HARDIN: Welcome to the Health and Human Services Committee. I am Senator Brian Hardin, representing Legislative District 48, and I serve as chair of the committee. The committee will take up the bills in the order posted. Since there's one of them, there's one posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify in a day, please fill out one of the green testifier sheets on the table in the back of the room. Be sure to print clearly and fill it out completely. Please move to the front row. Be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name-- this is the part everyone forgets-- spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, and then we're going to use what is called an annotated process today. What that means-- and we're looking at the number of people here, and this may not be an issue at all, though others may arrive later-- what an annotated process does is we play ping pong; we go back and forth. And we're going to pop through proponents, opponents neutral, and we'll do an hour of each. OK? We're prepared for that today. And kind of the big idea of what this process does is-- it's just no fun to have to stay around until the end of the day, and so we try to move people through in that process that kind of helps out. So, that's what that is about. If you wouldn't mind, when a person gets up and moves, and if you're going to-- planning to testify within that hour-- we'll start with the proponents. Kind of crowd to the front, if you don't mind. That's very helpful. For those of you in the room, how many of you sitting here intend to testify today? Can I see hands? Great, most of you. And that's, that's what we should be seeing. It's a bummer when there's a whole bunch of people and two hands go up, and, and that's OK, we want people to be here, but that's why we have additional rooms, so that people who are simply here to be in the Capitol that are not testifying have somewhere to go. OK? We'll start with the introducer's opening statement and then rotate through. We'll give you a heads up so that you'll know, hey, we're ten minutes away from moving over to the, you know, proponents, opponents, neutral. That way you're not shocked when you're the next one. OK? It's kind of like kids going to McDonald's. You kind of got to give them a five minutes, four minutes, three minutes-- we all work that way, right?

We're going to be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining, and red light indicates you need to wrap up your final thoughts and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. Has nothing to do with the importance of this bill; it's just part of the process, as senators have other bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room; such behavior may be cause for you to meet one of our strapping troopers sitting here in the room. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. of the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will it be included in the committee statement. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

RIEPE: Thank you, Chairman. I'm Merv Riepe. I represent Omaha and this fine town of Ralston.

FREDRICKSON: John Fredrickson. I represent District 20, which is in central west Omaha.

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

QUICK: Dan Quick, District 35, Grand Island.

HARDIN: To my left is our research analyst, Bryson Bartels, and to my far left is our committee clerk, Barb Dorn. Our pages for today are Tate and Wesley. Are you both UNL students? Good. I wanted to make sure you weren't interlopers from Iowa or somewhere like that. And so, with that, Senator Holdcroft,--

HOLDCROFT: All right.

HARDIN: LB512.

HOLDCROFT: Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. For the record, my name is Senator Rick Holdcroft, spelled R-i-c-k H-o-l-d-c-r-o-f-t, and I represent Legislative District 36, which includes west and south Sarpy County. I have introduced LB512 for one purpose. No matter how any of us feels about the issue of abortion, we can all agree that no pregnant woman should ever be neglected or endangered by a careless abortion provider. My district includes part of Bellevue, which has an abortion facility that is infamous for careless abortion practices. This legislation is not just about the-- that facility; it applies to any facility that provides abortion-inducing drugs. The recent history of the Bellevue facility, though, is a big part of the reason I think it's important to bring LB512 and have a conversation about this issue. The evidence from a 2023 investigation into the facility in Bellevue shows there is an urgent need for a basic standard of care to be established to protect women going through chemical abortions in Nebraska. For three months, three separate people at the Bellevue facility illegally dispensed abortion drugs without a license. This affected 229 women, 89% of the patients they saw during these three months. This carelessness and neglect was corrected only after a complaint was filed and DHHS intervened. Right now, we have no standard of care around, around this, and careless disregard for patients in an abortion setting needs to be addressed. LB512 is a first step towards establishing a basic minimum state standard of care. In Nebraska today, abortion facilities are not required to screen for ectopic pregnancy before dispensing abortion pills. They are also not required to do any follow-up after sending a woman home with abortion-inducing drugs. This is unconscionable, given the serious consequences that can follow. According to the statistical report of abortions for 2023 from the Nebraska Department of Health and Human Services, more than 80%, 80% of the abortions performed in Nebraska are now done with abortion-inducing drugs. Ectopic pregnancy is a serious, can be fatal, and is not affected by the drugs most commonly used to cause abortions. The American College of "Obstreticians" and Gynecologists, which have been an outspoken opponent of any kind of abortion regulation for decades, nevertheless concedes that medication abortion is not recommended for parents-- patients with confirmed or expected ectopic pregnancy. 1 to 2% of all pregnancies are ectopic, and the largest published study of first term-- first trimester medication abortion patients showed an ectopic pregnancy rate of 1.3 per 1,000 pregnancies. Nebraska averages a little more than 2,000 abortions per year, all of them in the first trimester. That means there are likely to be 2 or 3 women per year who request an abortion in Nebraska who unknowingly have an ectopic

pregnancy. I think that 2 or 3 women per year being placed in danger of death from a ruptured fallopian tube, perhaps very far from the nearest emergency room, is worth doing a simple screening to prevent. And yet, we do not currently require a screening to be done. We don't take this seriously enough. We need to start doing so now. Many complications that take place after ingesting the abortion pill can also be quite serious. The best and most thorough studies have shown complication rates for chemical abortions between 3% and 20%. The most common complications include hemorrhage, incomplete abortion-- incomplete abortion also requiring surgical intervention-- and infection. These complications rarely, but occasionally, include death. Yet, no complications in this state are ever reported because we have no reporting requirement in place for chemical abortion in Nebraska. That needs to change. We have no knowledge of what women are going through, except when they are brave or angry enough to tell their stories. You will hear one from-- one of those stories this afternoon. You "shav"-- should have in front of you a white copy amendment, AM209, which makes one important change to the original bill. I heard information shared by medical professionals with widely differing opinions on abortion. One thing they did agree on is that while testing and treatment of Rh-negativity in the first 12 weeks of pregnancy was standard practice for many years, the consensus on that issue has recently changed. In 2024, several medical organizations concluded that the weight of the evidence did not show there was a benefit to administering the RhoGAM in the first 12 weeks of pregnancy. The portion of the bill that would have required this step has been removed in AM209. This issue was the subject of most of the opposition correspondence I received. Based on the evidence, I am happy to remove it, which is-- which, in my opinion, ought to resolve any good faith objections to the bill. I would like to invite-- I would, I would invite you to prepare for the arguments you are likely to hear from those in opposition to L [SIC] (LB)512. The first argument: Rh testing and treatment is no longer standard practice in the first 12 weeks of pregnancy. Agreed. And as I said a moment ago, this has been addressed by the removal of this section from the bill. I expect opposition testimony based on this anyway. Argument number two: we already are doing this. I have heard from one abortion provider that they are already doing what this bill requires. Based on the results of the investigation of the Bellevue facility, I am skeptical that everyone is already following a protocol of screening for ectopic pregnancy and checking in on patients for complications. But if anyone is doing so, LB512 will impose no additional hardship on those facilities. Argument number three: this bill is effectively a ban on med-- medication abortion. This argument, of course, is

incompatible with the one that abortion providers are already doing what the bill requires. They cannot both be the true-- be true. And if screening for ectopic pregnancy and requiring a follow-up for complications would cause an abortion facility to stop doing business, that tells you more about their business model and what they care about than it does about the bill. Argument number four: some medications that are known to cause abortions also have non-abortion medical purposes. And this is true, which is why the bill says, in Section 2, that the term "abortion-inducing drug" does not include "a drug, medicine or other substance that may be known to cause an abortion but is provided for other medical reasons." Argument number five: medication abortion is safe and effective. There is currently no way to evaluate the truthfulness of this claim. As I said a few minutes ago, we have virtually no reporting requirements in Nebraska or in the United States for complications of abortion pills. This fact being understood, the argument that-- since we have no complications reported, there must not be any-- is circular, and reveals nothing. The most thorough study ever done on this issue, which followed more than 42,000 post-abortive women in a European country with a national-- nationalized health care system showed a 20%, 20% complication rate. Some studies show a lower rate, but no study has ever shown the rate to be zero. We need to know the rate and seriousness of abortion pill complications in Nebraska. LB512 would help us get there. I think we can all agree that no pregnant woman should ever be neglected or endangered by a careless abortion provider. The fact is that we do indeed have careless abortion providers in Nebraska. There is an urgent need for a standard of care to be established before someone is seriously hurt or dies because of the negligence of bad actors. This bill is about keeping women safe from careless people in a position of trust. I think that is something we can all get behind. Chairman Hardin and members of the Health and Human Services Committee, thank you for your consideration of LB512. This is not anti-abortion legislation; it is the establishment of a badly-needed basic standard of care. Thank you.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Cold-- Holdcroft for, for being here today. I have a couple of questions for you, but I, I first kind of want to acknowledge a little bit of the elephant in the room here, which is that we-- this, this biennium, we, we kind of happen to have an all-male HHS panel and committee. And so, I just want to acknowledge, you know, none of us on this committee have ever had the personal experience of, of being pregnant ourselves. And, you know, I think regardless of how you feel about abortion, I'm,

I'm sorry that we're going to be making decisions on this committee that are deeply personal and have zero representation of the population that's most impacted. That said, a couple of questions I do have for you are-- regarding the bill. So, the first is that you mentioned the, the facility in Bellevue, and I'm wondering if you might be willing to share with the committee some of that information that you, that you shared. I had not heard about that before, so I'd be curious to look-- see, if you could share that information.

HOLDCROFT: I can. We do have a, a, a witness who has a lot of experience with the Bellevue, and she will go into great details about what she has heard-- at-- heard down there. But the issue with-- in short with the Bellevue abortion facility is that they have essentially part-time doctors who fly in from out of state. None of them live here.

FREDRICKSON: Mmhmm.

HOLDCROFT: And they come in maybe one or two days a week. They come in, they do a cursory examination, they provide the pill, they send the woman home to have her miscarriage in her bathroom, alone. And their advice to them is, if you have any problems, go to the emergency room. Don't call us, because we're closed. They're only open when the doctor's there. And so, you'll, you'll hear a bit more about that from one of our testifiers.

FREDRICKSON: OK. OK. Another question I have is I-- so, I'm looking at the bill, and I, I haven't had a chance to read the full amendment, but my understanding is the amendment just strikes the Rh testing--

HOLDCROFT: That's correct.

FREDRICKSON: --part of it, is that correct? OK. So, I guess one question I have is it's-- it appears to me that this bill would put into statute a follow-up with the provider in a, in a 14-day period and--

HOLDCROFT: 3 to 14 days.

FREDRICKSON: 3 to 14 days.

HOLDCROFT: Correct.

FREDRICKSON: So, I was curious, are you aware of any other medication or medical procedure that has required follow-up, that we have in statute?

HOLDCROFT: That we have in the statute? I'm not aware of that, but the FDA does recommend 14 days for "followship"-- follow-up on these, these, these drugs.

FREDRICKSON: OK. And that was my other question, too. Was the 3 to 14 days-- why not 21, 28? Was it just the FDA recommendation?

HOLDCROFT: Yes.

FREDRICKSON: Is that what that was based on?

HOLDCROFT: And actually, the 3 days, the minimum is because typically, you're given 2, 2, 2 pills. You're given one which essentially cuts off nourishment to the baby in the womb, and then you-- within 48 hours, 24 to 48 hours, you're supposed to take the second pill, which causes contractions. And so, the mother goes into labor and expels the baby. So, 3 days is about when she's going to start to see some issues. And if there are issues, then we want to have that, that timeframe for the doctor to be available in, in case she needs to, needs to contact a physician.

FREDRICKSON: OK. Thank you, Senator Holdcroft.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. You said in your comments that-- primarily, I think-- correct me where I'm wrong, but--

HOLDCROFT: I will.

RIEPE: --you were focused-- I'm sure you will. That it dealt with the abortion clinic. Why wouldn't you limit this piece of legislation down to specifically abortion centers as opposed to a sweeping network of every practitioner across the state of Nebraska? Because I think-- what is there? One, maybe two?

HOLDCROFT: Two.

RIEPE: Two? OK.

HOLDCROFT: And that's what the bill does. The bill only addresses medications that are given for chemical abortion. So, if you have another OB-GYN that is giving some other drugs that cause a chemical abortion, it's not applicable. It's used for other medical reasons. That's the key thing, used for other medical reasons other than abortion, then that's not applicable under this bill.

RIEPE: But, did you say Medicaid?

HOLDCROFT: Medical.

RIEPE: Oh, medical. OK. Because I was--

HOLDCROFT: No. I mean-- so, if you're prescribing this abortion-- well, an abortion-- a, a drug that will cause an abortion for other medical reasons, not just because you want a chemical abortion, but there's just something else that's going on, and you're-- I mean, as you said, I mean, this rule is only going to apply to probably two locations in Nebraska. It's not going to--

RIEPE: That's, that's what I'm thinking.

HOLDCROFT: It's not going to affect your typical OB-GYN. She's probably do an ectopic ultrasound anyway, and probably some other tests before she administer-- prescribes these drugs. And she's going to have-- he or she-- is going to have a follow-up. So really, the, the, the bill is not going to affect your typical OB-GYN, who's-- only really the abortion clinics. So, it's--

RIEPE: Well, the language isn't there specifically that it focuses on that. It says abortion clinics and such. Also, my question--

HOLDCROFT: Well, it says-- and I'll-- see, I have this here.

RIEPE: I read this last night, word for word, and I did not see in there one time that it says abortion clinics.

HOLDCROFT: It says in Section 2-- in Section 2-- the bill says in Section 2 that the term abortion-inducing drug does not--

RIEPE: Is this the white paper? The white one? The new one?

HOLDCROFT: No, this is a-- this is in my statement. But Section 2 of, of the bill--

RIEPE: Oh. Is it in the bill, though?

HOLDCROFT: It's in the bill.

RIEPE: OK. I [INAUDIBLE]

HOLDCROFT: Section 2. It's a-- it does not include a drug, medicine, or other substance that may be known to cause an abortion but is provided for other medical reasons.

RIEPE: OK. But one of those other medical reasons is often following a miscarriage, so that you need to go to a non-invasive process. That's the application.

HOLDCROFT: And so, the bill does not apply in those cases.

RIEPE: OK. I assume that-- can you tell me what has been the Food and Drug Administration's-- have there been any reports-- and I'm not talking about on med-- web pages on, on the internet, I'm talking about respectable journals-- that have said that there's a danger? Because they've gone through some pretty serious testing of the-- by the FDA. I trust, I trust with the FDA. I don't know what--

HOLDCROFT: Well, first of all, I would challenge that there's been any, any collection of problems with chemical abortions, because there's no-- to our knowledge, there's no, there's no requirement for physicians to report, in a chemical abortion, any adverse conditions. And--

RIEPE: My, my response to that would be-- is that chemical abortions have not been around that long, not like routine abortions. Well,--

HOLDCROFT: Routine abortions?

RIEPE: Routine-- abortions were-- at the time when Jesus walked the face of this earth, there were abortions at that time. But so, that's-- but there aren't a lot of necessary studies about complications that I'm aware of. Of course, that's not something I read on-- about, with routine abortions. But I don't want to get hung up there totally. I just-- I-- you know, I think we're challenging the FDA. I think we're also challenging the physicians' practice if there aren't-- you know, I'm trying to figure out-- you said that there is no set standards of care, but I can't think of any other medical procedure where we have a state law that dictates a standard of practice.

HOLDCROFT: Well, I think we should in this case, because there are plenty of women in danger.

RIEPE: But we might be putting a number of other people in danger under their medical practices.

HOLDCROFT: Well, if, if you can bring those to my attention, I'll be happy to include them in my bill.

RIEPE: Well, I would have someone that knows more about medicine than either one of us to do that. But the other one that I would-- I have a concern about is with the requirement for the second visit. If it's 3-13--

HOLDCROFT: 14 days. 3 to 14 days.

RIEPE: My-- I'm speculating here-- is that the woman might come for the pills, but if she's going to have to pay for a second visit and she's OK, satisfied, she's not going to come back because of the cost, because of the necessity of trying to schedule something within 14 days. And so, what does that do, then, for the doctor? And I'm not trying to defend someone running an abortion clinic. I'm clearly not. But the burden then falls back on that physician to have to do the reporting, and he doesn't have the information. He has to report it back to DHHS.

HOLDCROFT: Correct.

RIEPE: He has nothing to, to, to-- he has nothing to report.

HOLDCROFT: Correct. If the woman-- if-- there's no requirement for the woman in the bill to return for the-- we were only given the opportunity for her and the requirement for the doctor to make-- allow time for a return visit. The bill does not-- let's see, there's a statement in the bill that says that no woman upon whom an abortion is attempted, induced, or performed shall be liable for a violation of the Chemical Abortion Safety Protocol Act. So, she could not get into any trouble if she doesn't show up for the exam. As far as the imposition on the doctor, I'd rather have that in place, that's-- that follow-up exam in place for her to use, than not have it in place.

RIEPE: Well, and I did notice on page 4, Section 6, that it does-- what you said, no woman shall be liable. And yet, it-- but it fails to mention that no physician shall be liable. So, it seems to me that there's quite a bit of potential liability in here for physicians.

HOLDCROFT: Well, that's because the physicians are-- that we're trying to target here are, are being very careless with their patients, and we're trying to ensure that there's a-- the standard of care for this procedure.

RIEPE: So what is the punishment? I didn't see anything in there that says criminal punishment, $500 a day,--

HOLDCROFT: No, we didn't have any specific. But I would expect that if there's a violation of, of this statute that the Department of Health and Human Services would be alerted, and then would do an investigation, and the doctor might lose, might lose their license.

RIEPE: I'll give you this one and ask you to respond to this. Tightening these standards, fundamentally, you're also going to have to tighten the standards of the U.S. Postal office because many of these will become off the webs, and they will be direct mail to a woman, if you will, or delivered within days. I don't know that this will be able to-- I know I used the term, be able to block abortions, because there is a workaround.

HOLDCROFT: Well, to receive these abortion bills over-- in the mail is illegal in the state of Nebraska.

RIEPE: It is, or it would be under your bill?

HOLDCROFT: It is now illegal to receive these pills in the mail.

RIEPE: And how is that policed?

HOLDCROFT: Well, it may not be policed, but it's illegal. And in Nebraska, unlike what a lot of people say, people follow the law in Nebraska. So, to just, you know, do away with it and say it's not being enforced is not an argument for, for getting rid of that rule.

RIEPE: Well, I think we'll see how that plays out.

HOLDCROFT: OK. Thank you, Senator Riepe.

RIEPE: Thank you, good sir. Thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Got me-- got some more questions now.

HOLDCROFT: Of course.

FREDRICKSON: So, what I-- so, one thing that you had mentioned that, that concerns me a little bit. So, you had said that there would be potential punitive measures taken, or enforcement on medical providers who might be [INAUDIBLE]

HOLDCROFT: I think-- I think that whenever a doctor doesn't perform a standard of care, then his license is subject to review and, and revocation.

FREDRICKSON: Certainly. If-- so, so my question would be that the-- so-- but the way I understand this bill is that this is not in line with medical best practices. And so,--

HOLDCROFT: What makes you say that?

FREDRICKSON: --in a situation, like--

HOLDCROFT: What specifically in my bill says that--

FREDRICKSON: Well, the American College of Gynecology and Obstetricians [SIC], for example, have different guidelines around medication abortion than what you're prescribing. And so, my question for you would be-- you're implying that there should be enforcement against a medical provider for prescribing this, based on your bill, your statute. But the conflict that's going to occur is that medical provider is going to have to go against standards of care and best practices based on their medical boards. And so, do you see how that could put a provider in a situation where it's saying, I either follow the law as written by Senator Rick Holdcroft, or I follow the standards of care as written by boards of medicine?

HOLDCROFT: This bill is all about standards of care. So, exactly what is the bill-- that is, is--

FREDRICKSON: Also, the American College of Gynecology and Obstetricians [SIC] has no requirement for the in-person visits, for example, the follow-up visits in person. And I'm sure we'll hear more from testimony, and I'll defer to the medical experts on that. But it's clear to me that this is different than what is-- and we, and we can talk about this more in the future. My only quick question is, I'd be concerned to be a medical provider that is sort of having to make a decision that would either be in conflict, what is sort of suggested based on clinical standards of care, or what's suggested by the state. Because it sounds like one decision or the other, should this pass as it's currently written, would be in conflict. And so, they'd be at risk for enforcement of a-- if-- of not obeying the state law if they follow standards of practice, but if they don't follow standards of practice and they follow the state law, if written in this way, then they'd be at risk for punitive measures on the other hand for

practicing out of the scope of standards of care. Do you see what I-- do you see-- do you understand the conflict I'm describing?

HOLDCROFT: No, I really don't, and--

FREDRICKSON: OK.

HOLDCROFT: You know, we'll, we'll agree to disagree on that. Again, what my bill tries to do is, is establish a standard of care for chemical abortion. And that means checking for an ectopic pregnancy, and then doing a follow-up, and then reporting any unusual conditions.

