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Health and Human Services Committee March 14, 2019

**HOWARD:** [RECORDER MALFUNCTION] Services Committee. I'm Senator Sara Howard and I represent the 9th Legislative District in Omaha, and I serve as chair of this committee. Today we're continuing a series of briefings with the agencies and we'll be hearing from the Division of Public Health. But before I do that, I'd like to invite my colleagues to introduce themselves starting on my right, with Senator Murman.

**MURMAN:** I'm Senator Dave Murman, District 38, from Glenvil: Clay, Webster, Nuckolls, Franklin-- Franklin, Kearney, Phelps, and southwest Buffalo County.

**WALZ:** Lynne Walz, District 15: Dodge County.

**ARCH:** John Arch, District 14: Sarpy County.

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

**HOWARD:** Fantastic. And with that, we'll invite our Division of Public Health to tell us a little bit more about the work that they do.

**BO BOTELHO:** Good afternoon, Chairman, Chairwoman Howard and the members of the Health and Human Service [SIC] Committee. My name's Bo Botelho. I'm the interim public health director. We're currently recruiting for the public health director, chief medical officer in Nebraska. We haven't, haven't identified or hired one yet. Public Health is a large division of HHS. I have three deputies. The deputies will actually come up and speak to the program specifically and give you more in-depth information. One of my deputies isn't here, the community health deputy Mark Pyle. He's on a phone call with NEMA right now, and one of his divisions is the public health preparedness and emergency response. So they're very busy across the state right now as we have weather events going on pretty much everywhere around Lincoln. So with that, I'll bring up my first deputy, Ashley Newmyer. She has health records, vital records, epidemiology, and informatics. And the other deputy that is here is Darrell Klein, who is in charge of facility, professional, and occupational licensure, investigation, and environmental health services. Thank you.

**HOWARD:** Thank you. Good afternoon.

**ASHLEY NEWMYER:** Good afternoon, senators. I'm Ashley Newmyer, as Bo mentioned, one of the deputies with the Division of Public Health. I cover the health data section. And so in the handout that was provided

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to you, you will see that on-- sorry, one moment here-- starting on the bottom of page 2, you'll see this visual, which is a wheel that represents the ten essential services of public health. There are nine services around the wheel and then one in the middle. Also, each of those services can be categorized into a component, assessment being the component that my areas cover. And so I will give you a little bit more detail, as well as I'll give you some briefing over Mark Pyle's area since he is not able to be with us today. So the two units that are in the health assessment area, or the health data area, is the vital records and then the epidemiology and informatics unit. So vital records covers all of the birth, death certificates, marriage-- maintains the vital records of the citizens of Nebraska. Epidemiology and informatics unit-- that area covers our health data collection, our statutory registry repositories. The purpose is to assess the health burden, as well as some of the risk factors, of various health conditions across the state. We focus on infectious disease, that communicable disease, investigation and control, as well as we have components that focus on injury surveillance, chronic disease, cancer assessment. So my areas, if you kind of categorize them, they're-- we're really trying-- we're focusing on assessing the entire health of the state of Nebraska. One area covers what is the population of the state, what are the births, what are the deaths-- underlying causes. And then the other area really focuses on those health conditions that affect the citizens of our state and making sure that we're monitoring those trends accurately, measuring those, providing the information that's needed for programming, prevention, evaluation of programs, To move-- moving on to the next slide. So I just mentioned a couple accomplishments from our area. So previously we had done some work in the vital records area to improve the customer service response times for customers coming in to request certain certificates. We were able to improve the wait time for those people from 30 minutes to 5 minutes. We've also responded to various infectious disease outbreaks, consisting of: foodborne, influenza, healthcare-associated infections. And then, also in this area, we have implemented opioid overdose prevention efforts. This includes the Prescription Drug Monitoring Program, pain management guidance that was developed and has been distributed, as well as increasing awareness of the lifesaving drug naloxone. So looking towards the future, our, our main focus is going to be continuing to build those community partnerships to provide support and help implement these opioid prevention efforts, and then continued readiness to detect infectious disease outbreaks and

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emerging diseases in Nebraska. I can pause here if we have questions about that area and, if not, I can move on to the next area.

**HOWARD:** Sure. Senator Cavanaugh.

**CAVANAUGH:** Sorry. I just-- thank you. Just was wondering how your accomplishments, how you cut the time from 30 minutes to 5 minutes.

**ASHLEY NEWMYER:** So I believe that we had an assessment that was done. So this involves people that are physically coming into our office and then requesting certificates. And I know an assessment and a process improvement project was done with the Governor's Center of Excellence [SIC], and I believe it was, it involved the intake request, cutting out some steps in that process to intake the information, process, and then get the certificate back out. So I don't have the specific details, but--

**CAVANAUGH:** Oh.

**ASHLEY NEWMYER:** --it was basically a big process improvement project, and we've been very happy with it because it's been successful and--

**CAVANAUGH:** Thank you.

**HOWARD:** Other questions? Senator Arch.

**ARCH:** A couple of questions. One, do you interface with NeHII at all?

**ASHLEY NEWMYER:** We do, yes.

**ARCH:** And how?

**ASHLEY NEWMYER:** So with a Prescription Drug Monitoring Program in statute, the department collaborates with NeHII as a health information exchange. And so around that program, we work with them collaboratively, collaboratively as a partner to manage or to implement the Prescription Drug Monitoring Program. They kind of, they do the technical aspects; we do the management, administration, registration of the program.

**ARCH:** Registration of the program with?

**ASHLEY NEWMYER:** Healthcare providers to--

**ARCH:** Oh, OK.

**ASHLEY NEWMYER:** Yeah.

**ARCH:** Do you have access to the data in the PDMP?

**ASHLEY NEWMYER:** We only have-- we receive surveillance files from the PDMP for grant reporting purposes.

**ARCH:** Which would be anonymized? I mean is there-- I mean it's just, it's just aggregate data. Is that all you're talking about?

**ASHLEY NEWMYER:** We, we receive the raw data and then we analyze and aggregate the information.

**ARCH:** When you receive the raw data, you receive patient information, patient identifiers?

**ASHLEY NEWMYER:** Yes.

**ARCH:** OK.

**ASHLEY NEWMYER:** Um-hum.

**ARCH:** Thank you.

**HOWARD:** Other questions? You can continue.

**ASHLEY NEWMYER:** OK. So I will do my best to cover the community health area, which is overseen by Mark Pyle. So the community health partnership prevention area, as you see, also covers additional services of the 10 essential services of public health. This is primarily around prevention, programming, it informs and educates the community, forms part, forms community partnerships, and provides linkages to the needed health services. This area includes four units: community and rural health planning, health promotion, life span health, and public health preparedness and emergency response. In the community and rural health planning section, there are, there are several offices. So we have the rural health area, community health, developmental disabilities which does advocacy, health disparities and health equity area, emergency health systems which comprises the trauma system and then has liaisons with local health departments and other community partners that really help form the public health delivery system in Nebraska. Moving onto the next section is health promotion. Here is where we have dental health, chronic disease, infectious disease, preventative health services, and Tobacco Free Nebraska. And here they're really promoting rural health-- or I'm

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sorry-- oral health, preventions of cancers, and preventions of hepatitis, HIV, SUD, and tuberculosis. In the lifespan, health, and preventative health area, we have maternal and child health, immunizations, women's and men's health, reproductive health, women, infant, and children are commonly referred to as WIC, and then the newborn screenings area. His final area is preparedness and emergency response. There's emergency preparedness. This is where we connect with healthcare and hospital preparedness. We have medical countermeasures, which includes the Strategic National Stockpile and then the City Ready, Readiness Initiative. And the other deputy, Darrel Klein, will be able to provide you some more information about the preparedness that's going on currently. Next slide is a depiction of the public health system, and so it's important to view public health as a system. Public health forms community partnerships and delivers services throughout the state. Our state agency really connects and works with the locals on a daily basis. You can see this is a fairly complicated diagram. It's not just a bidirectional; it's kind of multidirectional, working with a variety of partners to actually deliver public health services. And then, finally, a few accomplishments. So the Tobacco Quitline call volume increased by just over 3 percent. We, there were additional six designated, designated six hospitals as trauma centers and then four at as stroke centers. We have submitted an application to the Health Resources and Services Administration to continue funding of the state Office of Rural Health. We implemented Nebraska Walkable Communities Initiatives [SIC], which involves working with local communities, especially in rural areas, to help improve infrastructure to encourage that increased physical activity. WIC has completed the rollout of the eWIC across Nebraska. And then we have the fifth highest childhood immunization coverage rate for children ages 19 to 35 months. So that is a really, really important preventative health measure. So looking forward, one of Mark's main, main initiatives is to improve the public healthcare delivery system and work through local community partners to make sure we're effectively delivering a system across the state, so.

**HOWARD:** Are there any questions for, for Ms. Newmyer? Seeing none,--

**ASHLEY NEWMYER:** OK.

**HOWARD:** --Mr. Klein?

**ASHLEY NEWMYER:** Thank you.

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**DARRELL KLEIN:** Thank you. I'm Darrell Klein. I'm deputy director of licensure for the Division of Public Health. We've met before. And I've got some additional information about the current emergency response and can talk a little bit about our emergency response efforts because I was the attorney that supported that area. And, but, but first an overview. I was assigned responsibility for small font today, and it's reflected in my, my slides which have the raw numbers of people that we're responsible for. On the, on the wheel representing public health, the areas that that I'm over basically fall under "enforce the laws" and "assure a competent work force." So we're kind of the police side of public health. But I won't, I won't read the numbers to you but you see we have a number of professions and health occupations, facilities, and businesses. And we issue active credentials to 185,700-some individuals in Nebraska. So if you compare that to the, to the population or to the work force, you see that we touch a lot of folks' lives. And that's in the health side of it. On the environmental side, it's mostly radon abatement, measurement and abatement. Nebraska's in an area, unfortunately, where we've got high radon levels. So you see the numbers there. We regulate the companies that measure radon and mitigate it. And you can see the number of mitigation systems installed. This is just last year. Asbestos abatement-- that has that has abated a little bit. It got its start when they were moving the, the national effort to get the asbestos out of schools. And a lot of that type of a part of the abatement has happened. But you still run into older construction, and particularly for demolition where the, the handling of the materials has to be in conformance with the law to avoid exposures of, not just the workers, but also the public. And then lead-based paint, where we've got the listed numbers of companies and, and the workers that they have. We had, as I say, we had about, about 4,850 mitigation systems for radon last year, 1,500--so asbestos abatement projects, and about 58 that were, were dealing with lead-based paint. Additionally in the Environmental Health Unit, we have radiological health. We license the uses of radioactive materials and generation, radiation generating equipment, primarily x-ray machines. That shows the number of the licenses that we've got and we regulate. And then, finally, the public health laboratory is under my responsibility, and the lab last year ran 63,207 tests. So they test anything from, from water to, to blood, and they're very, very busy, as you can see. Some of our accomplishments-- I want to mention, too, I also have the Investigations Unit and I kind of feel bad that I left them off and didn't give you raw data. But they-- the Investigations Unit is responsible for investigating complaints under the Uniform

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Credentialing Act, which basically supports the Licensure Unit, which showed the, the healthcare professionals. And when a complaint comes in, it's in, it's, it's basically assessed to determine if, on its face, it would be a violation. There's a process where we work with the professional boards and the Attorney General's Office in conducting the investigation, and then the results of, of the investigation are forwarded to the Attorney General's Office for their assessment, to determine whether or not to file a petition. So when you look at all those raw numbers under the Uniform Credentialing Act, the Investigations Unit is working to support the department and the Attorney General's Office in those investigations. And some of our accomplishments in the last year-- again, process improvement, which Ashley mentioned, trying to lower the amount of time taken for the, between the, an application for renewal and the issuance of that renewal license, I think we've made great strides there. There's, there's additional work to be done always, and the folks are working hard to do it. And we've got an RFP out for an updated license information system, moving to automated survey and inspection processes, and we've improved on-line renewal for healthcare facilities. Part of the impact on the Licensure Unit, with the flooding, has been a number of closures-- or evacuations, I shouldn't say closures-- of nursing facilities and assisted living facilities across the state. And Russ Wren is over at the Nebraska Emergency Management state Emergency Operations Center, and he's there as-- I don't think the ESF 8 desk, which is public health and medicine, is formally stood up, meaning the, with each emergency, Emergency Management determines which positions will be staffed. But we have a representative over there. The state Emergency Operation Center is open 24/7. In addition, information about any sort of emergency-- and in this instance primarily flooding-- is entered into ESS software, Essential Suites-- something or other-- software. And we have access to that software and have it up on display in the State Office Building in an area that we call the emergency communications center. The information there is being shared from the health, from the emergency preparedness people with the Licensure Unit people. My Licensure Unit also yesterday began and finished contacting every nursing facility and assisted living facility in the state to determine what their status and what their plans were. We actually had one facility-- I don't recall the name right now-- but they implemented their emergency evacuation plan only to be turned back by the State Patrol because the route was impassable. So they deftly moved to plan B and, and did a good job with it. One of the Skyline facilities, which I believe was either largely or completely empty

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because the residents had been transferred out, has been used by another facility as their evacuation point. So-- and none of the Skyline facilities have needed to evacuate. So that's a little update that's kind of on everybody's mind. And late last night, one of Ashley's folks came in late. All three emergency-- or all three deputy directors-- were in a briefing for the emergency yesterday, and it occurred to us that we should map our healthcare facilities in flood plains across the state. So we had a person who, after completing a full eight days of training, came into work and created a bunch of maps for us so that we could have a better idea for it. So with that, I'll shut up for a minute and answer any questions that you might have for me.

