'm not touching that. Thank you. All right, we'll take the next invited testimony. Welcome.

MEGHAN SHEEHAN: Thank you, Chairperson and members of the Department of Health and Human Services [SIC] for allowing me to testify today. My name is. Dr. Meghan Sheehan, M-e-g-h-a-n, Sheehan, S-h-e-e-h-a-n, and I'm here to voice my opposition to LB626. I specialize in reproductive psychiatry and I work with my OB/GYN colleagues to help women realize their reproductive goals. In addition to the concerns voiced by my colleagues, I would like to discuss two main issues with LB626. The first is that it removes psychiatric diagnoses in emergencies from medical emergencies as exemptions to the ban. The second is that it severely limits the amount of time that we have to help counsel our patients on important decisions about pregnancies. According to the CDC, mental health conditions, including suicide and substance abuse, are the leading underlying causes of pregnancy-related deaths at 23 percent. This is no small issue. Women, especially women of color and disadvantaged status, are dying at a higher rate of pregnancy-related mental health issues in our country. This is more than everything that's more well recognized like bleeding complications, infections, cardiac conditions. Under Section 3(b) of LB626, it removes psychiatric illnesses and diagnoses from the medical emergencies as exemptions. This discounts the seriousness of these illnesses and puts into question the veracity of mental illness being medical illness. Forcing the continuation of a pregnancy in the face of serious mental illness and suicidality isn't just a legal and ethical issue, but from my own personal experience, it's a logistical issue for which Nebraska is ill prepared. For example, I had a woman who walked into a field with a backpack. And in the backpack was a knife and a one-piece swimsuit. She was found with deep lacerations on her abdomen. She had been denied an abortion because she was too far along. She took the swimsuit to try to cover up the bleeding and stem it. She was acutely suicidal and psychotic. We hospitalized her on a specialized unit for pregnant patients with psychiatric disorders and forced her to continue her pregnancy against her will because she was suicidal and psychotic. If we're going to take all patients who have mental illnesses and force them beyond the six-week mark to continue their pregnancy, this is, this is not something that the state is capable of doing. It takes an incredible amount of resources. It's very complicated. No psychiatric hospital would accept these women because of the medical risks. So they'd be housed on OB/GYN floors, increasing the risk to themselves, other patients, doctors.

HANSEN: Can you-- you got your red light.

MEGHAN SHEEHAN: Thank you.

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

RIEPE: You've worked hard. You've been a doctor and I'm trying to just-- for clarification purposes, it says reproductive psychiatry, which is a field I have not heard of. But I assume that you're a psychiatrist, M.D. psychiatrist, not a Ph.D. psychologist? Is that--

MEGHAN SHEEHAN: That's correct.

RIEPE: OK.

MEGHAN SHEEHAN: I am a M.D. psychiatrist. I completed my medical, medical training, then residency in psychiatry, and then a fellowship in what we call consultation-liaison psychiatry--

RIEPE: OK.

MEGHAN SHEEHAN: --which is not clear what it does, but it's the intersection of medical issues and psychiatry.

RIEPE: OK, thank you. I just needed clarification. Thank you.

HANSEN: I'd like to ask just one quick question, if I could. With your testimony with the second paragraph, you said, according to CDC, suicide, mental health conditions are the leading underlying cause of pregnancy-related deaths at 23 percent. Why? Like, like what are, what are they-- I'm-- because that-- I-- it almost seems like a leading kind of sentence. Like, there-- it's a leading cause of death because they're pregnant. Is it because of that or is it because of other things or because of substance abuse? Is it because of socioeconomic issues?

MEGHAN SHEEHAN: Sure. When they looked at causes of death in the pregnant population, such as hemorrhage that we talk about, infections-- the category of mental illnesses that would encompass psychosis, depression, anxiety, suicide, substance use disorders, overdoses, that cloud of diagnoses is the leading cause of death in pregnant women above all the other medical complications.

HANSEN: OK. Thank you. Appreciate that.

MEGHAN SHEEHAN: No problem.

HANSEN: Yeah, Senator Day.

DAY: Thank you, Chairman Hansen, and thank you, Dr. Sheehan, for being here today. So I just wanted to clarify. I had asked the introducer earlier about-- I think Senator Cavanaugh and I both asked. You mentioned the text in the bill about medical emergencies. And we asked whether or not suicide or suicidal ideation in a pregnant women would be included in a medical emergency. And from your testimony, as I understand it, what you are saying is that suicidal ideation or suicide attempts even would not be considered medical emergencies under the text of this bill and would not be exceptions to not being able to get an abortion. Is that correct?

MEGHAN SHEEHAN: That's correct. As the bill reads, it says no condition shall be deemed a medical emergency based on a claim or diagnosis that the woman will engage in conduct that will result in her death or substantial irreversible physical impairment of a major bodily function. So these would be all of the mental health diagnoses that would cause someone to act to harm themselves.

DAY: OK. Thank you. And I have just one more question. You mentioned later in your testimony obstetric floors will already be overcrowded and will not be able to safely house suicidal or mentally ill patients for long periods of time. So if a woman does-- if this bill were to pass, pass, a woman presents as pregnant and suicidal and is provided some type of counseling, but continues to present as suicidal-- you're, you're saying here that we don't have the infrastructure in Nebraska in terms of hospital space to safely house pregnant women for long periods of time or can you clarify that for me a little bit?

MEGHAN SHEEHAN: Sure. It's, it's, it's not a rare issue, but it's not a really discussed issue--

DAY: Um-hum.

MEGHAN SHEEHAN: --like a lot of psychiatric care. But if, if a patient is-- has intent to harm themselves or others, then that is a psychiatric emergency and they need to be hospitalized either voluntarily or involuntarily against their will. This is kind of where psychiatry differs from other medical specialties and we cross into the line of legal issues and decisions. So if a patient remained suicidal, she would need to be hospitalized either by her consent because she doesn't want to die, she wants help, or against her will because she wants to leave the hospital and wants her freedom. Either way, she's in the hospital. If she's-- has an advanced pregnancy or has an intent to harm herself or the potential of harming a fetus, a psychiatric hospital will not have the ability to care for advanced

pregnancies, women who may deliver or neonatal care. It's not present in psychiatric hospitals. Those women ended up-- end up being housed on OB/GYN floors with psychiatry consulting to try to have sitters available 24/7 to watch the patient, to try and recreate a safe environment like a psychiatric hospital. There's no recreating that. There's no eliminating risks in a hospital room and there's no providing therapy like you would in a psychiatric hospital.

DAY: OK. Thank you. I think I understand that a little better. I'm just-- and I would maybe further ask, what does the application of that look like? If a woman is, is-- involuntarily has to be put in the hospital and she is at immediate risk of hurting herself or harming the fetus, what are the interventions that stop her from doing that?

MEGHAN SHEEHAN: Absolutely. I was fortunate to train at UNC in North Carolina, which has one of the only or the only inpatient reproductive psychiatric unit. So they specialize in taking care of these women and being able to have OB/GYN right there and being able to have infants visit their moms who maybe have postpartum depression or psychosis. In the case of a patient who is suicidal and pregnant, forced care-- if they refuse-- would look like this. So if a patient refuses care and is at risk of ending their lives, then we need to treat against their will. And we evaluate them for the capacity to make that choice. If they lack that capacity, we hope we have a surrogate decision-maker who could consent for things like antipsychotic medication, antidepressant medication. Oftentimes, we don't have surrogate decision-makers. It goes to-- the end of the line would be doctors. Sometimes patients are so acutely at risk of injuring themselves, it would involve restraints, four-point restraints. These things are really difficult to do in pregnant patients, especially as their pregnancy progresses, because they shouldn't be flat on their back and restrained. They need to really be able to be on their side. They need to be able to move to eliminate the risk of blood clots. Antipsychotic medication-- enforcing that has its own risks and doesn't look pretty when you're doing it against a pregnant patient's will. All of those measures to sedate, to physically control, to continue these things-- we can do that and we do that for small periods of time all the time. But when we're looking at long periods of time-- and I have been in the situation of forcing a pregnancy for weeks at end that was unwanted because the patient was suicidal and wanted to injure her abdomen-- it takes immense staff effort. It's heartbreaking. It, it feels very cruel to do this to someone. And at the end, it, it isn't a pretty picture. It isn't a baby and their mom. It's-- the state has already removed the children who were at the home; the baby is removed at birth; the mom continues to be hospitalized against her will till

she hopefully gets better. And in the case of the patient I talked about, she was discharged without psychosis and her suicide-- suicidality was resolved, but she did end up committing-- or dying of suicide a year later.

DAY: Thank you, Doctor.

MEGHAN SHEEHAN: You're welcome.

HANSEN: Any other questions? Thank you very much for your testimony. We'll take our next invited testimony. We have three more left.

DANIEL ROSENQUIST: Good evening, Chairman Hansen and members of the committee. My name is Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. For the record, I'm a family physician from Columbus and the current president of the Nebraska Medical Association. I'm here to do-- today to express the Nebraska Medical Association's opposition to LB626. After a review of the bill, our physician members expressed concerns about the impact to women's healthcare if this legislation were to be enacted. LB626 would create, create an incredibly short window for women to seek medical care and assess their pregnancy, their overall health with a physician upon realizing they may be pregnant. Even if a woman realizes she may be pregnant very early into a pregnancy, access to care at an early stage may be very difficult, especially within the narrow timeframe created by this bill. This means any specialized medical care or guidance as to the viability of the pregnancy and its impact on the woman's health would generally not occur until after rhythmic activity could potentially be detected. LB626 would greatly restrict the care that can be offered to these women whose own health may be jeopardized by the pregnancy. Section 4 of the bill attempts to provide an exception if abortion is necessary in the case of medical, medical emergency and Section 2 attempts to provide a definition, a definition of a medical emergency. I'm sure it's well-intended, but in reality, the language sometimes demonstrates the inherent problem when attempting to legislate the practice of medicine or the art of medicine. Physicians regularly make decisions, medical decisions in difficult circumstances that may not be very black-and-white. This is especially true when dealing with a high-risk pregnancy, concurrent diseases and the many other complications that arise during a pregnancy. These types of complex healthcare decisions must continue to be entrusted to physicians in conjunction with their patients. Finally, while LB626 does not explicitly contain a criminal penalty, we have heard from members who fear that criminal penalties from other statutes may attach to the provisions of the bill-- of this bill. Nebraska Statute

28-336 provides that the providing of abortion while "using anything other than accepted medical procedures is a Class IV felony." While it is not clear whether such a law is intended to apply to perceived violations of LB626, even the threat of criminal, criminal actions could have a detrimental effect to patient care, especially at the very critical stages of pregnancy under this bill. NMA is committed to preserving the physician-patient relationship, protecting physicians' clinical judgment, and opposing the criminalization of physicians who provide evidence-based care. And for these reasons, we oppose LB626. I'm here to answer questions.

HANSEN: Any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Before I ask my questions, you cited a statute where it's a criminal penalty. Could you-- I couldn't--

DANIEL ROSENQUIST: 28-336.

M. CAVANAUGH: 28-336. Thank you. So one of the concerns that I have expressed a few times today is the reasonable medical judgment. And you touched on this a little bit, but if this were enacted, could you maybe talk a little bit more about what that would look like?

DANIEL ROSENQUIST: I think what it becomes, it becomes an impediment to just the good give-and-take conversation that you have with the physician and patient. I mean, I'm a family physician and that's what I do all day long. And we don't try to necessarily treat. I try to educate and make the best decisions for people. And I think what this sometimes may do is it may put a barrier between actually having that very down-to-earth, very heart-to-heart, very open, honest conversation that may be necessary. We would all like a successful and a great outcome. We know that's not always possible and sometimes the best outcome is the least of a-- of all the bad options.

M. CAVANAUGH: Right, unfortunately.

DANIEL ROSENQUIST: Yes.

M. CAVANAUGH: So when you mentioned that Statute 28-336 and you said that you've heard from many physicians-- and you are a family physician, so I'm sure-- in Columbus, I believe. So I'm sure that you have dealt with a lot of different pregnancy situations as a result. But when you are in that position of, of giving the standard of care for your patient, and you know that if you, if you don't fall within

these parameters, that you are concerned about it being a criminal penalty.

DANIEL ROSENQUIST: Yes. And I think there's always this-- you know-- I, I-- like I said, I'm sure it's well-intended. It's just the unintended consequences and that open door that it potentially leaves. And I think that unfortunately, potentially could judge-- influence your judgment and your decision-making and recommendations, conversations. And that's not necessarily conducive to good health.

M. CAVANAUGH: Right, because the implication is more than just losing your license.

DANIEL ROSENQUIST: Yes.

M. CAVANAUGH: Thank you.

HANSEN: Any other questions? Can I ask just one quick question? Did the NMA, like, as a board decide the opposition?

DANIEL ROSENQUIST: So we had-- so the NMA is 3,000 physicians. And I would tell you that the opinions and opinions of the members is as varied as everything you've heard today, from one extreme to the other with a lot-- you know, this bell-shaped curve and a lot in the middle and a lot of them too on the ends. We had-- at our annual meeting, we had resolutions that we talked-- discussed this and then, and then we kind of went through this. But then we came back to the board and say, OK, now we have these resolutions, how do we implement these? How do we do what is best for the NMA and for the membership and the health-- and for Nebraskans?

HANSEN: OK. What was at the top of the bell curve? Like, what, what does the NMA see as an acceptable time? I'm kind of-- or was there [INAUDIBLE]?

DANIEL ROSENQUIST: So-- yeah, I wish I could answer that and I don't think we have that, because that is such a-- I think that curve is maybe a lot flatter and it may be very difficult. And again, part of this is, is our legislation-- what the-- what we really want to do is protect that provider-patient relationship, which is very important and vital to so many things in medicine.

HANSEN: OK. Thank you.

DANIEL ROSENQUIST: Sorry.

M. CAVANAUGH: So another piece of criminal code that is mentioned in here is 28-209 [SIC]. And that's OK, you don't have to have all the criminal codes memorized. It's, it's due-- it's around sexual assault. And it says that a healthcare provider is required by-- so-- sorry. Let me see. If a-- if the physician performs or induces an abortion in the case of sexual assault or incest pursuant to subdivision (3)(b) or (c) of Section 4 of this act, the physician shall certify in writing that the abortion was performed because of sexual assault or incest and that the physician complied with all duties of a healthcare professional-- provider required by this section of law. This section of law is mandatory reporting for a minor. So would we-- how does this-- is this clear? Is this mud? Just speak to it, I guess.

DANIEL ROSENQUIST: Yeah. I mean, obviously, we, we try to do everything we can anytime time there's a sexual assault of a minor. We try to understand the laws of the state of Nebraska and, and report those as difficult as that must be, because any time we do that, we have to make sure that that, that individual has the ultimate protection.

M. CAVANAUGH: But if the patient is not a minor.

DANIEL ROSENQUIST: And the-- and, and the, the problem with that is, as you heard before-- and I have some other, some of the people that I deal with and that assist me and help me deal a lot with what's called the Center for Survivors in Columbus. And as we know, many sexual assaults are not reported and will not be reported. They may tell me in an exam room, but they may also request that I not put it into the records. And we have to be very careful because unfortunately, sometimes spouses or significant others or somebody else may make-- with now open access to your records, they may demand that they can look into your medical records after they know you've been in the office. So we have to be very cognisant and very aware, which makes it a very, very difficult situation.

M. CAVANAUGH: I have a follow-up if that's-- so currently, the statute that they reference does not require police involvement for an adult. And I guess my question to you and to the medical community is how then do you certify that this person is-- has been sexually assaulted? If you're not required to make a police report, you're only required to tell them that they can make a police report, will that be adequate for the medical community to perform that abortion feeling secure?

DANIEL ROSENQUIST: I can't-- I don't--

M. CAVANAUGH: OK.

DANIEL ROSENQUIST: Wish I had that answer.

M. CAVANAUGH: OK. Thank you.

HANSEN: Any other questions? Thank you, Dan.

DANIEL ROSENQUIST: See you next week.

HANSEN: We have two more in the list of preferred testifiers. Welcome.

JENNIFER GRIFFIN: Thank you. Am I good? Members of the Health and Human Services Committee--

HARDIN: Can we get your name, I'm sorry.