FREDRICKSON: OK.

HOLDCROFT: That's, that's all it is. And, and, and also, the American College of Obstetricians and Gynecologists, which has, has been a radically pro-abortion organization for decades, has stated for years that before a medical abortion is performed, that the clinician should confirm pregnancy and estimate gestation. And as we know, you know, 12 weeks is the limit.

FREDRICKSON: Mmhmm.

HOLDCROFT: So, I-- you know, you can quote specific pieces from the American College of, you know, OB-GYNs. But it's-- again, it's, it's about taking care of women who are having these chemical abortions. And at least at the abortion facility in Bellevue, they're not being cared for.

FREDRICKSON: Sure. So, yeah, I mean, if there-- if there's a facility that you have specific concerns with, that's another conversation. But certainly, I would defer to the ACOG on what is--

HOLDCROFT: Why?

FREDRICKSON: --best standards of care.

HOLDCROFT: Why? Why? What makes them so special? They're just an organization. They're not-- they have no-- they have no medical authority.

FREDRICKSON: OK. We can agree to disagree on that.

HARDIN: Additional questions? Senator Riepe.

RIEPE: Thank you, Chairman. We talked about accreditation. Are the, are the abortion facilities accredited by anyone? Is that a-- another

vehicle to say, are you working to the standard of care? Like-- I mean, like, we have accreditation of the OB-GYNs and every other discipline. I, I don't know.

HOLDCROFT: That's a good question. They are subject to inspection by the Department of Health and Human Services, and we're going to have a testifier come up and tell you about their last inspection and what was found.

RIEPE: OK.

HOLDCROFT: And my, my-- and I have actually approached the, the, the department about, you know, what are they going to do about these discrepancies? But it appears the DHHS is reluctant to enforce these even minor standards of care applications. And that's why I think it needs to be put into statute, so they know what they're supposed to be looking for, and that it's being carried out.

RIEPE: I just come back to-- if they're falling short, then they need to be held accountable.

HOLDCROFT: Well, I think you'll see in the report here that the, the facility in Bellevue falls way short. In my opinion.

RIEPE: OK. Fair enough. Thank you.

HARDIN: Additional questions? Will you be with us to testify at the end?

HOLDCROFT: I do have to leave for-- I have another bill coming up in Judiciary, but I'll stay, go testify, and then I'll come back.

HARDIN: Thank you. Proponents. And so, it's about-- "ish," it's about 2:05. So, for about an hour we're going to go on the proponents side, and then we'll switch over to the opponents side, and then we'll go to neutral after that. Welcome.

TIMOTHY TESMER: Good afternoon. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Dr. Timothy Tesmer, T-i-m-o-t-h-y T-e-s-m-e-r, and I'm the chief medical officer of the state of Nebraska, working within the Division of Public Health in the Department of Health and Human Services, DHHS. I'm here to testify in support of LB512. Nebraska abortion reporting for 2023 shows 82% of abortions performed in Nebraska during 2023 were performed via medical chemical route. I would like to share information on the potential complications caused by the drugs used in

performing a chemical abortion. Mifepristone and misoprostol are approved by the federal Food and Drug Administration-- FDA-- to be taken in combination to end pregnancies up to 10 weeks gestational age. The usual dosage is for the patient to take mifepristone on day one, followed by misoprostol on day two or three. Mifepristone blocks progesterone, and misoprostol causes uterine contraction and emptying. Complications a patient may experience after taking abortion-inducing drugs include nausea, weakness, abdominal pain or cramps, vomiting, headache, diarrhea and dizziness. Complication rates are difficult to assess, due in part to inadequate follow-up, but studies on emergency room visits have shown complication rates from 2.9% to 3.7%. Important risks associated with mifepristone are atypical infection and prolonged heavy bleeding. A risk of uterine rupture exists with misoprostol, particularly when used beyond eight weeks of gestation. The examination of a patient prior to being given an abortion-inducing drug is essential to assess any contraindications such as ectopic pregnancy, chronic adrenal failure, long-term corticosteroid use, or known bleeding disorders. It is equally important to have a follow-up visit between the physician and the patient, so the physician can assess the patient for any adverse events and confirm the pregnancy was completed-- completely terminated. Doing so lessens the chance of further complications such as atypical infection and prolonged heavy bleeding. This visit also provides a forum for the patient to discuss with the physician any questions they may have, and is truly in the best interest of the patient. To put this into better perspective, data accumulated from state agencies in South Carolina, New Jersey and Arkansas show, for the collective years 2016 to 2023, increased emergency room visits due to medically-induced abortion complications, which, upon detailed analysis, was attributed to the FDA policy change on enforcement of the in-person dispensing requirement. The department did request that minor technical changes be made with the reporting form in the bill. We appreciate Senator Holdcroft's willingness to work with us on an amendment to address these issues. We respectfully request that the committee advance the bill to General File. Thank you for your time. I would be happy to answer any questions on this bill.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Good to see you, doctor.

TIMOTHY TESMER: Thank you.

RIEPE: Questions I have, is it your contention that the FDA has failed in its approval process?

TIMOTHY TESMER: Senator, I don't know how to comment on that. The FDA is the FDA. I don't know-- I can't-- I don't know that it's my place to say that they failed on that. They know that they started looking at especially mifepristone around the year 2000, and then updated through their-- what they call the REMS, the Risk Evaluation Mitigation Strategy [SIC]-- evaluated that around 2016 or so, and then with the advent of the COVID pandemic in 2021, I think they sort of backed off on their requirements for in-person dispensing. And then, I think in roughly 2023, they made that more of a permanent change. So, for me to say that they've failed, it'd be difficult to say.

RIEPE: Because the bottom line is they released it for public consumption.

TIMOTHY TESMER: Well, they released it without the recommendation, or without the requirement of in-person dispensing.

RIEPE: OK. That's a detail I'm not familiar with. The other question is, are physician currently that are using the two [INAUDIBLE], they then ignoring standard of practice and, and therefore exposing themselves to liability by prescribing the pills?

TIMOTHY TESMER: Senator, again, I'm not sure standards of practice. I'm not an OB-GYN, so I, I-- I'm-- I don't know that I want to tread into that arena, necessarily. So.

RIEPE: My third-- and I'll-- and I promise this'll be my last one. This is a-- this is a cupcake one. To get a physician appointment within 3 to 14 days is a miracle. So, if you have to go back for the second visit, at least with my physician-- maybe he's holding me off, but I couldn't possibly ever get an appointment in 3 to 14 days.

TIMOTHY TESMER: Well-- OK, that--

RIEPE: See, I told you this is the easy one.

TIMOTHY TESMER: --that may be the case-- that may, that may be the case. But I, I, I think-- I'd like to think that most physicians are going to be aware of the nature of their patients' conditions, and there will always be time on the schedule to see those patients that need to be seen.

RIEPE: Would you give me a note to that effect to take to my doctor?

TIMOTHY TESMER: I will-- happy to-- if somebody give me a prescription pad, I'll be right-- write it out.

RIEPE: Thank you. Thank you. I appreciate that.

TIMOTHY TESMER: You're welcome.

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

HARDIN: Senator Fredrickson?

FREDRICKSON: Thank you, Chair Hardin. Thank you, Dr. Tesmer, for, for being here. I appreciate what you said a little earlier, you are not an OB-GYN, and I'm looking forward to hearing from some on their thoughts on this bill. You had-- I'm-- your testimony had something that caught my eye. I think it-- in the last sentence, on the fourth paragraph down, you say a risk of uterine rupture exists with misoprostol, particularly when used beyond eight weeks of gestation. Is that included when you use misoprostol-- is that specific to using it for abortion care, or is that any use of misoprostol after eight weeks of gestation?

TIMOTHY TESMER: Well, I'm not-- I don't know that it would be advised to use misoprostol in pregnancy if you were going to use it. Anoth-- another use of that drug is for the treatment of gastric ulcers--

FREDRICKSON: Yeah. Well,--

TIMOTHY TESMER: --in those patients, so-- I mean, but that would be a contraindication right there, to do that.

FREDRICKSON: Yeah. Well, I'll, I'll, I'll give you some context. So, we, we heard a bill in here a couple of weeks ago for a lay nurse-- or lay midwives, which enumerated misoprostol as something that they could prescribe.

TIMOTHY TESMER: Mmhmm.

FREDRICKSON: And we were told this is very safe to prescribe. In fact, safe enough for someone with a high school education, with some continuing education, to give it at a home birth, for example. And now, I'm hearing that there's a risk of this, from you, beyond eight weeks of gestation. So, I guess I'm trying to-- I'm having a hard time why the department might not be concerned about that happening with a home birth with a midwife, but might be concerned in this context.

TIMOTHY TESMER: OK, could-- I'm, I'm not quite following you there, necessarily. It--

FREDRICKSON: Is the-- I guess my, my, my-- I guess the, the bottom line-- I'm not trying to get into a gotcha with me, but I think the bottom line of my question is, is misoprostol something that is safe to use?

TIMOTHY TESMER: Well, I'd have to say yes. It's safe to use--

FREDRICKSON: OK.

TIMOTHY TESMER: --in the right context, in the proper context, in the proper situation. Or, or for-- proper condition.

FREDRICKSON: And, and when you say right or proper context, how-- who would determine what the right or proper context was?

TIMOTHY TESMER: Well, I mean, that would be up-- for sure-- for certain, it would be up to the physician or the provider, or the physician,--

FREDRICKSON: OK.

TIMOTHY TESMER: --to determine that.

FREDRICKSON: OK. OK. Thank you.

TIMOTHY TESMER: Mmhmm.

HARDIN: I have a question.

TIMOTHY TESMER: Mmhmm.

HARDIN: We're kind of talking about, philosophically, when's the right time for the Department of Health and Human Services to step in and maybe throw the flag on a play? Let's take this out of it and substitute something else. Is there a time, or-- that you can think of when we see dangers on one side of it that the department wouldn't raise a question and say there seem to be people getting hurt on the other side of a particular treatment? Wouldn't the department say, we see a problem, that people are being harmed? Our laws protect that, but we've reached a threshold. Is it the, the department's purview or responsibility to step in if they see that a medical practice, common or not, seems to have adverse outcomes? Isn't that part of what we pay all of you to do, is to throw those flags?

TIMOTHY TESMER: Thank you for the question, Senator. I don't know quite how to answer that, because I'm one part--

HARDIN: Those are the ones we focus on here, yes.

TIMOTHY TESMER: I'm one part of the department.

HARDIN: Right.

TIMOTHY TESMER: OK? I mean, obviously, with the-- helping people live better lives is the mission of the HHS.

HARDIN: Right.

TIMOTHY TESMER: Certainly, my role is to per-- look at things from an objective medical lens relative to the safety and health and well-being of Nebraskans, so-- but as far as when should, when should someone throw the towel in, or-- difficult question for me to answer.

HARDIN: Well, so, when should someone say, wait a minute, there was a-- an infraction just occurred. We rely on the regulatory powers of the department to say, eh, we're running at the end of the leash on this one. Some people are being harmed by something, and we need to rein it in.

TIMOTHY TESMER: Well, if, if, if an infraction occurs, then there is a specific investigative process--

HARDIN: Sure.

TIMOTHY TESMER: --that happens,--

HARDIN: Right.

TIMOTHY TESMER: --and it may come, let's say, come across my desk, let's say, as far as some sort of a disciplinary action, if it's requi-- if there's one that-- needed or required. And then, there are different ways to, to do that.

HARDIN: And then there are new laws, sometimes, that are introduced that essentially create the law that flows to the statute, that flows to the regulation, since that's how it always works.

TIMOTHY TESMER: Mmhmm.

HARDIN: And I'm just saying-- and it's the role of the department to essentially guide us in that regulatory process. Today, what we're looking at is the possibility-- with the bill-- of a new law that starts redefining that regulatory process,--

TIMOTHY TESMER: Mmhmm. Mmhmm.

HARDIN: --fully and finally. And I'm just simply asking for a clarification that that's always how it works, isn't it? That it always flows from bills to laws to statute to regulation. And I'm asking you from the end of that line, at a regulatory standpoint, it's OK for you to point out, as a department, well, we have some areas where we don't have enough law to help us in this process of determining what is most safe. Correct?

TIMOTHY TESMER: OK. I mean, as you well know, I mean, with DHHS being a code agency,--

HARDIN: Right.

TIMOTHY TESMER: --we enact, we work on, we-- again, enact regulations, laws as brought forth by the Legislature or through the governor-- through the governor's office. So, I mean, we're there to help. We're there to aid and assist.

HARDIN: Other questions? Thank you. LB512, proponents. Welcome.

RICHARD WURTZ: Thank you. My name is Dr. Richard Wurtz, R-i-c-h-a-r-d W-u-r-t-z. I'm a medical doctor. I'm testifying in favor of LB512. I'm a family physician, I do obstetrics. I've taken care of hundreds and hundreds of pregnant women and delivered hundreds and hundreds of babies these 25-plus years. I've never needed to resort to nor refer for abortion. Abortion is reprehensible; there is no sound medical, scientific or ethical justification for it. But one can vote to regulate more tightly something that one finds morally reprehensible to reduce unnecessary casualties. My testimony for this bill in no way justifies the abhorrent act of abortion. There are two types of abortion, namely medical or surgical. I will talk about medical. Though I am not in favor of any abortion, neither am I in favor of wanton neglect of pregnant women who are already victims of abortion in general, and are further victimized in particular by unnecessary complications when medical abortions are done without proper patient evaluations, indications, procedures, follow-up, or reporting of complications. In other words, a physician should apply the standard of care to these women regarding proper medical care. I'll briefly touch on these now. Patient evaluation should be done in person, with the ultrasound documentation of gestational age, location of pregnancy. Even the ACOG emphasizes the importance of ruling out ectopic pregnancy before medical abortion, particularly in those with risk factors, performing a physical exam and laboratory evaluation, as

with any pregnant woman. As an example, studies of medical abortion excluded women with anemia. They also performed ultrasound for gestational age, sexually transmitted infections evaluations, as these infections increase ectopic pregnancy risk and post-abortion infection. American Society for Reproductive Medicine stresses the importance of ultrasound evaluation prior to medical abortion, and current data from the New England Journal Medical--or England Journal of Medical Medicine [SIC] article published in 2024 indicated more adverse outcomes, with early medical abortion before a pregnancy is visualized on ultrasound compared to later medical abortion after ultrasound confirmation. Indications and procedures and follow-up refer to, number one, how old is the unborn child? Number two, is she an appropriate candidate? Number three, does the patient have instructions for follow-up care with emergency accessibility, physician phone numbers, call coverage? Reporting complications is self-explanatory. Medical abortions carry a four-fold risk in the complications over surgical abortions; most notably among these are hemorrhage and infection. In the Nebraska 2020 statistical report of abortions to the Department of Health and Human Services, only one complication out of 2,800-plus abortions was reported. This is not consistent with current reports of medical abortion complication rates of 3% to 20%. Regarding ACOG, ACOG is a committee opinion; ACOG does not necessarily represent standards of care recommending this situation. A standard of care would be, like, surgical scrubbing, et cetera. You can go above the standard of care even if it was a standard of care. Like, you can say, I think you don't have to do ultrasound, but it's a good idea. Like, I don't think you have to test for a UTI if you have symptoms, but it's a better idea to test for UTI, because sometimes they come in, it's not UTI, it's diverticulitis. So, to go above the standards, I think, is, is reasonable. If you would say, well, this is the standard of care, you don't have to follow it. I don't think that's reasonable. Time's up.

HARDIN: Do you have anything more to add? OK. Questions? Senator Meyer.

MEYER: Thank you, Mr. Chairman. Thank you for being here today, today, doctor. I, I kind of wanted to ask this question before, but I'm glad I waited for you, with your expertise. We talked about-- Senator Fredrickson talked about ACOG, and a standard of practice. So, standard of practice would not preclude doing a post- or pre-op when a, a [INAUDIBLE]--

RICHARD WURTZ: No. In fact, pre-op-- post-op would be-- sorry, go ahead.

MEYER: Well, I, I mean, that seemed to be an issue, whether standard practice-- standard of practice would be that a pre and post would be extraordinary, but it would seem to me, from a layperson's standpoint, it should be customary that that would be done anyway.

RICHARD WURTZ: I mean, it's part of the global. Part of the global fee, in fact. Post C-section, two-week follow-up, you don't bill for that. It's part of the global fee.

MEYER: Thank you. And if I may, Mr. Chairman, with the mifepristone, and then the misoprostol-- the combination, is that what enhances the uterine contractions? And where I'm getting-- where I'm going to on this is, if the "misopristol"-- prostol is prescribed for other medical conditions, does it react to the uterus the same way, or is it a combination of the two drugs that cause the possible rupture of the uter-- uterus in, in discharging the, the baby?

RICHARD WURTZ: Mifepristone is only dis-- discovered and, and evaluated for abortion.

MEYER: That-- and it just cuts off the--

RICHARD WURTZ: It was, it was from the same drug company that the Nazis founded, actually, in Germany. You can research that. But it's only for abortion.

MEYER: Thank you.

RICHARD WURTZ: And it's an anti-progestogen. It blocks the progesterone receptors. Progesterone is pro-gestation for the-- it enhances the nutrients to the baby. So it blocks that. So, de facto, the baby dies, and misoprostol dilates the uterus and also contracts the, the-- dilates the cervix, and also contracts the uterus.

MEYER: Does the misoprostol-- does that have the same reaction if it's prescribed by a doctor for another medical ailment? Does, does it have the same effect on the uterus as it would be for a chemical abortion?

RICHARD WURTZ: Well, we use it for induction of labor at much lower dose, later in the pregnancy.

MEYER: Are, are there any other medical ailments that it's prescribed for?

RICHARD WURTZ: You can prescribe it for stomach ulcers. It's just not commonly prescribed for that, ever.

MEYER: OK. Thank you.

HARDIN: Additional questions? Senator Hansen.

HANSEN: Thank you. I want to expound a little bit on what Senator Fredrickson said earlier concerning certified professional midwives. I think what he was talking about was about misoprostol and their ability among the medical community to use that to treat postpartum hemorrhage. Correct? That's usually what they can use that as well for?

RICHARD WURTZ: Yep.

HANSEN: OK. That's-- [INAUDIBLE]--

RICHARD WURTZ: We use it for--

HANSEN: --I want to make sure I got the right one. I think it's misoprostol, so.

RICHARD WURTZ: Yeah. Misoprostol is used not only to induce labor, but for, for postpartum hemorrhage. Correct.

HANSEN: OK.

RICHARD WURTZ: Much higher doses.

HARDIN: Other questions? Seeing none. Thank you.

RICHARD WURTZ: Thank you.

HARDIN: Proponents, LB512. Welcome.

JUDY MANSISIDOR: Well, thank you. Good afternoon, Chairman, and committee members. My name is Judy Mansisidor. LB512 is necessary and well-provided-- needed accountability and safety--

HARDIN: Could I ask you to spell your name, please?

JUDY MANSISIDOR: Oh, sorry, J-u-d-y M-a-n-s-i-s-i-d-o-r. It will provide accountability and safety for women undergoing chemical abortions in Nebraska. I live in Bellevue. We directly observe three different abortionists rotating through the facility at 1002 West Mission. Not one of them lives in Nebraska. Tamer Middleton lives in Georgia, Jill Meadows lives in Iowa, and Aaron Campbell lives in Pittsburgh and travels across the country committing abortions. Exhibit one provides their licensure details. Physicians are

acceptable to-- accessible to clients in person for less than 48 hours each week while they are committing abortions. If an abortionist comes to Bellevue in week one, that abortionist is not typically seen at the clinic again until week three or four. When an abortionist comes to our state, he or she does two back-to-back days of abortions, and leaves the clinic by about 3 p.m. of the second day, each weekly visit spending less than 48 hours at the clinic. One of the physicians, Aaron Campbell, was quoted in Mother Jones magazine saying, direct quote, "I tell patients from Texas, if they have to go to the hospital for excessive bleeding to just tell the E.R. that you were pregnant and you think you're having a miscarriage." "I know you live in New Mexico, but just so you know, if you go to Texas for some reason, say that. They cannot tell the difference between a miscarriage and a medication abortion." Exhibit three is the full article, reprinted for you. Aaron is effectively telling patients to lie to other doctors in an emergency situation. LB512 mandates conditions that are necessary to protect the health and safety of the women in legal chemical abortion. We see with our own eyes that the three doctors committing abortions in Bellevue are not at the clinic long enough for any follow-up. In fact, they leave the clinic and do not return for weeks after administering the second day's abortion pills. This leaves the local E.R. units to handle any excessive bleeding. This is patient dumping. Aaron Campbell tells women to say they think they are having a miscarriage if they have to go to the hospital for excessive bleeding. Think about that situation. Staff at the E.R., we-- will be apologizing to the woman about her miscarriage and talking about her baby when she really had a chemical abortion and does not want to hear about her aborted baby. It is a deceptive, cruel and selfish but effective way for an abortionist to hide from any complications or accountability that arise from an abortion he has committed. LB512 mandates accountability for the safety of women for the entire chemical abortion process. LB512 mandates that abortionists follow up with their patients. LB512 is a safety net for women choosing legal chemical abortions. Please advance LB512 out of committee. Keep women choosing legal chemical abortionists [SIC] safe. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I was trying to listen carefully to your testimony. I think you're, in my opinion-- correct me where I'm off, here-- you're comingling regular abortions that these physicians are coming in and doing, and the chemical, and that they're not following up with either side, so I got a little [INAUDIBLE]--

JUDY MANSISIDOR: I'm respectfully correcting you. I'm only talking about the abortion facility at 1002 West Mission, and they are only chemical or medication abortions. Thank you for your question.