**HOWARD:** Are you able to share a copy of those maps with the committee?

**DARRELL KLEIN:** I don't think that there's any reason we couldn't. We've got, we've got the statewide and then we've got breakouts for insets for, for Omaha and Lincoln and, I believe, Columbus. So yes to that.

**HOWARD:** Are there questions? Senator Walz.

**WALZ:** I kind of missed-- sorry, somebody was texting me when you're talking about the plan. So you are asking each assisted living facility for a copy of their evacuation plan?

**DARRELL KLEIN:** I don't think we asked them for a copy at this time. We called them up to inquire about their status and what their plans were if they needed to. In general-- and I'm drawing from my past now rather than my present-- healthcare facilities are, are required to have plans in place to, to deal with hazards. And the feds have recently very strongly updated their requirements for nursing facilities which, so at the state level that's been updated, too. Those are quite comprehensive. They have to have tabletop exercises. They have to test their generators on a periodic basis. Essentially for the rest of the disasters that, that are likely to take place, it would essentially range from if their power went out or if there were flooding or other things that were threatening their continued operation, they need to have some sort of plan of what they would do with their residents. And typically for a, for a flood situation, it's, you know, moving to higher ground essentially.

**WALZ:** Um-hum.



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**DARRELL KLEIN:** And then the problem there is, is if the road between you and higher ground is lower. That's what happened to one, one of the facilities. I think what we asked to do today was for them to just tell us. It was also an opportunity to raise their awareness, you know, find your plan and be ready to implement it. And that's the sort of thing, those plans would be the sort of thing that we would go out and inspect for on a regular basis. I think the calls today were more like, are you in trouble, do you need any help,--

**WALZ:** Um-hum.

**DARRELL KLEIN:** --do you have your plan in mind for what you might need to do.

**WALZ:** OK. And I know that assisted living facilities are a very broad range of--

**DARRELL KLEIN:** Yeah.

**WALZ:** --large to, you know, homes. So are you talking every assisted living facility, thus homes or just the large ones?

**DARRELL KLEIN:** I didn't get a list.

**WALZ:** OK.

**DARRELL KLEIN:** But I was told that they contacted-- they started at the-- they, they picked north to south. And it turned out more of the problems are north, apparently.

**WALZ:** Yeah.

**DARRELL KLEIN:** And I was told that they contacted every nursing facility, which would include skilled nursing, and intermediate care, and every assisted living facility.

**WALZ:** OK.

**DARRELL KLEIN:** And I know some of my other people were in touch with their facilities. So there are other categories of licensure that, that folks reach out to, too.

**WALZ:** All right.

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**DARRELL KLEIN:** And you're right. The acuity for the folks involved ranges all over the place.

**WALZ:** Yeah.

**DARRELL KLEIN:** So I think-- let me let me check here. There may have been a hospital involved already, too. So I think they are OK to return. So yeah. And the information I've got, as, as I was telling Senator Howard, if it's 20 minutes old, it's old. It's constantly evolving.

**WALZ:** Um-hum.

**DARRELL KLEIN:** But I guess the point is we're on top of it; and so far, so good.

**WALZ:** Hmm. Thank you.

**DARRELL KLEIN:** Um-hum.

**HOWARD:** Other questions? Seeing none, thank you, Mr. Klein. Anything else you two would like to add? No? All right. This will close the Division of Public Health briefing and the committee will start its hearings at 1:30.

[BREAK]

**HOWARD:** Welcome to the Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha. And I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

**MURMAN:** Hello. I'm Dave Murman, District 38 from Glenvil: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and part of southwestern Buffalo County.

**ARCH:** John Arch, District 14: Sarpy County.

**WILLIAMS:** Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer and the north portion of Buffalo Counties.

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

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**HOWARD:** Also assisting the committee are our legal counsel, Jennifer Carter, and our committee clerk, Sherry Shaffer, and our committee pages, Maddy and Erika. Is Erika coming?

**MADLINE BROWN:** Yeah, later.

**HOWARD:** OK. She's coming later. OK, perfect. A few notes about our policies and procedures. Please turn off our silence all of yours, your cell phones. This afternoon we'll be hearing three bills, and we'll be taking them in the order on the agenda listed outside the room. On each of the tables near the doors to the hearing room you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note, if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m., the day prior to the hearing. Any handout submitted by testifiers will also be included in the record as exhibits. We ask that you please bring ten copies and give them to the page when you come up to testify. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin the light will be green. When the light turns yellow, that means you have one minute left and, when the light turns red, it is time to end your ten, testimony and we'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone; then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements, if they wish to do so. We do have a strict no-prop policy in this committee. And with that, we'll begin today's hearing with the gubernatorial appointment of Roger Wells for the Nebraska Rural Health Advisory Commission. Now Mr. Wells was not able to join us today. Is there anyone wishing to speak on Mr. Wells's behalf today? How long do we wait?

**SHERRY SHAFFER:** That's fine.

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**HOWARD:** No time, all right. So seeing no, seeing no one wishing to speak, this will close the gubernatorial appointment for Roger Wells-- we will reschedule it, he was not able to join us today-- and open the hearing for LB62, my bill to provide for education regarding treatment of trichomoniasis; and I will hand it over to Senator Arch.

**ARCH:** Welcome, Senator Howard.

**HOWARD:** Thank you, Senator.

**ARCH:** And you may begin.

**HOWARD:** All right. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 in midtown Omaha. And today I'm presenting you with LB62, a bill that adds provisions to expedited partner therapy. So in 2013, it was my first year in the Legislature, and, and this was my priority bill, was to create expedited partner therapy. So as you're considering your priorities as first-year senators, know that this was mine. So expedited partner therapy was something that had been tried, had been brought previously and had failed several times. And I came from-- I was working at a federally qualified health center. I had worked at a nonprofit in Chicago that did maternal and infant health policy. And I thought it was wacky that we didn't allow expedited partner therapy, because it's a treatment method for STDs. And in Omaha specifically, Douglas County, we have a very challenging rate of chlamydia and gonorrhea infections. Essentially what expedited partner therapy is, is a method for a provider to, if they have a patient that presents with a sexually transmitted disease-- only chlamydia and gonorrhea-- and they indicate that their partner is unable or unwilling to come in for treatment, which means that they'll go home with their antibiotic but their partner would not get treatment so then they would subsequently be reinfected by their partner, the provider, in their discretion, can offer them a prescription for themselves and a prescription for their partner for an antibiotic. This was very challenging, right? It was the first time that we were really considering the opportunity for somebody to give a prescription to somebody that they'd never seen. But when we thought about the public health impacts, one, with our high rates of STDs in Omaha and Douglas County, and when I considered, because I had come from a maternal and infant health background, the impacts of chlamydia and gonorrhea specifically on birth outcomes, because what we were seeing were a woman would come in in her first trimester, she'd get all of her tests for her pregnancy, they'd find out that she had chlamydia and gonorrhea-- gonorrhea specifically-- she would go home.

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She would be reinfected by her partner after receiving treatment and then, by the third trimester, the gonorrhea would be back and irreversible damage would be done to that baby. So gonorrhea, in particular, attaches to the eye sockets of a fetus, and then the eyes never fully develop, and the baby is born blind. So this year, in an effort to make sure that expedited partner therapy can be used effectively, I'm, I'm asking the committee to consider adding trichomoniasis to the allowable illnesses where a provider can use expedited partner therapy. You have the CDC handout for trichomoniasis, so I won't talk about some of the signs and symptoms of trichomoniasis. But more I want you to remember that for trichomoniasis, in particular with pregnant women, it can lead to preterm births and low-birth-weight babies. And this is an absolutely treatable disease. And so when we think about the things that we can manage and the things that we can address, adding trichomoniasis to the list of diseases that can be addressed with expedited partner therapy seems like something that could be very straightforward. So the CDC estimates there are about 20 million new STIs every year, predominantly among our youth. And there are already several other states who are, are adding trichomoniasis into their statutes. I'm happy to try to answer any questions you may have about this bill, or about expedited partner therapy as a whole. And that concludes my opening remarks.

**ARCH:** Any questions for Senator Howard?

**HOWARD:** You want to talk about the symptoms?

**ARCH:** I have one.

**HOWARD:** Yes.

**ARCH:** Did your bill pass your first year?

**HOWARD:** Oh my gosh, John Arch. Yes [LAUGHTER]. So you think that I'm like a nervous Nellie now. That was my first priority bill; yes, it did pass.

**ARCH:** Oh, wow.

**HOWARD:** We had 37 votes; it came out of committee unanimously.

**ARCH:** Um-hum.

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**HOWARD:** And it was just one of those things where I learned a lot about how the Legislature works by picking the right priority bill to sort of cut my teeth on. But yes, thank you for asking.

**ARCH:** Are, are others identifying this, as well, in this type of, in this type of a program?

**HOWARD:** Yeah. So trichomoniasis, there are five states that have started adding it. Really when you look at-- and I know that there are public health folks who will come behind me-- but STDs kind of move. So you'll see-- we're starting to see antibiotic-resistant gonorrhea come from the West Coast, so they sort of move. And so you want to make sure that, if you have a law like, like expedited partner therapy, that you're anticipating what's coming next; and what's coming next for us is trichomoniasis.

**ARCH:** Hmm. OK, thank you.

**HOWARD:** Thank you.

**ARCH:** Other proponents for this bill? Welcome.

**SARAH CADA:** Thank you. OK, I'm going to try not to talk too fast. Good afternoon, members of the Health and Human Services Committee. My name is Dr. Sarah Cada, S-a-r-a-h C-a-d-a, and I'm testifying on behalf of the Nebraska Medical Association, in support of LB62. I'm an obstetrician and gynecologist here in Lincoln. I graduated at the top of my medical school class at the University of Kansas in 1996. I completed my OB-GYN residency at the University of Iowa in 2000. I was on staff at the University of Iowa, Department of OB-GYN, until 2002, and I've been in private practice since then. This bill adds trichomoniasis to the list of diseases allowed under expedited partner therapy, which means that if I'm treating a patient and diagnose her with trich, I can also prescribe for her sexual partner without examining that partner. Trich is a very common sexually transmitted disease. It is the most common nonviral sexually transmitted disease in the world. Although symptoms of trich vary, many people who have the parasite cannot tell they are infected. A patient of mine might not know that she's infected, but we could discover, through an exam or a pap smear, that she has trichomonas. To diagnose trichomonas on exam, it can be done easily by taking a sample of her discharge and examine it under a microscope. For men it requires a urine collection or a Q-tip test. Trichomonas infections peak at the age of 20, and then again around 50. Clinical consequences of untreated trichomonas

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include painful urination and intercourse. It also doubles the risk of acquiring HIV. It increases the risk of pelvic abscesses, cervical cancer, and preterm delivery. Treatment is indicated for symptom, symptomatic and asymptomatic men and women. Seventy percent of male partners of women with trichomonas will test positive. Single-dose therapy with metronidazole, which is an antibiotic that is cheap, is safe and effective. From a public health perspective, expedited partner therapy makes sense. The purpose of expedited partner therapy would be to decrease the prevalence of asymptomatic carriers. The risks of expedited partner therapy would be: one, the partner wouldn't be seen and tested for other STDs; and two, the past medical history of the partner would be unknown. This could be remedied by having the patient talk to the pharmacist when picking up their prescription. The benefits to public health by decreasing trichomonas infection in Nebraska would be decreased rates of cervical cancer, preterm birth, and HIV. In summary, the NMA supports LB62 in its mission to provide care to those in need. Thank you, and I'd be happy to answer any questions.

**ARCH:** Any questions? Yes, Senator Williams.

**WILLIAMS:** Thank you, Senator Arch. And thank you, Doctor, for being here. And you went over part of this, and I'd just like to go just a little deeper so we clearly understand. You, you would be prescribing for somebody that you didn't see, didn't examine. Are there risks?

**SARAH CADA:** So the, my patient would see me, and I'd--

**WILLIAMS:** Right.

**SARAH CADA:** --call her and say you have this infection. I'd give her a prescription and then I'd give her a prescription to give to her partner.

**WILLIAMS:** Correct. Is there-- what is the risk of her partner taking the antibiotic that you're talking about without having seen you or talked to you? Is there risk there?

**SARAH CADA:** So if the patient had an allergy to the medication or had some other chronic health problems, then it could be an issue. But I think if the, if the partner takes the prescription in, gets it from the pharmacist and asks to talk to the pharmacist, reviews the side

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effects, complications, interactions with the pharmacist, it would be a nonissue.

**WILLIAMS:** And you're doing that currently with other sexually transmitted diseases.

**SARAH CADA:** Yes.

**WILLIAMS:** Have you had any problem with those kind of risks with that?

**SARAH CADA:** No.

**WILLIAMS:** Thank you.

**SARAH CADA:** You know and most of the-- you know I do have 40-year-olds that get diagnosed with trich, but most of the patients that I've had with trichomonas have been in their 20s, and most of their partners are young and healthy, like they are. And so the risks really are low.

**WILLIAMS:** Thank you.

**ARCH:** Senator Cavanaugh.

**CAVANAUGH:** Thank you, Vice Chair Arch. Thank you for being here. And with the current diseases that you can prescribe for a partner, do you direct the, your patient to tell their partner that they should speak to the pharmacist in case there are any interactions?

**SARAH CADA:** We do. I ask them: Is your patient, is your partner healthy? Do they have any other health problems that you know of? I say it really would be best for them to go in to the STD clinic at the Health Department if they could. But I really want them to get treated, so I'm going to go ahead and give them this prescription. And then they both should get treated and then they have instructions about waiting till they are intimate again to try to decrease the recurrence rate.

