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

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

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

RIEPE: Merv Riepe, Legislative District 12, southwest Omaha and the good people of Ralston.

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

HANSEN: Also assisting the committee is our research analyst, Bryson Bartels; our committee clerk, Christina Campbell; and our committee pages for today, Ken and Mataya, right? OK, good. A few notes about our policy and procedures for this morning. Please turn off or silence your cell phones. You'll be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill out-- please fill one out and hand it to Christina or one of the pages 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 an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying. 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 testimony and we'll ask that you wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, 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. And on a side note, the reading of testimony that is not your own is not allowed unless previously approved. And as usual, we have a strict no prop policy in our committee. So with that, we'll begin today's hearing with LB590. And welcome, Senator Holdcroft.

HOLDCROFT: And this is not my first bill.

HANSEN: Oh, darn it.

HOLDCROFT: This is my second.

HANSEN: They had so many questions to grill you on. So OK, well, so much for that.

HOLDCROFT: Good morning, Chairman Hansen and members of the Health and Human Services Committee. For the record, my name is Senator Rick Holdcroft, R-i-c-k H-o-l-d-c-r-o-f-t. I represent Legislative District 36, which includes western and southern Sarpy County. I am here today to discuss LB590. This bill will increase the personal needs allowance for qualifying individuals from $60 per month to $100 per month. The last time this allowance was increased was with the passage of LB366 in 2015. This bill was sponsored by former Senator Patty Pansing Brooks and cosponsored by former Senators Kathy Campbell and Colby Coash. After being amended, it increased the allowance from $50 to the current $60 per month. Basic personnel-- personal needs are provided to Medicaid recipients with alternate living arrangements as required by law. These include basic personal hygiene items such as toothbrush, toothpaste, dental floss, dental adhesive and cleaner, shampoo, bath soap, deodorant, more-- mostright-- moisturizing lotion, comb, razors, incontinence supplies, sanitary napkins, and related supplies and facial and bath tissue. If a resident chooses to purchase a specific brand that is not provided by the nursing home, their personal needs allowance can be used. According to the American Council on Aging and Nursing Home Residents, personal needs allowance can be spent towards a variety of personal items and services not provided by the care

facility. This includes clothing, shoes, vending machine snacks, specialty food, multivitamins, haircuts, toiletries, magazines, books, knitting needles and yarn, greeting cards, postage, and cell phone bills. According to data from the Bureau of Labor Statistics, since 2015, the average nonseasonally adjusted price of footwear-- footwear has gone up over 5.5 percent. Men's trousers and shorts have gone up over 3 percent. Nonprescription drugs such as multivitamins have increased in price over 2 percent since 2015. Chairman Hansen and the members of the Health and Human Services Committee, thank you for giving your attention to LB590. I would appreciate it if the committee would give this bill timely consideration and advance it to the full Legislature for debate. I would be happy to answer any questions you might have.

HANSEN: Thank you, Senator Holdcroft. Are there any questions from the committee? I have one question.

HOLDCROFT: Yes, sir.

HANSEN: So you're saying prices for items went up maybe like 5, 6, 7 percent since last time we raised this?

HOLDCROFT: Well, per year, yes.

HANSEN: OK, well, per year. OK. I was just kind of curious. OK. I see no questions. We'll see you at close.

HOLDCROFT: Yes.

HANSEN: OK. All right. Good deal. Well, we'll take our first testifier in support of LB590.

JINA RAGLAND: Good morning, Chair Hansen and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d, here testifying on behalf of AARP Nebraska in support of LB590. As Senator Holdcroft said, Medicaid's personal needs allowance is the amount of monthly income a Medicaid-funded resident can keep of their personal income. Since room, board and medical care are covered by Medicaid, most of one's income must go towards the cost of their care. The personal need allowance is intended to cover the resident's personal expenses-- expenses which are not covered by Medicaid. This may include, but are not limited to hair care, vitamins over the counter, clothing, magazines, snacks, cell phone service, and others. The opportunities for these residents to spend money on things to improve their quality of life have expanded tremendously, but with

that comes a price tag. The current levels of the personal needs allowance is prohibitive. For example, some female residents living in nursing homes cannot afford things like having their hair done for more than once or twice in a month. Keeping in mind this may be the only thing that brings them joy or they look forward to every week. And then they have any-- then they don't have any resources left over for basic things such as clothing, phones, stamps, snacks, and so forth. Haircuts are roughly $15, weekly shampoo and settings are roughly $20, and perms are over $20. Residents often have the opportunity to purchase a small treat for themselves here and there: popcorn, Ice cream, their favorite candy. For my grandma, the one thing that brought her joy was having a small glass of red wine every night before she went to bed. Just one glass and it was small, but it was something that she had done for most of her adult life, and it brought her joy. But it was something she had to supply on her own, amongst other things. If they want-- they want a personal cell phone or a phone in their room, they-- that, too, can exhaust their entire monthly allowance. Many people also spend $20 to $25 a month to prepay their funeral expenses so their children won't be burdened. Add all that up and you'll find the $60 comes up short. This modest increase to a resident's allowance would make a world of difference to many people. Now, I want to take this one step further. I think we can all agree that the pandemic created some hardships for all of us, but those in long-term care and assisted living facilities likely have been most negatively affected. Social isolation is real. Residents were merely cut off from the outside world in lockdowns, many facing months of not being able to hug, touch or speak face to face with their loved one. They had conversations with them through their picture windows or through plexiglass. Electronic devices were a must. Cell phones and tablets were a must. And not only in allowing a means to communicate with the outside world and loved ones, but also to provide entertainment while enduring the downtime. How many of you played Candy Crush crossword puzzles, Solitaire, Trivia? Those are all online games and I think we all play them, but residents do that too: online exercise programs, online books, movies, and television programs and many other things. But these items come with a cost. Many facilities work to provide opportunities for connection with devices, but they had to be scheduled and they were not something they could access whenever they wanted or needed to readily. Even before the pandemic, social isolation and loneliness were considered serious health risks for older Americans, especially those in long-term care or assisted living facilities. These factors significantly increase a person's risk of mortality from all causes, potentially rivaling the

risks of smoking, obesity and high blood pressure. Social isolation and loneliness are also associated with higher rates of clinically significant depression, anxiety, frustration, irritability, and suicidal ideation. Isolation and loneliness are associated with a 50 percent increased risk of developing dementia, a 32 percent increased risk of stroke, and nearly a fourfold increased risk of death among heart failure patients, according to separate studies. With 43 percent of adults aged 60-plus in the U.S. reporting feeling lonely, the rates of social isolation and loneliness were already at the level of a public health crisis. We believe that increasing the personal needs allowance will allow our most vulnerable the ability to better meet their personal needs, maintain a level of independence and dignity, combat isolation, and improve overall mental and physical health, which in turn saves medical costs, especially for those on Medicaid to the state. We helped my grandma, Grandma Lizzie [PHONETIC], nothing-- with nothing-- but nothing brought me more joy than purchasing that bottle of wine and taking it to her when she needed it. She had dementia, so she didn't know who I was, but she knew who the bottle of wine was. And truly it's the little things that do add up. Many families help where they can and when they can, but not all families have that ability. Many have covered their costs on their own, but have depleted their savings and spent down to the point where their savings is gone. And they must now rely on the state to assist in paying for their care. My grandmother, Grandma Lizzie, [PHONETIC] saved for years and paid her way. Her life was extended due to dementia and Alzheimer's for probably many more years longer than she had wanted. But maybe it was the wine. I don't know. This in return caused her to have to spend down and rely on Medicaid and-- and family members to assist in paying for her care. Thank you to Senator Holdcroft introducing the legislation and thank you for the opportunity to comment. And I would be happy to try and answer any questions.

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

M. CAVANAUGH: Thank you. You just so much reminded me of my own grandmother who at the lake that she lived at there was a mail boat that went by [INAUDIBLE] every day, and she would have her glass of Chardonnay when the mail boat went by. She was [INAUDIBLE] 90.

JINA RAGLAND: It was red wine for grandma--

M. CAVANAUGH: Yeah.

JINA RAGLAND: --but it was a little bit. But it was a must and it was an every night. Thank you, Senator Cavanaugh.

M. CAVANAUGH: Thank you for talking about the importance of joy.

JINA RAGLAND: Absolutely. Thank you.

HANSEN: Any other questions? I have a couple.

JINA RAGLAND: OK.

HANSEN: Because I had to address the fiscal note obviously, $2.7 million and then 3.6, and I know some are federal funds, but it's still taxpayer money.

JINA RAGLAND: Correct.

HANSEN: And the fact that we've increased it $10 every time we've done it, you know, when was the last time, five, six, eight years ago, and we're increasing it by $40, which I know inflation has gone up and affecting things. It just seems like a lot to me, I think. And then also, do they-- do these-- do these kinds of people that this will be affecting, do they get any other kinds of personal income--

JINA RAGLAND: So---

HANSEN: --like Social Security or?

JINA RAGLAND: OK. So to get to your first question, Senator, I know the Bureau of Labor Statistics was brought up on inflation for other things, but I also want to reference $60 in 2015 as now worth $72.18 today. So we're not to the $100 mark, but we have moved up on the scale in consideration of that, but also the cost of programs, services and whatever else. I think you start big. I mean, I think there's room for compromise on this and that's what happened in 2015. And certainly if we can move the dial just a little bit further, that would still be more helpful; $100 would be fabulous. But if it gets to $70, that's something to think about, too. As far as other income, when they qualify for Medicaid, they're only living off of generally their Social Security income. They have to spend down to even qualify for Medicaid, first of all. And so they're not getting anything extra in their pocket, which then, you know, it all goes to their care. And then what's left over the $60 is all that they have left.

HANSEN: Social Security all goes towards their care.

JINA RAGLAND: Yes.

HANSEN: They don't get any of that in personal income?

JINA RAGLAND: No, no. Because when you qualify for Medicaid, that's-- it all goes-- that's your spend down--

HANSEN: Sure.

JINA RAGLAND: --on the Medicaid.

HANSEN: I know a certain percentage they still would be able to use for personal [INAUDIBLE].

JINA RAGLAND: Just the $60.

HANSEN: I hate to sound like the callous--

JINA RAGLAND: Yeah no it's a great question.

HANSEN: I don't want to deny your grandma her glass of wine. That's what it sounds like now when I ask questions.

JINA RAGLAND: Well, and $60 doesn't buy a lot of wine--

HANSEN: Yeah.

JINA RAGLAND: --if you buy the right kind so.

HANSEN: Yeah. OK. We'll get-- thank you very much.

JINA RAGLAND: Thank you, Senator.

HANSEN: I will take our next testifier in support.

EDISON McDONALD: Good morning.

HANSEN: Good morning.

EDISON McDONALD: My name's Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We want to thank the Senator for introducing this bill. We support LB590. Personal needs allowance is the monthly sum of money that residents who receive Medicaid may retain from their personal income. Any income above the allowance is applied toward the cost of their care. This allowance is intended for residents to spend at their

discretion on items such as telephone expenses, a meal out with friends, cards to send to family, reading materials, hobbies, haircuts, salon, hairdresser activities, clothing, magazines and books, favorite brand hygiene and toiletry products, supplements and multivitamins, vending machine snacks, birthday cards to send to family, etcetera. These are the most valuable dollars to our members themselves. It's the only money they really feel like they have personal control of. Come to realize that when I hang out around our members, I can't bring a Coke without being prepared to buy a Coke for others because even that dollar or two for a vending machine soda means everything to them. Or it could be a tablet in order to help communicate. But frequently they don't even get those little things because a lot of times, as you're going through the complexities of budgeting out for an individual who's on Medicaid, that's kind of used as kind of money to help when things don't quite add up and help to make sure that really they're getting everything that they need from day to day. So with that in mind, I also want to talk about a little bit different subject, Medicaid unwind. The federal pandemic is set to start ending next month, and we will start to have assessments throughout the year going back through every individual and redetermining their-- their care. And with that, we're going to see a huge removal of folks off of Medicaid, but we're also going to see a huge increase, we think, in shares of cost. That's how much an individual pays in out of their-- out of their pocket. So one thing that I really hope that you all will consider within the fiscal note, the department went and said that they wanted to have it start in October. I think it would be much better and helpful for all of your constituents as you start to get those calls. One of the best flexibilities that you have are those personal needs allowances. So to go and start that, you know, sooner rather than later is going to be a lot easier as those individuals start to really work on shifting their budgets. With that, I'll just urge your support of the bill and open for any questions.

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

RIEPE: Thank you for being here. I will try to get back away from the testimony creep, if you will, on the other subject back--

EDISON McDONALD: Yeah.

RIEPE: --to this one.

EDISON McDONALD: Yep.

RIEPE: Is-- is there anything that because of some of the compromised position of these people, even $40, is there someone that kind of helps them that says, you know, you're going to want your care, you're going to want this, you're going to want that? Just like a youngster, don't spend-- don't spend your full $60 or soon to be--

EDISON McDONALD: Yeah.

RIEPE: --$80 or $100, whatever it is.

EDISON McDONALD: Yeah.

RIEPE: Don't spend it In the first week--

EDISON McDONALD: There-- there--

RIEPE: --and compromise yourself.

EDISON McDONALD: Yeah. They're supposed to have the flexibility and there's a concept called dignity of risk like, you know, we-- and basically the concept is we all have the right to be stupid and, you know, go and say, I'm going to spend all of my $60 up front because each person should have, you know, that ability for choice. But most of the time, what you describe happens is that a staffer or a family member will say, oh, yeah, you don't want to spend this all at once.

RIEPE: I hate to see them spend their full $60 on sports betting.

EDISON McDONALD: Yeah, but they, you know, I would say this is money that they really learn about, they think about, and they hold on to so tightly where even, you know, is talking about going and getting a soda from the soda machine. Like, you know, that's-- that's big for them.

RIEPE: I was on HHS at the time when we did this major improvement up to $60 and were assured at the time that that would be forever. No, it's not true.

EDISON McDONALD: Yeah, I wouldn't expect that.

RIEPE: Yeah, well, I might have had some exaggeration there, but OK. Thank you for being here.

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

EDISON McDONALD: Thank you.

HANSEN: Anybody else wishing to testify in support of LB590? All right. Seeing none, is there anybody who wishes to testify in opposition to LB590? Is there anybody wishing to testify in neutral capacity? All right, seeing none, we'll welcome up Senator Holdcroft to close. Oh, and with that, while you're working your way up here, we did have some letters. We had three proponent letters in support.

HOLDCROFT: First thing I have to do is correct what I said earlier about the percentages. It is a total percentage over the last seven years with a 2 percent, 5 percent. So-- and as was mentioned earlier, that $60 back then is worth-- inflation would be about $72 now. And back to LB366, which apparently Senator Riepe was-- had something to do with. The original request was for $75 per month, and it was reduced to $60. So it was the-- the evil HHS back then I guess that reduced that to $60. Back to the-- the point on, yeah, the-- and just let me relate an experience I had with my mother who passed away a couple of years ago but she was-- she was, you know, in the end she thought she had a good plan and she really did. I mean, she-- we sold her house. She had some savings, some investments. And so she went into a home, a nice-- a nice assisted living facility with about, you know, $300,000, $400,000 in the bank. And we thought that was plenty. And then we found out it's $4,000 a month to stay in a typical nice assisted living facility. That was when she first went in there and it went up about $500 every year. So she was paying like $5,500 every month. And so that eats quickly down on your savings. And when you get down to a point where you only have $4,000 left in assets, that's when you qualify for Medicaid. And then we take their Social Security, we take everything they have in income. We pay for the rest so that they can live in a Medicaid facility, not necessarily a nice place. And then we give them $60 a month to pay for their additional costs. So I think it's been seven years since we've raised this. We may not raise it to $100 because it does have a significant impact. As you mentioned, the-- I would also mention there are about 6,000 residents in nursing homes that qualify for this and about 2,000 residents in assisted living. And that's why it adds up so quickly. I mean, it's a per month fee and you have that number of folks who qualify. So I appreciate-- I'll be happy to answer any further questions that you have, but I appreciate advancing the bill.

HANSEN: Thank you, Senator Holdcroft. Do you think you could address the amendment real quick?

HOLDCROFT: I'm sorry?

HANSEN: Was there an amendment that you gave to us that you handed out?

HOLDCROFT: Was there an amendment? Oh, I think there was a--

HANSEN: It looks like a simple amendment. I just didn't know if you could touch on it.

HOLDCROFT: Yeah, I think we changed-- we took out "at least." t Yeah, so once again, there's a-- we just struck on page 2, line 4, we-- we struck "at least."

HANSEN: OK. Is there a reason why? Is it because there were some more people getting paid more than $60 or less than $60, or--

HOLDCROFT: I'll have to--

HANSEN: --is it just more of a cleanup type thing?

HOLDCROFT: Yeah.

HANSEN: It sounds like it. I just didn't know if there was any specific purpose behind it. OK, cool. All right. Are there any questions from the committee?

WALZ: I just have a [INAUDIBLE].

HANSEN: Yes, Senator Walz.

WALZ: First of all, thank you for bringing this bill.

HOLDCROFT: Sure.

WALZ: I really appreciate it. Did you have any opposition?

HOLDCROFT: No.

WALZ: Thanks.

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

HOLDCROFT: Thank you.

HANSEN: All right. That will end the hearing for LB590 and we will move on to the next one, LB664. And we will welcome Senator Riepe to open. Welcome.

RIEPE: Thank you, Chairman Hansen. And good morning, members of the Health and Human Services Committee. My name is Merv Riepe, it's M-e-r-v R-i-e-p-e, and I represent the 12th District, which consists of southwest Omaha and the good folks of Ralston. I have introduced LB664 on behalf of the Attorney General's office to make two modifications related to the Nebraska False Medicaid Claims Act. The first modification would parallel recently enacted federal legislation authorizing the Nebraska Medicaid Fraud and Patient Abuse Unit to investigate and prosecute cases of abuse, neglect, or exploitation of Medicaid recipients who receive medical services inside and outside institutional settings. The second modification would authorize the Attorney General access to applicable records of any resident living in a Medicaid-funded facility when investigating and prosecuting cases of abuse, neglect, or exploitation regardless of whether that resident is a Medicaid recipient. Medicaid Fraud Control Units were authorized by Congress in the mid 1970s to investigate and prosecute the abuse, neglect, and exploitation of residents in Medicaid-funded facilities. This congressional mandate extended to all residents, regardless of whether they were on Medicaid. However, contrary to federal authority, Nebraska Revised Statute 68-945 prohibits the Nebraska Medicaid Fraud and Patient Abuse Unit from reviewing or obtaining information concerning a non-Medicaid resident of a healthcare facility without the patient's consent or court order. Reviews of legislative history of this passage does not uncover the reason for this prohibition. LB664 fixes this, making Nebraska law consistent with Congress-- Congress's intent and aligns the statute with similar provisions found in 49 other states. Thank you for your time, your attention, and I would be happy to take questions. Please note that D. Mark Collins, Assistant Attorney General and director of the Medicaid Fraud and Patient Abuse Unit will be following me, and I'm quite confident he'll have more answers than I.

HANSEN: Thank you, Senator Riepe. Are there any questions from the committee> Seeing none, thank you. We'll see you at close.

RIEPE: I'll be staying.

HANSEN: All right, good. All right. We'll take our first testifier in support of LB664. Welcome.

MARK COLLINS: Thank you. Good morning, Mr. Chairman, members of the committee. I am Mark Collins, M-a-r-k C-o-l-l-i-n-s. I'm an Assistant Attorney General and I'm the director of the Medicaid Fraud and Patient Abuse Unit in the Nebraska Attorney General's Office. The Medicaid Fraud Unit is a federally mandated law enforcement entity whose two primary responsibilities are the investigation and prosecution of cases of provider fraud perpetrated by providers of Medicaid services and the investigation and prosecution of resident abuse, neglect, and exploitation of-- that occurs in facilities that receive Medicaid funding. Our unit was created back in 19, excuse me, in 2004, and it's opened nearly 2,450 files for investigation. We've obtained 136 criminal convictions, recovered 90-- over $96 million in settlements and judgments in civil cases, and obtained another $17.3 million in court-ordered criminal restitution in our cases. I speak in support of LB 664, which makes two modifications to our state statutes regarding our ability to investigate and prosecute abuse, neglect, or exploitation that can occur with Nebraska's most vulnerable citizens. First, the bill allows the Attorney General to investigate and prosecute abuse, neglect, or exploitation of residents, excuse me, of Medicaid recipients who do not reside in an institution setting. This new authority was passed by Congress in the COVID-19 relief bill and was signed by the President back in January of 2021. Before this legislation passed federally, Medicaid fraud units were restricted to investigating cases only when they occurred in facilities that received Medicaid funding, such as a nursing home. But many residents, excuse me, many recipients of Medicaid receive their healthcare services in a manner that is designed to allow them to remain at home rather than an institutional setting. And these citizens can be vulnerable to criminal acts of abuse and neglect and exploitation in their homes. So Medicaid fraud unit staff have the knowledge, the training, experience to pursue these matters and now are federally permitted to do so. And Section 1 of LB664 authorizes the Nebraska Medicaid Fraud Unit to conduct those investigations and prosecutions. And Section 2 of the bill amends Nebraska Statute 68-945. And as I mentioned earlier, Medicaid fraud control units were authorized by Congress back in the 1970s. And one of the missions was to investigate and prosecute abuse, neglect, exploitation of residents in Medicaid-funded facilities. But that congressional mandate extended to all residents, regardless of whether they were on Medicaid. However, contrary to that federal authority, the Nebraska statute that we

operate under prohibits us from reviewing or obtaining information of a non-Medicaid resident, such as a private payer resident, of a healthcare facility without that person's consent or a court order. And as reviewed, the legislative history concerning this anomaly, we don't see a reason for that prohibition, and no other state in the country has that prohibition in their law. That prohibition hampers our ability to protect non-Medicaid residents for several reasons. A victim may not be able to consent to the release of records due to their infirmity. A victim may have a power of attorney, someone acting on their behalf, but that person may be a suspect in that crime and requesting consent from them would tip them off about the investigation. Or obtaining a court order to obtain records can waste valuable time in an investigation, especially if there's been a sexual assault or a physical injury to a resident. So LB664 fixes that anomaly. It allows our resident, excuse me, allows our units to access the records of any resident in Medicaid-funded facilities when we investigate and prosecute a crime of abuse or neglect or exploitation involving that resident, regardless of whether they're on Medicaid. The federal regulations on this matter are clear. 42 CFR 1007.11(b) states in part that a state Medicaid fraud control unit shall review complaints alleging abuse and neglect of patients or residents in healthcare facilities that receive payments under Medicaid and may review complaints of the misappropriation of funds or property of patients or residents of such facilities. The regulation makes no distinction between a Medicaid and a non-Medicaid resident. So LB664 makes Nebraska's law consistent with Congress's intent. It aligns our law with the provisions found in 49 other states, and it strengthens our ability to protect our most vulnerable citizens. For these reasons, we would respectfully request on behalf of the Attorney General that the bill be advanced to General File. I would note that I have provided the committee with my written testimony and appended to that is the federal authority that I mentioned so you can see what the federal rule says and what the language in the Code 19 bill says as well. So with that, I would be more than happy to answer any questions the committee members may have.

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

BALLARD: Yeah. Thank you, Mr. Chairman. Thank you, Mr. Collins, for being here. I'm going to ask you kind of a broad question. Can you just paint a picture? Give us more understanding of Medicaid fraud? Is it a problem in Nebraska? I know you mentioned some-- some dollar amounts from case from settlements. But just kind of give me an

understanding of the issue this is in Nebraska, just kind of contrast it with around the country as well.

MARK COLLINS: Well, we do two things. We do investigations of cases of fraud against the Medicaid program that are perpetrated, again, by Medicaid providers who overbill the system and bill for services they don't render, double bill, do things of that nature. And when the unit was founded back in 2004, there were 48 other states who had MFCUs and Nebraska didn't. And so it's only been since that time, in the 17 or 18 years that the-- that the unit's been up and running. And I've been with them for 17, that we've recovered, you know, these $100 million and have also gotten over a hundred criminal convictions for Medicaid fraud. The other thing we do is investigate cases of abuse, neglect, and exploitation of residents that reside in Medicaid facilities and hopefully now Medicaid recipients who receive services in their homes. And there have been a lot of cases, especially of financial exploitation, that occur in the nursing home setting, where a person who has power of attorney, a child, a niece, a nephew has the ability to control a resident's finances and they're spending that money. They're stealing that money and spending it on themselves, for example, rather than using it to pay for services that would otherwise be available to that resident. And there's a lot of those cases of financial exploitation in Nebraska and elsewhere in the country. It's-- it's not a phenomenon that is limited to Nebraska by a long shot. We do see cases not only of financial exploitation, but also of physical abuse. We have also seen cases of sexual abuse. And it's important with the work that we do and the training that we have that-- that we go out into the counties to do these kind of cases because they have [INAUDIBLE] at it. And so it's a-- it's a valuable service, especially to the rural parts of Nebraska and it happens out there. It's not just an Omaha problem. It's not just a Lincoln problem.

BALLARD: OK. Yeah. In your 17 years, have you seen the problem become worse, become kind of stagnant, what have you kind of? I'm just looking for trends. Just give me some insight.

MARK COLLINS: On the abuse or on the-- on the fraud side, where fraud is committed by Medicaid providers, and we only look at providers, it's Medicaid recipient fraud. Medicaid cheats, you know, that where somebody is receiving benefits and they aren't entitled to them, that's-- that's investigated by somebody else and that's in the special investigation unit in DHHS. Congress mandates us to do provider fraud. Provider fraud is a constant battle. The means by

which fraud is committed change because people who are engaged in fraudulent activity are always probing the system and looking for weaknesses in the system where they can-- where they can take advantage of weaknesses, especially in the manner in which Medicaid claims get paid, OK, because it's a largely electronic process. So the problem is always going to be there. It hasn't-- what has changed are the modes, the methods and the means that the fraud is committed. And as far as patient abuse and neglect, we see far too many cases of financial exploitation of residents that reside in Medicaid facilities. It's just amazing and it can relate back to that, you know, some of the money that a resident might have to pay for those daily needs that were expressed or talked about in-- in the prior bill, you know, and that money's not available to them because somebody has taken it

BALLARD: Thank you for being here. Thank you for your work.

MARK COLLINS: Thank you.

HANSEN: Any other questions for the committee? This bill sounds really familiar.

MARK COLLINS: It should, yep.

HANSEN: Yeah.

MARK COLLINS: Yeah, you're right.

HANSEN: I think somebody introduced it last year or two years ago.

MARK COLLINS: Yes, they did. I appreciate you carrying that for us two years ago.

HANSEN: Yeah.

MARK COLLINS: And we're looking forward to pushing it over the goal line.

HANSEN: OK, well, good. All right. Well, seeing no other questions, thank you very much.

MARK COLLINS: Thank you.

HANSEN: And we will take our next testifier in support of LB664. All right. Anyone else wishing to testify in support? Seeing none, is

there anybody who wishes to testify-- testify in opposition to LB664? Seeing none, is there anybody who wishes to testify in a neutral capacity? All right. I don't see any. Senator Riepe, if you want to come close-- he waives closing. All right, even better. All right. OK. All right. Well, with that, we did have, I believe, one letter in support from Jina Ragland from the AARP of Nebraska. And with that, that'll close our hearing on LB664, and we will open up for the next bill, which is LB13. And welcome, Senator Blood to open. Good morning.

BLOOD: Good morning. And hello to my friends yet again at the Health and Human Services Committee. My name is Senator Carol Blood, spelled C-a-r-o-l B as in boy-l-o-o-d as in dog, and I represent District 3, which is the western half of Bellevue, Bellevue and southeastern Papillion, Nebraska. Thank you for the opportunity to bring forward LB13, which seeks to expand Medicaid coverage of breast milk in the state of Nebraska. Our intent with LB13 is to address the ongoing issues of prescribed breast milk for at-risk infants covered by Medicaid. Medicaid taking on this cost to prescribe human breast milk for its clients is in the best long-term interest of the hospitals and their patients. It can be costly for hospitals, and there's no law in place which will protect patients from being charged for breast milk costs or processing fees. With this in mind, we can assure that both hospitals and patients are protected. Even if a hospital prescribes donor human milk, it is an expense that many cannot afford. The average cost is $3 to $5 per ounce, and babies can consume between 32 and 48 ounces of milk per day. In states where neither Medicaid nor commercial insurance covers donor milk, families sometimes buy unregulated breast milk online or receive donated milk from friends or family because it could be less expensive. In both cases, there is a risk of transmitting diseases or exposing infants to prescription or illegal drugs. The FDA, excuse me, actually warns against buying breast milk from unregulated banks or online marketplaces. Barriers to donor-- donor milk disproportionately affects mothers insured by Medicaid, as well as black infants and American Indian or Alaska Native infants due to their higher preterm birth rates. Even though these populations are the most likely to need donor milk, March of Dimes studies show that they are less likely to receive it at discharge from NICUs. The combination of higher rates of preterm births in black and American Indian, Alaska Native communities, combined with lower rates of receiving donor milk, put these infants at increased risk for illness and death. This is a bill that is designed for very specific infants; The infant's birth rate is below 1,500 grams; the infant has a congenital or acquired condition that

replaces the infant at high risk for development; the infant has infant hypoglycemia; the infant has congenital heart disease; the infant has had or will have an organ transplant; the infant has sepsis; or the infant has any other serious congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the infant. These morbity-- morbidities require additional expensive treatments and longer stays in the neonatal intensive care unit. The morbidities also increase the risk of long-term chronic illness, rehospitalization, and neurodevelopmental and neurocognitive delay. Human milk has been shown to reduce both the incidence and severity as some of these morbidities and therefore has an indirect impact on the cost of the NICU hospitalization for the better. Simply put, early intervention with human breast milk can mean reduced contact with the healthcare in the child's future. This also means that Medicaid potentially will have to invest less money when it comes to potential future claims for that child. This isn't a bill that will allow Medicaid to cover all costs for those who wish to purchase breast milk for personal use. This is only for at-risk infants under six months of age who have been prescribed human breast milk by a medical professional or up to one year, if deemed medically necessary. As of September, at least 17 states and the District of Columbia had enacted legislation requiring Medicaid coverage for donor milk. Indiana became the most recent state last August. Coverage varies based on the patient's length of time and settings. Coverage is required when donor milk is considered medically necessary, but states' definitions vary. For example, Illinois requires an infant to meet one of seven medical requirements ranging from low birth weight to hypoglycemia. Louisiana considers donor milk medically necessary when several criteria are met, including infant health, caregiver ability, and source of donated milk. State laws also differ in coverage period. Kansas covers up to three months of donor milk; New Jersey up to six months; and Louise-- Louisiana covers up to 12 months. Some states require either inpatient or outpatient use, and others cover both settings. Florida stipulates that donor milk is covered only in a hospital setting. Utah covers only outpatient donor milk, and New Jersey covers both inpatient and outpatient milk. Illinois, Louisiana and New Jersey recently passed legislation requiring commercial insurance coverage for donor milk. These policies also vary in the patients and settings covered and may limit coverage to milk from accredited milk banks. Breastfeeding also confers global environmental benefits. Human milk is a natural renewable food that acts as complete source of baby's nutrition for about the first six months of life. There are no packages involved as opposed to infant

formulas and other substitutes for human milk that require packaging that ultimately may be deposited in landfills. So for every 1 million formula-fed babies, 150 million containers of formula are consumed. And while some of those containers could be recycled, most end up in landfills. So based on data recently given to our office by Nebraska neonatologists, approximately 10 percent of all newborn infants are prescribed at least one bottle of donor milk. Nebraska had approximately 24,291 live births, according to the most recent census. Thirty-five percent of those births were financed by Medicaid here in our state. And so it's clear that we created a need for a prescribed option for these at-risk children. And so I appreciate all of you today for listening and hopefully helping move Nebraska forward to truly being a pro-life state by protecting our most precious resource, our children. And as our current Governor continues to preach, Nebraska's future is our children. So I'm happy to answer any questions from the committee, but I think I have several testifiers here that are more knowledgeable when it comes to the medical aspect of breast milk.

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

RIEPE: I have a question. Thank you for being here. My question is this. The-- I assume the donors are those providing the milk. Is that-- are those volunteers or are they reimbursed for?

BLOOD: I think we have [INAUDIBLE] here today maybe, maybe not, that could answer that question more accurately.

RIEPE: OK.

BLOOD: So-- but the people that-- that give the breast milk are clearly donors. I mean, it's not their child and--

RIEPE: Yeah.

BLOOD: But I don't know if there's money that passes hands or what the circumstances are, to be very frank.

RIEPE: Because it took me back to the fiscal note, which is $300,000-some in year one. I'm trying to sort through whether that was the product cost or whether that's the administrative overhead and--

BLOOD: Well, and it--

RIEPE: --delivery cost, etcetera.

BLOOD: If you look at the numbers, do you have all three pages of the fiscal note in front of you?

RIEPE: I think so.

BLOOD: Actually have the right fiscal note today so. So if you look at category one, which would be 0 to 6 months, they're estimating maybe 35 infants that are under that weight, the prescribed weight we have in the bill. They said the average length of visit is 46 days, which does not mean that they'll necessarily be getting that prescription for 46 days. But that's what they're saying, is that this many kids are born, their average length of stay in-- in the NICU is 46 days. If there was 24 ounces per day, it'd be $4.50 per ounce. So that would be the $173,880 right there for category one. Then they go to category two and category three. But the chances of it going beyond category one are pretty slim. So I think this is a fair fiscal note. But if we're worried about the fiscal note, I would just keep it clearly and at six months. And if it's deemed medically necessary beyond that, we can take-- we can amend the bill to not even say that. I think that they're-- I mean, they're saying 6 to 12 months, one unique count of patients, 12 months to 12 years, category three. I'm not sure where they're getting that in the bill. And I have to go back to the bill with a fine-tooth comb, because I'm not for sure that number is coming from because we wouldn't-- the milk is not meant for anybody over--

RIEPE: Thank you.

BLOOD: --one year so.

HANSEN: Yes.

RIEPE: [INAUDIBLE] question. Thank you.

BLOOD: So that's where the-- so wherever they're purchasing, be it Denver, be it Iowa.

RIEPE: OK.

BLOOD: Or if they are getting it from donor moms in the hospital.

RIEPE: Now, my other concern gets to is this a benefit that's provided by many or even some commercial insurance. I'm real sensitive to the fact that in some cases my perception is that the Medicaid program

itself is a gold program and is much better than many of my constituents can afford. They're resentful of that. And--

BLOOD: Fair enough.

RIEPE: -- in this committee we are faced with expanded Medicaid over and over and over and over to the point where it's-- all of us should want to be on Medicaid.

BLOOD: I guess I would counter that with children don't ask to be born into poverty. And we have Medicaid for a reason because we don't want these children to fall through the cracks, that it's not morally--

RIEPE: Children don't want to be born near poverty either. And some of those are the ones that don't qualify for Medicaid and they're struggling to come up with insurance if they don't have employer paid so.

BALLARD: Well, you're talking to somebody who's--

RIEPE: I'm a hard cold administrator I guess it's not.

BLOOD: You're talking to somebody who's self-employed and pays for her own health insurance and has thousands of dollars of medical bills coming in this month for a family member. But I can tell you that I-- I don't slight other people for having insurance that protects their families because I wish-- I wish that I had an employer, which we work for the Nebraska Legislature who doesn't give us benefits.

RIEPE: Well, [INAUDIBLE] a price.

BLOOD: You know, I hear you're saying. I hear what you're saying. Yeah, for a price that none of us can afford unless we're retired and wealthy. So I can say that I hear what you're saying, but you have-- you don't know in advance in most cases that you're going to have a child that is premature and you hope that you have a full-term pregnancy and you hope that you have a healthy child. But that doesn't always happen. And so we've kept this bill pretty narrow. And I do hear what you're saying, but I don't see people wanting to switch over to Medicaid. But that is indeed also what Medicaid is there for, because we-- is it right to allow a child to have lifetime health issues because we couldn't provide them with breast milk for a month? Is it-- is it right to allow that child to possibly potentially die, which is what we're talking about? If you look at those illnesses, many of those illnesses are issues that the breast milk is prescribed.

It's not a choice. It's prescribed by a healthcare professional. So where do we draw the line when it comes to prescriptions? Are we saying, OK, well, insulin has gone up ten times more than it was the previous year. I know you really need insulin, but we want you to cut it down by half because the cost is getting to be too much on Medicaid. I mean, where do we draw the line? We-- we have Medicaid. It's available for our children and well it should be. Children don't ask to be born into poverty. And there are definitely a lot of people that are not on Medicaid, more now that we've had Medicaid expansion and afford it. And yeah, there will always be people living paycheck to paycheck that can't afford to have good healthcare. And that's unfortunate. But at the same token, I know very few people that would fault a child for that. And that's what we're doing is we're talking about children right now. So I do hear what you're saying, but I look at the aspect is we can't keep saying we're a pro-life state and that children are our future, but say only that that family can afford health-- can afford healthcare, because that's kind of what we say when we say things like this. And that concerns me. But that's my personal opinion. I do respect what you have to say and I understand where you're coming from, but we have an opportunity to give these kids a better start. I would rather give a child breast milk than medication that may or may not work when we know breast milk, in many cases, especially gastrointestinal things, will be beneficial. They will have fewer ear infections. They will have-- you're a chiropractor, you know these things. So we know that ultimately Medicaid will pay less on their healthcare expenses if we get it up front.

RIEPE: We also find that children are used as a shield to justify anything and everything. And there are a lot of children that are born into parents that aren't eligible for Medicaid. I go back to the thing that the department or DHHS themselves openly admit that Nebraska Medicaid is one of the richer programs in the country.

BLOOD: Well, good for us that we love our children that are born in Nebraska and we want to give them a good start.

RIEPE: Tell that to the taxpayers, too. OK? Or--

BLOOD: I can tell you, having traveled the entire state of Nebraska for 14 months, that when it comes to our kids, that people want our kids to have a good start. You hear it from our own Governor's lips.

RIEPE: OK. I don't want to go any further with it. Thank you.

HANSEN: Any other questions? I have a couple of questions. Is formula covered under Medicaid? It is, isn't it?

BLOOD: I believe so, yeah.

HANSEN: OK. Because I would--

BLOOD: I will double-check that, but it would have to be.

HANSEN: And I have to mirror a little bit of what Senator Riepe is saying.

BLOOD: If-- if it's a prescribed one.

HANSEN: OK.

BLOOD: Right?

HANSEN: I don't even know if it's prescribed but I think in general.

BLOOD: So there are certain types of formula, I think that that would be covered under what is the federal program in reference to milk?

HANSEN: WIC?

BLOOD: WIC, yeah.

HANSEN: Yeah.

BLOOD: So I do know that if you have, I say a baby with a gastrointestinal issue and there are certain types of formulas that are prescribed that are really expensive.

HANSEN: Yeah.

BLOOD: That Medicaid does cover that.

HANSEN: OK. Well, I was going to say I-- I have to mirror what Senator Riepe was saying to some extent about being careful about where we spend our money. However, I would much rather give my child breast milk than formula any day, in my opinion, just because of formula, the way it's made in my opinion, is not the most advantageous for a child's health. And so I think breast milk, like what you alluded to, is-- can maybe even help cut down on some other ailments that a child might have later on. And so that's just my little clip.

BLOOD: Yeah, that's right. Senator.