JENNIFER GRIFFIN: Yep. My name is Jennifer Griffin. I'm a physician. It's J-e-n-n-i-f-e-r. My last name is G-r-i-f-f-i-n. I'm an OB/GYN physician and I'm the medical director of the Olson Center for Women's Health at Nebraska Medicine. Nebraska Medicine is a nonprofit integrated healthcare system that includes two hospitals and nearly 70 clinics in the Omaha area and beyond. At Nebraska Medicine, patients come to us because we provide the most comprehensive spectrum of care and the highest level of expertise in a range of specialties, including trauma care, organ transplantation and cutting-edge cancer treatment. Our patients deserve the very best care that we can provide and our opposition to LB626 is rooted in the barriers it will create between our patients and the standard of care that they deserve. I want to be clear that Nebraska-- at Nebraska Medicine, we do not provide elective termination of pregnancy. Our position on LB626 should not be interpreted to reflect a position on abortion. But we have very grave concerns about ways in which this legislation will delay and diminish care available to our patients. As any of us who have practiced medicine know, healthcare can be very unpredictable. The ability to plan for, let alone legislate every potential clinical scenario, is impossible. I would like to provide a few examples of scenarios that will not clearly fall under the existing medical exceptions in LB626. For a patient whose pregnancy has a congenital malformation, which is incompatible with life, carrying a pregnancy to term will significantly increase the risk of death for that pregnant woman. For a patient whose water breaks early in pregnancy, the chance of continuing the pregnancy to viability is very low. The pregnant woman, in the meantime, is at risk of serious complications, including hemorrhage, sepsis, kidney damage and waiting for the situation to become a medical emergency could be dangerous. In the case of

excessive bleeding before viability, it would be outside the standard of practice to transfuse a woman and continue to observe her while she bleeds. When a patient receives a cancer diagnosis in pregnancy, the treatments can be toxic to the fetus. In some cases, hormones during pregnancy may actually fuel the cancer's growth. Treatment and continued pregnancy may be incompatible for the life of the mother. The medical exempt-- the medical emergency exception would functionally require a provider to delay intervention until the patient's condition has deteriorated to the point of near death or for the language of the law, a serious risk of substantial and irreversible physical impairment to major bodily functions. How imminent is this risk to be? How life-threatening? Our physicians will be forced to make split-second decisions about whether the medical care can be interpreted to meet this subjective wording in this law. The hospital will-- this bill will turn hospital rooms into complex conversations belonging between a doctor and a patient and her family into legal consultations at potential costs to patient care and safety. We ask policymakers not to create barriers to, to a physician's professional medical responsibility and judgment. We oppose any effort to penalize providers for delivering medically necessary care to patients and interfere with the relationship between doctors and patients. Thank you.

HARDIN: Thank you, Dr. Griffin. Questions? Senator Cavanaugh.

DAY: Go ahead.

M. CAVANAUGH: OK. Thank you, Doctor, for being here. You talked about cancer diagnosis in pregnancy and this bill would change that-- the care of the woman with cancer would receive, delaying treatments. Would it delay treatments because it would be viewed as potential life-threatening to the fetus?

JENNIFER GRIFFIN: That is a possibility. There are some types of cancer treatment that-- for certain cancers that can be delivered safely during pregnancy and other treatments would be incompatible with maintaining the pregnancy.

M. CAVANAUGH: And so therefore, if the treatment-- the course of treatment-- recommended course of treatment is incompatible with continuing the pregnancy, under this law, they would not be able to receive that treatment.

JENNIFER GRIFFIN: Correct--

M. CAVANAUGH: Thank you.

JENNIFER GRIFFIN: --because the treatment could cause harm to the fetus.

M. CAVANAUGH: Thank you.

DAY: Thank you, Vice Chair Hardin, and thank you for being here today. Appreciate your testimony. So some of the questions that Senator Cavanaugh had asked of Dr. Rosenquist about sexual assault made me think of a couple of things that I was going to ask you. So related to the exception of rape in this bill, is it possible for a woman to be raped or sexually assaulted and not know for several weeks after-- beyond the sexual assault whether or not she's pregnant?

JENNIFER GRIFFIN: I think that's absolutely possible. Again, that's-- as Dr. Patel referenced earlier, people tend to know they're pregnant earlier when they are wanting to be pregnant and after an-- after a rape or an assault, women may not really be in the frame of mind to even know when their period was or what to expect. So that's certainly a scenario where things could be delayed. The majority of victims of assault do not present to an emergency room immediately at the time of the assault and so they don't necessarily get that counseling that they should be considering the possibility of pregnancy. And so that's definitely a scenario where people would potentially be delayed in their acknowledgment of being pregnant at that point.

DAY: OK. Thank you. And so if a woman were sexually assaulted and did not find out for several weeks beyond that, that, that due to the assault, she became pregnant, if she were to come to you and say "I was sexually assaulted, I would like to terminate this pregnancy, I'd like to have an abortion," how would you protect your license as a doctor? How-- what would you-- considering that there would possibly be no markers anymore of sexual assault at that point, how would you--

JENNIFER GRIFFIN: Right.

DAY: What would the situation look like for you as a physician?

JENNIFER GRIFFIN: I think that's a very difficult position. I mean, in my reading of this bill, we would not be able to act unless we were able to really verify that the patient had an assault, which would probably require her to have filed a police report. You know, I don't know what that would look like in terms of her word to her physician with no evidence, no police report and so on. I'm not sure that the law would allow that as an exception.

DAY: OK. Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you. And while you're not under oath, I would ask you this question. We've talked a lot about situations for incidents of sexual assault, which then in-- turn into pregnancy. So you'd have one number for sexual assaults, another number for pregnancies. On relationship 1 to 1,000, what-- is there some rate, some number in there? I mean, I-- my initial inclination-- of course, I'm not exposed to this-- is that it, it wouldn't be too high average. It's something that's, like, 1 percent.

JENNIFER GRIFFIN: Well, I'm trying to think of how best to answer that question. I think-- I mean I--

RIEPE: You're the expert.

JENNIFER GRIFFIN: I think the, I think the risk of pregnancy in, like, an individual menstrual cycle, if a person is using no kind of form of contraception, could be about 20 percent potentially in terms of just having a pregnancy when you're just not using contraception and you're sexually active.

RIEPE: Or sexually assaulted.

JENNIFER GRIFFIN: Well, people who are sexually assaulted or having intercourse voluntarily sometimes and potentially also could be assaulted. So it's hard to sort that out of, of-- you know, a woman, of course, could just have a single episode of assault. That's a possibility, too. But that's-- it's obviously an issue that has a wide variation.

RIEPE: That's a lot of numbers. [INAUDIBLE] Thank you.

HANSEN: Any other questions? Yes, Senator Walz.

WALZ: I just have a quick question. Thank you for being here. I'm just curious, how does the medical community feel about the-- how comfortable are you with the 20-week ban, the current 20-week ban? I don't know if you can answer that question or not, but I'm just--

JENNIFER GRIFFIN: Well, I would say, you know, the 20-week ban does, does restrict activity of doctors. There are situations currently that the medical-- the OB/GYN community would widely agree is appropriate for termination after 20 weeks. And in the, in the-- based on the

current state law, we have to refer those patients to other states if they do choose to seek that care. So there is a restriction currently on our practice with the 20-week ban. And so this would obviously be much different because by 20 weeks, at least we have some knowledge of the pregnancy, whereas at six weeks, we have virtually no information about the pregnancy to be able to counsel the patient on what her risks may be going forward.

WALZ: Thank you.

HANSEN: Any other questions? Seeing none, thank you for coming. All right, we have one more invited testimony. Welcome.

LINDA HARDY: Thank you. Chairman Hansen and members of the HHS Committee, my name is Dr. Linda Hardy, spelled L-i-n-d-a H-a-r-d-y. I have been a registered nurse for over 46 years and a nurse educator for the past 19 years. My doctorate is a Ph.D. in nursing education, unlike my colleagues here, all the physicians that have come ahead of me. I am the current president of the Nebraska Nurses Association. I am speaking for the NNA in opposition to LB626 because of four specific elements within the bill. My comments are congruent with the American Nurses Association's position statement on sexual and reproductive health, dated March 7, 2022, and a press release dated June 24, 2022, regarding reproductive health and human rights. Our first concern, the NNA is concerned that this bill usurps the right of patients to make their own healthcare decisions. Our code of ethics for nurses discusses the moral and legal right to self-determination of our patients. The NNA strongly supports this right. Number two, the right to privacy will be violated by requiring the patient to disclose either sexual assault or incest to the physician in order to obtain reproductive services. And I refer you to page 4, lines 10 through 16. Number three, this also violates the right to confidentiality between the patient and the healthcare provider by requiring the physician to certify this very private information. Number four, finally, we are concerned about our physician colleagues having their license to practice put in jeopardy by this bill. The Nebraska Nurses Association recognizes that, recognizes that there are many different opinions within the 30,000 RNs in Nebraska regarding sexual and reproductive healthcare issues. However, all nurses are bound by our code of ethics and our professional duty to support our patients. Because of these four areas of concern, the NNA is opposed to LB626 and we ask the committee to not advance the bill. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Well, you lucked out.

LINDA HARDY: I did. I was happy a lot of them answered your questions ahead of time.

HANSEN: All right. Thank you. OK. So now we'll start moving on to general testimony in opposition to LB626. And then people who want to testify, if we can just kind of slowly work our way up here as well, up to the front. And then we'll-- what worked good last time was I'm going to go on one side of the room for one and we're just going to alternate each side so that people aren't kind of jumping up all over the place. All right, we're all set. Welcome.

JULIA KEOWN: All right. Yes, thank you. All right. Thank you for the opportunity to speak in front of you. My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am a native Nebraskan, a mother, registered nurse and sexual assault forensic examiner with 16 years of direct-care experience serving domestic violence victims and those of sexual assault. I have the honor of serving as the state of Nebraska's healthcare representative on a commission that works to improve outcomes for victims of child sexual abuse and sex trafficking of children in Nebraska. I also serve on a healthcare committee that analyzes Nebraska legislative bills that will affect our patients. I am not here on behalf of either the commission or the committee. I am here solely advocating on behalf of my patients. So I have gone over this bill with a fine-tooth comb. And what I basically am, am seeing is going to happen for the victims of sexual assault in Nebraska is ostensibly that, through no fault of their own, if they get pregnant, they are basically quite likely statistically-- and I'll go through that in just a minute-- they'll end up having to be forced to carry their pregnancy to term and because of Nebraska statutes, be forced to co-parent or share custody with their rapist, which sounds completely insane, but I will go through it. And I did do my research. It's on the second and third page. So what I see happening. A patient is raped. They're not quite like-- they're not very likely to report that rape. Statistically, only, like, 20 to 30 percent of patients will ever report rapes. And that's just because of a myriad of social barriers and safety issues. So the patient can be diagnosed with a rape-related pregnancy usually two weeks later. Of note, this is outside of my five-day window that I have after the assault to collect forensic evidence. So this patient's going to go to their physician for an abortion. The physician knows that this bill, if enacted, is going to require them to certify in the medical record a legal document that the patient was raped before performing the abortion. Certifications in such cases that would be based solely on the patient's words with no exam or kit. And the physicians know-- they're smart-- that their licenses, their very livelihood is at stake because

of this bill. That if the director listed on pages 8 and later of this bill takes issue with their certification of sexual assault, then they can have their licenses stripped. So what's going to happen? You're going to have providers who are going to refuse to provide abortions for rape victims, OK? I see that my, my red light is over, so--

HANSEN: Yep, we-- you can finish up really quickly here.

JULIA KEOWN: I will do so.

HANSEN: Sorry--

JULIA KEOWN: I will do so.

HANSEN: --it goes by pretty fast.

JULIA KEOWN: No, that's OK. I know, I know. So the patient's going to be denied an abortion, right? They're either forced to get an illegal abortion or they're forced to carry the baby to term. In the state of Nebraska, we are not in compliance with the federal recommendations for best practice for termination of parental rights of a rapist. So in 2017, Senators Howard and Pansing Brooks did their best, but termination of rapist parental rights in Nebraska requires a conviction for sexual assault on behalf of the rapist, which happens in approximately 2 to 3 percent of the time.

HANSEN: OK, I'm, I'm going to have to stop you there. Sorry.

JULIA KEOWN: No problem.

HANSEN: But I will see if there's any questions from the committee.

JULIA KEOWN: Absolutely.

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

JULIA KEOWN: Yes.

M. CAVANAUGH: Thank you.

JULIA KEOWN: Yes.

M. CAVANAUGH: Thank you. You started to speak on what I was going to ask about.

JULIA KEOWN: Yeah.

M. CAVANAUGH: The 2.8 percent sexual--

JULIA KEOWN: Yeah.

M. CAVANAUGH: -- assault cases that would lead to felony. So is it 2 point-- 2.8 percent of reported cases result in felony charges?

JULIA KEOWN: This could be total.

M. CAVANAUGH: OK.

JULIA KEOWN: So on that third page--

M. CAVANAUGH: Not that that's any better.

JULIA KEOWN: No, that's, that's OK. Reported, I can tell you I-- I've seen about 700 cases go by in my career and I have been called to testify in one of them. So that kind of gives you an idea.

M. CAVANAUGH: So if, if you don't report it, you can't have the abortion under this bill. And if you do report it, then you're reporting the individual who assaulted you, which then I assume means that they would be given notice that you are pregnant. And if your provider doesn't provide you with the abortion because they don't feel comfortable doing so because they're concerned about this bill--

JULIA KEOWN: Yeah.

M. CAVANAUGH: --you may not only have exposed yourself to--

JULIA KEOWN: To violence.

M. CAVANAUGH: Yeah. So then that person, unless they get a felony conviction, has parental rights over--

JULIA KEOWN: In the state of Nebraska.

M. CAVANAUGH: Cool. Thanks.

JULIA KEOWN: Very-- and like I said, all that homework for that is on the second page.

M. CAVANAUGH: OK. Thank you. Sorry, I didn't mean to be flippant with that.

JULIA KEOWN: No, I--

M. CAVANAUGH: I just--

JULIA KEOWN: Shocking. I went down a rabbit hole--

M. CAVANAUGH: I didn't-- this is--

JULIA KEOWN: --last night on this.

M. CAVANAUGH: --new information--

JULIA KEOWN: Yeah.

M. CAVANAUGH: --for me, so.

JULIA KEOWN: Yeah, so.

HANSEN: Senator Riepe.

RIEPE: Senator Hansen--

JULIA KEOWN: Yes.

RIEPE: --thank you, Chairman. Are you Omaha-based?

JULIA KEOWN: Lincoln.

RIEPE: Lincoln.

JULIA KEOWN: Yes.

RIEPE: OK. Let me ask this question. I have--

JULIA KEOWN: Of course.

RIEPE: --four and I'll try to be brief. Does Lincoln and Omaha have a designated rape hospital?

JULIA KEOWN: Oh, that is--

RIEPE: Some urban areas do.

JULIA KEOWN: --a fantastic question. I will tell you that I only work in one facility in Lincoln. I cannot speak to Omaha and I cannot speak to the other hospital system in Lincoln.

RIEPE: OK. Do you have a relationship with the Nebraska Highway Patrol?

JULIA KEOWN: I do not.

RIEPE: That's a follow-up. OK. Then do you have a relationship with, from my perspective, Omaha Project Harmony, which deals with a lot of these.

JULIA KEOWN: Oh, yes. I'm-- in, in, in that commission that I'm on, I, I do, um-hum.

RIEPE: OK. That's all I need.

JULIA KEOWN: They're wonderful people--

RIEPE: Thank you.

JULIA KEOWN: --yep.

HANSEN: Senator Day.

DAY: Thank you, Chairman Hansen, and thank you for being here. OK, so this was something that I was not aware of either. You mentioned the part about in Nebraska, if you keep a baby conceived from sexual assault, which many women you are saying under LB626 would be forced to do because they would have no evidence of--

JULIA KEOWN: Yep.

DAY: --rape. Your rapist will likely retain parental rights to the child, including visitation and/or custody. So, as Senator Cavanaugh mentioned, you would not only be exposing yourself--

JULIA KEOWN: Yes.

DAY: --to potential violence, you're also exposing the child to potential violence.

JULIA KEOWN: Exactly.

DAY: OK.

JULIA KEOWN: Exactly. So what I will tell you is rape is a crime of power, control and humiliation, right? That's, that's the reason that rape is rape. What's going to happen when this rapist knows that they have power and control over you with respect to what is probably the most precious thing in your life, which is your child.

DAY: Um-hum, thank you.

HANSEN: Any other questions? All right, seeing none, thank you for coming.

JULIA KEOWN: Thank you.