**CAVANAUGH:** Thank you.

**SARAH CADA:** Yeah.

**ARCH:** A couple questions.

**SARAH CADA:** Sure.



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**ARCH:** Is, is this really an antibiotic, a prescription for an antibiotic?

**SARAH CADA:** Yes, um-hum.

**ARCH:** Is that, that's what you're doing? It's just--

**SARAH CADA:** It's a one-time dose of antibiotic.

**ARCH:** OK. Do you ever receive the name of the partner? I guess my, my question is more, how, how is a prescription filled when there isn't a name? Or maybe you do receive a name.

**SARAH CADA:** Well, you can ask the-- I would ask my patient the name of her partner and could write that on the prescription.

**ARCH:** OK. So you have a name that if you're going to--

**SARAH CADA:** Right.

**ARCH:** --prescribe for a partner,--

**SARAH CADA:** So you do have a name.

**ARCH:** --whether you're doing it electronically, e-prescribing or, or a script.

**SARAH CADA:** Right.

**ARCH:** OK, thank you.

**SARAH CADA:** Sure.

**ARCH:** I don't think there's any other questions, so thank you very much.

**SARAH CADA:** OK.

**ARCH:** Other proponents for this bill? Welcome.

**ADI POUR:** Good afternoon, senators. My name is Adi Pour, A-d-i P-o-u-r. I'm the Douglas County Health Department director. But I'm testifying today in response for Friends, which is the association for all the local health directors in Nebraska. The local health directors are really in support of LB62. Like Senator Howard already mentioned, this was a big deal in 2013, because we had struggled with STDs, and

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especially in Douglas County. And we are trying to look at what are the different strategies that we could use and are not using to really address this issue. According to the CDC, 43 states have laws that indicate that expedited partner therapy is permissible. Half of the states that permit expedited partner therapy explicit that this is for sexually transmitted infections, which would include trichomoniasis. The other half of the state reference chlamydia and gonorrhea only; Nebraska is in that group. And three states-- Maryland, Ohio, and Wisconsin-- are referencing chlamydia, gonorrhea, and trichomoniasis. What LB62 would do, it would allow-- as you already have heard from the physician before me, it would allow expedited partner therapy for trichomoniasis, not just for chlamydia and gonorrhea. And when I asked my healthcare providers in our clinic, how often do you actually provide expedited the partner therapy, they are very, very careful, and they showed me a packet that actually goes along to the, to the patient. And we looked at it. The highest amount was in January, where actually ten patients received expedited partner therapy prescriptions. And that means it is a prescription, and it does have the name and address of the partner on it; it's not just a prescription that they could give to anybody. This is really important. So we have heard about the side effects, what they are. We have heard about that it is not reportable. I had staff go back in 2018, at our small Douglas County STD clinic. There were 246 patients that were diagnosed with trichomoniasis. When I talk to my healthcare providers and say, would this be, would this be a tool that you would use, their eyes closed and they said, yes, it would be beneficial for several of our patients. We have patients who come in all the time, and their partner just doesn't have either a medical home or doesn't have time to go and see a medical provider. So what this is-- I think we need to be aware of it-- it's only a tool. It isn't going to eliminate chlamydia, gonorrhea, and trichomoniasis, but it is an additional tool that we are giving clinicians to make them comfortable that they can do this under the law. And that's what this is all about.

**ARCH:** Thank you.

**ADI POUR:** Questions?

**ARCH:** Any questions for Dr. Pour?

**ADI POUR:** Thank you.

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**ARCH:** I don't see any. Thank you very much.

**ADI POUR:** Thank you.

**ARCH:** Other proponents for this bill? Welcome.

**RUTH TRECKER:** Good afternoon, Chairperson Howard, members of the committee. I'm Ruth Trecker. I'm a nurse practitioner with Planned Parenthood. It's R-u-t-h T-r-e-c-k-e-r. I've been with Planned Parenthood for a little over 25 years. I've seen hundreds of cases of trichomoniasis. And I work in both the Iowa clinics and the Nebraska clinics, and we're trying to get the same thing passed in Iowa. A lot of times the, the ones we see are teenagers. The, the boy does not want to come in or he can't come in, or we see people from rural communities that it would just be very difficult for them to make it into Lincoln or Omaha to go to the clinic. And this makes it much easier for the partner to be able to get treated, because otherwise she's just going to get reinfected. We do strongly encourage the person to tell their partner that they should come into the clinic, that they should go ahead and get tested also. But this is, you know, some, some people just won't. The urine test and the swab test for men are not near as accurate as they are for the women, even though if she has it we know he has it. A lot of times the guy will have a false negative, and this way he gets treated even if his test-- if he were to come in, his test would possibly show a false negative, where we know he has it and so we like to just get him the medication if we possibly can. Most of the stuff in my little handout is something that people have already gone over. I just want to-- one of the questions was, how does a partner get educated about this. Well, we send them home with an extra set of brochures, both about the infection and about the medication. It's been my experience any time I pick up a new prescription at the pharmacy, if it's a new prescription, the pharmacist always pulls you aside and goes over things with you. Probably the-- in 25 years I think I've seen one person who was allergic to it, who broke out in hives. And most of the time they'll say they just get an upset stomach. Well that's a side effect, not a, not an allergy. The main concern is we emphasize to the patient that she needs to tell her partner that he cannot have any alcohol 24 hours before or 24 hours after he takes the single dose. And even if he did drink, it, it'll just give him a bad, really bad stomach ache. So that's about the worst that would happen if he were to slip and drink and-- but we emphasize that to them that is very important that they don't have any alcohol. We have noticed a big uptick in the number of

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cases, that in 2015 we had 20 cases, in 2016 we had 69, in '17 we had 74. In 2018 there was a very slight little dip, and we think that's because in Omaha they have an outreach clinic that they're getting more people treated there, so fewer of them are coming into Planned Parenthood. But just through the month of January in 2019, we've already had 16 cases. So we're-- if we keep that trend, we're going to probably have well over 150 by the end of the year. So we really want to get these partners treated. That pretty much summarizes it because otherwise I'd just be repeating what everybody else already said. But does anybody have any questions?

**ARCH:** Thank you. Questions? Senator Cavanaugh.

**CAVANAUGH:** Thank you. Thank you for being here today. Are these cases, are they 69 individuals in 2016, or is that 69 cases so it could be repeat visits [INAUDIBLE]?

**RUTH TRECKER:** The 69 times that we've diagnosed.

**CAVANAUGH:** So it could be the same person [INAUDIBLE].

**RUTH TRECKER:** True. It could be like she came in in March and came back in again in September, yes.

**CAVANAUGH:** So that number could be lower just by [INAUDIBLE].

**RUTH TRECKER:** But it also-- this, this number only includes the people that were diagnosed--

**CAVANAUGH:** Right.

**RUTH TRECKER:** --at the time of their visit, too. It doesn't include the people that it showed up later on a pap smear and then a week later we called them and said, hey, this showed up on your pap.

**CAVANAUGH:** OK.

**RUTH TRECKER:** You need to come in and get treated.

**CAVANAUGH:** Okay. So if we-- I'm just asking, I guess, if we were to allow their partner to have this medication, then the number of times that they're visiting would end up decreasing.

**RUTH TRECKER:** Hopefully, yes.

**CAVANAUGH:** OK.

**RUTH TRECKER:** And we do strongly encourage them to come back three months after they've been treated to retest them and make sure. We retest them for chlamydia, gonorrhea, and trichomoniasis, all at the same time.

**CAVANAUGH:** Thank you, and I'm very impressed that you can pronounce that word. [LAUGHTER]

**RUTH TRECKER:** That's why we call it trich for short.

**ARCH:** All right. Other questions?

**RUTH TRECKER:** Anybody else?

**ARCH:** Seeing none, thank you very much.

**RUTH TRECKER:** OK, thank you.

**ARCH:** Other proponents for this bill? I don't see anyone else wishing to testify in favor, so we did have some letters from: Jessica Furmanski, People's Family Health Services, Inc.; Ryan King, Choice Family Health Care; Brenda Council, Women's Fund of Omaha; Amy Miller, student at the University of Nebraska Medical Center; and Dr. Renaisa Anthony, herself-- on behalf of herself. Are there any opponents to this bill? Is there anyone that would like to testify in a neutral capacity? We had no opponent letters and so, seeing no neutral, Senator Howard is waiving close. And so this will close the hearing on LB62.

**HOWARD:** OK. And this will open the hearing for LB555, and we will wait a minute for Senator Hunt.

**CAVANAUGH:** Should I go first?

**HOWARD:** Do you want us to have Cavanaugh go first?

\_\_\_\_\_ : I'm sorry, I didn't hear you.

**CAVANAUGH:** Do you want me to go first?

\_\_\_\_\_ : Yeah, go ahead.

**CAVANAUGH:** Is she going to be a while?

\_\_\_\_\_ : She [INAUDIBLE]. I don't know. I guess her other hearing is taking long.

**HOWARD:** OK.

\_\_\_\_\_ : I'm sorry.

**HOWARD:** All right. So we'll change the agenda and start, and open the hearing for LB692, Senator Cavanaugh's bill to change provisions relating to commemorative certificates for a nonviable birth.

**CAVANAUGH:** Good afternoon, Chair, Chairwoman Howard and colleagues on the committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h. I represent District 6, west-central Omaha, here in the Nebraska Legislature. LB692 is a simple bill. Under the current law, if a pregnant person experiences a miscarriage at a healthcare facility, or a healthcare provider determines they have, the provider is required to tell them that they may get a commemorative certificate for their nonviable fetus. LB692 changes this from a government "shall" to a patient-driven action. So the backstory on this is that Barrett, who you all know quite well-- when we were in the early stages of visiting the doctor, we found out that there was two. And after weeks of observation early on, it was determined that one of those was not viable. And it was at a point in the pregnancy in which nothing had to be done, that the first baby/fetus was just reabsorbed. And that was kind of it for us. And that was, you know, upsetting and difficult. But then we kind of fast forward to July 2018, July 10, 2018, and that beautiful little boy that you all know came into this world with quite, quite a roar. And when we were at the hospital, we had to rediscuss what happened early on in the pregnancy, and it wasn't a good time to be having this conversation. We were focused on the birth of our child we had been anticipating. We had complications during Barrett's birth that were traumatic and difficult. And so I kind of started looking into this. And this isn't something that I want to eliminate at all. I just wanted to change the way that we're doing it. So it doesn't prohibit a provider from offering this. It just changes the language so that the provider doesn't have to offer it, which offers the provider that flexibility of knowing their relationship with the patient and making sure that it's an appropriate conversation to have. The patient can absolutely ask for it at any point in time, can ask for commemorative certificate. It's not something that my husband and I chose to do, but it's, it's an option and the opportunity that I wish for every family to have because I think it's really important to grieve that loss in the way that is

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appropriate for you. And I appreciate so much the thoughtfulness that went into this legislation last year. I just want to do what, in my view, is strengthening it to be more reflective of a compassionate approach to something that is supposed to be compassionate for families. So with that, I, I did not ask anybody else to testify in support of this because I viewed it as a cleanup bill and something that I very much personally am happy to speak to, if you want to ask me any questions.

**HOWARD:** Are there questions? Senator Arch.

**ARCH:** I do; I do have a question--

**CAVANAUGH:** Yes.

**ARCH:** --because I was I was looking at the language on this. And what the bill appears to do is it strikes the "shall advise," the "shall," right?

**CAVANAUGH:** Yes.

**ARCH:** "Shall" advise, and it, and it leaves it then upon request by the patient. So it didn't go to "may" advise. It drops the "shall" advise and now it is up to the patient to initiate the conversation. Is that how you understand it?

**CAVANAUGH:** That is how I understand it, and my intention was not to take that authority away from the provider. So I actually would be fine with changing the "shall" to a "may," entirely. I mean that, it kind of-- this was drafted in the early days of being on the job. So I have reflected on that and I think just changing that "shall," that, that word "shall" to a "may" instead of reorienting it would effect the same thing.

**ARCH:** The, the question then that I would have, as it is worded now, is that then, of course, how does the patient become aware that this, this is available?

**CAVANAUGH:** Sure.

**ARCH:** And that would be--

**CAVANAUGH:** Right. And so that the, the-- as I understand it, the health, the healthcare provider still can absolutely have that conversation when you have all of the conversations that you're having

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about what the next steps are, and if a procedure needs to be had or not, and what resources are available to you for grief counselling, that this would be part of that. It's just not a requirement that it's part of it. And by making it not a requirement for women, who I have come to find that this happens to a lot of women, that they have that, that what they call a vanishing twin, so when you're in the delivery room that the hospital wants to ensure, you know, that they've covered what they're, what they have to do. So it's just I want to make sure that people don't feel that pressure so that they can take the temperature of the situation. But you make a great point on the way that it's written currently. I think that it would-- I would be more than fine with, with changing just reintroducing it with changing "shall" to "may;" I think it achieves the goal.

**ARCH:** Thank you.

**HOWARD:** Senator Williams.

**WILLIAMS:** Thank you, Chairperson Howard. And thank you, Senator Cavanaugh. I was fortunate enough to be on this committee last year when we heard the testimony on this. And it was very difficult testimony on the part of many women who came and sat in that chair and talked about their experience with this. My question relates along the line of how-- have you had an opportunity to visit with the senator that brought that legislation last year to see her reaction to this particular change and this approach?

**CAVANAUGH:** I did inform her that I was bringing this very early on, like day one on the floor, I let her know that I was bringing this bill. We haven't had further conversation about it, but I'd be happy to have further conversation with her about it.