HANSEN: So the question is, so $4.50 an ounce they have in the fiscal note, is that what Medicaid-- is that what we cover? Because I know--

BLOOD: That's what they're proposing that it's going to cost.

HANSEN: --there's an allowed amount. I just didn't know--

BLOOD: Right.

HANSEN: --if that was the allowable amount, OK, or if that's just in general how much it costs. I was trying to figure it out. So OK. That's all I just had a question about. Any other questions from the committee? All right. Seeing none, we'll see you--

BLOOD: All right.

HANSEN: --at the close.

BLOOD: Thank you.

HANSEN: All right. We'll take our first testifier in support of LB13. Welcome.

JULIE WAGNER: Hello. Good morning. My name is Julie Wagner, J-u-l-i-e W-a-g-n-e-r. I'm a clinical dietitian in a neonatal intensive care unit in Omaha, and I have over ten years of experience working with donor human milk as a component of medical nutrition therapy for hospitalized premature infants. With a few revisions, I would support LB13. Donor milk is an important short-term therapy for hospitalized premature and high-risk infants when mother's own milk is unavailable. It is important that NICUs have access to an adequate supply of donor milk for these fragile infants when we do not have enough of their mother's own milk. For instance, studies show that feeding donor milk confers a protective effect against necrotizing enterocolitis, a devastating disease affecting the intestines, in very low birth weight infants when compared with feeding preterm infant formula in the early days and weeks of life. The American Academy of Pediatrics recommends that donor milk be used in high-risk infants when mother's own milk is unavailable or insufficient and that donor milk base-- donor milk use be based on medical necessity, not financial status. The nutritional quality of donor milk, however, is inferior to mother's own milk, primarily due to the extensive processing necessary to ensure its safety. In the hospital, we fortify and supplement donor milk with

additional nutrients for our preterm infants, and we closely monitor growth. We transition babies off donor milk and onto an appropriate infant formula well before hospital discharge and well before six months of age. Long-term use of banked or otherwise processed donor milk, particularly without close medical management, could put infants at risk of hyponatremia, vitamin deficiencies, and growth failure. I suggest that the language of LB13 be revised to exclude donor milk coverage for infants over six months of age. Gestational age or weight-based coverage limit could also be considered to prevent excessive and unnecessary donor milk use. The majority of level II, III, and IV NICUs in Nebraska are already using donor milk for their premature and high-risk infants in some capacity, with the hospitals assuming the cost. Requiring Medicaid coverage of donor milk for these hospitalized infants would be an important step toward equal access to donor milk for hospitalized infants across the entire state. To my knowledge, seven NICUs in Nebraska are currently obtaining pasteurized, frozen, banked donor milk from various regional milk banks accredited by the Human Milk Banking Association of North America, known as HMBANA. Two Nebraska NICUs, including one large level III NICU, use donor milk from a company specializing in a different human milk processing method that results in commercially sterile, shelf stable donor milk. This is an important distinction. Shelf stable donor milk may be chosen by a hospital for a variety of reasons, including reduced labor hours required for preparation, less waste due to a longer time to expiration, and improved macronutrient profile due to specialized filtration and processing. The language of LB13 should therefore be amended to include FDA-regulated shelf stable donor milk in addition to HMBANA banked donor milk. I am grateful to Senator Blood for proposing Medicaid coverage of donor milk for Nebraska's premature and high-risk infants to help ensure more equal access across the state to this necessary therapy. I support LB13 with the aforementioned revisions to include all regulated donor milk products currently in use in Nebraska hospitals and to limit coverage to prevent excessive use. Thank you.

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

RIEPE: I have a question.

JULIE WAGNER: Um-hum.

RIEPE: And I totally agree with the advantages of breast milk over formula. I totally support that. My question would be this based on

your comment here that says that donor milk needs to be based on medical necessity and not financial status. If you had a family that was on commercial insurance and they have a $5,000 deductible and they're stressed because of all the other bills that they have, do you think the administration of your-- and I think it's an NICU, it's obviously one of the hospitals and I can probably guess-- I could-- I could give you probably two or three hospitals and be spot on. Would that administration then make some concession to that family, in your opinion, or are they going to play the hardball and say, tough, too bad, you pay it?.

JULIE WAGNER: Currently, all of the hospitals that are using donor milk in Nebraska are observing the cost and not billing the patient, regardless of--

RIEPE: You know that to be a fact.

JULIE WAGNER: Yes. I'm-- I'm 90 percent sure. I've spoken with all of the NICUs. Yes, I've spoken with all of the NICUs in the last couple weeks just to verify.

RIEPE: I appreciate the fact that you've explored that because that can be a barrier--

JULIE WAGNER: It can be, yes.

RIEPE: --to the kids that, quote unquote, of medical necessity, regardless of their insurance.

JULIE WAGNER: Right. So the-- the hospitals see the huge benefit of providing donor help to a very specific population and the cost savings in preventing all of the various conditions that providing donor milk in a specific context can provide. So right now, anyway, all of the NICUs that I'm aware of, the hospital-- in Nebraska the hospitals are absorbing the cost of the donor milk.

RIEPE: Good Thank you. Thanks for being here. Thanks for coming in.

JULIE WAGNER: You're welcome.

HANSEN: Any other questions? I'd like to ask a couple of questions, very similar to what I asked last time. Were you testifying [INAUDIBLE]?

JULIE WAGNER: I did not. I was here to observe.

HANSEN: OK. Since we test the mother beforehand, typically, and then we test the milk after, why do we pasteurize it? [INAUDIBLE]

JULIE WAGNER: It has to be pasteurized to ensure safety for hospitalized infants. You have to make sure that there's no bacterial growth, no other pathogens that-- I mean, the babies that we're giving this to are so immune compromised. It absolutely has to be pasteurized-- pasteurized or sterilized.

HANSEN: OK. I thought we tested for viruses and bacteria as well.

JULIE WAGNER: We do. But to ensure absolute safety, I mean, there's just-- I don't think there's any way around it. The way that human milk regulation is set up in the country, I-- it's just too risky to not be absolutely sure that it's been pasteurized or sterilized to be completely safe for those super high-risk infants.

HANSEN: All right. Good. Thank you. All right. Seeing no other questions, thank you for your testimony. We'll take the next testifier in support. Good morning.

ANN ANDERSON BERRY: Good morning, Chairman Hansen and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I am a UNMC faculty member and the medical director of the-- for the Nebraska Perinatal Quality Improvement Collaborative or NPQIC. However, today I am not speaking as a representative of the university. I am here today to testify on behalf of NPQIC and in my role as a private citizen with professional expertise on the value of breast milk for infants. I understand that there are ongoing conversations on how to enhance donor milk availability to the most vulnerable infants in Nebraska. As a medical director of NPQIC, I coordinate collaboration with all of Nebraska's delivery hospitals to support perinatal clinicians and serve Nebraska communities. With other public health leaders and key stakeholders, we are committed to improving healthcare outcomes for all Nebraska mothers and babies. Implementation of quality improvement initiatives to address perinatal health issues and reduce maternal and infant mortality and morbidity is a key part of this work. In fact, one of our first collaborative initiatives was to increase exclusive breastfeeding in the first days of life across our Nebraska birthing hospitals. And we have made great improvements in this for Nebraska. Breast milk is the best source of nutrition for newborns, especially for those who are ill or premature. It provides all the necessary nutrients for growth and development and contains antibodies and other

immune boosting factors that can protect against infection. Neonatologists used donor milk to-- to prevent necrotizing enterocolitis and sepsis. These are the primary indications for donor milk. According to a study published in the Journal of Pediatrics, these premature infants who were fed breast milk also had a lower risk of death and chronic lung disease compared to those that were fed formula. Donor milk is a product that is collected from mothers who have surplus supply after providing for their own infant's nutrition. It is important to understand that donor milk is a processed product and that processing degrades the nutrients present in breast milk significantly. Plastic containers bind nutrients. Antibodies and proteins are denatured fat soluble vitamins, including A, E and the carotenoids are present at levels of 18 to 53 percent of those in mother's own milk or formula. Processed human milk ends up with significant deficits as compared to mother's own milk. Donor milk is frequently used as a bridge to mother's own milk in the hospital intensive care setting, but is not an ideal form of solo-- sole nutrition for any [INAUDIBLE] need. It should be prescribed in specific medical conditions and not considered complete nutrition for general populations. I am in favor of financial coverage for donor milk for hospitalized infants who may medically benefit from it if mother's own milk is not sufficiently available. Currently, hospitals are assuming coverage for the cost of providing select high-risk patients with donor human milk when indicated. However, I strongly suggest amendments to LB13 as written to revise covered patients for donor human milk use. As LB13 is currently written, I anticipate use of donor milk would expand coverage for a greater proportion of infants who are not commonly receiving donor human milk and infants where the medical benefits of receiving donor human milk will likely not exceed the cost of financial coverage. I suggest amending the bill to include coverage for infants less than six months of age, as there is no medical evidence that this population would benefit-- or greater than six months of age, as there is no medical evidence that this population would benefit from donor milk and there is significant risk of malnutrition. I would also recommend input from a team of medical experts from across Nebraska who can work together to provide duration limitations for coverage of specific medical conditions. In example, most infants born less than 1,500 grams only receive maximal medical benefits for prevention of necrotizing enterocolitis by receiving donor human milk until they reach a certain gestational age or weight. Allowing coverage of commercially heat-processed donor human milk purchased outside an established human milk bank would also allow for best distribution of this resource in rural Nebraska. Commercially

sterilized shelf stable donor human milk is available and makes usage more feasible for medical units with limited freezer availability. Likewise, the expiration duration after opening containers of commercially sterilized shelf stable donor milk is longer than that of pasteurized, thawed donor human milk, therefore limiting waste. To best benefit Nebraska moms and babies, we need to ensure that we have appropriate lactation support, high-quality breast pumps for women with state-- women with state insurance, time to pump at work and safe places in every workplace to express breast milk. Thank you to Senator Blood for your steadfast advocacy for perinatal health. Support for breastfeeding in Nebraska is critically important as mothers strive to provide breast milk for their infants. LB13 provides an opportunity to discuss how to enhance the availability of donor milk in rural areas. Healthcare professionals like myself and the NPQIC would be pleased to work with DHHS to see how to increase the access of donor milk and improve breastfeeding rates and improve care in Nebraska. Thank you.

HANSEN: Thank you. You should have this down pat right now. I think it's like the 10th time I've seen you.

ANN ANDERSON BERRY: Are you sick of me yet?

HANSEN: No. You're getting right on almost to five minutes--

ANN ANDERSON BERRY: There you go.

HANSEN: --right away. Good. Any questions from the committee? Seeing none, thank you very much, appreciate it.

ANN ANDERSON BERRY: Thank you.

HANSEN: Does anyone else wish to testify in support of LB13? Seeing none, is there anybody who wishes to testify in opposition to LB13? Is there anybody who wishes to testify in neutral capacity? Seeing none, we'll welcome Senator Blood back up to close. And while she's doing that, I will mention that we did have 15 letters in support of LB13 and 1 in a neutral capacity.

BLOOD: Fair enough.

HANSEN: Welcome back.

BLOOD: So you may be surprised to know that I actually agree with them, this should be at six months. And actually, when we sent it up for drafting, it was at six months. So we were surprised when the one

year came down. And because we were all drinking from fire hoses this year with all-day hearings and there is quite a line to get things amended, we decided to just run with what we had. So we would be happy to present with an amendment to keep it only at six months because that was our original intent. We feel the descriptions are good in reference to the-- based on all of our research in other states and based on what we see in the NICUs, we felt that the definition as to who should be allowed the prescriptions of human breast milk are effective. We would strongly encourage DHHS to meet with our subject matter specialists to-- to better define what these children would look like and-- and maybe change the verbiage a little bit. But we wouldn't need that to move the bill forward once we amend it to six months. I can leave that up to DHHS. And DHHS does have a breast milk specialist, by the way, already, just so you know. Because as you remember when we talked about the milk bank, that we have known since, I think it was before 2014, that it used to be our report card when it came to breastfeeding was dismal in Nebraska, which is surprising to me. And so efforts were made by the-- the Legislature and by experts in Nebraska, such as many who have testified over the last few bills, to move things forward. And now we're in a much better place. But we can't let that change. And I'm glad that Senator Riepe got an answer to his question in reference to the hospitals absorbing this cost. As we know, hospitals, many are trying-- are struggling right now because they are experiencing a shortage in their workforce and they're paying more for workforce because they're bringing in nurses from other states to fill in and physicians from other states. We know that right now the state's not being very friendly when it comes to financial support, at least with the initial budget that's been presented. Excuse me. I have to cough. I apologize. Not COVID. And I just know that we can do better. This is a great bill. This is consistent. And the fiscal note drops substantially when you go back to the six months. I believe it goes to like $170,000 is what it says then and that is doable. You don't see DHHS here coming in against it. We have already discussed it, and they're very excited to continue the movement to make sure that every child has a good start in life.

HANSEN: All right. Thank you. Are there any questions from the committee? All right. Seeing none.

BLOOD: All right. Thank you for your time. This is my last breast milk bill for this year.

HANSEN: Okay. All right.

BLOOD: All right.

HANSEN: Sounds good. All right. Well, that will close our hearing for LB13, and that will close our hearings for this morning.

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

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

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

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

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

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

HANSEN: All right. Also assisting the committee is our legal counsel, legal, legal counsel, Benson Wallace, our committee clerk, Christina Campbell. And our committee pages for the, for the day are-- I lost them already-- there you go, Payton and Ethan. So a few notes about our policy and procedures for today. First of all, it's going to be kind of loud, so-- it's all right. They do their best to kind of quiet everybody outside, but when they open the doors and close them, we hear a little bit of noise, but we do our best to make sure that it's as quiet as we can so we can make sure we hear everybody who's testifying. If you do have any cell phones, make sure you please silence them or turn them off. And we will be hearing one bill today and it's listed in the order outside of the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina or one of the pages when you come 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 a note, if you are not testifying but have an online position to submit, the Legislature's policy is that all comments for the record must be received by the committee [RECORDER MALFUNCTION] system to testify today. And that's the little box right in front there. Each testifier will have 5 minutes to testify. Actually, today, we're going to narrow it down to 3 minutes. So the goal for today is to hear as many people as we can in the allotted time that we have. So we will be allowing three-minute testimony for two hours and then two-minute testimony for the remaining hour. The opposition will get one hour to testify in total and-- the supporters will get one hour and the opposition will also get one hour so we afford the luxury to both the opponents and the supporters of the bill. And at the end-- three hours, excuse me. Yeah, sorry. And then we also have neutral, neutral, neutral testimony at the end, but we are reserving that only for state agencies who come in, in a neutral position. So when you come up to testify, the light will be green. When the light turns yellow, that means you have one minute left to testify. And when the light turns red, we will ask you to end your testimony and wrap up your final thoughts as soon as you can. You might get a helpful reminder for me when the light turns red just to make sure we kind of move things along, as well. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing with this bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill for a total of 3 hours, then from those in opposition for a total of 3 hours and then followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make a closing statement if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless it's been pre-approved. And finally, we do have a strict no prop policy in the hearing today. So if you happen to have pictures or you want to bring up a prop or a sign or something else, please keep it to yourself. That way we're fair to everybody else. So with that-- oh, yes. And on another side note, we're going to do our best to make sure we kind of keep it as quiet as we can. So please, even though some people might be asking questions, the hearing is a lot to hear from people and not from the crowd. So, please, no clapping, no noise. You will get one warning if we do and then after that, I will have to ask the page to get you to leave. So when you-- when we enter people, we'll enter them from one door. And then when you exit when you're done with your testimony, we'll have you exit out of that door on that side over there, if you can, please. We'll also be kind of rotating each side.

So we'll take testifiers from this side of the room first and then we'll take testifiers from this side of the room first, after we get through the invited testimony. So both sides will have invited testimony and a different number of people. We're going to go through the invited testimony first. And this is who the introducer preferred to have testify first that might have pertinent information and then we'll go to everybody else for, for testimony on their end. So, I think I covered everything. So with that, we will start with today's hearing and it is LB574 and we will welcome up Senator Kauth to open.

KAUTH: Thank you, Chair Hansen.

HANSEN: Welcome.

KAUTH: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Kathleen Kauth, spelled K-a-t-h-l-e-e-n K-a-u-t-h, and I represent District 31 in Millard and south Omaha. LB574, the "Let Them Grow" bill, is designed to protect kids with gender dysphoria from irreversible, destructive, experimental medical procedures until they have reached adulthood. LB574 prohibits performing medical procedures or prescribing medications that alter the appearance of a child's gender. This includes cross-sex hormones, puberty blockers and a wider variety of gender-altering surgeries. I do not take the implications of this bill lightly and I recognize the emotions that exist among all the stakeholders and in this room today. As legislatures, the future and safety of our children are top priorities. It is in the interests of the state of Nebraska to protect the most vulnerable of its citizens. I believe in and support parental rights and I support the balance therein. We have laws that protect kids from abuse, exploitation and from exposure to dangerous substances like alcohol and drugs. As adults, we understand that a child's brain is not fully formed and cannot comprehend the ramifications of making irreversible medical decisions. We see this in the way that we treat children differently than adults when they interact with the criminal justice system. The intent behind "Let Them Grow" is to give children the time they need to work through the gender dysphoria and any other complicating issues they may be experiencing before they engage in radical, irreversible and damaging interventions to alter their appearance. The facts are that these novel and irreversible procedures lack sufficient long-term research, yet our country and our state are witnessing a push to encourage youths with gender dysphoria into these interventions. To this end, LB574, "Let Them Grow," prohibits puberty blockers, cross-sex hormones and gender-altering surgeries until the age of

majority in Nebraska, which is 19. One of the most disturbing aspects of the current trend with gender dysphoric youth is the risk of suicide. Parents and children are being told that a young person experiencing gender dysphoria is more likely to commit suicide. The studies that are cited are rife with flaws and weaknesses in study design. New analysis shows rather than solving the problem, medical interventions make the risk of suicide worse once all the surgeries are completed. A 30-year study out of Sweden documents how individuals who have complete gender-altering surgery are 19 times more likely to kill themselves. Once the intensity of the treatments and the surgeries are complete, these individuals are still dealing with issues that the surgeries have only made more complex. In recent years, countries that have been on the forefront of progressive LGBTQ-plus policies like Sweden, Finland and the UK have reversed their stance on gender-altering drugs and procedures for minors. Sweden now prohibits these irreversible medications and surgical procedures under the age of 18. Finland advises that under 25 not engage in them and prohibits under 18 and the UK is in the process of shutting down its largest gender clinic, the Tavistock Institute, and it has now ruled that children under age 16 cannot consent to puberty blockers. We owe it to our children to pay attention to what these countries, who are decades ahead of us on this journey, are doing and why. You will shortly hear from doctors detailing the drugs and the surgeries. They will talk about how damaging it is to the body to halt puberty. Puberty blockers can cause disruption in bone and brain development, increase body fat, possibly arterial hypertension and infertility. Cross-sex hormones can cause blood clots, high triglycerides, cardiovascular disease, high blood pressure, diabetes and destabilize certain psychiatric disorders. And those are in children. You will hear about how some of the co-existing factors such as depression, anorexia and autism that make kids vulnerable to this ideological movement and the proliferation of online pro transition sites and groups. You'll hear that the vast majority, more than 85 percent, of kids with gender dysphoria will desist if left alone in a process called watchful waiting. These children need therapy to deal with the coexisting mental and emotional struggles they are experiencing, not irreversible, harmful, experimental medical procedures. Gender services have become a very lucrative field of practice. Vanderbilt University Medical Center's Clinic for Transgender Health physician, Dr. Shayne Taylor, describes how she persuaded the hospital to "get into the gender transition game." In a video, the doctor emphasizes that gender transition is a big money maker. The costs of off-label use of puberty blockers and cross-sex

hormones reminders is nearly 10 times the amount as it is for adults. The American Academy of Pediatrics has been criticized by other organizations, such as the Academy for Eating Disorders, for their recent stance on approving medications and surgeries inappropriately for children regarding their recent approach to childhood obesity. Their independence from a financial reliance of pharmaceutical companies has been questioned. Clearly, there are financial motivations for pushing these treatments for gender transphoria [SIC] on vulnerable youth and their desperate families. Finally, you will hear from some incredibly brave individuals today and I implore you to give them your full attention. These are people who have experienced firsthand the pain of gender dysphoria, the pressure to relieve that pain through irreversible medical transitions and the devastating after effects. I am in awe of the courage these individuals show. They are targeted and attacked by those who do not support their decisions to detransition or to speak out against the process and against these experimental procedures. Thank you for allowing the "Let Them Grow" bill to be heard today. I am open for questions.

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

DAY: Thank you, Chair Hansen, and thank you, Senator Kauth, for being here today. You mentioned a study, a study in Sweden talking about 19 times-- do you perhaps have the information on where that comes from?

KAUTH: I will get it to you. The Karolinska Institute. And we have the studies.

DAY: OK. Thank you.

KAUTH: Absolutely.

HANSEN: Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Kauth. I'm sorry. First, I just want to start out by-- and I'm going to make this announcement periodically just for anybody that's watching that needs it, that you can text "start" to 678-678, in case you were needing support today during this hearing. And also you can call 1-866-488-7386, again, if you need help. So.

KAUTH: Repeat that, because [INAUDIBLE].

M. CAVANAUGH: Oh yes, thank you. 866-488-7386. For anybody that is watching at home or in this room, if you need any help today, please be sure and reach out and don't, don't do this alone. So thank you for letting me get that in. I want-- a couple of questions about how this bill kind of came to you. So oftentimes we work with advocacy groups or individuals. Did you work with anyone on bringing this bill?

KAUTH: This bill came about because in the summer, the Biden administration decided that it was going to withhold free and reduced lunch money from schools that did not have a gender inclusive policy allowing--

M. CAVANAUGH: Sure.

KAUTH: --boys to play on girls teams and boys and girls to share locker rooms. And that's how it started.

M. CAVANAUGH: But in, in the drafting of the bill and bringing it forward--

KAUTH: Absolutely. I called on different states, I called on Nebraska Family Alliance, I called on the Catholic Conference, I called on every group I could think of that had experience with this. I worked with a senator in Arkansas, Omaha-- pardon me, not Omaha, Ohio. I talked with people in South Carolina. It, it's been a long process.

M. CAVANAUGH: And a follow up to that. Sorry, I made notes on the bill, so I'm referencing them. I am more technology than paper, but-- so did you work with any healthcare entities locally?

KAUTH: See all the doctors behind me?

M. CAVANAUGH: I don't, but I assume that they are.

KAUTH: There's a lot of doctors behind me. Yes. And we, we brought in a lot of doctors to talk about this.

M. CAVANAUGH: OK. But in the drafting of the bill, because I have some questions about some of the language in the bill. And so I'm just wondering if the medical community was involved in drafting of the language?

KAUTH: They, they reviewed it. Yes.

M. CAVANAUGH: OK. I have other questions. Are you planning on closing because some of them might be answered during--

KAUTH: Yeah, I'll, I'll do a close.

M. CAVANAUGH: I think that I maybe will save those and see if they're answered during the course of this. Thank you.

HANSEN: Any other questions from the committee? All right. Seeing none, we'll see you at the close, which I'm sure will be shortly. [LAUGHTER]

M. CAVANAUGH: The jokes.

HANSEN: Jokes today. All right.

WALZ: He's so funny.

HANSEN: So just for reference, so we will be the same for both sides, the 3 hours will start when we have the first testifier. So with that, we will, we will, we will invite the first invited testimony in support of LB574. Welcome.

SCOTT NEWGENT: Good afternoon. My name is Scott Newgent. S-c-o-t-t N-e-w-g-e-n-t. My name is Scott Nugent. I'm a lesbian and I'm a trans man, but my most important role is that of a parent to three incredible children. I'm a mother and a woman who has given birth and carried life. I'm here today to put an end to the idea that medical transitioning children is about human rights. It is not. It's about money. Market research predicts that gender-affirming care will generate more than $5 billion by the end of the decade. The truth is, is that medical transition is experimental, it's dangerous and it doesn't cure anything. But convincing you it does unlocks insurance companies and governments to pay for it. We now have children's hospitals all over Europe that are halting the medicalization of children. The leading country in Sweden has shut down all medical transitioning. All of Europe is doing the same thing. They're calling it the biggest medical scandal in modern history. Yet here in the United States, we think it's about human rights. It is not. I underwent more than $1 million worth of surgeries and hormone therapies to change from Kelly, a woman, to Scott, a trans man. And I almost died in the process. In fact, I still have infections. As you can see right now, I'm suffering from one. These infections will shorten my life because these procedures are experimental. I tried to kill off the female side because I was sold a lie. I was told that I

was a man trapped in a woman's body, that my masculine traits and my strong personality were proof that I was really a man. I was told if I pumped myself with testosterone, all my self-loathing would magically disappear, remove my breasts, alter my genitalia, but I was tricked. You cannot transition your pain away. You only add to it. If only I had embraced my differences. If only the medical community would have accepted me for who I was, my wife, for who I was. We need to let these children have time to learn to love their natural bodies and embrace their differences. With gender interventions, there are no pause buttons. Ten thousand complaints against Lupron, against Precocious Puberty. Testosterone is irreversible. Males on estrogen can be permanently sterilized in four months. Are you really going to listen to or take stock in the AAP that follows the WPATH, an entity that accepts unix as a gender for children, an entity that has never held up in a court of law anywhere in the world as a baseline for care? Medical transition is experimental, all of it, except for top surgery. And that's the truth.

HANSEN: OK. I see that your red light is on. Thank you for your testimony.

SCOTT NEWGENT: I'm just going to say one more thing, and then I'll leave.

HANSEN: Briefly, is fine.

SCOTT NEWGENT: The-- fine. For you to do and do the right thing today, you will be considered a bigot, but tomorrow you will be a hero. This is wrong on every level. I've done it. I've researched it. I've talked to hundreds of transgender people. Don't do this to kids.

HANSEN: Hey, Scott. Hey, Scott. Hey, Scott. OK. Like I mentioned before, please, no applause. If I have to and I really don't want to have to, if we hear too much noise, the clerks will come and, and remove you. So, Scott, sorry.

SCOTT NEWGENT: It's OK.

HANSEN: We're going to see if there's any questions from the committee, if that's OK. Is there any questions? Yes, Senator Walz.

WALZ: Thank you, Chairman Hansen. Can you just talk a little bit about your life prior to the surgery? Like, just tell me a little bit about yourself prior to.

SCOTT NEWGENT: Why, why I decided to get it?

WALZ: Yeah.

SCOTT NEWGENT: It's a good question. It's a really good question. And here's the truth. I was 42 years old. I was a successful business sales executive, but I was married to a woman that didn't really embrace being a lesbian. And so it came at a time where, you know, we had been together for a while. And over the years, I always heard that, you know, you do this like a man, you do that like a man. It just kind of went in my ear and out the other ear. And then when the social contagion started coming in, the Jazz, Jennings and the this and the that and, you know, some some different family issues. You know, I just kind of said, hey, you know what? Maybe, maybe I was born in the wrong body. And that was just something that was just grabbed onto. And then after that, you know, being vulnerable, I, I went to a therapist, a transgender woman therapist, because I thought that would be the best thing to do. And within 5 minutes, she looked at me and said, how long have you been wearing male clothing? I was a business sales executive. I looked like Gillian Anderson. Nobody would think that I was a man. But that sentence at 42 absolutely changed my life. I won't get to meet my grandkids. This will kill me. These infections will kill me. This is serious. This is not about human rights. But that one sentence changed the whole trajectory of my life. And then I went to a gynecologist who said to me, oh, wow, you've got a nice little jaw there. Have you ever been tested for intersex? The issue is that insurance wasn't paying for it at that time, but I could write a $70,000 check. So at 42, if I'm not able to navigate through this, you think that children with an immature frontal lobe can? You're nuts. All of you are nuts if you think you can.

WALZ: Thank you.

HANSEN: Thank you. Are there any other questions from the committee? All right, Seeing none, thank you for coming. Appreciate it. All right. We'll take our next invited testifier.

MARIO PRESENTS: Welcome. Thank you. My name is Mario Presents, M-a-r-i-o P-r-e-s-e-n-t-s, and I am the director of chapters for Gays Against Groomers. We are a coalition of gay, bisexual and trans people dedicated to the protection of children from LGBTQ ideology in media, education and medicine. We support LB574 because it provides children the opportunity to grow up naturally and not subject them to untested, controversial and sometimes disastrous procedures. Children aged 8 to

14 are undergoing rapid changes in the body. An immature amygdala, coupled with elevated developmental hormones prevents the ability of foresight in teens and our society takes great measures to assure that these impressionable minds are protected. Beer commercials can't show consumption. Movies have a rating system and no one under the age of 18 is allowed into an NC-17 movie, even with a parent. Radical gender ideology is trying to convince rational, sane people that a child can choose their gender at the onset of puberty. Your bill offers protections for those with an identifiable medical condition, which everyone can agree with. I also have a medical condition in my family that presents itself in classic Punnett square fashion. My father worked hard to make sure that my condition didn't leave us permanently disfigured and three out of his four boys had the necessary medical procedures. It was never expected or assumed that the state would finance, support or take care of our medical needs. This is the assumed responsibility of a father and a family who want to see their children grow up into healthy, mature adults. Family support is the most important part of mental health, according to psychologists the world over. Perhaps this is why Thailand made parental consent a cornerstone of their gender-affirming legislation in 2013. Even for those we consider adults, without parental consent, those age 20 and younger are prohibited from receiving gender-affirming care. Anyone under the age of 18 is barred from these procedures completely. And adults who truly need this care are followed closely by endocrinologists and therapists throughout their long-term care to avoid rejection of this new identity, which is also included in their law. Never before in history have so many young people been rushed to hormone blockers, chest binders and double mastectomies as they are now. Children are not an experiment, nor will we allow them to become lifelong pharmaceutical dependents. Join history and protect the children of the future by letting them grow up into healthy adults the way that they're meant to be. Just let them grow. Thank you.

HANSEN: Thank you for your testimony. Will, will you hang on for one second? We'll, we'll see-- are there any questions from the committee? All right. Seeing none, thank you very much. All right. We'll take our next testifier, invited testifier. Welcome.

LUKA HEIN: My name is Luka Hein, L-u-k-a H-e-i-n. I was born in Nebraska and I've lived here all my life. And I'm here today, not only as someone who has been through the gender-affirming care system as a minor, but as someone who is a victim of it and is-- has been greatly harmed by it. I was a young teenager with a history of mental health issues who was groomed and preyed upon online and as a result,

spiraled into a hatred of both towards myself and my body. The medical system did not look into or seem concerned about any underlying causes that led me to distress and made me feel the need to escape my body at such a young age. Instead, I was affirmed down a path of medical intervention that I could not fully understand the long-term impacts and consequences of due to both my age and my mental health conditions. At 16, the very first medical intervention I ever had was a double mastectomy. And a few months later, I was put on cross-sex hormones, both through U-- UNMC, through Dr. Amoura. As a result of this so-called gender-affirming care, if you could even call it care, at 21, I deal with constant joint pain, my breasts are gone and I do not know if I will ever be able to carry a child someday. I will deal with these consequences for possibly the rest of my life, never knowing if they'll go away and feeling abandoned by the medical professionals who did this to me. My parents were baited with the threat of me committing suicide, despite the fact I maintained I was never suicidal. They were told, would you rather have a dead daughter or a living son? These are not the words of a medical professional, but the words of an activist. I was just a teenager who needed actual help, not surgery. I needed that chance to grow up safe and whole, but it was taken away from me in the name of gender-affirming care. I will have to live with this forever and so will the many others like me who are now stepping forward and sharing their experience with the system. Children cannot consent to being lifelong medical patient, patients. Puberty and growing up are not diseases that need to be fixed with surgery and medicine. Children deserve to know that their body isn't something that needs to be fixed. They deserve to grow up whole and they deserve to be given a chance at life as an adult before that is taken away from them by these medical practices. Thank you.

HANSEN: Thank you for your testimony. Are there questions from the committee at all? Thank you for coming. All right. We'll take our next invited testifier. Welcome.

ERIN BREWER: Thank you. My name is Erin Brewer, E-r-i-n B-r-e-w-e-r. I'm a former trans kid. I started identifying as a boy in first grade after a brutal sexual assault. And I have no doubt that if I'd had the option to take puberty blockers and cross-sex hormones, that I would have done everything I could of to obtain them, including threatening suicide. In the short term, it would have been so much easier for me to kill myself as a girl in an attempt to be a boy with puberty blockers, cross-sex hormones and surgery than to work through the very difficult feelings of my trauma. Initially, I probably would have felt better. Testosterone is a controlled substance and almost anyone who

takes it initially feels a sense of euphoria. It would have boosted my confidence and increased my energy. It would have allowed me to completely disassociate from myself as a girl and create a new persona to pretend that the horrible trauma that triggered my gender dysphoria didn't happen to me. But in the long term, it would have reinforced the mistaken belief that caused me to develop gender dysphoria, that it was too dangerous to be a girl. If I had been medically transitioned, I wouldn't have gotten the help that I so desperately needed to work through my fear and shame and self-hatred. I never would have realized that my transgender identity was a coping mechanism and I have talked to dozens of detransitioners who were not so lucky, like those sharing their story here today. I am grateful to those who helped me to understand that my gender dysphoria was the result of a sexual assault and not because I was inherently flawed or born in the wrong body. Puberty blockers and cross-sex hormones allowed children to avoid facing their problems and avoid-- and-- whether that be grappling with homophobia, struggling with autism, or trying to recover from significant trauma. It is our job as adults to give children the message that no matter how intense and how difficult their feelings are, that they can work through them without disassociating from themselves to become a different person, without irreversibly damaging themselves in the process. We know that encouraging children to run away from their pain and struggles is not a good solution, even if it makes them feel better in the short term. It is natural for children to do, to do what they can to shut down difficult feelings, which is why we have policies to stop them from self-medicating with drugs and alcohol. We need similar policies to protect children from the dangerous effect of puberty blockers and cross-sex hormones. I urge this committee to provide the children of Nebraska who are struggling with gender dysphoria the same gift I got. Please vote for this important legislation. Thank you very much.

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

RIEPE: First of all, I'd like to thank you and the other people that have stepped forward with all the courage that you've given. I guess the question-- and I don't want to delve too much, get too personal. That's not my intent. But in reading your document, it looks like you've made the journey alone. You didn't mention parents or other significant adults in here.

ERIN BREWER: I actually was very lucky. As a child, when I went into first grade and insisted that I was a boy, my teacher noticed that I

was also very aggressive in trying to act like a boy. I wanted to go into the boys bathroom and rather than affirming that I was a boy, which is what would likely happen today, she sent me to the school psychologist for assessment. And the school psychologist came up with a plan to help me to overcome the very difficult feelings I was having. So I had lots of support from loving and caring adults and I'm very grateful to that.

RIEPE: And I assume this happened outside of Nebraska. Thank you very much again.

ERIN BREWER: Thank you.

HANSEN: Are there any other questions? I have one. What's it like? And I maybe should have asked this from the first testifier, because they can shed some light on this if they had a little extra time. What's it like sharing your testimony publicly like this to the trans community as a whole?

ERIN BREWER: It has been incredibly devastating. I have lost friendships. I've lost very close family members. I've been threatened. Somebody walked up to my son and said, I hope you know that the LGBTQ community wants to kill your mother. It's been incredibly difficult. And one of the reasons that there aren't more people behind me ready to testify is that they're worried about losing their jobs. They're worried about being bullied. They're worried about their kids being bullied. They're worried about their personal safety. I've been spit on, I've been tripped, I've been called terrible names for speaking out and telling my story. It's incredibly difficult to come up here and talk about my childhood trauma. It's incredibly difficult to come up here and rehash all of that, but these kids are worth it. We love them so much and we're willing to put ourselves, our lives, our jobs, our livelihoods on the line to protect them.

HANSEN: Thank you.

ERIN BREWER: Thank you.

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

CAT CATTINSON: Thank you. My name is Cat Cattinson, C-a-t C-a-t-t-i-n-s-o-n, and I'm a detransitioned woman. I experienced discomfort around my biological sex beginning in early childhood, but I didn't learn about transgenderism until age 13 in the mid-2000s,

when I accessed my first website for female to male transgender people. After I learned about gender dysphoria, I had an epiphany. The reason I had social difficulties, was bullied and felt uncomfortable in my body was because I was meant to be born a boy. Back then, I didn't find any information on puberty blockers, which are now readily available for minor girls. I began starving myself and throwing up after meals to erase the feminine curves I was developing. As I lost weight, my health deteriorated and I was diagnosed with anorexia. Doctors were concerned, as they could see I was underweight, even when I insisted I felt fat. At no point did anyone affirm my anorexia by agreeing with me that if I felt fat, I must be correct. Why is it that later, when I told providers I felt like a boy, my delusion was affirmed? Both eating disorders and gender-affirming care, a euphemism for medical abuse, result in irreversible harm. I continued to struggle with eating disordered thoughts and gender dysphoria throughout my teens-- my teen years and early adulthood. I considered medical transition but hesitated to take testosterone because I had been a singer my whole life and my voice was an integral part of my identity. By age 28, I was desperate. I believed that if I didn't transition, I would kill myself. I now know that the transition or suicide narrative is a pervasive manipulation tactic based on pseudoscience. I came out as transgender publicly and several months later I called Planned Parenthood, who prescribed me testosterone without ever meeting me in person. Not long after that, I talked to a different Planned Parenthood doctor who wrote me an approval letter for a double mastectomy. Initially, the testosterone made me euphoric, but it wasn't long before I suffered health complications such as heart palpitations, body pain and urinary incontinence. I was so convinced that medical transition was my only option that I probably would have kept going if it weren't for a sudden voice change that robbed me of my ability to sing. My voice was and still is hoarse, raspy and painful. I thought, what have I done to myself? Hoping to heal my voice as much as I could, I stopped testosterone. I realized that rushing into irreversible changes hadn't been the right course and I also canceled my surgery and legal name change. Today, I accept that I am a woman and that is an immutable, biological fact. I am extremely grateful I was not offered puberty blockers, hormones, or surgery as a minor. If I had been, I would likely suffer from infertility, osteoporosis, brain damage or any number of unknown health issues as these interventions are experimental. No minors should be allowed to suffer permanent damage at the hands of doctors. I wholeheartedly support LB574. Thank you.

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

M. CAVANAUGH: Thank you. Thank you for your testimony and I'm very sorry for what you've been through. It's--I-- as Senator Hansen mentioned, it's very hard to come and share stories like this in such a public forum. So thank you for doing that. And I, I, I hope this does not diminish your experience at all, but I wanted to ask if this happened to you, well, in Nebraska? In Nebraska care, because we're specifically talking about what Nebraska care looks like and that's not to diminish your experience at all. I just wanted clarification on that point.

CAT CATTINSON: No, I am not from Nebraska and this did not happen to me in Nebraska, but the measures that trans activists are, are pushing for is they want it everywhere. It's ubiquitous. And kids all across the country are hearing this ideology.

M. CAVANAUGH: I understand. And I, I apprec-- again, I very much appreciate you sharing your experience and I'm very sorry for you-- what you've been through. I just needed that clarification. But thank you for being here.

HANSEN: Chris, any other questions from the committee? Seeing none, thank you for coming.

CAT CATTINSON: Thank you.