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

SHANNON VACCARO: Thank you. Good aft-- good evening, I guess. My name is Shannon Vaccaro, S-h-a-n-n-o-n V-a-c-c-a-r-o, and I'm here to oppose the bill, LB626. I'm here to provide perspective on the intricate nuances of the patient-physician relationship from the perspective of a patient and mother. Nearly 11 years ago, my husband and I found out we were expecting our first child. The pregnancy progressed without issue during the first two trimesters. My baby's biophysical profile at the 20-week ultrasound showed that baby was on track. At my 28-week appointment, we were escorted back to a patient room, did the routine questions, and my physician came in to check baby's heartbeat. She was having a hard time finding it and suggested we have an ultrasound and were moved to the room across the hall. The sonographer came in with our physician and began to search for baby's heartbeat. I knew immediately something was wrong and then I heard the words expecting parents fear most, "I'm sorry. There is no heartbeat." My husband and I were then forced with going through the unimaginable, having our pregnancy medically induced. And after 14 hours of labor, my son Alfie [PHONETIC] was stillborn the next day, on April 6, 2012. My physician was gracious, kind, comforting, loving and had all the resources necessary to ensure my delivery occurred in the least traumatic way possible. My husband and I again became pregnant and delivered our second son, Vinny [PHONETIC], in September of 2013 via C-section due to the mental trauma endured by my first delivery and his breech positioning. After Vinny, we were unsure if we could endo-- endure another pregnancy. The stress, anxiety and trauma almost seemed too much. However, much to our surprise and despite birth control, in June of 2016, we found out we were again pregnant. It took me several days to come to terms with the-- experiencing an unplanned pregnancy, but we slowly welcomed the surprise. Unfortunately, at our second appointment, at gestational age of approximately eight to ten weeks, we learned that I was experiencing a miscarriage. Again, my provider was able to go through all options for ending the pregnancy naturally at home, at home, with the assistance of medication or by having a D&C. I was able to choose how my pregnancy ended, electing to have a D&C to try and reduce the mental and physical trauma endured during a second lost pregnancy. Because of the D&C, we were able to do genetic testing and found out our baby would have been a little girl named Anna [PHONETIC]. I understand the legislation being proposed, proposed

may not have directly impacted my birth choices, but for me that is not the point. The point is that I had a choice and was able to work with my provider to make the best decision for me. I do not expect any of you to be able to fully comprehend the trauma my husband and I have endured, nor would I want you to. But I do expect that you trust me and other women and other families to make the best medical decisions for them with the guidance and support of their trusted providers. Our State Legislature has no right to come between the decisions made between women and their providers. Each pregnancy is nuanced, difficult and deeply personal. Please allow them to stay that way. Thank you.

HANSEN: Are there-- they may have some questions for you.

SHANNON VACCARO: Oh, yep, sorry.

HANSEN: I just want to make sure.

SHANNON VACCARO: Yeah.

HANSEN: Are there any questions? Nope, there are none. Thank you for coming. And one more thing I'm going to mention-- and I did have to mention this the previous, previous group, please don't clap or make a whole lot of noise if we can so that we can get people moving so we can hear them, so. All right, we'll take the next testifier from this side of the room. Welcome.

JODANNE HEDRICK: Good evening, Senator Hansen and committee members. My name is Dr. Jodanne, J-o-d-a-n-n-e, Hedrick, H-e-d-r-i-c-k. I'm a board-certified obstetric-- obstetrician and gynecologist and have practiced in Nebraska for over 20 years. I'm from Michigan originally and chose to live in Nebraska. I am here as my own representative and my opinions are my own based on my review of scientific evidence. I oppose LB626 for many reasons, but today I am here to speak to you about the effect this bill will have on physicians' medical licenses. In Nebraska, it takes a physician approximately 12 to 16 weeks to obtain a Nebraska license. Physicians are obligated to report any restrictions, suspensions or revocations that may have been placed on their hospital privileges or medical licenses. Should LB626 become law, this could have a significant impact not only on a physician's ability to practice in Nebraska, but in any other state should they be found to perform an unlawful abortion. There are abnormal intrauterine pregnancies and C-section scars, fallopian tube openings, and in the cervix. These pregnancies, which all require medical attention and dissolution, would be considered unlawful termination should they have

a heartbeat. Subsequently, the physician's medical license could be subject to suspension or revocation. What doctor would want to obtain a medical license in Nebraska under those circumstances? I have proudly served on the board of medicine and surgery for the past four years. I have been involved in the licensing of current Nebraska physicians and those desiring to practice in our great state. I understand the process and requirements of applying and obtaining a Nebraska medical license. I believe this bill will reduce the number of medical license applications in our state. I believe that this will cause physicians to leave our state. In states with broadly worded, restrictive anti-abortion legislation, they are already feeling the change in the medical workforce. I have spoken to a national OB/GYN hospitalist recruiter who informed me they can't refuse-- they can't recruit physicians to Texas even for temporary assignments. Resident OB/GYN physicians who train in Texas will have less skills for the management and treatment of patients in states without restrictive abortion law. Utah is struggling to fill positions for maternal fetal care. Seventy-one percent of our Nebraska counties have limited or no access to maternal fetal care and 15 percent have low to moderate access to care, according to the March of Dimes. Is this what we want for our Nebraskans? I have spent 29 years of my life dedicated to serving and caring for people. Outside my OB/GYN practice, I donate a significant amount of my time to our great state to ensure the health and safety of all Nebraskans. LB626 will ultimately result in fewer physicians, more restrictions and further barriers to medical care. Don't be Texas. Please oppose and do not pass on LB626 and thank you so much for your time and consideration.

HANSEN: Thank you. I think a majority of us don't want to be Texas for different, for different reasons. All right, are there any questions? Yes, Senator Day.

DAY: Thank you, Chairman Hansen. Thank you, Dr. Hedrick, for being here today. You mentioned in your testimony resident OB/GYN physicians who train in Texas will have less skills for the management and treatment of patients than states without restrictive anti-abortion laws. And I had briefly talked about this with a previous testifier. So I think we-- especially those of us that have sat on the Health and Human Services Committee for a few years-- have become really proud of the level of medical care that we have here in the state of Nebraska. Do you see this bill reducing the quality of the medical care that we have in the state?

JODANNE HEDRICK: Recently, Nebraska was actually rated nationally for preterm labor and birth prevention and we received a D. So I think

that says quite a bit right there. I think, you know, when we have to send our residents out of state to receive training in abortion care, that's problematic because that tells me that we are training less qualified physicians than those who had the same access. You heard Dr. Griffin say that it is a requirement of the ACGME for us to provide that education for our residents, but they can choose not to-- well, I should say they can elect-- opt out to not perform that. In Michigan, where I trained as part of Wayne State University, where we did maternal fetal medicine care, I spent a month in genetics while I was there, learning the intricacies and difficulties in performing those types of terminations. They are extremely difficult and hard and no woman makes that decision to terminate her pregnancy for whatever reason very lightly.

DAY: So essentially, even if-- let's say LB626 were to pass. Doctors will still need to be trained in abortion care because there could be life-threatening emergencies and doctors would be not as well-trained, is what you're saying? So women would be presenting with life-threatening emergencies to doctors who would not be as well-trained as they would be if this bill were to not pass?

JODANNE HEDRICK: Potentially. I don't think that there's been enough data to say, because we haven't been living in this circumstance with many restrictive states for a long period of time. And it will take time to collect the scientific evidence that we need and scrutinize it in order to determine if physicians in states where they don't seek to go out of state for training and what their skill set will be in dealing with complex medical emergencies that require a termination of a pregnancy when the mother's life is at risk.

DAY: OK. Thank you. I just have one more question.

HANSEN: Yep.

DAY: OK. You said Utah is struggling to fill positions for OB/GYNs in many of their major hospitals. Seventy-one percent of Nebraska counties have no access to maternal fetal care. And I'm assuming you're referring to rural Nebraska?

JODANNE HEDRICK: Correct--

DAY: So--

JODANNE HEDRICK: --52 counties where women drive over 90 minutes to receive care during their pregnancies.

DAY: OK. And so in those counties, we would say if a woman were to have a medical emergency related to-- she was pregnant and she was having a medical emergency. She would have a long trip to try to get to anywhere who would be able to provide her with the care that she would need in that situation. Is that-- I mean--

JODANNE HEDRICK: That's correct.

DAY: Are we lengthening that time, shortening that time with this bill?

JODANNE HEDRICK: Well, if you have limited access to care and you're having to drive 20 minutes when you're actively hemorrhaging because you have a placenta previa or a placenta that covers the cervix, that could be quite problematic to get adequate care in a timely fashion. And by the time she arrives to the hospital, might be severely anemic. The baby could have passed away from significant maternal blood loss.

DAY: OK.

JODANNE HEDRICK: It is problematic.

DAY: Thank you.

HANSEN: All right, any other questions? Yes, Senator Riepe.

RIEPE: Thank you for being here. I think the note was-- is about the-- if this bill-- the impact it would have on training of OB/GYNs. But I, I think it's safe to say, and correct me if I'm wrong, those standards are not set by the state of Nebraska. Those standards are set by the profession in terms of what's responsible or required for an OB/GYN certification or residency program.

JODANNE HEDRICK: That is correct. That is set by the ACGME, ACOG is what the requirements are to graduate from a residency in the United States. But you can see if we have very restrictive laws, our residents may have less training compared to others at Creighton University or University of Nebraska.

RIEPE: Creighton might not be the best example, given it's a Jesuit school, but OK.

JODANNE HEDRICK: They still have to meet the same requirements as the University of Nebraska in allowing their residents to have the opportunities to train in that area.

RIEPE: OK, fair enough. Thank you.

JODANNE HEDRICK: Thank you.

HANSEN: Any other questions? Seeing none, thank you very much. Appreciate it.

JODANNE HEDRICK: Thank you so much. Thank you.

HANSEN: Just a heads up to the testifiers coming up here pretty soon, in about five minutes, we'll be about an hour left of testimony and we're going to go to two minutes. So, so just maybe collect your thoughts and try to condense stuff if we can. Welcome.

MEGHAN OAKES: Thank you. Chairman Hansen and members of the committee, thank you for allowing me to testify tonight. My name is Dr. Meghan Oakes. It's M-e-g-h-a-n O-a-k-e-s. And I'm a double-boarded reproductive endocrinologist that specializes in infertility. I spent four years in an OB/GYN residency, followed by another three years in fellowship, studying reproductive physiology, the intricacies of human fertilization and embryo development and implantation. And this makes me eminently qualified to speak to you tonight about pregnancy dating. Pregnancy is dated based on the first day of a woman's last menstrual period, meaning that when a woman ovulates, she is potentially two weeks pregnant. And by the time she has a positive pregnancy test, four weeks pregnant. An electrical impulse originating from early myocardial cells can be detected as early as five weeks and five days. If we take this electrical impulse to be the heartbeat, as defined by LB626, we are allowing women a mere 12 days to decide if they want to end their pregnancy, 12 days to make one of the hardest decisions they're ever going to face. Fifteen percent of women have rock-solid, normal 28-day cycles. Everyone else falls outside that range. Ten percent of women suffer from polycystic ovarian syndrome, the hallmark of which is irregular menstrual cycles. Based on 2020 March of Dimes data, there are over 37,000 women in Nebraska who suffer from PCOS and do not reliably get a period. Women at the extremes of their childbearing years may have irregular cycles, as do women who are breastfeeding. And three separate NIH studies estimate that 48 percent of unplanned pregnancies occur in women using some form of contraception. All of these women are going to be much slower to consider a pregnancy if their menstrual cycle is late, increasing the chance that termination is no longer an option. There is an approximate one-month wait to see one of the few abortion providers in Nebraska. A woman with the most regular of menstrual cycles who recognizes her pregnancy as early as possible still would not be able

to get an abortion under LB626, as she would be eight weeks pregnant by the time she was seen. Practically speaking, this makes LB626 a near-total abortion ban. Most Nebraskans want to retain access to safe and legal abortion. The proposed legislation does the exact opposite. This legislation flies in the face of what your constituents want and I urge you to not advance LB626. I'd be happy to take any questions.

HANSEN: Are there any questions from the committee? Seeing none, thank you. We'll take the next testifier on this side of-- sorry. We'll take the next testifier. Welcome.

REBECCA WELLS: Good evening, Senator Hansen and committee. I'm Rebecca Wells. My background is maternal child health. I grew up in Lincoln. Soon after college, went out to the West Coast, Loma Linda University, and got my master's in mother and child nursing. Taught nursing, pediatric and maternity for a number of years at Union College and went back and became a nurse midwife. That's what I've been since 1997 so I have a good background and learned to look at data. And I'm going to bring out something that you haven't really heard. I'm concerned that it's going to do something you didn't intend. It's going to increase maternal mortality. Abortions still happen where it's illegal. There were many abortions with deaths before it was legalized by Roe v. Wade and they occur in countries where abortion is illegal. And I'm concerned it's going to increase child poverty. The women that have abortions, most of them are unmarried. They are poor. They're in their twenties, most of them in their upper twenties. There are-- disproportionately, most of them are women of color. They are black or Hispanic. Most of them already have at least one child, 60 percent of them. So these are not women that are just, you know, young women. They're, they are-- over-- about half of them are below the poverty level so they're poor. And so what we're going to do is make women that are already suffering and are disadvantaged, more disadvantaged by forcing them to have another child. The reasons people have abortions, one of the big ones is that they can't afford another child. They want to finish education. They don't want to be a single mother. There can be maternal health problems and fetal defects and we've heard about that. My concern is that this-- women that have access are going to be able to get medication abortion over the Internet or they're going to be able to travel to another state. We're going to hurt the poor women that cannot access abortion. And in Texas, by the way, what I found out is in 2020-- their data just came out in December of 2022. It was very late and it had an alarming racial disparity. Black deaths were up to 53.3 per 100,000, one-- the white non-Hispanic 19.1. It hurt the, the black women or the, the ones that are poor. And this is a huge, huge problem that I don't think has

been mentioned today. And so I wanted to bring that to your attention. And I don't think that is your desire. I care about women and children greatly and I know you do. And I know those of you that signed onto this bill do. And it's something that maybe you didn't think about.

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

REBECCA WELLS: Any questions?

HANSEN: Yes, Senator Riepe.

REBECCA WELLS: Yes.

RIEPE: I haven't asked this before, but what's your prediction in terms of chemical abortions?

REBECCA WELLS: Chemical abortions? I believe it's 53 percent of abortions now are medication abortions. They are safe up to ten weeks of pregnancy, according to the FDA. And they are-- oh, and this, this on your handout-- it is so much more dangerous for women to go to term, 14 times higher risk of death than an abortion, an illegal abortion-- a legal abortion. And so telling a woman "carry the pregnancy to term," the risk is not the same. As a certified nurse midwife-- I had this in my latest continuing education, that we cannot-- we got to give women options because guess what? The risks are not the same for an induced abortion versus a term pregnancy. And so they have to make that decision and we need to support them. And as a nurse midwife, that's what I-- that's my whole goal is giving women information and supporting them and what's right for them.

RIEPE: Back to my original question--

REBECCA WELLS: Yes.

RIEPE: --53 percent, that's up from what? What was it a year ago? What was it two years ago? What's--

REBECCA WELLS: Medication is getting higher and the thing is--

RIEPE: How much higher?

REBECCA WELLS: --it will be, it will be able to be accessed by your women that are more affluent, more educated, more Internet savvy. It can be obtained even from outside the country. And so the ones that are hurt are the ones that, you know, don't have the ability to manage

these things. Or the woman that has a fetal defect-- and by the way, anencephaly, where there is a lacking of the fetal brain, I looked that up and that can that-- not be reliably diagnosed typically until 12 to 13 weeks of pregnancy. Those children are definitely not going to survive. And to tell a woman, especially what if it's a black woman whose risk of death is so much higher than a white woman, that she has to carry a pregnancy where the baby is not going to survive? This bill has problems so please don't advance it.

RIEPE: Back to my original question.

REBECCA WELLS: Yes.

RIEPE: The 53 percent, you know, if it's 20-year-olds, they're pretty savvy in terms of internet and access and I mean, they will-- if it's available--

REBECCA WELLS: It'll still be available to some women. Yes, it will. We'll be hurting the women that are the most vulnerable.

RIEPE: Who don't have what, a computer?

REBECCA WELLS: And it's probably going to increase our welfare rolls and everything else because, you know, they're not going to be able to access these things. Any other questions?

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

REBECCA WELLS: Thank you.

HANSEN: We'll take the next testifier on this side of the room, please. Welcome.