RIEPE: Well, I would, I would say you talked a lot about regular abortions in the process.

JUDY MANSISIDOR: Not one abortion done in Bellevue, Senator, correct-- respectfully, is anything but chemical. So, I'm not sure what you are saying is a regular abortion. But in Bellevue, it's chemical or medication abortions only, and that is the regular operation there.

RIEPE: You just repeated it, though. You said chemical or medical.

JUDY MANSISIDOR: Some people call them chemical abortions, other people call them medication abortions. Respectfully, they are the very same thing. You are given the first pill and the second pill that they were talking about.

RIEPE: I have no further follow-up. Thank you, Chairman.

HARDIN: Other questions? Seeing none. Thank you. Proponents, LB512. Welcome.

MATT HEFFRON: Good afternoon. My name is Matt Heffron, M-a-t-t H-e-f-f-r-o-n. I'm an attorney with the Thomas More Society, a national nonprofit law firm headquartered in Chicago with an office in Omaha. Studies show that the complications from mifepristone, misoprostol regimen are much more prevalent and more dangerous than the secretive abortion industry acknowledges. For instance, there have been two-- one study that's reported-- both of them with the National Institutes of Health and the U.S. Food and Drug Administration, which showed that between 2000 and 2016, there were complications in 1,941-- almost 2,000-- classified as severe, 532 were life-threatening, and 20 resulted in death. Now, while apologists for the abortion industry tend to quibble with the abortion adverse statistics, no one can reasonably deny that they could have severe or life-threatening consequences that can result from chemical abortions. That's particularly a problem in Bellevue because, as you've heard, the abortion-- the abortionists there, the abortion doctors live out-of-state and they dispense abortion drugs, and then promptly travel out of Nebraska before the most acute misoprostol-caused cramping even beguns-- even begins. Now, the alarming conditions at the Bellevue condition demonstrate why regulation is needed. You've already heard about a, a 2024 HHS violation report concerning 2023, in

which, during a three-month period, 229 of 258 patients who were seen were dismissed-- dispensed misoprostol by a physician who did not have a required dispensing pharmacy license. Let that number sink in for a moment. 229 times. That's 88% or 89%, and that's only a sampling. Just one three-month sampling. And it's even more astounding when you think that the-- that this clinic in Bellevue, this abortion clinic in Bellevue, was rampantly violating Nebraska drug dispensing law in August of 2023 it occ-- when it occurred, it occurred less than a month after HHS had just given them a warning for violating the same law. And in fact, on the next day after they received that warning, many abortion patients were seen entering the Bellevue abortion clinic despite that no dispensing partic-- practitioner license would be issued to that clinic for several months. Likewise, abortions were conducted on May 3, 2023. Despite that, according to all available records, there was no doctor licensed in Nebraska, there was no active dispensing pharmacy licensing at the time, and in fact-- get this, the clinic itself was not licensed. On November 7, 2023, it contin-- this is after the, the three-month period-- it continued. At least ten prescriptions for misoprostol were filled with Dr. Aaron Campbell's name falsely written on the label.

HARDIN: Mr. Heffron, we are in the red, but--

MATT HEFFRON: I see that, and, and, I--

HARDIN: --would you wrap up soon, please, sir?

MATT HEFFRON: --I can wrap up. Dr. Campbell was the same one who was--

HARDIN: OK.

MATT HEFFRON: --who advises his patients to lie. And Dr. Campbell did not receive an operational license until November 15, even though they were forging his name on November 7. That's the sort of stuff that needs regulation. And for that reason, please advance LB512.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: I just wanted to take the opportunity. I, I had the opportunity to work with your dad, a physician at Berger [SIC] Mercy. He was a real gentleman.

MATT HEFFRON: Thanks, Senator Riepe. I appreciate it. He was an obstetrician as well. And I would like to answer one of your questions. You, you asked whether or not the abortion facility in Bellevue was accredited. They were not. And in fact, on their

licensing issuing form, in June of 2023, it had a spot where you could select whether you'll choose to be accredited, and they chose no, they will not choose to, to ask for accreditation from any organization.

RIEPE: But there are accreditation agencies out there. We've just not demanded that.

MATT HEFFRON: We don't-- I, I don't think the law in Nebraska demands that. They have the opportunity to become accredited; they chose not to be accredited.

RIEPE: OK. Thank you for that knowledge.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chair. Since-- repeatedly, for months, they were practicing, essentially, without a license. What, what penalties-- evidently, there's no consequences for doing that in the state of Nebraska. Why was this continued and allowed to go on, quite frankly?

MATT HEFFRON: Well, that's, that's a sore subject, actually. HHS was well aware of it when the violation occurred on-- and the notice was-- went out on July 6 of the violation of the law. They entered-- the, the Bellevue abortion clinic entered a compliance agreement, which basically says we promise to be better in the future. And as I told you, less than a month later, they were already rampantly violating the same law. When that was brought to HHS attention, they went in, did an investigation; they found that, indeed, on just one three-month sampling, there were all of these violations. And once again, they didn't even bother slapping the wrist of the abortion clinic. They had to make another promise not to violate it again. And in fact, they were asked to also get a second license for dispensing pharmacy physician. And the last I checked in October, they still had not done it.

MEYER: If I may, Mr. Chair,--

HARDIN: Yes.

MEYER: --just, just a follow-up. So what, what consequences are there? What, what consequences could be imposed upon the clinic--

MATT HEFFRON: Sure. The--

MEYER: --for these violations? I mean, it seems like, you know, we promise we'll do better, and we don't. Sounds like some conversations

I had with some of my high school kids at one time. But it seems like there's a-- absolutely, they're thumbing their nose at the Department of Health and Human Services in violation of regulations. No consequences at all?

MATT HEFFRON: Well, there are consequences. It's just whether or not HHS will go about and administer those consequences.

MEYER: We don't have the will to enforce regulations, or?

MATT HEFFRON: That, you'll have to bring up HHS and some of their representatives talk about it. I don't know why they won't. I do know that they have it within their purview to shut down the Bellevue abortion clinic. They also have it within their authority to put severe, severe limitations, reporting requirements, that sort of stuff. None of that's going on. And I don't know why, but we do hope that, that we'll find out why it is-- and I could maybe give you one explanation, and it's just a-- it's just conjecture at this point. And that is, in reading the emails-- which we received from open records requests-- between the Carhart abortion clinic and HHS personnel, it's pretty clear that there's a real cozy relationship, a first-name relationship there, and they look the other way. Why that is, I don't know.

MEYER: Thank you. I appreciate that.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Mr. Heffron, for being here and for sharing your testimony. You, you mentioned out-of-state providers or medical providers who, who aren't living in Nebraska. Just kind of curious, is that unique? Is that-- I, I mean, do we see that in other fields of practice, or is that only specific to abortion care? Or is that something that we see with other types of medical practice?

MATT HEFFRON: You know, I see it in abortion care because that's one of my focuses. I couldn't, couldn't address other medical practices. I do have a couple of brothers who are doctors, and as Senator Riepe indicated, my father was a doctor as well. They stay in one place, and they, they administer to their patients in one place. When their patients have follow-up complications, they're there for them. That's one of the, the really severe problems with fly-in abortionists. And that is they come in, they dispense a drug that has clearly got problems, and then they fly right back out again. And these poor women

are left without any recourse. That should change, and that's what LB512 can change.

FREDRICKSON: OK. But my, my understanding is that we see traveling doctors for many medical specialties, E.R.s, et cetera, et cetera, especially here in Nebraska as well. So, thank you.

HARDIN: Senator Quick?

QUICK: Yeah, thank you, Chairman. I know you mentioned something about dispensing of drugs. And so, I know, like, doctors can prescribe, they can give drugs. Can you talk a little bit more about who all can administer or, or give the-- you know, prescribe these drugs?

MATT HEFFRON: Sure.

QUICK: And how that licensing works.

MATT HEFFRON: And, and as I understand it, an abortion clinic or any clinic can get a physician licensing pharmacy permit. And they have to, if they are going to dispense the drugs from their clinic. Otherwise, a judge-- sorry. A doctor will write a prescription and it'll be filled out at a pharmacy that has license-- a pharmacy license. In this case, though, the abortion clinics want to dispense the drugs right there on-site, and so they have to have a similar pharmacy license dispensing license themselves. That travels with the doctor. For instance, when Dr. LeRoy Carhart, the infamous founder of that abortion clinic died, with him went his pharmacy license. Also with him went, went the license for the clinic. And so, the clinic continued to practice, even though he was long dead. They didn't have a license, a dispensing license for a long time as well. And interestingly-- this is just one more slam on that clinic-- another reason why it should be regulated. Dr. Carhart had developed a bit of a celebrity status, even though he, he had lots of problems, dead patients, that sort of thing. He developed a celebrity practice by being upfront about his abortion practice. Almost two years after he died, it was still on their website that he was the abortionist at that clinic. And it went on about all of his various awards and all, never mentioning that the people who come in to see that celebrity doctor were not going to see him, because he's dead. This clinic is just out of control.

QUICK: And-- just one other question, but how does that compare, like-- so, in a hospital setting, you have doctors, and they see patients, and I'm sure it's a lot different. But do you have any

opinions on that, how that works? Or maybe even, like, people who work doing home care, and-- they have to go through a doctor, I think, to give those medications, because the patients are prescribed those. But how does that work [INAUDIBLE]?

MATT HEFFRON: I, I-- I'm sorry. I'm just smiling only because I thought, boy, if I was going in to see a particular, say, shoulder doctor, and he was one of the best in town, and I found out that they were advertising that he was the best in town or the best around, and went and found out that he'd been dead for a year-and-a-half, I'd be kind of shocked. I think I'd leave. So, I, I don't really know how it compares. [INAUDIBLE].

QUICK: OK. Yeah, thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. Is this a Nebraska-specific practice, where doctors fly in, prescribe this medication, and leave? Or is this practice happening in other states?

MATT HEFFRON: You know, we see it other places. And we know, particularly the doctor who was mention-- been mentioned frequently, Dr. Aaron Campbell, because he likes to talk to national magazines-- had stated that he goes to various states. He lives in Pittsburgh. He'll fly into Las Cruces, New Mexico; he'll fly into a place in Indiana; he flies into, well, into Omaha. And so, at least some of them do that. And in fact, for years, since we've been litigating over pro-life matters, we have known of doctors who fly in from various places. It's happened for years here in Omaha. Not necessarily-- not at the Carhart Clinic, because LeRoy Carhart was there, but in the Planned Parenthood clinic, they used to have doctors flying in there a lot. It's-- it happens because-- well, I don't think there are many respectable doctors who want to do abortions. And so, they have to bring them in from other places. That's my opinion.

BALLARD: OK. Thank you.

HARDIN: Any other questions? Seeing none, thank you. LB512, proponents. Welcome.

MARION MINER: Thank you. Excuse me. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here on behalf of the Nebraska Catholic Conference which advocates for the public policy interests of the Catholic Church and advances the gospel of life

through engaging, educating and empowering public officials, Catholic laity, and the general public. The conference supports LB512. Our position on abortion is well-known. The human person, from the first moment of his or her existence has human dignity and the rights of a human person. Foremost among these is the inviolable right to life. Any practice that in purpose, intent and effect directly ends the life of an innocent person should never have the sanction of human law. That said, it is not always possible to establish consensus on this principle as a matter of policy. In those circumstances, there are still legitimate and important goals we can all pursue together for the benefit of ordinary people, including pregnant women. Many of these goals have very broad public support, and the conference has successfully advocated for many of them with as broad and bipartisan a coalition as possible. Example of this, of this include various expansions to Medicaid, especially for prenatal and postpartum coverage for both moms and babies, laws to streamline and make possible better research on maternal mortality and morbidity, laws to combat sex trafficking, the creation of the Pregnancy Health Act, and many other proposals. We have also advocated for expanding the Earned Income Tax Credit and the-- creating a new child tax credit program. These are all centered on meeting medical, social, and material needs of pregnant and postpartum women and their families, and LB512, in our view, is in the same vein as these proposals. One goal I think we can all share is the assurance that pregnant women are not treated carelessly and negligently by abortion providers who follow no discernible standard of care. Different abortion providers in Nebraska follow different practices. They can all be evaluated individually on their own merits, but there is no question that some providers in Nebraska follow no recognized standard at all, and that this hurts women. No matter what choice a pregnant woman makes, she has dignity that must be acknowledged in principle and respected in action. She does not deserve abandonment to careless people in an industry that proves itself time and time again to be unconcerned with her well-being. LB512-- I just want to reiterate this-- is, is super simple. Really simple. You screen for ectopic pregnancy, you schedule a follow-up afterward, you report complications. It's that simple. That's why Senator Holdcroft is talking about a basic minimum standard of care. Basic minimum standard of care. If you cannot meet those standards, if that's too burdensome, that says a lot about your business model, and it's not anything favorable that it says about your business model. I have a few more things to say, but my time is up, so I will stop there.

HARDIN: Thank you. Any more-- anything more to add?

MARION MINER: Sure, thank you. So, one thing that Dr. Wurtz mentioned-- and I just, I just wanted to reiterate, if I had the opportunity to-- is this question about the supposed conflicting standards of care. And one of the things that he, that he mentioned is there's a difference between, right, having a certain bar as a standard of care, and then the state saying you have to have a higher bar than that, and having two things that are fundamental in conflict, which is not the case with LB512. There's nothing in LB512 that's in conflict with any discernible standard of care that I'm aware of, and if there is, I'm sure that, that-- you know, everyone who's here in support of this bill, what they want to see is that there is some minimum standard of care established. Maybe there are some abortion-- people who provide abortions as a full-time practice who follow some discernible standard of care, and that's good. You know, to the, to-- to the extent we're speaking about abortion, I'm glad that they at least have enough respect for these women that they're following up with them and screening them for potentially fatal conditions. But as we can see from Bellevue, there are people in this state who are practicing this as a full-time profession who have no standards at all. And the, the hurt is applied to the women who come to them. 229 women in one sample in three months who were prescribed abortion pills by people who don't have a license. These are the people who are saying you don't need to regulate us. Why should they get any benefit of the doubt that they are doing what is needed to be done to take care of these women who come to them and trust that they have the professional expertise and care enough to follow up with them, to make sure that they don't end up somewhere hemorrhaging in Valentine, however many hours from the nearest emergency room, because nobody cared enough to do a simple test to make sure that that doesn't happen to them? That's what this bill is about.

HARDIN: Questions? How do other states compare in the vein that you were just saying had this, this lack of a standard that is going on here?

MARION MINER: I can-- I, I don't have that right on hand with me. The one state that I know has very similar standards to what's been per-- what is been proposed in LB512 is Texas, and its standards are more stringent than this, a lot more stringent than this.

HARDIN: I see.

MARION MINER: Like I said, this is very basic. It's minimum. We really hope that this is something that ev-- that everyone can get behind.

HARDIN: OK. Thank you. Any other questions? Thank you.

MARION MINER: Thank you.

HARDIN: Proponents, LB512. Welcome.

SANDY DANEK: Thank you. Good afternoon, Mr. Chairman, and members of the committee. 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. As a statewide grassroots organization, I'm here representing thousands of Nebraskan-- Nebraska pro-life households in support of LB512. Supporting the dignity of a woman who participates in an abortion is not an approval of the procedure, but an admission that while she is making a choice that we cannot endorse, she is worthy of protection and proper care. When the Planned Parenthood abortion facility here in Lincoln opened in 1995, I was committed to being there to offer options other than abortion to women going into the facility. During my initial commitment, I was motivated by saving the baby. As I spent more time in front of this facility, I began to see the real challenges of the mother. While I still care greatly for saving the pre-born child, I could not help but be moved by what I witnessed. The pressure and despair a woman is often made to feel, which only adds to her challenges, as she sometimes believes she is backed into a corner and that abortion is her only way out. A chemical abortion, like all abortion, involves the deliberate destruction of a unique, precious individual human life. Women undergoing this procedure often encounter the sight of their baby, and have talked about seeing their limbs, their eyes, their tiny bodies. They are then left with this image that can be a life-changing traumatic event. Studies reveal the abortion pill is five times more dangerous than a first trimester surgical abortion, and yet, the FDA no longer requires the manufacturer of these abortion drugs to report complications, unless it results in death. This means the true number of complications is kept from women, leaving them blind to the risks they take when opting for this method. As reported in the 2023 Nebraska Health and Human Services abortion statistics, 82% of abortions performed in Nebraska were chemically-induced. This has an effect on many Nebraska women physically, emotionally, and spiritually. LB512 would require that an abortion facility screen women for ectopic pregnancy that, if left untreated, could be fatal. It also would require follow-up, to look for complications such as infection, sepsis, hemorrhage, or prolonged bleeding and much more. It has been said that Nebraska is a pro-life state. Our laws and elected officials reflect this. We believe every human life has intrinsic value, and we continue to offer the necessary means to support a woman. Nebraska has eight times more pregnancy help

organizations than abortion facilities. We can do better for these women and their babies. We urge you to advance LB512. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. You've committed a life of time of work to this, and good for you. God bless you for it.

SANDY DANEK: Thank you.

RIEPE: My, my question gets to be-- is do we have-- do we know what percentage of physical abortions are performed outside of abortion clinics per se? My sense is-- I don't know. I know a number of doctors. I don't know any physicians that perform a regular-- what we'd call, I guess--

SANDY DANEK: So, you're talking-- when you say regular, are you talking surgical?

RIEPE: Yes.

SANDY DANEK: Yeah. Well, I mean, if we're looking at 82% chemical, then probably the remainder, for the most part, would be surgical.

RIEPE: It'd be-- sorry.

SANDY DANEK: Obviously, the, the, the procedure of chemical abortions have grown greatly around the country, but significantly so in Nebraska.

RIEPE: OK. But the ones that aren't, are most of those then done in an abortion facility?

SANDY DANEK: Yes.

RIEPE: OK, so it's kind of either the, the pill, or they go to an abortion clinic.

SANDY DANEK: Yes. And even in some cases, chemical abortions can result in a surgical abortion if it is incomplete, if it is unsuccessful.

RIEPE: Sure.

SANDY DANEK: Then, they have, have to then go through a surgical procedure.

RIEPE: OK. OK. Thank you for being here, and again, thank you for your hard work.

SANDY DANEK: You bet. Thank you, Senator.

HARDIN: Other questions? Seeing none. Thank you.

SANDY DANEK: Thank you.

HARDIN: Proponents, LB512. Welcome.

ADAM SCHWEND: Thank you, Chairman Hardin, and members of the committee. For the record, my name is Adam Schwend, A-d-i-- A-d-a-m S-c-h-w-e-n-d, and I am the regional director for Susan B. Anthony Pro-Life America. I'm also a Nebraskan, and a resident of the city of Lincoln, and I'm happy today to testify in favor of LB512, which will establish a common-sense standard of care for the administration of abortion drugs, which account for, as you've heard, 80-- over 80% of the abortions performed in Nebraska. To cut to the chase, this bill does three things. First, it requires that a doctor determine that a woman is pregnant and screen her for ectopic pregnancies. According to the information that I have just provided you by Dr. Ingrid Skop of the Charlotte Lozier Institute, the symptoms of what occurs after a woman ingests misoprostol-- the second abortion drug-- can mask the symptoms of a tubal rupture caused by an ectopic pregnancy. A woman can think she has completed a chemical abortion when in fact she is at risk of death because of an ectopic pregnancy. Second, it requires the doctor to offer the mother a follow-up appointment. Of course, the mother may or may not show up to this appointment, but she is given that choice. We are often lectured on two points by the abortion industry: that this is an issue of choice, and that it is a matter between a woman and her doctor. This provides the choice of care, and gives her an opportunity to follow up with the actual doctor that actually examined her and actually prescribed the abortion drugs, rather than to have one meeting with a doctor whom she has never seen, has no relationship with, and will never see again. Again, pointing to Dr. Skop's comments, at least 1 in 20 chemical abortions fail, and "requile"-- require surgical intervention. Instead of being rushed to the emergency room, she is able to meet with the doctor who actually examined her. Finally, it requires that the doctor report any complications that occur. That reporting would have no identity-- identifying information; the woman's identity would be totally and truly protected. The dirty little secret in abortion reporting in the United States, particularly in pro-abortion states, is that it simply doesn't exist in most places. In some places, it's even banned. This

allows the abortion industry to claim that there are few complications, that these-- and that these drugs are safer than they actually are. In reality, they are making that claim based on totally incomplete data. In order to get reliable abortion data, we often rely on individual studies, or from Eur-- data from European nations, where data is far more complete. Mr. Chairman, I think it's obvious that the three things that this bill does create a very basic, unintrusive safety protocol, protecting the women-- health of women who make this choice. One objection we may hear from the abortion industry's lobbyists is that they already do all of these things, so this bill is unnecessary. And if that's the case, I'm very glad to hear it. However, not everyone who prescribes abortion drugs follows these common-sense health and safety standards. If some in the industry do, then I would hope that they would expect their colleagues to do the same, and if they have colleagues, colleagues who don't, would want them to be held accountable. Mr. Chairman, this-- again, this bill develops a simple but important health and safety protocol that protects women's health and safety. We urge the committee to advance LB512 without delay. Thank you very much. I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here. I see that you're a physician?