**WILLIAMS:** I think part of the concern would be along the line of the questioning that you just had with Senator Arch about that, the, the potential moms that don't have any clue that there's any--

**CAVANAUGH:** Right.

**WILLIAMS:** --availability of something like this, and if--

**CAVANAUGH:** Which is why, I think, taking--

**WILLIAMS:** --some--



**CAVANAUGH:** --Senator Arch's--

**WILLIAMS:** Yeah.

**CAVANAUGH:** --suggestion would probably be the best course to ensure that providers don't misread this as now I have to wait for them to ask for it, which I think is an excellent point.

**WILLIAMS:** Thank you.

**CAVANAUGH:** I'd be happy to offer that amendment and also to share it with Senator Albrecht, as well as the committee.

**WILLIAMS:** Thank you.

**CAVANAUGH:** Thank you.

**HOWARD:** Any other questions? Seeing none, will you be staying to close?

**CAVANAUGH:** I will be staying to close.

**HOWARD:** Fantastic. We'll invite our first proponent testifier for LB692.

**CAVANAUGH:** Thank you.

**HOWARD:** Seeing none, is there anyone wishing to testify in opposition?  
Good afternoon.

**NATE GRASZ:** Good afternoon, Chairwoman Howard and members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z, and I'm the policy director for Nebraska Family Alliance. First, I would just like to say this is a very difficult issue and I would like to thank Senator Cavanaugh for the sensitive nature in which she is approaching it today in the hearing. Last year the Nebraska Legislature passed into law LB1040, a compassionate and much needed piece of legislation to create an optional, state-issued commemorative birth certificate for families who suffer the tragedy of losing a child to miscarriage. That legislation was voted out of this committee unanimously and passed on a final vote of 44 to 1, after an outpouring of support from mothers and families across Nebraska, as well as many OB-GYNs and the Nebraska Hospital Association. These families and doctors shared how important and helpful it is to grieving parents for healthcare practitioners to be able to offer them something tangible to recognize

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and validate their loss. As one OB-GYN wrote to the committee, these mothers and fathers are suffering. They suffer quietly and often feel alone and hopeless. Everyone heals in their own way. But how incredible it is to show these parents, suffering in silence, that they are supported and not alone. By offering the option of recognizing the loss of pregnancy, the state of Nebraska can help support the one in four women who will suffer a miscarriage. I believe it is the least we can do. Families grieving the loss of a child deserve to know that this commemorative certificate honoring their child is available to them if they so choose. The legislation before you today takes this away. Under state statute, the only requirement of healthcare practitioners regarding the certificate is when they are attending a miscarriage, which is defined as a pregnancy loss occurring before 20 weeks. They are to inform the woman of her option to request the certificate. LB692 strikes this language and replaces it with the option for a patient to request a certificate. But how is the patient supposed to make that request if they aren't told it's an option that they have or even know that it exists? Hospitals are not required to provide paperwork about the birth certificate, and the mother can choose to apply the certificate at any time in the future if she chooses to do so. She is not required to fill out any paperwork or to make a decision about the certificate that day. Other issues that may arise in these situations, such as the handling of fetal remains or death certificates, are addressed in entirely separate laws and hospital policies, and have not been altered or in any way. In summary, the only effect of LB692, as written, is to limit the number of families who learn about this option after suffering a miscarriage. This would be a heartbreaking mistake because, while it may seem like a small thing to some, to many families receiving something tangible with their child's name on it, recognizing their existence, and affirming their loss is everything. But this certificate can't help families who need it the most if they never know it's an option they have. Hospitals have their own policies on how to handle these incredibly difficult situations and, if they are ever handled insensitively, it should be addressed by working directly with individual hospitals and doctors, not by removing the ability for every other woman and family to hear about the certificate and retraumatizing the woman and families who value it. I'd like to close by sharing with the committee that, after the bill creating the certificate was passed into law last year, our office received a call from a woman who thanked us for supporting that bill. Her name is Marilyn. Marilyn shared with us that she had miscarried twin boys at 18 weeks. Her loss occurred more than 50 years ago but, because it was

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documented in her medical records, she was eligible to receive certificates with the names of her twin boys on them. Marilyn wanted us to know that, upon receiving her certificates in the mail, she immediately held them to her chest and twirled around with joy because, for more than 50 years, she carried that burden and grief. And finally she got the closure and healing she so desperately sought. Marilyn called this a miracle she thought would never come. With the creation and availability of this certificate, no one today should have to wait 50 years anymore to receive the validation and recognition of their loss. Don't take away what for many families might be their only opportunity to hear about this compassionate option that is already helping bring healing and closure to grieving parents. Thank you.

**ARCH:** Thank you for your testimony. Any questions? Senator Murman.

**MURMAN:** Yeah. Thanks for coming in. I wasn't here last year, so I just want to make sure I completely understand this. This, the legislation that was passed last year only requires the hospital to tell the mother that this certificate is available, and it's totally up to the mother whether or not she does anything about it.

**NATE GRASZ:** Thank you for the question, Senator. Yes, that is correct. It's an option that is available to them. It isn't automatically administrated or required; it's a choice that each woman and family would have.

**MURMAN:** OK, thanks a lot.

**ARCH:** Other questions? Seeing none, thank you very much.

**NATE GRASZ:** Thank you.

**ARCH:** Are there other opponents to this bill? Welcome.

**JENNIFER HENNING:** Hi. Jennifer Henning, J-e-n-n-i-f-e-r H-e-n-n-i-n-g. I had the blessing to be asked to come last year and testify about my family's journey with infertility. Senator Williams was here, and there was a lot of mothers who gave a lot of really good testimony and shared their grief and their journeys with miscarriage and loss. I watched the clip for Senator Cavanaugh and, first and foremost, I have to say I'm terribly sorry. I'm disgusted and appalled by the way that you were treated, and I feel like it was very insensitive, what happened. And I feel like that needs to be addressed with hospital

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administration, because I firmly believe in educating, informing, and advocating parents, and I believe if you don't provide the information of the services or things that are out there for families, you're not giving them the ability for choice. I personally would have loved to have the ability for my doctor, my OB doctor, my infertility doctor, my high-risk OB, for any of those doctors to come to me and say: Hey Jennifer, we have this commemorative certificate, it's \$12.00, this is what it does. It would have opened the lines of communication with my provider regarding postpartum depression. It would have given me an opportunity to keep the lines of communication open. I would have been able to have the chance to be informed, be empowered, be educated. My husband would have been elated that we opened the discussion instead of suffering in silence. So many mothers-- they don't have miscarriages, they don't have loss in the hospital; it's when they're at home and they're suffering in silence. And they're the ones who are suffering silently, and it's kind of this stigma and this taboo that nobody really talks about it. What happened last year is a lot of people came together and were celebrating or commemorating loss. I believe that removing the language for providers to inform and educate families, and mothers like myself who have lost three babies, is detrimental because you're taking away my ability to choose. I'm the one who's paying the \$12.00 for the certificate. If I don't want to do that, I don't have to; it's my choice. But at least my provider got to inform me of my ability, and my choices, and my opportunity. That commemorative certificate is something that-- it validates, it validates our babies. We spent \$30,000 plus on each baby to miscarry through fertility treatments. And here, we miscarry and they're gone. And that memory is just suffered in silence. And with these commemorative certificates, we celebrate. We celebrate their memory, we celebrate that we're better parents to our children that are living now. And by removing the language, a mother like me has the potential to never know that and the potential to never have the education or the ability to pay that \$12.00 to get a certificate and celebrate. So while I understand a very inappropriate, poor, icky experience happened, I don't believe one experience should affect potential mothers that really need that open line of communication, but also need that tangible evidence that their baby was validated. They're celebrating. So I would hope that you would really take that into account because, again, I'm a mother who really values those certificates. And there was many mothers here that we put a lot of time and effort to make sure that our babies are validated. And I hope that you don't forget about those babies and you let every OB-GYN and

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high-risk and fertility doctor out there, make sure that we keep mothers and fathers informed, educated, empowered.

**ARCH:** Thank you; thank you. Any questions? Thank you; thank you for coming today.

**JENNIFER HENNING:** Thank you.

**ARCH:** Are there any other opponents to this bill? Welcome to the committee.

**MARION MINER:** Thank you, Vice Chairman Arch and members of the committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r. I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the Gospel of Life by engaging, educating, and empowering public officials, Catholic laity, and the general public. Excuse me. I'm here to express the reasons for the conference's opposition to LB692. I'm not going to provide a whole lot of information that really hasn't been provided already. A lot of that rationale has been explained, but it would re-strike, strike the requirement that healthcare practitioners who attend or diagnose the nonviable birth inform the mother that, upon her request, she may receive a certificate of nonviable birth from the state, in recognition of the brief life of her child. The bill would leave intact the possibility, the possibility that a family could risk request such a certificate on their own initiative. The conference opposes this change because we believe the law, as it now stands, has helped many women and families acknowledge, grieve, and heal from the pain associated with the loss of a child in early pregnancy. Many of those women and families would never have had access to that opportunity had they not been informed of it by their healthcare provider. And I know I did have a chance to talk with Senator Cavanaugh about the bill, and, and, and I know she, she's, she's aware, she's expressed to me that she really is aware of the benefits of having that available for women. And I do understand, too, the reason for her, for her suggested change. But our opposition again is really related to the fact that we think women need to know that that's something that's available to them. So the conference, for those reasons, asks that you not advance LB692. And of course, I'm happy to take any questions that you may have.

**HOWARD:** Thank you. Are there questions? Seeing none, thank you for your testimony today.

**MARION MINER:** Thank you.

**HOWARD:** Our next opponent testifier. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Cavanaugh, you are welcome to close.

**CAVANAUGH:** Thank you, Chairwoman Howard and Health and Human Services Committee. As was stated in the opposition, I, I hope, and I think that Senator Arch's suggestion which I have already given to my staff-- and we will move forward today with an amendment to present, of just going back to the original bill language and striking the "shall" and making it a "may." I, in no circumstance, want to eliminate the access and ability for families to get the certificate. I think it's a wonderful thing that the body did last year and that these advocates did last year. I just-- my intention remains to make sure that it is done in a way that is appropriate for each individual situation. One of our testifiers spoke about postpartum depression, which is a very significant, severe thing, and loss of a child can only exponentially increase that. And just making sure that families have what they need in these difficult times is really, really important. And I hope that, with the amendment, we can move forward in a way that is even more compassionate than we currently are. I think this is a great bill. I just want to make it an even better one. So it's one of those times where one word change could make a big difference. So I thank you for your time, and I encourage you to advance LB692 once the amendment comes to you.

**HOWARD:** Senator Arch.

**ARCH:** Thank you. And I, I just wanted to clarify something. I didn't want to miscommunicate that I wasn't suggesting an amendment, but rather was asking whether that was your intent.

**CAVANAUGH:** I--

**ARCH:** So if you--

**CAVANAUGH:** I appreciate that.

**ARCH:** That's just a clarification.

**CAVANAUGH:** I know. I know that you weren't suggesting an amendment.

**ARCH:** OK.

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**CAVANAUGH:** And I appreciate you flagging it for me in that way. But I am taking it forward as an amendment.

**ARCH:** As a-- yeah, as your amendment.

**CAVANAUGH:** Yes, as my amendment.

**ARCH:** Thank you.

**CAVANAUGH:** Thank you.

**HOWARD:** Senator Williams.

**WILLIAMS:** Thank you, Chairperson Howard. And again, thank you, Senator Cavanaugh. We have many discussions, sitting in these seats, about the distinction between "shall" and "may." And your original bill, as it came, and the original opposition testimony that was presented was not based on whether that was a "may" instead of a "shall." I would be interested in knowing what change in opposition there might be to that, because we sit here oftentimes and our arguing that we can put something in the "may" language--

**CAVANAUGH:** Um-hum.

**WILLIAMS:** --and that just gives the hospital, or whatever, the opportunity to just not do it because there is one less thing they have to do.

**CAVANAUGH:** Right.

**WILLIAMS:** I think the success of this program depends on mothers knowing that this process exists. So I think that's a discussion that I would like to be sure we're all on the same page of, going forward with this.

**CAVANAUGH:** Absolutely. And that is certainly something I will discuss with the opposition testifiers. I will say that, the way that it is written, I understand the concern that it would put the onus entire-- it appears to put the onus entirely on the patient. In my particular situation-- this was in December of 2017 and the bill was passed in 2018. So the initial conversation I had with my provider was before the bill. So it was with like so many other women. So there was no conversation about a death-- or not, I'm sorry-- a birth certificate, but there was conversation about how I was doing, how my spouse was doing, what, what we needed, what was going to happen moving forward.

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So we had all of those conversations. And knowing my providers the way that I do, I have no doubt in my mind that we would have had this conversation there. They would have told me about this as an option there. But being in the delivery room it is-- with a live birth-- it's, it's not a, not a good time. We'll just put it that way. So just opening up that flexibility, that we don't have to have that conversation at an inappropriate time but more that it can happen at an appropriate time and that the appropriate provider can have that conversation.

**HOWARD:** So just, just to clarify, because, because we are requiring our providers to do this, and it's at the provider's discretion in terms of the timing, would it be wise to recommend that this is a conversation that you have upon discharge, so when somebody is leaving the hospital as part of your discharge materials?

**CAVANAUGH:** So I mean, really, anything other than the delivery room would be better. But really, when you find out-- but so I guess I should I should take a step back. When you find out, for every person it's different. For me it was in the ultrasound room at the clinic. For some people, it will be in the delivery room. They might have an emergency C-section or, you know, there's so many complications, like preterm birth. So having it in state statute, stipulating when that conversation happens, I think is, is challenging. Doctors are-- and OBs and-- they're trained in this. I mean I did have a conversation with my midwife, before discharge, about postpartum depression. And so that, you know, I, I suppose it could be a part of that conversation. I guess I don't-- I'm not sure what the answer to that is.