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

ATOA VAIASO: Hi. Hi. My name is Atoa Vaiaso. That's A-t-o-a V-a-i-a-s-o. I'm here to share my testimony. I started taking hormones when I was 19-- this is back in the eighties-- when I was 19. I thought I was a woman trapped-- being trapped in a man's body. So I started to pursue my journey into becoming a woman. I started taking estrogen and boosters. I started to have breasts. I started to look and feel like a woman. I lived as a woman 24/7. But as time went by, I realized this is not the life that I want to live. This is not what I want myself-- for myself. I wanted to get married and have children. I stopped taking the hormones. I met a beautiful woman. I've been married now for 23 years, 23 wonderful years. I wish I had someone that, that could have told me about consequences in taking female hormones. I thank God that I never went as far as having the operation, but I'll never have a chance to say, she's got my nose or

he's got my eyes. Yes, I don't have children of my own, but I haven't-- I have become a man because I didn't get the sex change operation. Let the children grow up to be adults and decide for themselves. When I started down this path of becoming what I thought I wanted to be, I did not have anybody to tell me the consequences I'd face. Now that I have changed my mind, I thank God that I-- for bringing me through what I've been through. I'm a living example that you can change your mind and turn your life around. Don't do to the kids what I did to my body. Don't take away from the children a chance to change their minds. Thank you.

HANSEN: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for coming.

ATOA VAIASO: Thank you.

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

TIFFANI FROST: Thank you. Good afternoon, Senators. Thanks for hearing us today. My name is Tiffani Frost and I live in Bennington. T-i-f-f-a-n-i F-r-o-s-t. I come today in support of LB574. Most people that are here today argue against this bill, saying that--sorry-- insisting that if a transgender person doesn't receive gender-affirming care, they will commit suicide. I've heard it hundreds of times. I've actually heard it from my own child's mouth. I've heard it from a therapist. I will not argue that transgender and gender dysphoric people are in a great deal of distress because they are. However, let's get to the root of their distress rather than permanently medicalizing them. My child was in therapy for years before he came out as transgender. Long before he even knew what transgender meant, he suffered from depression and anxiety. After I expressed my concerns about moving forward with permanent changes and refusing to affirm my son's identity, my son's therapist tried to explain to me that disagreeing with my child about his desire to transition, my child, my child equated that to me not loving him. You see, the therapist tried to convince me that my son's brain wasn't equipped to make decisions that will permanently alter his body. Many people that identify as transgender also suffer from a variety of a variety of mental health comorbidities. Instead of flooding children's bodies with puberty blockers, cross-sex hormones and mutilating their bodies, let's focus on providing better mental healthcare. And I'm not talking about the affirmative model of mental healthcare, I'm talking about gender exploratory therapy, instead, as the appropriate model. According to the Gender Exploratory Therapy Association,

gender-affirming therapies fall short when it comes to a list of concerns, including the idea that our kids gender id-- identities are not fixed as adolescents. Identity exploration is a normal part of a child and young adult development. So why would we introduce a medical intervention without letting that development take place? So let's get to the root of the problem and help our kids explore why they feel the way that they do. Let's get to the root of the distress. Address their anxiety, depress-- depression, ADHD, autism and the other host of, host of comorbidities that many of them face when they are questioning their gender. Thank you for your time.

HANSEN: Thank you for testifying. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here and sharing your story. I know as a parent, that's hard to go through. If this were enacted, there would be parents that felt differently about what they were being told by the therapist was the right course of action for their child. And I guess, I'm just-- on the other side of that, you were able to make the choice that you felt was right for your child. This would not allow-- afford another parent to do the same thing. Do you-- well, you don't have to, but would you want to speak to that or how you-- do you see it differently than I'm seeing it? I guess I'm just looking for some more insight.

TIFFANI FROST: My idea is that we are here to protect our children and performing experimental checks on our kids is not beneficial, whether it's my child or someone else's child.

M. CAVANAUGH: OK. Thank you. I appreciate that. Thank you for being here.

HANSEN: Seeing no other questions, thank you.

TIFFANI FROST: Thank you.

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

GREG BROWN: Good afternoon. Dear Chairperson Hansen and members of the Nebraska State Legislature Health and Human Service Committee, my name is Greg Brown, G-r-e-g B-r-o-w-n. I live in Kearney. I have a Ph.D. in the Biological Basis of Health and Human Performance. I'm a professor of exercise physiology. I'm here today to speak in favor of LB574 on my own behalf. My statement does not represent any type of statement

on behalf of my employer. From a biological point of view, human beings are either male or female. While there are disorders of sexual development that may be called intersex, which can be identified through laboratory tests, these disorders affect less than 0.02 percent of all humans and a person with an intersex condition is still biologically either male or female. Don't let anyone to try-- try to tell you otherwise. Humans are either male or female based on their biology. Gender dysphoria is not the same as intersex, but you're going to hear people who try to conflate the two. Instead, gender dysphoria is when a person has a gender identity that does not align with their biological sex, but there is no biology-based test for gender identity. You can't get an X-ray, an MRI, a CT scan or a blood DNA or genetic test to identify gender dysphoria. Puberty blockers are a class of drugs called gonadotropin-releasing hormone agonists. They cause the pituitary gland to stop producing follicle-stimulating hormone and luteinizing hormone, which then interferes with normal puberty when administered to children. Puberty blockers are not FDA-approved for treating gender dysphoria. I just can't fathom stopping the normal and healthy process of puberty in a child and then calling it healthcare. There are very few studies of puberty blockers on growth and development in children, but what those few studies show is that administering puberty blockers to gender dysphoric children does not simply pause puberty while gender dysphoria is resolved. Instead, over 90 percent of the children who are prescribed puberty blockers continue on to a lifetime of pharmaceutical treatments and surgery. However, the current research shows that even after eight years of puberty blockers and then cross-sex hormones, biologically male individuals still have more lean body mass and body height than biological females. In other words, using puberty blockers and cross-sex hormones does not cause a person to change their biological sex. And as you hear-- heard, puberty blockers and cross-sex hormones do not alleviate depression, anxiety or other common psychological comorbidities associated with gender dysphoria. Nebraska has laws to protect children from the effects of using alcohol, tobacco and other harmful substances. I encourage you to pass LB574 to protect Nebraska's children from the harmful effects of puberty blockers, cross-sex hormones and unnecessary surgeries. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? You must have done that good of a job. No questions.

GREG BROWN: All right.

HANSEN: All right. Thank you very much.

GREG BROWN: Thank you.

HANSEN: All right. We will take the next invited testimony. Maybe wait one second here.

JENNIFER BAUWENS: Give me a chance to nestle into this chair.

HANSEN: OK. You can get, you can get started whenever you like.

JENNIFER BAUWENS: OK. Good afternoon, Senator Hansen and members of the HHS committee, my name is Dr. Jennifer Bauwens, that's B-a-u-w-e-n-s. I'm a licensed therapist and a clinical researcher. I currently serve as the director of the Center for Family Studies at Family Research Council. On the basis of over 25 years of experience as a clinician providing trauma therapy to children and as a researcher investigating the psychological effects of traumatic stress, I offer my support for LB574, Let Them Grow Act. Historically, children have been treated as a special and a vulnerable class in both the psychological and research fields. Greater caution has been applied to children in light of the fact that they do not have the neurological capacity to understand life-long decisions. Thus, we've always proceeded with caution when regard to interventions for children, particularly when the evidence is weak or the research methods are in the early phases, which is the case in the, in this body of literature. What is being referred to as gender-affirming care is in direct opposition to our knowledge regarding development and our understanding of good research and treatment. Compared to other psychological disorders in the DSM-5-TR, gender dysphoria is currently being treated with the most invasive interventions connected to a psychological issue. Gender-affirming care has also created a mono-- a monopoly on treatment options, as it demands that there is only one way, only one way to treat gender dysphoria. And by comparison, I would really urge you to look at the Cochrane Collaboration website, cochrane.org. Just type in any disorder you want, but you can type in depression and you'll see a whole host of treatments that you can use to treat depression for children. But when it comes to gender dysphoria, there's actually only one way. There's only one path and that is to try to make a child to be someone else. There are a number of concerns that I have with-- both clinically and with the research and just to name a few: one, these interventions are being endorsed based on consensus, not evidence. That means the practices were voted on rather than standing on the merits of solid research findings addressing gender dysphoria; two, the success rate for nonintervention for gender dysphoria already exceeds what most psychological success

rates for most psychological interventions; and three, the research around this practice does not account for competing diagnoses or variables. For example, 45 percent of trans-identifying folks reported childhood sexual abuse. And that's from the Williams Institute, which is a LGBT think tank. And I can tell you as a trauma clinician, someone who has experienced sexual trauma, it's not uncommon for them to hate parts of their body or want to get rid of those aspects of themselves that made them vulnerable. And four, we often hear the claim that a failure to provide these interventions will increase the risk of suicide, but this approach is actually unethical and a clear departure from the practice of empowerment and self-management, which are important goals of mental health practices. These kids deserve better and we should be innovating--

M. CAVANAUGH: I'm sorry. You have the red light, if you could just wrap up your thoughts.

JENNIFER BAUWENS: Oh, I'm sorry. Yes. I would just say I, I would love to see room for innovation around these practices that kids could have multiple ways for their gender dysphoria to be treated. Thank you for that.

M. CAVANAUGH: Thank you, Dr. Bauwens. Are there any questions from the committee? OK. Senator Walz.

WALZ: Thank you. Thanks for coming today. You know, as I listened to the past testifiers, I'm just kind of wondering what, what type of opportunities have they or do people have for counseling and what barriers are there for opportunities for counseling?

JENNIFER BAUWENS: Yeah, I love my profession. I love helping children in their most vulnerable time. But unfortunately, my profession has gone off the rails. And what, what we have right now is so much pressure. I mean it's-- I feel the pressure coming out here to say, you know, coming against my field because we have an affirmation pathway. When, like I said, when you look at Cochrane Collaboration and you type in gender dysphoria, there's one meta analysis on the-- on this whole topic and yet the science is supposed to be settled. So as a clinician, there is immense pressure to go down this path of affirmation. There are many other ways that we can treat it because we know 45 percent are experiencing abuse.

WALZ: Yeah, I'm, I'm more curious on what type of opportunities are available and what are the barriers for people to have that opportunity for counseling?

JENNIFER BAUWENS: Yeah. So if--

WALZ: Is it money, is it-- can you talk to--

JENNIFER BAUWENS: Sure. I think it's primarily in-- at the get go. You come in for an assessment and if you say your issue is gender dysphoria, you're-- guess what? You're going to be onboarded to that path. But if you start saying, you know, I've had this trauma in my life, then all of a sudden, there are all these other options and opportunities for other root issues to be assessed. But if, if gender dysphoria or something of distress about, about your incongruence with your biological sex and your perceived sex or perceived gender is, then you're, you're automatically put on a different pathway and, and you're not going to find help.

WALZ: OK. Thank you.

BALLARD: I'll go next.

HANSEN: Senator Ballard.

BALLARD: Appreciate it.

HANSEN: I just do what I'm told here. So.

BALLARD: Hey, don't we all. No. Can you-- we're receiving a lot of correspondence about the potential for suicide. We're seeing a lot, a lot of emails correspondence about the potential for suicide. I think one of the testifiers even said, I'll read verbatim: that they're abated in threats of committing suicide. Can you unpack that for us through here?

JENNIFER BAUWENS: Yeah. So the first thing I'd like to say is when I first started my career, I, I was trained on a suicide hotline. And we were never, ever taught to say to someone, to plant the seed of, If you don't get X, Y, Z, then you might commit suicide. Second, I worked in this domestic violence space and we would often hear the story that-- I'll just wait a second-- we would often hear the story that, you know, maybe the person abusing-- if I-- if you leave me, I will commit suicide. So that is manipulation. I would often tell the person I was working with, you know, you can't live your life based on that

threat of suicide. Of course, we're going to assess. We care about this person. But I'm not going to live under and make all of my decisions based on that threat. Here's the problem when it comes to a family that's getting-- bringing their child to treatment and they're told, if you don't do X, Y, Z, if you don't take your child down this affirmation path, then your child is likely to commit suicide. First of all, that is an intervention. We can clearly identify there is an independent and a dependent variable at work here. The independent variable is the, the actual act of saying you are going to commit suicide. That is motivating that parent to do what you want them to do and not giving them options. I'm trained in all kinds of things: EMDR, trauma-focused CBT-- when a client comes to me, I can say, these are your options. If this one doesn't fit for you, here are a number of different paths you can go. But gender dysphoria, if you don't affirm, then this child's going to commit suicide. That, that is a bad practice. It's unethical. And it could, and it could actually-- I mean, if anyone here is a clinician, you could be reported to a board for planting that kind of seed into your client. And three, the empirical data doesn't support this claim. So here we have, we have some-- this, this bold proclamation, which the suicide literature is a much long-standing body of work, says that there are certain risk factors. We know if somebody has mental illness, if they, if they have a trauma history, if they have substance abuse, those types of things, those are clear risk factors that someone might predict that someone might commit suicide. But the suicide literature even notes that there isn't a clear package that's going to say this person will in fact, commit suicide. And here it is with, with this type of care, we have these large predictions that are just absolutely unfounded by, by the, the data.

BALLARD: Thank you.

JENNIFER BAUWENS: Sorry for that long answer, but--

HANSEN: Senator Riepe.

RIEPE: Thank you, Senator Hansen. Thank you for being here. How do we help parents as they're-- have concerns-- and all parents are concerned about their children and how that's going to unfold. Do we make sure that we get them to some individual who's maybe in a neutral position? So that if you go to the wrong therapist from the get go, you're likely to be pushed in a certain direction. So that first decision is critically important. So we need to-- I don't know how we sort through that other than through ethics, but how do we get-- help

parents out to find a, a therapist in their community that can be objective and help them work through this?

JENNIFER BAUWENS: Well, that's a really tough question. And--

RIEPE: Good.

JENNIFER BAUWENS: --and because right now, the, the fact is that if you bring a child to a therapist and you mention gender dysphoria, then the pathway is clear. So you, you don't talk about gender dysphoria. And that's, that's really-- that's sad because the, the child could be helped. But the risk is, more likely than not, they're going to be told, oh, here's what you do. Let's start the child on puberty, puberty blockers. I read some case notes not too long ago and this child had a preexisting diagnosis of autism. The mother had some OCD, obsessive-compulsive issues going on. Clear risk for-- you may be more familiar with the old diagnosis, Munchausen by proxy. None of that was assessed. It was noted. It was clear that it was there, but it was ignored. And, and the child even admitted-- here's a nine year old boy who was told that he was a female lesbian. And he, he even said, I don't know the difference between reality and fantasy. And yet, he was still put-- he was still recommended to go down this path. So, so in some-- to answer your question, there-- if you bring in gender dysphoria, you're at risk here. If you talk about other issues that are driving the child, that might be a safe-- somewhat of a safeguard. But unfortunately, the current state of the profession is going to tow this line.

RIEPE: I spent a number of years as, as an administrator over at pediatric [INAUDIBLE]so I want to back this up. Is it a failure of pediatricians of not spending more time, because I would think that they would know the history of the child. They should know and I would think that they would be more objective than if you immediately go to a therapist. And I'm asking you. Am I nuts? [INAUDIBLE].

JENNIFER BAUWENS: Yeah. That's a little hard for me to answer just because I'm not in the, in the physiological medical space. But there's certainly so many entities out there that stand to profit when we have a surgical market that's exponentially increasing based on treating those with gender dysphoria. Then we, we know that there's, there's potential for, for risk. And then also, you have to remember, the academy and all of these-- some of these groups, the AAP, they-- they're all siloed and they, they are currently buying into this way of thinking. So I also worked on an academic journal for about 10

years, so I understand the peer-reviewed process quite well. And, and I know what gets through into publication and I know what is rejected. And when there's a certain way of thinking, there's a certain discourse that's popular, we stick with that. And, you know, if you think of it, we've been down this path before. We've seen the effects of the lobotomy in the forties, right? We, we saw Yale, all these great, you know, America's prized institutions heralding the lobotomy as a great practice to help psycho-- physiological, invasive intervention to help a psychological issue. And where are we today? We're instituting these really radical interventions, physiological, physiological interventions to treat a psychological issue.

RIEPE: Professionals seem awfully quick to label something that this is evidence-based. And now-- and then it depends upon whose evidence are we basing that answer.

JENNIFER BAUWENS: Yes.

RIEPE: And it's almost like-- I'm stumbling a little bit here. It's like, you know, fact finders. And you're saying, OK, who's doing the fact finding and how-- what is their bias? Because we all have a certain level of bias.

JENNIFER BAUWENS: Right.

RIEPE: So, you know, don't believe everything you hear.

JENNIFER BAUWENS: Yes. And they're all in a room together voting based on, but based on the best available evidence, not causal evidence. This is cross-sectional data, mostly cross-sectional data. There's a-- there are a few studies here and there that are longer term. But, but as you've heard today, sometimes it takes a while for the effects of, of an intervention. That-- we know that's the case, whether it's physiological or psychological. Just the fact that you're engaging in the intervention has an effect. But we don't know that because-- about this issue, because nobody has tested that. And yet these are children. Right.

RIEPE: It's never popular for anyone in a group, we all know it. It was group decisions and so to be the outstanding one that's defiant of the group decision, is, is a stand-alone position and oftentimes, very lonely.

JENNIFER BAUWENS: Yes. It is.

RIEPE: We're glad you're here.

JENNIFER BAUWENS: Thank you for having me.

HANSEN: All right. Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here and sharing your perspective. Something that just kind of spurred a question while you were talking with Senator Riepe is this is-- this gender-affirming care. This, this approach is the national standard for care?

JENNIFER BAUWENS: Yes. This is based off of WPATH guidelines.

M. CAVANAUGH: OK. So in Nebraska, if we were to change how we approach gender-affirming care, we would then not be in compliance with WPATH?

JENNIFER BAUWENS: So, I'm sorry. What's your question?

M. CAVANAUGH: If we were to enact this legislation, we would be going in, in opposite or-- not in opposite. We would not be in compliance with WPATH's recommendations?

JENNIFER BAUWENS: Right. You'd be more in compliance with science.

M. CAVANAUGH: OK. [LAUGHTER]. OK. I'm, I'm, I'm more asking for the technical side of things.

JENNIFER BAUWENS: OK. Sorry.

M. CAVANAUGH: So thank you. That's very helpful clarification.

HANSEN: All right. I actually have a couple of questions. Can you explain what WPATH is? Are they a government controlled entity or are they a regulatory authority? Like, I hear-- I heard it a few times already today. I'm just a little unfamiliar with it.

JENNIFER BAUWENS: Yeah. They're not a government authority. They're a board that's gathered together that have, basically, trans activist a part of them and they have developed guidelines that they believe are the way to intervene for people who have gender dysphoria or, or some kind of distress about their biological sex. So those folks have come together and they've written out their guidelines and that's pretty much what's been adopted across the world. But it's not based on, on good, sound, empirical data. And every, every person, as, as Senator Kauth introduced, every, every person that starts to look at this data

backs away from the practice because it's, it's all there. If you really want to see the effects of these procedures, it's all there to see that it's not helping mental health outcomes. And we do not have the kind of data to establish a causal relationship between gender-affirming care and an outcome of robust mental health that-- it's just not there.

HANSEN: OK. I think Senator Riepe and yourself in that conversation you were having, kind of hit the nail on the head a little bit. We're starting to see, at least I think, a little bit of a trend towards like, journals, studies and journals that are kind of driven a little bit more based on a gender emotion sometimes? From both sides. I'm not saying one side or the other. The British Journal, I think, just came out with their editor, who kind of had a lot of issues with the British Journal, and then The Lancet had to retract one of their stories, I think, not too long ago with COVID. And that's a, that's a normalist thing, I think, for The Lancet. And so I had just one question for more of a historical context.

JENNIFER BAUWENS: Yes.

HANSEN: Can you explain the difference between-- or why between-- was it DSM-4 and the five with gender dysphoria? Was there a change there?

JENNIFER BAUWENS: Yes.

HANSEN: Or is it four? I can't remember which ones they were.

JENNIFER BAUWENS: Well, there's-- the-- I'll just tell you that there's been a lot of politics around the use of the diagnosis, gender dysphoria. So I believe it was in 2017, that Denmark backed away from even having a diagnosis. And some of the scholars that have written on the transgender issue have said, we don't even think that this should be used, but the Americans need insurance reimbursement, so we continue to use a gender dysphoria diagnosis. So, again, there's, there's a lot of politicking in the medical science around, around real distress, around real pain. I'm not sure if that clearly--

HANSEN: It does.

JENNIFER BAUWENS: --answered your question, but, but--

HANSEN: Yeah. I knew there was some kind of contextual or a kind of historical difference between DSMs there at one point or another.

JENNIFER BAUWENS: So yeah. And the diagnosis itself is really interesting because it's based on a lot of stereotypes you see are things that-- and that doesn't mean that-- it-- I want to qualify that. There is real distress for, for some folks. But there are also-- if you look at the diagnosis, there's a lot of wiggle room, just like there is with any diagnosis. But when you, when you look at this one in particular, there's, there's a lot of wiggle room. And the other thing that's disconcerting to me is that the observation period for this diagnosis is six months. And you look at other dis-- disorders in the DSM that we would consider are more long term or, or something that you would, you would see over time with a person, which if you're making this kind of surgical, surgical move or something that's going to impact your body for the rest of your life, you'd want to have the kind of evidence that says, oh, this is going to be stable over time. This person's not going to decide to detransition in a year. Right. I mean, hopefully we would all agree that. We'd want to see some stability in the outcome. But what you see in the diagnosis itself, it's a six-month observation time, the same for adults as it is for children. And when we look at these other disorders that are-- that have that kind of characterological long-term impact, you see an observation period of at least a year with a recommendation that the diagnosis isn't typically made until the person is 18 years old. Again, with recognition that what we already know about the brain, which is the most crucial aspects of the brain, the limbic system, aren't fully developed until a person is 25 years old. And there's really good science behind that-- 20,000 brain scans from the NIH.

HANSEN: OK. Thank you for answering my question. And I think you're right. Obviously, just in the testimony alone we've heard so far, there's a lot of distress involved with this, so you're right. Any other questions on the committee? All right. Thank you very much for your time.

JENNIFER BAUWENS: Thank you for having me.

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

JAIME DODGE: Chairman Hansen, members of the committee, thank you. My name is Dr. Jaime Dodge, J-a-i-m-e D-o-d-g-e. I'm speaking as a private citizen and proponent of LB574. Views and opinion reflect my own and are not meant to be a representative of any organization. I've been a practicing physician for 20 years and am board-certified in family medicine. And as a Nebraska physician and parent, I am for the protection of children in our state. The mental health of children is

a present crisis and children experiencing gender questioning and gender dysphoria are particularly vulnerable and in need of your help. I feel strongly that this measure will help protect them from unnecessary harm. And patients, families and clinicians cannot make informed healthcare decisions without knowing the likely benefits and potential harms of the various interventions. We have gaps in our knowledge at present as to which interventions are actually the most effective in the long-term outcomes of those interventions. This is due, in part, to a lack of a standard approach to treatment of children experiencing gender dysphoria in the U.S., as well as a lack of long-term, well-designed studies as to the outcomes of said treatments. We've recognized the importance of the assessment and care of childrens' mental health prior to any pharmaceutical or surgical interventions. Multiple U.S. medical societies agree on this. Presently however, European countries, considered pioneers in transgender care, have changed their course to emphasize psychological treatment in children and to prescribe puberty blockers only in very severe cases or to simply stop prescribing them completely. Swedish health authorities have deemed risk of treatments with puberty blockers and gender-affirming hormonal treatment currently outweigh possible benefits and we ask whether we should follow their example. We recognize that children questioning their gender are at particular risk for suicide. Seeking to intervene to improve and save the lives of those children, we must consider the research on the relationship between adolescent cross-sex intervention and mental health. We observed that since the introduction and widespread use of puberty blockers, in particularly in those states that allow greater access to those treatments, suicide rates among young people have increased. Research shows that cross-sex interventions do not provide convincing evidence of improvements in mental health, as very few studies actually make comparisons to a control group. Suicide rates remain markedly elevated above the background population after gender reassignment surgeries have been performed. The measure before you would pause our current approach and allow us to fill the gaps in our knowledge, focus care on social and emotional development and mental health and pursue further studies on the long-term effects of medical and surgical interventions. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? You're off the hook. Thank you.

JAIME DODGE: Thank you.

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

JEANNE GREISEN: Good afternoon. My name is Dr. Jeanne Greisen and I'm a pharmacist. I'm also a hormone specialist through PCCA, specializing in bioidentical hormone replacement therapy. I'm here today to provide information regarding hormone therapies, including estrogen, testosterone, spironolactone and puberty blockers. These drugs should not be used in children for gender-affirming therapy. Despite the warnings, these hormones are included in protocols at UNMC, as well as the WPATH standards of care, version 8. Gender-affirming care uses high doses of hormones. High doses can create a plethora of unwanted side effects and have detrimental effects on health. I provided you with information on the long list of side effects and risks involved with these medications. When girls are given testosterone, irreversible damage can occur, such as deepening the voice, body and facial hair growth, scalp hair loss and infertility. Emotionally, testosterone can create agitation, anger and irritability. Withdrawal can occur with abrupt discontinuation and the patient can experience major depression, restlessness, irritability and insomnia. Halted growth has been reported in adolescent boys and girls. Boys given high estrogen are at risk of blood clots, gallbladder disease, diabetes and migraines. Pediatric use and safety has not been established. What has been seen in adults can be extrapolated to children, including growth of certain tumors. Estrogen should only be used in children when clearly indicated. Of note is that estrogen use can result in short adult stature if treatment is started before the end of puberty. Both estrogen and testosterone can cause cardiovascular events, including stroke and death. Spironolactone is added to the regimen to block testosterone resulting in breast enlargement. However, this drug has been shown to be cancer- causing. This alone should be reason enough not to use in children. This drug can cause mental confusion, headache and drowsiness. Last, leuprolide or Lupron is used to stop puberty and development. The long-term effects of this drug in children is unknown, but may include a further compromise in adult stature. Although no clinical studies have been completed to determine if fertility is reversible, animal studies have shown recovery, while immature rats were shown no recovery after the medication is stopped. This class of medication can include psychological side effects of anger, aggression, depression, nervousness and even suicide. To cover the full extent of these medications would take many hours. The published data shows these medications are dangerous to use in children or the data is lacking in some cases. This type of therapy will undoubtedly create a patient for life, whether it's continuing the therapies or to treat the damages done by these therapies. Medical

professionals need to look at their oath of "do no harm." While claiming to be wise, they became fools.

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

MARION MINER: Good afternoon, Chairman Hansen 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 to express our support for LB574. As theories of sex and gender inconsistent with nature and the natural moral law are increasingly prevalent in popular culture, it is essential for the law to protect children while they develop and mature physiologically, emotionally and spiritually. Opponents of LB574 will argue that they wish to affirm the equal dignity of and society's respect for persons who feel a sense of incongruence between their biological sex and the gender with which they identify, which, of course, is often accompanied by feelings of anxiety and of being unaccepted. Love, compassion and respect for such persons who are our brothers and sisters, along with an affirmation of their equal dignity and worth, is due to them. With this affirmation, we fully agree. Pope Francis has spoken with feeling on this issue on several occasions. Speaking on what he has called the ideology of gender, he reminds us that it is one thing to be understanding of human weakness and the complexities of life and another to accept ideologies that attempt to sunder what are inseparable aspects of reality. Elsewhere, he describes this gender ideology as an expression by the contemporary world of frustration and resignation, which seeks to cancel out sexual difference because it no longer knows how to confront it. Sex is a bodily and biological reality and whether we receive it and respect it matters. Gender is how we give social expression to that reality. A healthy culture promotes the integrity of persons, in part by cultivating manifestations of sex differences that correspond with biological realities. It supports gender expressions that reveal and communicate the reality of our sexual natures. A misguided concept of gender, on the other hand, denies, conceals and distorts the realities of our nature and hinders human flourishing. Most alarmingly, it exposes emotionally vulnerable children to dangerous and sometimes irreversible wounding of their own bodies, permanently engaging in battle against what will be the life-- the body's lifelong struggle to heal itself. What LB574 refers to as gender-altering procedures are not treatments of any pathology. They suppress normal and healthy bodily development, interfere with the normal and healthy functioning

of the human body and alter or remove healthy organs and tissues. The acts themselves harm the body and heal nothing. Violations of the principles of medical ethics have been-- become more tolerated in recent years. They should not be tolerated when it comes to children, especially when the consequences can be permanent. We urge the committee, therefore, to advance LB574. Thank you.

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

M. CAVANAUGH: Thank you. Thank you for being here today. I just noticed that your references to Pope Francis are from 2016 and 2015 and not in reference to his most recent statements just days ago.

MARION MINER: Sure. Would you like me to address those?

M. CAVANAUGH: I think that would be-- give us a fuller picture of--

MARION MINER: Yeah. So the reference that Pope Francis made a few days ago was to the fact that he did not think it would be productive for countries to criminalize homosexuality. Those were the effort and those were the references that he made.

M. CAVANAUGH: Thank you.

MARION MINER: That's not what we're dealing with here.

M. CAVANAUGH: Right. Right. I just want-- I feel like-- to do justice to the Pope's views, we should make sure that we're doing justice to them and that he also says that we need to treat the LGBTQ community with compassion and not as though they are sinners. I'm not--

MARION MINER: One-- 100 percent, yeah.

M. CAVANAUGH: I'm just-- I just wanted that said for the record. And I also think this is a great opportunity, if you don't mind, for me to reiterate that anybody here today in this room or outside of this room that is struggling and needs help to please text "start" to 678-678 or call 1-866-488-7386. Again, if you are struggling, you are not alone. Please call 1-866-488-7386. Thank you, Mr. Miner, for bearing with me.

MARION MINER: Thank you, Senator Cavanaugh.

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

MARION MINER: Thank you.

HANSEN: All right. We will take the next invited testimony.

SUE GREENWALD: Hello, committee. My name is Sue Greenwald, S-u-e G-r-e-e-n-w-a-l-d. As a pediatrician who spent 35 years taking care of abused children, I'm old enough to remember when the genital mutilation of minors was considered child abuse, but that was before it became insanely profitable. In Obama-- ObamaCare in 2010, mandated the coverage of transgender procedures and at that time it affected only about one in 10,000 people. But now, every major university hospital has a transgender clinic with a menu of surgeries offered. Last year, Vanderbilt University exposed the field as a big money maker and said entire hospitals can be supported by these surgeries as they require multiple follow-ups. That means that people are not cured by these surgeries. Instead, they become lifelong patients, requiring more surgeries to fix the complications. Luring in young patients before they can understand the adult consequences keeps the profit coming in. Dissenting doctors are threatened and silenced, many of them who would otherwise be here today. Major medical associations depend on these universities for membership and, and donations, so they decided they could live with defining gender affirmation as telling a girl she is a boy and conversion therapy as telling a girl she is a girl. And in fact, the 2018 American Academy of Pediatrics report for gender-affirming care, which is often quoted by court judges and policy makers, was actually written by one doctor and approved by the same doctor and he is a gender care specialist. Planned Parenthood is selling cross-sex hormones, promoting gender ideology in schools through their CSC curriculum, which was recently thwarted in much of Nebraska. And in some states, the Planned Parenthood clinics are moving offices right into the schools, which overcomes the problem patients too young to drive themselves across town. Hormones are lifelong treatment. The younger the patient, the longer you can profit from them. And drug companies are not complaining. This windfall to the medical industry is coming from your insurance premiums and Medicaid taxes as these treatments are all mandated. Who could have guessed in 2010 that an entire industry would be created from a loophole designed to help a few disenfranchised people and starting as young as age three. In some of these clinics, a high percentage of the affected youth suffer from autism or childhood trauma. All they want to be is accepted. Some are socially awkward and they're convinced by peers that their problems will go away if they just change their body. The peer groups, both at school and online, tell them we'll accept you and we'll celebrate you, but only if you'll

change your body to, to, to comport with what we would like to see. And some teachers in those schools stand ready with a trans closet and willingness to keep secrets. School counselors are being trained to isolate the child from the parents and support the transition. The pipeline goes from school to the clinic and the family suffer.

HANSEN: All right. Thank you for your testimony. We'll see, we'll see if there's any questions from the committee here. Yes, Senator Walz.

WALZ: I, I just want to kind of piggyback off of the question that Senator Hansen had a little while ago regarding visits to pediatricians. And if, if you have a, a young person that comes to your office and talks about having social diff-- difficulties and, you know, maybe thoughts of suicide, can you kind of talk about the process that you go through with that family?

SUE GREENWALD: Are you, are you talking about a person coming in and saying they're suicidal? Is that what--

WALZ: Suicidal--

SUE GREENWALD: --you're asking?

WALZ: --right. Having the-- I mean, we've heard from, you know, four or five testifiers that we're in some deep depression. So as children coming in to see you, what kind of process do you take the family through to help them?

SUE GREENWALD: You know, in my 35 years of practice, I've never had somebody come in and say I'm suicidal. They, they are having problems sleeping, they're getting into trouble, they're getting on drugs. They're hanging out with the wrong friends. Their grades are dropping. The signs are always peripheral. It's, it's, it's not as, as cut and dried as people would like to think. I don't know if that answers your question.

WALZ: No, not really. It's OK. That's all right. I'll see if I can find--

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. As a pediatrician, you know other pediatricians. How many of your patients would come in there and, and express to you their concerns and their questions and then how do you address those in terms of what they should do, where they should go?

Do you have them come back and do you [INAUDIBLE] routinely or is it much like many pediatric offices? It's routine, this is your three month, this is your six, this is your annual, yada, yada, yada.

SUE GREENWALD: Given that I, I treated traumatized children, my practice was a little different than a lot of the average practices and, and I did address a lot of those issues. It's a off the topic, but a real challenge in our area. And Kearney is having mental health practitioners to refer those people, too. And many times, they had to be referred to someone in Omaha or Lincoln. And, you know, I retired from general practice about five years ago. And as I said, this really wasn't an issue. Transgender wasn't talked about five years ago. Gender dysphoria was an extremely, extremely rare condition five years ago. But the social contagion that we are experiencing now has made it a forefront thing. And five years ago, people talked about things like anorexia and there were other-- there are other ways that children express their anxiety than gender dysphoria. That was an extremely rare condition five years ago.

RIEPE: What impact do you feel social media has on it?

SUE GREENWALD: A huge effect because social media is ubiquitous now and kids who are depressed and isolated, they turn to social media for company. The social media, particularly TikTok, will, if a child looks up gender dysphoria or transgender or anything related, it has an algorithm to take them down the rabbit hole. And, and it's extremely damaging. And I'm sure that that-- the fact that so many children now have cell phones and access to social media is part of why we find ourselves in this position.

RIEPE: Thank you.

HANSEN: Thank you. Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Do you consider being gay to be a social contagion?

SUE GREENWALD: I'm sorry, I can't hear you.

M. CAVANAUGH: Consider homosexuality a social contagion?

SUE GREENWALD: That-- do I think that homosexuality is more likely to make children transgender?

M. CAVANAUGH: No. Do you, do you view it as a social contagion? Are people gay because it's a social contagion?

SUE GREENWALD: Of course not. No.

M. CAVANAUGH: Well, people used to think-- used to say exactly what you're saying about being transgender and so that's why I asked the question.

SUE GREENWALD: Oh. No. I mean, I mean, five years ago, who mentioned the word gender? It was you were male or female. It just-- it wasn't-- this is, this is a social construct that has been invented. And as I testified, the ObamaCare law said in 2010, that transgender procedures would be covered, but they actually didn't start being covered in 2017. So in 2017, is when all these clinics geared up.

M. CAVANAUGH: Sure. And, and, and I appreciate that's part of your testimony. I was just-- I asked and you answered my question. Thank you.

SUE GREENWALD: OK.

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

SUE GREENWALD: Thank you.

HANSEN: And I know we have a few more invited testimony to go. So, just so we make sure we have time for the general public to speak as well, I wouldn't say hurry, but we'll try to make sure we can narrow it the best we can. Especially if we've heard testimony already once before. With that, welcome.

JULIA EMERSON: Hello, my name is Julia Emerson, J-u-l-i-a E-m-e-r-s-o-n. I'm a family physician from western Nebraska. I mention that my views are my own and not necessarily the views of my employer and I have no conflicts of interest. I'd like to address today the health risk of both the medical and surgical gender-affirming treatments that are being offered to children and adolescents. So there's essentially three major experimental treatment options: first are puberty blockers, which you've heard, already spoken about today, hormones used-- basically chemical castration. They're being prescribed to otherwise healthy, gender-confused children at a age-- at a young age to block the development of male or female physical characteristics. To date, there's no sufficient research that's been

done to show the long-term side effects beyond 12 months. Short-term side effects are many. You've heard some-- osteoporosis, mood changes, depression, increased suicidality, which many of these children are already dealing with. There's also some possible slowing of brain development. The FDA recently warned about a condition consisting of brain swelling and vision loss, liver damage, seizures, heart damage, also the potential for permanent sterility when combined with cross-sex hormone treatment. So that is the second treatment option, estrogen and testosterone, which also carry a lot of risks of blood clotting, high cholesterol, weight gain, mood changes, diabetes, stroke, high blood pressure, cardiovascular disease and infertility, also increasing in certain cancers. Many of these risks are higher than at naturally occurring levels in adult [INAUDIBLE] males and females. There's no studies on the long-term effects when starting these drugs in childhood and adolescence. And finally, sex reassignment surgeries: this is permanent. And these surgeries are prone to serious complications, causing victims to be lifelong patients of a medical system that has been too quick to cater to gender ideologues. These procedures essentially remove healthy, functioning body parts to be replaced with ineffective imposters. Female-to-male surgery, in particular, is very risky. It requires making a penis and scrotum from a-- from muscles and skin taken from arms and legs. Many complications, which include a lack of blood flow to the new organ or new graft, urinary dysfunction including permanent incontinence, chronic pain, non-healing wounds, graft rejection, open fistulas, allowing urine and feces to leak into other body parts. The penis and clitoris that are formed are often nonsensory and nonfunctional. The result of reassignment surgeries is permanent sterility. The complications lead to more surgery, more dissatisfaction, regret, isolation, depression and suicidality, the very things that transgender treatments were supposed to remedy. I urge you to support LB574 and protect children.

HANSEN: Thank you. Any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you. My question is this: as a practicing physician and if you had a case, would you recommend that you do a-- I don't know whether there would be a sperm count that would be-- could be collected and frozen or eggs so that at some time in the future, maybe they want to be a parent and you can have a child who has their eyes and has their characteristics?

JULIA EMERSON: I know that, that some centers that are doing transgender reassignment surgeries do offer, you know, egg collection and sperm collection. You know, it's costly. It's not always successful. You'd have to probably have a surrogate in order to accomplish that.

RIEPE: Probably limited facilities that would be able to accommodate that as well. OK. Thank you.

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

JULIA EMERSON: Thank you.

HANSEN: We'll take the next invited testifier. Welcome.

JENNA DERR: Thank you.

HANSEN: You're good to go.