ADAM SCHWEND: I am not, no, but Dr. Skop is.

RIEPE: Oh, I'm sorry. [INAUDIBLE].

ADAM SCHWEND: Yes. And I-- if, if I may, Senator, I would offer a, a personal conversation with Dr. Skop. She, she is an OB-GYN in the state of Texas. And unfortunately, she could not be here today, but she is hap-- happy to virtually meet with any of you to have discussions about any concerns that you may have.

RIEPE: Was she alerted to our snow? Is that why she--

ADAM SCHWEND: She's a very, very smart doctor, so she may have figured it out herself.

RIEPE: We would be in Texas if we could, and maybe some of us. Today, we've heard a repeated comment about ectopic pregnancies, and I'm going to-- what's the probability of that? Because I've been around for a while, been in the hospital business for a long time. I'm not familiar with that being a common procedure, or a common occurrence.

ADAM SCHWEND: It is, it is fairly irregular, probably about 1 to 2%. But I would also point that there are a number of other complications that can come along, with these-- with the, the ingestion of these, these drugs that will result in one of 20 of them requiring surgical intervention, whether it be dealing with ectopic pregnancies or an incomplete abortion, where they have to go in and do a surgical abortion, as Ms. Danek was talking about.

RIEPE: OK. Thank you. Thank you for-- again for being here. Are you from Texas?

ADAM SCHWEND: I am not from Texas. I'm right here in Lincoln.

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

HARDIN: Senator Fredrick-- Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your testimony. I, I want to make sure I heard something correctly. So, is your understanding based on the bill, LB512, the follow-up requirement piece of that is that, that would be required to be seen by the exact-- the same provider that originally prescribed the medication. Is that your understanding?

ADAM SCHWEND: I believe that would, would be a, a follow-up, but I would, I would, I would cede to the, the sponsor on that, yes.

FREDRICKSON: Sure. OK. I'll follow up with him. Thank you.

HARDIN: Additional questions? Seeing none. Thank you.

ADAM SCHWEND: Thank you very much.

HARDIN: LB512, proponents. This will be our last proponent, most likely. And then we will switch over to opponents. Welcome.

ELIZABETH NUNNALLY: Thank you. Good afternoon, Chairman Hardin and members of the committee. My name is Elizabeth Nunnally, E-l-i-z-a-b-e-t-h N-u-n-n-a-l-l-y, and I'm here testifying on behalf of Nebraska Family Alliance and all of the families we represent who believe women and children deserve better than to be abandoned to the harms of chemical abortion. LB512 is necessary because it establishes a basic standard of care to protect women's health. It is appalling that over a three-month period, over 200 women in Nebraska were prescribed powerful and potentially dangerous drugs by unlicensed individuals. Clearly, more protec-- protections are needed to keep

Nebraska women safe from dangerous abortion practices. This bill also requires an in-person examination before an abortion pill can be prescribed, to confirm a pregnancy and screen for an ectopic pregnancy. If a woman is not screened for an ectopic pregnancy before taking the chemical abortion pill, symptoms of the ectopic pregnancy can go undetected. Delayed treatment is dangerous and can cause serious complications, and in some cases, can be life-threatening. Studies show that chemical abortions often cause serious adverse events, many of which go unreported. LB512 requires a follow-up visit to be scheduled to document and monitor these adverse complications. Out-of-state abortionists flying in to prescribe chemical abortion pills and then leaving is not health care, and no pregnant woman in Nebraska should ever be endangered by a careless abortion provider. For these reasons, we urge the committee to advance LB512 and help protect women's health and safety. Thank you.

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

ELIZABETH NUNNALLY: Thank you.

HARDIN: We'll do one more proponent because that went faster than I anticipated it would. One more proponent, LB512. Very well, we are going to switch to opponents. LB512, opponents. Welcome.

ELIZABETH CONSTANCE: Good afternoon, Chair Hardin, and members of the committee. I'm Dr. Elizabeth Constance, E-l-i-z-a-b-e-t-h C-o-n-s-t-a-n-c-e. I'm a double board-certified OB-GYN and reproductive endocrinologist, and a board member of the Nebraska Medical Association. I'm testifying today on behalf of the Nebraska Medical Association, NMA, in opposition to LB512. As a physician organization, the NMA consistently opposes policies that interfere with physicians' clinical judgment, particularly when these policies create inconsistencies with medically-accepted standards of care, or when they create additional challenges or barriers for patients accessing care. LB512 names itself the Chemical Abortion Safety Protocol Act, however, guidelines for medication abortions already exist. These guidelines allow physicians to proceed according to the best scientific evidence in conjunction with their clinical judgment to provide care based on the unique needs of the patient. I would like to provide a couple of examples of the challenges this bill would create, but first, I want to note that pregnancy termination occurs in a variety of circumstances, including ectopic pregnancies, pregnancy complications that threaten the life of the pregnant person, and non-viable pregnancies. Under Section 2 of the bill, all of these medically-necessary uses would be impacted by the regulations imposed,

impeding and limiting access to potentially life-saving medical care. As a fertility specialist, I see patients frequently that suffer from recurrent pregnancy loss, and as-- in that setting, I prescribe medications that would be regulated by LB512 for management of missed abortions and ectopic pregnancies on a weekly basis. LB512 mandates an in-person follow-up process that is not backed by evidence. The American College of Obstetrics and Gynecology [SIC], ACOG, states that routine in-person follow-up is not necessary after uncomplicated medication abortion. Instead, clinicians should offer patients the choice of self-assessment or clinical follow-up. Requiring in-person follow-up does nothing to improve patient safety, but it does put an unnecessary and undue burden on our patients, particularly those from rural communities who may have to travel several hours to be seen by their prescribing physician. I'm glad to hear that Senator Holdcroft has heard concerns about the Rh testing requirement written initially in this bill, and has committed to removing that. I do think that this illustrates the perils of legislating medical care, as research is constantly changing and guidelines evolving to reflect the most up-to-date and accurate information. Putting medical guidelines into state statute does not allow for this evaluation-- this evolution or flexibility. I would also like to take some time to address some questions about ectopic pregnancies. In the handout on-- the ACOG guidelines for medication abortion up to 70 weeks [SIC] of gestation. On page 7, it outlines the overall ectopic pregnancy rate in the general population between 6 and 14 per 1,000; that's not 6%, that's 0.06%. However, in studies for a patient seeking abortion, ectopic pregnancy rates are lower, at 1.3 per 1,000 pregnancies; that's 0.13%. And it does recommend that patients with a medical history of ectopic pregnancies, risk factors, or other symptoms suggestive of ectopic pregnancy should be receiving a clinical evaluation. That does not necessarily have to include ultrasonography. To sum up, these examples illustrate the challenges with attempting to legislate the practice of medicine. These challenges are particularly concerning when they complicate providing health care to pregnant patients. The Nebraska Medical Association respectfully asks that you do not advance LB12 [SIC]. Thank you for your time.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thanks for coming.

ELIZABETH CONSTANCE: Thank you.

HANSEN: We've heard the, the ACOG mentioned a few times. Is that, is that typically literature that is the-- that is used in the obstetrics

and gynecology world as like, a standard of care? Like, like, like we use these a lot to determine how we treat pregnant gals and kids--

ELIZABETH CONSTANCE: It is. So, the ACOG, the American College of Obstetrics and Gynecology [SIC], is the body that sets best practice guidelines for the-- for obstetrics and gynecology physicians, similar to the American Academy of Family Practice [SIC] sets those for family practice physicians, et cetera. So, each specialty has an organization; ACOG is, is ours, as OB-GYNs.

HANSEN: OK. Where do you practice, again?

ELIZABETH CONSTANCE: In Omaha.

HANSEN: Do you practice, like, privately? Or do you practice, like, in a hospital, or is it both, or?

ELIZABETH CONSTANCE: I have a private practice fertility clinic.

HANSEN: OK. And I think I can ask this, but is abortion a routine practice where you're at?

ELIZABETH CONSTANCE: So abortion, as the medical term, means the ending of a pregnancy. So, that includes miscarriage care, that includes treatment of ectopic pregnancies, which we do a lot of in the, in the fertility space.

HANSEN: So, kind of-- you do the whole broad range?

ELIZABETH CONSTANCE: Of primarily miscarriage and ectopic pregnancies. Because prim-- our, our primary practice is helping people get pregnant. But, but we use these same medications in the management of--

HANSEN: Terminating a pregnancy.

ELIZABETH CONSTANCE: Ectopic pregnancy and miscarriage management.

HANSEN: Do you use it to terminate a pregnancy that's not ectopic or a miscarriage?

Personally, no.

HANSEN: No? OK. All right. Can I ask you why? Is it just because you're worried-- is it a concern about the use of them, or just-- you just don't want to do it? Or, is it more of a safety thing? Or?

ELIZABETH CONSTANCE: No, it's not-- it's definitely not a safety thing. It's-- my, my specialty, what I have focused on, is fertility care. And so, that is what I focus on.

HANSEN: OK. All right. I'd like to get your unique perspective-- if I could, Chair-- Chairperson-- about the testimony from the supporters about the Bellevue clinic stuff.

ELIZABETH CONSTANCE: Mmhmm.

HANSEN: Do you have any opinion on that at all, on kind of what they're seeing, and what's going on there? Your professional kind of opinion?

ELIZABETH CONSTANCE: Yeah. I have no personal knowledge of what is or is not happening at the Bellevue clinic. I do know that as a state, we have a mechanism in place for-- if there are concerns about the safe practice of physicians or any other health care provider, there's a, there's a mechanism in place for reporting those to the state Board of Medicine, and so, we-- I would suggest we already have an avenue for reviewing concerns about illegal or inappropriate medical care.

HANSEN: OK. All right. Thank you. Appreciate it.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Dr. Constance, for being here and sharing your testimony. So, I appreciated Senator Hansen's questions about ACOG, specifically. I guess I kind of have a broader question in terms of the medication that's specific to this piece of legislation. Is, is it just ACOG that has the stance around this, or is this kind of widely acc-- sort of accepted in the medical field beyond ACOG, even? I mean, in terms of-- can you kind of shed some light on that?

ELIZABETH CONSTANCE: Yeah, it-- it's widely accepted. So, I mentioned the American Academy of Family Practice [SIC], they also have a statement supporting the safe use of mifepristone and misoprostol--

FREDRICKSON: OK.

ELIZABETH CONSTANCE: --for, for medication abortions, as well as supporting guidelines that do not require ultrasonography as part of that,--

FREDRICKSON: OK.

ELIZABETH CONSTANCE: --that, that prescription process.

FREDRICKSON: OK. And can you share any further information on the data that exists out there on the safety of, of these medications, or even further than that, like, the frequency of, of-- I know this talks about adverse events, for example, so, sort of, like, kind of truly adverse events. I think the introducer of the bill certainly has good intentions with the sense of, you know, wanting to ensure the safety of, or people-- or women who are pregnant, and I think that I, I, I would be curious to hear from you a little bit more about the safety of, of the medication.

ELIZABETH CONSTANCE: So, we, we do actually have robust data on the safety of these medications. They've, they've gone through the FDA process, so there is, there is a stringent requirement to, to go through that FDA approval process. It requires multiple layers of studies confirming dose, confirming safety, and confirming efficacy of the medications. And so, these medications have gone through that process already. We have-- the, the FDA-recommended regimen for early miscarriage management and medication abortion is the same, and it's that combination of misoprostol and mifepristone, with an alternative option being misoprostol alone if mifepristone is, is not available. I do have-- you, you mentioned, you know, reporting of adverse events. I do have concerns about, you know, the adverse events in this bill that would be required to be reported. Primarily, the first one says specifically "heavy or prolonged bleeding." This is how these medications work, whether we're using them for miscarriage or, you know, an abortion for an unwanted pregnancy, that-- that's how these medications work; they cause heavy bleeding. And so, this bill would require me to report to the state every single time I use these medications for miscarriage management, because every single person who uses these medications for miscarriage management is going to have heavy bleeding. And so, those aren't even the standard adverse events that are looked at in studies. And I think that there was another part of your question, right?

FREDRICKSON: Yeah, just, just, just the-- I-- well, that, that, that kind of hit on that. I was just kind of curious to know about-- a bit more about the adverse effects, or the adverse events.

ELIZABETH CONSTANCE: Yeah. Oh, sorry. So, for true adverse events, there, there are studies, one in particular looking at 20,000 medication abortions that found a true adverse event rate of 0.3%.

FREDRICKSON: OK. OK. And final question, if the chair allows.

HARDIN: Sure.

FREDRICKSON: Yes. Final question. I asked this of the introducer. Are you aware of any other medication or medical intervention or procedure that we require in statute a prescribed sort of amount of follow-up, or a prescribed sort of regiment for, for care?

ELIZABETH CONSTANCE: No, I am-- I'm not aware of any medication, procedure, or medical specialty that has specific follow-up enshrined in state statute.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Hansen.

HANSEN: Thank you. You made me think of another question. So, it's not so much-- your concern is-- or, problem with the bill is the state regulating the use of this medication, it's more the why. Because, like, we, we, we do lots of regulation and use on certain medications; there's opioids, fentanyl, you know, right? Saying you only prescribe this much in this certain amount of time, and then who's who you can prescribe it to, and all these kind of rules and regulations we have on certain medications. So, it doesn't sound like that's your concern. It's more that you don't think it should be, be-- for what reason?

ELIZABETH CONSTANCE: Well, I would suggest the, the, the requirements for reporting in this bill are much more stringent than the requirements report-- of reporting for narcotics. So I think this is undue and unnecessary level of requirement that we don't have for anything else, including narcotics and, and much more, quite frankly, you know, dangerous medications that are-- exist, that are out there.

HANSEN: I would think the reporting, though, is similar to opioids, because they have-- the, the, the physician has to report to the PDMP. So, they have to-- almost do a follow-up to the state through the PDMP, and that would be kind of a-- you say there's no other medications we, we require the physician do a follow-up on or report to the state on, but opioids, we do.

ELIZABETH CONSTANCE: Well, I-- so, I prescribe narcotics for post-op pain relief for patients all the time. I, I do not have to do this level of reporting for that.

HANSEN: OK. Thank you.

HARDIN: Help me understand this. Would you-- kind of talk me through how would you counsel someone who comes to you and says, I would like to seek a chemical abortion? What-- kind of walk me through that process. As Senator Fredrickson said at the beginning, we're short on ladies on this panel, and so, educate us. I mean, what does that-- what's that look like? You know,--

ELIZABETH CONSTANCE: Yeah.

HARDIN: Kind of take-- tell the story, if you wouldn't mind, start to finish, for us.

ELIZABETH CONSTANCE: Yeah. I, I think that there will, will be other people coming up to testify that have in more direct experience with this, in the setting of providing abortion care. I can tell you, you know-- and again, it's very similar. In the process of using these medications in the setting of pregnancy loss management, we talk to patients, we talk through the risks of the medications, we talk through the expected side effects, so, we talk through the amount of bleeding we would expect them to have, the amount of cramping they would-- we would expect them to have. We do confirm gestational age. There's a lot of-- there's robust data that shows a, a well-known last menstrual period is accurate, the-- you know, 98% of the time, if not more. So, it doesn't necessarily have to be ultrasound confirmation, but it can be confirmation of gestational age based on last menstrual period, reviewing for any symptoms or signs of ectopic pregnancy, which is also very accurate. And then,--

HARDIN: Can I, can I ask about that?

ELIZABETH CONSTANCE: --and then prescribing medication.

HARDIN: I mean, what are those signs of an ectopic pregnancy?

ELIZABETH CONSTANCE: So, it would be unilateral, which means pain on one side or the other, as well as-- risk factors would be if they've had a history of infection, they've had a history of previous ectopic pregnancy, things like that.

HARDIN: OK. Gotcha. Journal of Medicine basically says-- Journal of American Medicine says 1 in 20 women who take abortion drugs have to see a doctor to finish that abortion. Is that your experience, that it's about 1 in 20 that you know of, who might come back to you and say, I, I think I need more help?

ELIZABETH CONSTANCE: I'm not familiar with the study that you're referencing. I'd say, in my personal experience, that we have to follow-up these medications with a procedure very rarely.

HARDIN: Very rarely. So you would say less--

ELIZABETH CONSTANCE: Less than 1 in 20 for sure.

HARDIN: Less than 1 in 20. I see. OK. Thank you. Any other questions? Seeing none. Thank you. Opponents, LB512. Welcome.

ADELLE BURK: Hi. Good afternoon, Chairperson Hardin, and members of the committee. My name is Adelle Burk, that's A-d-e-l-l-e B-u-r-k, and I'm senior manager of public affairs at Planned Parenthood North Central States. PPNCS proudly operates health centers in Lincoln and Omaha and through telehealth, providing essential care to over 8,000 patients in Nebraska each year. I'm here to oppose LB512. When activists pushed for Initiative 434 last November, they made the case to voters that the measure was a compromise that would settle the issue of abortion in our state. But we knew the goal of these anti-abortion groups was to chip away at access to care until abortion is completely banned in Nebraska. So unfortunately, it comes as no surprise that bills-- including LB512-- were introduced this session to create more restrictions on abortion in our state. We oppose LB512 because it is unnecessary government overreach, and interferes with best practices for medical care. Health care decisions, including abortion, should be guided by medicine and science, not determined by politicians arbitrarily choosing how or when a person can access care. First, LB512 mandates a specific follow-up process with a patient 3 to 14 days after their medication abortion. This is unnecessary to legislate, because physicians are already under an ethical and often legal obligation to provide follow-up care to patients, no matter the service they provide. PPNCS already follows a thorough process for providing and following up with patients who receive medication abortion. This process includes verbal-- sharing verbal and written information about the procedure, providing patients with a phone number for an on-call nurse, and doing direct follow-up both one week and four weeks after the procedure. I reached out to Senator Holdcroft, as he mentioned, to share our current procedures, and he agreed that PPNCS's process meets the intention of the bill to ensure that patients are getting appropriate follow-up from a provider. However, we are concerned that LB512 creates a one say-- one-size-fits-all mandate that doesn't consider the patient's individual needs. There is no medical reason for the bill's specific and arbitrary 3-to-14-day follow-up mandate, except to make it more

difficult for patients and providers to comply. And, as Senator Holdcroft said earlier, there's no other medical procedure with a specific follow-up protocol mandated in state law. Finally, LB512 requires additional reporting for medication abortion providers on adverse events. These reporting requirements are unnecessary, and intended to burden abortion providers and restrict access to care. In reality, research shows that states which overregulate abortion care experience worth-- worse health outcomes for women and children. Let's be clear: every method of abortion, including medication abortion, is exceptionally safe; far safer than pregnancy, safer than childbirth, and safer than many other routine procedures such as colonoscopy. Professional medical organizations like ACOG agree that medication abortion is safe, and has been used by over 3 million women in the U.S. since its approval by the FDA in 2000. In summary, LB512 is medically unnecessary, provides no benefit to patients, and is designed to restrict safe access to abortion. For these reasons, we respectfully urge the committee to not advance LB512 to General File. Thank you.

HARDIN: Questions? Safer for everyone, except perhaps for the child who's lost 100% of the time.

ADELLE BURK: Was that a question?

HARDIN: That was a summary, contradicting you.

ADELLE BURK: OK.

HARDIN: Additional questions? Senator Hansen.

HANSEN: Thanks for bringing, like, your-- you brought two, two parts of the bill specifically that you have issues with, and [INAUDIBLE]

ADELLE BURK: Yeah. Yeah. And, and initially, we were also concerned about Rh, but, but yes, just those two.

HANSEN: Yeah, yeah. The, the follow-up process and the Rh are the two big ones, right?

ADELLE BURK: In addition to the Rh, it's the reporting requirements.

HANSEN: OK. Yes. Yeah. Follow-up reporting stuff. So--

ADELLE BURK: Yeah.

HANSEN: If-- so, if he got rid of the reporting-- or kind of the follow-up reporting stuff, and the Rh stuff, would, would you be a neutral on the bill, you think? Or?