**HOWARD:** That's OK; you don't have to know. Any other questions? Seeing none, thank you for your testimony today, and this will close the hearing on LB692 and open the hearing on LB555, Senator Hunt's bill to adopt the Sexual Assault Emergency Care Act and provide for disciplinary action against hospitals. Welcome, Senator Hunt. Whenever you're ready--

**HUNT:** Thank you very much. Good afternoon, Senator Howard and members of the Health and Human Services Committee. I'm Senator Megan Hunt, M-e-g-a-n H-u-n-t, and I represent District 8 in midtown Omaha. Today I'm presenting LB555, a bill to adopt the Sexual Assault Emergency Care Act. This bill would ensure that sexual assault survivors are guaranteed access to medically accurate information about emergency contraception and are given this treatment upon request. The intent of this bill is to ensure that survivors have access to proper, medically



necessary treatments during one of the most traumatic times in their lives. I've also brought an amendment to the bill with, that my team and I worked on, in partnership with the Nebraska Hospital Association, to address some of their concerns about the penalties for noncompliance. And I'll just say, as a blanket statement going forward, anybody who has objections to this bill, because of the penalties or because of the reporting requirements, I'm more than happy to work with them to get it to a place that's agreeable to everybody. Sexual assault survivors are some of the most vulnerable patients that go through our healthcare system, and healthcare practitioners have an obligation to inform these patients of all their options and provide them with quality care. Currently hospitals may adopt policies that restrict the ability of healthcare providers to inform or distribute emergency contraception to rape survivors. I'll say that again: A form of necessary medical care can be withheld from a patient in Nebraska. Most into, most institutions unwilling to provide emergency contraception base that decision on the false notion that emergency contraception is abortifacient, that it causes abortions, which it doesn't. Emergency contraception does not cause a fertilized egg to be destroyed. This is simply a medical fact. Emergency contraception simply prevents the implantation of an egg, which usually happens within five days of unprotected sex. It does not end an established pregnancy. If you're pregnant, emergency contraception will not end your pregnancy. Emergency contraception options are out, are available outside of emergency care facilities; you can buy it at most drugstores. But the effectiveness of emergency contraception is reliant on time. It's most effective 12 hours after unprotected sex and decreases in effectiveness every 12 hours after that. Policies allowing public and private healthcare workers to object to providing emergency contraception in cases of rape violates rape survivors' human rights and freedoms. Rape survivors can experience depression, eating disorders, PTSD, and substance abuse. Anxiety about beginning an unwanted pregnancy after rape is significant for many and causes additional trauma. Pregnancies from rape are often associated with poor health outcomes for both the mother and child. In these cases we often see delays in prenatal care, early-term labor, low birth weights, and negative psychological outcomes. Access to this care is vital to the well-being of sexual assault survivors, and there's no reason that hospitals should be allowed to take away a patient's choice to receive this care. I had a clinical nurse specialist who specializes in forensic nursing, so this is the nurse that handles people who are reporting rape, who come in to the hospital when they are sexually assaulted. And this woman is

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one of the first people that they talk to, and administers the rape kit, works with law enforcement-- all of that. She wasn't able to make it here today because the interstate was closed down, unfortunately. But she submitted her letter to me, and I distributed it to all of you as well. And I wanted to make sure that you take a look at her expert testimony there when you get a chance. And with that, I will take any questions.

**HOWARD:** Thank you. Are there questions? Senator Arch.

**ARCH:** Thank you, Senator Hunt. Can you-- I, I was, I was reading your, your testimony and, and you make a distinction between it does not cause a fertilized egg to be destroyed versus it simply prevents the implantation of an egg. Can you, can you amplify that for me, it, you-- what's the distinction in your mind?

**HUNT:** Sure. Pregnancy occurs when a fertilized egg is implanted in the uterus. Emergency contraception prevents implantation from occurring.

**ARCH:** So, so, OK. It's, OK. That helps me understand. So your view is that pregnancy occurs when the implantation occurs, not when the egg is fertilized.

**HUNT:** I, yes. There are people coming up behind me who can testify more on that, too.

**ARCH:** All right.

**HUNT:** I'm not a medical expert.

**ARCH:** Nor am I.

**HUNT:** But we do know that emergency contraception does not cause abortion. That's why it's available over the counter at CVS and Walgreens.

**ARCH:** Thank you.

**HOWARD:** Other questions? Did you have a follow-up?

**ARCH:** No.

**HOWARD:** OK, perfect. Seeing none, will you-- oh, Senator Williams-- jumping in.

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**WILLIAMS:** Thank you. I, I, sorry to-- Senator Hunt, could you track through the, just so we understand it and get it into the record also, the penalty provisions of your legislation--

**HUNT:** Sure.

**WILLIAMS:** --for, for failure to comply?

**HUNT:** Yes. So the Hospital Association, I think very rightly, objected to the penalties in the original bill, and we worked with them to bring an amendment to ensure that hospitals wouldn't lose their license, you know, if, if this provision wasn't abided by. So as you see in the amendment on page 4, line 23, we changed the, we changed the penalty. So for the first complaint it's just, it's just a written warning to the hospital, stating that it has failed to provide services in compliance with this act. And then for the second and any subsequent warning after that, they have a fine of \$1,000 on the hospital. I also want to state that this, this fine doesn't go to the employee. There's also nothing in this bill that would prevent employees who object to providing emergency contraception from being forced to do that. The, the onus is on the hospital to make sure that patients receive medically accurate, research-based information about the availability and the effectiveness of emergency contraception. It doesn't mean that individual practitioners have to administer it. So for example, if Senator Cavanaugh was the nurse and she said: this violates my beliefs, I don't want to do that-- Senator Williams, would you please see this patient, you could do that and still be in compliance with the law.

**WILLIAMS:** So overseeing the, the compliance side then would be the Department of Health, Division of Public Health in the department?

**HUNT:** They would have to investigate complaints.

**WILLIAMS:** So would it--

**HUNT:** The, the patient would--

**WILLIAMS:** --become part of a, an ongoing examination of the hospital by this agency to determine if there are, are violations?

**HUNT:** I'm not sure, but I can touch on that in my closing after I have a minute to just double check, because I don't want to say the wrong

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thing. But I know that it would be the patient's responsibility to complain about this to the DHHS.

**WILLIAMS:** I, I would, I'm, I'm wanting to know and be sure I understand what additional burden, if any, we're putting on the department.

**HUNT:** Um-hum. I think DHHS is here to speak to that.

**WILLIAMS:** OK.

**HUNT:** And that, it looks like a lot of that is outlined, on page 3, about the department's responsibility to make sure that hospitals are in compliance, but I'll check on that in this little interim time and get back to you in closing.

**WILLIAMS:** Thank you, Senator.

**HUNT:** Thank you.

**HOWARD:** Any other questions? Seeing none, you'll be staying to close?

**HUNT:** Um-hum, thank you.

**HOWARD:** Thank you. Our first proponent testifier for LB555? Good afternoon.

**RAEHEL KRAMER:** Good afternoon. My name is Raechel Kramer; that's spelled R-a-e-c-h-e-l K-r-a-m-e-r, and I am the assistant manager at the health center for, of Planned Parenthood of the Heartland in Lincoln, Nebraska. Planned Parenthood provides sexual and reproductive health at two health centers in the state of Nebraska, and our vision includes communities where sexual and reproductive rights are basic human rights, and where every person has the opportunity to lead a healthy and meaningful life. We strive to treat all of our patients with dignity and care, while providing them with the best scientifically based and nonjudgmental information about their healthcare and their bodies. Emergency contraception is a hormonal birth control taken after sexual intercourse that works primarily by delaying or inhibiting ovulation. Plan B or generic versions of the same medication are offered over-the-counter and can be taken up to 72 hours after intercourse. Another version of emergency contraception named ella is available via prescription only and can be used up to five days after intercourse. Finally, the copper IUD, if placed within five days after intercourse, can act as emergency contraception, as

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well. Planned Parenthood offers all three types of emergency contraception to our patients and counsels all birth control options when patients are seeking emergency contraception at our health centers. Emergency contraception does not induce abortion and should not be confused with mifepristone, also known as the abortion pill. According to the National Protocol for Sexual Assault Medical Forensic Examinations, overall well-being is improved when survivors have a positive experience with the criminal justice system and the medical system after their assaults. However, a survivor cannot have a positive experience with a healthcare system that refuses to provide them with everything they need in order to move forward from their assaults, including if the patient would like emergency contraception. At Planned Parenthood, we regularly see patients who have been denied access to time-sensitive emergency contraception and other healthcare services requested immediately following a sexual assault. This means that our patients, managing their own recent traumas, receive only part of the care that they need and are forced to do their own research on where to find the emergency contraception. And they must obtain additional transportation to our health center and retell their trauma to more healthcare providers in order to get the care that they deserve from the very beginning. For sexual assault victims, in particular, the experience of being denied care during their first interaction with the medical system after it, an assault can be incredibly traumatic. Planned Parenthood proudly serves anyone who needs care, no matter what, and our focus is on patients' needs. To be the best advocates we can be for our patients, though, we are strongly advocating that those patients receive all of their care from the place that they initially go for care following the sexual assaults. Continuity of care and the essence of time are both critical factors to sexual assault survivor patients, and we want to maximize, we want to-- sorry, minimize-- how many times a patient must relive their trauma and support policies that get a patient care as quickly and as seamlessly as possible. While we maintain that freedom of religion is a right that must extend to all, religious beliefs must not be used to discriminate against others. Providers who use religion to dictate and deny sexual and reproductive health information and care, place the responsibility of finding care on the sexual assault survivor. That causes an undue burden. The risk of pregnancy from rape can be a cause of serious trauma to a victim of assaults, and it is the responsibility of healthcare organizations who work with sexual assault survivors to provide a full range of accurate healthcare options available to them. For these reasons, we ask that you vote to

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advance LB555 to General File. And thank you, Senator Hunt, for bringing this issue to light and advocating for better policies.

**HOWARD:** Thank you. Are there questions? Senator Murman.

**MURMAN:** Thanks for coming in. I've got to apologize before giving this question, because there may be some behind you that can answer it better than you can.

**RAECHEL KRAMER:** OK.

**MURMAN:** But just in case, I want to ask it anyway. Typically, do you know when fertilization takes place, how soon after intercourse?

**RAECHEL KRAMER:** That question I wouldn't be fully prepared to answer. I don't hold any medical licensure or anything like that. I'm just here to advocate on our patients' behalf.

**MURMAN:** Well, that's fine.

**RAECHEL KRAMER:** Yeah.

**MURMAN:** Well, the reason I ask is because you've mentioned plan B can be taken 72 hours after, ella can be taken five days after. And I don't know, but I'm just asking, you know--

**HUNT:** Yeah.

**MURMAN:** I assume possibly fertilization would take place before that, so--

**HUNT:** Yeah. And that information I'm not entirely sure on. I know that sperm can live in a woman's body for up to five days after intercourse. So I would assume that the connection to the five-day range on those other emergency contraceptive options is related to the life of the sperm and the ability to fertilize during [INAUDIBLE] time, but I'm not entirely sure.

**MURMAN:** OK, yeah. I'm just trying to clarify if, possibly, those would be abort, abortive pills or not. So thank you very much.

**HUNT:** Um-hum.

**HOWARD:** Other questions? Seeing none, thank you for your testimony today. Our next proponent testifier? Good afternoon.

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**AMY MILLER:** Hello. Dear Chairperson Howard and members of the Health and Human Services Committee, my name is Amy Miller, A-m-y M-i-l-l-e-r, and I am a second-year medical student at the University of Nebraska Medical Center. I'm here today to provide the committee with relevant medical information and my own personal support for LB555. Let me begin by saying thank you. I know the work you do here is not easy, and I'm extremely grateful to, for this, to the state of Nebraska because it has given me a lot. I grew up in Norfolk, and I attended the University of Nebraska at Lincoln, and that, was then accepted into the University of Nebraska Medical Center. At the beginning of medical school. I had naively assumed that every woman who was sexually assaulted was offered complete medical treatment at every emergency department in the state of Nebraska, including appropriate counseling and medication. It was not until later that I discovered that their emergency departments, that OB-GYNs and other doctors recommend going to, if sexually assaulted, and others that they tell their patients to avoid because they do not regularly dispense emergency contraception. This breaks my heart. In my work as a medical student, I work really, really hard to try to develop relationships with the people that I see. I try to get them to trust me, the doctor who I'm working for, our healthcare system that has so often failed them in the past. How can I tell them to trust the system if there are only select places that they can go to receive appropriate care? I am well aware of the strong stances regarding women's reproductive rights, but emergency contraception is exactly what it is stated to be: emergency contraception. These medications do not cause abortions. Let me repeat that: These medications do not cause abortions. They're ineffective if implantation has already occurred. There are two main forms of emergency contraception. There's copper intrauterine devices, or IUDs, and oral medications. Copper IUDs prevent fertilization by creating a local inflammatory response that make sperm unable to travel up the fallopian tubes where the egg is released. If the sperm cannot reach an egg, fertilization does not occur and there is no pregnancy. Oral medications work in a variety of ways, either by giving a large hormone dose and fooling the body into thinking ovulation has already occurred or by blocking the reset, the hormone receptors that regulate ovulation. But all prevent the egg from being released from a woman's ovaries. If there is no egg released, fertilization cannot occur and there is no pregnancy. These medications' mechanism of action is extremely similar to other oral birth controls or in other intrauterine devices that women get every day. LB555 does not force physicians to provide services that go against what they believe in. However, it does provide a pathway for

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women to get the necessary services that they need to get complete and essential healthcare after a sexual assault. When a woman is sexually assaulted, there are many, there are a million things running through her brain. How did this happen to me? What will I do now? She is terrified and scared and vulnerable. The last thing she needs to be thinking about is, am I going to the right ER to get the care that I need. One in three women will be sexually assaulted in her lifetime. I'm asking you, please, do not make me tell 33 percent of my future patients which ER they need to go to so they can receive appropriate care. I'm asking you to please support me, my colleagues, my future patients, and all of us at risk of having an unplanned pregnancy because of sexual assault, by bringing LB555 to the floor of the Legislature. Thank you.