ABIGAIL DELANEY: Thank you. Good evening. Thank you for the opportunity to present tonight in opposition of LB626. My name is Abigail Delaney, A-b-i-g-a-i-l, Delaney, D-e-l-a-n-e-y. I am a double board-certified OB/GYN and a reproductive endocrinology and infertility specialist. I want to speak tonight-- to you tonight as someone who grew up in a conservative family and who has voted both Republican and Democrat in elections over the years. I want you to know that this is not political for me. I want to speak to you tonight as someone who used to think of themselves as pro-life. I believed I was pro-life because that's what my parents were. That's what my church taught me. During medical training, despite acknowledging that abortion was necessary, I ultimately thought of myself as mostly

pro-life, with exceptions. Abortion during my medical education was limited, and, as someone who had always thought of myself as pro-life, I chose not to pursue extra training on abortion. As those alluded to earlier, I opted out. In my first year practice, I showed up with-- I showed-- a patient showed up with a fever and a high heart rate at approximately 16 weeks gestation. She was ultimately diagnosed with an overwhelming intrauterine infection known as a septic abortion. There was still a heartbeat. The institution I was at required hoops for me to go through to terminate the pregnancy. I had to obtain an ethics committee consult. I then had to have two other providers sign off. By the time that was completed, the patient's condition was worsening and she was remote from delivery. Because I did not have that training, I had to call in another provider in order to do the dilation and evacuation. Despite years of training, despite the desire to help people desperately, despite everything I had believed, it was actually my pro-life stance that ultimately put this patient's life in danger. Because I was reticent to acknowledge abortion as healthcare, because I had opted out of abortion training, all I could do was assist the other doctor who provided the necessary life-saving operation. I can tell you there has not been a day that has gone by since that day in that operating room where I don't think about that patient, a mother of three, and how she was saved. I am here to tell you that if you do not acknowledge abortion as healthcare, women may die and my story is proof of it. I don't need you to think that abortion is OK. What I do need you to do is allow me to be a doctor. I need you to get out of our exam room. And I need you to allow me to shoulder the ethical burdens of the profession I chose and continue to allow me to take care of patients without government interference.

HANSEN: Thank you. All right, are there any questions from them, from the committee? Seeing none, thank you. Next testifier in opposition to LB626.

JANET PRICE: Hello. I'm Janet Price, J-a-n-e-t P-r-i-c-e, and I'm here to tell you that you will never ban abortion with or without this bill. And I know that because you are going to force abortions into the back alley, done by quacks in unsterile environments because that's where we were when I was a young adult. It took a lot of work to get legal, safe abortions for women. The other thing that I would like to point out from the testimony I heard earlier today, that if you pass this bill, LB626, that's the start of how we are going to chip away at women's rights. There-- this will not be enough. There will be more people who want to take more things away and make it more difficult for these women to get abortions. But my real question today is what is going to be happening to our children who are having

children? In Nebraska, you're not an adult until you're 19. And let's assume that there are young people out there who are sexually active-- because they are-- and that they don't have enough information about pregnancy to know how to prevent it if they're having relations. So some of them might think that you can never get pregnant the first time you have sexual relations. What about a young girl who thinks she is really, truly, deeply in love? What about young person who has birth control but it doesn't work? So I'm asking you, how will this bill affect these young people when it's not rape, it's not incest, their life is not yet in danger, and yet they don't understand in that first 20 weeks that they are pregnant? And if they have-- because-- a lot of them won't even know. They won't know the, the symptoms of being pregnant. They're too young. And just as a reminder, a year ago, a year ago, July, there was a ten-year-old that was pregnant in Ohio that needed an abortion in Indiana. So it happens at a very young age. So how does the bill affect these kids?

HANSEN: Thank you for your testimony. Are there any questions? Seeing none, thank you. We'll take the next testifier on this side of the room, please. Welcome.

BRADY KERR: Thanks. Thank you for allowing me to speak today. My name is Brady Kerr, B-r-a-d-y K-e-r-r. I am a board-certified neonatologist and have practiced medicine in Omaha since 2005. I'm also a volunteer member of the Douglas County Fetal and Infant Mortality Case Review Team. I'm also the father of two girls, ages 11 and 9. I'm here to speak in opposition of this bill. I truly hope that you have not made up your decision on how you're going to vote. As a neonatologist, I take care of babies who require ICU care after birth. Most of them are born prematurely. Some have congenital anomalies and some are born at the limits of viability, which is about 22 to 23 weeks of pregnancy. It's my job to keep these babies alive and when that doesn't happen, I don't succeed, it sucks. As part of my job, I routinely meet with expectant parents to discuss the anticipated life-and-death decisions they will face for their babies. Most of these conversations are extremely difficult. What is right and true for one family may not be right and true for another. I have both professional and personal experience with this situation. I've been on both sides of the fence, so to speak. With one of our pregnancies, my wife and I learned during her first trimester that our fetus had anencephaly. We were trying to get pregnant and being closely followed by reproductive endocrinologists and high-risk obstetricians that were my friends and colleagues. We learned that our baby had anencephaly. If you don't know what that is or what the long-term implications of that diagnosis mean, you should vote against this bill. Anencephaly is a neural tube

defect where the baby's cerebrum never forms. With no cerebrum, their babies will never speak, never understand speech, never have memories or develop a personality. There is no treatment. There is no cure. If the baby doesn't die or isn't stillborn, they will die hours or days after birth from apnea. They basically stop breathing. Given that my wife and I had amazing access to medical care and received VIP treatment, the diagnosis was made in the first trimester, between nine to ten weeks, but certainly not, not before six weeks. I'll try to finish quickly. As an expectant father, one of my worst fears had come true. I'd also been on the doctor side of this fence in taking care of anencephalic babies. My wife and I had to decide were we going to continue on with this pregnancy and all the risks that subsequently ensued and the heartache? Or are we going to, to terminate? Luckily, we had a choice. I'll stop there since my time is up and take questions.

HANSEN: All right, thank you. Are there any questions? Seeing none, thank you for coming today. Appreciate it.

BRADY KERR: Thank you.

HANSEN: All right, we'll take our next testifier. I know that two, two minutes goes kind of quick, so I apologize, but this is how we can get some people heard, so. Thank you.

TONI CHRISTENSEN: Hello. My name is Toni Christensen. I'm not a doctor or anything, but I am a patient and I would just like to share my story with you today. I suffered from what is called gestational trophoblastic disease, or molar pregnancy. You may feel like you're pregnant and may be presumed to be a normal pregnancy, but what is really happening can have a very bad effect on a woman. Me and my doctor didn't even know right away that it wasn't a viable pregnancy, certainly not within the first four to six weeks. At first, everything appeared normal. Then what appeared like a normal pregnancy began appearing on ultrasound, more like cells dividing rapidly and without producing anything that appeared like a baby. Molar pregnancies can cause serious complications. The cells can grow into surrounding tissue, cause a type of cancer called choriocarcinoma. It can spread to other parts of the body, including the lungs. A therapeutic abortion was needed, the sooner the better. And other complications can be sepsis, uterine infection, pre-eclampsia, shock and death-- possibly my death if things hadn't been taken care of in a timely manner. When a woman can't even get decent maternity care, let alone any form of paid maternity leave or decent childcare to help her when she goes back to work, to me, that's just bad policy makers that want

to control women that don't know what they're talking about and have no conscience. I also remember stories from my mother of a great-aunt who was forced into pregnancy by an abusive husband. She became quite depressed, even suicidal. At that time, abortion was illegal and married women had few to no rights to their own body. She saw the only way out was with a coat hanger. She not only killed her fetus, but she also bled to death. Making abortion illegal is not the answer. It will only drive it underground and women will fall prey to illegal operations and do-it-yourself abortions. I thought this country was beyond that kind of thing.

HANSEN: Thank you for your testimony.

TONI CHRISTENSEN: OK.

HANSEN: We will take the next testifier in opposition from this side. Welcome.

KACIE WARE: Hi, my name is Kacie Ware, K-a-c-i-e W-a-r-e, and I'm here in opposition to LB626. I personally got an abortion when I was 16 here in Nebraska. While I was legally old enough to consent to sex in Iowa, which means the rape exception wouldn't apply to me, I was not old enough to decide to get an indepe-- get an, an abortion independently. Therefore, I used the time-consuming judicial bypass process, the way that you get special permission from a judge to get an abortion without notifying your parents. Abortion was clearly and unequivocally the best choice for me. Unfortunately, I've been here to testify against abortion restrictions and bans for the last several years. Each time I come here, I have to decide which parts of my personal experience may move you to change your mind about banning abortion. Should I explain that my pregnancy resulted after years of sexual abuse at the hands of a man twice my age? Should I explain that as a high school student, I got straight As, placed on-- played on varsity sports teams and had ambitions for college? Should I explain that since I had my abortion, I finished high school third in my class, graduated college with academic honors, got married, had two kids, and finished an MBA problem [SIC]? Frankly, neither the circumstances of my abortion nor my personal or professional accomplishments are any of your business. As I mentally prepared to attend this hearing today, I wondered if your colleagues from the Judiciary Committee gave you a pep talk about how best to get through the day while ignoring us and being as moved as possible. Today, you've heard about abortion stories surrounded by tragedy. Stories about wanted babies that would never survive, stories wrapped up in incest and abuse like mine. I'm fearful that you will not consider the

deep impacts this bill will have on Nebraska families, impacts you'll never really understand. Without my abortion, not only-- I-- would I have not been able to achieve the things I've mentioned, but it would force me to deal with the unsurmountable tragedy of having my own child being abused by their father, as my rapist went on to have children and rape his three-year-old daughter. It's unbelievably vain and cruel that you believe you know better, better than I do about what is best for my life. I hope you all can find some humility and vote against LB626. Thank you.

HANSEN: Are there any questions from the committee? Seeing none, thank you. We'll take testimony from this side of the room. Welcome.

MACY WALZ: Hi. My name is Macy Walz, M-a-c-y W-a-l-z, and I am an OB/GYN resident physician. I care for two patients in one and sometimes more. And this is a job that I'm honored to do. While it is mostly filled with celebrations and happiness, it always has the potential for profound sadness and lost. I cared for a woman-- let's call her Samantha-- who was pregnant with twins. She had many roles, including being a busy-- being a mother to a busy toddler, working a full-time job, being a wife, and then she added hospital patient to her list of roles. Samantha was diagnosed with preeclampsia, a pregnancy-related disease that causes risks of seizures, stroke and death. When preeclampsia is identified early in pregnancy, we start a workup in order to identify a cause other than pregnancy. Samantha's workup returned normal, except for the ultrasound of her babies. One fetus was found to be abnormal and the cause of her illness. Samantha was getting sicker and every morning in the hospital, as her blood pressure reached dangerous and life-threatening thresholds, she was counseled on her options by her healthcare providers. Her medical options included doing nothing, reducing the pregnancy from two to one with an abortive procedure, or induce labor and deliver both twins who were too small to live on their own. She weighed the idea of doing nothing and waiting, waiting for the fetuses to die and waiting for her own death. Samantha wanted to know what would happen if she decided to do nothing and wait, but no one knew that answer. What I did know as a trained physician was if Samantha decided to reduce her pregnancy or opt for induction, she would significantly reduce her chances of permanent damage to herself. She was asked to make an impossible decision: do I save myself or do I save my babies? Samantha didn't want to die. She didn't want her future children to die. She didn't want to make this decision. But the reality of the situation is she was allowed to make this impossible decision. LB626 would not have allowed Samantha the option to choose and this bill would have

sentenced her to death. She is your daughter, your sister, your niece, your wife. Samantha is you and she deserves the right to live.

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

MACY WALZ: Thank you.

HANSEN: We'll take testimony from the next one. Thank you. Welcome.

KATIE ANANIA: Thank you for hearing everyone today. My name is Katie Anania. It's K-a-t-i-e A-n-a-n-i-a and I'm a resident of Lincoln, Nebraska. You know, I really don't mind waiting six hours to give my testimony because that's shorter than the drive I'll have to make to another state if I ever need an abortion if this bill is passed. So in the weeks between LB626's introduction to the Nebraska Legislature and today, many of the people in my social circle have scheduled vasectomies and tubal ligations for themselves. The best reason I can surmise for this is that some of us would rather withhold our fertility altogether than put it in the hands of legislators that have authored this bill. For one, the bill's premise rests on unsound medical science. The proponents of this bill want us to believe that by detecting any electrio cart-- electrocardiac activity in a human fetus, that that fetus can be understood as sentient. Or, in the words of the bill, any cardiac activity means that its rights supersede that of the person carrying it. And remember that the settled medical science states that this cardiac activity is not a heartbeat. Here are the facts: LB626 relies on a scientifically incorrect definition of "heartbeat" and a fantastic and bad-faith definition of "child." Is an attempt-- it is an attempt by some legislators to protect human life, but only in the most-- in the narrowest and most disingenuous way possible. Without seeking out other ways to generate prosperity for families such as wage growth or subsidized childcare, LB626 fictionalizes scientific facts in a short-sighted attempt to control what takes place inside the bodies of private citizens. I'm here to assure you today that people who can become pregnant, including those planning vasectomies and tubal ligations right now, can tell the difference between a viable future and a forced one. We recognize the difference between job opportunities and pay increases that solve Nebraska's wage stagnation and families that are created by force. We see the distinctions between educational opportunities and the defunding of public schools.

HANSEN: I'm going to have to-- you hit the red light. Sorry, you were getting in-- you were really getting into it, so. So we'll have to end your testimony.

KATIE ANANIA: Thank you. And this is so generous. I just-- I think the point that I'm trying to make is that people will not stop wanting free will over their bodies when that free will is taken away. And I encourage you to take this into account. Thank you.

HANSEN: All right. Thank you for your testimony. We'll take the next testifier.

DARCI O'NEEL: Good evening. Thank you for having me. My name is Darci O'Neel and I approach you today as a victim advocate of almost four years now, as well as an adopted person. So I want you to imagine, please, being sex trafficked at 18 years old and your trafficker getting you pregnant three times in three years to make it impossible for you to leave them. And then trafficking you out to someone else and allowing them to get you pregnant for a fourth time, making it so you literally cannot escape them. Your only option is to carry the baby to term and co-parent with your rapist who keeps you locked in a basement. Or the ten-year-old girl who was raped by her neighbor and now has an estranged relationship with her daughter who ended up in foster care, being bounced from family to family because obviously a ten-year-old is not able to be a parent. My victim advocacy perspective here is abusers take away their victim's power and control over their own body. In the case of sexual abuse, the victim is violated in a specifically intimate way. As a functioning and ethical society, it is our responsibility to empower survivors. If survivors can't access reproductive healthcare after an attack, the state perpetuates that abuse. The state is complicit in the continued abuse of the survivor by safeguarding the rights of the abuser. Abusers have access to the child and therefore have continuous power and control over their victim. Please take a moment to imagine co-parenting with someone who has violated you in the worst imaginable way. At the very least, please listen to those with the knowledge and expertise to guide you in best trauma-informed practices. Thank you.

HANSEN: Thank you. All right, we'll take our next testifier on this side of the room, please. Welcome.

ROSEMARY THORNTON: Hello. My name is Rosemary Thornton, R-o-s-e-m-a-r-y T-h-o-r-n-t-o-n. I'm a retired teacher. I'm a widow with four grown children and I'm a member of the First United Methodist Church, but I represent myself. As to abortion bill, LB626,

I oppose any bill that disallows a woman to have power over her own body. That is, a law that says she must carry the six-week-old embryo in her uterus to a full-term baby. Therefore, I oppose LB626 introduced by Senator Joni Albrecht.

HANSEN: OK. Thank you.

ROSEMARY THORNTON: That's all.

HANSEN: Appreciate you coming. All right. We'll take our next testifier on this side of the room. Welcome.

HARPER SCHUPBACH: Good afternoon, Chairperson Hansen and members of the committee. My name is Harper Schupbach, H-a-r-p-e-r S-c-h-u-p-b-a-c-h, and I'm here to speak in opposition to LB626. To begin, I am here with the Lincoln East High School Feminist Club, but I'm also here to present a perspective from that of a teenage girl and a high school student. I recognize that abortion is a polarizing and yet deeply personal issue. However, seeing a bill like this that limits my access to healthcare brings me great concern for myself and all those capable of pregnancy in the state of Nebraska. As a young person, at 17 and a junior in high school, one way my perspective allows me to recognize that LB626 fails to acknowledge the realities for a vast population of young women-- my friends, my classmates, me-- is lived experience that we do not have regular menstrual cycles, including myself. In addition to my anecdotal evidence, research published in 2022 by the National Center for Biotechnology Information reports that in their study, 41.3 percent of teenage girls had irregular menstrual cycles. The likelihood many would have the knowledge of pregnancy before six weeks with these cycles is extremely low. USC in 2021 reported that one in three people are not able to confirm their pregnancy until after six weeks. To conclude that women would be at least aware that they are pregnant at that point, but also be able to have a means to make an appointment with a provider, if they even know how to or have the financial means to at the age that they are, and make a decision regarding their healthcare at that time is an unrealistic and harmful presumption. I worry for all other young people and myself that this ban could therefore negatively affect our futures. Our goals of becoming doctors, firefighters, lawyers, legislators and world travelers could easily become irreparably derailed with this arbitrary and misguided piece of legislation. For those reasons especially, I strongly oppose LB626, and recommend it be kept off the floor of the Legislature. I'm happy to answer any questions.