JENNA DERR: My name is Jenna Derr, J-e-n-n-a D-e-r-r, and I'm a physician. I speak on behalf of myself today and I support LB574. When I became a physician, I took an oath to first do no harm. And today I choose to speak publicly because children in our state must be protected. There are other physicians who would like to be here today, but are not because they're fearful of professional repercussions. Today, you hear testimony in opposition to this bill and the opposition may reference and quote, commonly depended upon research to support their position. I would like to quickly review two of these foundational studies that I've, I've included additional studies and an in-depth analysis for you all to review later. A pair of Dutch studies published in 2011 and 2014 are routinely cited and used to support gender-affirming care in the U.S.. These studies have significant flaws. They were funded by a personal grant to one researcher from a for profit company whose funders are undisclosed and therefore, conflicts of interest cannot be determined. The initial flaws also include the following: small sample size, lack of long-term follow up and lack of a control group. There were 70 participants in the first study and 55 in the second. Participants were surveyed upon initial evaluation at the Gender Identity Clinic prior to initiation of cross-sex hormone treatment and then after gender reassignment surgery, about one and a half years later. Participants were not followed into adulthood. That is-- thus, it's unclear how future relationships, experiences and sterility may affect their perception of well-being. Additionally, all participants underwent medical

intervention. A significant flaw is related to the measurement tool used to assess gender dysphoria, which led to the conclusion of the study that gender dysphoria resolved after gender reassignment surgery. However, the initial measurement tool was not the same as the final measurement tool, thus nullifying the results of this widely referenced and depended upon research. Another issue is that participants who experienced medical or psychological complications were excluded from the study, therefore skewing the results in a positive direction. Those who were not included as participants were simply noted to be nonparticipants. What happened to these people? Additionally, all participants were required to undergo intensive psychosocial therapy. It's impossible to determine how much of an effect this played in any positive outcomes. Likewise, there wasn't a control group who underwent psychosocial social therapy without medical intervention, which may also be helpful in determining the necessity of medical intervention, if at all. Additionally, the Dutch approach to adolescents is different from the U.S., so conclusions are difficult to generalize. The Amsterdam Gender Identity Clinic does not provide physical medical interventions before puberty, and parents are advised in watchful waiting. Adolescents are only considered eligible for puberty suppression when they are diagnosed with identity-- gender identity disorder, live in a supportive environment and have no serious psychosocial problems interfering with the diagnosis and treatment protocol. If there are problems identified that may interfere with the physical medical intervention, treatment is actually postponed. In summary, considering these two studies to be foundational and reliable is concerning at best and there are multiple reasons to be cautious. Thank you for your time.

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

RIEPE: Thank you, Senator Hansen. My question is this: it notes here, first line, which I get read through, you're a physician. Are you a family medicine doctor?

JENNA DERR: I am a family medicine physician.

RIEPE: OK. Good for you. Thank you.

JENNA DERR: Yeah.

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

JENNA DERR: OK.

HANSEN: We'll take our next invited testifier.

LINDA VERMOOTEN: Good afternoon, Senators. My name is Dr. Linda Vermooten, L-i-n-d-a V-e-r-m-o-o-t-e-n, and I practice as a clinician, counseling for 27 years, primarily with trauma. My specialty was working with childhood sexual survivors and rape. And so this comes into play a lot when we're talking about this whole gender identity, because when you begin to do the research, you find that a lot of people that are coming into this category have experienced the trauma of being raped during their childhood. So you have to ask the question, if you were raped during your childhood and often that's by someone in their own home-- a parent, the sibling or somebody close to them, is that going to infect the way that you think? Absolutely, because you're trying to defend yourself. So if I can become the gender of the one that is hurting me, that's going to make me powerful. That's going to prevent me and that's going to protect me from this ever happening again. If I become that gender, then do I, in effect, become unattractive so therefore I will not be attacked anymore? These are some of the questions that are being asked in the practice, in the setting. So we see that children are most open to suggestion. We also know that adolescents, we are fickle. We want one thing in the morning, one thing in the afternoon, one thing that night and one thing the next morning and it's not the same. There's no consistency at that age because our brains are not fully developed yet. And science tells us, is that for a woman, your brain is not fully developed until your early twenties, about 22, 24. And for men, it does not happen until age 26. Now we want to take a decision that is going to be life altering to a child for the rest of their life and allow them to make this decision when their brain does not have the capacity to think things through. There's a multiplicity of things that we don't allow children to do because we don't believe that they are mentally competent. They can't smoke, they can't buy cigarettes, they can't buy alcohol, they can't drive, they can't vote, they can't legally get married because there's an age of consent when we assume that people can make a decision and our practice and our profession does not help us. Why? There are not many more of us yet today. Because one of the things that the profession says in this whole arena is you are not allowed to speak to your client about alternatives if they raise the question of dysphoria. So when you're prevented from addressing other alternatives, what choice do you have? Not much. And it's not saying that-- we are not saying that this individual can never have a surgery, what we're saying is let them grow up until an

age when they can clearly have more mental capacity. Although their brain is not yet fully developed at age 19, they have a better, better chance of making an accurate decision. Just because we can do something, does that mean we should do something? There's a lot of children that are very suggestive, like autistic children and mismatches that are pulled into these groups and they begin to be manipulated by their peers that say, well, we accept you. If you-- you're just like us, you need to hang out with us. And they pull in all the people that don't fit anywhere else. And so then it's by suggestion and they're very open to suggestion.

HANSEN: All right. Thank you, Doctor, for your testimony. Your red light is on.

LINDA VERMOOTEN: Excuse me.

HANSEN: And now you can get a glass of water. You're fine. It's good timing. All right, we'll have to see if there's any questions from the committee. Yes, Senator Day.

DAY: Thank you. I just wanted to mention, as a woman who was a victim of child sexual assault and someone who is also neurodivergent, that we are capable--

LINDA VERMOOTEN: Sorry, I can't hear you.

DAY: --of making decisions for ourselves and sometimes conflating trauma to gender dysphoria can be really problematic for people who are watching. So for anyone who is watching, just because you are a victim of child sexual assault or also neurodivergent does not mean that you are not capable of making decisions about your own life.

LINDA VERMOOTEN: That is true. However, if your brain isn't developed, Senator, then how do you make an accurate, informed decision? As being a survivor myself, if I were growing up today--

DAY: I don't know I had a question for you. I just wanted to make a statement.

LINDA VERMOOTEN: All right.

DAY: Thank you.

LINDA VERMOOTEN: Thank you, Senator.

HANSEN: Any other questions from the committee? All right. Seeing none, thank you. And again, we'll try to remember to kind of keep our voices down if you can, please. Thank you. Welcome.

KAREN BOWLING: Good afternoon, Senator Hansen and members of the committee, my name is Karen Bowling, K-a-r-e-n B-o-w-l-i-n-g, and I serve as the executive director of Nebraska Family Alliance. We support LB574. When a child is struggling, she needs compassionate care that supports human flourishing for a lifetime. We recognize this is a difficult issue for families and believe that every child has intrinsic value created in the image of God and must be treated with dignity and respect. There has not been adequate research on the use of puberty blockers and cross-sex hormones. What we do know reveals that there may be long-term, even potentially irreversible consequences to which children are not ready or able to meaningfully provide consent, both legally and cognitively. The first [INAUDIBLE] of medicine is do no harm. LB574 is reasonable, thoughtful public policy that ensures Nebraska's children receive help when needed without permanent harm. Treatment, not transition. Minors in Nebraska are not eligible to make other life-altering decisions, as previous testifiers have stated. Regret is real. Many transgender identified people eventually discover transitioning does not solve the distress they feel about their bodies and they make the decision to return to identifying as their biological sex. They often explain they were never offered comprehensive psychological care before they were referred to for puberty, puberty blockers, hormonal care and medical procedures that could not be rectified when they changed their minds. Keira Bell, now 25 years old, had a similar journey and on December 1, 2020, won a lawsuit against Gender Identity Development Service. Bell claimed doctors should have challenged her more about the decision to transition before starting medical treatment as a minor diagnosed with gender dysphoria. Puberty blockers are associated with significant neurological and bodily harms. They have been observed to increase depression symptoms and harm bone development. And see my noted citations. Nebraska has a compelling interest in protecting its citizens from harm, particularly our children. This is why child welfare laws, child labor laws and worker health and safety codes exist. LB574 addresses a child safety issue and it's our duty to protect every precious boy and girl. Nebraska kids count. Thank you for your time. I'll take any questions.

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

M. CAVANAUGH: Thank you. Thank you for being here. In your testimony, you stated that, that they often explain they were never offered comprehensive psychological care. Who is, who is they? Who are you referencing?

KAREN BOWLING: Why, thank you, thank you, Senator Cavanaugh, for that question. And as some of our previous tran-- people that now identify as detransitioners, they, I think, explain very thoroughly that currently, a lot of the prescriptions that are to be given and advice--

M. CAVANAUGH: Sorry. My, my question is who is the they you are referencing?

KAREN BOWLING: Mental health providers.

M. CAVANAUGH: So, I mean, are you, are you referencing children in Nebraska?

KAREN BOWLING: Yes. So I will just tell you-- thank you for clarifying your question, Senator. It is a common question and call that we get to our office. Do you have counselors that you can refer to us? Are-- we're in a situation as a family and we understand how difficult that is as a family because they want another counselor, because who they went to only offered one advice.

M. CAVANAUGH: And then do you, then do you refer them to another counselor?

KAREN BOWLING: Yes. If we have opportunity, we absolutely-- if we've been invited to do so, we do.

M. CAVANAUGH: OK. And then you mentioned someone by the name of Keira Bell. Is this person from Nebraska?

KAREN BOWLING: She, she is not from Nebraska.

M. CAVANAUGH: OK. I'm trying to, I'm trying to decipher from our testimonies what has happened in Nebraska. So that's why I'm asking these questions about--

KAREN BOWLING: I will note, Senator Cavanaugh, I think that is really important and some of our detransitioners here today are from Nebraska--

M. CAVANAUGH: Yes.

KAREN BOWLING: --but were not asked. So thank you for clarifying that.

M. CAVANAUGH: They mentioned that they were from Nebraska, so I didn't feel that--

KAREN BOWLING: Thank you.

M. CAVANAUGH: --I guess I, I, I am trying to clarify when, when it's not clear to me, but OK. So, so your organization does refer families that are seeking-- that have been informed that their child may be experiencing gender dysmorphia and they want to seek a different type of care than what's initially been offered to them. They reach out to your organization and you are able to refer them to a, a mental health provider that, maybe, more suits the needs of the entire family?

KAREN BOWLING: Whenever we can, we do. It depends upon the request of the parent.

M. CAVANAUGH: OK. But you are able to?

KAREN BOWLING: We do have-- it is very limited here in the state of Nebraska, unfortunately.

M. CAVANAUGH: The number of providers or?

KAREN BOWLING: The care that families may be requesting.

M. CAVANAUGH: OK. I just want to make sure that when families are-- and we heard from a parent that they were not in line with the, the, the advice that was being given, given to them. And a lot of this particular bill is over parental control and healthcare decisions. And so I just want to make sure, and I think I'm hearing from you an affirmative, that when parents are getting counseling that they don't feel is appropriate for their child, that they have another avenue and that they have actually turned to your organization to help direct them to that mental healthcare that they feel is more appropriate for their family and, and I think that you're saying yes. Does that seem like we're, we're understanding each other? OK.

KAREN BOWLING: I understand where you're coming and my answer is it's just as I stated, whenever we can. I will be honest with you, Senator Cavanaugh, the pool to, to come from is not as easy as I thought it would be--

M. CAVANAUGH: Sure.

KAREN BOWLING: --in this current culture.

M. CAVANAUGH: We have, we have a workforce shortage and everything.

KAREN BOWLING: Yes.

M. CAVANAUGH: So thank you for your testimony.

KAREN BOWLING: Thank you.

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

KAREN BOWLING: Thank you.

HANSEN: We'll take our next invited testimony.

DAVID BEGLEY: Good afternoon. My name is David Begley. D-a-v-i-d B-e-g-l-e-y. I'm an attorney in Omaha and I was educated by the Society of Jesus in Omaha. In his "State of the State" address to the legislature, the Oklahoma governor said, we must protect our most vulnerable, our children. After all, minors can't vote, can't purchase alcohol, can purchase cigarettes. We shouldn't allow a minor to get a permanent, gender-altering surgery in Oklahoma. To that, I would add no puberty blockers. The New York Times likes to think of itself as the paper of record in the United States. Most people would agree with me that The New York Times is one of the most liberal organizations America-- in America today. So I took note when The New York Times published a story on November 14, 2022, which stated, quote, concerns are growing among some medical professionals about the consequences of the drugs and, quote, There is growing evidence of potential harm from puberty blockers. The bottom line here is that puberty blockers to minors is experimental. After World War II, the civilized world agreed that it was unethical to perform medical experiments on humans, especially on children. General George Marshall was one of the leaders of the military in World War II and thereafter. He was a five star general. He made many life-altering decisions there as general, as Secretary of State. And he would ask himself, what if I am wrong? And I would submit that the doctors that are doing this stuff and their parents that are consenting to this, they need to ask themselves, what if I am wrong about this decision regarding my child? Now I attached to my testimony some questionnaires, which are on the website, Nebraska Medicine. I presume that they were giving puberty blockers at Nebraska Medicine and possibly doing gender reassignment surgery. We

heard from someone here today said that it is going on. And I'm calling on the Attorney General or the State Patrol to investigate and if Nebraska Medicine performed medical experiments on children, those people need to be fired. And, and I would submit to you that if they have informed consents in their file signed by their parents, that's legally ineffective. You can't consent to your kid to have irreversible, permanent physical damage. That's just legally ineffective. So, as others have stated, the state of Nebraska has a compelling interest in protecting children, minors from medical experimentation that can cause permanent physical harm. You've heard all from the other doctors, bone problems, brain development-- it's just-- this is just morally evil. It's got to be stopped. Thank you.

HANSEN: Thank you for your testimony. Any questions from the committee? Senator Riepe.

RIEPE: Senator Hansen, thank you. My only question is, what's your line of specialty as an attorney?

DAVID BEGLEY: Well, I've, I've done a lot of things. I actually did medical, medical malpractice defense, commercial litigation. Right now, I'm doing elder law and estate planning, but I, I still do some other litigation in real estate.

RIEPE: OK. Thank you.

DAVID BEGLEY: Thank you.

HANSEN: Any other questions? Seeing none, thank you. All right. We'll take our next invited testimony, please. Welcome.

JEANETTE COOPER: Good afternoon. My name is Jeanette Cooper, J-e-a-n-e-t-t-e C-o-o-p-e-r, and I'm here to support LB574 on behalf of Partners for Ethical Care, a secular, nonpartisan, all volunteer nonprofit organization. I am a mother. It is the greatest fear of every parent to outlive her own child. It makes sense for a parent to choose transition when they are faced with that choice from unethical and misinformed professionals. It makes sense for a mother to choose a sterile desexed child over a dead child. It makes sense for a parent to consent to the removal of healthy breasts, rather than the removal of her daughter's body from the morgue. But if an therapist, social worker or doctor gives you or anyone else this scenario and implies that if you do not consent to these harmful interventions, then you'll be responsible for your child's death, I want you to report them to

the State Licensing Board for unethical care. I have had parents do so. This form is on the state's website. Citizens have a duty to assist the government in one of its major roles: to regulate licensed professionals. This is what this bill is about. The government is in charge of protecting consumers from unethical practices and unscrupulous providers of any product or service. That is what this is about. The suicide myth assumes only two options: transition or suicide. It is a false dichotomy. There is always more than two options. But stopping normal puberty, administering cross-sex hormones and removing healthy body parts should never be an option. I have run an online group of thousands of parents, some of whom are in this room. And they do not affirm their child's transgender identity. Rather, we support our children's social, emotional, psychological and physical needs as human beings. And every day, we have more and more reports of children who have desisted from their transgender identity. We let our kids wear what they want, cut their hair any way they please. We are liberal like me and conservative. We are atheist, like me and religious. We are diverse. I am not aware of any children of parents in our group who have committed suicide because they were not affirmed. In other private online groups that I personally am in, we read accounts of parents who affirmed their child's transgender identity, but their children still committed suicide. I have read many. The promises of transition joy did not save their lives. It was snake oil. What actually helps children who are struggling with psychological distress and has the best evidence is cognitive behavioral therapy, or CBT, which would address the emotional reasoning that their children are using. Emotional reasoning is saying that because I feel something, it must be true. Feeling like a girl is an example of this. That's why the affirmation model doesn't prevent suicide. It's a feeling in somebody's mind. There's nothing physically wrong with their bodies. When my daughter expressed thoughts of suicide, I spent a full day with a suicidologist. Suicide is complex. It doesn't involve legislative testimony. That will never cause someone suicide. I learned that, in order to have a completed suicide according to Jack Klott, a suicidologist with over 45 years of experience, a person will have all four of these things: one, hopelessness; two, aloneness, isolation and a feeling of abandonment; three, self-hatred; and four, the inability to cope.

HANSEN: I, I hate to cut you off. You're, you're going for it, but the red light is on, so sorry. Are there any questions from the committee? OK, Seeing none, thank you for your testimony. We'll take the next invited testifier. Welcome.

RUSS BARGER: Thank you. Thanks for having us here today, committee and Senator Hansen. My name's Russ Barger, R-u-s-s B-a-r-g-e-r. I'm an attorney here in the state and my entity is-- or my testimony is my own. I'm not operating on behalf of anyone else. LB574 provides additional legal protection to children. You know, as I sit here watching this testimony and thinking about what you have to deal with, there's two words that come to mind-- courage and duty. Not only you, but the rest of the body are going to have to summon both of those things to do the right thing. Nebraska's elected officials have a right and a duty to protect minors' health and safety. It's clear from the case law that states have the final say as to the parameters of health and safety of their citizens. That includes setting out the standard of care. Well, a couple of things that I need to mention to the committee that maybe you haven't heard yet, as there's probably going to be things from the opponents talking about how other states have enjoined parts or entirely the laws that'll be similar to this. You still have to summon that courage to do the right thing. Some of the things you're going to need to do are have appropriate statements of fact to support whatever your final statute looks like. Arkansas had a great set of findings of fact to protect them. Let me read to you from a recent Eighth Circuit Court of Appeals decision where they enjoined part of Arkansas' similar statute: a minor born as a male may be prescribed testosterone or have breast tissue surgically removed, for example, but a minor born as a female is not permitted to seek that same medical treatment. Because the minor sex at birth determines whether or not the minor can receive certain types of medical care under the law, this statute discriminates on the basis of sex. That's under Brandt v. Rutledge. That's an Eighth Circuit decision. We are under the Eighth Circuit. Nineteen states' attorneys general are opposing this decision. Its lack of logic is breathtaking to me. What this reminds me of as I watch this play out, is our partial birth abortion battle over a decade ago. Partial birth abortion proponents use similar industry-driven experts to strike down Nebraska's partial birth abortion ban. The industry experts claim theoretical instances where the D&X procedure was the only one that was available and necessary for certain women. They couldn't really identify any of them, but they said it could happen. Later, Congress made factual findings saying D&X was never necessary and the Supreme Court upheld the federal version of that law. You need to make sure that you have the correct statements of fact to support [RECORDER MALFUNCTION] You have people who are sterile. You have people who are irreversibly harmed. I need you to do the right thing. Thank you.

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

JOSEPH MULKA: Hello. Thank you, Senators. My name is Joseph Mulka, J-o-s-e-p-h M-u-l-k-a. I've been a practicing physician in Lincoln for 11 years, board certified in physical medicine and rehabilitation, as well as holding a doctorate of biomedical engineering. My wife and I have eight children. I am here today offering my own testimony for myself. It does not reflect the views of my employer. I'm here today to give my support to LB574. The state of Nebraska prohibits any person under the age of 21 to consume alcoholic beverages and prohibits any person over the age of 21 to provide alcoholic beverages to a person under the age of 21. As a physician, this law implies to me that the state of Nebraska views persons under the age of 21 as not having reached an age where they are capable of making the decision to consume a substance that has the capacity to alter the future course of their life through the potential physical consequences of death or disability to themselves or others, or the potential legal consequences that possible felony charges could have on their ability to pursue certain careers. In this way, the state of Nebraska and its laws seeks to protect the vulnerable from making life-altering decisions until they have reached an age at which they are fully capable of discerning all of the possible consequences of their actions. Senators, I believe that we, as representatives of the people of Nebraska in law and medicine have the responsibility to provide the same level of protection to children seeking medical treatment that will permanently alter their bodies, affect their ability to father or mother or child, or potentially set them up for numerous medical complications relating to unnecessary and major elective surgery. In my medical practice, I have countless patients relate to me that they regret certain decisions they made in their youth out of ignorance that have affected their life as an adult. These are primarily in relation to musculoskeletal conditions and consequences related to obesity, which pale in comparison to the potential anguish, depression, and anxiety that may stem from altering certain characteristics of their appearance or sexual functioning in the same way that the laws of the State of Nebraska protect children from having persons provide them with alcoholic beverages. We, as representatives of the people of Nebraska, should protect our children from parents or legal guardians who would consent to having these permanent, body altering medical procedures performed on their children. As a community, we are raising the next generation of

Nebraskans. I support LB574 because as a physician, I believe it to be a moral and ethical duty to do so. Thank you very much for your time.

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

JOSEPH MULKA: Thank you.

HANSEN: And just for everyone's, just so everyone kind of knows, the hearing Room 1510 is now open as a second overflow room. I know we have one overflow room currently and it's pretty warm in there. I just stepped in there for a little bit and it's like an oven. So in case you want to get out of there and go somewhere different. And for everybody in this room, but also everyone watching on TV here in the Capitol, Room 1510 is now open as a second overflow room if you want to go down there. All right. And with that, the next invited testifier. Welcome.

STEPHANIE JOHNSON: Thank you. My name is Stephanie Johnson, S-t-e-p-h-a-n-i-e J-o-h-n-s-o-n, and I am here on behalf of Nebraskans for Founders' Values. I just-- thank you, Senator Hansen, and the rest of the committee for the opportunity to come speak. I am just really a proponent of this bill and honored just to be here to protect our children from this. According to reuters.com that was published in 2021, the number of children ages 6 to 17 identified with gender dysphoria has quadrupled. And that was from 2017 to 2021. And from ages 6 to 17, the number tripled that were children using hormone therapy, hormone blockers. Want just tell you a little bit about myself, I have-- there's so much research, but you've heard so much today. Because of all of this going on in our society, a situation in my own life has brought back to my remembrance from when I was 12 years old and I asked my mom about it two years ago and all this was escalating and there were gender clinics popping up all over the country and all these children and little girls wanting to become boys. And I asked my mom if she remembered when I was 12 and I was doing sit ups every night. I would go run around our block as fast as I could. I was a tomboy and I was very underdeveloped, and I was proud of being a tomboy. And I did not-- I saw my friends starting to go through puberty and getting breast and getting-- they were developing. I was not. And I didn't want to. And so I was doing all these things to try not to go through puberty. And I held it in and it scared me because I thought, what is wrong with me? And I remember going up to the kitchen and asking my mom and telling her the truth about why I was doing all the things I was doing is because I didn't want to go

through puberty. I, I liked being a tomboy. I played with all the boys at recess. I did all of that. And she said, Honey, let's talk about it. We did. She said, you're athletic. You're a tomboy. And I was. Fast forward until I was, you know, 14, 15, I started liking dresses. I started being able to fix my hair, wearing makeup. But guess what? I put on my baseball hat and I would go out to the field and I would do all the things. I'm from western Nebraska. So I had my tomboy side and I had my girly side. And if I were to tell that story right now, as a 12-year-old little girl in front of the propo-- the opponents to this bill, I would be a perfect candidate for gender dysphoria. I would have had gender dysphoria. And I, I don't know what the damage would have been done to me. I would have agreed to it. I tell you that right now, hands down, I would have agreed to it because I didn't want to become voluptuous woman. So I just want you to consider that and save little girls like me who just need a time to grow. Consider that, please. And don't give them experimental drugs that will change their life forever. So let them grow. Thank you.

HANSEN: Hang on for one second. Got to stop you, sorry.

STEPHANIE JOHNSON: Yes, sorry.

HANSEN: We'll see if there's any questions from the committee. Any questions from the committee? OK, well, seeing none, thank you.

STEPHANIE JOHNSON: All right. Thank you.

HANSEN: All right. We'll take the-- should be the last invited proponent testimony, if there is one.

_____: Proponent or--

HANSEN: Proponent, yep. I don't know if we have any more invited testimony. I just want to make sure if we have any more invited testimony. It looks like we don't. OK, good. All right. So now we'll take the next proponent. We'll take from this side of the room first, the next proponent testifier. All right, we'll get started here in just a second. Let's kind of settle down here a little bit. And in case there are some people who did testify, if they want to go in one of the overflow rooms they're more than welcome to and open this up a little bit or they can stay here. I think we're doing pretty good so far. I think we're just about ready. OK. And if I can say one more thing, just a pet peeve of mine. When we stand up out of the chairs, the things tend to smack in the back of it, and we can hear it pretty

loud. So if you can, just maybe hold on to the chair when you kind of get up, that might help cut down on some of the noise, though, so. All right, we're all ready to go. All right. Welcome.

PAUL EHERNBERGER: Thank you. Welcome. Hello, Senators. I'm a retired man who was in a career of marketing. And my name is Paul Ehernberger from Rogers, Nebraska. Children in Nebraska need LB574, the Let them Grow Act to be passed.

HANSEN: If I can interrupt you really quick, can you spell your first and last name for us for the transcription?

PAUL EHERNBERGER: Oh, yes. Paul, P-a-u-l, Ehernberger, E-h-e-r-n-b-e-r-g-e-r.

HANSEN: Thank you.

PAUL EHERNBERGER: Thank you. Well, we really need this. The legislation is necessary to prevent children and teenagers from doing physical, emotional, spiritual, and psychological harm to themselves that they will regret for the rest of their lives. At our local city council meeting last night, I learned that Nebraska youth cannot legally buy or smoke cigarettes until age 21. Adults who sell cigarettes to minors are subject to criminal prosecution. Likewise, the lucrative industry that provides puberty blockers and hormones to children or perform surgery on sex organs of minors should not be able to fabricate a market that fills their coffers by deceiving Nebraska families. Legitimate gender dysphoria is not a new thing, but the fad for teenage girls to mutilate their bodies this way is a new thing. A century of extensive research revealed that only one out of 10,000 children suffered from gender dysphoria. That's like finding a needle in a haystack. If you tried to lift 10,000 pennies, you would feel the weight of 55 pounds. Compare that to the weight of just one penny. That's the ratio we're talking about here. True gender dysphoria is extremely rare. One hundred years of scientific research has shown that when you do find a case of truly natural gender dysphoria, it's almost always a small boy, and that boy has a 70 to 90 percent chance of just naturally growing out of it. But we now face a craze for up to 30 percent of teenage girls reported in a single class to seek self-worth through gender transitioning. In the past decade, university hospitals offering these services to minors have sprung up all over the country, including Nebraska. Do no harm. The overall marketing of this social phenomenon appears to be systematic and lucrative for many industries. I've seen books for small children in

my hometown rural library that would groom little girls to become victims of this social phenomenon. Do no harm. Social media has fueled this craze for teenage girls.

HANSEN: Paul?

PAUL EHERNBERGER: Yes.

HANSEN: Your red light kicked on.

PAUL EHERNBERGER: Oh, sorry.

HANSEN: Sorry. Nope.

PAUL EHERNBERGER: Well, you know my position.

HANSEN: Yep. Well, this is good.

PAUL EHERNBERGER: I appreciate the time.

HANSEN: Glad we could hear from you.

PAUL EHERNBERGER: You can read the rest.

HANSEN: So wait one second just to make sure if there's any questions from the committee. Seeing none, thank you very much for coming. I apologize in advance if I have to cut you off. I feel bad doing that, so. Welcome.

KATHY WILMOT: Thank you for this opportunity. And I want to thank the senator for bringing this bill. My name is Kathy Wilmot, K-a-t-h-y W-i-l-m-o-t. I want to make it clear I'm speaking on my own behalf and also on the behalf of Nebraska Eagle Forum, which is an organization that has worked for decades to protect our children and our constitutional rights and our families. And we definitely need this bill. I'm going to walk away from my testimony because you've heard it all today, but I want to encourage you and the fact that our children are the future of this nation. And we need that future. We're looking to each one of you to protect them. And it's critical they can't change this. I faced a major medical issue myself. And I know that the doctor was very careful to outline to me every option that I had, not just one. And then he let me know what the results of each one of those possibilities would be for me. And then I went home and had to wrestle with what's the best decision I should make? And you just couldn't tell what that best decision was. And that was as an adult.

And I'm going to tell you, that was difficult. And these children are not, our youth are not able to make those decisions and understand the implications. I don't understand parents that jump at these ideas without fully researching. I feel bad for those children because they deserve every option that they can get, but we need to protect them until they're old enough to make those decisions. So I hope you'll support this bill. Thank you.

HANSEN: Thank you for coming. Any questions from the committee? Seeing none, thank you. And we'll take the next proponent testifier. Welcome.

DOUG KAGAN: Good afternoon. Doug Kagan, D-o-u-g K-a-g-a-n, Omaha, representing Nebraska Taxpayers for Freedom. Our group oppose a state taxpayer funding for gender altering procedures for individuals under the age of 19 for several reasons. These procedures are cosmetic or enhancement in nature, not compelling medical ones. It is not cost effective because the few receiving such treatment does not warrant taxpayer funding. These surgeries cost up to an expense of $50,000, not counting accompanying drugs and hormone treatments. We believe that allowing state funding will force taxpayers eventually to pay for similar procedures like elective cosmetic surgeries on other parts of their body or even race alteration surgery. Furthermore, the Biden administration is allowing federal dollars to pay for sex change surgeries with accompanying chemicals that can permanently damage bodies. This administration endorses these procedures on minors without parental consent. LB574 would serve as a bulwark against this arrangement. An increasing number of states prohibit direct or indirect use of public monies granted or paid to entities and personnel that provide gender changing procedures. Bills in four states, including neighboring Missouri, exclude such surgeries as a tax deductible healthcare expense. A host of reputable medical authorities here today already have categorically stated that these procedures can cause serious medical and psychological trauma. So I'm going to skip the rest of that paragraph. And in conclusion, we believe use of taxpayer, taxpayer dollars unwarranted and urge you to advance LB574 out of committee. Thank you.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you very much. We'll take the next proponent testifier. Oh, we'll take one from the right side. You're right. Yep. I've learned to go back and forth, otherwise everyone just starts looking at each other and confused, so. All right. Welcome.

DENISE BRADSHAW: Welcome. Thank you very much for your time, Senators. My name is Denise Bradshaw, D-e-n-i-s-e B-r-a-d-s-h-a-w. I came down today to testify to a story very similar to Stephanie's. Growing up, I was a ferocious what they would call then a tomboy. I really hated being a girl. It grossed me out so much, I couldn't think of anything more mature than gross, but it just grossed me out so much to be a girl. I am so grateful that I had a mom that didn't suffer from this variant Munchausen syndrome that seems to have overtaken so many parents. They stood by me. They didn't-- even though they did not understand me, they stood by me and knew that the pre-teen and teen years was just a time of great change, a lot of emotion, and a lot of insecurity. But they never wavered in their love for me. And they let me just be and figure it out on myself. I was so lucky. I grew up to be the person I am today. A mom and a woman who went on-- has worked for women's rights over the years many, many times. I am grateful for what I went through. It brought me here today to explain to you that not all dysphoria needs to be surgically fixed. It needs time to heal. And please give these children that time to heal. I was lucky enough to have parents who gave me that. Maybe others aren't that lucky. But surgery isn't the answer. Give the children time to heal and to grow. And that's all I have. Thank you very much.

HANSEN: Thank you for coming.

DENISE BRADSHAW: You bet.

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

DENISE BRADSHAW: Thank you.

HANSEN: We'll take the next proponent testifier from this side. Welcome.

MICHELLE BALES: Thank you. I'm Michelle Bales, M-i-c-h-e-l-l-e B-a-l-e-s. I'm here today to support LB574. I am from Nebraska. My children are from Nebraska. Senator Cavanaugh, this is my story. I would like to add something you and the mainstream are acknowledging. Until very recently, the majority of individuals experiencing gender dysphoria had been sexually abused in some way. We must be willing to look at the root cause if we truly want to help our kids. This is relevant to my story. I am the mother of four daughters, three of whom have decided to join the LGBTQ community. It started when my third daughter was in sixth grade. She went to a friend's house for a sleepover where she was introduced to pornography, which is a form of

sexual abuse. A year or so later, she got involved in a sexually charged relationship with a boy, which was kept secret from us. When the relationship ended, she spiraled into depression, even attempting suicide. Thankfully, the Lord spared her life. However, this was when she started thinking she was a boy. We talked with her about it many times, but she would always say one thing to us and do another. During this time, we discovered the medical community was not for us. Our daughter was seeing a therapist for her depression. Unbeknownst to us, that therapist was providing so-called gender affirmation. That's all she needed to confirm in her mind what she was believing. We did not find out about that affirmation for at least a year, but we did see the drastic changes she was making. She changed her wardrobe, started lining her breasts, and cut her hair. Then she had our now former family doctor tell her she didn't know what it was like to be born in the wrong body because she is not that kind of doctor. This from a doctor who delivers babies and declares their gender at birth. Now when the child is 16, she is unable to speak truth. Meanwhile, another suicide was attempted. This time the hospital refused to call our daughter by her born gender and given name despite our insistence on it. They were not interested in explaining why she was dysphoric only on blaming us for her anxiety because we refused to call her a boy. These medical professionals encouraged my daughter to believe the lie. She chose to move out of our home during her senior year so she could continue pursuing this transgendered lifestyle. In October, she started taking testosterone. She is only 18 years old. She has not emancipated herself. Neither have we relinquished our rights as her parents. And yet she is getting hormones from somewhere without parental consent. The damaging effects that have already happened to her body are heartbreaking to see. She once had a beautifully natural soprano voice and sang all the time. It has been replaced with an unnatural sounding lowness. She has facial hair and her acne has noticeably increased. More than that, the long-term effects can be infertility and osteoporosis. Not to mention out of control mood swings and an increased risk of breast cancer. Even if at some point she stops taking the hormones, she will not experience a full recovery, her voice will never return to what it was and she will have to shave the rest of her life. It is difficult to swallow the hard reality that the dreams we had of watching our daughter walk down the aisle to marry a young man and then have a family have likely been taken away. I believe this bill must be passed into law. But for the record, I also believe that any and all so-called gender affirmation treatment of a minor should be illegal. Thank you.

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

M. CAVANAUGH: Thank you. Thank you for sharing your story here today. I just want to make sure. Is your child being prescribed testosterone without your permission?

MICHELLE BALES: I believe she is going to Planned Parenthood.

M. CAVANAUGH: Because you can purchase testosterone over the counter as well.

MICHELLE BALES: She is, she is getting it from Planned Parenthood.

M. CAVANAUGH: OK. So she is getting--

MICHELLE BALES: I believe so.

M. CAVANAUGH: Are they-- I'm sorry, I don't know--

MICHELLE BALES: And there's-- they still need parental consent.

M. CAVANAUGH: For prescriptions,--

MICHELLE BALES: Yes.

M. CAVANAUGH: --parental consent. Yes.

MICHELLE BALES: And she is not 19.

M. CAVANAUGH: Right. That's what I, I wanted to find out if, if we were talking about prescriptions that are happening without parental consent or if we're purchasing things over the counter. Because with testosterone, that is something that is available. But thank you again for your testimony and for answering my questions.

HANSEN: Any other questions from the committee? Seeing none, thank you. OK, we'll take the next testifier in support. Yep. Pretty soon, as an FYI, we will be moving to two minute testimony so we can get as many people in as we possibly can. We'll do our best to make sure we kind of get everyone heard and not cut you off as fast as I can. But just to kind of put your thoughts in order so we can kind of condense things if we need to. Thank you.

KATHERINE YOHMAN: Thank you. My name is Katherine Yohman, spelled K-a-t-h-e-r-i-n-e, and Yohman is spelled Y-o-h-m-a-n. And today, I am

speaking as a proponent of LB574. I would like you to all know that I'm the oldest of seven. I have five younger brothers. My youngest just turned five in January and my oldest turned December-- 15 in December. I am 22 years old, a member of Gen Z. I am what is considered elder Gen Z and Gen Z has the highest transition rate the world has ever seen. Generation Alpha, which covers children born between 2010 to the mid 2020s, is predicted to have even higher rates of gender transition. I would like to point out that the attempted suicide rate is 41 percent in the U.S.A. In Sweden, where medical transition is bankrolled by the government, the attempted rate remains the same, 41 percent. Why is that? Gender dysphoria is a symptom. It is often the sign of a larger problem like sexual trauma, depression, and BPD. I would like to tell you my story for a moment. I was, again, was the oldest of my siblings, and I watched my mother get beaten for two years from the ages of 13 to 15. Nothing made me more sad than thinking if I was a son, I could save my mother. I sat between my mother and her abuser almost every time it happened, and I couldn't stop blaming myself for being born a woman. It wasn't until I reached my older teenage years about age 17, that I realized I didn't need to be a man to defend the people I loved. I would also like to point out the true definition of compassion. Compassion does not mean enabling someone to hurt themselves. It does not mean enabling a person to be put into a statistic that is likely to try killing themselves. What it means is protecting their best interest and protecting them and making sure they don't try to hurt themselves later in life. Sorry, the lights-- I don't know how much time I have.

HANSEN: You still, you still got a little bit time yet.

KATHERINE YOHMAN: OK.

HANSEN: You can keep going.

KATHERINE YOHMAN: I don't know why our modern culture has forgotten what the true definition of compassion is. Parental compassion embodies the idea of keeping your children's best interests at heart, understanding that what they might want now may not be what they want 10, 20, 50 years down the line. I want to say that I am not up here today speaking from a place of hate. I am not up here speaking from a place of anger. I am up here speaking from a place of deep sadness because I want to ensure our children are safe. I will always fight good and hard, even if I fight alone. And that is a quote from Dr. Susan La Flesche Picotte, I believe I'm pronouncing that right. And I

want to just highlight that we are not alone today. We may be the minority, minority, but we are not alone. Thank you.

HANSEN: Thank you for coming to testify.

KATHERINE YOHMAN: Of course.

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

KATHERINE YOHMAN: Thank you.

HANSEN: We'll take our next testifier on this side of the room. And after you are done, we'll start two minute testimony. So just FYI.

TRACEE BAKER: No problem. OK. Thank you. Thank you for being here allowing me to testify. My name is Tracee Baker. That's T-r-a-c-e-e B-a-k-e-r. First, let me just say that I have an 11-year-old daughter that I feel is at high-risk category for falling into this social contagion. But what I want to tell you as a story about my 20-year-old self, and then at that time my six-year-old cousin. I was a sophomore in college and found myself pregnant with a boyfriend that wanted nothing to do with my pregnancy. I determined the best decision for myself and my unborn son was to have a family adopt him. I was blessed enough that my-- that family ended up being my an uncle and my six-year-old cousin who is their biological child. My family did, and we still do have Sunday dinners every week. So I was very close with my aunt, uncle, and cousin. My cousin at six, understood I was pregnant and that one day the baby from my belly would come home with them and she would have a brother. On March 6, 1993, my son was born and two days later, my aunt, uncle, and cousin took my son home. Almost immediately upon getting home with her new brother, my six-year-old cousin began asking, who are my real parents? For the next several months, my cousin continued with this question, even though my aunt and uncle showed pictures of her in my aunt's belly, pictures of them at the hospital after she was born. She was hysterical, could not sleep, and insisted she had other parents like her brother. Finally, after therapy and some time, she was able to understand that her parents were her biological parents. I tell you this story because children like my cousin at the time do not have the ability to comprehend such adult concepts such as adoption, and they should not have to try to understand anything like gender identity. We need to stop forcing these subjects on our children at school, and we need to let them be children. We need to quit pushing our adult

ideologies and thoughts on them. We need to quit putting them on puberty blockers that are harmful to their young bodies. We need to quit butchering them before they can fully grasp the finality of their decisions. Please for the grace of God, and to protect our innocent, young-minded children, pass this bill. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you. We'll take the next testifier on this side of the room. Welcome.