ADELLE BURK: So, the follow-up process-- so, that's the remaining piece that you're talking about would be the follow-up process? Or--

HANSEN: Yeah, the follow-- yeah, the follow-up-- the recording. Like, yeah, the-- like, so they-- the patient doesn't have to come back after 3 or 14 days?

ADELLE BURK: Sure, sure. So, it's the specific 3-to-14-day requirement in terms of that, that specific time frame that has-- is a concern of ours, because that is distinct from what we currently follow. And so, right now, as I mentioned, we have a one-week after follow-up, and then four weeks after they initially get the, the medication, we do a follow-up as well. So, part of the concern with that 3-to-14-day window specifically is that it is not always possible to confirm that a pregnancy has ended within 14 days through certain methods. So, you would need to do an ultrasound or a blood test specifically to confirm that a pregnancy has ended, within that specific window. So, it reduces the number of options and forces an in-person follow-up, as opposed to, you know-- with a one-week, you know, contact with an, a registered nurse, and then a four-week follow-up, you can do like a urine pregnancy test confirmation, for example.

HANSEN: OK. So, if they did a follow-up with not the prescribing physician, but with some other health care provider, would that be better?

ADELLE BURK: It would definitely be better--

HANSEN: OK.

ADELLE BURK: --because, you know, I think what you're getting at is the point that we are trying to put a one-size-fits-all mandate on providers within state statute, whereas medical providers sometimes have diff-- slightly different practices to meet the needs of patients.

HANSEN: OK. I was going to ask you another question. Darn it. I think you brought up ultrasounds. So-- and maybe somebody after this can answer this, too. I, I don't know if it's best practice, or if it's typical, or if it's something-- it seems like the genesis of this bill is to make sure that when women get chemical abortions, they-- or they seek that, is that we as a state are making sure, like a lot of people

say, is that's our job, is to make sure that people are safe. And I think that's what this bill's intent is.

ADELLE BURK: Sure.

HANSEN: And I get where you're coming from with, with, with some of the issues. I think that also the genesis of this bill-- which is not uncommon-- is when we hear of issues that are occurring in the public where, maybe, the prescription of medication, or standards of care where we're seeing issues, and that-- and now we have to legislate something. I think that's maybe what this is coming from? I-- I'm wondering if-- my question is if an ultrasound-- I, I don't think it's in the bill-- before prescribing these medications is a standard of care.

ADELLE BURK: So, my understanding is that the Legislature has previously passed legislation requiring an ultrasound prior to any abortion. That said, I'm not a doctor, so--

HANSEN: That's all right. [INAUDIBLE] All right. Thanks.

ADELLE BURK: Thank you.

HARDIN: Additional questions? Seeing none.

ADELLE BURK: Thank you.

HARDIN: Thank you. Opponents, LB512.

EMILY PATEL: You do have some studies in there regarding RhoGAM that you can disregard. Thank you. Chairperson Hardin and members of the Health and Human Services Committee, my name is Emily Patel, E-m-i-l-y P-a-t-e-l. I'm here representing my own views and not those of my employer. I'm a Nebraska native, a mother, a wife and a doctor with nearly 20 years of experience as a double board-certified OB-GYN and maternal fetal medicine specialist. LB512, the Chemical Abortion Safety Protocol Act, is a thinly-veiled attempt to make abortion care more difficult under the guise of safety. Research has shown that medication abortion with medications like misoprostol and mifepristone is safe and well-regulated. The requirements of LB512 are burdensome and unnecessary, aimed solely at making medical care harder for patients to obtain and for physicians to provide. To illustrate my concerns, consider a hypothetical case. Imagine an 19-week pregnant woman in North Platte, Nebraska, whose bag of water has ruptured. She's transferred to a higher-level facility four hours away from home. There, she develops an infection, and her care team counsels the

family that an abortion is recommended to save her life. Under LB512, the physicians must not only assess whether her con-- her condition meets criteria under the current abortion ban, but then also comply with the bill's burdensome regulations. After the procedure, per LB512, she must now return for a visit with the same provider, hours away from home. This is an added burden to a grieving family who may have other barriers to care. Moreover, LB512 requires physicians to report detailed information to DHHS, an unprecedented level of oversight intended to intimidate providers and discourage them from offering care. Let me be clear: LB512 will not improve patient safety or health outcomes; it is about controlling women's reproductive choices. If safety were the priority, regulations on misoprostol would be consistent across all of its uses, including labor induction, post-partum hemorrhage, and gastric ulcers. Just last week, this committee heard "testimean"-- testimony on LB374, which would allow direct entry midwives to prescribe misoprostol without oversight or reporting requirements. Meanwhile, Viagra, despite risk of heart attack, stroke and death, remains easily available online, without a physician visit. These inconsistencies make one thing clear: this is about restricting abortion, not protecting patients. Instead of creating more unnecessary obstacles, lawmakers should focus on actual public health priorities, like reducing maternal mortality, expanding prenatal care access, and addressing Nebraska's shortage of OB-GYN providers. I urge you to oppose LB512 and stop this needless interference in the patient-physician relationship. Let medical professionals and patients-- not politicians-- make medical decisions. Thank you.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: I'm glad you brought up midwives. This gives me a chance to talk about it for a second. Actually, it's not direct entry midwives; it'd be certified, professional midwives. Direct entry midwives are the ones we're not legislating. Those would be the ones that would have a lower requirements.

EMILY PATEL: Noted.

HANSEN: But [INAUDIBLE] the misoprostol. You're right. It's-- [INAUDIBLE] with hemorrhaging. And, and I feel like that bill reduces maternal mortality, expands prenatal access, and addresses Nebraska's critical [INAUDIBLE] of OB-GYN providers and those giving birth, so. I felt like it was a good bill, but I just want to make sure, because-- we don't get off the rails too much on that. And I wanted to ask a

couple of questions about-- that I asked previously of the other medical provider about-- where do you practice?

EMILY PATEL: I'm in Omaha, Nebraska.

HANSEN: In private, or with others?

EMILY PATEL: I am in a private practice at a hospital system.

HANSEN: Providing abortion care, or no? Or-- I should specify, and I've learned-- terminating preg-- I don't know how to-- I don't know how to [INAUDIBLE]

EMILY PATEL: Yeah, I mean, either one is fine, termination of pregnancy, abortion care. Yes, I provide it in cases like what I laid out as an example, here.

HANSEN: With the-- with chemical-- so, you've experienced these--

EMILY PATEL: Correct.

HANSEN: OK. All right. OK. Just like I pronounced. Just curious. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Dr. Patel, for being here and for your, your testimony. I was, I was kind of intrigued. You, you, you talked about some of the safety and, and sort of medication that's prescribed online or not; you mentioned Viagra being one that is quite easily obtained online. Do you-- can you speak at all to the safety of managing medication abortion via telehealth or, or online?

EMILY PATEL: Yeah, absolutely. And there is actually a study included in the handouts that I gave, but there have-- especially during COVID, that was brought up earlier. That was a time where telehealth really took off, and that provided an opportunity to actually study telehealth, especially as it pertains to abortion access. And one of the studies that I included in there looked at what is called asynchronous versus synchronous telehealth. So, synchronous meaning that you are face-to-face with a provider on a call, for example, versus asynchronous, where they may answer a series of questions online, and then a provider can look at that information and make a decision about medical care that way. And looking at both forms of telehealth, they found that this is a safe and effective way to

approach abortion care, and that it did not increase the risk of ectopic complications from that, which I have heard is one of the concerns today.

FREDRICKSON: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I found a little levity here, and maybe appropriateness going to an all-male panel. It says on the second page, and I quote, "Meanwhile, Viagra, despite risk of heart attacks, strokes and deaths remains easily available online without a physician's visit." So, I guess that's the male answer to restrictiveness or not.

EMILY PATEL: Correct. I, I feel like it's important to draw these parallels, because when we are sitting here talking about restricting or regulating medications for safety purposes, then we need to be consistent in that. And this is an example that I'm giving where there is certainly inconsistencies. The risk of death from Viagra is about 4 in 100,000 as opposed to less than 1 per 100,000 with misoprostol, for example.

RIEPE: So, is it your suggestion that we amend this bill to include Viagra for men?

EMILY PATEL: I am not going to suggest how you should handle bills. That is not my role.

RIEPE: Just curious.

EMILY PATEL: And I would also point out too, since we were-- we're talking about regulation of medications, narcotics were brought up. Just, again, for insight there, prescription narcotics cause over 15,000 deaths per year in the United States. So again, comparing narcotic regulation to a drug like misoprostol is certainly not apples-to-apples.

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

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, doctor. I have a question about the asynchronous care versus synchronous care. What would happen-- so, you said in one of your handouts there are charts.

20-- about 20% is synchronous care. Does that sound-- does that sound right?

EMILY PATEL: I'm sorry, I, I don't have that exact number. Yes.

BALLARD: That's OK. So, what, what would happen--

EMILY PATEL: And I, and I don't have my studies--

BALLARD: That's OK. That's OK.

EMILY PATEL: [INAUDIBLE] to reference.

BALLARD: They're very interesting. So, what would happen if, if adverse effects would happen in asynchronous care? What would be the protocol?

EMILY PATEL: So, I don't provide telehealth, but I can tell you what my-- what, typically, we would do in any case when we're prescribing these medications, is we're going to give patients precautions, we're going to give them instructions about how to take the medication. Precautions, things that they should look out for with any medication I prescribe, I do that. So, that would include something like misoprostol. So, for example, if I'm prescribing misoprostol or mifepristone to a patient, for-- in my case, I prescribe them commonly in cases of a stillbirth where I need to do a procedure the following day, I'm going to talk to that patient about what they can expect. Bleeding, cramping, potentially spotting, abdominal pain, nausea, vomiting. We would go through all of those symptoms, and then outline when those symptoms are severe, and which they should come in. So, that, that would be the same for telehealth as well.

BALLARD: OK. And would there be any follow-up in a telehealth?

EMILY PATEL: There, there does not need to be.

BALLARD: OK. Thank you.

EMILY PATEL: Mmhmm.

HARDIN: Additional questions? Senator Hansen.

HANSEN: Can you clarify a little bit about the-- again, the-- a previous question I asked about the ultrasound process?

EMILY PATEL: Mmhmm.

HANSEN: Yeah, I know it's a state law. So, how does that work? So, if you make the decision, then, to prescribe chemical abortion medications, how, how does the ultrasound process work? So, they come in to see you--

EMILY PATEL: Mmhmm. Yeah, so--

HANSEN: Like, where's the informed consent, or what do you have to tell them, or?

EMILY PATEL: Right. And I should clarify, too, that when I'm talking about the fact that I perform abortions and terminations, it's in cases like maternal-life-is-at-risk kind of a situation. So, I cannot speak to how, for example, Planned Parenthood or the, the folks in Bellevue might operate. But in terms of doing an ultrasound, I mean, yes, it's pretty straightforward. There's both abdominal ultrasounds and transvaginal ultrasounds that can be used to identify if there is an intrauterine pregnancy, a gestational sac, any risk for ectopic pregnancy. But again, ectopic pregnancy is not always identified on ultrasound, so it's, again, not a requirement for, for that kind of a diagnosis.

HANSEN: OK. And you--

EMILY PATEL: Hopefully that answers that.

HANSEN: Sorry. Who are your professional opinion to-- can you mention anything about, like, with the-- proponents were talking about the Bellevue clinic?

EMILY PATEL: I-- and I-- no, I can't.

HANSEN: OK. Just curious.

EMILY PATEL: Mm-mm. I can't speak to that.

HANSEN: First time I heard it too. And then, how do-- we, we care a lot about standards of care. And so, I'm going to go back to the opioid, examples about-- sometimes it's difficult for us to tell if prescribing physicians or physicians in general are following standards of care. And so, that's when we have to legislate it sometimes, is-- which is what we have done in the instance of opioids, the reporting process, how much they can prescribe. Do you think that's appropriate in this instance, that we can at least legislate something that we feel is not following standards of care, or we're seeing there might be a public risk?

EMILY PATEL: I would go back to what has been said before, and I would agree with. If there are concerns about the way that a provider is practicing, we have avenues to report those providers, and that is the avenue that should be taken rather than a blanket bill that is supposed to legislate and, and, and impact, then, multiple areas of medicine. So, my stance would be that people should be reporting those providers that they have concerns about.

HANSEN: OK. Thank you.

HARDIN: Additional questions? It seems like you would characterize what you do as very different from things that have been reported about Bellevue. Is that a, an accurate characterization?

EMILY PATEL: I don't know how to answer that question, I guess. Can you, can you tell me what you mean by that?

HARDIN: They have a very negative reputation. It seems like you don't.

EMILY PATEL: I hope that I have a positive reputation, yes.

HARDIN: And I guess I'm asking you to paint the difference. How does that-- how does one get such a, a negative reputation and someone else not?

EMILY PATEL: I would venture to guess that because it's an abortion clinic, that is where-- that people just tend to-- there's a lot of negativity surrounding that. Unfortunately, because it is, it is health care, so. I, I can't speak to-- outside of that, though, because I'm not-- I don't have any personal experience with that clinic.

HARDIN: Senator Meyer.

MEYER: Thank you, Mr. Chair. Just to follow up with what, what the chair was asking. It appears that there were sufficient, in fact, many deficiencies in that clinic. You mentioned that there are lots of reporting opportunities and boards in place in order to regulate people that aren't doing it right. Why wasn't that followed through, here? And I, I-- you can't speak to Bellevue. I know.

EMILY PATEL: Sure.

MEYER: Where did we drop the ball here? I mean, it appears that-- once again, were-- we were focusing primarily on the Bellevue clinic and the deficiencies there. And just about all the testimony has been--

from the medical community-- that we are doing everything right; we're pristine, and we've never made a mistake. And yet, we still have these-- in this particular instance, a glaring deficiency, but nothing happens.

EMILY PATEL: Mmhmm.

MEYER: Why, why aren't-- if, if you were aware of that provider, if anybody was aware of that provider that wasn't following the rules, why didn't they report them? Evidently, Department of Health and Human Services was aware of it, they did nothing. So, where were the-- where were the boards for the doctors that were supposedly-- or the nursing profession that were prescribing these things off schedule, more or less? You know, I-- everybody's held harmless here, everybody's innocent, nobody did anything wrong, and you don't have to regulate us. And yet, we have a problem. So, so how do we approach that?

EMILY PATEL: Well, it raises the question to me-- and again, I mean, this is, this is not something that I have any personal experience with, having not been at that clinic, but it also raises the question that this is-- this was reported and investigated, that it was found that there was no wrongdoing. That's also a possibility.

MEYER: It would appear that there's a great deal of documentation that there was a great deal of wrongdoing, quite frankly. I, I don't think the, the facts are disputed, particularly with what was presented previously with the Bellevue clinic, so. I guess what I'm trying to get at is we appear to have a deficiency, and what I'm hearing, essentially, from the medical community primarily is, hey, no harm, no foul, just leave us alone, things are just perfect the way they are. In, in a layman's interpretation of what the presentations have been, of course. But, but it, it seems like we've got someone concerned-- we-- we've got legislation concerned about helping women, protecting their health. And for the most part, the medical community is pushing back and saying, no, no, everything's fine. And there are some glaring deficiencies with regard to some of the outcomes of the chemical abortions. They have some, some, some numbers that are quite troubling on the number of deaths, and, and maybe that's attributed just to the normal reaction to the, to the drugs that are being given, as you had alluded to. The excessive bleeding, I think the previous doctor had mentioned that, the excessive bleeding is a natural outcome of, of prescribing these drugs. And, and so it, it might be listed as a major medical problem here, but maybe that's a normal process of, of, of the drugs working. But, but for me, I'm troubled by, by-- my words, not yours-- a seemingly not necessarily cavalier approach, but a dismissal

that there's even a problem here. And there-- to me, there seems to be a problem.

EMILY PATEL: I think it needs to be stated for the record that there is no physician that's going to be up here testifying that would argue that a physician who is-- ha-- doing wrong, who is not practicing standard-of-care medicine and out of bounds with what they are doing, not licensed, et cetera, should be turned in and should have disciplinary action. I don't think anybody up here would disagree with that. I can't speak to what has gone on at Bellevue, so I don't know where the ball was dropped. I couldn't say.

MEYER: I, I know. And, and that's not on you. And I, I, I apologize for--

EMILY PATEL: No, it's--

MEYER: --kind of just putting that on you, because that was not my intention, so. Thank you. I appreciate your time.

HARDIN: Senator Riepe.

RIEPE: May I talk across?

HARDIN: Please.

RIEPE: You know, my, my piece is, is, as I listen and hear, is that the real problem is with the two abortion clinics. It sounds like they're out of control. And so, to me, rather than addressing all the physicians, we need to focus on the problem, and the problem is with those two. I think the answer to that gets to be-- some experience with this-- is the Joint Commission on Accreditation of Health Care Organizations. We could stipulate in an amendment that they are required to be accredited by the joint commission. That will bring sta-- standards, that will bring inspections, and that will not affect the physicians that are practicing appropriately within professional judgment. But it will bring the, the hammer down on these two abortion clinics who have been-- it sounds like to me-- being, you know, very unprofessional. And I say that with limited knowledge and understanding, but I've dealt with the joint commission, and they would-- they will bring the hammer on them, hard.

MEYER: I appreciate that. I, I will respond. The deficiency of the Bellevue clinic and Dr. Carhart was quite well-documented, Omaha World-Herald and, and pick a national publication. And I find it ironic that-- and the medical people that we're discussing this with

never heard of it. Never heard of it. Not aware. I'm just not aware. I find that very hard to believe.

EMILY PATEL: No, I'm aware of the clinic. I never worked there, so I don't have any personal experience.

MEYER: Well, there has been testimony from profess-- medical professionals. Well-- no. In fact, one in particular. Nope. Never heard of it. I, I, I find that very disingenuous. So. But I appreciate your perspective.

RIEPE: I'm just trying to say-- how do you--

MEYER: I'm, I'm not holding them responsible.

RIEPE: I admit that there seems to be a serious problem. And now, how do you go after it in an orderly way without punishing everyone? I-- my example is use a rifle on it, not a shotgun. You don't need to blow everybody all at the same time.

MEYER: Get a .22 instead of a .30-06, is that--

RIEPE: You pick and choose. You know more about guns than I do.

MEYER: Thank you.

EMILY PATEL: I-- I'd like to just--

HARDIN: Sure.

EMILY PATEL: --speak to that point, though, that, yes, I think most of the physicians here have heard of the Bellevue clinic and Dr. Carhart. But to state that I would know what he is doing as a practitioner, or what some other doctor in Kearney is doing is, is not realistic, so.

MEYER: It, it, it was specific to the Carhart clinic, was--

EMILY PATEL: Yeah.

MEYER: --the questioning, and-- which is-- which I found disingenuous. But, but I-- once again, I, I, I thank you for being here. I appreciate your, your observation.

HARDIN: Additional questions? Seeing none. Thank you.

EMILY PATEL: Thanks.

HARDIN: LB512, opponents. Welcome.

TAYLOR GIVENS-DUNN: Thank you. Good afternoon, Chairperson Hardin, and members of the HHS Committee. My name is Taylor Givens-Dunn, T-a-y-l-o-r G-i-v-e-n-s-D-u-n-n, and I'm the policy and power-building manager at I Be Black Girl. We're the only reproductive justice organization in Nebraska that centers black women, femmes and girls, and we would like to express our strong opposition of LB512. LB512 is not just unnecessary, it feels like a direct attack on reproductive autonomy, disproportionately harming black women and other marginalized community. This bill imposes redundant requirements on physicians for prescribing medication abortion, creating barriers under the guise of safety, when in fact the safety of medication abortion is well-documented and overwhelmingly clear. According to the FDA, medication abortion has been used safely for over 5 million people in the U.S. since its approval in 2000, and the complication rate overall is less than 0.4%. To put that into perspective, this makes it statistically safer than common medications like penicillin, and even safer than many routine medical procedures. What LB512 truly does is tie the hands of medical providers, inserting unnecessary bureaucratic obstacles into deeply personal health care decisions. It undermines the doctor-patient relationship, disregards the expertise of medical professionals and forces them to navigate unwanted-- unwarranted hurdles instead of focusing on evidence-based care. Providers are already held to rigorous medical standards, as I think we've heard today, through their licensing boards and professional organizations. Adding additional require-- "auding" these additional requirements serves no purpose other than to create delays and confusion, ultimately harming patients. These delays, we know, disproportionately affect those who already face systemic barriers to health care, including black women, rural communities, and individuals with lower incomes. I think this bill also sets a dangerous precedent by allowing legislative bodies to override some of these medical standards, and I think, at I Be Black Girl, we continue to assert that when lawmakers rather than medical experts dictate health care practices, the result is not improved patient care. Instead, it's reduced access, increased stigma, and in some cases, life-threatening delays. I think we want to be really, really clear that LB512 isn't about safety, it's about control. And Nebraskans deserve laws grounded in facts, not fear. We urge this committee to not advance LB512, and instead, stay on the side of evidence, equity, and the fundamental right of individuals to control their own bodies and health care decisions. Happy to answer any questions.