HANSEN: Thank you. You might want to rethink the legislators part after today. But good for you for having ambition. That's awesome.

HARPER SCHUPBACH: Thank you.

HANSEN: Any questions from the committee? Thank you. I'll take the next testifier on this side of the room, please.

CAROL HINKLE: Good evening. My name is Carol Hinkle, C-a-r-o-l H-i-n-k-l-e. It doesn't matter. It doesn't matter when life begins. It doesn't matter whether an embryo or fetus is a human being or not. The entire argument is a red herring, a distraction, a subjective and unwinnable argument that could not matter less. Nobody has the right to use your body against your will, even to save their life or the life of another person. That's it. That's the argument. You cannot be forced to donate blood or bone marrow or organs, even though thousands die each year on waiting lists. Your organs cannot be harvested after death without your or a proxy's permission. Denying people with uteruses the right to abortion means they have less bodily autonomy than a corpse. Abortion is healthcare, period.

HANSEN: Thank you for your testimony. We'll take the next testifier on this side of the room, please. Welcome.

SMRITI GANESH: Hello. Good evening, Chairperson Hansen and members of the Health and Human Services Committee. My name is Smriti Ganesh, S-m-r-i-t-i, last name, G-a-n-e-s-h, and I'm here to speak in opposition to LB626. I'm sitting here as the vice president of the Lincoln East High School Feminist Club, as well as someone who would be greatly affected if this bill were to pass. With me are other members of the Feminist Club who were able to leave school early to demonstrate our frustration and disappointment at LB626. Abortion bans like this, this one cannot be discussed without acknowledging the barriers they create to higher education for young women like us. When women's education is interrupted by pregnancy and childbirth, it delays their career, decreases their pre-professional experience and fragments their peer networks. For this reason, LB626 places my peers and me at a crucial intersection of risks; not only the rate of unintended pregnancy, a highest among college-aged women, but single mothers are significantly less likely to graduate college than their peers, with 28 percent compared to 57 percent, respectively. In the 50 years since Roe was decided, women have come back-- have come to make up nearly 50 percent of the United States workforce. In the last few years, we've outnumbered men at medical schools. When you prevent us from pursuing higher education, you decrease the number of educated

people in our state. This is why I imagine my future-- when I imagine my future, I just consider the influential women in my life-- my teachers, my doctors, my mentors-- and wonder if they would be where they are right now if they had their right-- their rights cho-- to choose stripped from them at my age. I feel frustrated that my ability to choose what my life looks like is being legislated in front of me, that suddenly I have to consider moving out, out of state for college, away from my family, my friends and the state I love, because it might not provide me with the healthcare that I need. Thank you so much for your time and I strongly urge you to oppose LB626 and keep it off the floor of the Legislature.

HANSEN: All right. Thank you. All right. We will take our next testifier on that side of the room, please. Welcome.

JENNIFER HILL: I'm ready. Thank you, Chairman Hansen and members of the committee, I'm Dr. Jennifer Hill, J-e-n-n-i-f-e-r H-i-l-l, a board-certified obstetrician/gynecologist and a former rural family physician in Nebraska. I am opposed to LB626. I have the best job, but I would like to share some difficult situations that I've gone through with my patients. I recall a woman in her early twenties pursuing a college degree. She went to have a drink at her friend's house. The next thing she remembers is waking up on his couch. She realized she'd likely been drugged and asked if anything sexual had occurred. He denied it. About six weeks later, she had symptoms of pregnancy. She had not been sexually active prior or since. At this point, she was eight weeks pregnant. Imagine her shock, confusion, embarrassment and heartache. She couldn't bring herself to report the rape. She needed to know all of her options. She has to decide whether to derail her education to raise a child, or deal with the heartbreak of adoption or abortion. She is the one who will have the daily reminder of a traumatic event whose health must be monitored closely for life-threatening complications. Absolutely no one else's morals or beliefs should affect her decisions. Endometrial ablation is a procedure that burns the lining of the uterus to decrease heavy menstrual bleeding. Pregnancy is not advised after this procedure due to risk of complications, the most worrisome of which is abnormal placental attachment, which can cause severe hemorrhage. I performed the procedure on a married woman whose husband had had a vasectomy. Due to this, she refused permanent sterilization. Several years later, she divorced and sought contraception in my office. She unfortunately had a contraceptive failure and became pregnant. She needed to be aware of the increased risk of severe, severe illness or mortality if she continued the pregnancy. She had two other children who needed her. She needed to know her options. At what point was her life deemed

at risk? Is the risk of hemorrhage enough? How badly does she need to hemorrhage to consider her condition life-threatening? None of us want people to have abortions. We are the ones who are willing to wake up at 3 a.m. and sacrifice precious time with our families to help bring healthy babies into this world. We simply understand the complicated issues surrounding human reproduction. We want people to make these difficult decisions themselves without interference from politicians. Please do not advance LB626. Thank you for your time.

HANSEN: Thank you for coming to testify. We'll take our next testifier on this side, please.

JENNIFER HARNEY: Chairman Hansen and members of the Health and Human Services Committee, my name is Dr. Jennifer Harney, J-e-n-n-i-f-e-r H-a-r-n-e-y. Thank you for hearing my testimony. I'm a physician specializing in rural family medicine. I practiced my first four years following training in my hometown of Aurora with a population of 4,500 people. I'm in opposition of LB626 and would like to draw attention to the unintended consequences any such abortion ban will have on our rural citizens. For some background, 40 percent of Nebraska's babies born between 2016 and '18 were in rural, rural portions of the state. In recent years, and due to a number of factors, fewer and fewer critical access hospitals are offering maternity care. More than half of the counties in our state do not have maternity care services. Putting rural healthcare in perspective in the setting of abortion access, there are several points to consider, but the underlying theme to all is rural hospitals do not have the same resources as large hospitals for maternal care. There are no after-hours ultrasounds to diagnose emergency ectopic pregnancies or infected miscarriages when a woman comes to the ER at 11 p.m. There are no OB/GYNs trained on procedures to safely remove an ectopic pregnancy, infected miscarriage or treat a severe hemorrhage. When these emergencies happen at a small hospital, current transfer times for us to move a patient to a bigger hospital are often two-plus hours. In a pregnancy-related emergency where an abortion is life-saving, a ban would place further delay on a woman's care where we may be able to give a dose of medicine to begin treating prior to transfer. If LB626 were to pass, this treatment for a critically ill woman would be delayed. This would inevitably result in unnecessary severe illness, lack of future fertility and death. There are often no specialized tests available that can help a family find out if a baby they've wished for has a lethal abnormality. While a family in a rural setting-- or an urban setting may discover their unborn child has something like anencephaly at ten weeks, many small hospitals don't offer or know how to interpret these tests. When these catastrophic events occur, access to a high-risk doctor or OB/GYN to

discuss options for care is critical. I myself have a medical condition where, if I were to become pregnant without months of planning, my baby would be high-risk for a very small head, very small brain and severe heart disease and death, so the right to hospice or palliative option for such a pregnancy is something I want for myself as well as the patients I care for.

HANSEN: Thank you for coming to testify. I will take an opponent from-- can't remember which side I was on-- that side of the room. Yeah. OK. I'm losing track here. Welcome.

KERRY RODABAUGH: Good evening. My name is Dr. Kerry Rodabaugh, K-e-r-r-y R-o-d-a-b-a-u-g-h, and I live in Omaha. The last time I was in this building was as a fourth-grade elementary student on a school field trip. I am now a GYN oncologist at Nebraska Medicine. I'm here today not to speak on behalf of my personal opinion, but as an oncologist on behalf of my patients. I am not speaking on behalf of my employer. I am board-certified in Obstetrics and Gynecology, Gynecologic Oncology and Hospice and Palliative Medicine. I take care of women who have developed cancer of the pelvic organs and am an expert in complex pelvic surgery. I am the surgeon they call when patients are hemorrhaging on labor and delivery, or there are complications of the placenta invading through the uterus, sometimes into the bladder. I have dedicated my life's work to the care of women through all stages of life and disease. What I do every day, walking these women through their cancer journeys and being present at the end of their lives, is difficult and heartbreaking. I am here today to speak in opposition to LB626. Cancer affects approximately one in every 1,000 pregnancies. As oncologists, we have three main ways to treat cancers: surgery, chemotherapy and radiation therapy. Surgery on a pregnant uterus ends the pregnancy. Most often, chemotherapy in the first 12 weeks of pregnancy is not advised because of teratogenicity and is not recommended, and radiation is never recommended to the pelvis in pregnancy, so a lot of our options are limited. In the instance of a cervical cancer, when a pregnancy is diagnosed later in the pregnancy, we try to get the patient to deliver early but when it's in the first half of the pregnancy, we recommend termination. So physicians need to be able to-- these decisions must be made between the patient, their oncologist and their maternal fetal specialists. So I encourage you to vote in opposition to LB626. Thank you.

HANSEN: Thank you for coming in today. We will go to the next testifier. And we will go on this side of the room, thank you very much. Yes. Welcome.

TYNE TYSON: Thank you. Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. My name is Tyne Tyson, T-y-n-e T-y-s-o-n. I'm a fourth-year medical student hoping to match into OB/GYN for residency in about 47 days. I was raised in North Carolina and I moved to Omaha for my education. I'm going to try to keep this fast. If what you've already heard has not convinced you medically or morally about this bill, nothing will. So I want to offer my perspective as a young professional who moved to Nebraska for graduate school. I'm coming into my professional life. You could potentially get 30 years of tax revenue off me as a clinician. That's quite a bit of money. And I cannot stay in this state if I-- if this bill passed. If my license was at risk, if I did anything that was even perceived as being an elective termination, I would be stuck holding the bill for two point-- for-- excuse me, a quarter of a million dollars for medical school. And if you don't have a license, you can't practice medicine and I'm not trained as anything else. This is too high of a risk for me and it's probably too high a risk for most of my colleagues. We will not be able to stay in this state. You will lose revenue from us as physicians and you will lose revenue from everyone else who will leave when they cannot get adequate medical care. This is something that is important to young people and young professionals. If you want Nebraska to thrive economically, you will oppose LB626. Thank you very much.

HANSEN: You did do that pretty quick so that's good. You've got time left over.

TYNE TYSON: I told you.

HANSEN: All right. Thank you. We'll take our next testifier, please.

DEANN PAULSON: Hello. My name is Dr. Deann Paulson, D-e-a-n-n P-a-u-l-s-o-n, and I am a board-certified OB/GYN and I practice OB/GYN in a rural community. I practice and am from Dodge County and I have lived in the state my whole life. I'm going way off script here-- except I did train in a state where I was trained to do abortion access, second trimester abortion access. I left the state for training for that reason. I wanted to be able to provide good care for my patients. Currently, as an OB/GYN in Beatrice, Nebraska, I serve patients from ten different counties. My patients travel one to two hours for their OB care to see me. Patient-- physicians are leaving the state. I have had a partner leave the state. We are going to see a crisis of qualified OB/GYN physicians in the state if LB626 passes and for that reason, I oppose it. I'm completely off script, so.

HANSEN: All right. Thank you for coming. We'll take our next testifier on this side of the room, please.

LAUREN NELSON: Good evening.

HANSEN: Hello.

LAUREN NELSON: My name is Lauren Nelson, L-a-u-r-e-n N-e-l-s-o-n, and I'm going off script because we got 2 minutes now. I am a primary care, internal medicine physician in Omaha, Nebraska. I take care of complex adults with multiple medical problems, medical problems that cannot be written into law. I am also a faith-filled Catholic woman, a wife, a mom. My utmost goal is to preserve life. Banning abortion will not preserve life. I'm going to expound upon the idea of transplants. We don't force people to have transplant surgeries, to donate a kidney to an adult, to a child, because people have bodily autonomy. But not only that, because we're forcing people to have a surgery that has potential complications that would put a person out of work, unable to earn money. We also don't force transplants because that's not the solution to the problem. We solve the problem by improving healthcare and supporting patients. We don't solve the problem of abortion by banning it. We save lives. We save women, families, children, by addressing the underlying problem. Forcing people-- forcing women to carry a baby is the same as forcing someone to have a kidney transplant. I also I'm going to share quickly a personal conundrum I deal with. I have a autoimmune disease that has anywhere from a 50 to a 15 percent five-year mortality rate. I take numerous immunosuppression medicines. One of them is methotrexate. Methotrexate can be used for autoimmune diseases, cancer and abortions. If I get pregnant next week and I give myself my methotrexate injection, what is my intent-- to save my life or to end the pregnancy? And I don't know the answer to that question. I don't know how a judge or an attorney could. Thank you.

HANSEN: Thank you for coming to testify. We will take our next testifier on that side of the room.

ALYSSA RUTAN: Good evening, Chairperson Hansen and committee members--

HANSEN: Welcome.

ALYSSA RUTAN: My name is Dr. Alyssa Rutan, A-l-y-s-s-a, Rutan, R-u-t-a-n, also going to go off script a little bit here. So I really appreciate the opportunity to speak with you all tonight. I am a board-certified obstetrician/gynecologist and I've been practicing in

the Lincoln community for the last decade and taking care of the women of Lincoln and the surrounding communities. I'd like to point out and reinforce what some of my colleagues have already discussed and that some of the diagnoses which we have not fully addressed in the bill include pre-viable, preterm, premature rupture of membranes, anencephaly, trisomy 13, trisomy 18 and renal agenesis, to name a few. I'd like to also point out that genetic screening cannot even start until approximately 9 to 10 weeks when we can initiate, initiate cell-free DNA genetic screening, with confirmatory testing occurring 15 to 16 weeks gestation. As you've already heard from my colleague Dr. Patel, gross fetal anomalies cannot be detected until we do our anatomy ultrasound, which is typically done at 18 to 20 weeks gestation. I'd like to move on and point out that I also have concerns regarding physician liability, specifically those related to intrauterine pregnancies, which are ectopic, including Cesarean section, scar ectopics and cornual ectopic pregnancies. I'd also like to let you know that my perspective is coming from one who opted out of the elective abortion training. I've never performed an elective abortion, but after 14 years of taking care of patients behind closed doors, it has really opened my eyes to the very many shades of gray and the extenuating circumstances that these women face every day. And watching these women go through their decision tree makes empathy and understanding very forthcoming, regardless of my own beliefs. So I would urge you to please not advance LB626. I do not feel that this is the right piece of legislation for physicians to take care of the women of Nebraska. Thank you for your time. Really appreciate it.

HANSEN: Thank you. Thanks for coming to testify. We'll take our next testifier and on a side note, we've got about 10 minutes left. 8:05 is when we are going to be done with testimony. So for those who do not get a chance to testify up here personally, make sure you have that white sheet filled out or if you, or if you ended up signing one, that at least puts it on the record that you came here and that your position was heard. And all that kind of makes a difference, so. Just FYI. Welcome.

KAREN BELL-DANCY: Good evening. I am Karen Bell-Dancy, K-a-r-e-n B-e-l-l-D-a-n-c-y. I serve as the executive director of the YWCA of Lincoln. I've come before this committee on several notes in the past and tonight we are coming to oppose LB626. On behalf of my board and the women that we serve and girls, we believe that in-- currently, in our nation, we are really in a healthcare crisis. And it's even more evident that there is a complete disparity when we look at different communities, especially communities of color. We represent such a small number in relation to the majority in our nation when it comes

to accessing adequate healthcare and the ability to get the support from the government and the healthcare system on making qualified decisions of what we need to do in support of ourselves as individuals and our families. I had the opportunity just a few years ago to be in D.C.-- which I have to lobby a lot on behalf of my organization and-- during the Kavanaugh hearings, and I'm sharing with you a personal testimony that I had to do during that time and sitting in the Durkin's [SIC] Building and meeting with our senators from the state of Nebraska to talk about the real differences when it comes to healthcare and especially for communities of color. You only have to look around this room and you don't see many that look like me. So imagine when we are in that healthcare setting and that environment, that we need that real support and having those, hopefully, to understand the lens of how we look through and we live through the world. And we want to have that kind of advice and that support to help us make the decisions that are really important to us. I am the first African American to serve as the executive director of the YWCA of Lincoln in 137-year history. I would like to say that at this time, we are implementing policy that embraces all of us and it is support of all of us. And not only that, to give us that personal respectability that we should have as we govern our own bodies. Any questions I'm willing to answer at this time or any other time.

HANSEN: OK. Thank you for coming to testify.

KAREN BELL-DANCY: Thank you.

HANSEN: And we will take our next testifier on the left side of the room..