THOMAS MORGAN II: Greetings. My name is Thomas Morgan II, T-h-o-m-a-s M-o-r-g-a-n II. I'm here because there's obviously a war for the mines going on that many people are either aware of or they're not aware of. And right now, we're talking about children and how fragile they are. Many people have been here to actually share their testimony that have been on both sides of this. So I won't have to go into that too much because it's very apparent. Right? Right, war for the minds. Your SARS-corona and COVID. I have traveled this country over 100,000 miles since March 15 of 2020 without a mask on. Yet, I am still here. That's as adults, whether you wore a mask or not, that's a war for your minds that has been going on. So if our children are dealing with this and you have been charged with taking care of them in the institutions that can either do the right thing or not do the right thing, do the right thing. And by not do the right thing or do the right thing, it's very simple. You take care of the children. You don't allow companies that are here for money to put this garbage on our children. As a veteran fighting the wars, while they're saying that this is going down, I heard mid 2000s and they have all your alpha males overseas fighting. And there's a reason that that happened and we're suffering the consequences of that right now. If you're in the middle of this war that's going on, then it's up to you to do the right thing. And the right thing is to take care of the children. It's that simple. It's that simple. Anything else after this is nonsense. You take care of the children. That's our future. Thank you.

HANSEN: Thank you for coming to testify. Any questions from the committee? Seeing none, thank you for coming. Take the next testifier from this side of the room, please. Welcome.

DENNIS SCHLEIS: Greetings. My name is Dennis Schleis, spelled D-e-n-n-i-s S-c-h-l-e-i-s. Nebraska must join the increasing number of states that already have passed or are in the process of passing the legislation barring taxpayer funding for gender altering procedure, also known as "GAPs." In 2021, Kansas-- excuse me, Arkansas passed a

law banning "GAPs" for minors, and Texas bill, HB1029, reads: No funds authorized or appropriated by state law shall be expended for any gender assignment. Then we go to the state of Ohio in year 2022, HB454 prohibits the distribution of public monies to organizations or individuals that offer gender transition procedures to minors. And then we go to another example, the state of Mississippi, Senate Bill 2728, public funds are forbidden for direct or indirect use of an organization or individual that provides gender transition services to anyone under 18. I believe Nebraska must pass LB574. Thank you.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you very much. We'll take the next testifier from this side of the room. Welcome.

ELIZABETH DAVIDS: Hi there. My name is Elizabeth Davids, E-l-i-z-a-b-e-t-h D-a-v-i-d-s. I would encourage you to go watch the two and a half hour Jordan Peterson extensive interview with Chloe Cole, much of which Luka has already described. But I thought I would add some details. Chloe convinced herself that removing her breasts would be the answer to her struggles, and doctors were only happy to receive payment for removing her breast tissues, cutting off her nipples, scraping adjacent skin, and replacing the nipples in a more masculine location for her chest, and reorienting her nerves into other areas on her torso. It was only a month after the surgery that she began deeply regretting her surgery and realizing the full weight of what she as a young teenager had been allowed to do to her body that she can never undo. She said of that time, I felt like a monster. In some cases, like Chloe's reconstructive surgeries can make the situation even worse. No one told her what the possible side effects were. As an 18-year-old now, Chloe has to wrap her chest every day because of the constant leaking from her chest. She experiences joint pain and urinary tract issues that are common side effects from the cross-sex hormones and experiences sexual dysfunction as an 18-year-old that is typical for women in their 50s. She breaks down and cries on camera weeping, how was I supposed to know? And from a male's perspective, this is TullipR on Instagram, no one told me that the base area of your penis is left. It cannot be removed. Meaning you're left with a literal stump inside that twitches. When you take testosterone and your libido returns, you wake up with morning wood without the tree. Because even if I had a sex drive, my neovagina is so narrow and small, I wouldn't even be able to have sex if I wanted to. And when I do use a small dilator, I have random pockets of sensation that only seem to pick up pain rather than pleasure. Any pleasure I do get comes from the prostate, which was moved forward and

wrapped in the glands from the penis, meaning anal sex isn't possible and can risk further damage. Then there's the act of going to the toilet. It takes me about ten minutes to empty my bladder. It's extremely slow, painful, and because it dribbles, no matter how much I relax, it will then just go all over that entire area leaving me soaking. How is it that at age 35 I run the risk of smelling like p*** everywhere I go?

HANSEN: With that, we'll have to end your testimony because the red light is on. OK, we'll see-- one more quick, just to make sure there's no questions from the committee. Seeing none, OK, we'll take the next testifier. Welcome.

ANGIE KLEIN: Thank you. Good afternoon, I'm Pastor Angie Klein from Bellevue, Nebraska. A-n-g-i-e K-l-e-i-n. I want to be honest with you in this room today, there was a time in my 20s that I wanted to rearrange my skin because I had a desire to be a man rather than a woman. I was already living with my lesbian partner for over six years and thought that my life would be better if I would just transition to what my heart felt like. I thought mistakes were made when God designed me. And as a woman, that I would make-- I would take matters into my own hands and rearrange my skin to match my inner desire to be a man. Mind you, that was in my 20s. Twenty-two years ago, I left my lesbian partner and the LGBTQ community for good. I am glad that I never rearranged my skin on my body to match an inner desire that was fleeting since childhood. At the age of 40, my husband and I had our first child and I was overwhelmed by the thought that my decision in my 20s not to transition gave me the opportunity to bear children and was able to breastfeed both of my children. The way my body was designed allowed me to live in the fulfillment of how I was created as a woman. I have trans friends who have transitioned back to how they were created. One lives with the consequences of puberty blockers. She will never bear children, all because she chased the desire deep inside her that told her that she was something else. My other friend lives with his consequences as well. Both of them struggle with what the puberty blockers did to them physically, mentally, and chemically. And yet some in this room think that puberty blockers are a safe thing to give children. Many say these drugs are completely irreversible and that there is no on and off switch for puberty. Nothing could be further from the truth. I [INAUDIBLE] support LB574.

HANSEN: Thank you for your testimony.

ANGIE KLEIN: Yes.

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

ANGIE KLEIN: Yep.

HANSEN: We'll take our next testifier in support on this side of the room.

AMBER PARKER: A-m-b-e-r P-a-r-k-e-r. Members of the committee in front of you, you will have a Nebraska Medicine form. It is ages 13 to 18 years of age. It is what we would call the one of the starts of the process to transition. I had just spoke with Luka and she had shared with me that Dr. Jean Amoura and Megan Smith-Sallans were both in the care of what she had went through, and now she is in the, in the transition. I want to let you know that WPATH, which stands for the World Professional Association for Transgender Health, has two members at the Nebraska Medicine. It's underneath the gender care clinic providers. Dr. Jean Amoura is a specialist in transgender care and hormone therapy who serves both adolescents and adults. I want you guys to look down at the end of your paper where there is an address. And I want to tell you, these words are missing: transgender clinic. On the last page of what I had handed to you, it says: Do you have a desire to have surgery in the future? Yes or no? If yes, what kind of surgery are you interested in? Chest reconstruction, hysterectomy, oophorectomy, metoidioplasty, phalloplasty, breast augmentation, removal of testes, vaginoplasty, tracheal shave, facial feminization surgery. I want to let you know that Megan Smith is married to the trans activist Ryan Sallans, and Ryan Sallans has been invited to the Lincoln Public School system. Excuse me. People were unaware, there was talks, I believe, on the puberty blocker side, as well as the word psychosexual needs being met for children in the context. These questions need to be asked. I myself have been targeted by the LGBTQ militia.

HANSEN: Thank you.

AMBER PARKER: Thank you.

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

AMBER PARKER: Thank you.

HANSEN: We'll take our next testifier in support on this side of the room, please. Welcome.

TIFFANY CARTER: Hi. Thank you. My name is Tiffany Carter, T-i-f-f-a-n-y C-a-r-t-e-r. I have a big packet of stuff for you. I know two minutes isn't a lot of time, so I'm not going to go over all of it, but I just want to talk about the illusory truth effect. Basically what that means is the more you hear something, the more it becomes truth. So that second package, I have some pictures for you. I have listed here for you 76 books that are available in the Nebraska public libraries. I can't verify every single one in the school libraries, but I know that a lot of them are there. I've been doing research for over a year on, on school book contents. So when you think about this illusory truth effect, the more that you hear something, the more it becomes true. When you have board books and children's books that are pushing these ideologies, some of these books are, are suggested to be zero to 3 years old, then it's no wonder that we have this thing going on that we call a contagion with all of this stuff because we're pushing this as a young age. The other thing I wanted to talk about there is that article for teens-- "Trans and Teens: The Social-Contagion Factor Is Real." Basically, what we have already heard today about different countries that they're seeing that this is happening. And then I have a couple studies from the American College of Pediatricians. The main thing I want to say here, the American College of Pediatricians recommends an immediate cessation of these interventions talking about puberty blockers and the surgeries, as well as an end to promoting gender ideology via school curricula and legislative policies. Healthcare, school curricula, and legislation must remain anchored to physical reality. And I'll leave you with that. I really hope that you take a chance and actually read these things because the science shows what we've already heard today. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you. We'll take the next testifier in support from this side of the room, please. Welcome.

BRENDA McGILL: Thank you. My name is Brenda McGill, B-r-e-n-d-a M-c-G-i-l-l. As previously stated, just because you can do something doesn't mean you should. Children have rights. But let me be clear. The idea that children's rights are to do as they wish inherently conflicts with the established children's right to be protected from all forms of exploitation. Natural children's rights supersede governmental decree. Furthermore, government exists to protect natural rights. What are our state values? Is Nebraska in an image competition with coastal states, or do we as a midwestern state, set our own standard? Nebraska has been proud to offer the good life, a place

where families can raise their young amid an environment of the sanctity of family and American values. But where is the good life in the modern era's exploitation of children? I'm referring to the medical transitioning industry with a projection of significant, unprecedented growth potential. Medical transitioning procedures do not offer children liberation. Rather, they put children and future generations under subjugation by subverting parental authority and disregarding children's natural right to protection. Our children are the greatest national treasure, indeed a heritage from the Lord, not a commodity to be cashed in on.

HANSEN: Thank you for your testimony.

BRENDA McGILL: Thank you.

HANSEN: Are there any questions from the committee? Seeing none, thank you. We will take our next testifier in support from this side of the room, please.

KATHY ADAMS: My name is Kathy Adams, spelled K-a-t-h-y A-d-a-m-s. I am from Kearney, Nebraska. And thank you, Senator Hansen, for welcoming us here today. And thank you, Senator Kauth, for introducing this bill and working so hard on it. Nineteen and a half years ago, a baby was conceived, but the mother was not positive who the father was. The man she thought to be the probable father requested a paternity test. But then the baby girl was born with the same color of hair and eyes resembling the baby pictures. No test was needed. The mother had an older daughter from a previous relationship. She felt that since she and the older daughter called him by his first name, that it would be appropriate and less confusing for the younger daughter to call him by his first name as well instead of daddy. The couple eventually married but remained dysfunctional. Both had their faults. Father's job had him working out of town one week and then the next week he would be at home. So mom pretty much took over the household. The wife was headstrong, impulsive, irresponsible, and was in control. This girl went through a lot of wondering who she was, and, and she felt unaccepted at her school. She went on to start wearing eccentric clothing, fishnet stockings, black clothing. She felt like she wasn't accepted at her school so then the parents moved her and her older sister to Kearney High School, where she got in with another group that she felt accepted by. And there was a bisexual boy that was paying her attention. Moving on, mom got a new job and as time went on, would come home later and later from work many times. And then she admitted that she had decided that she was lesbian. Another real

confusing thing for this girl. This girl ended up having transitional surgery, her breast removed at 17 years old, five days before her high school graduation. I asked her why there was such a big hurry to have this done. There was no big hurry. She was not suicidal. And that girl is my granddaughter.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you. We will take the next testifier in support from this side of the room, please.

ALLIE FRENCH: Hello, everyone.

HANSEN: Welcome.

ALLIE FRENCH: My name is Allie French, A-l-l-i-e F-r-e-n-c-h. I am representing Nebraskans Against Government Overreach. Before I get started, I know some people are going, well, what the heck is a group against government overreach doing being a supporter of a bill that a lot of people feel gets in the way of the patient-doctor relationship and even parents making decisions for their own children? However, if you take a look at the science, and trust me, I've gotten plenty, even from our opposition, we don't take information just from one side. As of recent, I've talked with Derek Landers [PHONETIC], who is a employee for one of the transgender clinical-- clinics here in Omaha that provides therapy to minors. So I can assure you I am getting science from both sides of the aisle here. If you take a look at the science, you will see that it is experimental, every single last bit of it. If you take a look at the American College of Pediatrics [SIC], you'll see on their website that they state there is not a single long-term study to demonstrate the safety or efficacy of puberty blockers, cross-sex hormones, and surgeries for transgender believing youth. This means that youth transition is experimental and, therefore, parents cannot provide informed consent, nor can minors provide assent for these interventions. Moreover, the best long-term evidence we have among adults shows that medical intervention fails to reduce suicide. If you go on to read from the University of San Francisco, you will find that many of these treatments last for at least until you reach the age of 50, especially if you've had your ovaries removed. You have a lifelong treatment. You may cause your blood to thicken and experience strokes. While gender affirming hormone therapy usually results in improvement in mood, some people may experience mood swings, or worsening of anxiety, depression, or other mental health conditions as a result of this shift. Other medical conditions may be impacted by gender affirming hormone

therapy. Through research-- though research is lacking, more time is needed and these people don't have the ability to make an informed decision, which is why our group opposes or supports LB574 and opposes their ability to get that treatment or surgical adjustments. Thank you.

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

ALLIE FRENCH: Thank you.

HANSEN: All right. We'll take the next testifier in support on this side, please. Welcome.

SHERRY JONES: I'm Sherry Jones, S-h-e-r-r-y J-o-n-e-s. In the current state of our world, I believe LB574 is absolutely necessary to protect our children. And that is exactly what this act is about, protecting our children from making life-altering decisions they are truly not capable of making considering their frontal cortex is not fully developed. Any of us who have been around children or have raised them know that a child may have difficulty choosing which cold cereal to have for breakfast. If they have difficulty with a decision such as this, which has no lasting ramifications, how can they possibly make decisions of great magnitude which may decrease their bone mass, cause joint problems, impair their memory, render them sterile for life, and increase their risk of suicide? If a child is truly experiencing gender dysphoria, how about helping them embrace their biological sex through counseling rather than sending them down a medical pathway of puberty blockers, cross-sex hormones, emulating surgeries? This bill, LB574, will not restrict adults from making such decisions for themselves. And I think that's important. We are talking about children, individuals under the age of 19. Having been a teacher for 35 years, working with children in grades K-9th grade, I can assure you they are not developmentally capable of making a life-impacting decision such as this. Again, this act is about safeguarding our children. How can we protect our children from greedy medical practitioners who are disregarding their oath to do no harm? How can we protect our children from pharmaceutical companies with dollar signs in their eyes? How can we protect our children from activists with a social agenda to advance. The Let Them Grow Act offers this protection. I will leave you with an admonishment that I believe will be wise to contemplate and seems applicable for a time and topic such as this. It is from the Book of Isaiah 45:9 "What sorrow awaits those who argue with their Creator. Does a clay pot argue with its maker?

Does the clay dispute with the one who shapes it, saying, 'Stop, you're doing it wrong!' End of quote. Let's help our children embrace the way they are fearfully and wonderfully made. Thank you.

HANSEN: Thank you for testifying. Any questions from the committee? Seeing none, thank you. We'll take the next testifier in support from this side of the room, please.

KAMI RILEY: My name is Kami Riley, K-a-m-i R-i-l-e-y, and I'm a proponent for LB574. I think we all need to take a step back and look at the children that are part of the trans community. I'm thinking specifically about the group that's in their late teens and early 20s that have already started to transition or have plans to. Some of those individuals will probably speak to you today with heartbreaking stories and plead for you not to advance this bill. It's understandable that they feel that way because they're the ones being affected by the results of these bills. This bill is telling them they can't have what they think they want. What person under the age of 19 wants to be told no? I want to be clear that I don't think we should dismiss their stories or their pain. These children are victims of an ideology that is purposely being pushed on them to destroy them and the family unit. They're being told lies by adults with an agenda that don't care about them as long as they accomplish their goal. They're innocent victims and my heart breaks for them. Everything they're feeling is real. The sadness, loneliness, hopelessness, fear, anger. It's all real. They believe they found a way to be happy by changing their gender. And now you're going to take their happiness away from them. You're the enemy in their eyes. When they found the LGBTQ community and were welcomed in with what they thought was unconditional love and acceptance, they were quickly turned against their families and anyone outside the community that didn't affirm their feelings. They've been made to believe that anyone who isn't in the LGBTQ community hates them, and especially those that are Christians. They've been trained to be activists for the cause, told their families don't love them, and that the community is now their family. Sadly, as many have come to find out, if you choose to leave the LGBTQ community, you'll lose those so-called friends and will be considered an enemy also. The love of the LGBTQ community is not unconditional. The love of a parent is, and sometimes we have to love them enough to tell them no. No, this is not in your best interest and I'm doing this because I love you. Senators, I ask that you show them that kind of love by supporting LB574.

HANSEN: Thank you. Any questions from the committee? Not seeing any, thank you. We'll take the next testify in support. Welcome.

MARNI HODGEN: Hi, good afternoon, Senators. My name is Marni Hodgen, M-a-r-n-i H-o-d-g-e-n. I just want to start off by saying I had a great speech written, but when Senator Kauth got up and gave her opening statements with all the science and the studies, it is exactly what I had planned to say. So, you know, puberty blockers, a suicide prevention as a fear-based argument to convince parents to utilize gender affirming care. But then the Sweden study was shown that actually people who have transitioned, they still have mental health problems afterwards, and the suicide risk is 19 times higher. So just want to reiterate that and now I'm going to kind of go off the cuff. We have safeguards in place for a reason, and that's to protect the most vulnerable in our society, our children. I urge you all to protect our children from the irreversible, permanent life-altering and potential health complicating issues that stem from gender dysphoria. I first of all, really just also want to say I'm praying and hoping that you are all taking to heart the raw, courageous testimonies of the invited guests. I just really wanted to tell them I commend you. I really applaud what you are doing because it takes bravery to share your stories of detransitioning. It takes guts to go against the grain of what was once your community. So thank you. You know, kids always think they know what is best for themselves. And I, I just got to say, I'm tired of seeing this society that we're, that we're adopting this permissiveness and this indulgence of their confusion. And we need to get back to being an authoritative parenting style as a society where we are nurturing and responsive to them. We're not dismissing them, but we still need to set firm limits. And that is exactly what this bill does. It gives them time, gives them maturity, allows brain development to occur. And that's really what, you know, that's 100 percent why I support this bill. And I'm sorry, I'm a little-- not great at speaking out the top of my head, but thank you so much for your patience today.

HANSEN: Thank you for coming. Any questions from committee? Seeing none, thank you. We'll take the next testifier. Welcome.

ANGIE EBERSPACHER: Hello, my name is Angie Eberspacher, A-n-g-i-e E-b-e-r-s-p-a-c-h-e-r, and I'm here today in support of LB574, the Let Them Grow Act. While earning my degrees in early childhood in elementary education at UNL, I was required to take courses in child development. There are many scientific biological facts that have remained constant: XX chromosomes are female, XY chromosomes are male,

and brain and emotional maturation doesn't occur until you reach the mid to late 20s. The National Institute of Mental Health, NIMH, website provides insight into the maturation of adolescent brains. This passage is taken directly from NIMH. Though the brain may be done growing in size, it does not finish developing and maturing until the mid to late 20s. The front part of the brain called the prefrontal cortex is one of the last brain regions to mature. This area is responsible for skills like planning, prioritizing, and controlling impulses. Because these skills are still developing, teens are more likely to engage in risky behaviors without considering the potential results for their decisions. Science tells us that teenagers are not prepared to make lifelong, life-altering decisions about their bodies. Minors who take puberty blocking hormones or undergo double mastectomies or castration do not have the brain development to make such irreversible decisions. There are further studies by Dr.-- that Dr. Paul McHugh, former presi-- chair of Department of Psychiatry at Johns Hopkins, and Dr. Kenneth Zucker of the Clark Institute in Canada, have cited studies of 70 to 80 percent of these children outgrow their gender dysphoria and accept their original gender. LB574 would provide time for adolescents to grow, to physically and mentally mature before undergoing impulsive, irreversible surgical procedures. I ask that you, I ask that you advance this bill. Thank you.

HANSEN: Thank you for your testimony. Any questions from the committee? Seeing none, thank you. And we'll take the next testifier in support. You guys are doing good. Two minutes, you're nailing it right on. All right.

ASHLEY JARMIN: Hello, my name is Ashley Jarmin, A-s-h-l-e-y J-a-r-m-i-n. I was going to tell you a story about my son. How when he was little, he was convinced he was a ninja turtle. However, I am sure most of you can recall a time when your child wanted to be a princess, a fairy, a dinosaur, or whatever they were excited about at the time. As I was working on my comments, I realized I was basically writing my own version of Matt Walsh's "Johnny the Walrus." So instead, today, I'll tell you my story. I'm a child of divorce, like many in the '80s and '90s. Divorce always causes some form or degree of trauma. Mine was relationally. I didn't trust easily, and I was very socially awkward. I was more tomboy than girly girl and I didn't fit in. I felt very isolated and alone a lot of the time. I didn't like how I looked. I didn't like the things my peers liked. I was alone. Like many young girls, I was often asked about my future. Did I want to get married and have kids? Did I want to work? Did I want a career and a family? My response as a young child into my late teens was that I did not

want to get married. It was absolutely something I did not want. At 19, I married. I now have four children. Had I been able to pursue that, my life could be very, very different. Please protect our vulnerable children. Please advance this bill.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you for coming. Appreciate it. We'll take our next testifier. Welcome.

S. WAYNE SMITH: Good afternoon. I'm going to take a little different twist. I'd like to see this bill to include school and college employees. And a third-grade girl in Lincoln came to her grandmother and asked, am I a girl? Will I always be a girl? How sad--

HANSEN: Can I interrupt you for one second? Sorry.

S. WAYNE SMITH: Oh, I'm sorry.

HANSEN: Can you spell your first and last name for us?

S. WAYNE SMITH: Yes. S. Wayne, W-a-y-n-e, Smith, S-m-i-t-h.

HANSEN: Sorry, to interrupt you. Sorry.

S. WAYNE SMITH: I just got excited there. Anyway, the little girl said, am I a girl? Will I always be a girl? How sad to ask such questions. Teachers who plant seeds of transgenderism are involved in child abuse. These teachers are cultural Marxists. They want to normalize transgenderism. So I have some suggested changes here. Section 1 of the bill talks about unprofessional conduct and includes conduct that is detrimental to the public interest, including but not limited to. So I assume this includes educators. So that there is no misunderstanding, I recommend that Section 1, item 17 be added, K-12 school and college employees indoctrinating children in gender ideology. Section 5 (1), line 7: No healthcare provider. I think you should add or K-12 school or college employees shall refer an individual younger than 19 years of age for gender altering procedures. In Section 5, item (2), line 12 should also include the same phrase after the word practitioner. And then in Section 7 talks about civil action. I think you should include K-12 school and college employees in that section also. Also, I'd recommend that you increase the age to 25 rather than 19. Thank you.

HANSEN: Thank you for your testimony.

S. WAYNE SMITH: OK.

HANSEN: Any questions from the committee? Just make sure. Not seeing any. Thank you. Take the next testifier on this side of the room, please. Welcome.

WARD GREISEN: Good afternoon, everybody. So my name is Ward Greisen, W-a-r-d G-r-e-i-s-e-n, and I'm testifying here in support of LB574. I've been hearing more and more about the harm that is done to young kids through gender affirming care. What once was a small percentage of kids being diagnosed with gender dysphoria has become something completely different. There has been a spike in the western world of kids with transgender identification. Teenage girls seeking treatment in the UK have seen a decade to decade increase of over 4,400 percent. Think about that for a second. I don't think anybody is denying gender dysphoria exist, but we need to understand what the drivers are for the massive increase in cases. While pausing on these irreversible treatments for kids, peer review study showed before this became a politicized issue that 80 to 90 percent of children reverted back to their biological sex if left alone. That doesn't mean we don't treat negative emotions these kids may have like depression and anxiety. What it does mean is we allow kids to grow and mature to the point where they're capable of making these significant lifelong decisions regarding treatments. We've heard a lot about what's going on in Europe and the UK in the Tavistock Clinic, and I urge everybody to kind of take that to heart. You might ask why in Nebraska we would pay attention to what's going on, you know, across the world and, and what lessons can we learn? But think about it this way, if a child can burn his hand on a stove top in Europe, they can burn their hand on a stove top in Nebraska. And we need to think about that. So we need to apply those lessons here, and that's why I support this bill. Thank you.

HANSEN: Thank you. Any questions from the committee? Seeing none, thanks for coming.

WARD GREISEN: Thank you.

HANSEN: We'll take our next testifier in support on this side of the room. Welcome.

RICH RILEY: Hi. Thanks. My name's Rich Riley-- excuse me-- R-i-c-h R-i-l-e-y, and I'm a proponent for LB574. Those of you that are parents know that children change their mind. Sometimes within a minute. Sometimes it changes with the season. But you always know they

will change their mind, and almost everything is given enough time. Let's remember back to the days of being a teenager and what it was like to have all of those insecurities and confusing feelings. I'm sure we all remember the loneliness that we felt at some point, how it felt to be left out or picked on or just ignored by the people you wanted to be friends with, those feelings like I'm not smart or pretty or athletic as others, nobody likes me, I'm just weird. Not, not to mention how awkward and alone we felt when puberty hit. But in those days, our parents understood the facts. The fact that children don't have the capability to make important decisions that will have lasting consequences, they knew that the science showed our brains that fully developed until 25. Most of, most of us here today can probably say we did things before we were 25 that we wish we hadn't. Thankfully, many of us can look back at their bad choices, laugh because they have-- they were choices they didn't have long-term consequences. So let me ask you, has the science changed? No, because the science is facts. Facts don't change. So when they would-- so why would we consider letting a child make a life-altering decision that will have permanent, irreversible effects. Change-- children change their minds. That's why we do what we do. Doesn't matter if it's 3 or 16, they still change their minds. And these teens and young adults that you're hearing from who believe down in their soul that they know what's right for them, they may feel very different in five to ten years or by the time-- by then, it's too late. The damage will be done. To let a child make a decision to mutilate their body is abuse. I know, it's time. I just ask that you guys do the right thing and just-- they won't say thank you now, but someday they'll look back and be glad that they were-- that, that you were strong team of Nebraska senators that cared enough to tell them no.

HANSEN: Thank you very much.

RICH RILEY: Thank you.

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

RICH RILEY: Thank you. Thanks for your time.

HANSEN: We'll take the next testifier on this side of the room, please.

KATHY FAUCHER: Good afternoon, Senators.

HANSEN: Welcome.

KATHY FAUCHER: My name is Kathy Faucher, K-a-t-h-y F-a-u-c-h-e-r. Last year-- I am a parent in Bennington, Nebraska. Last year, the school administrators in my school district exercised poor judgment when they showed a video to high school students without first obtaining consent from the parents. The video instructed on promoting gender ideology, catching many students off guard and putting teachers who don't agree with the content of the video in a highly uncomfortable position. A high school girl was interviewed in the video and stated that there is nothing wrong with being a lesbian and some people like multiple genders. Another girl stated, I identify as a bisexual woman. Yet another girl in the video stated, I identify as pansexual. This girl then explained that some peers tell her, oh, you are bisexual. She stated, this is not the same as being pansexual, and this mislabeling was offensive to her. When I questioned the video, the school administration responded to me by claiming that they must teach gender ideology because of Title IX. The school is mandated to provide training on how children view themselves. The problem is children are not organically coming up with new gender identities. They are fed these ideas from social media, their peers, and the curriculum that's barreling down from the U.S. Department of Education. I have talked to exasperated parents, some Democrats, some Republicans. The point being, these parents don't vote the same way. Nevertheless, they told me stories about their minor children and their adult children coming home from Nebraska schools, middle schools, high schools, and the universities declaring themselves as pansexual or not being a woman. But now they must go by they, them.

HANSEN: Kathy, sorry to interrupt you. Your red light came on.

KATHY FAUCHER: Two minutes?

HANSEN: Yeah.

KATHY FAUCHER: All right. Thank you very much.

HANSEN: Yeah, let's just see if there's any questions. Any questions from the committee? All right. No. Thank you for sharing your testimony.

KATHY FAUCHER: Thank you.

HANSEN: We'll take the next testifier in support from this side of the room, if there's any left. We've got one here.

ALEX STEPHENS: Hi. Yeah, there you go.

HANSEN: Welcome.

ALEX STEPHENS: Welcome. My name is Alex Stephens, A-l-e-x S-t-e-p-h-e-n-s. And a quick correction of the record. Testosterone is a Schedule III class drug. If you, Senator Cavanaugh, know anyone who is prescribing the drug without a prescription, please report them to the proper authorities. Which actually gets to my point. Many speakers today have told you about all the harms effectuating sex in the form of surgery can do to minors. But I don't believe that is all that needs to be heard before banning the practice towards minors. Another aspect is how it's advanced to children, both by medical agency surgeons and government workers such as school personnel. A common refrain made by those who profit off of the surgeries is that they are the only intervention that is possible for gender dysphoria. There are several problems with that. First off, is that most people who get these surgeries have never been properly diagnosed with gender dysphoria, so-called gender specialists, or unfortunately now little more than drug dealers who give out permission slips to obtain the surgery and the prescription drug because they can actually obtain money by the pharmaceutical company and the surgeons for having done so. They, they are not trained to look for other common comorbidities that cause gender dysphoria, especially autism, depression, and anxieties over being a teenager and substance abuse. Genital mutilation won't fix a broken home, it won't give someone two parents, it won't stop drug use solution that's marketed towards the most vulnerable in our society. And to say it's marketed isn't inaccurate. From children's books to gender surgeons actually marketing their product to eight year olds on TikTok, this stuff is actually marketed because it's incredibly profitable. And we actually have seen many hospitals say that the only way they are going to maintain their current status is through making enough money through sexual effectuating surgeries. Thank you.

HANSEN: Thank you. Any questions from the committee? We have one question here. Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you for that clarification. Yes, I, I was speaking incorrectly about testosterone boosters. So thank you for clarifying.

ALEX STEPHENS: Yeah. Yeah. Yeah, Estradiol can be a, a nonprescribed drug in the form of certain birth control in certain portions of the country.

M. CAVANAUGH: Yes, I appreciate that. Thank you.

ALEX STEPHENS: Um-hum.

HANSEN: We'll take our next testifier. Just really quickly, get a show of hands. How many are left to testify in support? OK. All right. I think what we'll do is we'll actually go until 5:00. We'll go an extra ten minutes. Squeeze a few more in and we can. We'll do the same for the opposition as well. So you're all set.

BEN TAPPER: Dr. Hansen, good to see you. Thanks for your patience. My name is Ben Tapper, B-e-n T-a-p-p-e-r. Let me remind you that we used to do frontal lobotomies up to the year of 1954, and most of the medical establishment adopted that as a good idea. I believe we're going to look back in 50 years and realize how terrible of an idea that these gender affirmation surgeries really are. And make no mistake, gender dysphoria is an identity crisis. And I believe that our identity is found in Christ. And unless we realize that and recognize that, we'll never fulfill that void. No surgical procedure, no pill, no medical procedure will ever fill that void unless we recognize our true identity that's found in Him. First and foremost, I study vaccinations and I study wellness and epigenetics. I study the developmental stages in the nervous system. Make no mistake, we have DNA protein and cell lines from female and male cell lines that are in these vaccines. Going to give you an example, WI-38 is a female cell line from lung from a three-month-old gestational fetus that's used in the polio, MMR, hepatitis B, and influenza vaccines. My question is, what does that have on the nervous system on a developing stage from an epigenetic influence? I'm not saying that this is the direct cause of all gender dysphoria. Obviously, there's social media influence from the LBGTQ and also I think from these vaccinations. This is a gross overreach from the pharmaceutical industry. We need to restrain the power of the pharmaceutical industry, the medical establishment, because this has nothing to do with health. This has everything to do with financial gain and an agenda. Thank you.

HANSEN: Thank you, Dr. Tapper. Any questions from the committee? Seeing none, thank you. We'll take next testifier. Welcome.

BEN STANGL: Thank you. My name is Ben Stangl, B-e-n S-t-a-n-g-l. And I've got a song for you, "Everybody's fancy. Everybody's fine. Your body's fancy and so is mine." And that song was sung by the civil rights progressive Mister Rogers who in that song said, "Boys are boys from the beginning. Girls are girls right from the start." And so I

support LB574. I think it's a defense of a standard. So I'm going to cut to the chase and say there's a standard here. It's apparent to everyone, apparent to Mister Rogers, apparent to children, apparent to all of us that from the beginning we were made male and female. And this is not, this is not optional for parents to even change or, or decide differently for their children. That's for adults, mature adults to deviate from that standard if they so choose. So I support LB574 and I would go on to say that if there's anyone who has confusion about this, that there's answers and many reasons, you know, already stated today why LB574 is important, but the answers are also found in the Bible. So look in Psalm 139, I would encourage anyone who's struggling today to read from Psalm 139. With that, I take any questions.

HANSEN: Thank you. I think it's the first time in four years I've had anybody sing during a hearing, so-- let alone Mister Rogers, so thank you for that. Any questions from the committee? All right. Seeing none, thank you. Take the next testifier in support, please.

KAREN ANDERSON: Good afternoon. Thank you all for hearing us out. My name is Karen Anderson, K-a-r-e-n A-n-d-e-r-s-o-n. I'm going to do the tomboy testimony, join a couple of the other ones. I think it is morally wrong and unethical to encourage or convince children, convince children they must be transgender if they feel uncomfortable in their bodies, which is normal when growing up, especially during puberty. Children change their minds many times throughout childhood, and they do not have the maturity, wisdom, or understanding to make such drastic, life-changing decisions that may be irreversible. When I was growing up, I too wanted to be a tomboy. I can remember as far back as kindergarten and I would beg my mom to wear boys clothes and to cut my hair short. It was called the pixie back then, and she'd let me do it in the summertime, and if I really begged her, she'd let me wear boys clothes. And I-- all it was, was I thought it was more fun to be a boy. I thought their clothes were more comfortable. They got to do things that I wanted to do, like play football or go and play guns, pretend to play guns outside. And so I just think it would have been very devastating to me if I had some of the things going on now, if I had different parents, teachers, coun-- school counselors, psychologists, that would actually encourage me that I probably should be a male, because I-- that would have been devastating mentally, emotionally, physically, and spiritually, because once I hit puberty, I could care less about being a boy. That completely went away. So I just urge you to think about how children are so-- they change, like as said before, they change their minds so much and they're so

vulnerable. And it doesn't take much for someone to whisper in their ear and tell them something, you know, that, well, you must be transgender if you don't feel comfortable in your own body, or you must be transgender because you don't like the sound of your voice on a recording. I think that we need to be reasonable and this is-- surely is about the rights of the children. It doesn't matter--

HANSEN: Ms. Anderson, sorry to interrupt you. I'm sorry, red light came on.

KAREN ANDERSON: Thank you. That's OK.

HANSEN: All right. Thank you. We'll take our next testifier in support, please.

AARON GILLILAND: Good afternoon.

HANSEN: Good afternoon.

AARON GILLILAND: Can you hear me OK?

HANSEN: Yep.

AARON GILLILAND: All right. My name is Aaron Gilliland, A-a-r-o-n G-i-l-l-i-l-a-n-d. Greeting, Senators. I encourage you today to support the Let Them Grow Act without amendment from our more liberal colleagues. This act will cease the sexual mutilation of children done in the name of a social contagion. Ten years ago, Chris Beck, a decorated Navy SEAL, having chosen to transition to a woman under the name Kristin, was appearing on a news broadcast to debate the new trend. This debate was probably the most infamous and perhaps contentious transgender discussion to date. It sparked a cultural phenomenon. Ben Shapiro stood his ground and asked the question, why are we mainstreaming delusion? After this discussion, things even got more heated. Kristin eventually physically threatened Shapiro. However, ten years later, after this facts don't care about your feelings discussion, Mr. Beck has chosen to detransition and live his life as God made him. Chris is happier than ever to finally not be living under a delusion. Mr. Beck describes being pushed into psychological evaluations post-combat at the Veterans Administration, which led to misdiagnosis, incorrect intervention, and eventually living a lie as Kristin. Every medical doctor that testifies against this bill should be looked at with the same disdain as a tobacco lobbyist. They most likely stand to financially benefit from these children's mutilation. Remember, there are years of pharmaceutical

research and surgical profit for each of these confused children. Last thing I'll say going off script, I want to really commend Mr. Newgent, and others who are here who are going through this process of trying to combat this ideology. And you've heard from them directly, they're victims of this. We need to listen to them. Thank you for your time.

HANSEN: Thank you for your testimony. Any questions from the committee? Seeing none, thank you. Take the next testifier in support, please. Welcome.

STEVE DAVIES: Thanks, Senator Hansen and to the other senators on the committee. I'm going to abbreviate. My name is Steve Davies, S-t-e-v-e D-a-v-i-e-s. And I just want to leave you with the impression that this so-called gender affirming care is a life sentence. Thank you.

HANSEN: Thank you for your testimony. All right, we'll take our next testifier in support, please. Welcome.

SCOTT THOMAS: Thank you, Senators. My name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s. I'm with Village in Progress Nebraska. To the best of my knowledge, we're the only organization in the state of Nebraska dedicated exclusively to the preservation of human rights in the state of Nebraska. And as such, I would support the prohibition of this practice as a matter of international treaty in accordance with the UDHR, Article 25, Section 2. And I'm willing to take any questions from the senators.

HANSEN: OK. Are there any questions from the senators?

SCOTT THOMAS: Thank you so much for keeping it going as long as you can, man. I appreciate you all so much.

HANSEN: Yeah, we're getting it. Thanks for coming. Appreciate it. All right, we'll take our next testifier in support, please.

BRITTANY HOLTMEYER: Hi.

HANSEN: Welcome.