**HOWARD:** Thank you. Are there questions? Senator Cavanaugh.

**CAVANAUGH:** Thank you, Chairwoman. Thank you for being here today.

**AMY MILLER:** Thank you.

**CAVANAUGH:** Do you know what kind of medicine you want to specialize in?

**AMY MILLER:** I think I want to go into OB-GYN. I know that's probably shocking.

**CAVANAUGH:** Hey, it's-- that's wonderful. And have you been working in, have you done your residency-- I suppose you're second year, you haven't done your residency yet.

**AMY MILLER:** Yeah. So I start, I start my clinical [INAUDIBLE] on April 1st.

**CAVANAUGH:** OK.

**AMY MILLER:** Um-hum.

**CAVANAUGH:** Great. Well, thank you for being here today and for providing some information that I certainly didn't know.

**HOWARD:** Any other questions? Seeing none, thank you for your testimony today.

**AMY MILLER:** Thank you so much.



**HOWARD:** Our next proponent testifier?

**TIFFANY SEIBERT JOEKEL:** Chairperson Howard and members of the Health and Human Services Committee, my name is Tiffany Seibert Joekel, T-i-f-f-a-n-y S-e-i-b-e-r-t J-o-e-k-e-l, and I'm here to testify in support of LB555 and thank Senator Hunt for bringing this important issue forward. So as soon-to-be Dr. Miller just told us, sexual assault is incredibly prevalent among women. I think it's also important to keep in mind it's also incredibly important among young women and girls. One in nine girls under the ages of 18 experiences sexual abuse at the hands of an adult. Of victims of sexual adult [SIC] that are under 18, 34 percent are under the age of 12, 66 percent are age 12-17. And in Nebraska in 2017, there were 346 cases of sexual abuse of children that were substantiated by the department. So that means known by the department and substantiated by the department. We believe that these women and girls need access to medically accurate and factual information and healthcare to prevent pregnancies that may result from the sexual assaults. Pregnancy resulting from sexual assault is, is fairly calm, or can be common; 5 to 7 percent is the postrape pregnancy rate among reproductive age. And an unintended pregnancy as a result of the sexual assault tends to be especially high among adolescents because, in many cases, they are not using regular contraception at that point, and because they are more likely to be subjected to repeated assault and victimization by an adult. It is clearly within best practice to offer emergency contraception to victims of sexual assault to prevent pregnancies. This is well established by the Department of Justice and the National Protocol for Sexual Assault Medical Forensic Examinations of adults and adolescents, but also very clearly established by the American College of Obstetrics and Gynecology. Even the U.S. Conference of Catholic Bishops has recognized the importance of healthcare that prevents pregnancy for sexual assault survivors in their ethical and religious direction, Directives for Catholic Health Services, Number 36, the text of which was included in my testimony. I wanted to talk a little bit-- well, do I want to really talk about how pregnancy occurs? Probably not, but I will. So I think to your question, Senator Murman, it's a good one. So pregnancy is really all about timing. It is all about where a woman is at in her cycle when the sexual activity occurs. As was previously stated, sperm can live in a, in a body to fertilize an egg for five to six days. Emergency contraception works primarily by-- it's sort of an emergency brake preventing ovulate, ovulation. So it's attempting to tell the body or fool the body into thinking it's already ovulated and not to ovulate, not to release the

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egg that can then be fertilized. Although there is, depending upon it where a woman is at in her cycle, there is some evidence that it does thicken cervical mucus which makes it difficult for the sperm, more difficult for the sperm to reach the egg to fertilize, and there may be some limited evidence that it prevents implantation. Where there is consensus is that it does nothing to disrupt an established pregnancy. Implement, implantation-- it does nothing to disrupt a fertilized egg that is implanted on the uterus, uterine wall. The CDC and the NIH, the American College, College of Gynecologists and Obstetrics has said that emergency contraception is, does not harm an existing pregnancy, and it does not increase risk of miscarriage, birth defects, etcetera. I think that is your strongest evidence that it is not about terminating a pregnancy; it is entirely about preventing one. I would also argue LB555, in its clear definition of what this bill covers, emergency contraception and the definition, definition on page 2, it says preventing pregnancy, not terminating one. I think it's really important. There was a lot of focus on compassionate response in the previous testimony and bill, and I think that's really important. And I think that extends-- victims of sexual assault have had their power and control absolutely taken away from them. And what we're asking in this bill is that healthcare providers help reinstate some of that power and control by giving them all the information that is available to them. No one's forcing these assault survivors to take emergency contraception. That is a personal choice that needs to happen with their provider and their families and their faith, in their faith tradition and all their issues that are important to them. It is about recognizing, with compassion, the trauma that they've gone through, the trauma that a pregnancy that they would have to carry to term could create for them, and giving them all options available for their healthcare.

**HOWARD:** Thank you. Are there questions? Senator Murman.

**MURMAN:** Thanks a lot for coming in.

**TIFFANY SEIBERT JOEKEL:** Sure.

**MURMAN:** Thanks a lot for, you know, answering my question, I guess. But I still haven't got the complete answer, and I'll try and keep asking it, because it's--

**TIFFANY SEIBERT JOEKEL:** Sure.

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**MURMAN:** --until someone comes in that can answer it for sure. When does fertilization take place after intercourse?

**TIFFANY SEIBERT JOEKEL:** So [INAUDIBLE], I will give you a tighter answer when I, you know, respond with something much more scientific than what I will give you right now. But so if, if a sexual, the sexual assault, for example, in this case occurs, it would require the, for the sperm to meet the egg, it would require an egg to be present. So if it happens to be in the course of the woman's ovulation, it, there may be an egg available for which the sperm can fertilize. So if, if that's, if that's the case, there may be some impact of these, of this medication in, in making it harder for the sperm to reach that egg. So that would be the impact. I think it takes-- between fertilization and implantation, when the, when the pregnancy has been established on the uterine wall, it takes around 12 days. It can take up to 12 days, I would say. I think what's the important distinction here, Senator, is between fertilization, so when the sperm meets the egg, by most definitions that is not considered a pregnancy because naturally women will pass 50 to 60 percent of fertilized eggs naturally. So just because every egg is fertilized does not mean that's a pregnancy. I think medically the definition of a pregnancy is when it is established on the uterus, has implanted on the uterine wall. And that is the stage at which these medications have no impact. I would also note that it is in best practice and in this protocol to give all victims a pregnancy test prior to administering this medication for a couple of reasons: one, to know if there is an established pregnancy-- if there isn't, there's no need to provide or if there is, there's no need to provide this medication because they are already pregnant. It's also important to know that information because there are many enhancements for criminal penalties. So if a rape were committed against a pregnant woman, that's important for law enforcement to know. So they're-- in most cases it is breath, best practice that a pregnancy test will be taken to establish whether or not a pregnancy already exists prior to even talking about these kinds of options with the patient.

**MURMAN:** OK. So that brings up a couple more questions. So, so fertilization would take place before the fertilized egg is implanted into the wall.

**TIFFANY SEIBERT JOEKEL:** Correct.

**MURMAN:** So it would most likely be within 24 hours, 36 hours?

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**TIFFANY SEIBERT JOEKEL:** I don't know the time line. I, I know it can take up to 12 days for a fertilized egg to implant.

**MURMAN:** Um-hum.

**TIFFANY SEIBERT JOEKEL:** I promise you I am not a doctor so I will do, do my best to get you really concrete information about those time lines, and I can share that with the committee. But that's the importance of getting this, this medication to victims as quickly as possible because the primary method by which these emergency contraception prevents pregnancy is by preventing ovulation, by stopping that egg before it can meet with the sperm to become fertilized. That's when it is most effective. And so depending upon where the woman is in her monthly cycle, that's what we're, that's where it is most effective at preventing the pregnancy.

**MURMAN:** OK. Thank you. And then you mentioned that there are stiffer, it's a stiffer penalty if the woman is already pregnant.

**TIFFANY SEIBERT JOEKEL:** Yeah, there are enhancements on lots of criminal penalties when women are pregnant. Yeah.

**MURMAN:** Thank you.

**TIFFANY SEIBERT JOEKEL:** Sure.

**HOWARD:** Other questions? Seeing none, thank you for your testimony today.

**TIFFANY SEIBERT JOEKEL:** Thank you.

**HOWARD:** Our next proponent testifier? Seeing no one wishing to testify as a proponent, we do have some letters for the record: Scout Richters from the ACLU of Nebraska; Marcella Peltz, representing herself; Kenna Barnes, representing herself; Toukatha Phommakhanh, representing herself; Dr. John Else and Sherry Miller, representing the League of Women Voters of Nebraska; Morgan Beal from Voices of Hope; and Sarah Williams, representing herself. Is there anyone wishing to testify in opposition to LB555?

**DARRELL KLEIN:** Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I am deputy director of the Division of Public Health for the Department of Health and Human Services. I am here to testify in opposition to LB555, which proposes adoption of the

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Sexual Assault Emergency Care Act. The department supports helping victims of sexual assault when they arrive at hospitals for emergency care. However, the provisions that set specific, mandated time lines for investigations of complaints regarding noncompliance with the act, and the provisions for disciplinary action for violations of the act, are at odds with the provisions used by the department for other healthcare facilities, subject to the Healthcare Facility Licensure Act. The Division of Public Health has a complaint intake area specifically designed for the receipt and triage of complaints about healthcare facilities and services. Trained intake staff are responsible to review and triage complaints for all types of licensed healthcare facilities and services in the state. The intake staff currently conduct an average of over 1,000 intakes and triages per month. The Licensure Unit office of acute care facilities is responsible for all inspections and investigations of the 334 acute care facilities that are licensed or federally certified. And of those facilities, there are 84 licensed and federally certified hospitals that have emergency departments. The Division of Public Health Licensure Unit is the agent for the Centers for Medicare and Medicaid Services, CMS, as the state survey and certification agency, based on the Social Security Act. The state survey agency is required to implement CMS-outlined guidance for triage and complaint procedures and investigations of federally certified facilities and services. And while not all of the licensed healthcare facilities and services are also federally certified, the department has adopted the CMS guidelines for triage to be utilized for both federally certified and state licensed healthcare facilities and services to ensure consistency for similar types of noncompliance, whether the facility or service is licensed, federally certified, or both. The bill requires immediate investigation. A complaint triaged as "immediate jeopardy" under the CMS triage requires an onsite investigation within two days of the triage. These are allegations that, indicating there is a serious injury, harm, impairment, or death of a patient, or the likelihood for such, and there continues to be immediate risk of serious injury, harm, impairment, or death of a patient unless immediate, immediate corrective actions are taken. And the next [INAUDIBLE] level of triage is high, which requires an on-site investigation within 45 days of the triage decision. The majority of complaints triaged as high are investigated within 14 days of receipt and triage of the complaint. The department believes continued use of the CMS triage guidelines is appropriate to ensure appropriate response, to ensure the protection of the public. While this act's requirements to have the complaints investigated immediately,

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investigative staff may need to be reassigned from other current survey and investigatory duties to meet the day, deadline. And this will delay current investigations and surveys and will increase travel costs as surveyors typically travel together and may, in these events, have to be reassigned, so requiring individual travel. Since 2018 the acute care office has investigated 139 complaints at hospitals, in addition to 40 federal surveys and multiple state licensure surveys. Twenty-three of the 139 hospital investigations were conducted within two days of receipt of the investigation, as they were triaged by the complaint intake staff as potential immediate jeopardy issues. The department's also concerned with the bill's requirements for imposition of specific disciplinary actions for noncompliance with the act. The department currently has a guide for licensure disciplinary actions for healthcare facilities and services which was developed and implemented with all regulated healthcare facilities and services in November of 2012, and the guide provides program managers, administrators, and directors with a consistent framework for determining everyone is treated fairly and in the same manner. The guide basically looks at whether an issue is isolated, recurrent, or widespread and also takes into account the gravity and severity of the violation, ranging clear from no actual harm, to slight potential, to clear up through death. Disciplinary actions can include requiring the facility to submit notification of policies, prohibit admissions, imposition of fines, and clear up to revocation. The guide provides direction how to impose those. Finally, the bill does not provide an exemption for those hospitals which are religiously affiliated from being mandated to practice against their moral or ethical beliefs. For these reasons, the department opposes LB555, and I would be happy to answer and address any questions you may have. And thank you for your time.

**HOWARD:** Thank you. Are there questions? Senator Cavanaugh.

**CAVANAUGH:** Thank you, Chairwoman. Thank you, Deputy Director, for being here today. If Senator Hunt, in her opening remarks, mentioned that she was willing to work on some of those-- losing my words-- authority or actionable things for the HHS, if she were to amend them in some way, could you-- do you find a path forward?

**DARRELL KLEIN:** I could certainly say that the department would look at those. There's a team that assesses the bills, and I can't speak or set absolute policy. And then, secondly, I'm here to testify with the bill, as written. One of the aspects that, that would remain-- it

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sounded like the imposition of discipline would still set out a separate set of guidance for what would be imposed, and that would still be contrary to how we treat everybody else. And it would be contrary to how we treat a violation by a hospital for any other aspects. But, of course, we would look at and respond.