HARDIN: Questions? Senator Riepe.

TAYLOR GIVENS-DUNN: Yeah, please.

RIEPE: I would simply like to comment here-- very much appreciate-- I like facts,--

TAYLOR GIVENS-DUNN: Sure.

RIEPE: --I like sources, and you've documented your statistics, and I appreciate that very much. Thank you. Thank you for being here.

TAYLOR GIVENS-DUNN: Of course. I-- of course. I think when we're talking about issues such as these that have the potential to impact so many Nebraskans, we don't have to reinvent the wheel for some of these things. There is really credible data that exists around these things, and I think you've been handed some of that data today, and I think-- anything I can do to make that easier for you all as you make this decision is a great thing. Thank you.

RIEPE: Thank you.

HARDIN: Other questions? Seeing none. Thanks.

TAYLOR GIVENS-DUNN: Thank you so much.

HARDIN: Opponents, LB512.

MARY KINYOUN: Oh, did you say proponents?

HARDIN: Opponents.

MARY KINYOUN: Opponents. OK. Sorry. Good afternoon. My name is Mary Kinyoun, M-a-r-y K-i-n-y-o-u-n, and I am the chair of the Nebraska section of the American College of Obstetricians and Gynecologists, or the infamous ACOG from this discussion. And I'm a practicing board-certified OB-GYN in Omaha, Nebraska. The Nebraska section of the American College of Obstetricians and Gynecologists, representing physicians and partners in Nebraska, is dedicated to advancing the health of all those in need of obstetric and gynecologic care, and specifically opposes LB512, which will impose strict regulations on the administration of medication abortion in our state. Mandating two in-person appointments with a physician, one before receiving the medication and one within 3 to 14 days after administrating, is burdensome and unnecessary. Moreover, medication abortion, such as mifepristone, is a safe and effective form of abortion. Requiring patients to attend two in-person appointments with a physician does nothing to bolster the safety of an already safe medication. That's

why the FDA removed its requirements at a national level to be administered in person. This bill appears to be politically motivated rather than based on legitimate health concerns when you're "legistating" a medication that's safer than things like Tylenol and penicillin. As a result, it could have far-reaching negative effects on the access to essential health care for the people of Nebraska. In addition, LB512 creates barriers to care, and disproportionately affects those in rural areas who may face difficulties in traveling for multiple appointments. Ultimately, patients should have the autonomy to make health care decisions in consultation with their physician, but mandating two in-person appointments without medical necessity undermines this principle. We've heard that this bill will not affect the general OB-GYN who doesn't provide abortions, but I would argue that whenever there is undue legislative burden on any aspect of reproductive health care, collateral damage can occur. Requiring providers to report medication abortion drugs to the Department of Health and Human Services with the complications such as heavy bleeding to induce a miscarriage or a termination of pregnancy, which is the expected outcome of the medicine--medication is an egregious and unnecessary requirement for these medications. Creating this burden and reporting requirement could cause confusion and even delays into dispensing these vital medications. I think any OB-GYN in the state of Nebraska could tell you a story about a patient undergoing a pregnancy loss who was not granted their prescription for something like misoprostol when they were going through a pregnancy loss due to confusion about abortion laws. Adding non-evidence-based legislative interference into reproductive health care hurts Nebraska women. We urge the Nebraska Legislature to reject LB512, which imposes unnecessary and burdensome restrictions that are not grounded in scientific evidence while further limiting access to safe and essential reproductive health care. I included our practice bulletin for medication abortion up to 70 days of gestation. I know that there has been some talk that these are just guidelines. This has 128 citations of scientific studies, peer reviewed, that guide our guidelines on medication abortion. Thank you. I'll take questions.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Ms. Kin-- kin--

MARY KINYOUN: Kinyoun, like "minion."

FREDRICKSON: Kinyoun like "minion." I like it. Thank you, Dr. Kinyoun, for, for being here and taking the time to testify. You said something, I want to make sure I, I heard it correctly. You said

that-- you ask any OB-GYN, they would haul [SIC] stories of someone who was maybe experiencing a miscarriage, who was, who was denied their medication. Can you elaborate on that a little bit more?

MARY KINYOUN: I've certainly had patients go out to community pharmacies asking for their misoprostol and getting the runaround about getting this medication, whether that's for miscarriage or whether that's for cervical ripening, for gynecologic procedures. And I think many of us can tell you the same thing. When you add additional legislative confusion, people don't know what they're supposed to do. Will the pharmacist question, oh, is this supposed to be reported to DHHS? Did the doctor do that? Am I-- is my office going to get a bunch of calls, being like, hey, we can't give this because did you report it to DHHS? There are-- when you legislate medicine, it causes confusion.

FREDRICKSON: Yep. Is this a new phenomenon since the passage of LB574?

MARY KINYOUN: Yes, definitely more so.

FREDRICKSON: OK. So prior to that, this was not--

MARY KINYOUN: I didn't have significant issues prior to that.

FREDRICKSON: OK. Thank you.

HARDIN: Questions? Seeing none.

HANSEN: I got one.

HARDIN: Oh, you've got one.

HANSEN: Thank you, Chair. Sorry.

HARDIN: Sure.

HANSEN: I'm, I'm looking through the information that you, that you gave us. Do you see any issues with women who take progesterone or birth control pills, and then the use of these medications, increase in side effects, or any-- it looks like it's a little inconclusive.

MARY KINYOUN: So, there is some data that if you give someone a shot of Depo-Provera, which is a very large dose of progesterone intramuscular that is meant to provide birth control for three months, it could decrease the efficacy of mifepristone. It doesn't increase side effects, but could overwhelm the anti-progestin effect and cause

issues. You can still provide birth control pills, as those don't seem to interact. The recommendation, as far as a progesterone-containing IUD is that the pregnancy should have completely passed, and you should be certain that the pregnancy is passed before inserting an intrauterine device. But other than that, it's nothing that would make this medication dangerous by any means, but could make mifepristone less effective.

HANSEN: OK. Thank you.

HARDIN: Other questions? Seeing none. Thank you. Opponents, LB512. Welcome.

SHERI ST. CLAIR: Hi. I am Sheri St. Clair, S-h-e-r-i S-t. C-l-a-i-r. I'm speaking this afternoon on behalf of the League of Women Voters of Nebraska. Back in 1983, the national board of the national League of Women Voters announced its public policy position regarding reproductive rights. We believe that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices. Hence, our Nebraska League supports the right to safe, accessible abortion care for those who may become pregnant. Deeply-held personal health decisions should always remain between the patient and their doctor, not with legislators. Bills like LB512 create medically-unnecessary barriers that hinder access to medication abortion, a safe and highly effected method of abortion, according to the World Health Organization. LB512 poses troublesome restrictions for both the patient and the doctor. Patients, especially those in rural areas, already travel long distances for doctor appointments. Now, state-mandated, state-mandated in-person follow-ups in a prescribed time period creates another hurdle. Doctors are required to make special reports to the Department of Health and Human Services, and must complete a state-generated form documenting follow-up appointments within 30 days after the end of the calendar month in which the abortion-inducing drug was provided. It's worth noting that the encumbrances and potential liabilities of new abortion restrictions overburden obstetricians and gynecologists, creating a chilling effect demonstrated by a drop in OB-GYN interns and the loss of these physicians in areas where abortion is severely restricted. This loss of physicians impacts the care of all women, especially in rural areas. Recent research has demonstrated this point clearly, with states that have the most restrictive access to abortion care report fewer maternity care providers, more maternity care deserts, and higher maternal and infant death rates. In 2023, medication abortions represented 82% of the total abortions in Nebraska. A total 2018 study from the World Health Organization

reported that follow-up care is not necessary following a medication abortion. Of course, individuals always have the option of follow-up care, if desired. Mandating appointments through "regislated"-- through legislation demonstrates a clear example of government overreach and a breach of an individual's right to privacy. The League opposes LB512 because it restricts access to medication abortion, a safe, highly-effected [SIC] method of health care widely used by people seeking abortion care in Nebraska, and we urge the committee not to advance this bill to General File. And I've included on your handout our sources that were cited for this information.

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

SHERI ST. CLAIR: OK.

FREDRICKSON: Next opponent. Good afternoon.

JOY KATHURIMA: Good afternoon, Vice Chair Fredrickson, and members of the Health and Human Services Committee. My name is Joy Kathurima, spelled J-o-y K-a-t-h-u-r-i-m-a, and I'm testifying on behalf of the ACLU of Nebraska in strong opposition of LB512. LB512 creates unnecessary restrictions on medication abortions for Nebraskans seeking abortion care. An estimated 1 in 4 women in the United States will have an abortion in her lifetime. According to the Guttmacher Institute, medication abortions accounted for 63% of all abortions in the formal health care system in the U.S., and they account for 82% of all abortions in Nebraska, as reported by DHHS. The safety and effectiveness of medication abortion is undeniable. Since the year 2000, the FDA has extensively studied medication abortion, and continues to update its guidance. And in 2021, the FDA lifted medically-unnecessary restrictions that had required in-person provision of mifepristone. This bill explicitly goes against FDA guidance. Nebraska already requires medication abortion patients to go through state-mandated counseling at least 24 hours prior to their appointment, and those seeking medication abortion must also have an inpatient appointment with their doctor before they can be prescribed the medication. The restrictions found in, in LB512 are not related to patient health and safety, but instead are attempts to push abortion care further out of reach for more Nebraskans. The chemical abortion language in this bill, just like abortion restrictions in general, are based in politically-charged rhetoric rather than medicine or science. LB512 creates more hurdles for those seeking a medication abortion and creates a particularly heavy burden on patients traveling from rural or out-of-state areas to seek care by including a requirement for an

in-person follow "pointment" that is not medically necessary. For these reasons, we urge the committee to indefinitely postpone LB12 [SIC]. Thank you, and I'd be happy to answer any questions.

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

JOY KATHURIMA: Thank you.

FREDRICKSON: Next opponent.

BAILEY JOY AANENSON: Hello, my name is--

FREDRICKSON: Good afternoon.

BAILEY JOY AANENSON: --Bailey Joy Aanenson, that's spelled B-a-i-l-e-y J-o-y A-a-n-e-n-s-o-n. I'm a new member of the League of Women Voters, but also I'm here to represent myself and other young women in this state. One of the major concerns that I want you guys to consider is, as a young person who's just started off in her career, is working with her partner, and is trying to figure out where they want to live, what kind of career they want to go, and things that they need to consider in their state-- you might consider things like cost of living, drivability and stuff like that, but bills like this force us to consider a much darker possibility. I'm specifically wanting to speak on behalf of the idea that people who want to start families in this state, that this bill could really harm. But also, I am a scientist, an engineer by trade, so I like my numbers. So, I have a couple of references that I want to speak to. First of all, according to a paper that was published in 2014, in the Journal of Natural Medicine, 99.8% of chemical abortions that were administered did not have serious health effects, so that's, like, 0.2%. And just like the Viagra example from earlier, I want to make a comparison to a 2018 randomized control trial that was put in elementary pharmacological and therapeutic journal [SIC] that found that CSGIE-- which, in case you guys are not medical people, I am not-- that is bleeding, obstruction, perforation events that occur from the stomach downward-- that should sound fairly similar to symptom B that's listed in your bill-- that happens in about 0.75% of ibuprofen users and 0.6% of Aleve users. I don't know about you guys, but I have ibuprofen in my bag right now, and I use it regularly. And it's crazy to me to think that we would require additional requirements like follow-up appointments for medications that have similar, if not lesser safety, safety risks. As was kind of previously mentioned, one big risk and thing that me and my friends and my community are concerned about is

the brain drain that can happen from this. We already talked about how we don't have enough providers, we're having to rotate through people in the state, and then the providers that we do have would be at risk, with this bill, of being turned in if a patient doesn't return for their second appointment. They could be-- their license, or-- could be revoked for things that are kind of out of their control in that respect. And so, as we lose these maternal care providers, both in state and experts that do this a lot and rotate in, that can create really dangerous situations for people like me that are considering starting a family in this state, because the reality is, if you have less maternal care doctors in your state, you're just going to have more maternal deaths. And that makes a very scary reality for a lot of people like me. And so, as we're going through and making these decisions as young working professionals, women and families in your community, I just want you to consider that. Thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none. I will say, you know, I, I, I, I share your concern. I mean, I think that if we want good quality health care, it's important that we keep high-quality doctors in our state. And one of my concerns about possibly running abortion further and further underground is that that will only increase unsafe practices. So, thank you.

BAILEY JOY AANENSON: Thanks.

FREDRICKSON: Just to remind folks, we will have one more opponent before we will switch back to the proponents. So, you will be our last opponent for the time being. Good afternoon.

JULIA KEOWN: Good afternoon. Thank you, everyone, for being here. My name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am a critical care and interpersonal violence and sexual assault forensic nurse examiner in Nebraska. I come to you on behalf of the Nebraska Nurses Association, the NNA, which represents the more than 30,000 nurses in Nebraska. We are here in opposition to LB512. All nurses in Nebraska and the United States of America are bound by our code of ethics and position statements delineated by our overarching parent organization, the American Nurses Association, or the ANA. The following statements from the ANA represent the NNA's position on LB512. Quote, "Nurses and nursing organizations have an obligation to speak against legislation and social policy that undermines health equity, human flourishing and the common good." "Respect for human dignity requires the recognition of specific patient rights, in particular the right to self-determination," including making one's medical decisions.

"Everyone has the right to privacy and the right to make decisions about sexual and reproductive health based on full information and without coercion." "Nurses protect recipients of care from unwanted or unwarranted intrusion." Privacy is the right of the recipients of care to control, access to and to disclosure-- or, excuse me, and to disclose or not disclose information pertaining to one's self and to control the circumstances, timing and extent to which the information may be disclosed. "Nurses have an ethical obligation to safeguard the right to privacy for individuals, families and communities. LB512 requires the patient's physician to send various treatment information to the department 'in addition to any information required by the rules and regulations adopted and promulgated by the department' in Section 5, Part [SIC] 1 of the bill," LB512. All nurses in Nebraska and the United States are bound by our code of ethics and our professional duty to our patients. LB512 increases barriers to health care for our patients and infringes upon patients' rights to privacy and confidentiality in their medical care. For these reasons, the NNA is opposed to LB512, and we humbly and respectfully ask the committee to not advance this bill.

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

HANSEN: Thank you. Similar question that I've asked before. So, it, it doesn't sound like you're against the bill because it puts in some rules or regulations on the medication; you think it's too much?

JULIA KEOWN: I honestly cannot speak on behalf of the, the organization on a whole for being against parts of the bill or the whole bill. What I will say is legislating health care and medicine is almost never in the best interest of the patients and medical providers, especially in a situation like this, where it is-- only the patient and the medical providers know the social determinants of health, all of the gray area that go into making a decision like this. And those should be, really, the only two parties that have any sort of decision-making to do. Legislation needs to stay out of it.

HANSEN: So all the barriers or legislation we have put in place for other medications, the Nebraska Nurses Association-- I don't think they've ever came and testified against any of those. Like, when we talk about--

JULIA KEOWN: What would you be talking [INAUDIBLE]?

HANSEN: --opioids, for instance, or when we-- when we put in some barriers about how physicians have to prescribe it, how often--

JULIA KEOWN: Absolutely.

HANSEN: Barbiturates, I think to some extent-- I think we even have some-- maybe some stuff in the statute about how they can prescribe that.

JULIA KEOWN: Mmhmm.

HANSEN: Those are OK, though.

JULIA KEOWN: That's going to be beyond my scope of knowledge. I am not a provider, I'm not one who prescribes those. What I would mention again, though, is that a previous provider testified to the fact that 15,000 people a year are dying from opioids, and so that is obviously a different situation than this situation where, obviously, the 0.3% adverse events are a significantly different number than 15,000 people.

HANSEN: OK. Can I ask one more question real quick?

FREDRICKSON: Sure.

HANSEN: How does the Nebraska Nurses Association come to a conclusion about their opinion on something like this? Or on--

JULIA KEOWN: That's a great question.

HANSEN: Like, do they-- do you guys have a legislative board or something like that? That--

JULIA KEOWN: Yeah, so that's a great question. What we do is we look at the code of ethics, right? So, in the testimony, it says that our code of ethics for the American Nurses Association, which is the parent organization, I think it-- I think there's-- it covers about 5 million nurses in the United States, or whatever number it is. That's really what we look to, right? We also look at their position statements. The position statements are very well-researched, and they delineate as well how nurses are to practice.

HANSEN: OK. But when you say "we"-- that-- the "we" is what I'm curious about.

JULIA KEOWN: Yes. So then, we, as the legislative committee for the Nebraska Nurses Association, we get together, we, you know, kind of decide votes on bills that we think are going to hinder access to our patients, to medical care, or to help get access to medical care for our patients. And then, whatever stance that we end up taking is based on our code of ethics.

HANSEN: Was it pretty unanimous, the vote that came out of legislative committee?

JULIA KEOWN: For this one, yes.

HANSEN: OK. Good.

JULIA KEOWN: Yeah.

HANSEN: Thanks.

JULIA KEOWN: Yeah, of course.

FREDRICKSON: Other questions from the committee? Yes. Senator Meyer, yes.

MEYER: Thank you, Mr. Vice Chair. I just, I just have one comment. I know that it was testified earlier that prescribed opioids, there was 15,000 deaths, kind of a-- deaths, I believe you, you had mentioned that also. I just wanted to point out proportionally how many hundreds of millions of prescriptions for opioids as compared to the anti-abortion dr-- or, the abortion drugs. There's a proportionality there that, that probably needs to be addressed, because it's vastly, greatly-- opioids are, are prescribed in much, much higher numbers. So, it might not, might not be a direct proportional, but that needs to be taken into consideration when we look at 15,000 opioid deaths off prescriptions as opposed to what are-- what the prescriptions are for medical abortions. So, I just wanted to point that out. We-- we've heard that a couple of times, and it's a proportional thing, quite frankly.

JULIA KEOWN: Absolutely, it is. You're right. Which is why it is helpful to have that 0.3%. And so it gives you that proportion, right? So, I'm not sure what the percent of-- or, a proportion is on the opioid prescriptions--

MEYER: My next question, if, if we were--

JULIA KEOWN: Yeah.

MEYER: --going there, that would have been my next question.

JULIA KEOWN: Oh, sorry. Go ahead.

MEYER: So-- but, but real-- I realize it's not-- you don't have that, so.

JULIA KEOWN: Yes.

MEYER: But I appreciate your time. Thank you.

JULIA KEOWN: Yes.

FREDRICKSON: Other questions from the committee? Seeing none. Thank you for your testimony. So, we will now be shifting to neutral testifiers. We're going to take a five-minute break for-- to give committee members an opportunity to use the restroom. But we will then shift to neutral testimony-- testifiers for an hour, and then back to proponents after that. [BREAK] Are we up? Are we live? We're going? OK, good. We're on. All right. So, we are now moving on to folks testifying in the neutral capacity. Is there anyone here to testify in the neutral capacity to LB512. Great. Good afternoon.

TERESA FONDREN: Good afternoon, Vice Chair Fredrickson, and members of the committee. My name is Teresa Fondren, T-e-r-e-s-a F-o-n-d-r-e-n, and I am speaking on behalf of myself and Abolish Abortion Nebraska. Opponents of LB512 oppose it because they are pro-abortion. Proponents of LB512 are for it because they are pro-life. As an abolitionist, I know abortion is murder, yet neither group treats it as such. Therefore, I find myself in the neutral category. But I am against the bill. I am against it because God is against it. Be assured, God is not neutral in what He says about this kind of legislation. God says "You shall not be partial in judgment." Deuteronomy 1:17. This bill is partial in favor of mothers who killed their pre-born children and prejudiced against the human beings in their wombs. It allows women to commit murder via abortion with total impunity. God says, in James 2:9, "if you show partiality, you are committing sin." This bill explicitly shows partiality, and thus, to support it is to commit sin both against God and against fellow human beings. God says, in Proverbs 17:15, "acquitting the guilty and condemning the innocent, the Lord detests them both." This bill acquits every mother who kills her pre-born child with chemicals, and it condemns to death the innocent children murdered via abortion without mercy and without trial. This bill acquits the guilty and condemns the innocent. The Lord detests this. God says "woe to those who [...] deprive the

innocent of his right" in Isaiah 5. This bill, rather than supporting equality before the law, which is our state motto, continues to deprive innocent pre-born children of their right to life. Woe to those who do this. God says "woe to those who call evil good and good evil." Isaiah 5. Proponents of this bill say it is good because it will make abortions safer, but abortion is not safe for the innocent human beings which it kills. This bill plainly treats abortion like health care which can be regulated, rather than murder, which must be abolished. God says, in Romans 14:4 [SIC] that the role of the governing authority is as the servant of God, an avenger who carries out God's wrath on the wrongdoer. This bill allows murder of innocents to take place without penalty for those committing the act. To support this bill as a civil magistrate would be to abdicate one's God-given duty to punish wrongdoers. The holy word of God shows very clearly that this bill is something that God hates. I urge you not to pass it out of committee. Instead, I implore you to heed the biblical counsel given to you by over 130 pastors in Nebraska on January 23, both to draft a law which immediately abolishes abortion as murder without exception or compromise, and to proclaim a day of humiliation, fasting, and prayer for Nebraska, because much innocent blood has been spilled in our land.