BRITTANY HOLTMEYER: Brittany Holtmeyer, B-r-i-t-t-a-n-y H-o-l-t-m-e-y-e-r. I was recently elected and sworn in as a Papillion La Vista school board member. I am testifying on my own behalf and I do not represent my district. This world has so much division and I'm a mom. I'm a mom of two. And just being out there in the hallway this morning, I could just, I could just feel the difference between how

they were treating the ones that were out there treating us than the compassion that they are showing. And I myself, Christian mom, I love everybody. I don't care if you want to be Spider-Man one day. I don't care if you want to be a cat. I don't care if you want to be the opposite sex. Whatever you are, I will always love somebody. I just always have to remind myself that because God has made us each fearfully and wonderfully made. As it's been said already, and to love one another, as I have loved you, let them grow. I can't believe we're here talking and debating about should we allow or not allow children under 19 to mutilate their bodies. These same children who want to be Spider-Man when they get older. The next week they want to be a police officer. My six-year-old who changes his hairstyle every time he gets it cut. These are children. Let them be little. And their innocence is slowly-- it's actually being fastly taken away. We have so much influence in this world to become transgender, be the opposite sex. Where does this come from? One thing that I can think of is cell lines in the vaccines. There's over 14 different vaccines that contain aborted fetal cell lines, or maybe it's 13.1 from the insert, not tested for impairment or fertility or mutagenesis, other influences from counselors, friends, celebrities, books and movies shown in school to filling out surveys in school. It gets kids thinking, should I be this way? Should I think this way? Should I feel this way? And maybe I'll try this. Schools, are they really a safe place or are they a place where it's slowly becoming a healthcare center? I had spoken about a child at the last hearing in high school speaking with a counselor behind her parents back about becoming the opposite sex. This has got to stop. These children are our future and they are collateral damage. Thank you.

HANSEN: Thank you. How many more testifiers do we have? OK. We'll just finish up really quick then, so if you, guys, whichever one wants to come up next. Welcome.

BEN WAMBERG: Hi, everybody. My name is Ben Wamberg. It's B-e-n W-a-m-b-e-r-g. Representatives and members of political authority in the state of Nebraska, one's decisions shouldn't be at the behest of another unless harm is going to be done, perhaps most appropriately, when the harm is actually aimed at oneself. Following the goal of the Hippocratic Oath to do no harm, we must safeguard ourselves against the referendum and redefinition of harm without great cause. These are, like, legitimately treacherous intellectual waters that you guys are trying to navigate today. I don't envy the task, but I very much appreciate that you're taking the time to do it. Whatever one's personal feelings about the procedures in question, the facts are that

the effects of puberty blockers, e.g., chemical castration drugs and those even more invasive procedures on offer as a solution to gender dysphoria are neither benign nor benevolent. And while it may be equally difficult to argue that they are malignant or malevolent, there is no doubt that we know obvious willingness of pharmaceutical conglomerates to forego honesty for the sake of profits. Fighting for the use of these procedures and drugs on children, therefore, is morally wrong. It's not to say ever that we want to take freedom away. Personal choice must be maintained. But we also cannot ignore the fact that children in the process of development will change their minds. We're not just making choices for this generation. We're condemning and removing their procreative abilities, their ability to pass on their own values to the generation that comes after them. I beg you, don't take these kids, children away from them. Don't allow it to be done for the sake of what might potentially turn out to be fad psychology. That's all I got.

HANSEN: Thank you--

BEN WAMBERG: Thank you.

HANSEN: --for your testimony. And we'll take one more testifier in support. And as a reminder, if those either watching this or listening right now, if you had not-- if you did not have a chance to testify in person, you can always fill out the white sheets that are being handed around or that are in the room and write down your position so it's on the record. So that way you can at least have your voice heard in one aspect. Welcome.

SARA FOCHS: Hello. My name is Sara Fochs. That's S-a-r-a F-o-c-h-s. Everything has really been touched on that I had planned to speak, but-- say, but you guys were handed a form that was for 13- to 18-year-olds, I believe, by Amber Parker handed them out. I have one question to ask you guys, and that is, do any of you feel like a 13-year-old is old enough to have sex? If a child is too young to be having sex, they are too young to be changing their sex. That's all I got.

HANSEN: All right. Thank you. Any questions to make sure? All right. There are none. All right. So what we're going to do now since the time has been allotted, we will end up-- we will exit the room of the proponents, and then we will work the opponents in here and start their testimony. So we'll take a break, a short break for about ten minutes.

[BREAK]

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

DAY: Good evening. Senator Jen Day, Legislative District 49 in Sarpy County.

WALZ: Hi, my name is Lynne Walz and I represent Legislative District 15, which is Dodge County and Valley.

RIEPE: I'm Merv Riepe. I represent District 12, which is southwest Omaha and the good folks of Ralston.

HANSEN: Also assisting the committee is our legal counsel, Benson Wallace, and our committee clerk, Christina Campbell. And our pages for today are Payton and Ethan. At least we got them around for a little bit longer anyway, so. So just a few notes about policy and procedures about how this meeting is going to be run. If you do have a cell phone, please silence it or turn it off, if you could, please. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Christina or one of the pages when you come up to testify. This will help keep an accurate record of the hearing. If you are not testifying on 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. So people here in the room or people outside listening, if you do not get a chance to testify due to time constraints, that's the next best way to do it so your voice is on the record and your opinion is as well, so we can have that, actually, so the senators know where everything kind of stands. Also, I would note if you are not testifying, but have an online position comment to submit, the Legislature's policy is that all comments for the record must have been received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask you if you do have any handouts that you please bring ten copies and give them to the page. We will be using a light system for testifying today. Each testifier

will have three minutes to testify. When you begin, the light will turn green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we ask that you will wrap up your final thoughts as quick as you can. And I don't mean to be mean, but if you go too far pass to red I might have to interrupt you, so I apologize already. When you come to testify, please begin by stating your name clearly into the microphone and please spell both your first and last names. The hearing on each bill will begin with the introducer-- oh, we don't have to wait about that part. And that's good, we've got that one down here. On a side note, the reading of testimony that is not your own is not allowed until unless it's previously approved. And we do have a strict no-prop policy in this committee. So if you happen to have a prop or a picture or something you want to bring up, maybe just kind of hold on to it yourself so we can kind of be fair to everybody else. Also, on a side note, let's please try not to make any noise so we can make sure we can get as many testifiers in as we can and we can hear everybody clearly. So I know sometimes either questions that are asked or testifiers that come up, say some stuff you might feel like you want to clap, please don't or yell or do something else. We'll just do our best to kind of hold the fort down if you can, please. So if you can-- if you're willing to leave after you testify, I think that's what we're going to try to do here after we get done with the invited testimony so we can kind of work more people in from the outside. When you are done testifying, please exit out that door right there so we can kind of shuffle people in and kind of move around a little bit here. So we'll do our best to get as many people heard as we can. So the time-- what we will do for the testifying of opposition is the exact same thing we did for those in support. We were, were going to go 3 hours, but we're actually going to go 3 hours and 15 minutes. And let's see, that will start when we have our first testimony. So with that, we will welcome up our first testifier in support, and you're more than willing to go.

JOSEPHINE LITWINOWICZ: All right. Good evening, members of the Health and Human Services Committee. My name is Josephine Litwinowicz, legal first name, Vincent. So that's J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z. And I really empathize with those testifiers. I mean, this is tough. I can only-- I don't have my Venn diagram, doesn't have any intersections. And so I, I, I don't have a lot of facts, but I can tell you my story. And I got a song too, but I'm not going to sing it. I like to keep America beautiful. So today I'd like to express my heartfelt objection to LB574 and facilitate hopefully a

beautiful magic that can be accomplished in a gathering of the two or three. You know, that's where God's always with you, with the disposition to a good kind word, justice, and inclusion. We non-sis females and non-sis males sometimes called transsexuals are not perversion. I am not perversion. And there's nothing trans about me either. I am certainly a female. Very unfortunately, with the body parts of a male. I just know I'm a female and I don't feel ashamed. But I'm freaking tired just like the rest of us. And I'm extremely cornered and angry sometimes. And this is going to be hard for me to do because I've never done quite like this so I'll try to get through it but I got a three minute. So I listened to the song and the whole song. This girl is lying on a field, she just, you know. And so that teenage feeling [INAUDIBLE]. And I realized myself as this girl lying on the grass, who is now a woman that doesn't know her past because she never lived it. And perhaps that nonrecognition of my true self could have been avoided with the intercession of my gender reality made clear from curriculum exposure at school. I am female because that's-- I know that's how I feel. I identify with mannerisms, body language, etcetera. I am just some kind of tomboy too, actually. And so-- and that's, that's-- let's go with that. All right. So that's me in the photo there on the front page. And I, I know-- and me singing these words in the scene now-- song now. So that's me in the past. And I'm singing the words now. How dare you say that you don't want kids to be put up or deal with it, you know, you know, transgender or whatever. When I hear this kind of cruel crap, all I want to say deep down within is how, how do you think I like freaking dealing with it? I exist enough. Can you speak it? And we are all supposed to go to school to be educated and part with facts. And are trans youth going to have to suffer continuously throughout future history by ignorance of reality? We're just another minority population, you know, you know, you know bullied. And so an education, you know, ethics, civics and statistics, and now we have to add another one. And yes, you know, I want to find a soul mate with that teenage feeling. So I missed, you know, that it is what I can do now. And because I personally only want to be with a cis-woman for whatever reason, do you think that me acting this way is a good way to capture that funny, good, strong, intelligent, emotionally ripe and [INAUDIBLE] woman such as myself? I don't think so. No, I really don't. We are not making it up. Do you think that-- some people and kids might know and so-- oh, let's see, let's go with-- that's fine. Oh, there's a, there's a quote by John Prine, too, "I got so much love that I cannot hide." Well, you might want to read up on it if you want. Oh, go ahead and tell me that I recruit or I don't exist like Governor Ricketts says. I dare either to

say it to my face. I do not like-- I do like the $5 million investment-- I'll just finish-- proposal amount for increasing mentoring in Nebraska, especially mentoring someone like me that I do at an LPS school. I am a mentor and I think it's the most important thing I've ever done in ways. It's just about being a friend and having a break with from the normal, hectic day. Without being a peer, parent or therapist, your character integrity come through anyway, as it must. I can't wait to meet Mr. Osborne to thank him personally and I've asked about--

HANSEN: Josephine, thank you. We got-- we have the red light there.

JOSEPHINE LITWINOWICZ: All right.

HANSEN: You had a little extra time. Good.

JOSEPHINE LITWINOWICZ: I can't wait.

HANSEN: OK. Well, thank you for coming.

JOSEPHINE LITWINOWICZ: Again, so hot.

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

M. CAVANAUGH: Thank you. Thank you so much for being here and for always showing up. You are in front of every committee so often and your advocacy does not go unnoticed.

JOSEPHINE LITWINOWICZ: Well, I have lots of problems.

M. CAVANAUGH: I, I think maybe it's advocacy. But thank you and thank you for sharing your story with us. I just did want to take this moment to state I think this is a good time to remind everyone that is struggling today that if they need help, that they can text START to 678678 or you can call 866-488-7386. You're not alone. You are loved. You are seen. You are valued. And thank you so much for your testimony today and for being here.

JOSEPHINE LITWINOWICZ: Yeah, that's cool, you doing that every now and then. Well, thanks, guys.

HANSEN: Yep.

JOSEPHINE LITWINOWICZ: Have a good one.

HANSEN: Yep, thank you for coming.

JOSEPHINE LITWINOWICZ: Three sacral, swollen sacral vertebrae, and Meat Loaf said "Two Out of Three Ain't Bad," you know.

HANSEN: And so just so everybody knows, we do have some invited testimony that we will have up here first. And once we get them done, then we'll kind of move on to everybody else, so. So with that, we will bring up our first invited testimony in opposition. Welcome.

CAIT SMITH: Hello. All right. Hi, everybody. My name is Cait Smith. It's spelled C-a-i-t, last name Smith, S-m-i-t-h. I am the trans youth policy lead for the Trevor Project. I'm from Kansas City, but I currently live in Denver. And I'm here to urge you to oppose LB574. The Trevor Project is the world's largest suicide prevention and mental health organization for LGBTQ young people. We offer a suite of 24/7 crisis intervention services and suicide prevention programs. The Trevor Project additionally publishes comprehensive annual surveys that entail LGBTQ youth mental health. The most recent of these surveys in 2022 had over 30,000 young respondents. LB574, titled the Let Them Grow Act would effectively ban best practice evidence-based transgender medical care for transgender youth. Transgender medical care generally refers to a suite of evidence-based care and support that is navigated by a team of medical professionals in partnership with the young person and their parents or caregivers. It is supported by every major medical association in the country. And really quickly, I'm going to read just a few of those for you all: The World Health Organization, the American Academy of Pediatrics, the Endocrine Society, the American Medical Association, the American Psychiatric Association, the World Professional Association for Transgender Health, the American Academy of Pediatrics-- oh, I said that twice, the Pediatric-- the Pediatric Endocrine Society, and the American Academy of Child and Adolescent Psychiatry. Research overwhelmingly supports and shows that trans youth benefit, their well-being benefits when they have access to the care that they need. In February of 2022, the Journal of American Medical Association published new research that found that gender affirming healthcare for trans teens was associated with 60 percent lower odds of moderate or severe depression and 73 percent lower odds for suicidality over a 12-month follow up. And according to our own surveys in Nebraska, 50 percent of LGBTQ youth in the state considered attempting suicide in the past year, including 58 percent of transgender youth in Nebraska, 85 percent of LGBTQ youth in Nebraska also reported that recent politics has

negatively impacted their well-being. I ask you to support trans youth and to oppose LB574. Thank you.

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

CAIT SMITH: All right. [INAUDIBLE]

HANSEN: Right off the bat. All right, we'll take our next invited testimony in opposition, please. Welcome.

MIKE HORNACEK: Good evening. Dear Chairperson Hansen and members of the Health and Human Services Committee. My name is Mike Hornacek, M-i-k-e H-o-r-n-a-c-e-k, and I'm here today testifying in opposition to LB574 as a CEO, a man of faith, and a very concerned father. These are all my identities and they are as important to me as my child's. My job as a CEO is to attract and retain talent. I cannot do that in a state that would so blatantly discriminate against LGBTQ+ youth and their families. We should be encouraging an environment that welcomes all to attract, attract top talent and employers to Nebraska. Our young workforce will leave Nebraska if a bill like this is passed. I know this because my family and I will leave Nebraska if this bill is passed. In my role as the CEO of a nonprofit service provider that seeks to end hunger and homelessness in my community, I know full well the devastating effects, the discrimination, abuse, aggression, and a fear on display in LB574 have on youth homelessness. LGBTQ+ youth become homeless because they do not feel safe and loved and supported in their homes. This bill seeks to enshrine that lack of safety into law and will contribute to higher levels of suicide, human trafficking, substance abuse, and physical abuse. In my work, we are left to clean up the mess and be the family and support system that was supposed to love and support these youth. There are approximately 150 unaccompanied homeless youth in the state of Nebraska, and roughly 40 percent identify as LGBTQ+ according to the most recent point in time count. LGBTQ+ youth are also 120 percent more likely to report homelessness than their heterosexual and cisgender peers. As a man of faith and someone that grew up in the church and has been a member of my congregation for nearly 20 years, I'm also disturbed by the amount of people I see that call themselves Christian, who are using fear in the Bible to spew hate at transgender youth and their families. Jesus would have never acted in this way. He promoted love and acceptance. [RECORDER MALFUNCTION] this time with poor, sick and the disabled. He didn't divide people. He brought them together through love and compassion. My wife and I are also parents of a transgender youth and

have invested significant resources in research and education to ensure we were supporting our child in the appropriate way. We've engaged with multiple physicians, psychologists and psychiatrists over the past decade and more to ensure we were headed in the right direction supporting our child. This bill represents an extreme intrusion into my family's life, into my child's life. This is that we do not have a right to decide how best to care for and support each other as a family. Those decisions are not yours. They are not anybody else's. They belong to my family and no one else. I had more, but I'll stop there because I'm--

HANSEN: Yeah, sorry. Got a whole roomful of people that might think otherwise, so.

MIKE HORNACEK: I'm happy to answer any questions.

HANSEN: Thank you for your testimony, first of all. Are there any questions? Yes, Senator Walz.

WALZ: Thank you, Chairman Hansen. Thank you for coming today. I appreciate your story.

MIKE HORNACEK: Thanks.

WALZ: I'm just curious as, as you were talking, you just-- you seem like a very good father, first of all.

MIKE HORNACEK: Thank you.

WALZ: So I was wondering, are there other-- is there, like, a parent group for parents who are going through this and can, you know, use you as a support or-- I'm just curious.

MIKE HORNACEK: Yeah, there, there were parents that were before us that provided education and research in a support group and we do the same now for others because we've been on this journey for 12 years. My child is 16 now and has been a part of gender-affirming care for seven, seven years roughly, give or take. This is not a new journey for us. We've been on this journey for a really long time and have put in a significant amount of time and effort into making sure we were appropriately taking care of our child.

WALZ: Yeah, well, thank you. Thank you for your testifying today.

MIKE HORNACEK: Thank you.

HANSEN: Any other questions? Yes, Senator Riepe.

RIEPE: Thank you, Senator Hansen. Well, I'm not a big fan of government overreach. But we also, as a state and Legislature, have some responsibility for the safety and welfare and the goodness of the citizens of the state. So we do have-- we have a dog in the fight, if you will. This is not directed at the LGBQ population, but my question to you would be, is we've heard a lot today about the frontal cortex development and that fundamentally, it doesn't happen-- and particularly, some of the citation says it doesn't happen until a male is maybe 21 to 25. Some people would probably argue for males it doesn't happen until maybe they're 50. But that said, how do you-- I mean, so we're talking about the age here. We're talking about--

MIKE HORNACEK: Yeah.

RIEPE: --13, 12.

MIKE HORNACEK: I mean, from a specific medical perspective, I'll let the medical professionals that are coming after me speak specifically to that. But I can share from my own personal perspective as a father. Our child knew at three and it didn't waver. It started at two and I thought it was a phase. I mean, it hasn't stopped. It hasn't wavered. And she, she has known from the very beginning how she identified and it hasn't, it hasn't moved an ounce.

RIEPE: Given that, I understand your commitment. Thank you. Thank you.

MIKE HORNACEK: You're welcome.

HANSEN: Any other questions from the committee?

MIKE HORNACEK: Sorry.

HANSEN: Just making sure. All right, thank you for your testimony. All right, we'll take our next invited testimony, please. Welcome.

ELIZABETH CONSTANCE: Hi. Chairperson Hansen and members of the Health and Human Services Committee, thank you for the time to speak with you today. My name is Dr. Elizabeth, E-l-i-z-a-b-e-t-h, Constance, C-o-n-s-t-a-n-c-e. I am double board-certified in obstetrics and gynecology and reproductive endocrinology. I am speaking to you today on behalf of the American College of Obstetricians and Gynecologists, which is the governing body that sets best-practice guidelines for all OB/GYN physicians and in opposition to LB574. As a reproductive

endocrinologist, I have three years of specialized training in the management of reproductive hormones and have published research on the reproductive effects of gender-affirming hormone therapy, which makes me exquisitely qualified to testify today on the use and safety of the medical treatments being targeted in this bill. The American College of Obstetricians and Gynecologists first published a practice guideline for OB/GYN physicians relating to healthcare for transgender and gender-diverse individuals in 2011. This document was most recently updated in March of 2021 and states that the majority of medications used for gender transition are common and can be safely prescribed by a wide variety of healthcare professionals with appropriate training and education. Puberty blockers have been used since their development in the early 1980s to stop puberty in children who are going through it too early. As such, we have over 40 years now of widely accepted data that these medications are safe in children. In fact, they have been FDA approved for use in children since 1993. From this data, we know that puberty blockers are reversible once they are stopped and there are no documented long-term negative effects. Short-term effects on bone development are temporary and reversible once puberty resumes, whether that puberty is spontaneous or medically induced. These medications are critical in the treatment of transgender teens, as they allow for puberty to be paused while the individual grows and matures, buying them and their family precious time to make decisions about whether or not additional treatment is desired without feeling rushed into a decision. Additionally, inducing puberty by prescribing hormones such as estrogen or testosterone is also well-established therapy. We use these medications commonly for children who are born with ovaries or testicles that don't produce their own hormones. Many of these conditions are specifically excluded in this bill, which suggests that the author of the bill does not believe them to be harmful for all kids. So I ask you if we can agree that these treatments are safe and effective for the kids with the excluded medical conditions outlined in this bill, why single out transgender youth and withhold safe and effective medical treatments from them? How, when we know that access to gender-affirming medical care has been shown to decrease symptoms of moderate to severe depression by up to 60 percent and decrease suicidality by up to 73 percent in transgender kids, can we in good conscience withhold safe, effective and lifesaving treatment from them? I urge you to stand with widely accepted, established medical guidelines and not advance LB574 out of committee. Thank you and I'd be happy to answer any questions.

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

M. CAVANAUGH: You go first.

RIEPE: We compete--

M. CAVANAUGH: We do.

RIEPE: --to see who gets their hand up first. Thank you for being here. I initially said to myself, why is a-- an OB/GYN here? And then when you said the word "hormone," then I-- it kind of registered with me so thank you. Now, is it your position to fully support parental engagement in a discussion with youth? We hear stories-- don't know whether they are true or not true-- that at times, educators might take it upon themselves to embrace children and so that's where it gets into a lot of the emotion.

ELIZABETH CONSTANCE: Um-hum.

RIEPE: So.

ELIZABETH CONSTANCE: So I'm not, I'm not an educator.

RIEPE: But, but if you, but if you had a family that came to you to talk about hormones--

ELIZABETH CONSTANCE: Um-hum. In the, in the context of providing medical care, the family is a huge part of that discussion from, from the very beginning. Well, I-- we have a lot of pediatrician colleagues who are here today as well. That's usually where that conversation starts, is with their family practice or their pediatrician. And, and-- but that's a-- it's a family discussion and it's something that parents are, are very much involved with at every step of the way.

RIEPE: Yep and as a former hospital administrator, I can tell you, we never touched-- we wouldn't let anybody touch a patient at the risk of it being assault if you proceed forward without that. The other one because you're professional. And this one I'll probably instead of people to get their-- you know, about the frontal cortex development, which I asked before. I was saving that for an MD, but I get overanxious, anxious. But where do you think and what implication does this have on when surgery or medical or other more serious things other than counseling can come into the play?

ELIZABETH CONSTANCE: Well, I think it's a fair question. I think we let teenagers make a lot of decisions. We let them drive vehicles. We let them choose career paths and where they go to college. We let people under the age of 25 get married and buy guns. So, you know, we-- if we're going to outlaw every adult decision for anyone under the age of 25, that's one thing. I think, I think we could all agree that that's not logical. And so I think, you know, with medical decisions, medical treatment in general, whether it's treatment of diabetes or cancer or gender-affirming care, we institute an informed consent model, which means we talk to patients. And for minors, patients and their families about the risks and benefits and then we let the families make the decision that's best for them.

RIEPE: My response would be driving a car is significantly less life altering than having surgery.

ELIZABETH CONSTANCE: Yeah, I mean, I, I--

RIEPE: Some of these have parents or parents of kids, I guess.

ELIZABETH CONSTANCE: Yeah. I mean, I think young adults do a lot of things that have lifelong impacts on themselves and others.

RIEPE: I'm not sure they're comparable, but I'll yield to my friend who--

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank, thank you. Thank you for yielding, Senator Riepe.

RIEPE: On the rest of my time.

M. CAVANAUGH: Dr. Constance, thank you so much for being here. I have a couple of questions. The first is we've heard a lot about studies. And one thing that-- I don't know if you're the right person to answer this or not, but talking about control groups. I mean, when we do a study, we have a control group. And so I'm just kind of curious how that works when we're talking about gender-affirming care. Maybe you could speak to that a little bit?

ELIZABETH CONSTANCE: Yeah, absolutely. So anytime we do research in human subjects-- so people-- that research protocol, the-- has to be approved by an institutional review, review board at whatever institution the researcher is at. So these IRBs read the research protocols, the, the planned treatment, the proposed control or lack

thereof, and decide whether the research is ethical. Gender-affirming care is such established medicine at this point in time that no institutional review board will approve a, a research study for transgender kids that has a control group. So it's like if we had a study about diabetes, you wouldn't take a group of type one diabetes and-- people with type one diabetes and give one group insulin and withhold insulin from the others because it's life saving. And so this is-- this medicine has become in the medical establishment so well established that it is considered unethical to have a control group that does not have access to that care.

M. CAVANAUGH: Thank you for that clarification. So we did hear-- and I don't know if you were able to hear any of the testimony in support. There was quite a bit of testimony around the adverse effects of, of these puberty blockers or hormone therapies. And you stated that there is no documented long-term negative effects. And I know that your specialty is helping individuals build their families that are struggling with reproductive fertility. And so that being your area of expertise and you saying this and some of the things that we heard were concerns over infertility, I just wanted to give you the opportunity to maybe expound on that a little bit more. Because I would say that was a theme that I, I felt was stated numerous times. And I don't want to diminish any of the previous testifiers and their own personal experiences, but I would like to hear your medical opinion on this.

ELIZABETH CONSTANCE: So with puberty blockers specifically, they are immediately reversible. So this is why they're often used because it, it, it puts puberty on pause. It gives families time to make decisions. If they decide to move forward with hormone therapy, they can do so. If they decide not to move forward with hormone therapy and they stop the puberty blockers, their natural puberty will immediately resume. We don't give these puberty blockers until puberty has actually already started. So we're not talking about young children. We're talking about teenagers at the beginning of puberty.

M. CAVANAUGH: And so what I'm hearing is puberty blockers are not the same thing as hormone therapy.

ELIZABETH CONSTANCE: Correct.

M. CAVANAUGH: OK. That's a big distinction I was not picking up on. Thank you.

ELIZABETH CONSTANCE: Absolutely. Yeah, so the, the puberty blockers just stop puberty, put on pause. As soon as you stop them, natural puberty either continues or you can start hormones for gender-affirming puberty.

M. CAVANAUGH: OK.

ELIZABETH CONSTANCE: So the, the puberty blockers themselves are completely reversible. There are no long-term negative effects of that.

M. CAVANAUGH: OK. Thank you. I feel like I'm asking for a biology lesson, sorry.

HANSEN: Any other questions? I might have one. Just to clarify one of the statements you made about we use these medications commonly for children who are born with ovaries and testicles that don't produce hormones. So you're giving them hormones to facilitate that process to get that to work?

ELIZABETH CONSTANCE: Correct. So there's a variety of conditions called differences of sexual development, where people are born with nonfunctioning gonads, so nonfunctioning ovaries or testicles that don't make hormones. And so then they have to be given hormones to go through puberty at the same time as their peers.

HANSEN: OK. I think I might-- just to play devil's advocate a little bit, I think that it might be a little apples to oranges because you're giving them hormones, I'm assuming the ones that they're lacking, to, to have them go in a certain direction. I think what we're talking about maybe pertaining to this bill is you're giving hormones to have them go the opposite direction.

ELIZABETH CONSTANCE: The hormones themselves are the same. So the safety of the hormones is no different than if their body was not producing them or if their body is just not producing the correct ones.

HANSEN: OK, just to make sure I get this right. So if you have a young female who's not producing enough estrogen and progesterone, you give them that and it helps them kind of go through puberty because they're lacking those. That is just as safe as giving the same thing to a male to do the opposite?

ELIZABETH CONSTANCE: Because we're talking about pre-pubertal children. So a prepubertal male still doesn't have any-- isn't making hormones, any kind of hormones. So you're, you're giving the hormones to induce a particular puberty.

HANSEN: But I'm asking are they, are they just as safe?

ELIZABETH CONSTANCE: Just as safe.

HANSEN: OK. That's what I was wondering. Any other questions from the committee? All right, thank you for coming. Appreciate it. All right, we'll take our next invited testimony in opposition, please. Welcome.

JEAN AMOURA: Thank you. Chairperson Hansen and committee members of the Health and Human Services Committee, my name is Jean Amoura, J-e-a-n A-m-o-u-r-a, and I live in Omaha. Thank you for allowing me to express my opposition to LB574 today. I work at Nebraska Medicine, but my statement today is mine alone. I am board certified in obstetrics and gynecology. I was born in Nebraska. I studied here and I have been practicing medicine here for over 20 years. While my original specialty training did not include management of transgender care, I recognized this as a significant unmet need just a few years into my practice. I sought out the additional training from experts around the country and connected with therapists locally who had experience in providing gender-affirming care. I continued to follow expert guidance and new research in this field, as with every other aspect of my medical practice. I worked with many families from across the state who were seeking help for their children. They've been parents from cities and small towns with no background in gender identities or LGBT activism, but they were present as their child developed and they witnessed the distress and despair their child experienced when the world around them didn't see them as they saw themselves. These are parents who knew the truth of their child, that this wasn't messaging coming from YouTube or TikTok, but a deep understanding that this child had of themselves. They knew that they must find a way to protect their child and allow them to reach their greatest potential. These parents are not experts in gender theory. They are simply experts in their own child. They sought input from clinicians and chose pathways they believed would help their child survive and thrive, just as any of us as parents would. I've worked with dozens of families of teens seeking gender-affirming care. They're referred from across Nebraska by their family doctor or pediatrician or therapist after lengthy conversations and careful evaluation. I continue these conversations and support the families in their medical decisions.

I've witnessed many young people emerge from a state of isolation and fear to enjoying a life where they can safely and confidently attend school, make friends, play in band and plan for college. My experience is not unusual. There is robust evidence that transgender youth do well when they are supported. LB574 would harm our communities and our children by removing lifesaving treatment options from parents as they stand up for their children. It would force doctors and other healthcare providers to conceal and withhold treatment from young people that the American Academy of Pediatrics and the many other organizations you've heard already endorse is well within the boundaries of standard care. And it would create clinical practice where lawmakers can overrun the fine-tuned judgment of cautious and thoughtful clinicians who have committed to do no harm. I ask you not to advance this bill.

HANSEN: All right, thank you for your testimony.

JEAN AMOURA: Thank you.

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

DAY: Thank you, Chairman Hansen, and thank you, Dr. Amoura, for your testimony. So you mentioned getting referrals from family doctors.

JEAN AMOURA: Um-hum.

DAY: What is the typical process in which families will come to you? Like, what does that look like?

JEAN AMOURA: So virtually always for young people, they are referred by a mental health provider or primary care provider. So might it be a family medicine or a pediatrician. When they are referred, before they're even-- before they're-- any appointment or anything is made with me, we first require that we have received written support, a letter from their primary mental health provider. And if they have not started to see a mental health provider, we make sure that they find a mental health provider, work with that person to discuss their gender dysphoria specifically so that we can have written documentation that they have worked with a qualified mental health provider and that person has made an assessment. Once we've received that, then they-- you know, in the system that, that we have it-- with my employer is-- in my clinic is that they also then are evaluated by a psychologist with expertise in gender dysphoria and adolescents specifically. After they've had that assessment, then the family meets with me, the

parents and the young person. And all of this, again, typically happening when they are at the very least already entering puberty is typically when, when we would meet with them because there's no medical intervention that would be necessary or appropriate before that time.

DAY: OK. Can I ask another one? So this bill not only would, as I, as I read it, outlaw any kind of surgical intervention, it would also create a punitive action for anyone providing a referral.

JEAN AMOURA: That's my reading of it as well.

DAY: OK. So, so doctors wouldn't even have the option of referring patients or families to someone who specializes in gender-affirming care. Is that what I'm understanding correctly?

JEAN AMOURA: That's, that's, that's how I understand it as well. And I think certainly that the, the mental health providers and the physicians that I know of that, that, you know, are currently, again, across the state and part of the folks who have referred people to me in the past are-- that's-- I mean, they-- many of them have been in contact with me because of concerns about where, where they will send future patients, you know? It's-- this is a situation and a diagnosis that comes up fairly rarely, which is, you know, part of why there are not many doctors that do this care. And it's important, especially for young people, that it's done in a-- with the infrastructure to have a lot of checks and balances in that. And people are very concerned about where they will refer patients when, when the situation does come up.

DAY: So that would be my next question is if this were to pass, what would be the options for parents of children who are experiencing gender dysphoria?

JEAN AMOURA: I believe that they would need to seek care outside of the state.

DAY: OK. And they-- but they couldn't be referred to someone outside of the state?

JEAN AMOURA: That is--

DAY: OK.

JEAN AMOURA: --also my understanding.

DAY: OK.

JEAN AMOURA: Um-hum, yep.

DAY: Thank you.

HANSEN: Any other questions? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Dr. Amoura. So I-- it was passed out, I think, more than once, a form from-- that has your name on it.

JEAN AMOURA: Yep.

M. CAVANAUGH: So I'm assuming it's from your office, Specialty Care Center. And it looks like it's an intake form. And I just-- since it has your name on it and it's--

JEAN AMOURA: Yeah.

M. CAVANAUGH: --been brought to our attention a couple of times, I wondered if you could give us not-- a brief overview of what--

JEAN AMOURA: Yeah.

M. CAVANAUGH: --what the starting of this process looks like when somebody comes to you. Why do they fill out this form and then what are the next steps?

JEAN AMOURA: Yeah, absolutely. No, I mean-- and this is a big part of why I wanted to be here today to frankly be very transparent about, about the process in our clinic. I have been very careful in starting doing this work to, to do it with great care. And it's been a slow and very deliberate process. Similarly, I'm very transparent when we're talking with parents or families who are interested in speaking with us, speaking-- having an appointment with me so that we can give them information like this on the website ahead of time to try to alleviate concerns about things-- questions that may come up. We have lots of information on the website. The goal is, is not to-- that we're informing anyone that they need to see us or take any-- you know, accept any treatment. It is that the patients are seeking us out and we want to be able to provide that experience as just as the least stressful as possible so that they understand in advance the kinds of questions that we're going to be going over during the first visit. The, the information, for example, about surgeries that people may be interested in pursuing. Some-- you know, many transgender people are

looking at pursuing hormones, many are not. Many-- some trans people are looking at pursuing surgery, many are not. It's part of just my comprehensive evaluation of someone to get a sense of what their goals are, what areas of their body are causing them distress or dysphoria so that I'm, I'm fully informed that I can be discussing with them what the medications that we might be looking at, will or will not do. That I can make sure that, that we're very clear about what their, what their treatment plan is going to accomplish. It's just a part of our-- of a comprehensive discussion of risks and benefits, as I would do with any treatment that I, that I provided someone.

M. CAVANAUGH: Thank you.

JEAN AMOURA: Um-hum.

M. CAVANAUGH: If you don't mind--

HANSEN: Yep.

M. CAVANAUGH: --a follow-up. So this is the first time this has been mentioned today. Many of the patients are seeking treatment through hormones or surgery, many are not. So people are referred to you and they learn about some of these, these options available to them and they don't take them, correct?

JEAN AMOURA: Yeah. I mean, that's-- right.

M. CAVANAUGH: OK.

JEAN AMOURA: It's, it's not an automatic that-- I mean, I would say my statement earlier was just that many trans people--

M. CAVANAUGH: OK.

JEAN AMOURA: --want hormones or want surgery and many do not.

M. CAVANAUGH: Do not.

JEAN AMOURA: So it's not--

M. CAVANAUGH: It's not a universe-- it's not a monolith.

JEAN AMOURA: Correct.

M. CAVANAUGH: OK.

JEAN AMOURA: Exactly. I would say more often when people are scheduled to see me, they, they-- it's not just that they were referred, but they actively want to be seen in the gender clinic. It is because they, they already have expressed that they want to start on hormones. I, I don't do any surgeries, just as an aside. But they've already expressed that they want to start on hormones or that they just want more information. And plenty of people come in and decide that they don't want this or don't want it right now. Yeah, so it's not, it's not like it's, you know--

M. CAVANAUGH: Sure.

JEAN AMOURA: --a-- I mean, these are-- as with any kind of medical care, there's a case-by-case decision-making that you're trying to tailor to. What are the needs? Is this person ready and appropriate to take this next step? So trying to get as many sort of points of input as possible as we go along. Monitoring after we start, if they do decide to start on hormones. To monitor the, the physiologic effects, but also the emotional effects. And it's a pretty close contact that I'm maintaining, particularly with young people.

M. CAVANAUGH: Thank you.

JEAN AMOURA: Um-hum.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Like my colleague to my left, I too have your intake form, I believe.

JEAN AMOURA: Yes. Um-hum.

RIEPE: It says on this form, it says 13 to 18 years--

JEAN AMOURA: Um-hum.

RIEPE: --on the form. I assume that that's that category. And yet, you know, my question would be is I see no parental signature on here for underaged. It says-- you know, to keep the parents involved.

JEAN AMOURA: Right.

RIEPE: It seems like a very critical missing piece because these children are children and they're under age. They're not--

JEAN AMOURA: Absolutely.

RIEPE: --legal adults. They're not emancipated.

JEAN AMOURA: Absolutely. No, the-- make no mistake. The, the parents or guardians are involved in every step of the way in my clinic.

RIEPE: But you wouldn't know it by--

JEAN AMOURA: They--

RIEPE: --looking at the form.

JEAN AMOURA: The, the form is sent actually to the parents. It's available on the website, so anyone could look at it. But as far as making an appointment in the clinic, that's only going to happen through a parent. The, the involvement with the, the assessment that's done by the psychologist that's on my team must involve parents at that assessment. And the visits with me always involve parents.

RIEPE: Who do you assume is going to fill out the form, the 15-year-old or the parent?

JEAN AMOURA: Potentially-- I mean, I honestly would welcome a 15-year-old to fill it out because what's going to happen is that when we are actually meeting for a clinical visit, I'm going to have this in my hands and I'm going to be going over what-- whoever filled out the form, what they had listed. So--

RIEPE: If I have a 15-year-old fill out the form, I-- as the guardian or the parent, I want to see what they put on there so that I can say--

JEAN AMOURA: Right.

RIEPE: I need to maintain my relationship with my 15-year-old.

JEAN AMOURA: Absolutely. So again, the, the-- someone could access this just simply by looking on the Internet. If they are, however, actually engaging with our clinic, seeking an appointment, etcetera, all of the communication is with the parent or guardian. A-- an electronic file with this document-- we're not, you know, asking people to go look on the Internet for it. An electronic file of this document and the consent form, which you don't have, but the-- we also do have a consent form specifically for gender-affirming hormone

therapy. Those two electronic files are sent to the parent who's responsible and who's been in contact with us about making the appointment.

RIEPE: One follow-up question, Mr. Chairman. I'm just looking at what's the level of activity in your practice? How many, how many-- I'll call them patients, clients? How many do you have in, say, a years' time or six months?

JEAN AMOURA: Yeah. Probably in a six-month span, probably a couple hundred.

RIEPE: OK. And some of those, I suppose, are a curiosity or not that made a decision. So you're there to help make that decision?

JEAN AMOURA: That's, that's, that's exactly right.

RIEPE: OK. Thank you. Thank you for being here.

JEAN AMOURA: Thank you.

RIEPE: Thank you for sharing.

JEAN AMOURA: I just do-- sorry, I just wanted to add on the consent form because you had asked about there was no place for the parents to sign on this. And again, this is just used as an intake. The consent form that's required to start treatment-- so this is kind of just for me to start a conversation when they come in for the visit. That conversation includes the parents and the young person and myself.

RIEPE: OK.

JEAN AMOURA: The consent form must be signed by the young person and the parent and myself. And it--

RIEPE: I don't-- excuse me.

JEAN AMOURA: Yeah.

RIEPE: I don't disparage people, but they have been known to, to forge their parents signatures on school reports and a bunch of other things so that could all happen. OK. Thank you.

HANSEN: Any other questions from the committee? I think you answered my questions. Mine was-- the biggest one to do with consent, right--

JEAN AMOURA: Yep.

HANSEN: --and the parental, parental involvement with consent or consent to treat, you know?

JEAN AMOURA: Yes.

HANSEN: And same thing when you do-- when you do start treatment, you have parental consent. Is there any kind of steps you take before that?