STEPHANIE GUSTIN: Chairperson and members of the Department of Health and Human Services Committee [SIC],--

HANSEN: Welcome.

STEPHANIE GUSTIN: --thank you for allowing me to testify today. My name is Dr. Stephanie Gustin, S-t-e-p-h-a-n-i-e, Gustin, G-u-s-t-i-n. I am here to voice my opposition to LB626 and to provide you with a new perspective you haven't heard about yet today. I am a double board-certified OB/GYN, a reproductive endocrinology and fertility specialist and as such, my-- the nature of my life work is to help individuals and couples experience parenthood. Early pregnancy is my expertise. Amongst individuals and couples who so desperately desire a child, we can often reliably detect the presence of a pregnancy prior to the time that one should actually expect their next menstrual

period, as early as three and a half weeks. Beyond that, we monitor these highly-desired pregnancies with hormone levels and ultrasounds, looking for interval changes compatible with established trends towards an ongoing healthy pregnancy. We see fetal cardiac activity-- not an actual, structural heart, but myocardial cells sending electrical impulses as early as five-and-a-half weeks gestation-- which, amidst our patients, is a most welcome sign. But when this patient returns and her pregnancy still has evidence of myocardial function but no growth in the otherwise aspects of the pregnancy, we counsel our patients that their pregnancy, despite having persistent fetal cardiac activity, is abnormal and will likely miscarry. This happens more than you would expect. An estimated 15 percent of pregnancies past a six-week of gestation will miscarry. We offer continued surveillance to our patients just like this, hoping for a miracle, yet realistically prepared for the inevitability that eventually the pregnancy will demise. Sometimes that in-- inevitability takes weeks, weeks of watching a flicker slow and then finally stop. Right now, our patients have a choice, a choice to wait and watch or a choice or let go of the inevitable and look towards new life. This bill would take that choice away. This bill would require patients who so desperately want a pregnancy to painfully linger with the finality of an impending miscarriage against their will. I am here to tell you that this bill has the capacity to traumatize and disempower individuals whose primary goal is to experience pregnancy. And I'm asking you to oppose this bill.

HANSEN: Thank you. We'll take our next testifier on the right side.

ALY PEELER: All right--

HANSEN: Welcome.

ALY PEELER: --I'll be quick. I'm Aly Peeler, A-l-y P-e-e-l-e-r. I am here on behalf of my creative community and industry workers, many of which are uninsured and underinsured, many of which don't have the know-how or access to understand even if we-- within, you know, six weeks that we're pregnant. Something that hasn't been discussed I want to bring up today-- and seeing a lot of the clinic escorts, they'll tell you this as well. We're already seeing ramifications of other states that have put these bans. I have a friend whose-- I have permission from a lot of people who couldn't be here that wanted me to share their stories-- that found out they're pregnant very early on, actually, knew instantly that they already have two kids, were not in any situation to carry on another one, made the phone call to set up an abortion. Well, because of so many other states and an influx of so

many people coming in, it was over like 23 days before she could get into an appointment. They did say, hey, you can actually get into Ames, Iowa, a little sooner if you're willing to make the drive. So here we have something that we're not discussing, which is an inequitable access to abortion care, because abortion has been happening since the beginning of time. It's going to continue to happen. But what we're going to see is only those that can afford to travel, only those that have, maybe a support system are going to be able to get these resources. So we're already seeing the effects of other states and, and you know, having these bans. So please, please, please, please oppose this. Don't even bring it to vote. This is affecting our creative people. It's, it's so frustrating to me as someone who-- I have two kids. And I don't need to share my story, but I had an abortion when I was younger, one in which wasn't traumatic. It was a wonderful experience for myself. And it was a pill you take. You know, and it's not something that has to be a trauma story we tell. And although I've been crying, listening to people, but to everyone, it's, it's not a terrible thing. I wouldn't have the life I had had it not been able to make that choice. So I just want to, you know, thank you to everyone who is here that doesn't get to speak. I feel honored to get to maybe be one of the last people. But thank you for-- and please oppose this. This is ridiculous, so thank you.

HANSEN: Thank you. We'll take another testifier. Welcome.

ELIZABETH CONSTANCE: Thank you. Chairperson Hansen and members of the committee, thank you for the time to speak with you today regarding LB626. My name is Dr. Elizabeth, E-l-i-z-a-b-e-t-h, Constance, C-o-n-s-t-a-n-c-e. I am double board-certified in OB/GYN and Reproductive Endocrinology. I'm also director of fertility preservation at my organization, where I help individuals with cancer preserve eggs and sperm before undergoing treatment that can make them permanently sterile. It is one of these patients I want to tell you about today. Sarah was in her mid-twenties and had just married her high school sweetheart with whom she was planning to start a family in their rural Nebraska hometown, when she was diagnosed with a very aggressive form of cancer. Luckily, her cancer was caught early with high survival rates associated with treatment at this early stage. Because Sarah and her husband desperately wanted children, she was referred for egg freezing before starting chemo. When we did an ultrasound to start her fertility treatment, we discovered, to her shock, that she was 12 weeks pregnant. Sarah and her husband were now faced with an impossible situation. If she chose to continue this pregnancy, it would mean delaying chemotherapy, which would cause her cancer to progress to a more advanced stage and significantly decrease

her chance of living more than five years past diagnosis. Her other option was to terminate this highly desired pregnancy so that she could start chemo immediately and therefore have a better chance of living to see her children grow up. Sarah's situation is one of the many gray areas mentioned today that is left out of the exceptions in this bill. Her life was not in immediate danger, but forcing her to carry this pregnancy would have significantly shortened her life and prevented her from receiving standard-of-care cancer treatment. As she cried in my arms that day, she confided that until that very moment, she had been staunchly pro-life and never imagined making the choice she was about to make. But this is precisely the point. Even though she never thought she would exercise that choice, she did, in fact, have a choice. If she had chosen to continue her pregnancy and risk advancing the stage of her cancer, she would have done that with a peace of mind, knowing that she had made that choice for herself. If LB626 goes into effect, I ask you who decides what constitutes sufficient risk to the life of the mother? Is it a risk of dying today, tomorrow, next week? For Sarah, she would have likely survived the pregnancy, but may not have lived to see her child's first day of kindergarten. As someone who has dedicated my career to growing families in Nebraska, I can tell you unequivocally that LB626 will harm Nebraska families.

HANSEN: Thank you. We'll do one more.

STEPHANIE HARTMAN: Chairperson Hansen and members of the committee, thank you for allowing me to speak. My name is Dr. Stephanie Hartman, S-t-e-p-h-a-- S-t-e-p-h-a-n-i-e H-a-r-t-m-a-n. I'm speaking in opposition to LB626, which would further restrict and essentially and effectively ban abortion access in the state of Nebraska. I'm a physician and board-certified internal medicine doctor in Omaha and completed all my medical training in this state. My personal experiences during my medical training and the practice of medicine for over a decade have shaped my views on abortion. These experiences have allowed me a deep understanding of the complexity of the decisions around one's own body. These experiences in education also afford me the expertise and knowledge to understand that the translation of medical terminology into law is fraught with dangerous and life-threatening consequences. No two medical scenarios are alike. I was trained to respect the dignity of the human in front of me and allow them the information in order for them to make an informed decision. These are deeply personal decisions that should be left to the trust of the individual with the counsel of their choice. Personally, I have spent thousands of hours in counsel with patients about their medical choices and decision-making. Some of these

discussions have centered around life or death. Some of these patients have also sought the counsel of a priest, pastor or other trusted advisor before formulating their decision. There does not need to be an abandonment of faith to allow another individual the right to the dignity and humanity of their own choice about their own body. I call on you to respect the principle of patient autonomy and support ensuring access for all patients to the full range of reproductive healthcare services, including abortion. Such reproductive healthcare decisions are foundational to the patient/physician relationship and a patient and one's decision about whether to continue a pregnancy should be a private decision made in consultation with a physician, healthcare professional and without interference from the government. I'm counting on you to take the necessary action and vote no on advancing this bill out of your committee. Thank you.

HANSEN: Thank you. OK. Well, that will conclude our opposition-- our time for opposition testimony. I think it went over about 5 minutes, so we will end up clearing the room because then now we have to bring in neutral testimony. And neutral testimony, what I had mentioned before is very specific. There will be no opposition people coming in for neutral testimony or proponents who didn't get a chance to testify because we had a bunch of both. This is typically reserved for state agencies to give neutral testimony about how it's going to affect either the judicial branch or the executive branch. So for now, we'll clear the room and we'll move on with neutral testimony in a little bit after a five-minute break.

[BREAK]

HANSEN: All right. So now we are on to neutral testimony. And we're going to be a little bit strict with neutral testimony, which I think-- I appreciate everyone at least making sure that they will be neutral. If we start kind of veering one way or the other, we might, kind of, have to stop you just to be fair to everybody else who's kind of waited in line, and who didn't get a chance to speak. So the first thing-- the first neutral testimony we want to bring up is anybody who is affiliated with the-- a state agency can come up first. Welcome.

MINDY LESTER: Thank you. Good evening, Chairman Hansen and members of the committee. My name is Mindy Lester, M-i-n-d-y L-e-s-t-e-r, and I'm here on behalf of the Nebraska Attorney General. I currently serve as chief of the AG's Health Law Section. And in that capacity, I have knowledge regarding the disciplinary process for licensed healthcare professionals. I am testifying on behalf of the Attorney General's Office in a neutral capacity to provide information to the committee

regarding how the health licensing system works. The Uniform Credentialing Act was enacted by the Legislature to license and regulate persons and profe-- and businesses that provide healthcare and health-related services, and to protect public health, safety and welfare. The Attorney General has the responsibility of prosecuting violations of the UCA. The UCA grants the director of Public Health the authority to deny a credential, refuse renewal of a credential or discipline a credential. If the director is not licensed as a physician in Nebraska, then Section 81-3115 mandates that a chief medical officer be appointed and that that chief medical officer be licensed to practice medicine and surgery in Nebraska. If a chief medical officer is appointed, he or she shall perform the director's duties in administrative licensure cases. The UCA regulates healthcare professions through a complaint-driven process. Once a complaint is filed, the department screens the complaints to determine whether there is sufficient information to indicate a potential violation. If there's an affirmative finding, that complaint is assigned to an investigator who completes an investigation including interviews, collection of documentation and other materials, and completion of an investigative report. That entire investigation is submitted to the appropriate Medical Licensure Board or Health Licensure Board for review and consideration in closed session. The AG's Health Law Section currently reviews all investigations. The board makes a recommendation to the Attorney General's Office, which may be broadly one of three options. First, the board can recommend the matter be closed with no action if there's no violation. Second, the board can recommend that the Attorney General enter into an assurance of compliance with the licensee, where there is an instance of a minor technical violation of a UCA statute. Third, the board may recommend the Attorney General pursue discipline where there's evidence of a substantial violation. The board may recommend that the license receive a censure, a civil penalty, a limitation, be placed on probation, suspended or revoked. Following this process, the UCA requires the AG to, to determine whether the licensee has violated any statutes or regulations and to decide whether to file the petition. After consideration of the evidence, the director or CMO has jurisdiction to dismiss the action or impose discipline where there is clear and convincing evidence. LB626 does not present a material change to this process. The process will continue to, to undergo consideration by the appropriate board. The board will review the investigative materials and make a recommendation to the AG. The AG will file a petition if there is a sufficient evidence of a violation of the Act, as we do in all instances of UCA violations. LB626 does require the director or CMO to make a finding as to whether the

licensee performed or induced an abortion in violation of the Act. If there is such a finding, the director or CMO must then enter an order revoking the license. In that event, the license would be eligible for a request for reinstatement following two years, and that request would be considered following approval of the board and the discretion of the department. This concludes my prepared testimony. Thank you for the opportunity to testify today and I would be happy to answer any questions about the disciplinary process.

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

M. CAVANAUGH: Thank you and, full disclosure, I have a few.

HANSEN: OK.

M. CAVANAUGH: I didn't know you were going to be here, but I'm, I'm happy that you are, because I do have a--

MINDY LESTER: Great.

M. CAVANAUGH: --few questions, so thank you. And-- just-- I'm overly excited at 8:00 at night that you're here, so thank you.

MINDY LESTER: That's good.

M. CAVANAUGH: OK, so the Credentialing Review Act. So typically in, in this process, we go through the-- what we call the 407 shorthand, but the credentialing review process, which is the scope of practice change. And in that process-- I'm not sure how familiar you are with those--

MINDY LESTER: Sure.

M. CAVANAUGH: OK. And so in that process, there's the whole review team and the credentialing review process from the Board of Health. They make recommendations; we have this lovely report. And then, we generally try to then, after that has been approved, introduce legislation around that.

MINDY LESTER: Sure.

M. CAVANAUGH: Without going through that process, we don't have that documentation from the Board of Health.

MINDY LESTER: So my response to that would be that my experience with the 407 review process is to affect the scope of practice for a physician. And I did not review this as a scope of practice bill. It appears to be legislation that just deals with what is the law in Nebraska. And we have a lot of statutes in the UCA that are not scope of practice and did not go through the 407 review. I did not specifically evaluate it in that regard, but that's been my experience.

M. CAVANAUGH: OK, that is helpful. I might want to follow up with you later in the future about evaluating in that way and see--

MINDY LESTER: Sure.

M. CAVANAUGH: where that would mean. If other people have questions, I can pause as well. Sorry.

HANSEN: OK. I don't see any.

M. CAVANAUGH: All right. One of the concerns that I have in here is the--what even starts the investigation? So a complaint?

MINDY LESTER: Um-hum.

M. CAVANAUGH: But how?

MINDY LESTER: Complaints can come in a number of ways. Other healthcare professionals are mandatory reporters in some circumstances, not all. Those are in 38-1,1124-- 124.

M. CAVANAUGH: Wait. Can you say that again?

MINDY LESTER: I can. Sorry. 38-1,124 and 38-1,125. Those are the mandatory reporting obligations for when a licensed healthcare professional has to either report someone in their own profession, someone in a different profession or themselves. So there's mandatory reporting laws in Nebraska. Aside from that, anybody in Nebraska can file a complaint by going to the Nebraska Department of Health and Human Services website. So that's how they start. 99 percent of the time, if not more, it's a complaint on the website from a community member, a patient, a pharmacist with a doctor, you know, all kinds of, you know, somebody who's been in a salon chair and witnesses something from some other-- you know, those are all examples.

M. CAVANAUGH: Sure.

MINDY LESTER: So that's how it happens. The complaint is initially screened by the department for kind of a surface-level view of does it look like there might be a violation? And so, they're, they're well-trained to say, well, it looks like this guy was drunk at work. So that's pretty clear, we should investigate that. There are others that are not as clear, and so we also have a full board review process. So if the department closes the complaint without investigating, then the complainant has statutory right to ask for a full board review. And that full board review then takes the complaint to the board and the appropriate board can say, we agree, you should not have opened this, we're done; or they can say no, actually we think there is a violation, please open this for investigation. So there's some protections in place to make sure that there's some, some, some checks. In addition to that, if whoever's reviewing it at the department is not sure, there are board consultants available to look at that complaint and tell us if it should be opened for investigation. But we don't fish; we are complaint driven. If we don't receive a complaint, then we're not going to look at things. There's the one exception that's not quite as clear, which is that, if as we're investigating something else there is an obvious violation, then our public health and safety duties says we need to look into that.

M. CAVANAUGH: So back to-- thank you for that. Back to-- my sort of original intent is I still don't understand how we can have complaints in these situations and not be violating HIPAA.

MINDY LESTER: The Department of Health and Human Services is an oversight agency. There's an exception to HIPAA that allows us access to everything except substance use records that are protected by 42 CFR Part 2.

M. CAVANAUGH: OK.

MINDY LESTER: Other than that, we have access to everything and we can get everything. And we do.

M. CAVANAUGH: I'm so glad you're here. Thank you.

MINDY LESTER: I'm glad to be here.

M. CAVANAUGH: That's helpful clarification. So if an individual-- but this does open us up to any, any individual can make a complaint.

MINDY LESTER: Yes.

M. CAVANAUGH: And, and then that would-- you would have to do-- take some course of action. So-- correct? I mean, at least initial course of action to either--

MINDY LESTER: The department will at least screen the complaint to determine whether, whether it's going to be investigated and then present it to the board.

M. CAVANAUGH: How would--

MINDY LESTER: All complaints are not opened.