**CAVANAUGH:** OK. So just to clarify, you're willing to come to the table with Senator Hunt to work out some of the issues, and so--

**DARRELL KLEIN:** If, if there, if there's any amendment offered to it, we would, we would take a look at that and give our concerns.

**CAVANAUGH:** And I guess I'm, I'm not familiar with-- this, in your mind, specifically strikes religious exemption.

**DARRELL KLEIN:** The, it, I wouldn't say it strikes it. There, there's no provision in there for an exception, so it's essentially an additional mandate for hospitals, some of which we know may have, since they're affiliated with religious, may have a conscious objection to this.

**CAVANAUGH:** But they should, they shouldn't need that explicitly stated, should they? I mean that's already protected, they're already protected in their operations.

**DARRELL KLEIN:** I'll give, I'll give one example. In the area of, for instance, what people would call advance directives, I believe the law requires that a facility tell everybody who's admitted what their policy is. And so if a facility is unable to honor the advance directive, they're not required by the law to follow the advance directive. They are required to state what their position is, and that's kind of a balancing between the concepts and the rights, if you will. So I'm not saying this bill strikes anything. It's just we note that there is no exception for those facilities that may have objections.

**CAVANAUGH:** OK. So if religious facilities that are, are exempt under the law, remain, that protection remains for them, and Senator Hunt works with you on the time lines, the department could--

**DARRELL KLEIN:** We'll sit down and we'll look at whatever would be offered for each of [INAUDIBLE], these, essentially, three issues that we've raised. Yes.

**CAVANAUGH:** OK, thank you.

**DARRELL KLEIN:** Thank you.

**HOWARD:** Other questions? Mr. Klein, how many surveyors do you currently have?

**DARRELL KLEIN:** If I had my notes from prior testimony, I'd be able to tell you. I can't give you the exact number offhand; I can respond with that.

**HOWARD:** OK, I can respond with that.

**DARRELL KLEIN:** Yes.

**HOWARD:** Wonderful. And then did you get a chance to speak with Senator Hunt about your concerns prior to the hearing?

**DARRELL KLEIN:** No, I did not.

**HOWARD:** OK. Thank you. Any other questions? Seeing none, thank you for your testimony today.

**DARRELL KLEIN:** Thank you all for your time.

**HOWARD:** Our next opponent testifier? Good afternoon.

**MARION MINER:** Good afternoon, Madam Chair Howard 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. 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 life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here today to express the conference's opposition to LB555. LB555 would impose a legal mandate on hospitals to dispense emergency contraception to a woman who has been a victim of sexual assault. Emergency contraception is defined broadly in the bill as a drug approved by the federal Food and Drug Administration that prevents pregnancy after sexual intercourse. As a practical matter, this includes drugs with interceptive and abortifacient effects, drugs which would have their effect after fertilization and thus, even though they occur before implantation in some cases, would kill new human life. And I'd like to call your attention to the first footnote at the bottom. Those are a couple of studies which treat that in detail about the-- in many cases the low anovulant effectiveness of



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drugs such as plan B and their high interceptive and then abortifacient qualities. A previous testifier mentioned directive number 36 from the Ethical and Religious Directives for Catholic Healthcare Services. I'm going to call your attention specifically to that directive and read from it as follows: Compassionate and understanding care should be given to a person who is the victim of sexual assault. Healthcare providers should cooperate with law enforcement officials and offer the person psychological and spiritual support, as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the potential, from the sexual assault. If after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have, as their purpose or direct effect, the removal, destruction, or interference with the implantation of a fertilized ovum. Because a new, unique, and distinct human being comes into existence at fertilization, administration of emergency contraception after fertilization, including before implantation, results in a direct termination of a human life. This is a line that any medical professional who knows life begins at conception and objects to abortion cannot cross. Senator Hunt's bill does not contemplate this nuance and does not provide for it in the bill. A hospital's failure to comply with this mandate would lead, first, to a formal rebuke and an assurance that the deficiency has been corrected; second, to the imposition of a \$1,000 dollar fine for each individual failure to comply; and, as originally written, to the hospital losing its license at the sixth offense. So it's our understanding that Senator Hunt may be amending that bill to remove the penalty of license revocation. But even so, the bill imposes truly Draconian penalties for practices that healthcare professionals at various hospitals in the state will not, and simply cannot, perform. The result will be that skilled medical providers will be driven out of emergency medical care because of their moral objection to participating in abortion. There will be tremendous downward pressure on physicians with moral objections to either comply with the moral practices or get out of certain fields of healthcare. Nothing in this bill protects the conscience rights of physicians not to participate. And I would note that, although the bill itself is not specifically directed at physicians and other healthcare professionals, does not mandate that specific persons participate. It doesn't protect against adverse action by a hospital which may, in emergency situations, really exert pressure on

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physicians to do what the hospital's policy is to do or what the law requires them to do. And an example of that would be-- there was a case that got a lot of publicity in the state of New York in the last couple of years, where a nurse, who had conscientious objections to abortion, was nevertheless pressured to participate in the abortion and she did, against her own conscience. So I'd like to-- I don't remember her name right offhand. I didn't know that it would need to recall that story today, but I'd encourage you to, to look up her story. I'd also like to point out that patients also have religious and moral beliefs and the right to give their own informed consent before being subject to medical intervention. Many women would choose not to take abortifacient drugs if they were aware they had already conceived. I want to, I want to reiterate again, I really encourage you to read the medical studies that I have attached there in footnote 1 that call attention to the fact that plan B, which is probably the most frequently used emergency contraception drug after a sexual assault, as well as many other drugs that are often used in these cases, are not particularly effective in many cases at preventing ovulation unless they are taken at a particular early time in a woman's cycle.

**HOWARD:** Mr. Miner.

**MARION MINER:** Yes.

**HOWARD:** You're at the red light.

**MARION MINER:** Oh, thank you. With that, I'll go ahead and take any questions that you have.

**HOWARD:** Are there questions? Senator Cavanaugh.

**CAVANAUGH:** Thank you, Chairwoman. Thank you, Mr. Miner, for being here today.

**MARION MINER:** Um-hum.

**CAVANAUGH:** So as I asked previously to Deputy Director Klein, it's my understanding that this bill does not eliminate religious exemptions. So I don't know the practice. I have never been to St. Anne's here in Lincoln. It's the hospital, correct?

**MARION MINER:** St. E's?

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**CAVANAUGH:** St. E's, yes. So that they have a religious exemption as a religious hospital. So that would still be in place, so it wouldn't be violating--

**MARION MINER:** So I'm going to give you my understanding of this, so when it comes to after the Smith-- employment decision, Employment Division v. Smith Supreme Court case in the, in the, I want to say it was 1990 or 1992, the holding in that case was that a generally applicable and facially neutral law does not violate religious liberty. And so because Nebraska does not have a Religious Freedom Restoration Act in place-- we don't have a state RFRA-- laws that are facially neutral and generally applicable, which this one is, would not provide any protection for anybody with religious objections.

**CAVANAUGH:** OK. I guess I will have to consult with some lawyers to see if that is the case. I don't think that the intention, though-- Senator Hunt can speak to that-- is to conflict with that. I guess I have some concerns about what we're hearing from you. It seems to directly stand in, in conflict to what we were hearing from medical professionals that testified beforehand, and also conflicts with what you even read from the Catholic Bishop, Conference of Bishops. So if appropriate testing, which we heard that they, you are given a pregnancy test, there is no evidence that concept, conception has occurred already which, if you're doing an emergency room visit, it's likely happening as soon as possible. Part of it is that you're doing a rape kit and meeting with authorities. So it's very, almost impossible to say that fertilization has occurred.

**MARION MINER:** So what you're looking for there is-- and again, I would, I would direct you to those, to those footnoted studies-- that's footnote 1, that treat this situation in detail. But basically what--

**CAVANAUGH:** Are these medical studies?

**MARION MINER:** Yeah. They're from the Linacre Quarterly, which is a medical journal. Yeah. So what I, I would direct you to those studies. Those show that-- so basically the Catholic teaching on that position is if conception, if you can establish that, that there hasn't been conception by the time that drug will have its effect on, on the woman's body to prevent ovulation, then-- so if conception will not have occurred by the time the drug takes its effect, then it's going to be morally permissible to administer that emergency contraception. If, however, you can't establish that that's the case, then it

wouldn't be morally permissible to do so. And that's the distinction that, you know, a Catholic hospital for example, or another hospital that maybe follows the same guidelines, if, if they have the flexibility to determine that for themselves, then they can determine whether it's morally permissible for them to go ahead and administer emergency contraception, which is to say they're willing, in some cases, many of them, to, to do so, but they need to have the freedom to determine whether or not, through, through a scientific analysis in the moment, whether or not there is a new life that's been established there. If not, they can go ahead. If it has, they simply can't because that's going to, that's going to have interceptor or abortifacient effects, which is after fertilization.

**CAVANAUGH:** OK.

**HOWARD:** May I ask a clarifying question?

**MARION MINER:** Sure.

**HOWARD:** So my understanding is that you can't tell if you're pregnant until your body starts releasing hCG hormone, but that doesn't happen until an egg has implanted. So how will we know if the egg has been fertilized?

**MARION MINER:** So, so you can't-- my understanding is that you can't necessarily tell for certain, at that, at that moment, right? But what you can tell is whether ovulation has occurred. So it's going to be the practice like of--

**HOWARD:** So you can tell if ovulation has occurred, right. So, so are you suggesting that we [INAUDIBLE]--

**MARION MINER:** Or is about to occur.

**HOWARD:** --that we have a, that we also apply sort of an ovulation test for a sexual assault survivor when they go to the emergency room?

**MARION MINER:** No. What I'm suggesting is that you leave it to the individual hospitals to determine what is morally permissible for them to do when somebody comes in to them. So my understanding of the protocol-- and I can actually get you a copy of a protocol from a, from a hospital in Illinois that uses this protocol; it's called the Peoria Protocol. So what they do, if I understand it correctly, is they try to establish, they ask the woman, for example, when her last period was, so it gives them an idea of where she is in her cycle. And

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then they can do blood and urine tests to determine whether there's been a lute, an LH surge, which can help them determine whether or not ovulation has occurred. If ovulation has occurred, then by the time that that drug, that that emergency contraceptive drug takes its effect, there's a high likelihood that that's going to have, again, an interceptive or abortifacient effect rather than a contraceptive effect. So that's, that's, that's, that's the call that the hospital has to be able to make in that situation.

**HOWARD:** So I think we can agree that we want sexual assault survivors to have whatever support that they need after, after something traumatic has happened to them. Do you feel the same way?

**MARION MINER:** Yeah. I direct you to that directive number 36, yeah.

**HOWARD:** So I'm, I'm trying to think of a way where-- because I do think that there's a conversation that we need to have about making sure that survivors have the broad range of services when they go to the hospital. And I think this bill is one vehicle for that. And so are there nuances to the language, considering the Peoria Protocol or considering sort of this Catholic teaching that could be added to LB555 to help address your concerns?

**MARION MINER:** I'd certainly, I'd certainly be willing to talk with Senator Hunt about that. It-- I'd certainly be willing to talk to her about it.

**HOWARD:** Because if the consideration is you, you have to have a pregnancy test and an LH test in order to make the decision about what sort of offerings you would give to somebody. Well, one, you never want to offer a test to somebody when they don't know that that's the test that they're taking.

**MARION MINER:** Um-hum.

**HOWARD:** And so I think there's maybe a broader conversation. But I do hope that, after the hearing, you'll have that conversation with Senator Hunt because I think, as a state, we want sexual assault survivors to know that we hear them and to know that we support them.

**MARION MINER:** Oh certainly, yeah.

**HOWARD:** Are there any other questions? Senator Cavanaugh.

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**CAVANAUGH:** Thank you. Thank you, Mr. Miner, again. So I have a lot of questions that I want to ask you, but I am, I recognize that-- or I believe-- just based on how you are addressed here that you're not a medical doctor.

**MARION MINER:** That's correct.

**CAVANAUGH:** So I'm going to reserve a lot of those questions. Did you consult a medical doctor in preparing your testimony?

**MARION MINER:** Yes, several.

**CAVANAUGH:** I guess I would just like to say that it would be helpful to hear from the medical providers that you're talking to about this, because I feel like a lot of the information that's in your testimony is in conflict to the medical expertise that we've heard today. And it, to me, feels a little bit more philosophical. And not that I'm in disagreement with your views; it's just that I don't know the-- I don't recognize them as based in science.

**MARION MINER:** So when a, when a-- how I'd respond to that is that, regardless of, of, you know, some people define-- you know, pregnancy is sometimes defined as beginning at implantation.

**CAVANAUGH:** Um-hum.

**MARION MINER:** Right? So even if you're defining pregnancy in that way, that doesn't change the fact of whether or not you've got a new human life at fertilization, which happens prior to implantation. So that, that is, that is-- I think we can, I hope we can agree it's a scientific fact that the human life begins at fertilization. So what happens, what, what the capability--

**CAVANAUGH:** OK, I think that that actually is not in agreement, though,--

**MARION MINER:** OK.

**CAVANAUGH:** --in the scientific community.

**MARION MINER:** OK. So, so I would represent that as being fact.

**CAVANAUGH:** That's, that isn't a, that is a, a belief. And it's a, it's a belief that I respect very much.

**MARION MINER:** Um-hum.

**CAVANAUGH:** But I don't believe that that is a scientific fact, and I don't think it's agreed upon in the scientific community. So I'm, I guess I'm just concerned that your testimony-- I don't want, I don't view your testimony as a, as an expert witness in the medical profession. I believe it as a-- you are sharing with us the beliefs of the Conference.