JEAN AMOURA: Right. So the-- yeah, they-- there's a consent to treat that we just have generally kind of for all care in the hospital. So that's of course required as a baseline. But specific to what happens is that during the-- usually before we even make the appointment, we send that out so that families can review that-- the information, the intake and the consent form so that they have some sense of what we'll be talking about. We have the actual visit, answer whatever questions come up at that time, and then they are informed that if and when they want to start hormones for their-- the young person, that the consent form will need to be signed and submitted. And they are encouraged to not sign and send it in until all of their questions and concerns have been asked. If that means another visit, then that's, that's completely appropriate. But they've, they've had the chance already to preview that consent form. But yeah, what we are-- when I'm starting someone on affirming hormone therapy, they are completing a separate specific consent form that details all of the points that we go over in the visit about what are the effects of the medications, how we monitor, what are-- you know, the-- all of the things that they should expect.

HANSEN: OK.

JEAN AMOURA: There's a separate consent.

HANSEN: With some of your patients, have you experienced any side effects from, from treatment?

JEAN AMOURA: Sometimes, um-hum.

HANSEN: What are they?

JEAN AMOURA: Yeah. I would say that the most common one is probably in folks-- one person earlier brought up the medication spironolactone that we use as a testosterone blocker for people that are seeking

feminizing hormone therapy. It is absolutely considered part of the standard treatment. It's a first-line treatment that I use as well, but it's the one that I feel like I have to caution patients the most on that it, it's, it's a diuretic. One thing-- sorry, just-- but just as an aside, these meds are all quite inexpensive. They're quite old. This is not like a case of, you know, Big Pharma and people making a lot of money on these meds. They're all-- actually, they've been around for a long time. Spironolactone is a diuretic so it's, it's removing quite a bit of water out of the body. And it used to be used as a, as a blood pressure medication. We don't use it for that anymore because we've got more advanced things for that. But you give a blood-- something that could be used as a blood pressure medication to a healthy young person they don't need, their blood pressure drops. So I'm having to counsel them about beware that you can kind of get a little bit orthostatic or just kind of a little bit dizzy going from laying down to standing up and that sort of thing. Drink lots of extra water. So they're, they're like nuisance sort of side effects, but that's, that's the-- one of the big ones that I counsel folks about.

HANSEN: OK.

JEAN AMOURA: Um-hum.

HANSEN: Have you ever counseled anyone against doing gender-affirming care? Like, youth come in, you don't think they're a good candidate for it and you're just, like, I think you should see somebody else or--

JEAN AMOURA: Yep, I mean--

HANSEN: --I don't think this is right for you?

JEAN AMOURA: Sorry to interrupt. Yes, I, I would say, you know, the things that I am looking for, asking about and, and really carefully listening for when they're in that, in that-- particularly in that first meeting with me, is do I believe that they have a clear understanding of what the medications are going to do? And is that what they are seeking, etcetera? So I, I might have someone who comes in and says that they want to experience changes in their voice. They would-- they want to have more-- they want to masculinize in the sense of having their voice lower. And testosterone is going to do that. But they expressed some concern about developing facial hair and testosterone is going to do that. And so I'm going to look at that

person to say this is not going to be an appropriate medication for you.

HANSEN: OK. This--

JEAN AMOURA: This--

HANSEN: And this could be a 13-year-old potentially? I'm looking at your form. It says 13- to 18-year-old. So a 13 year old, you would do this to?

JEAN AMOURA: Well, usually for affirming hormones-- so these are the intakes when people come in. So I do see people that are any-- from the starting point of puberty forward is when, is when I might see someone. That's not necessarily when I would start them on affirming hormones if that's what they wanted. That we tend to try to correlate with having peer-concordant puberty so that they're entering puberty around the same age as their peer group rather than waiting until 18 or 16, etcetera. So--

HANSEN: I don't mean to ask a lot of questions.

JEAN AMOURA: Yeah.

HANSEN: I just-- these are questions I--

JEAN AMOURA: I--

HANSEN: --get from people and I'm trying to, like, make sure they get an answer so people can understand how the process works, not necessarily--

JEAN AMOURA: Absolutely.

HANSEN: --for my own curiosity.

JEAN AMOURA: I welcome it.

HANSEN: And so if I can ask maybe a couple more real quick?

JEAN AMOURA: Please.

HANSEN: Sorry, I don't mean-- I don't want to take up people's time either, so.

JEAN AMOURA: So do I, do I treat people that are 13 to 18 with affirming hormones? Potentially, yes.

HANSEN: Do you know off the top of your head the youngest patient you've had in your office that you treated?

JEAN AMOURA: I mean, I've seen-- that I've-- so the youngest person that I've seen is probably eight. They didn't need medical treatment. They-- the family and the child needed a consultation because their-- they had disclosed their gender identity since they could speak, similar to the story-- the, the parent, family that we-- the parent that we heard earlier. That's not at all uncommon and that folks will say we've been raising our child all in agreement and the school does not know what their sex assigned at birth was. The-- you know? And they get to be eight, nine and they start to get very anxious about what is going to happen when my body starts to change in ways that are completely different than how I'm living, how I identify, how everybody knows me. You know, the child that is assigned male at birth has been identifying as female since age-- since they could speak and has gone to school, has had a-- maybe the parents have changed their name. I mean, there's no one in their world outside of their immediate family that knows their sex assigned at birth. So it's critical that they, they start-- as you can imagine, they start to panic as they get to-- foresee puberty and imagine that their voice is going to change. Their hair-- facial hair is going to-- you know? So a lot of times, those folks will come in fairly young just so that they can kind of understand what could the landscape look like for us? What-- you know? So I see people that young. I don't treat them. I treat folks if they want see-- you know, are seeking treatment. The earliest they would need medical treatment is when puberty starts.

HANSEN: OK, OK. And one more quick question, sorry. I didn't catch the name of the clinic you work at.

JEAN AMOURA: Nebraska Medicine.

HANSEN: OK. I was just kind of curious about that.

JEAN AMOURA: Um-hum.

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

JEAN AMOURA: Thank you.

HANSEN: All right. We'll take our next testifier in support, please. Welcome.

DANIEL ROSENQUIST: Thank you. Good evening, Chairman Hansen and members of the Health and Human Services Committee. My name is Daniel Rosenquist. I'm a family physician from Columbus and the current president of the Nebraska Medical Association. The NMA is concerned with LB574 and the general interference it would represent to the practice of medicine. As physicians, we can certainly understand and we appreciate the concern about medical interventions for our young patients and the long-term impact those treatment decisions may have. These are the types of decisions we work through every day with our patients. As physicians, we have a duty to our patients in evaluating any potential risks, the benefits and the alternatives to any treatment that may be considered. Through a process-- what we call shared decision-making-- between the physician and the patient and/or family when appropriate, we do these processes every day. When an individual treatment options are limited due to impositions placed by the government, it takes away this fundamental component of the physician-patient relationship. Debate about the appropriateness of a treatment protocol is welcome and necessary-- and a necessary part of ensuring high-quality healthcare in all areas of healthcare, but this debate must remain within the field of medicine. As physicians, a full medical history is obtained, including a mental health part-- as part of our management and discussion of various options. The treatments and procedures that issues-- at issue in LB574 are not taken lightly. As such, that means that such-- that patients and their parents must go through thorough screening, evaluation and management. Physicians who treat these youth do so in consultation with multidisciplinary teams of healthcare professionals, including from the mental health community. They proceed accordingly to criteria that is continually evaluated and routinely updated by medical experts. They do so based on the individual needs of the patient with the informed consent and shared decision-making. The number of physicians who practice in this area is relatively small, but many more physicians have difficulty with LB574 for high-quality evaluation and management of gender dysphoria. I myself, along with many other field physicians, feel that we may not be the most knowledgeable and most experienced physicians in this arena. But we have limited options for referral, potentially leading these individuals to seek care from others who may not uphold the same high standards that we have come to expect. In addition to the interference, the NMA has also had strong concerns with the provision of civil action that may be brought with-- within two years

of discovery of damages. It is unclear what constitutes a discovery of damages under LB574, but we have strong concerns that it could expose physicians to an unending threat of liability, even in instances where it's simply alleged that the physician referred the patient for these-- for consideration of these services. Referral means different things to different patients. This sets a dangerous precedent for professional liability in Nebraska. In conclusion, the NMA is committed to preserving the physician-patient relationship. With it comes-- when it comes to providing medical care, physicians are most qualified to navigate these difficult conversations in conversation with their, their patients as well as their families. And for this reason, we oppose LB574.

HANSEN: All right. Thank you, Doctor. Are there any questions from committee? I don't know who to go to first? We'll go to Senator Cavanaugh.

M. CAVANAUGH: I won the bingo. Thank you for being here, Dr. Rosenquist, and thank you for your testimony. I'm hoping you're the right person to ask these questions for because I've had them since the beginning. And if not, please forgive me. But on page 7 of the, of the bill, there's a lot of what you were referencing as far as the referral and direct and indirect and the two years of damages. And so pretty much page 7 is a concern for me. And I, I wanted to give you an opportunity to speak to some of this. On lines 14 to 15 of page 7, it talks about the behavior shall be considered unprofessional conduct as defined in statute. And I just pulled up the statute and I don't know what that means as far as I-- would that mean, what, loss of licensure or fines? What happens when you have unprofessional conduct?

DANIEL ROSENQUIST: Well, it goes to the Board of Medicine and Surgery and then they do an evaluation and then they issue a ruling based on what their findings and what their outcome is. It could be a, it could be a censure. It could be, it could be nothing. It could be all types of-- potentially loss of license.

M. CAVANAUGH: So a doctor in your position-- you're in Columbus, family practice-- and most likely if you had a patient that required gender-affirming care, you would have to refer them to somewhere outside of Columbus.

DANIEL ROSENQUIST: I mean, I'm-- and I'm probably not the most qualified person. And I want the-- I want these people to have the most high-quality evaluation--

M. CAVANAUGH: Sure.

DANIEL ROSENQUIST: --and treatment. And I'm not the most qualified and-- especially when there are experts in this field. And I would like to make sure they go to those experts and not someone else--

M. CAVANAUGH: Right.

DANIEL ROSENQUIST: --who may claim it.

M. CAVANAUGH: And that referral is that necessarily-- you aren't referring them to Dr. Amoura's clinic. You're referring them to a diff-- there's sort of an in-between.

DANIEL ROSENQUIST: Yes.

M. CAVANAUGH: OK. So in this bill, the way, the way I read it, you would not-- you would be prohibited from doing that.

DANIEL ROSENQUIST: That's my interpret-- that's our interpretation of the bill.

M. CAVANAUGH: OK. OK. And then Section 6, lines 16 to 19, talks about state funds shall not be directly or indirectly used, granted, paid or distributed to an entity, organization or individual that provides gender-altering procedures to an individual younger than 19 years of age. So that seems very problematic to me because we have a lot of large medical facilities. So if we are withholding state funds, we might not be in compliance with some federal laws. Is that--

DANIEL ROSENQUIST: That would be a concern, yes.

M. CAVANAUGH: OK. All right. Thank you for validating my concerns.

DANIEL ROSENQUIST: I don't, I don't have the legal background to say.

M. CAVANAUGH: All right. Well, thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you. Thank you for being here, Dr. Rosenquist. I guess I would like to remind the medical community that the state government does have a seat or has to have a seat at the table just because of our fiduciary duty to protect the public. And as a second piece, we are a very big payer, if you will, through Medicaid, the Feds through Medicare. So I think--

DANIEL ROSENQUIST: Absolutely.

RIEPE: --sometimes we're going to get into your business. That's just the way it is. The question that I have with you would be how extensive are long-term studies on dysphoria, including medication, surgery and counseling? Are-- and are any of those published in JAMA or other recognized journals?

DANIEL ROSENQUIST: I think they are public-- I can't tell you how long those studies have been done and been looked at. There are probably people that are much more qualified than I am to answer those questions, but at the same time, they are published in all phases of literature, including JAMA, nationally recognized JAMA, New England Journal of Medicine. That's all-- and others, but then also lesser journals as well. And so we always have to-- you always have to look at the reliability of those studies.

RIEPE: Sure. Absolutely. I guess my follow-up piece to that would be is I hope someone can maybe address this a little bit is it seems like Sweden, Finland, and New-- are, are retreating from where they were. And I'm just curious from physicians' perspective, why? What-- because they've been in the business longer than we. Well, what-- is what we're hearing true that they are retreating? And if so, why is it?

DANIEL ROSENQUIST: I can't answer that question. But my, my first question would be what were they doing before and are they backing down to maybe standards that others may be doing now? Maybe, maybe they were too liberal with their policies and what they-- or interventions and stuff and now maybe we're kind of backing down as the best evidence or evidence comes down to, like, maybe we should be doing this and this and not, you know-- looking better at-- I don't-- that's--

RIEPE: I'm just eager to learn more about it. All right, thank you.

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

DANIEL ROSENQUIST: Thanks.

HANSEN: We'll take our next invited testimony in opposition, please. Welcome.

HANNAH COFFEY: Hello. Senator Hansen and members of the Health and Human Services Committee, my name is Hannah Coffey, H-a-n-n-a-h

C-o-f-f-e-y, and I appear before you today in opposition to LB574. I am a doctoral student at the University of Nebraska-Lincoln and I'm here testifying on behalf of the Nebraska Psychological Association. This testimony does not necessarily reflect the views of the University of Nebraska. Suicide is the second-leading cause of death for Nebraskans aged 15 to 24 and the leading cause of death for Nebraska children between the ages of 10 and 14. Transgender youth are even more likely to struggle with thoughts of suicide and self-harm as a result of marginalization, targeted victimization and lack of support. According to the American Academy of Pediatrics, half of transgender youth have thoughts of suicide and one-third attempt to end their own lives. However, a child's community has an enormous capacity to either improve a child's mental state and level of safety or significantly harm them. Like all people, transgender youth are less likely to experience depression, anxiety and suicidal thoughts if they feel accepted and supported by their communities. But efforts to restrict rights or invalidate the experiences of transgender individuals, including through legislation, increase mental health distress among youth. Further, according to the American Psychological Association, access to gender-affirming treatment improves the mental health of transgender youth and can reduce their risk of depression and suicide to rates similar to cisgender children and teens. Gender-affirming care is a wide category that encompasses everything from providing counseling and support to hormone treatments to gender-affirmation surgeries. Unfortunately, this bill is written in such a way that it seems to equate any attention to gender dysphoria or gender creativity with genital surgery, which is rarely recommended for individuals under 18. According to the Endocrine Society's guidelines, appropriate care for children experiencing gender dysphoria or gender incongruence may involve reversible puberty blockers in early adolescence and possibly hormone replacement therapy later. Gender-affirming treatment not only improves the emotional state of transgender youth, it also makes them less likely to be targeted for bullying and/or violence by people who cannot tolerate the idea of gender variance. Professional organizations such as the American Psychological Association and American Academy of Pediatrics categorically oppose one-size-fits-all legislation that would deny gender-affirming treatment to all children and teens within this particularly vulnerable population. Transgender youth need access to evidence-based treatment, as approved by their guardians and healthcare professionals. Nebraska should be a place where transgender children are embraced and supported, not blocked from receiving the kind of care that can enable them to grow into healthy, productive

members of our community. In conclusion, transgender youth face many challenges, including dramatically increased risk of suicide and hate crime victimization, and this can be reduced by supportive communities. Transgender youth benefit from access to gender-affirming treatment. Transgender youth need and deserve our support. LB574 has the potential to cause significant harm to the mental health of Nebraska's transgender youth. We ask that you do not advance LB574. Thank you for your time and I'm happy to answer any questions.

HANSEN: Thank you for coming to testify. Are there questions from the committee? I might have just a couple of questions--

HANNAH COFFEY: Yep.

HANSEN: --about some of the things you cited here. One of the things you mentioned about according to American Academy of Pediatrics, half of transgender youth have thoughts of suicide, one-third attempt to end their own lives. Are those youth the ones that have done-- I got to make sure I get the right words-- hormone treatment or gender-affirming surgeries? Is that before or after?

HANNAH COFFEY: Not necessarily. It includes all transgender youth, regardless of whether they've gone through any type of medical transition.

HANSEN: So do they typically see the ones who have gone through the transition--

HANNAH COFFEY: So they--

HANSEN: --have less instances of suicide?

HANNAH COFFEY: Yes.

HANSEN: OK because I think you mentioned that in your, in your testimony there.

HANNAH COFFEY: Yes, there is--

HANSEN: Yeah, right here.

HANNAH COFFEY: --ample research that shows--

HANSEN: Similar to cisgender children--

HANNAH COFFEY: Yep.

HANSEN: --and teens, OK.

HANNAH COFFEY: Yep.

HANSEN: If I-- if you could, could you email me that study?

HANNAH COFFEY: Sure.

HANSEN: Because I'm not going to go through right now and all that kind of--

HANNAH COFFEY: Yeah.

HANSEN: --stuff. I'm just kind of-- more for curiosity's sake.

HANNAH COFFEY: Absolutely.

HANSEN: OK. That's all I had. Senator Riepe.

RIEPE: Quick question. Thank you, Chairman. My question would be on suicide attempts. To what extent-- how many are multiple attempts by the same person? Is that a statistic that's out there?

HANNAH COFFEY: Yeah.

RIEPE: Because in this statistic, we're bound to get some double-counting.

HANNAH COFFEY: Right.

RIEPE: I don't know what it is, but--

HANNAH COFFEY: Yeah. No, I think that's a fair question. And honestly, without looking at, like, individual research studies, I can't answer that question right now. But I think studies definitely vary in the way that they measure-

RIEPE: Sure.

HANNAH COFFEY: --suicide attempts. And so some will report the number of people who have attempted suicide so they wouldn't be counting people twice, for example, and others might include number of attempts. The way that the American Academy of Pediatrics words their support refers to the number of people, I believe. But I will double-check that and I can get back to you.

RIEPE: You can do your dissertation on it.

HANNAH COFFEY: Maybe.

HANSEN: Any other questions from the committee? Seeing none, thank you for coming to testify.

HANNAH COFFEY: Thank you.

HANSEN: We'll take our next invited testimony.

ISABELLA MANHART: And Senator Riepe, I've printed a JAMA study for you to read and yes, I have some information from the federal Department of Health and Human Services as well.

RIEPE: You read my mind.

ISABELLA MANHART: Members of the Health-- yes. Members of the Health and Human Services Committee, my name is Isabella Manhart, I-s-a-b-e-l-l-a M-a-n-h-a-r-t. I live in District 5 and I'm speaking in opposition of the so-called Let Them Grow Act. I could waste of my time addressing all of the falsehoods that I've heard in the past three hours from out-of-state individuals and people who have tragic-- and adults who have tragically internalized homophobia. But instead, I'd like to focus on the truth of what this bill means to trans youth and families like mine who live in Nebraska. I'm nonbinary. My little brother is transgender and I'm here today for him. I'm here today for my family and my friends and my community who shouldn't have to fight to ensure that we have access to healthcare. My brother is ten years old. He's known he was a boy since he could speak. He plays soccer and basketball and he does robotics and he does Reading Olympics. He plays cello and bass in a local youth orchestra and he loves to read and make his own movies. He loves animals and he wants to be a zoologist when he grows up. He's smart and he's funny and he's kind and he's transgender. Every day, I worry that he'll get bullied or hurt by kids his age because they can't see past the bigotry that our world teaches people. I shouldn't have to worry that the real bullies are elected officials. The fact that anyone could look at my baby brother and think deserves anything less than the basic human right to healthcare that supports his needs absolutely breaks my heart. Senator Kauth sent my family an email full of uncited facts in attempt to justify this bill. But the truth is that the Let Them Grow Act is just as misinformed as it is a misnomer. Gender-affirming care is in no way preventing trans kids from growing. In fact, according to the Federal

Department of Health and Human Resources, it does quite the opposite. Early gender-affirming care is crucial to the overall health and well-being of transgender children and you'll find that highlighted in the, the study that I printed out for you. According to the Trevor Project, the leading suicide prevention organization for LGBT young, LGBTQ young people who you heard before, 58 percent of transgender and non-binary youth in Nebraska seriously considered attempting suicide in 2022. By prohibiting our access to gender-affirming healthcare, you will contribute to that devastating statistic. The Journal of the American Medical Association, also printed for you, cites that odds of severe depression were lowered by 60 percent and odds of suicidality were lowered by 73 percent. I'm not exaggerating when I say that gender-affirming healthcare helps save lives. It allows us to grow into the people we've always known we are. I really-- I want nothing more for my little brother than to grow up healthy and confident in himself and that starts with respecting our right to make decisions about our own healthcare. Trans kids and our families, we know what's best for us. No trans and non-binary youth spoke as proponents. We're all here right now in opposition and we're demanding to be heard. As our state senators, you have the responsibility to stand up for Nebraska children and families. Don't advance LB574. Stand up for transgender children, as you would any other Nebraska kids. Thank you.

HANSEN: Thank you for your testimony.

ISABELLA MANHART: Yes and I welcome any questions.

HANSEN: And we have plenty of Kleenex up there too, so. Are there any questions from the committee at all? OK, you're off the hook.

ISABELLA MANHART: Well, I hope those studies are helpful for you and--

HANSEN: Thank you for bringing them too--

ISABELLA MANHART: --get some of those facts.

HANSEN: --by the way.

ISABELLA MANHART: Yes.

HANSEN: Thank you for your testimony. And on a side note-- I did it for the previous testifiers too. If we hear anybody else making noise again, I will have the Clerk remove you. So please try to hold that down, if we can, just so we can be fair to everybody else. Thank you. All right, we'll take our next invited testimony.

RACHEL OGBORN: I didn't give you too many copies so I'm sorry.

HANSEN: Welcome.

RACHEL OGBORN: Hello. My name is Rachael Ogborn. That's R-a-c-h-e-l O-g-b-o-r-n. Sorry, I'm a little emotional after that last testimony, but anyway. It's important to hear from the families that will be affected from this bill and my family is one of them. I have to say that I never thought that I would be driving to the Capitol to share my child's medical information with senators or with anyone for that matter. I do feel very scared and vulnerable today, but I'm here so I don't lose my child. Sorry. I know that sounds extreme, but so is this bill. Receiving gender-affirming care from licensed professionals has saved my child's life. Gosh, I'm sorry. I'm struggling.

HANSEN: Just take your time, it's fine.

RACHEL OGBORN: When my child's voice dropped, the world went dark for her. I didn't know this, as I made cute comments about my baby growing into a man. However, eventually I found out her truth after several emergency room visits. After evaluation by two different therapists and multiple professionals at UNMC, which is one of the best medical centers in the country, she was able to start testosterone blockers and estrogen. I went from having a suicidal, depressed, self-harming son who didn't see himself in the future at all to having a happy, healthy daughter-- sorry-- who smiles and talks at the dinner table. She wakes up early for school now and she's excited to see her friends. I'm so sorry. This is embarrassing.

HANSEN: Don't worry, you're just on national TV.

RACHEL OGBORN: I know. It's so awful.

HANSEN: And we're staring at you, so.

RACHEL OGBORN: I know. It's fine. Thank you for making me laugh. Now she's making plans for her future. Unfortunately, one of those plans is running as far away from Nebraska as she can. She feels under attack when she sees this bill and others in the media. And she said that-- she's told me that she's scared she's going to be a part of the next genocide in history. I know that the worry behind this bill is not wanting things forced on children and I absolutely agree with that sentiment. I'm not forcing this upon her. I would never in a million years wish struggles upon anyone like this, especially my own child. I wish that I could just have an-- she could have a normal high school

experience and the easiest life possible and that neither of us had to worry about her losing her medical care. If anyone's forcing anything upon her, it's anyone who endorses this bill. By denying her medical care, they'd be forcing their ideals and their desires upon my child. It's not any legislator's job to tell my children's doctor that she can't have healthcare. It's not any legislator's job to invalidate medical research or disregard statistics and data or make a moral show of my daughter's existence. I don't know why I'm here begging you guys to listen to medical professionals. I don't know why you're threatening the jobs of experts. How would you feel if someone denied you healthcare because they didn't believe in your medical needs? I urge you, please don't take away my daughter's right to receive healthcare and pursue happiness. Please don't threaten her existence in legislative bills. And if it makes you feel any better, neither myself nor my daughter have ever considered surgery for her as a minor, but it's absolutely nobody else's business anyway. I just want her to live into adulthood. Thank you and I'm so sorry I cried all over you.

HANSEN: It's all right. I've never heard so many sniffling in my life.

RACHEL OGBORN: Yeah, so sorry.

HANSEN: That's all right. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. First of all, everyone on this side of the table will tell you I've cried so many times.

RACHEL OGBORN: I know.

M. CAVANAUGH: My microphone and, like--

RACHEL OGBORN: Everybody's going to say I'm a crazy person and I'm sorry.

M. CAVANAUGH: Don't, don't apologize for it. Lean in. Lean in. You made me cry. I don't have any tissues, though, so I--

RACHEL OGBORN: It's my baby.

M. CAVANAUGH: Yes. I want to ask you about your daughter.

RACHEL OGBORN: Yeah.

M. CAVANAUGH: What are her interests?

RACHEL OGBORN: Well, she can find anything that nobody else cares about and make it interesting. I don't know. She, she loves everything. She reads books and tells me all about them. The most recent book she read, I think, was called Scythe and it was about some futuristic society and was telling me all about it.

M. CAVANAUGH: I see some fans behind you for that one, so.

RACHEL OGBORN: OK. She loves reading. She is the dungeon master for her D&D club at school. She joined a sign language club at school. By the way, she was never a part of any club at school before this year. She's also part of the SAGA club at school, which is, like, a sexuality and gender alliance for kids that don't quite meet the norm. They meet after school. She likes, you know, watching movies. She loves anime and playing video games.

M. CAVANAUGH: She sounds like she is very unique and special and very lucky to have an advocate mom. I, I did want to comment. You wish that she could have a normal high school experience. And as a child of the '80s, I would say that I don't think we want our children to have whatever--

RACHEL OGBORN: Sure. That's fair.

M. CAVANAUGH: --is a normal high school experience. But I really appreciate you being here and sharing your story. And as a fellow mom and crier, thank you.

RACHEL OGBORN: It's hard not to cry about your baby.

M. CAVANAUGH: It is impossible.

RACHEL OGBORN: Yeah.

HANSEN: Any other questions from the committee? I just have one more kind of--

RACHEL OGBORN: Yeah.

HANSEN: --technical question.

RACHEL OGBORN: Sure.

HANSEN: You mentioned that you had therapists and multiple officials at UNMC and that she was able to start testosterone blockers and estrogen.

RACHEL OGBORN: Yep.

HANSEN: Are you able to share where that occurred? Was it at UNMC or was it somewhere else?

RACHEL OGBORN: Yeah. So she still to this day sees two therapists not at UNMC, but elsewhere, but her doctor is actually Dr. Amoura. So the whole process is everything that she explained.

HANSEN: And you don't have to share companies--

RACHEL OGBORN: Yeah, that is all of it.

HANSEN: Just curious. Any other questions from the committee? All right, thanks for coming.

RACHEL OGBORN: Thank you and I'm-- again, so sorry I cried.

HANSEN: Grab a tissue on the way out. All right, we'll take our next invited testimony, please. And we should just have a few more here. Welcome.

ALEK DUNCAN: Hi. I'm Alek Duncan, A-l-e-k D-u-n-c-a-n. I'm testifying in opposition to this bill. I am 23, I'm trans and I'm testifying to share my real relevant experience as someone who's lived as a trans person for at least ten years. Gender-affirming healthcare is what allowed me to survive my youth. For as long as I could think, I've been just very uncomfortable in my skin. I always had a sense that something about me was different, especially from the girls at my Catholic school. I spent my adolescence feeling broken and disgusted with myself. I was a beautiful kid. I just was not a girl. And once I started puberty, whatever piece I knew was ousted and my body betrayed me. Everyone around me knew something wasn't right. My dad, the cop, my mom, the nurse. I cycled through at least a dozen therapists as a kid. Some heard my woes about gender and decided to try and fix me. Others just ignored it. And when I came out, the pushback from my family was immense. My dad absolutely refused to comprehend such a thing, which tore us apart for many years. And after trying basically anything else to prevent me from dying, my mom called the psychologist, who was renowned for her gender and sexuality expertise. I was 16 at that time and that's when my life really changed. My

therapist approached all facets of my identity without judgment and she did the same for my struggling family. And if I had not found her when I did, I know that I would not have made it to the age of 18. I would not have the healthy and beautiful relationships with my parents that I have now that we've all had to work very hard for. There are many misconceptions about young people transitioning. To medically transition requires years of rigorous mental and physical evaluations with many medical and mental health practitioners. And we've already addressed why it's crucial to entrust these decisions to them, but if that were the case, I would not be here right now testifying. In a group half full of people pushing for a bill that would have killed me as a kid, I feel that I am still the last person to be taken seriously. But our perspectives are more relevant in this room than anything else. Who else is meaningfully affected by a trans person transitioning? The precedent should be given to those who truly need access to this healthcare to survive. I know that many people at this hearing do not care for me or people like me, but what I understand more than anything is that you deserve to be at peace in your own body and in your own life. I also deserve to exist comfortably. I deserve to make decisions about my own body and my own life and I deserve that just as much as a child. I close with two requests. First, consider that each of us as humans are the experts on our own lives. And second, to quote a great song, just remember that it is hard to be a human being and it is harder as anything else. Thank you.

HANSEN: Thanks for coming to testify. Are there any questions from the committee? We are-- I thought we were going to be all gung ho on asking the hardest questions we can think of, but I guess there are no questions. So thank you for coming.

ALEK DUNCAN: Thank you.

HANSEN: Appreciate it. All right. We'll take the next invited testimony in opposition, please. Welcome.

SARAH MARESH: Hello. Chairperson Hansen and members of the Health and Human Services Committee, my name is Sarah Maresh, S-a-r-a-h M-a-r-e-s-h, and I am the health care access program director and an attorney at Nebraska Appleseed, testifying in opposition to LB574 on behalf of Appleseed. We are a nonprofit organization that fights for justice and opportunity for all Nebraskans. Because this bill is legally suspect and restricts healthcare access, Nebraska Appleseed opposes this bill. Significantly, this bill is legal sus-- legally suspect for multiple reasons, some of which I will briefly describe,

but happy to talk about it more. And it's more fully laid out in my testimony handed out. First, this bill is legally suspect under federal Medicaid law. Gender-affirming care restrictions and Medicaid have faced numerous legal challenges based on a variety of claims under federal Medicaid law and we have concerns about the legality of this bill under these laws. This bill effectively prohibits the use of state funds for gender-affirming care and would effectively ban that care from youth from being covered by Medicaid. Medicaid as a joint federal and state program. After a state chooses to participate in Medicaid, the state has to follow Medicaid laws. Relevant to this bill, Medicaid requires states to cover services for youth under 21, known as the Early and Periodic Screening, Diagnostic and Treatment, or EPSDT benefit. Under the mandatory benefit, the state must cover every allowable, mandatory and optional Medicaid service necessary to correct or ameliorate conditions for people under 21. CMS has already recognized that gender-affirming care fits within multiple categories of Medicaid coverage under federal law. Notably, a variety of categories of gender-affirming care are already covered by many states and in their Medicaid programs and is being reimbursed by CMS. Because CMS has determined that a variety of different services under the umbrella of gender-affirming care fits in the relevant categories of Medicaid coverage, individual states lack the authority to refuse to provide such services when it can correct or ameliorate conditions of a medicaid beneficiary under 21. The federal Medicaid Act also has requirements to ensure there aren't any discriminatory practices and this bill is also legally suspect under those that prohibit states from discriminating basis on solely on the diagnosis, illness or condition. Second, even outside of the Medicaid context, there are other questions about whether this bill is legal. Attempts to ban gender-affirming care have faced other legal challenges on constitutional and other non-Medicaid federal grounds in the Eighth Circuit, as you heard about earlier today. Not only is this bill legally suspect, LB574 also direct, directly restricts access to healthcare services and will have negative impacts on Nebraskans. Nebraska Appleseed is committed to ensuring that Nebraskans have equitable access to healthcare services and therefore opposes this bill. Thank you and I'm happy to answer any questions.

M. CAVANAUGH: Thank you, Ms. Maresh. I'm sure we all know I have questions, but we'll see if anybody else on the committee has questions first. All right, I'll dig in then.

SARAH MARESH: All right.

M. CAVANAUGH: This has been-- you're addressing one of the concerns that I had, which is on page 7, and the, the issue of us potentially losing Medicaid. If we were to enact this bill, would the state of Nebraska no longer receive Medicaid funds in your interpretation?

SARAH MARESH: Yeah, that's a great question. I can follow up with you more on that. I think one of the concerns we have about this bill is it opens up the state to legal liability in a variety of different ways, and that can come in many different forms when we're talking about Medicaid violations. So I'm happy to follow up with you more on that more specifically.

M. CAVANAUGH: OK. I think it'd be great if you followed up with the committee.

SARAH MARESH: Oh, great.

M. CAVANAUGH: And then you said the other liability issue outside of Medicaid is-- can you speak a little bit more about what's happening in other states?

SARAH MARESH: Yeah, definitely. So there has been a recent string of cases that have had challenges against gender-affirming care restrictions, both in the context of Medicaid, but also in the context of other federal laws and constitutional challenges. There have been a recent string of cases that have had success in this area. A lot of these cases are also still working their way through the court system. A couple notable ones is the Arkansas case I think someone mentioned earlier in their testimony. An Arkansas bill that was very similar to this one was challenged and the Eighth Circuit, which is our circuit, upheld a preliminary injunction banning that gender-affirming care bill from going into effect.

M. CAVANAUGH: OK, great. Thank you for that. Any other questions? Seeing none, thank you so much for your testimony.

SARAH MARESH: Thank you.

M. CAVANAUGH: I-- we'll take the next invited testimony.

E. SCOTT JONES: Good evening. I'm Reverend Doctor E. Scott Jones, S-c-o-t-t J-o-n-e-s, the senior minister of the First Central Congregational United Church of Christ in Omaha, Nebraska, the oldest continuously worshiping Protestant church in the city of Omaha. I'm also here representing the board of directors of the Nebraska

Conference of the United Church of Christ, my denomination. Our statement with cosignatories is the second page of what you're being handed. There are a handful of other clergy colleagues here today intending to testify and I hope you get to hear from them as well. Just last week, a mother in my congregation called me from the emergency room at Immanuel Hospital. She was there with her trans daughter who had attempted to end her life. The distraught mother kept talking about how awful society is to trans people. Now, I don't know if the daughter was following the news and the debate over this specific bill and ones like it. I don't know if the existence of this bill directly contributed to her suicide attempt, but I do know that the climate of bigotry and discrimination to which a bill like this contributes was a factor in her suicide attempt. So I come to you today as a Christian pastor who only last week cared for a family confronted by the need for gender-affirming care. I'm asking you not to further burden good people of Christian faith with unnecessary obstacles and political controversy. I'm asking you to uphold the dignity of the human person and to defend religious liberty and the freedom of conscience. In my denomination, the United Church of Christ, descended from the Pilgrims and the Puritans, we affirm that the beauty and blessedness of God's creation is present in all people. We make a conscious and deliberate decision to celebrate the diversity of creation as uniquely embodied in the people who are lesbian, gay, bisexual, transgender and queer. We honor the sacredness of people's lives, their extravagant welcome and unconditional affirmation of people of all sexual orientations and gender identities. The mission statement of the Nebraska Conference of the United Church of Christ proclaims to live under God's extravagant welcome and advocate for justice so that all people know love, safety, belonging and dignity. In what I distributed, you also have a letter from the Nebraska Conference of the United Church of Christ stating our religious opposition to this bill and all the clergy, congregations and laypeople who've added their names to the letter. This bill violates our Christian faith. It violates the sacredness of God's creation. It is antithetical to the Gospel of Jesus Christ. This bill discriminates against my denomination and my congregation, threatening our religious liberty and our freedoms of conscience. So I ask you not to advance and to oppose LB574. Thank you.

M. CAVANAUGH: Thank you, Reverend Doctor Jones. Are there any questions from the committee? Seeing none, thank you so much for your testimony. We will call up our next invited testifier and I may be

biased in saying possibly the best invited testifier, but that's just my own personal bias. Welcome.

ASH HOMAN: Hello. Thank you. My name is Ash Homan and A-s-h H-o-m-a-n and I am a trans person under 18-- or under 19, I guess. And first, I would just like to point out a quick thing that I think a lot of people seem to be confused on here. A lot of-- most people cannot get gender reassignment surgery before the age of 18 and the same with hormones such as estrogen and testosterone. And the option for kids under 18, which are hormone blockers, which just pause puberty. And if a child stops taking them, the puberty process will resume right where they left off. And this bill would limit the necessary gender-affirming care for the most vulnerable population at the moment, leaving teenagers more susceptible to suicide, discrimination, depression and other mental health disorders and problems, not to mention all the more people who would need to leave Nebraska just to get this care. So I'd like you to think of ways this bill would be hurting the state's future generations and taking those ways into consideration when passing other bills that deal with LGBT issues. I'm a trans teen and I would like to see you guys do better work for the people that will be living in the state you created and will have to fix it for themselves. And discrimination has always been a problem for trans people of any age and all this bill would do is perpetuate this by saying it's a mental disorder with treatment that needs to be pushed until the person is an adult and they can make logical decisions for themselves. Today's youth already have enough mental health challenges already and we don't need the added stress of having to live as our gender assigned at birth when we don't feel that way until we're old enough to change that. Whatever age a trans person starts to feel that way is the age that person should be able to start living as who they want to be. I'm not saying kids should be getting elaborate surgeries and taking permanent hormones at the age of seven. I'm saying the people introducing and passing these laws underestimate how much a child knows about their own body and about their own brain. These people need to trust kids to know what's best for themselves. I also find that as I listened to the proponents of this bill, I heard a lot of them talking about when they were young, they were called a tomboy and they thought of themselves as a tomboy. Being a tomboy and being trans are not the same thing and they cannot be compared accurately to each other. And gender-affirming care shouldn't have to wait until you guys say it should, it should start when they feel comfortable.

M. CAVANAUGH: You're in charge.

HANSEN: OK. That's right. OK, are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you so much. Ash, thank you for being here. Not to diminish all of the rest of the testifiers, but you are possibly my favorite testifier today.

ASH HOMAN: Thank you.

M. CAVANAUGH: And I appreciate you showing up and sharing your voice. It's so important and I just wanted you to know that I'm really impressed with you, so thank you.

ASH HOMAN: Thank you.

HANSEN: Any other questions from the committee? Doing pretty good.

ASH HOMAN: Thank you.

HANSEN: Yeah, you even got the shades on. Looking good too, so.

ASH HOMAN: Yeah. I was debating whether to wear them or not, and I was, like-- yeah.

HANSEN: OK. Good call. I think your mom would approve. All right. All right, thank you for coming. Appreciate it.

ASH HOMAN: Yes, thank you.

HANSEN: All right. We'll take the next invited testimony. Welcome. Now we're set.