HARDIN: Thank you.

TERESA FONDREN: Thank you.

HARDIN: Questions? Seeing none. Thank you.

TERESA FONDREN: Thank you.

HARDIN: Anyone else in the neutral? Welcome.

JEFF SPAHR: Thank you. Thank you for this opportunity to come before you-- this committee. My name is Jeff Spahr, J-e-f-f S-p-a-h-r. I'm representing Abolish Abortion Nebraska and myself. I have already emailed members of this committee why I am testifying in the neutral to LB512. Let me ask the committee a-- this. Looking back on the slave trade, I think we would all agree that it was unjust. So, let's go back to 1788, when British enacted the Slave Trade Act was the provision of limiting the number of enslaved people on slave ships. This act was to establish better health care for those enslaved. In measure, this act regulated slavery. Abolitionists such as William Wilberforce feared that the act would establish the idea that the slave trade was not fundamentally unjust, but merely an activity that needed further regulation. So, now let's go to LB512. Sections 3

through 5 and 7 sets forth the regulation of chemical abortion. My concern is in the portion of Section 2, with-- and this is just a portion of that-- with the specific intent of "interminating" the life of a pre-born child. Take that in. Terminating life. I thought our Constitution stated no person shall be deprived of life. Our state statute, Homicide of the Unborn Child Act, calls an act causes the death-- termination of life-- of a pre-born child at any stage of "divelment" to be murder. LB512 treats abortion as an activity that needs further regulation and not an activity that is unjust, like slavery and murder. Further, LB512 Section 6 and state statute 28-390 give legal permission and protection for the mother to engage in termination of life. This sounds just like what Senator Cavanaugh's LB53 pro-choice bill is being asked to do. It is not unjust-- is it not unjust to give permission for one specific group of people to murder another specific group of people without penalty? If LB512 is supposed to be pro-life legislation, it's a very unjust measure. When Nebraska became a state, to solidify its stance for legal equality for blacks, and acted in ours-- enacted our state motto, equality before the law. It is time to do something similar, and stop treating abortion of the pre-born as something to be regulated, as it been for the past 50 years. Instead, it's time to abolish abortion by granting the pre-born equality before the law. I conclude with a quote from William Wilberforce, edited to fit this situation. I confess to you, committee, so enormous, so dreadful, so incurable that abortion's wickedness appeared to my own mind was completely made up for abolition. A practice founded in "iniquily" of-- sorry. Made up-- for the abolition. A practice founded in iniquity and carried on as this was must be abolished, let the policy be what it might, let the consequences be what they are. I, from this time, determined that I will never rest till I effected abortion's abolition.

HARDIN: Thank you.

JEFF SPAHR: Thank you.

HARDIN: Questions? Seeing none. Thank you.

JEFF SPAHR: Thank you.

HARDIN: Those are the neutral, LB512. Welcome.

JARROD RIDGE: Thank you. Chair Hardin and the rest of the committee, thank you for giving us the opportunity to speak. My name is Jarrod Ridge, J-a-r-r-o-d R-i-d-g-e, and I come to you today representing End Abortion Nebraska. And just as my previous two colleagues brought to

you, we're offering a unique perspective, a critical perspective, rooted in God's words. You know, each of you received a copy of the biblical document that we gave three weeks ago that was referenced earlier, that is signed by 130 pastors here in Nebraska. It outlines a clear and God-honoring path to ending abortion. This morning, you heard Pastor Randall Klynsma offer the prayer in the session. He opened that prayer-- and he is one of our signers-- he opened that prayer in, in the Lord's Prayer, and he also-- a section of that was "thy will be done on earth as it is in heaven." He continued on, and he said grant that we and all men renounce our own will and, without disputing, obey your will, which alone is good, so that everyone may fulfill their office and calling as willingly and faithfully as the angels do in heaven. This bill does not align with God's will, and directly contradicts the instructions of the Lord Jesus. Regulating abortion is unjust, and this bill, along with other incremental pro-life measures, are iniquitous. Abortion is murder, as life begins at conception. To deny that is to reject God's word and to deny scientific fact. Abortion involves the deliberate taking of an innocent life with malice aforethought. This bill describes and permits a premeditated act: seeking out a pill to kill a pre-born baby. This bill perpetuates that evil practice by continuing to regulate murder and by prescribing conditions under which preborn children can be killed. Senators, I would ask you, would you ever allow a mother to give her one-day old baby a pill to end their life, if certain conditions were met? If not, why, then, do we treat the pre-born children differently? Are they not equally human? As Chair Hardin mentioned earlier today, there is one person in this mix that has completely lost 100% of the time, and that is the child. Our motto, as was stated, is equality before the law. That declares justice for all, including the pre-born. This bill treats pre-born babies unequally, and denies them justice. God has provided clear guidance on how you, his ministers with delegated authority, should govern. Isaiah 10 speaks directly to this kind of legislation as iniquitous by depriving preborn children of justice, and makes them prey. There's a woe pronounced in Isaiah 10:1, and it is directed to magistrates who write and approve bills like this. If you vote for this bill and pass this bill on, you bear responsibility for these unjust laws against the pre-born, and their blood is on your hands. And that concerns me, for you. We have all allowed this holocaust to continue for over 50 years. The blood of thousands of babies cries out from the ground, just as Abel's blood cried out after Cain committed the very first murder in Genesis 4:10. I urge you today, fear God rather than men; repent with me and do not advance this bill, but instead bring forth righteous legislation that provides equal

protection for the pre-born persons as any born person-- you and I-- in the state of Nebraska would have. 20 other-- 21 other states have already done this, so I urge you to do the same. Thank you.

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

JARROD RIDGE: Thank you.

HARDIN: LB512, those in the neutral. We're going to circle back around and go with proponents, LB512. Proponents. If we have no more proponents to LB512-- opponents, LB512. And just to check real quick. Sorry, just a moment. I want to-- hey, Scott, do we have anyone else in another room? Just checking.

_____: No, sir.

HARDIN: OK. Thank you.

ERIN FEICHTINGER: Getting out here earlier than you expected?

HARDIN: Yes'm. Welcome.

ERIN FEICHTINGER: Thanks for having me. Chair Hardin, members of the Health and Human Services Committee, my name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r, and I'm the policy director for the Women's Fund of Omaha. Inability to access an abortion can have a devastating effect on women. While the majority of people who have an abortion already have one or more children, the most common reason for choosing an abortion is not being able to afford having a child. When unable to obtain an abortion, pregnant women are more likely to end up living in poverty, and research shows that five years after being unable to get an abortion, pregnant people were more likely than those who were able to to be raising children alone without help, receiving government assistance like TANF, SNAP and WIC for longer periods of time, and less likely to be working full-time. The above is important to note, although you have all heard these arguments before. What's important now is that abortion care up to the end of the first trimester is legal in Nebraska, and it is already difficult to access abortion care in Nebraska. The scarcity of this care is particularly acute for Nebraska women living outside of Omaha and Lincoln who would be most impacted by this proposal, and who are already facing significant burdens to getting that care. Adding more time for additional follow-up appointments within 3 to 14 days means more time taken off work, it means lost income, it means difficulty securing child care for that amount of time. And of course, the cost of traveling and staying in town long enough to meet those additional

requirements. We want Nebraska women to be able to get abortion care within the scope of the law, and of course, we want anyone accessing abortion care to be provided high-quality health care throughout that process. We know that people who receive a wanted abortion are more financially stable, set goals, raise children under more stable conditions, and are likely to have a wanted child later. Imposing additional and unnecessary requirements makes it more difficult for Nebraska women to exercise their rights under the law and get the care they feel they need without even more barriers. We would urge you respectfully to keep this bill in committee, and I am happy to answer any questions to the best of my ability.

HARDIN: Thank you. Questions? Seeing none. Opponents, LB512. Welcome.

ABIGAIL DELANEY: Hi. Thank you for having me today. My name is Abigail Delaney, A-b-i-g-a-i-l; last name is Delaney, D-e-l-a-n-e-y. I'm a lifelong Nebraskan and physician specializing in reproductive endocrinology and infertility. I trained at the University of Nebraska for medical school and OB-GYN residency, and then completed my infertility fellowship at the Mayo Clinic in Rochester, Minnesota. So thus, I have spent all but three years of my life here in this great state. LB512 is simply another attempt at regulation of women's reproductive health under a false guise of safety. I think what I'd like to sort of hit on today is that there's a general misconception in the lay public that the treatment of abortion and the treatment of miscarriage are different. As someone who specializes in recurrent pregnancy loss, I am here to dispel that myth. The combination of mifepristone and misotrop-- misoprostol is safe, well-known treatment of early pregnancy loss. I know my colleagues gave you the ACOG practice bulletins as well as studies regarding that. This bill, while attempting to "furger"-- further regulate abortion, will also de facto regulate miscarriage management. Considering risk of miscarriage in the human population is 20% to 30% per pregnancy, this bill has the potential to affect multiple pregnancies and multiple people throughout the state. Lots of families will be affected if we are not able to appropriately prescribe and easily prescribe misoprostol. Consider, if you will, a patient who I just took care of, with recurrent pregnancy loss secondary to intrauterine scar disease, who presents with her fifth pregnancy loss in a row. Given her multiple losses and desire to prevent another uterine instrumentation surgery from a DNC, we may offer a combination of mifepristone and misoprostol. These patients in our clinic are already monitored closely to ensure resolution of that failed pregnancy. Because of safety of this medical therapy, it is unnecessary for patients to be followed up closely in person. Our patients drive on average-- since

there's only two clinics in the state-- two hours to see us. Post-miscarriage management can be handled on the phone, and with weekly follow-up of hCG levels; this bill would require those patients suffering from a loss to drive all the way back to see us and again relive the trauma of this loss. This is absolutely an added burden to a patient who is desperately desiring pregnancy and grieving with enhanced-- enhancing pain-- without enhancing patient safety. More concerning for me is that this bill promotes an unprecedented level of government oversight on routine female reproductive health. If particular-- in-- if we were truly concerned regarding the safety of medications, particularly misoprostol, since it's the more commonly-prescribed medication, we would regulate its use for a myriad of disorders. We use misoprostol for cervical ripening prior to induction of labor; we use misoprostol for treatment of gastric ulcers; we, we use misoprostol for postpartum hemorrhage. This be are clear-- this bill clearly is not concerned regarding safety of this medication, as that is not what is being proposed in this bill. This is, you know, unfortunately another veiled attempt to continue to intimidate providers who are simply trying to provide safe, evidence-based medicine. I would implore all of you to allow physicians to practice medicine without government interference. We are trained and capable of taking care of patients without blatant political overreach. This bill is not founded in science, and places on unnecessary regulations on the stand of care-- standard of care reproductive health. And I would en-- urge you to oppose this, and not advance it. And I'm, I'm more than happy to take questions.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I think you said that you've lived all but three years of your life--

ABIGAIL DELANEY: Yes.

RIEPE: Where is your practice at, now?

ABIGAIL DELANEY: It's in Omaha.

RIEPE: Oh, in Omaha. OK. With-- are you-- or maybe-- it doesn't matter who you're with.

ABIGAIL DELANEY: It's OK.

RIEPE: Thank you, Chairman.

ABIGAIL DELANEY: So, there are two, two infertility clinics in the state of Nebraska. We are both in Omaha. We do have a practice location in Lincoln for our patients, so that they don't have to drive as far.

RIEPE: Thank you for being here.

HARDIN: Senator Meyer.

MEYER: I just-- it's a question I probably should have asked previous providers, and, and-- do you think that, that Senator Holdcroft is trying to do a good thing with protecting women? Or do you think he has ulterior motives? Because I believe what he's trying to do is protect women from those providers, and he targeted some specifically that weren't providing proper care, were actually functioning outside of what, legally, they could do. So, much of what I hear today is contrary to what I think his intent is. He's trying to protect women from the bad actors. And it seems to me that the medical community is taking it as an attempt to reg-- unnecessarily regulate them. Is there some way we can find middle ground here? Is, is there a middle ground that we can find?

ABIGAIL DELANEY: I think there is. It's in the Department of Health and Human Services, and you guys are the committee that over-- serves that. I-- Dr. Tesmer can-- he testified earlier today, but I think regulation of bad actor doctors is important. And I think those questions need to be directed to him, and how we would legislate that appropriately.

MEYER: And, and, and yet-- if, if I may, Mr. Chairman-- so much of what I heard is the medical community can regulate themselves, and they really don't need any regulation from the legislative body. And yet, you are suggesting that the Health and Humans-- Department of Health and Human Services should be involved in it. Which I agree with, quite frankly. And so,--

ABIGAIL DELANEY: Well, they-- they're they ones who license us,--

MEYER: --there seems to be a disconnect.

ABIGAIL DELANEY: --and I agree that-- I was, you know, in preparation for this testimony today, clearly, I was not looking through particular investigations into the Bellevue clinic. I have never been there, I have never practiced there. I do not know their policies and procedures. I agree, in listening to the testimony, it does appear that there is some questions and concerns that I have as a provider,

but I believe that those should go through an investigatory body. When licenses are investigated, it goes through a body, and there is a board of medicine and health that I feel like should be, you know, in, in charge of that. And it shouldn't be blanket laws that regulate absolutely all of medicine at trying to sort of rail on one particular clinic. I think that is a-- that is a, a misuse of, of, of all of us.

MEYER: And I appreciate that. And I, I have no expectation that, that providers, the doctors that, that are practicing-- OB-GYN-- would know what actually was going on in the Bellevue clinic. I think we all were aware of the clinic and what it was doing, but as far as the, the specifics of it, obviously-- and I, I don't expect that of you. I don't, I don't expect that of any of-- and if I implied that previously, I apologize for that to all the medical professionals, but--

ABIGAIL DELANEY: I mean, I think-- the other thing I would like to say is that there are physicians that I may disagree with their management, right? And I may not 100% feel like patients that are referred to me for a second or third opinion, you know, really were taken very well care of prior to seeing me. But that doesn't mean that they were practicing evident-- like, incorrect medicine. And I would have to have an understanding of what actually happened at Bellevue to be able to sort of say whether or not what actually happened was a problem. And I think asking us, as the medical community, like, "what happened in Bellevue, do you agree or do you disagree?" without having that information is, is kind of difficult, because if there was an investigation and DHHS said that there was nothing that was done wrong, we can all disagree. We can all say like, I don't like how this was done. But if it was within the standard of care, then I think-- and if you lined up 100 doctors and they all said, I don't really like it, but it was standard of care, that's the position we're in.

MEYER: Well, I appreciate your time. Thank you.

ABIGAIL DELANEY: Thanks.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and taking the time to, to testify. You know, that's interesting that I-- Senator Meyer's question kind of got me thinking a little bit as well, and, and I, I hope I'm not mischaracterizing the intent of this bill, but I think-- my understanding, based on kind of what I've heard today, is that the real kind of goal is to ensure that folks are

perhaps protected from bad actors, I think, as Senator Meyers [SIC] had kind of mentioned. And you know, it's interesting-- when you were testifying, I was thinking a lot-- I-- I'm a mental health provider myself, and I've been thinking a lot about how, yes, I have colleagues in the field that I know are maybe trusted referrals and ones that I might choose not to refer to for various conditions or presenting concerns, based on levels of expertise. But my question is, you know, that, that, that we've seemed to be kind of hearing a lot about this, this, this Bellevue clinic and-- not so much that medical providers don't want to be regulated, but more-- certainly, if there is malfeasance or, you know, mismanagement of care, that in fact, DHHS should, you know, investigate that, and, and, and should their investigations find concerns, then appropriate steps should be taken. But it's also possible that their investigations maybe did not find concerns, in which case steps may not be taken. And I guess that's kind of the pickle we're, we're in. I mean, is that kind of your sense of this as well? Or?

ABIGAIL DELANEY: I mean, it's-- that's exactly right. I think, again, as I've stated before, I can have disagreements with colleagues on how things are managed. That's-- that is, that is medicine that-- you know, we do not live-- patients don't always follow the book. It's not a test question. Like, they don't always-- people practice differently and, and do things differently. And so, what I would say is that I can have disagreements, but from what I heard today, they were still following what would be an appropriate standard of care. So, while we can disagree all day long about that's not how I would take care of a patient, I'm just not sure that legislating an entire body of medicine, an entire reproductive field that really is, is the way that any government should do this. And I mean, I believe in kind of a smaller government that stays by itself. And, and again, this is-- that's not what this is; this is, this is regulating a specific medicine. There are-- you know, there are surgeons-- we're not, you know, regulating, you know, how specific surgeries are being performed, or how follow-ups are being formed. You know? And, and I think the bottom line is the reason we're not is because we don't have people outside of, you know, an ENT clinic wondering, well, how many people are going to have hemorrhage from a tonsillectomy, and nobody's sitting outside their clinics and documenting who's going in and who's going out and when they're going to be there and when they're not. And the reason that we don't have that is because HIPAA laws, but also because it's not politicized. And so, I think what's really frustrating for all of us in women's health care is that this has

become so politicized and all of us are under a microscope because of bills like this. And it's really unfortunate.

FREDRICKSON: Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, doctor. I just want to follow up on something you said in your testimony. It's-- so, a woman you see in your clinic that is experiencing infertility. So, you said if she has a miscarriage, she would fall under the provisions in LB512?

ABIGAIL DELANEY: There is-- in-- when I read it-- you know, I appreciate the statement and kind of the testimony from the writer of the bill earlier, but there is no-- it does-- it says intentional ending of a pregnancy, which again, when we code pregnancy loss, it's coded under missed abortion, which is a mis-- miscarriage. They haven't passed the tissue yet. Incomplete abortion. So, all of our procedures, the way that they're coded, the way that they're put into a record, is abortion. And so, what all of I think many legislators and politicians say is we want to get rid of abortion, and all of the OB-GYN community is saying, how, how do we-- we can't. Like, that is the ending of a pregnancy; however you end a pregnancy is an abortion. And so, what I'm saying is-- I have someone who has a miscarriage, and if I give them "mife" and "miso," I am terminating their pregnancy, even though the baby has already passed away, and I would technically have to put and, and write in that I gave that medication. Because if you search the logs, or if she had a-- she could have bleeding from Cytotec. I mean, it is-- you know, having had a miscarriage myself, and it, it is a lot of bleeding, and it-- that is, that is what you should expect from Cytotec. That is what you should expect from these medications. But if I end up in the emergency room and I tell somebody that there's a complication, then I-- I mean, I have to write it in. And so, my, my point is, is that, like, while, while that may not be the intent of the bill, there are multiple things that are in your-- interconnected about women's health. And by legislating one, you're affecting everybody else.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Hansen.

HANSEN: Thank you. Proper question. So, is there a code, then, for the termination of a live pregnancy?

ABIGAIL DELANEY: It's the same. It's a-- it's an abortion.

HANSEN: So, that would be under the same code of miscarriage abortion, ectopic pregnancy abortion? So those are not specified.

ABIGAIL DELANEY: Mm-mm. I mean, there's different codes for, like, incomplete abortion. They didn't, they didn't pass the tissue. Missed abortion is they haven't passed any tissue. Complete abortion is completely resolved. But it's-- they're all the same.

HANSEN: OK. I see.

ABIGAIL DELANEY: And then, ectopic pregnancy is obviously a pregnancy that-- that's different, and that is a termination. And I mean, a lot of times there is a heartbeat in an ectopic pregnancy.

HANSEN: OK.

ABIGAIL DELANEY: But my point is, is that, you know, in the medical community, we're trying very hard to follow the law and do the right things. And, and while I, I understand your intent of these bills, it's really hard to practice medicine when you're constantly trying to figure out where you fit in, in a bill. And, you know, I know Dr. Kinyoun mentioned earlier that it becomes very difficult when we have an entire community of medical providers, pharmacists, and everything and-- that are struggling to sort of, like, fit in these laws.

HANSEN: That's why I was asking that. If we're trying to be as specific as we can, I'm kind of curious to see if there's more specific terminology we should use.

ABIGAIL DELANEY: That's the problem, is that there's not.

HANSEN: Is that all ICD-10 codes?

ABIGAIL DELANEY: Mmhmm.

HANSEN: OK. Thanks.

HARDIN: Additional questions? Seeing none. Thank you. Opponents, LB512. Welcome.