**MARION MINER:** That's certainly part of it. But, but the contents of-- although I, myself, am not any expert in the medical field, as I've said, I've consulted with people who do know. And I'd be happy to get you in contact with people who can have those conversations. In fact, I wish they could be here today but, unfortunately, as I'm sure you know, people in the medical field are very, very busy people and often can't come on short notice. But I would refer you, too, to that not to get too far down this track, but when we talk about fertilization being the beginning of a distinct new human life, I would refer you to the embryology textbook used by UNL to this day which, which states that as a fact. And I think it's a pretty broad, pretty broadly agreed upon as a consensus. Whether or not a human person, at that stage, deserves protection is something that's more philosophical. And of course, our views on that are, are well-known.

**HOWARD:** All right. Any other questions? Seeing none, thank you for your testimony today.

**MARION MINER:** Thank you very much.

**HOWARD:** Our next opponent testifier? Seeing none, we do have one letter for the record: Karen Bowling from the Nebraska Family Alliance. Is there anyone wishing to testify in a neutral capacity?

**DONNA ROLLER:** Good afternoon, Senator Howard--

**HOWARD:** Good afternoon.

**DONNA ROLLER:** --and members of the committee. My name's Donna Roller, D-o-n-n-a R-o-l-l-e-r. I'm here as a neutral capacity, and I'm wondering why a male layperson has interjected his personal views, testifying on women's reproductive anatomy. And we are the women that bear the children and know our bodies and know what we need. And I want to say that all men create pregnancies, and they are the cause of rape. I find it-- and I think everyone that is not Catholic does not

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want those beliefs shared or put into a bill that affects the mass population of this state, as I need bills to protect my religious beliefs, too. So that we, we should not be legislating to one religious faith. I also find it disingenuous that men would testify against practices that are beneficial to women who have been subject to rape and violence, even if they are as young as 14 years old, and by a man. And there has been other several states, in Texas and in North Carolina, I believe-- I'm not sure-- that these, legislation has been passed against women's reproductive rights. And they have passed a counter bill, or suggested a counter bill that regulates men's sexual activity. So, you know, if we're going to go down this path, maybe that's the direction the state needs to take.

**HOWARD:** Thank you. Are there questions? Seeing none, thank you.

**MURMAN:** Yeah, I've got one.

**HOWARD:** Oh, Senator Murman.

**MURMAN:** Thanks for coming in.

**DONNA ROLLER:** Sure.

**MURMAN:** I guess you kind of caught me by surprise. I didn't read this that carefully. But are we just talking about women that have been raped here? I thought we were talking about all rape.

**DONNA ROLLER:** We're, we're talking about the, the rape-- how to address women who have been subject to violence from rape in the hospitals, aren't we?

**HOWARD:** I believe both genders are covered, but the predominant number of--

**DONNA ROLLER:** Well--

**HOWARD:** --sexual assault victims--

**DONNA ROLLER:** --the prominent are women--

**HOWARD:** --are women.

**DONNA ROLLER:** --and I am a women.

**MURMAN:** Yeah.



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**DONNA ROLLER:** And we are predominantly-- I mean we have a huge sex trafficking issue in this state. And we have a lot of missing and murdered women. And I'm here to speak out for that. So I mean I'm sure men are involved and, equally so, they should be represented.

**MURMAN:** Well, thank you, Thank you for speaking out. Yeah, my understanding was that rape could happen--

**DONNA ROLLER:** Oh, absolutely.

**MURMAN:** --you know, both ways.

**DONNA ROLLER:** Absolutely. It's horrible to-- no matter. But you know, today I am taking offense to men dictating about my body. I know my body. I know what happens in pregnancy, and I know what I do. And so, you know, anybody that's subject to trauma-- come on. We're, we're, we're not going to allow them to have the kinds of preventative care that they need? This is insane; I'm sorry.

**MURMAN:** Um-hum. Well, thank you very much.

**DONNA ROLLER:** Thank you.

**HOWARD:** Any other questions? Seeing none, thank you for your testimony today. Our next neutral testifier? Good afternoon.

**JUDY KING:** Hi. My name's Judy King, J-u-d-y K-i-n-g, and I'm totally not prepared for this, but listening to some of the conversations-- I'm an older woman and I mean we had-- for someone to tell me that I shouldn't have birth control or, because of their religion, is just so far out of my realm that I can't even imagine it. And if the-- I've been to the Education Committee, where the University staff-- you know, where there, where there's an issue with women getting attacked. And the universities are too busy to-- they've get too many things to do to, to track issues like that. I, I volunteer and I can get a group of women that'll be there to volunteer to help anybody that doesn't have enough staff to check out these issues. And I don't know if Health and Human Services-- I don't know if this gentleman needs help, but I will gladly volunteer to help him. And I can get tons of women to come up here and help him accomplish this task of checking these things out. I have a relative that actually needed that pill, was raped. And thank God, you know. Thank God. And I think maybe if you have questions about how a woman's body works, that you need to do more inquisitive-- you know, ask these women. Have a conversation with

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them how the body works, and we'll do the same for men. You know, we'll find out how your body works. But honestly, if you're going to be making legislative decisions on this, you need to find out this stuff before you get in here, and you should have found it out a hell of a long time ago. So thank you.

**HOWARD:** Thank you. Oh, are there any questions? Senator Murman.

**MURMAN:** Well, thanks a lot for testifying, and on such short notice especially. I, we did have some information from some of the testimony that was out of medical journals and I really appreciate that information. I know there's a lot of questions on how these, these things, by both men and women, about how all these things work. And, but I think those questions need to be answered for us to make, you know, informed decisions, as you said.

**JUDY KING:** Oh, I, I totally agree, and I'm glad that you brought it up. I'm glad that you're asking questions. But let's, let's get that done, you know, now before we have objections or make decisions on this, because--

**MURMAN:** Sure. And I just want to emphasize I have total compassion for anyone that's been raped.

**JUDY KING:** Yeah.

**MURMAN:** And I don't want to, you know, have the image that I don't. So thanks a lot.

**JUDY KING:** That's going to just make it harder on people in that situation. So thank you.

**HOWARD:** Any other questions? Thank you for your testimony today.

**JUDY KING:** Yeah.

**HOWARD:** Our next neural testifier? Seeing none, Senator Hunt, you are welcome to close.

**HUNT:** Thank you, colleagues. Thank you again, Chairwoman Howard. I want to especially, I want to thank all the testifiers who came here today. I didn't really do a ton of work to round up testifiers, and so all the people here who came to speak out on this issue I think should show us how much value there is in this idea behind this bill. I especially want to thank Miss Tiffany Seibert Joekel for pointing out

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all the medical facts involved that she shared, especially the part about the pregnancy test. You know if you're already pregnant, you're not going to get emergency contraception and, if you're not pregnant it's just going to prevent pregnancy. I think that's so important for people who have been raped to give them that opportunity to, to live a life without the child from, from that rape potentially. You can believe anything that you want, whether that's a religious belief or a philosophical belief. But we have to base legislation and policy on science, just like we base medicine on science. And this law doesn't require people who have philosophical or religious objections to giving this medication. I think that should apply to every medication. It doesn't require them to administer that to anybody. It just holds the hospital accountable; it doesn't hold the individual practitioner accountable. And that, to me, was a very important part of this bill so that, if anybody had an objection to putting a Band-Aid on a knee, if anyone had an objection to giving someone some Tylenol, or if anyone had objection to giving someone emergency contraception, to me, that's all the same thing because none of those things cause abortion. But I knew that, of course, this issue would come up in this committee. I expected to hear the opposition that we heard. And that's why I made sure that was in the bill so that, if someone had a, had an objection to that, they would not have to administer this medication. It sounds like DHHS had some reasonable concerns about this bill, and I want to make sure that this bill meshes with the procedures that they already have in place for compliance, and for reporting, and for inspections, and everything that they have to do to make sure hospitals are in compliance, because I agree that it's important that we have consistency. So after, after this hearing I'll make sure that we get together with them and find a way to address those concerns. Rape survivors are often taken to a hospital or a shelter by police or emergency medical technicians. And at that point many of these survivors don't have the time or the information or the opportunity to assess the hospitals where they're being taken. They don't have the time. It's not realistic to say that a rape survivor is going to figure out if they're going to a hospital that's going to administer emergency contraception. One of the most common responses that I got from constituents and voters when I brought this bill was: It shocks me that this isn't a thing already. It shocks me that I could be raped and I could go to the hospital for care and they wouldn't give me the morning-after pill but I can go get it at CVS or Walgreens. That's not based on science; that's bad practice. And we heard from, we heard testimony from medical professionals today that that's not best practices, and that's why we need to codify it into law because we

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know that that's happening. It's not right to put that burden of knowledge on survivors when they're going through some of the most traumatic stuff they ever went through. People in rural communities may find themselves in a position where there's only one local hospital. And if they do not provide emergency contraception, it may be extremely difficult for them to access appropriate care in a timely manner, if at all. Evidence has shown that people who hold marginalized identities experienced not only higher rates of sexual violence, but also higher rates of inequality within the healthcare system. There is definitely a social stigma against seeking help after rape. We know that because we can see the statistics of how many rapes are actually recorded and then, even lower statistics of how many survivors of rape actually seek medical attention for, for that trauma. And a lot of that is a byproduct of centuries of racism and sexism and classism and homophobia. I appreciated Senator Murman pointing out that men survive rape, too. It's very important to say that, and accept, I accept transgender identities absolutely. And men can get pregnant, too, and we need to make sure that they have access to emergency contraception. But the deeper root within the moral stance about various emergency care facilities, refusing to provide emergency contraception to rape survivors, is based on long-held beliefs and traditions and power dynamics that have gone unchecked, not based on science. So to deny patients access to life-changing and potentially lifesaving preventative care is unethical. It's unethical. It's unethical for hospitals to do this and it's inhumane. And Nebraska needs to hold all of our facilities to the global standard of care and provide emergency contraception to anybody who needs it after a sexual assault. And with that, I will close and answer any questions.

**HOWARD:** Thank you. Are there questions? Senator Murman.

**MURMAN:** Thanks a lot for bringing this bill, Megan-- or Senator Hunt.

**HUNT:** That's all right.

**MURMAN:** I hesitate to ask this question because it's, I know it's difficult. But I do know people that have been the product of rape. So we've talked a lot today about, you know, we want all the options available to people, someone that's been raped. We want to know all, everything. Well, if we're going to give them this option of contraception, shouldn't we also give them the option of how to take

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care of a pregnancy and how to, what services are available for a more-- excuse me-- adoption?

**HUNT:** Um-hum.

**MURMAN:** You know, get, look, I think all the options should be included.

**HUNT:** This bill only deals with people who are, who are, who have survived a rape. I think that what this bill does is it gives patients the choice about whether they want to take emergency contraception or not.

**MURMAN:** Um-hum.

**HUNT:** If a patient chooses not to take it, which is totally within their ability to do, especially I really don't think that people should be making choices without being informed with medically accurate information about what that test is going to do or what that pill's going to do or what that treatment is going to do. So if, if this bill goes into law, the provider will say to the survivor: These are the facts about emergency contraception. You know, during a rape kit there's many procedures that happen. It all happens so fast, and that the practitioner will say: Emergency contraception is this, this is what it does, here's some information about it. Would you like to take this? And the patient can decide, when they've been informed, whether or not they want to do that. If they decide not to and they become pregnant, there have always been pregnancy counselling services available. We have a very strong cultural, culture of valuing life and being very antiabortion, so I don't think that anything in this bill would prevent a woman from having a, a healthy and wanted pregnancy if that's what she wanted, even if that was the product of a rape.

**MURMAN:** Well, yeah. I do agree that rape, you know, is very traumatic. I should have asked the question earlier, but I assume that many of these, the people that come in after being raped. It could have happened, the rape could have been several days, several hours, several days, even weeks before the person comes in.

**HUNT:** I think, hypothetically, that's possible.

**MURMAN:** So--

**HUNT:** It's kind of understood that, when you survive an assault, you need to go in to the, to the doctor immediately to collect evidence,

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you know, to interact with law enforcement, and that's a big part of what hospitals do in these cases that-- the nurse who was going to be here to testify and, you know, we have no problem getting people, getting medical professionals to come provide testimony about this because this is the scientifically accepted position. This is the scientifically accepted data. So I would have no problem getting medical professionals to testify in support of this bill. But the nurse who was going to come in, she is a practicing Catholic, and-- I feel like I forgot where I was going with that. But what was your question?

**MURMAN:** Well, I assume many come in after being raped like hours--

**HUNT:** Oh, yeah, yeah.

**MURMAN:** --or days, even weeks.

**HUNT:** Yeah, I'm sure they do. But it's, it's, it's a lot harder to gather evidence and I think that-- I have no doubt that Nebraska hospitals would still provide those survivors the highest standard of care.

**MURMAN:** Sure. And-- but only counsel one way-- I mean I think it would be important to also counsel about, you know, maintaining a pregnancy if that might have happened, or the adoption services that are available and not to--

**HUNT:** I think it's--

**MURMAN:** --you know, traumatize the person any more than is necessary. But there is also trauma involved with making a really quick, rash decision and, you know, and having, you know, for instance, having an abortion and having to live with that the rest of your life.

**HUNT:** Well, one thing rape survivors are referred to is, is trauma counselors, people who can by, can provide trauma-informed counselling. And if a patient is pregnant, she's given resources on how to care for her pregnancy.

**MURMAN:** Sure. I just think it would be important to have all of the alternatives. If we're going to give one alternative, you know, have all the alternatives available.

**HUNT:** Thank you.

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**MURMAN:** Yeah.

**HOWARD:** Any other questions? Seeing none, thank you, Senator Hunt.

**HUNT:** Thank you.

**HOWARD:** This will close the hearing on LB555 and conclude the hearings for the day. We will not be [INAUDIBLE].