M. CAVANAUGH: --and then if a complaint-- that you said the complainant can petition for something?

MINDY LESTER: It's called a full board review under the UCA. So if the-- the complainant gets a letter that says we did not find sufficient information to open your complaint, so the complainant could then present more information. So the example, if we get a letter that just says, my doctor refused to give me my heart medication and I'll die without it, we're probably going to open that. But if they say the doctor wouldn't see me on Thursday and Thursday was the only day, the department's probably not going to open that. But more information might indicate that on Thursday, they asked for an appointment for their heart medication. And we didn't know that until we asked for more information and it changes the review.

M. CAVANAUGH: So specific to this legislation, a complainant would be, I know that Jane Doe had an abortion and it violates LB-- law as outlined in LB626.

MINDY LESTER: That's what I would expect is if somebody is filing a complaint saying that.

M. CAVANAUGH: But not the patient themselves.

MINDY LESTER: It could be. It's less likely.

M. CAVANAUGH: No, in this, in this specific scenario, I'm saying when a complaint is filed and it is not the patient filing the complaint, I mean, we can have lots of husbands, boyfriends, assailants filing complaints. What is the process going to be?

MINDY LESTER: There's nothing currently in the statutes or regulations that talks about that exactly. There is language about protection of the complainant. We review complaints to make sure that they're

legitimate, right? And so that-- the Attorney General's Office is not going to pursue discipline against a provider unless there's clear and convincing evidence of a violation. We also have no interest in victimizing people. That's not our goal. So I can't tell you for certain today how that would flesh out. Other than that, our goal is public health and safety and everything we do is with that goal in mind. So that includes making sure that all of our licensed healthcare professionals are acting competently and safely and also making sure we're not disciplining competent and safe practitioners for-- just to do it. And so we look at both of those things. Protection of the reputation of the, of the license classification is also important to public health and safety.

M. CAVANAUGH: OK. Bear with me. This is going to be a slight journey to get to the question. But one of the big concerns in this bill, in this piece of legislation, are how the exemptions would be allowable, permissible, all of those things. And so, when we're talking about victims of sexual assault, if you are a victim of sexual assault and you go to your doctor under this law or bill-- you go to your doctor, you say you want an abortion, you were assaulted. And your doctor has to do something. Now we can-- that, that's a whole other question I'll come back to is the something that they have to do, but it is put in your medical record and that goes to the department for collecting data on, on how many abortions are performed, et cetera. And now we have the assailant filing a complaint and this is how they are finding out if you had an abortion or not.

MINDY LESTER: We don't release information on our investigation to the complainants. That doesn't happen. 38-1,106 says no.

M. CAVANAUGH: But if you open up a-- but if you write back that you are opening an investigation, you are essentially admitting that there was an abortion.

MINDY LESTER: I, I would have to disagree with that. We have to open an investigation to protect public health and safety if anybody makes a claim--

M. CAVANAUGH: Right.

MINDY LESTER: --that there's a violation. So the only thing that the letter says-- and this goes from the department-- is we've opened this for investigation. That's it.

M. CAVANAUGH: OK.

MINDY LESTER: After that, the complainant can call the department, they can call me. I get calls all the time. And our process is we don't even tell them we recognize their name. We don't tell them we have the file on it until there is a public record, which there might never be. If that's the true fact scenario, then it's an exception. There would be no record. We will never release our findings to the complainant. There is no subpoena. There's no public records request that will ever allow that complainant or the assailant in that case to get those records.

M. CAVANAUGH: So this takes me to my other part of this. Let's say that there is an assault, and as we have heard many times today and, and, and lots of data, that those go underreported, significantly.

MINDY LESTER: Sure.

M. CAVANAUGH: And so it goes unreported in this case. And the assailant requests a claim be opened and you find that there is cause for the claim because it went unreported. Then what happens?

MINDY LESTER: Do you mean unreported to a criminal agency of some sort?

M. CAVANAUGH: Unreported to anyone other than the doctor. And the doctor takes you at your word.

MINDY LESTER: It's difficult to answer that because currently, the language in LB626 says that if you've been subject to an assault that resulted in pregnancy, it's an exception. And so without knowing what--

M. CAVANAUGH: But it also references those criminal statutes. So it says that it's an exception, but that your healthcare provider is required to report it.

MINDY LESTER: I'm sorry. If it says that they're required to report it to law enforcement, then I missed that part. So I'll just apologize for that. But--

M. CAVANAUGH: It was only, only for--

MINDY LESTER: --my reading was they were required to document it, which is already true of medical professionals.

M. CAVANAUGH: It says, if a physician performs or induces an abortion in the case of sexual assault or incest pursuant to the subdivision,

the physician shall clearly-- shall certify, not clearly, sorry-- certify in writing that the abortion was performed because of sexual assault or incest, and that the physician complied with all duties of a healthcare provider required by Section 28-209, which is the reporting of sexual assault, mandatory reporting. That only applies, I think, for minors. But I don't know. It, it's unclear to me if that would then extrapolate to apply to non-minors that they also have to report any sexual assault case to the police.

MINDY LESTER: I am most definitely not a criminal lawyer.

M. CAVANAUGH: OK.

MINDY LESTER: What I can tell you is that--

M. CAVANAUGH: See, I got so excited when you were here.

MINDY LESTER: --all healthcare professionals are already required to mandatorily report the sexual assault of minors.

M. CAVANAUGH: Yes.

MINDY LESTER: They're required. So there's no change to that.

M. CAVANAUGH: Right.

MINDY LESTER: The way that I read that statute-- and I look at things entirely through the discipline lens-- is this worthy of discipline or is this doctor or other healthcare professional doing OK-- is they need to document it in the record. If that's a record that's sealed from all other parties, then the department could consider that in regulation or, or it could become a practice that's appropriate. I can't fathom a situation where protecting that health record from the complainant were, were worthy of discipline. That wouldn't make any sense to me with the goal of public health and safety. So I didn't read that to be a change to anybody's current requirements.

M. CAVANAUGH: OK. Thank you. So if a complaint is opened and the department deems it to have some substance to it, what is then the trajectory? I'm, I'm wanting to know what access does the complainant get to any information in all situations? Is there any situation--

MINDY LESTER: Absolutely none. The only time that anybody gets any information is that if we file a petition, that becomes public. If we enter it into assurance of compliance, that becomes public. If there's the contested case, then it's public. But aside from actual action

regarding the license, they get nothing. And there's never been a circumstance in my seven years where I sent a complainant anything. We've certainly had the occasional time that the complainant is a witness because they were the patient who had a botched surgery or something of that nature or was assaulted by their physician. And then they are privy to the information that they hear at the public contested hearing. But that information is so highly protected that we don't share it within our own office, let alone outside the walls of our office.

M. CAVANAUGH: Thank you. If a physician loses their license under this, is there a path for them to get their license back in the future?

MINDY LESTER: So the statute on revocation is 38-148, and it specifically provides that once a healthcare professionals license has been revoked, it's revoked for all time, except that they may request reinstatement of the license following two years. After the two years, there's a reinstatement after discipline process, which is the very next statute. And it says that the department can only consider an application for reinstatement if the board approves. So it first goes to the board. The board looks at it. The way that process tends to work is they look at what has this person done in the last two years to remedy the conduct that resulted in revocation and then they make a recommendation or they prove or deny the application. If they've approved it, then the department looks at it and decides whether to grant it. If they deny it, they can request an appeal before the board.

M. CAVANAUGH: OK.

MINDY LESTER: So yes--

M. CAVANAUGH: OK.

MINDY LESTER: --they can.

M. CAVANAUGH: Yes. Thank you. I appreciate you explaining the process.

MINDY LESTER: There's no guarantee, but they can ask.

M. CAVANAUGH: OK. Thank you. That might be it.

HANSEN: OK. All right. Seeing no other questions--

MINDY LESTER: OK.

HANSEN: --thank you very much.

MINDY LESTER: Thank you very much.

M. CAVANAUGH: Thank you.

HANSEN: All right. And we will take our next neutral testifier.

________________: I'm no longer neutral, I'm opposed after that. So do I go up?

HANSEN: No. Thanks for telling me ahead of time, though.

WALZ: Change her-- does she change her-- she--

HANSEN: Well, she won't turn it in since she's not testifying. You can still fill out that white sheet, though, because then they'll still put you on the record as opposed or neutral, whatever. So.

________________: It was informative.

HANSEN: Awesome.

________________: Thank you.

HANSEN: Welcome.

ANGIE PHILIPS: Hello. Hello. My name is Angie Philips, that's A-n-g-i-e P-h-i-l-i-p-s. I am the founder of the Nebraska Legislative Study Group, which is an all-volunteer grassroots group with membership across the state. One of our goals, perhaps our largest goal, is to educate Nebraskans on the legislative process and their right and responsibility to participate as Nebraska's second house. Participation in public hearings is perhaps one of our greatest responsibilities and privileges as Nebraskans. And while the study group supports abortion access, I'm here today testifying in a neutral capacity to express concerns about the silencing of the second house through placing time limits on testimony. LB626 provides for the removal of abortion access to over half of Nebraska's population. And the very least this committee and the Legislature could do is be willing to sit through every testimony from every person that came to be heard today. I realize that this is, unfortunately, becoming more and more the norm of the Legislature in public hearings and it's important for you to recognize the impression that this leaves with the second house and the negative impact it has on civic engagement and participation. It's worth legislating, then it's worth discussing

with Nebraska's second house. And I'm requesting that this committee and all committees recommit to better communicating with and listening to Nebraska's second house, especially when you are legislating so, so much that is personal to us and our bodies. Thank you.

HANSEN: Thank you for coming. Is there any questions from the committee? All right. Seeing none, thank you. We'll take our next to-- neutral testifier. Whoever wants to jump up here.

JEFF SPAHR: Sir--

HANSEN: Welcome.

JEFF SPAHR: --could you remind me what-- how much time that we have.

HANSEN: You have 3 minutes. And if you could say your name and spell it for us, too. Thank you.

JEFF SPAHR: Hello, my name is Jeff, J-e-f-f, Spahr, S-p-a-h-r. I'd like to thank the committee for the opportunity to speak and recommend some amendments to LB626. Senators, you sit here having three roles: first, as representatives of your constituents; second, to uphold the Constitution in the state of Nebraska, which can be summarized in the Bill of Rights. All persons have certain inherent and inalienable rights. Among these are life, liberty and the pursuit of happiness; thirdly, being God's servants, you are protecting citizens, preserving order and aiding people to live peaceful and quiet lives. The main question then becomes, who is a person? Since I've been given 3 minutes, I would like you to turn the page to a section that has (a) to it. It's on the last page. Scientifically, at the point of fertilization, the sperm and ovum unite to form a zygote. This distinct and unique DNA, in essence, creating a foreign body that will travel freely for 5 to 6 days, then implants causing a cascade of reactions such as preventing the mother's immune system from attacking the foreign body. Back to normal script. A University of Arizona embryology professor, Dr. C. Ward Kischer, answers this question about a person in a 2002 ABAC fall article. Every human-- embryologist worldwide states that the life of a new individual human being begins at fertilization. The Nebraska preamble rightfully points to the ultimate source of our freedoms-- almighty God, who is our true source of human value, worth and dignity. Therefore, I plead with you to reject the arbitrariness of a heart, heartbeat bill and replace it with a full extension to pre-born image-bearers at fertilization. Reject unjust warnings and demand penalties for the intentional murder of pre-born and post-born children. Reject partiality and hold all

parties complicit and accountable for their actions. Reject the lack of action. You have genuine power to enact an equal protection law, turning to the "b" section. A law of equal protection gives the states more teeth to pursue rapists, "incestophiles" and sex traffickers.

HANSEN: We have to stop you there. Your red light did come on, so thank you for your testimony. We'll see if there's any questions from the committee? Yes, Senator Riepe.

RIEPE: I have a quick-- who was it-- and maybe I missed it. Who do you represent, yourself?

JEFF SPAHR: I represent myself. But we are-- I am part of an organization called End Nebraska-- End Abortion Now in Nebraska.

RIEPE: OK. So that almost makes you a proponent of the bill.

JEFF SPAHR: Because there's language in the bill that still allows for the killing of babies, then I would be opposed to that language.

RIEPE: Well, my point is I don't think you're neutral.

JEFF SPAHR: And that's why I am neutral, because this-- I-- this position does not allow me to be proponent, does not allow me to be opponent, so I have to be neutral in that particular case.

HANSEN: Thank you for your time.

JEFF SPAHR: That's the, the description we were given last year in the same type of setting.

HANSEN: OK. Thank you for your testimony. We'll take the next neutral testimony. Welcome.

GINA FRANK: Thank you. My name is Gina Frank, G-i-n-a F-r-a-n-k, and I'm here testifying in the neutral. I had not anticipated being here and testifying today, but then I was listening to earlier testimony. And Senator Hansen, you asked why a pregnancy might make someone suicidal and so I am here to answer that for you. Pregnancy, even if you want it, is extremely difficult. It is. You have a lot of hormones and it is terrible. Honestly, like, being pregnant is terrible. Even if you desperately want to be pregnant, it's awful. And so the fact that, the fact that-- if, if you don't understand that that is something that happens, then maybe you shouldn't be making laws that, that force people to be pregnant. So, I mean, that's like a really, really basic thing. There are lots of reasons why someone might be

pregnant, might be suicidal because they're pregnant. They could have been-- it could have been product of incest. They could have been raped. They could be just like, really, like, not in a place where they can be pregnant, where they, you know, they're in a bad relationship, maybe it wasn't right, but maybe it was, you know, a really bad decision. So that is something that you should probably take into account. And I would like to suggest that if you're going to go forward with this bill, that you also require that men use their bodies to save lives. So require men to be bone marrow donors, organ and tissue donors. If, if women are required to be-- to use their body to sustain a life, then why aren't we demanding that men donate their organs, tissues, fluids to save lives of kids with cancer?

HANSEN: OK. Thank you for your testimony. Appreciate it. We're going to do this one more time. I'll take the next neutral testimony. And if it's not neutral, it might be done.

TIMOTHY C. MELCHER: Hello, members of the Health and Human Services Committee. My name is Timothy C. Melcher, T-i-m-o-t-h-y C as in Clifford, M as in Mike, e-l-c-h-e-r, and I am here to point out technical issues with the bill. The first issue is that this bill does not include third degree sexual assault in its list of sexual assault exceptions. As a person who fathered a child out of third degree sexual assault, I can attest that it does in fact occur. The second issue is that a conviction is required for proof of sexual assault. Rape kits are only evidentiary proof of sexual acts, best collected within 72 hours, and are not necessarily proof that sexual assault occurred. A physical exam may yield discovery of bruises, which could be indicative of sexual assault. But again, this is only evidentiary. Bruises could be from acts of domestic violence and may not necessarily correspond to the sexual act in question. The third issue is that court can take up to a year or longer. Therefore, the baby may be born before a conviction is even given, defeating the purpose of the bill's exception. Inversely, prosecutors may rush a conviction in order to grant the mother the abortion except-- exception provided by this bill. The fourth issue implicates the physician. If a conviction is not given, the physician cannot legally certify that a sexual assault has occurred. If the physician assumes the sexual assault has occurred, performs the abortion, then discovers that the defendant was acquitted, would they be liable for misinformation and for unlawfully performing the abortion? There are a couple of points that I wanted to make and bring to your attention. So thank you for your time.

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

SUSAN KIRCHMANN: Good evening. You can start the clock already. You probably want to get out of here. My name is Susan Kirchmann, S-u-s-a-n K-i-r-c-h-m-a-n-n, and thank you for having me. Good evening. I am an attorney here in Nebraska. I graduated from the University of Nebraska College of Law in 2002. I'm providing this neutral testimony to point out what I see are some issues with the bill. I think you've got some due process problem regarding any potential criminal liability that may arise because of this bill, because it isn't specifically stated within the bill itself. The other problem that I think you have in a due process sense and in a definition sense is the vagueness regarding medical emergency as it's defined on page 2, starting at line 24. When you have all the words in the English language available to you and you're trying to define a crime, I would just suggest that you be as precise as possible and that the language used within this: so complicates the medical condition as to necessitate an abortion to avert death or for which a delay in terminating will create serious risk of substantial and irreversible physical impairment of a major bodily function. I, I would have a heyday with that as a criminal defense attorney. So if you really want to have people convicted under this statute, you need to be a lot more specific because I think any attorney can come up with explanations and an expert witness that would be able to certify that the physician's actions were not, in fact, against this law. So it's just something for you to be thinking about. Also, on page 4, lines 8 and 15, the reference to putting that information in the woman's medical record: physician shall keep the written certification in the woman's medical record. There's nothing within the bill that states how long the physician needs to keep that woman's medical record. There may be some other portions of law floating around out there or board standards, probably Miss Lester probably could have talked about that a little bit better, how long medical records are required to be kept. But I think that if you want that in the bill, it should also be specifically spelled out and included.

HANSEN: Thank you for your testimony.