DAYJAH IVIE: Hello, committee and Chair. My name is Dayjah Ivie, D-a-y-j-a-h I-v-i-e, and I'm here in opposition of bill LB512 as a concerned citizen and patient of Planned Parenthood. I'm testifying against this draco-- draconian bill that would completely outlaw

abortion in our state. Woman's health and bodily anatomy should be the guiding principles here, not rigid ideology. We live in a secular constitution and not in a theocracy. What may be medically necessary for one woman could be very different from another. I have Marfan syndrome, a serious connective tissue disorder caused by a mutation in my FBN1 gene that affects every system in my body. The most dangerous complication is an aortic aneurysm, which I have been diagnosed with. Getting pregnant would put my life at grave risk due to the immense strain it would have on my heart and vascular system. But finding a doctor that would consider my condition medically deemed necessary would be even harder with the strict laws already in place. This is why we cannot apply this one-size-fits-all approach to restricting abortion access. I'm pleading with you today to look beyond politics and religion when considering this bills. Member of the committee, too many women will needlessly die if we don't keep abortion safe, legal, and accessible to those who need it. As I speak in a room so divided, I hope we can come together to give the women in our lives a little dignity by voting no on LB512. I would like to say thank you to the doctors of Planned Parenthood for saving my life, and thank you to the members of the committee and chair for your time and patience on this matter.

HARDIN: Thank you.

DAYJAH IVIE: So fast, but--

HARDIN: Questions? Seeing none. Thank you.

DAYJAH IVIE: Perfect. Thank you.

HARDIN: Opponents, LB512. Welcome.

LINDA COLLINS: Thank you. Good afternoon, committee members. My name is Linda Collins. L-i-n-d-a C-o-l-l-i-n-s. I am a practicing board-certified OB-GYN in private practice in Omaha. I've been there since 2000, so 25 years. I trained at UNK and UNMC. I've been here my entire career, except for I did leave for four years for my residency. I am testiga-- testifying against LB512 as I feel the bill is entirely politically motivated rather than based on any legitimate medical concerns. The goal appears to be decreasing access to safe, essential and also legal health care for the patients of Nebraska. The American College of OB-GYN [SIC] strongly opposes this bill as well. The requirement of an in-person visit before and 13 [SIC] to 14 days after is burdensome and unnecessary. As physicians, we base many of our health care medical decisions based on outside reports, ultrasounds,

labs that are done elsewhere, and not necessarily in-person by myself. Medication abortions are safe and effective legal forms of abortion, and in-person visit requires nothing that will-- there is-- does not do anything to bolster the safety of these FDA-approved medications that have been available and in use for decades. This is why the FDA has removed any in-person requirements nationally. The bill is not consistent with national standards of care. It is vague; it does not even define specifically which medications would need to be reported. The mandatory requirements of reporting every case where medication is given for abortion care is meant to scare and intimidate physicians. It certainly does not protect patients. Yet, adverse-- yes, adverse effects can occur with these medications, and as an OB-GYN that's been practicing medicine and is board-certified, I am very adept at managing these complications. This is what we do in anything that we have a complication with. The list of complications in the bill includes heavy bleeding, which is, first of all, very subjective, and secondly, exactly what is expected with a medication that is causing an abortion, whether it is a, a miscarriage abortion or an elective abortion. That, that is the whole point of the medication. The patients are counseled on what is normal and what to expect, and what to do if they are experiencing heavier bleeding than normal or any complication. If this bill is passed, it will lead to a large increase, I'm afraid, of unnecessary surgical abortions instead. I ask that you let me take care of my patients without unnecessary, politically motivated, burdensome restrictions. The care of my patient should be between myself and my patient, without interference from the government. Thank you.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thank you. You have private practice in Omaha. So then, do you prescribe these medications for the termination of a pregnancy?

LINDA COLLINS: Yes. For, for, for miscarriages, very often.

HANSEN: But not for a live pregnancy?

LINDA COLLINS: Yes, I, I, I can, if the pregnance-- preg-- pregnancy has a major complication, I do. I do not perform elective abortions in my practice.

HANSEN: OK. All right.

LINDA COLLINS: But I use these medications on a weekly basis for miscarriages.

HANSEN: And I ask because I'm kind of curious about the informed consent process before a physician-- and I mean, I could ask a subs-- I probably should ask this, maybe some other ones-- the informed consent process of somebody walks in the clinic, says, I want chemically-induced abortion to terminate a pregnancy. Then what's the steps when it comes to informed consent? Like, is it-- and, and of course, in the ACOG you've mentioned-- the handout, you also mentioned about how the counseling process is supposed to be, and what they recommend. I was kind of curious to know how the, how the process actually works in reality, you know. And, and-- for the patient.

LINDA COLLINS: Well, I can't speak to an abortion with a heartbeat in, in the first trimester, but I mean, if it's a miscarriage, we have a handout.

HANSEN: Yeah.

LINDA COLLINS: We go over that with them, what to expect. We have a pre-printed handout of how to take the medication, what to expect, how long it should take, you know, the recommended follow-up. So, it's usually very clear and understandable. And I did hear some-- one of the other physicians mentioned that it's been challenging when we send these prescriptions to the pharmacy. I've-- I always feel like I'm now having to write on there "this is for a miscarriage," because they get there and the pharmacist is questioning this poor woman that just found out she's losing her pregnancy. They're questioning her about having an abortion. And it-- it's, it's, it's very upsetting for patients; it's upsetting for me, because then I'm getting a phone call from a patient that's hysterical, hysterical because she can't get her medications for her miscarriage. And I, I feel like this bill is just going to exaggerate that, and make it even harder on these patients.

HANSEN: OK. Thank you.

HARDIN: Additional questions. Seeing none. Thank you. Opponents, LB512. Welcome.

RYLEHE WOBIG: Hello. My name is Rylehe Wobig, R-y-l-e-h-e W-o-b-i-g. I am simply a young adult in Nebraska wanting to express an opinion. The LB512 bill is just another bill to control women. Medical abortion is already safe, with a 99.6% success rate and a 0.4% risk of major complications, with a mortality rate of less than 0.001%, according to the FDA. With such a low risk, why would we need this bill? Why can't we leave these types of decisions to the doctors? Implementing this bill could make it way more difficult for women to access safe

abortions, making it difficult for people to ask-- access abortions doesn't stop them from happening. You are simply taking away the risk-- or the easy way of getting an abortion. You are risking their lives. Instead, they become a lot more-- a lot less safe and introduce a higher mortality rate. In fact, in states such as Texas, where there are total abortion bans, the infant death rate has risen 5.6%, which has resulted in an estimated 478 additional deaths, must-- most of which-- 384-- occurred in Texas, according to the Johns Hopkins Bloomberg School of Public Health. Just because this isn't an abortion ban doesn't mean it doesn't threaten the ability to get an abortion. This bill could complicate our access to proper health care, with drugs being highly regulated. Instead, people will seek out more dangerous options without knowing the risks they are taking. People are already receiving proper medical care without this bill. Please leave the medication to the medical professionals. Thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you. Those in opposition to LB512. Opposition, LB512.

JOSEPHINE LITWINOWICZ: Good morning.

HARDIN: Welcome.

JOSEPHINE LITWINOWICZ: Good afternoon. I, I spoke-- I'm speaking last on purpose. I don't want to divert attention from the other-- what the other people say. My name is Josephine Litwinowicz, J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z. And, you know, I don't want double jeopardy either. There's going to be anti-LGBTQ bills. I mean, let's just, let's just be honest, that's the reality. You're going to-- and so, you tie me to another bill, and because I-- you know, but in that unbelievable combination. So, I'm at risk. And who else is at risk? Whoever you want. And I'm concerned about, you know, our, our Senate [SIC] is a-- is becoming-- like, it's a mirror of what's going on glob-- I mean, nationally. And, and so-- and it's-- it was disturbing to see the intensity of Corsi's reaction yesterday to Senator "McCavanaugh" [SIC] alluded to today. I was just a little ways away, and I, I could feel the heat. You know, so I-- you know what's coming down. And I mean, as, as far as speaking to-- I can't feel their pain, because I, I am, I am not susceptible to it. But that doesn't mean-- and, you know, I don't want to divert attention again. But, you know, this is-- I-- you know, I wanted to bring this-- so, I'm speaking also because, you know, you put me on with somebody else. What if you put me on with the death penalty, you know? And so, I think this is a-- there was something else I was going-- and-- well, just one thing. Remember when you, when you, when you, when you see 0.06%, that's

0.0000 times the number of, of events [SIC]. And that's, that's the number. So you're multiplying-- there's point-- there's three zeros and a six. Just keep that in mind, because it's actually kind of astounding when you, when you-- 0.06, you know, I always imagine that with stuff. I'm an engineer in the sciences, too. And, you know, it's, it's always good to think that way. And that's it. And, you know-- yeah, I don't want to go into all the other stuff. It's just-- I-- I'm concerned and, as an epilogue to this committee hearing, I-- I'm concerned about what I call even the radicalization-- appointees, you know, I just-- I feel, you know-- anyway, have a good one.

HARDIN: Thank you. Any questions? Seeing none. Opponents, LB512. We'll do one more swing. Anyone in the neutral, LB512? Any proponents, LB512?

SCOTT THOMAS: [INAUDIBLE]

HARDIN: OK.

SCOTT THOMAS: I did not fill out the, the paper [INAUDIBLE]. Is it all right?

HARDIN: That would be great.

SCOTT THOMAS: Senator Hardin, and the committee, my name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s. I'm with Village in Progress and USIDHR of Nebraska. Article 3 of the 1948 Universal Declaration of Human Rights gives a protection to human life and a deference to that. We're gonna testify in a neutral capacity because we support life, and we appreciate the intention of the bill. I don't think it goes far enough, personally. I heard somebody say-- I just want to speak to the comments that I heard in the room earlier, that America is not a Christian country, it's not a theocracy. This makes the word that I do extremely trying, because if you don't believe in God, then you don't believe that you have rights conferred upon you by God, or by the divine nature of your humanity, by being created in the image of God. And if you don't believe that you're created in the image of God, then you don't believe in American government, because it says in our Declaration of Independence that the reason for orchestrating the government was to protect your fundamental human rights, your inalienable human rights, God-given rights. So, I just got to push back on that. America is a Christian nation. Don't care if people like it or not. It's the best nation on earth. And God bless America, and God bless you, gentlemen, for the work you're doing. And the lady here as well. Appreciate y'all. Any questions? All right.

HARDIN: Questions? Seeing none. Thank you.

SCOTT THOMAS: Thank you, sir.

HARDIN: Anyone else? Pro? Con? Neutral? Well, we thank you. I think we were all taking bets that we might be here until fairly late this evening, so we appreciate the efficiency of it. Online, there were 278 proponents, 406 opponents, and 20 people in the neutral. We thank you. And, Senator Holdcroft.

HOLDCROFT: Thank you, Chairman Hardin, and members of the committee. I think, I think this should be considered for the consent calendar. [LAUGHTER] I think it has a, has a great opportunity for that.

HARDIN: Well, based on the time, yeah. Yeah.

HOLDCROFT: Yeah. So, I promised you that someone would be here to testify on her experience, her personal experience. And you know her; her name is Haile McAnally. She was Senator Lippincott's AA last year. She's also running for, for district. She sent me her testimony; I'd like to read it as part of my closing here: Members of the HHS Committee, I am in support of this bill, because I know firsthand what can happen when there are not significant safeguards in place for the abortion pill. When I found out I was pregnant, fear and doubt consumed me. But that fear didn't come from the pregnancy itself; it came from the voices around me telling me that I wasn't strong enough, that I couldn't do both, that my life would be over if I had a baby. I was made to believe that abortion was my only real option, so I walked into a Planned Parenthood, convinced it-- convinced this was the best path forward. The experiences were nothing like I expected. The clinic felt cold, sterile, and impersonal. I wasn't given time to process or even consider what I was about to do. The next step was simply to move forward; sign the papers, take the pill, and go home. Then, a doctor appeared on the screen, a face on a TV, not someone in the room with me. A doctor who never examined me, never looked me in the eye, never asked me anything about my personal situation. In a detached, rehearsed tone, they explained what would happen when I took these pills. I was told there would be cramping and bleeding, but nothing beyond what was normal. I was handed the first pill and given the second to take at home. That was it. I went home and took the second pill as instructed, completely unprepared for what was about to happen. The pain was immediate and overwhelming, far worse than anything I had been led to believe. The bleeding was uncontrollable. I found myself alone in my bathroom-- bathtub, unable to move from the sheer blood loss. I had been told to call the E.R. if something seemed

wrong, but by the time I realized there wasn't-- this wasn't normal, I didn't have the strength or the willpower to pick up my phone. I was alone. I thought I was going to die that day. I never spoke to Planned Parenthood or the physician again. No follow-up, no check-in. They had made it easy to get the pills, but when it came to what happened afterwards, I was completely on my own. I had trusted the professionals who told me this would be simple, but I was left in agony, abandoned by a system that had made abortion so accessible, yet so incredibly dangerous. Had there been real safeguards-- in-person medical evaluations, proper counseling, real informed consent-- I might have had the chance to rethink my decision. I might have been given the support I desperately needed to realize I was strong enough to do both. This bill is necessary because no woman should be rushed through a life-altering medical decision without knowing the full truth of what it entails, and without significant safeguards in place. No woman should have to go through what I did, especially not alone. I urge you to support the bill, and it's Haile McAnally. So. You know, Senator Riepe, you and I agree. The focus of this bill was supposed to be on, on the abortion clinics, and, and, and in particular, the bad actor abortion clinics that we have in Nebraska. And I thought that the wording in the, in the bill did that. We're, we're not focused on the normal OB-GYN miscarriage aftercare; we're really focused on elective, elective abortions. And if you looked at the bill, and again, Section 2, I'd like to just read it and see if this meets it. For purposes of the Chemical Abortion Safety Protocol Act, "abortion-inducing drug means a drug or other substance, including a regimen of two or more drugs or substances, that is provided to a woman known to be pregnant, with the specific intent of "termining" [SIC] the life of her preborn child. An abortion-inducing drug shall not include a drug, medicine, or other substance that may be known to cause an abortion but is provided for other medical reasons." So, I thought that would restrict us to the elective abortions that are being performed in the abortion facilities and would not impact the OB-GYNs who are just doing, you know, women's health. So, let me just address a couple other things. We heard that this is going to be a huge impact on, on women seeking abortions, it would be more hurdles. I'm not sure what hurdles those are. I mean, they're going to go to the abortionist, they're going to get a, a, an ultrasound to, to determine where the pregnancy is. That's pretty normal. I mean, it's not going to add that much. It's part of the, the, the examination before prescribing the pill. And then there is a follow-up examination, 3 to 14 days. And if the, if the patient is doing fine and she doesn't want to go to that appointment, there's no requirement that she does. The bill specifically says that a, a woman who is-- who

asks for an abortion or goes through those, those steps is not-- there's no consequences or penalties as a result of this bill. And then, the doctor has to report any complications. And they're listed. And maybe they are-- I mean, we got them from other states. That's where they came from. And there are other we could add, but if, you know, if, if they're too onerous, if they're not the right things, then, then we're happy to, to try to address that. A lot of people said this is a safe medication. We're ready and, and we will-- we'll provide you the studies that we have. And there-- the, the problem in the United States is we're not, we're not collecting this data. There's no requirement in Nebraska to, to, to report any complications from these chemical abortions, or in the United States. I'm not sure where the FDA gets its data. We had to go to a foreign country-- Finland, in this case-- who did a study of 24,000 women who had chemical abortions, and they had a 20% complication rate. 20%. So, we're happy to provide that information to you, but the idea that someone comes up and, and says this microscopic percentage, we have-- don't have any problems, it's because we're not collecting the data in Nebraska. So, that is part of this bill, if we have complications, to report. And they said it's a safe medication. Well, we know from this testimony it's not real safe. There's also-- I would encourage you to, to watch a film, put it on double time or whatever. It's called "Unplanned." It's the story of Abby Johnson, who was an attendant in an abortion clinic, her story, what she saw. She had two abortions: one surgical, one chemical. And they show her-- I mean, they have a scene where she's having her miscarriage in her bathroom in the tub, and it's horrific. So, it's not a safe medication. I mean, you get this pill, and it causes an abort-- and it causes an abortion. It, it causes, you know, "constractions." It causes a miscarriage. I mean, that's a powerful drug that's going to do that within a matter of 24 hours. There was some, some comment about the Leg-- you know, why are we legislating this, we don't legislate everything else. We legislate all kinds of medications in, in, in statute. Every year, we pass in Judiciary Committee what the controlled substance are and how they're-- how they can be prescribed. So, the idea that we're doing something special here by restricting, you know, prescriptions for these two, two drugs is, is just not true. I mean, we do it all the time. And we're really not restricting the, the prescription of these drugs; it's-- what we're doing is saying when you prescribe these drugs, then you need to do a pretest, a follow-up exam, and report any complications. That's all the bill does. I think the key thing-- and it was the last-- I think the next-to-last-- the difference here between what the, what the legitimate-- I guess I'll call it legitimate OB-GYN is doing in her day to day practice for women who

are really want to have a baby, and things go bad, is the term "elective abortion." Somebody used that. That's what we're trying to target here, is when women go for an elective abortion at an abortion clinic and they get prescribed these drugs, then they need to have a pre-test, they need to have a follow-up, and any complications need to be reported. So with that, I am open to any-- and also, I'm happy to work with you, Senator Riepe, on trying to crank this down to identify the, the bad actors that we're trying to get in this.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Holdcroft, for being here still, and stamina. I'll keep this-- I'll, I'll keep it fairly short. I only have one question. I was-- I, I, I appreciate you sharing the testimony of the individual who wasn't able to be here in person to share the story. My question is, did you know that this happened at-- did this happen in Planned Parenthood in Nebraska?

HOLDCROFT: I don't know. It just says-- this is all my information I have. And I'm certain-- we can certainly get that information from Haile.

FREDRICKSON: The, the only reason I ask is that it, it seems that-- it was implied that it was a telehealth visit. And my understanding is that it's illegal to do that currently in Nebraska, so.

HOLDCROFT: Well, I would, I would expect that this probably did happen outside the state.

FREDRICKSON: OK.

HOLDCROFT: She is-- Haile, I know is-- I think it was in San Diego, California. I think her husband was in the Navy.

FREDRICKSON: OK.

HOLDCROFT: So, it's very possible that it happened outside the state.

FREDRICKSON: OK. Sure. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you. Thank you for being here. I know it's been a long day for you and us, but, you know, my greatest concern is the joint commission. If you, as an organization, don't accept the joint commission, you are then required to have the state department of

health. So, I'm looking at the state department of health. If they haven't conducted some surveys and had written standards, I think we need to look to them for accountability. If they've let us down by not performing, then I think we need to go back, because I agree with you, we need to hold particularly these abortion clinics to some level of standards and performance. I'm not so concerned about practicing physicians, but I am concerned about the abortion clinics and such, so.

HOLDCROFT: Yeah, and I--

RIEPE: I think we share that, and I think-- which-- we can get there.

HOLDCROFT: I did go to the Department of Health and Human Services twice.

RIEPE: OK.

HOLDCROFT: I went to Director Corsi with the results from this inspection that they did.

RIEPE: They did an experience [SIC]?

HOLDCROFT: They did, they did-- and I think we passed it out. I think you have it in your-- there is a report there from 2023 of an inspection of the, the clinic in, in Bellevue where they identified these prescriptions that were made, 229 over a three-month period, that were not licensed. OK? That was probably the biggest discrepancy of the inspection.

RIEPE: But they didn't--

HOLDCROFT: But there were others. And, and there-- and you can even-- I think also included was the remedy, was get a license. And that's all they did.

RIEPE: OK. I'll serve, serve-- search through the papers I received today.

HOLDCROFT: Yes. Do that, and, and please send me back a report on, on each item [INAUDIBLE].

RIEPE: Aye-aye, sir.

HOLDCROFT: But I did. I went to Director Corsi directly. There's also another thing we haven't-- and I'm hoping they're still going to get

back to me on this. There is a statute in Nebraska that says when a doctor performs a surgical procedure, he or a designated other doctor is required to be in the area for the next 48 hours.

RIEPE: OK.

HOLDCROFT: OK? That, to me, is being violated, and I pointed that out to the director and his legal advisor. And I came, and then they said they'll-- we'll look into that. I came back for the second meeting and I said, well, what about this stat-- and they said it's not required in Nebraska. And I opened up the letter and I gave them the statute number and the, and the wording, and they said well, we'll have to get back to you. That was a month ago.

RIEPE: Most of these inspections, you get an opportunity to cure your problems. If you don't, they're supposed to close you down.

HOLDCROFT: Well, I'm, I'm here to tell you, their--

RIEPE: I think they're falling short.

HOLDCROFT: --their, their, their follow-up and inspection of the Bellevue abortion facility is, is lacking in my opinion. And that's why--

RIEPE: That's what it sounds like to me.

HOLDCROFT: Let's put something-- let's put something in statute that they can enforce. And then--

RIEPE: Well, I don't disagree. I just don't know whether this is it. That's, that's why we do screenings.

HOLDCROFT: OK. Thank you, Senator Riepe.

RIEPE: Thank you, sir.

HARDIN: Other questions? Seeing none. Thank you.

HOLDCROFT: Thank you.

HARDIN: This concludes the hearing for LB512 and our day today.