SUSAN KIRCHMANN: Thank you.

HANSEN: Any questions at all? All right. Thank you for coming.

SUSAN KIRCHMANN: May I be excused?

HANSEN: Yeah.

SUSAN KIRCHMANN: Thanks.

HANSEN: All right. Anybody else wishing to testify in the neutral capacity? Well, congratulations. You're our last one for the day.

WILL STEWART-STARKS: I will take advantage of it. I won't take all your time.

HANSEN: Well, you got 3 minutes. Take advantage of it.

WILL STEWART-STARKS: My name is Will Stewart-Starks. It's a long name to spell, W-i-l-l S-t-e-w-a-r-t-S-t-a-r-k-s. I wrote on there that I'm coming as an ambassador to the Lord, Jesus Christ. I don't really have a position for or against this particular legislation. I don't actually recognize it at all. And there are some things that I think that we need to consider as a body here representing his kingdom, which is coming to this earth. And I would just pray that each of you would consider his will as you move forward, as you vote. I think that it's often disregarded and there are just some very fundamental things that I've seen here. And just even talking to some of the represent-- or the senators, rather, where I feel like compromise is-- rules the day. There's not a principle; there's not a guiding point of, of law; there's not a, a standard that we're using. It's a measuring stick that is arbitrary and is always changing. And I would just challenge each of you, whether you support or oppose this legislation, to consider that. Why are you here? How did you get here? I'm, I'm excited to be here because God has put me here in this time and place and it's purposeful and we have a purpose. You've, you've reached this point where you're making decisions for a, a kingdom of sorts, a kingdom of Nebraska. And I would just pray that you would consider the one who has placed you in that seat when you move forward. We need to value people and-- all people. I feel like we've disregarded a lot of people in this process and I just hope that you guys would consider our Constitution, our founding document, as you move forward, but also just avoiding the wrath that God has for those that would put forward iniquitous laws, injustice and call it good. And just reading this, I just can't help but feel like he is an afterthought. And we wouldn't be here without him. So I just pray for you all and I pray that some of you will actually reach out and listen to, to individuals who would like to talk to you about this more. And I just pray for all of us here that we do the right thing. In Jesus' name. Amen.

HANSEN: Thank you for your testimony. All right. So seeing nobody else wishing to testify, I'm assuming. We will then bring up Senator Albrecht to close. Welcome back.

ALBRECHT: Well, it's been a while. I know it's been a long day, Chairman Hansen and members of the committee. I thank you for listening. I appreciate the time and attention to this bill. And I just want to thank all the testifiers: proponents, opponents and neutral. This bill, again, is simple. It protects babies with heartbeats from elective abortion. It's the human thing to do and I know that we all care for women and babies. So I hope the committee will advance this bill to the full Legislature. And again, I thank you for your time. I'm way past my bedtime. So thank you again.

HANSEN: Any questions? Yes, Senator Day.

DAY: Thank you, Chairman Hansen. OK. So you've sat in the room for--

ALBRECHT: Yes, I did.

DAY: --both sides of the discussion here. And I just wanted to ask you, after you heard everything from medical professionals relating to the potential dangers that the life of the mother, the person who is pregnant, would be put in. The fact that the exceptions aren't really going to function as exceptions. Related to-- again, the polling data that I had mentioned earlier that I have in front of me with Nebraska voters opposing legislation that would ban all abortions in the state by a 15-point margin and then the 2,500 comments that we had online, of which 62 percent were opposed to this bill, in addition to this stack of papers here that are all from people who oppose the bill. And then I had originally planned on reading the names of people who did not have the opportunity to testify that wanted to, but there are so many of them that I don't believe that I have time to do that. There's about 14 names on each seat-- or excuse me, on each sheet and there's about 17 sheets here of people that opposed this bill who did not get to testify, in addition to the ones who did over the course of the three hours. Do you still plan on prioritizing this bill, despite the fact that it's been very clear that the majority of Nebraskans don't want this?

ALBRECHT: I absolutely am going to prioritize this bill.

DAY: OK.

HANSEN: Any other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for sticking with us, Senator Albrecht. In your closing, you said that this is a simple bill, which I would respectfully disagree with; it is not a simple bill. But the intention is to ban elective abortion.

ALBRECHT: Yes.

M. CAVANAUGH: You heard from I don't even know how many people today about what this bill does. It does much more than ban elective abortion.

ALBRECHT: Senator Cavanaugh, that's your opinion. Mine is that these doctors today will continue to do what they do. They should not fear, between a doctor and a patient, what they want to do.

M. CAVANAUGH: So do you think that they were all lying?

ALBRECHT: I'm not saying anybody's lying.

M. CAVANAUGH: Well, they--

ALBRECHT: Don't put words in my mouth.

M. CAVANAUGH: Well, I'm, I'm asking you, I'm not trying to--

ALBRECHT: No, I don't think they, they-- they can feel a certain way, but so can I, and so can many Nebraskans--

M. CAVANAUGH: But they're the ones practicing.

ALBRECHT: --that want to see this take place.

M. CAVANAUGH: So you can feel a certain way and that's fine--

ALBRECHT: Um-hum.

M. CAVANAUGH: But if there's a--

ALBRECHT: It's not just about me.

M. CAVANAUGH: --that, that's true. But if they're the ones practicing, it's their practice--

ALBRECHT: Right.

M. CAVANAUGH: --their medical practice. And they are saying that they won't be able to do it, not that they feel, but that they won't.

ALBRECHT: But they would choose not to do it.

M. CAVANAUGH: What they would choose not to feel like they're--

ALBRECHT: Today, today they're doing everything that they're talking about--

M. CAVANAUGH: --they do not feel like they have a choice.

ALBRECHT: --and they're not having any loss that we know of. They didn't talk about losing anyone. They talked about the Texas law. There are a lot of things going on with this bill. But yes, it will remain my priority and I strongly believe that doctors can continue to do what they do to save the life of a baby.

M. CAVANAUGH: OK. So in the situation where a woman is diagnosed with cancer--

ALBRECHT: Um-hum.

M. CAVANAUGH: --and the treatment for her would kill the baby.

ALBRECHT: Again, that's between the doctor and the patient.

M. CAVANAUGH: But in your bill, does it allow for an abortion in that specific incidence?

ALBRECHT: Absolutely. I would say it does, yes.

M. CAVANAUGH: Because they don't believe that it does.

ALBRECHT: Well, but they're doing it now. You don't think they're not doing it now? They're giving them the choices today--

M. CAVANAUGH: Because it's legal now.

ALBRECHT: It will-- it'll be just the same.

M. CAVANAUGH: This would make it illegal.

ALBRECHT: It would not make it illegal. It's, it's not for--

M. CAVANAUGH: But there's no exception for cancer treatment.

ALBRECHT: Well, but there's-- you'd have to have that paid-- there would be so many more pages to that bill.

M. CAVANAUGH: That's OK. We've had long bills.

ALBRECHT: I get that. But I'm just saying they can do today what they're doing when this bill passes, as long--

M. CAVANAUGH: Then why, why would we pass this bill at, at all? If they can do today what they're doing?

ALBRECHT: Because the Supreme Court's asked to go back to the states and we have to codify exactly what they want us to do. And we are going to do this through a bill that talks about how to save babies--

M. CAVANAUGH: But we just--

ALBRECHT: --with a heartbeat.

M. CAVANAUGH: --we just sat through hours upon hours upon hours of testimony of people saying, experts saying that they cannot do what they currently do if this bill were enacted and what I am hearing from you is that you are disregarding all of that information that was presented to us.

ALBRECHT: I'm not at all disregarding. We had proponents and we had opponents and they all feel differently about this bill. This bill, in my eyes, allows the doctors to do exactly what they're doing.

M. CAVANAUGH: OK. So I'm sorry, if anybody else needs to jump in.

HANSEN: Senator Day.

DAY: So you mentioned the Supreme Court has overturned Roe v. Wade and we are going to do what they had asked us to do. What, what-- whose "they"?

ALBRECHT: They have given it back to the states to make a decision for their states, just as many have done.

DAY: OK. So who, who?

ALBRECHT: Roe has given it back to the states.

DAY: Yes, I, I understand. So who from each state makes a decision about--

ALBRECHT: We do.

DAY: --we do as legislators?

ALBRECHT: Yes. We absolutely do.

DAY: OK. So how do we as legislators make a decision based on what we think Nebraska wants?

ALBRECHT: Well, we speak to a lot of people and get the decisions from a lot of different areas and then we make our decision.

DAY: So if--

ALBRECHT: We just had a hearing for hours.

DAY: We did. So if, if we've become aware that the majority of Nebraskans don't want this, wouldn't that be a reason to not pass this bill?

ALBRECHT: If you think the majority is just those who have shown up and wrote letters, there are a lot of silent folks out there that-- from our districts that have let us know that they are absolutely for this, but they would never come down and testify.

DAY: I'm not just talking about those that showed up. I'm talking about those who have submitted testimony online and those who have participated in public polls.

ALBRECHT: I don't think I've ever voted on a bill based on the number of people who have testified because I might be on the completely opposite side of the fence.

DAY: So then how do you find out what-- how do you find out what people want?

ALBRECHT: I think it's a moral issue. It's humanity. It's saving the life of an unborn child who doesn't have a voice. That's how I made my decision.

DAY: So whose moral choice is it?

ALBRECHT: Well--

DAY: Is it yours or is it the person who is pregnant and the doctor's choice?

ALBRECHT: It's the baby. It's the unborn child in the womb who cannot speak for themselves. That's who it is.

DAY: So it doesn't bother you at all to know that women could die?

ALBRECHT: I don't, I don't believe that women can die. They're not dying today.

DAY: You just sat here and listened to doctors tell you that it will happen.

ALBRECHT: It will happen. But is it happening today? If it's not happening today, it shouldn't happen after this bill passes.

DAY: The doctor that was asked that question said that we don't have enough data yet on fetal death-- or, excuse me, on maternal death related to the recent implementations of this type of bill in other states, but she specifically said that women will die if this bill passes.

ALBRECHT: That's her opinion. It isn't--

DAY: Is her, is her opinion as a physician more important than yours as a legislator?

ALBRECHT: Well, I had, I had, I had my own team of people that came to try to talk to you and you didn't ask them one question. You only asked the opponents. So in my eyes, I've already talked to and I have, I have convictions that who I brought in here that you chose not to ask any questions of. I feel that what they have said, like you feel, as the opponents have said.

DAY: So you feel completely comfortable passing a bill knowing that women will die?

ALBRECHT: I'm not going to--

DAY: It's a yes or no question, Senator.

ALBRECHT: It is a question that isn't worth talking about because--

DAY: It's not worth talking about whether or not your constituents are going to die because you implemented a bill?

ALBRECHT: I'm not, I'm not going to go-- I'm not going to do the whole theater thing. I'm done for the day. If you have a question--

DAY: It's not a theater. Senator--

ALBRECHT: If you have questions to--

DAY: Senator, you have to understand--

ALBRECHT: --ask me, put them in writing and we'll talk about it.

DAY: --that when you bring these types of bills in here, you're going to have to answer these questions.

ALBRECHT: Well. I don't believe they're going to die.

DAY: And if you don't, and if you don't want to have these questions asked, then don't bring these types of bills. We just sat through 3 hours of testimony--

ALBRECHT: We sat through six.

DAY: telling us-- yes, telling us that women will die from this.

ALBRECHT: I don't believe that.

DAY: And I ask you if you are OK with knowing that women will die if this bill gets passed and you won't answer my question.

ALBRECHT: I'm not going to answer your question--

DAY: OK.

ALBRECHT: --because it's way off base. Thank you.

HANSEN: Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you, Chairman Hansen. OK. So on page 4-- this has been discussed a lot-- on page 4, roughly, lines 10 to 18, this is about sexual assault.

ALBRECHT: Um-hum.

M. CAVANAUGH: What is-- as the introducer of this bill, what is your intention for this process to be when an adult, not a minor, comes in to the doctor's office, requests an abortion, they're past six weeks and they say, I've been raped? What is your intention for the process to be?

ALBRECHT: Whatever it is today. If it has a heartbeat and it's living, then they're going to have choices to make. Right? You don't do it the night of the--

M. CAVANAUGH: What happens today is that a patient goes into their doctor's office and they don't have to say that they're raped in order to receive a medical abortion. So it's not what happens today. They

have to say, I was raped. So when they say that they are raped, how is that being documented so that the medical professional doesn't lose their license by providing the abortion?

ALBRECHT: It'll be documented just as it is today.

M. CAVANAUGH: It's not documented today. That's the point.

ALBRECHT: Well, it's going to be whatever it is today. They're going to handle it the same way.

M. CAVANAUGH: You keep saying that nothing is changing, but you are changing things. There are lines after lines after lines in this bill and you are changing things and you are just denying facts. You are changing something. And if it is the same as it is today, then they don't have to tell people that they have been raped. If it is the same as today, you do not need to tell your medical provider I was raped, I want an abortion. You just go in and tell your medical provider, I want an abortion.

ALBRECHT: If it doesn't say that they have to document it, then it's between the doctor--

M. CAVANAUGH: It does say that they have to document it now, in this bill, it documents.

ALBRECHT: Then--

M. CAVANAUGH: They don't have to document it now. They don't have to document why you are getting an abortion.

ALBRECHT: OK. So, so it'll be documented. If it says it'll be documented, it will be.

M. CAVANAUGH: But then how how are we proving, how is the doctor providing coverage for themselves by saying, this person told me I was raped, they were raped. So I put in their chart, they were raped and then the-- their assailant reports that they want to open a complaint because they think that the woman that they raped was pregnant and got an abortion.

ALBRECHT: Was there a police report? I'm sure there'll be several questions they'll ask.

M. CAVANAUGH: No, there will not be a police report because women don't report rapes to police. That's the problem. How do you enforce or how do you make this allowance for victims of rape?

ALBRECHT: We'll have to visit with you about it later on.

M. CAVANAUGH: Why later?

ALBRECHT: Because I don't know what you want me to tell you.

M. CAVANAUGH: I want you to tell me--

ALBRECHT: I will go back and talk--

M. CAVANAUGH: I want you to tell you what your intentions were. You wrote this bill. You introduced it on the second to last day. You've prepared to have this hearing today. We have sat here for 9 hours. I want you to tell me how you are actually protecting victims of rape, because I don't feel like you are and you're not being forthright with me in what your intention is here. Do they have to report it to the police? Is that the course of action that they have to take, then say that.

ALBRECHT: No.

M. CAVANAUGH: They don't have to report to the police?

ALBRECHT: No.

M. CAVANAUGH: Then why do you have a statute in here referencing reporting it to the police for a minor?

ALBRECHT: Because it's already the law.

M. CAVANAUGH: It's not the law for an adult.

ALBRECHT: Underage.

M. CAVANAUGH: If you are 44 years old and you go into your doctor's office and you say, I want an abortion, I literally don't have to do anything other than tell my doctor I want an abortion. Under your law, I would have to go and tell my doctor I want an abortion because I was raped. And then they would have to take that information and put it into my file. And then the question is, do they still give me the abortion? Because I haven't filed a police report, because I don't want my husband to know that I was raped. I don't want my family to know that I was raped. I don't want to go through it. So then what

does the doctor expect me to do in order for them to give me the medical care that I am asking for that you put forward is in this bill, an exemption for victims of rape. But you're not answering the question as to how that works, the functionality of it. Are you planning to change this?

ALBRECHT: Maybe I am. I don't know yet. I don't know. I've heard what I've heard tonight and I'll visit with you tomorrow. I'm done--

M. CAVANAUGH: I--

ALBRECHT: --answering questions.

M. CAVANAUGH: You--

ALBRECHT: I'm exhausted and--

M. CAVANAUGH: We're all exhausted, Senator Albrecht, and I appreciate that you're done, but you haven't answered my questions tonight.

ALBRECHT: Because I can't answer it for you.

M. CAVANAUGH: You didn't answer them earlier today.

ALBRECHT: I cannot answer it for you tonight.

M. CAVANAUGH: You wouldn't answer them earlier. And you're not-- you're just, you're just not answering them. And I'm disappointed that you would bring a bill like this, this important. We all agree that this is so important and you refuse to give the essential answer as to how you are protecting victims.

ALBRECHT: I can't give you an answer tonight.

M. CAVANAUGH: Well, then, when will you get me the answer? When will you get this committee the answer?

ALBRECHT: As soon as, as soon as I can.

HANSEN: Any other questions? All right. Seeing none, before we close, we did have some letters on LB626. We had 738 as proponents, 901 as opponents and 11 as neutral. So with that, I will close our hearing for LB626 and close our hearing for tonight.

ALBRECHT: Thank you.