CAMIE NITZEL: Respected senators and constituents, my name is Dr. Camie Nitzel. I am a licensed psychologist in the state of Nebraska, as well as the founder of Kindred Psychology. We are an inclusive and affirming mental health practice in Lincoln, Nebraska. In addition to psychotherapy and assessment services, we also host free support groups for parents of trans youth and support groups for trans adolescents and adults as well. I've been providing mental health services in Nebraska for the past 29 years. Don't do the math. In 1995, I saw my first transgender youth in therapy and have served gender-diverse populations consistently since that time. This is not new for me. I also have completed a Ph.D. in counseling psychology with an emphasis in gender and have sought significant amounts of post-doctoral training in providing gender-affirming care. Most

recently, under the umbrella of BHECN and UNMC, Kindred Psychology was awarded federal ARPA funds to train and provide supervision for clinicians to provide gender-affirmative care. This point bears emphasis. A panel containing experts from organizations such as Behavioral Health Region 5, Nebraska Department of Health and Human Services, Nebraska Department of Education, Community Alliance, NAMI and CHI Health recognized the need to further train the behavioral health workforce according to this model that this bill seeks to prohibit. Gender-affirming care is recognized as best practice from both a medical and a psychological perspectives. Of all of the perspectives I've heard today, a comprehensive explanation as to the breadth of services covered under gender-affirmative care has been missing. It is so much broader and more nuanced than hormonal and surgical intervention, which is not clear in this bill, And I'm happy to explain more about that later. One of the points that I wanted to make-- I see my light changed-- has to do with the, the way in which this affects licensed providers in the state. We-- because of the way the statute is written, we are going to be forced to choose between practicing ethically and practicing legally. And as a state that is receiving federal funds due to the paucity of mental healthcare providers in the state, I think that is really a concern and I'm happy to share more about that. But specifically having to do with the ways that we would be charged with unprofessional conduct by providing care or making a referral for, for this type of care.

HANSEN: Sorry, I've got to stop you. Red light.

CAMIE NITZEL: Nope, I saw it, I saw it.

HANSEN: Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: I would love for you to continue explaining the practicing ethically or practicing legally and the unprofessional conduct of care. Keep in mind that we do want to hear from other testifiers, but--

CAMIE NITZEL: Absolutely.

M. CAVANAUGH: --this is an area that is of particular concern for me.

CAMIE NITZEL: Yes, me too. So when we talk about the, the statutes by which we are bound as providers, we are bound to practice according to our codes of ethics. So APA, ACA, and as, as this is written, we would be guilty of practicing using unprofessional conduct if we, if we

provided gender-affirming care. But according to our standards, this is the best standard for our practice. And so we as providers have this conundrum of if I practice ethically according to the standards of my field, then I will be practicing illegally according to this bill.

M. CAVANAUGH: And so then when we're talking about the professional conduct, I believe-- unprofess-- considered unprofessional conduct-- and again, I looked at the statute. It is unclear as to what the course of action is. And I did ask that of Dr. Rosenquist, but if you could say a little bit more about what the course of action? It goes to the Board of Health.

CAMIE NITZEL: Yes.

M. CAVANAUGH: And then--

CAMIE NITZEL: Then they do an investigation. They make a recommendation to the Attorney General and then the Attorney General either then makes a recommendation regarding no action, censure, supervision being required due to a suspension, or the individual can lose a license to practice if they're found to have committed unprofessional conduct.

M. CAVANAUGH: OK, thank you.

CAMIE NITZEL: So we lose providers.

M. CAVANAUGH: Yes, thank you. That's very helpful.

HANSEN: Senator Riepe.

RIEPE: Mr. Chairman, thank you. As a little follow up to that, I'm curious because Nebraska is not the first state that's approached this, so I'm curious. I'm sure that you're in contact with like-professionals in Florida or other places. And how are they working? Are they doing a work-around or what are they doing? Do you know?

CAMIE NITZEL: I actually do not know what other professionals are doing in states where this has passed. I have only been in contact with people who are providing gender-affirmative care.

RIEPE: OK. Thank you.

HANSEN: Senator Day.

DAY: Thank you, Chair Hansen. Thank you for being here today. So could you just give me an idea-- I asked Dr. Amoura earlier. Typically, a-- like a family practice doctor would refer a family to you or what-- how does-- what does that-- like, how long would somebody see you before you would send them to someone like Dr. Amoura? Or what is the process there? A timeline would be helpful too.

CAMIE NITZEL: Right. So as, as a practice, we have seen everything from-- I read all of the intake that comes in and we've seen everything from someone making a self-referral, saying something like, I'm trans. I know I'm trans. I'm ready for this. Or a parent saying the same thing for their child. And they already know and are aware that they need to make an effort to engage in a certain process. And it's really about clinical judgment. I also have been working with people who for years are trying to sift through the nuances of what they experience in order to come to a decision. Sometimes I will make a referral to Dr. Amoura or someone like her to be able to let the person have a conversation from a more medical angle about what hormones might provide for them. And often, it's just information gathering.

DAY: OK. Thank you. And I just have one more question.

HANSEN: Yes.

DAY: So you had mentioned-- we talk a lot about surgical interventions and hormone therapy as being sort of the only things involved in gender-affirming care. Could you just briefly talk about some of the other things that are involved in gender-affirming care?

CAMIE NITZEL: Absolutely. So when, when we think about the, the number of things that we talk about with gender-affirming care, yes, it's hormones. Yes, it's surgery at some point. But there's such a complexity there that for me, that's one of the problems of having a carte blanche bill like this. And so things like knowledge of child and adolescent development and to be able to provide an overall assessment of the home environment a kid's development in general, when were they first experiencing? What is their peer group like now? Are they being influenced? Are they being bullied? Is this a sense of self that they're clear about or is more fluid? And so I think one of the points that's been missing is gender-affirmative care doesn't equal everybody transitions, right? Gender-affirmative care is a

supportive process to engage in with clients. And sometimes what happens is people get really clear about their gender identity and it's the same gender as was assigned at birth. And when we don't provide gender-affirmative care or when we tell providers you can't talk about this because you're going to lose your license, then we don't provide the sort of support and assistance that people need to be able to discern and kind of craft their own way through whatever that looks like.

DAY: OK. That's helpful. Thank you.

HANSEN: Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here.

CAMIE NITZEL: Sure.

BALLARD: You mentioned something in your testimony. You said experiences that led to this decision. It kind of corresponds with what the proponents said as well. Can you talk about working with your clients about those experiences that led to this decision?

CAMIE NITZEL: The decision to seek therapy?

BALLARD: Yes, decision to seek or gender, gender--

CAMIE NITZEL: Yeah.

BALLARD: Yeah.

CAMIE NITZEL: You know, sometimes people will have an aha moment that lots of things that they have previously understood as aberrant all of a sudden makes sense because, oh, they have, they have a word for it. So, for example, if someone learns in a health class, oh, there, there is a way to experience your own sense of gender identity that's like this, that's what I've been experiencing all of these years. I just have always called it wrong or called myself a tomboy. I'm not a tomboy. I'm-- I think I'm this, right? So that's, that's an example of something that might be a catalyst experience for someone to start exploring more. You're, you're eyebrow at me like--

BALLARD: I'm just-- no, no, no. I get what you're saying. A lot of proponents said they had a certain life experience. They called it trauma. Can you, can you dive into that a little bit?

CAMIE NITZEL: You bet. That's one of the parts of gender-affirming care is to be able to differentiate. So if someone is asking that, right, if they're asking a question, am I trans? Of course, their development, their school, their peer group. Has there been any trauma? What is the home environment like? Are they using substances of any kind? Right? It is such a diverse and complex constellation of things to be talking about. And you can't conflate trauma with gender identity. Sometimes those go together, right? Sometimes lots of other things go together as well.

BALLARD: OK. And I have one more brief question--

HANSEN: Yep.

BALLARD: --if I may, Mr. Chairman. And did you say you had-- you received ARPA funding for--

CAMIE NITZEL: Yes.

BALLARD: Can you expand on that a little bit?

CAMIE NITZEL: Yes. So in the last-- so-- what is it? Association for Rural-- it's federal funding to increase provider density and we're in rural areas that there are provider shortages. And so there was a competitive grant process and then the experts from the organizations that I shared reviewed the grant proposals and then awarded funding based on demonstrated need, the proposals themselves.

BALLARD: Thank you.

HANSEN: I have just a couple questions, if I could quick.

CAMIE NITZEL: Absolutely.

HANSEN: I don't want to give too much more time because I know there's people behind that are wanting to testify. Does this bill prohibit gender-affirming care?

CAMIE NITZEL: As I read it--

HANSEN: I thought it was more procedures and medications, not just gender-affirming care.

CAMIE NITZEL: Right, so the--

HANSEN: I know--

CAMIE NITZEL: --the way that it's written--

HANSEN: We have to differentiate because I know you're saying it's kind of a holistic and there's kind of, you know--

CAMIE NITZEL: Right. The way that it's written, as I interpret it, uses the same CMS codes that a physician would use. So when I, when I file to insurance for a one-hour therapy session, that is a CMS code that comes from Medicare, right, of 90837.

HANSEN: Um-hum.

CAMIE NITZEL: Dr. Amoura will have her own CMS code. They're the same, right? They'll be different codes, but we're, we're using the same book.

HANSEN: Sure.

CAMIE NITZEL: Right?

HANSEN: Is it under gender-affirming care? Like, is there a title that says gender-affirming care, here's your ICD-10 codes and all that kind of--

CAMIE NITZEL: So when you-- if, if you were my client and you were sitting in my office and you said, I wonder if I'm trans, if I am to say to you anything having to do with providing gender-affirming care, I couldn't make a referral to Dr. Amoura. We have lines and lines of people who leave their current providers because their providers aren't talking with them about it, right? So it is all coming from the same manual and the same book of-- and the same WPATH standards that inform my work, informs Dr. Amoura's work. It's, it's all the same.

HANSEN: OK. All right. Thanks for the clarification.

CAMIE NITZEL: You bet.

HANSEN: And I've heard this a couple of times in different testimonies, which is it's their best practices.

CAMIE NITZEL: Um-hum.

HANSEN: Who determines the best practices for--

CAMIE NITZEL: The experts in each field, so--

HANSEN: Is it, like, the AMA, or is it--

CAMIE NITZEL: Yep. And I can read you the list.

HANSEN: That's all right.

CAMIE NITZEL: So we have APA, which is the American Psychological Association that I'm a member of. Then there are divisions within--

HANSEN: OK.

CAMIE NITZEL: So Division 45 are experts in the fields of gender and sexuality. And those are people who publish, they do peer review.

HANSEN: So it's a multitude of organizations.

CAMIE NITZEL: Right.

HANSEN: OK.

CAMIE NITZEL: And those are the people--

HANSEN: That's what I was kind of curious-- I didn't know if it was one or if it was multiple ones that you guys kind of go by, so. OK.

CAMIE NITZEL: Yep.

HANSEN: Awesome. Any other questions from committee? All right, thank you very much.

CAMIE NITZEL: Um-hum.

HANSEN: Insightful. All right, do we have any more invited testimony in opposition? I think we might be done. So what we're going to do next is we're going to actually kind of try to get everybody to move forward and as we allow people to come in here. And if anybody is moving on or not testifying, if they want to leave, they can go out those doors. If they're willing to stay-- We'll welcome our first testifier in opposition to LB574. Welcome.

ELIZABETH WEEDIN: Chairperson Hansen-- thank you. Sorry, we had a bit of a rearrangement of chairs. Members of the Department of Health and Human Services Committee [SIC], my name is Dr. Elizabeth Weedin, E-l-i-z-a-b-e-t-h W-e-e-d-i-n. Thank you for allowing me the opportunity to express my opposition to LB574. I'm a double board-certified OB/GYN and reproductive endocrinology and infertility

specialist. In addition to acknowledging the safety of these hormone-modulating medications referenced in the bill, I would also like to speak to the limitation, if passed, this would put on physician referral to expert-level care for gender-affirming services in Nebraska. To illustrate this point, I would like to share a brief story and ask you to use your imagination to view how this landscape might look should LB574 pass. Born and raised in Nebraska, I spent much of my childhood in awe of this very building and what greatness it represents. Maybe even more so than most, as I walked down these very stone hallways hundreds of times as my mother worked at the Capitol for over 30 years. Most Nebraska children, however, have their first visit here on a field trip in elementary school. Maybe it was even your first as well. Nonetheless, please imagine for a moment you're a child once again walking up the giant stone steps to one of the biggest buildings you've ever seen. You might be excited, but also a little nervous. What could be inside? Will the people be nice? Your teacher hold your hand-- holds your hand and gently leads you in, giving you the calm reassurance as she excitedly introduces you to the experts who are inside, who are part of this unique legislative Unicameral that we have today. Now, picture this instead. You are walking up to another large building, but this time it's a hospital and you're holding your mother's hand anxiously wondering what will happen inside. Will the people be nice? Will they know how to treat you or who to send you to? Your mom squeezes your hand because inside of that building are the experts. They will know what to say. They will know how to help. The difference, of course, in these two scenarios is the type of expert whom the child is going to see. Currently in Nebraska, referrals are made from specialists like myself to experts in the field of gender-affirmation care who provide reassurance and treatment, as well as confidence that this care is safe, it is important, well established, and every person and every child matters to our community. But say this bill passes. Now imagine it's your child, this time holding your hand. And you walk into the doctor's office desperately hoping the expert can guide you, as you've never dreamt you would be facing this scenario. But now that provider says, I'm sorry, I can't talk to you about your child's concerns because I could risk my license due to a legislative bill that was passed. I can no longer refer you to someone who can provide expert care. The medical experts are now out of reach. They may have even moved out of state, all because a barrier to care has been inserted by legislation. I cannot begin to understand the full scope of what you all do, nor do I expect you to understand what I do. But what I do expect and desperately hope at this point is that you can respect that

we are the experts in medicine. As a reproductive hormone expert, I can tell you that these medicines are safe and the doctors that are prescribing them are qualified to do so. Furthermore, I desperately want to ensure that I can refer any patient without concern for my license. Yes, in close, please let the children grow, but do so through opposing LB574. As a physician and expert in reproductive hormones, a Nebraska native and a mother of three small children, oppose this bill. Protect the next generation by leaving the medical decisions to the medical experts. Thank you. I'll take any questions.

HANSEN: Yep. Thank you for testifying. Are there any questions from the committee? There are none.

ELIZABETH WEEDIN: Thank you.

HANSEN: Yeah, thank you. All right, so before I start taking testifiers up here, we're going to go from one side of the room to the next and we'll kind of go back and forth so that way, we're not kind of looking at each other, wondering who's going to go next. So we'll start on this side of the room with our next testifier in position. Welcome back, Senator.

JOHN McCOLLISTER: Chairman Hansen, members of the Health and Human Services Committee, my name is John McCollister, J-o-h-n M-c-C-o-l-l-i-s-t-e-r, and I reside in the 20th Legislative District. I understand there's a political mandate from a narrow segment of Nebraskans clamoring for the culture war legislation like we're hearing today. But with the dearth of bills to consider this legislative session, I would hope a wiser course of action would be for this committee to table this controversial legislation. First and foremost, it is a dangerous mistake for the Legislature to substitute its own limited medical judgment over families who are collaborating with doctors and mental health professionals based on established medical practices that are rooted in science. State senators, however well-intentioned, have no business injecting themselves into the doctor-patient relationship. In fact, the American Medical Association, AMA, has urged state governments to stop interfering with the treatment of trans youth. Moreover, it's clear that the passage of LB574 would put the state and-- state of Nebraska in serious legal jeopardy. A similar bill in Arkansas that bans gender-affirming care for trans minors was blocked from enforcement by the Eighth Court of Appeals. And as sure as the sun rises in the east, the language proposed in this bill would be challenged in court as well. Is this bill so essential to the well-being of Nebraskans that the Legislature

would advance it with its serious constitutional defects? As it is now written, Section 38-179 generally defines unprofessional conduct as any departure from or failure to conform to the standards of acceptable, acceptable and prevailing practice of a profession. Thus, the law clearly enacted by the Legislature requires physicians to comply with the standards of their profession when diagnosing and treating their patients. LB574 would turn this Legislature into a professional medical panel, what it is not equipped to become. Please let this legislation die in committee.

HANSEN: Thank you. Are there any questions from the committee? I guess they don't miss debating you anymore.

JOHN McCOLLISTER: Yeah.

HANSEN: All right.

JOHN McCOLLISTER: Thank you, Senator.

HANSEN: All right, thanks for coming. We'll take our next testifier in opposition from this side of the room, please. Welcome.

SHERI SHULER: Good evening. My name is Sheri Shuler, spelled S-h-e-r-i S-h-u-l-e-r, and I am from Omaha. My 16-year-old son hates math, he's obsessed with his phone and his room is an utter disaster. But he volunteers at kids theater camps. He's especially good with kids on the autism spectrum. He is a brilliant actor, singer and writer of poetry and plays. He loves his younger sibling, Spotify, Starbucks and horror movies. Sometimes I have to nag him to shower and other times, he spends so much time on his hair that he's late for school. In other words, my son is a typical teenage boy. He's also transgender. Before figuring that out, his not-so-typical mental health issues included self-harm, suicidal ideation and suicide attempt. We lived through some terrifying years as parents struggling to find help, sleeping on his bedroom floor and even multiple hospitalizations. One thing that finally helped was the transgender clinic. Partially because of the kind of misinformation heard today from the proponents of LB574, we were scared about beginning treatment. Like most parents, we wanted our son to be healthy and safe. After a lot of careful research, we concluded that not beginning hormone therapy was riskier and we cautiously moved forward. But only after his pediatrician, the doctor at the clinic, two psychiatrists and his therapist all agreed. It's been eight months on hormone therapy and our son is thriving. His mental health issues are more manageable now that gender identity is

not one of them. He has normal teenage problems like toxic relationships or friendship issues, but not mental health crises. When he was a toddler, he was critically ill at Children's in the PICU due to sepsis. Thank God the doctors could do what was needed to be done to save his life. No politician tried to interfere with the lifesaving medication he needed, but LB574 is exactly this; interfering with doctors' ability to save children's lives, including my son. Do not erase my son's progress, increase his risk of self-harm, and throw our family back into a chaos that we are just now emerging from. Gender-affirming care is lifesaving medical care. I beg you not to support sending LB574 past this committee.

HANSEN: All right, thank you for your testimony. Is there-- are there any comments or questions from the committee? No, there are none. I think you're just made your son more paranoid about his hair now. All right, we'll welcome our next testifier in opposition from the right. And just so everybody knows, in about eight minutes, we'll start moving to two-minute testimony so we can get as many people in as we possibly can. Same thing that we did with the proponents. We're going to do exactly the same for the opponents. We're actually going about 15 minutes longer. So just to kind of condense your thoughts when you kind of come up here. All right, welcome.

ALEX DWORAK: Good evening, Chairman Hansen and esteemed members of the Health and Human Services Committee. My name is Dr. Alex Dworak, A-l-e-x D-w-o-r-a-k. I reside in District 12. Thank you for serving the state of Nebraska as senators. It is in the spirit of our shared pursuit of the common good of all Nebraskans that I come before you today in opposition to LB574. I am speaking on behalf of my main employer, OneWorld Community Health Centers, and as a private physician. I grew up in Nebraska. I went to college and medical school here and did my family medicine training at the University of Nebraska, where I remain teaching faculty. I went into medicine to help people and I do that by providing primary care to underserved populations. Over the past 20 years of my career, I have delivered babies, worked as a hospitalist, taught hundreds of students and resident physicians, treated HIV, cured people of hepatitis C, and battled the opioid epidemic by prescribing Suboxone and to do all that in English and in Spanish. I faced down the worst days of COVID at risk for my own life and health, along with so many other dedicated colleagues. Providing gender-affirming care to children and adults who are born trans is just another part of my practice. It is one of many areas where I have studied and worked hard to gain mastery and expertise because there is a need for it and because it's the right

thing to do. This bill would take away my medical license for helping families by providing evidence-based standard care. LB574 grievously injures the relationship I have with parents and patients by inserting politics into the exam room. Why would the government tell me how to practice medicine? My treatment of trans children is supported by the consensus of 29 medical, psychiatric and child welfare organizations. This bill rejects the best literature, which shows improvements in mental health, reductions in suicidality, and improvement in overall well-being of children, adolescents and adults who are affirmed in their identity. This is an impossible choice for me as a doctor: abandon a segment of my patients and watch them suffer or lose my ability to practice. Even more importantly, this bill forces an impossible choice on families. It strips parents and guardians of their right to guide the moral and medical upbringing of children in their care, in consultation with medical and mental health providers. Please ask yourself what would you do to help your own child? How would you feel if your child needed evidence-based care to help their quality of life or even save their life and someone else besides you and their doctor got to tell you no? I oppose LB574 because it would deprive patients and their families the choice to receive recommended standard medical care. It would also target the licenses of medical professionals here in Nebraska, just like me, for providing compassionate and guideline-driven care for one of the most vulnerable segments of our population. Thank you so much for the honor of speaking. I'm happy to take any questions.

HANSEN: Thank you for testifying. Are there any questions? Yes, Senator Riepe.

RIEPE: I know you reside in District 12, so that makes you incredibly bright. So thank you for being here.

ALEX DWORAK: Thank you, Senator Riepe.

HANSEN: All right, any other questions? All right, thank you for coming to testify. Appreciate it. All right, we'll take our next testifier in opposition from that side of the room. Good evening.

WILLIAM MANHART: Good evening. My name is William Manhart. I'm here in opposition to LB574. I'm a parent of a transgender-- two transgender children. You saw one of them earlier, Isabella Manhart.

HANSEN: William, can you spell your name for me, please?

WILLIAM MANHART: Sorry. William Manhart, W-i-l-l-i-a-m M-a-n-h-a-r-t.

HANSEN: Thank you.

WILLIAM MANHART: Thank you. Before this bill moves forward, I would like this committee-- like the committee members to consider that this action is potentially creating a law for a problem that does not exist. This is a copycat bill that comes from a conservative lobby-- lobbyist group that has presented this type of bill in other states to create a distraction from real issues that exist. There are already safeguards in place, as Dr. Rosenquist and Dr. Amoura pointed out earlier, that prevent what this bill is proposing to act into law. This bill distracts from the real problems that exist in this state. For example, on the 21st of January, a man walked into a Target with a loaded AR-15 with three additional magazines. We are one of the two states that led the nation in nursing home closures. We have a nursing shortage and hospitals in rural areas are on the brink of closing. I hear about these issues regularly, but I don't hear about children being nefariously given hormones or gender-affirming treatment in some type of cabal because gender-affirming care is not a problem. This is simply political bullying by members of our legislative body against a marginalized group of people in our communities. Additionally, if parents have the right to decline vaccinations for their children, particularly the COVID-19 vaccination, a virus that has killed millions in this nation alone, why do senators who support this bill believe that they should limit the rights of parents to seek gender-affirming care for their transgender, transgender child? Care, which, according to our federal Department of Health and Human Services-- and I quote-- improves the mental health and overall well-being of gender-diverse children and adolescents. There's a citation below and I give other, other information that you can look at when at your leisure. Finally, please, please do your research. There are many studies and pediatricians and doctors that you've heard from today who will provide evidence and facts about benefits of gender-affirming care. This bill should not be based on opinions, religious beliefs or biases. I just want to add that the testimony made before in support of this was largely based on hypotheticals and fear, bias, religious beliefs. I do not see all-- I did not see all the support-- supportive testimony for this bill. I only recall one parent who was the parent of a transgender child. I am the parent of two transgender, transgender children and you will likely-- [RECORDER MALFUNCTION] parents behind me come up and testify who oppose this bill.

HANSEN: All right. Thank you for your testimony.

WILLIAM MANHART: Any questions?

HANSEN: Are there any questions? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. I guess I would like to respond a little bit to the accusation of political bullying. You know, we're spending 6, almost 7 hours today trying to hear both sides of the issue, trying to stay as open-minded as we could. So I'd like to think,

WILLIAM MANHART: And I appreciate that.

RIEPE: Political bullying, because we do have an interest in the welfare of the children of the state and I think everyone knows.

WILLIAM MANHART: Well, I appreciate your concern.

RIEPE: I just, I don't mean to sound defensive. I just want to make this clear. Thank you. Thanks for being here, and God bless you.

HANSEN: Any other questions? All right.

WILLIAM MANHART: Thank you.

HANSEN: Seeing none, thank you. We'll take our next testifier in opposition.

MEGHAN SHEEHAN: Thank you, Chairperson and members of the committee of Health and Human Services for allowing me to testify today. My name is Dr. Meghan Sheehan, M-e-g-h-a-n S-h-e-e-h-a-n. I'm a CL psychiatrist and I'm here to voice my opposition to LB574. I also have background in medical ethics having proven preserved former clinical chair of Ethics Committee at UNMC. One of the most important things children are tasked to do in development is to gain a sense of themselves in the world. That identity formation includes gender identity. It's a normal developmental process. This can involve ideas of gender that differ from traditional societal norms, things like gender diversity, expansiveness, creativity, nonconformity, fluidity, gender queer, age gender. I want to highlight something I said. I said traditional societal norms. Societies are ever evolving and norms are constantly rewritten. Do not think that because the terms are new and the public awareness is greater that the development of gender identity itself has changed. In other words, it's the traditions and words that have

changed, not the people. Endpoint. I work with many older adults who have such regret over a life lived falsely. I see the disruption and heartache when gender formation and identification is stifled. I also work with the youth that this bill would affect. LB574 is not a neutral decision to let them grow. The onset of puberty and development of secondary sex characteristics and menses is unwanted and devastating. If a child says, you're hurting me, you stop. Well, the youth of Nebraska are here to say clearly and bravely, you are hurting me. However, trans affirming treatment isn't just about the drugs and surgeries, it's about support and education, which is a huge proponent, a huge component of all care. As a psychiatrist, I work with them to see if there are other contributing mental diagnoses that we can treat that might be complicating the picture. I work as a team with all of the different people from the medical groups we've heard from today. The APA, American Psychiatric Association fully supports the use of medications to suppress the onset of puberty and allow the adolescent more time for cognitive and emotional development and possibly continuing with the gender affirmation process. Referrals for these services and families should be made between the physician, their parents and the patient. I oppose any effort to criminalize or penalize physicians for providing evidence-based care for their patients. I ask you to oppose this harmful legislation that restricts care and criminalizes medicine. Thank you.

HANSEN: Thank you for your testimony. Any questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. It's good to see you again. I think this is the last time, you were here last week, weren't you?

MEGHAN SHEEHAN: Yes, with strep throat.

BALLARD: Strep throat. Well, thanks for spending another evening with us.

MEGHAN SHEEHAN: Thank you.

BALLARD: So can you talk a little bit about the role of Nebraska in gender affirming care, especially from us, from a psychological perspective?

MEGHAN SHEEHAN: Yes. COVID did a lot of hard things to our world. One thing that it did that I am grateful for is pushing telehealth further. I do a lot of work at tela psychiatry because I'm a

sub-specialist in psychiatry of one of two in the state. Access to me is a little bit difficult for rural Nebraska. Because of COVID, we got to advance telehealth and get parity for mental health via Tela Communication and so I can access and help patients from all across rural Nebraska providing them the care that they would otherwise be denied. Because there's, there's no psychiatrists and definitely no CL psychiatrists out there.

BALLARD: OK. Thank you.

MEGHAN SHEEHAN: Uh-huh.

HANSEN: All right, seeing no other questions, thank you very much.

MEGHAN SHEEHAN: Thank you.

HANSEN: We'll take our next testifier in opposition from this side of the room.

ALEX HAMRIC: We did not get to print it out, so like every teenager, I will use my phone. Hello. My name is Alex Hamrick, spelled A-l-e-x H-a-m-r-i-c. I am 15 years old and I will be representing myself as a citizen of Lincoln, Nebraska. I would like to begin by saying I am not delusional, I'm not sick, I'm not indecisive. I am more than what this bill makes me out to be. I'm not simply a child that has lost their way. I am not ignorant to the magnitude of the choices I've made. I have faced harassment, bullying, threats of violence. I have been terrified, disrespected and ignored, all because I will not hide who I am. I am transgender and I am so proud to be. You are my representatives. You are meant to give me and people like me a voice, but if you stand in support of this legislation, you are not doing your job. You are meant to listen to your people, so listen to us. This will cause irreversible death. Suicides in children will skyrocket. And why? So you can stay comfortable? So you can hide your fear and cowardice behind parental rights? Tell me, Senators, is that a good enough reason for, for children to kill themselves? As someone speaking in opposition, I'm aware I am advocating for the status quo and we are all aware the status quo right now is not ideal. But this bill only stands to make it worse, not better. The negative impact of this legislation far outweighs the benefits. Now, if you stand in opposition, I applaud you. I applaud you to listening, for listening to the public and keeping us safe. I applaud you for, forgive me, but doing the bare minimum for the trans community. But if you are in support, I will not stand here and beg you to care. I will not stand

here and beg you to view me as a peer, knowing that I will never change your mind. I do not have that ability as a minor who is trans. I understand that if you do not see me as a peer and you do not see me as an equal, you never will. But that is not my job. My job is to just make you hear me when I say, the safety, the health, the lives and the future of the trans youth are in your hands. And I implore you, please choose the right thing to do with it. Thank you. And I will accept any questions at this time.

HANSEN: Thank you. Good job using a phone. That was good. All right. Any questions from the committee at all? Senator Riepe.

RIEPE: I also say nice job. Nice presentation. Thank you.

ALEX HAMRIC: Thank you.

HANSEN: OK. All right. Seeing no other questions, thank you very much for coming.

ALEX HAMRIC: Thank you so much.

HANSEN: All right. We'll take our next testifier in opposition.

LAUREN MASKIN: Good evening. My name is Lauren Maskin, M.D., L-a-u-r-e-n M-a-s-k-i-n. I am here before you as a board certified inpatient pediatrician who has been in practice for over ten years, as a mother and as a member of the Nebraska Chapter of the American Academy of Pediatrics. I'm here to share my experience and perspective in opposition to the Let Them Grow Act. I have cared for a large volume of children, predominantly teenagers, who have ceased being able to cope with maltreatment or mental health problems and therefore have attempted to take their own life. I fortunately usually see the ones that survive their ingestion, drowning, hanging, but not all do. In the state of Nebraska, according to the Youth Risk Behavior Survey, a suicide plan was made by 14 3 per cent of adolescents and 10.1 per cent actually attempted. I see the 3 per cent who attempted leading to injury, poisoning or harm by overdose that needed to be treated medically. We know that these rates have risen during the COVID-19 pandemic, and I expect regionally we will see that in the next survey. I share these statistics because I know we can all agree that as a public health priority to provide more mental health services to our youth and decrease the rate of attempted and completed suicides. LB574 is therefore a threat to Nebraskan's public health efforts because the rates of mistreatment, depression, self-harm and attempted suicide or

even higher, and the transgender and gender diverse TGD population. Based on the 2015 U.S. Transgender Survey, 39 per cent of TGD respondents reported serious psychological distress in the month prior, compared to only 5 per cent of the U.S. general population. Staggeringly, 40 percent of respondents have attempted suicide in their lifetime, compared to 4.6 per cent. 77 per cent of TGD individuals also have experienced maltreatment, including physical and sexual abuse, verbal assault, more harsh discipline at school or prohibition from dressing according to their gender, and some even experienced mistreatment from medical professionals. With those numbers, any bill that compromises the ability of a TGD individual to seek physical care that supports their identity, increases the risk of depression and suicide in that population. This bill is not about growth. This bill reinforces one viewpoint of the appropriate or typical physical attributes of a gender. It only supports the growth of adolescents who look at and want the same things as the status quo. This bill is about suppression. This is about restricting those children who are seen as different by interfering with their ability to have candid conversations with their medical professionals and explore therapies that support their mental and physical health. LB574 threatens the sanctity of the patient-physician relationship, and it systems, systematizes discrimination against TGD individuals. The decision to utilize gender affirming medical therapies is a very personal one. It should remain between patients, their legal guardians and their medical professionals. There are many challenges that the TGD children and their families already experience on a regular basis. According to the American Academy of Pediatrics policy statement, ensuring comprehensive care and support for transgender, gender diverse children and adolescents, which I provide a printed highlighted copy for you.

HANSEN: Doctor.

LAUREN MASKIN: These,

HANSEN: The red light went on. Sorry.

LAUREN MASKIN: Sure. Sorry.

HANSEN: That's not the end. Apologize.

LAUREN MASKIN: Didn't see that. Uh-huh.

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

DAY: Thank you, Chairman Hansen. And thank you, Dr. Maskin, for being here today. So you handed out a few things.

LAUREN MASKIN: I did.

DAY: Can you help me understand what all of this is.

LAUREN MASKIN: Sure. So I referenced the Youth Risk Behavior Survey. So I printed for you the two pages of that that relate to depression, suicide thoughts, suicidal attempts, and in the youth. It's a multi-page document. So I printed the most pertinent. I also provided the 2015 U.S. Transgender Survey. It's also a, I want to say, 300-page document. I printed a few of the highlights that involve the data that I stated in my statement. I have two letters from colleagues with their viewpoints. I have the ensuring comprehensive care and support for transgender and gender diverse children, adolescents. And there, they're 94 references from the medical literature about the support in research for gender coming care, including JAMA, Pediatrics, the Journal of Adolescent Psychiatry, American Journal of Public Health. And you can see the rest of the references, but there's a lot of them. And then I also provided for you, but didn't get a chance to mention one of a few studies that shows that gender affirming hormone therapy does decrease rates of depression and suicide, and that research is still evolving.

DAY: Thank you.

LAUREN MASKIN: You're welcome.

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

LAUREN MASKIN: Thank you.

HANSEN: We're going to start moving, we're going to start moving to two-minute testimony now. So in case that red light goes up a little bit sooner, that's why. All right. Welcome our next testifier in opposition to LB574.

JILL DIBBERN MANHART: Good evening, Health and Human Services Committee. My name is Jill Dibbern Manhart, J-i-l-l D-i-b-b-e-r-n M-a-n-h-a-r-t, and I live in District 5. I'm here today not only as a mental health therapist, but more importantly as a mother of two gender non-conforming children, a mother who wants nothing more than to help her children grow up in a world where they feel they are valued and loved. When legislators decide to introduce harmful bills

like LB574, they send the message, you do not belong. They spend their time focusing on whether transgendered children and their families have the right to make health care decisions on what will best support their needs. Aren't those decisions my decisions as a parent? They present their reasoning as if it's about children's well-being and protecting children, but it is really about their discomfort and judgment of something they do not understand. I have walked this journey next to my 10-year-old transgender son, a journey that began very young at age two, watching, wondering how to best support him. I have been fearful of the greater world, the hate and intolerance, but knew as his mom that this happiness, that his happiness and sense of self is the most important thing in the world. With bills like this, what I have feared most for my child has come true. This bill is not about supporting children. It is about others discomfort of whom my child is. My son is one of the most caring, loving individuals that you will ever meet. He is creative, athletic, adventuresome and kind. He just wants to go to school, play with his friends and be a kid. I would never want my child to be pushed to fit in some box to appease others discomfort. He is not a threat to you. But with this bill, you are a threat to him. This bill says you don't get the same human rights that other children have. I grew up on a farm in central Nebraska and have lived here my whole life. I have loved this state and overall loved raising my children here. But now I wonder if this place I have loved has a place for my family and me. Do we belong here anymore? We will be, will we be supported here? I'm heartbroken for your fear. I'm heartbroken by your intolerance. And most importantly, I'm heartbroken for the youth of our state who you are saying to right now, you do not belong. Thank you.

HANSEN: Thank you. Any questions from committee? Seeing none, thank you for coming. We'll take the next testifier in opposition from this side of the room.

SHANNON GODSIL: Hello to the committee.

HANSEN: Welcome.

SHANNON GODSIL: My name is Dr. Shannon Godsil, S-h-a-n-n-o-n G-o-d-s-i-l. I'm a board certified general pediatrician and I'm lucky enough to practice in Sarpy and Douglas County for the last ten years. I am privileged to not only care for all growing children, but those include our transgender community. I write and speak today on behalf of the Nebraska Chapter of the American Academy of Pediatrics in opposition to LB574. The Nebraska Chapter of American Academy of

Pediatrics represents pediatric medical providers across the state and works for the health and well-being of Nebraska children. The AP strongly advocates for comprehensive and evidence-based gender affirming care for all children. Gender affirming care means providing care which focuses on the acceptance and understanding of a youth's gender experience. This means recognizing that being transgender or gender diverse is a normal aspect of human diversity, and that gender is an interplay of biology, development, socialization and culture. Being transgender or gender diverse does not constitute a mental disorder. If any gender diverse youth has a concurrent mental health issue, it often stems from the negative experience and stigma in which they have lived. It is important to remember that youth who identify as LGBTQ-plus continue to face disparities from a multitude of sources, including inequitable laws and policies, social discrimination and a lack of access to health care. More than 55 per cent of transgender and gender diverse youth have faced suicidal ideation, a rate almost three times higher than their cisgender peers. Please, as a general pediatrician, let me watch and support and continue to help all of my children, including transgender health. Thank you so much.

HANSEN: Thank you. Are there any questions from the committee? Nope. No questions. Thank you.

SHANNON GODSIL: Thank you.

HANSEN: We will now take the next testifier in opposition on this side. And another side note, if we're going to be moving around when you get out the chair, it tends to smack the back of the chair and it makes a whole lot of noise out here. So if you can maybe just hold on to it when you get up, that will cut down some of the noise. Appreciate it. Thank you. Welcome.

NATASHA GALLETT: Thank you. Thank you, Health and Human Services Committee for hearing me today. My name is Dr. Natasha Gallett, N-a-t-a-s-h-a G-a-l-l-e-t-t, and I am currently in Omaha, Nebraska. I am a pediatrician and internal medicine resident physician, which means I specialize in the care of children, adolescents and adults. I currently am having specific education in a longitudinal experience at an adolescent clinic that does provide gender affirming care. I am testifying in opposition to LB574. My viewpoints are my own and do not reflect those of my employer. I cannot reiterate the support that I have for everyone who has come before me and that the most important thing that I see here is that this bill infringes upon the core tenet

of medicine that all physicians take an oath to at the beginning of medical school, which is, do no harm. You have heard time and time again that gender affirming care saves lives. Additionally, as my unique perspective caring for adults, I have seen them survive their suicide attempts and now have to be forced into a second puberty when they start this care at an older age. My goal has always been to return to a rural community and provide exceptional care for my exceptional patients so they can become exceptional community members. This bill, if it passes, I will not practice in Nebraska. I will not practice in rural Nebraska, where you so desperately need me. Thank you.

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

NATASHA GALLETT: Thank you.

HANSEN: We'll take our next test for an opposition. And I'm sorry, it's a 100 degrees in here, too, by the way.

SHANNON HAINES: Hi. Thank you, Senator Hansen for having us.

HANSEN: Welcome.

SHANNON HAINES: And thank you to the community members. My name is Dr. Shannon Haines, S-h-a-n-n-o-n H-a-i-n-e-s. And I am a pediatrician in Nebraska. My views are my own and they do not reflect that of my employer. And I am here to, in opposition of LB574. I come to you from a unique standpoint of being both a medical doctor and the parent of a trans child. Through my training, I have seen firsthand the positive effects of children receiving gender affirming care. There are some opponents of gender affirming care who claim that trans children are mentally unwell. However, it has been shown that trans children who are supported in their identities have levels of depression and anxiety equal to or less than their peers. Gender affirming care also reduces suicide attempts by at least 40 per cent, which you've heard numerous times throughout these presentations. This bill would interfere with lifesaving treatment and the secret physician-patient relationship. If this bill were to pass, it would hurt the children of nebraska. I have a 16-year-old son who is trans. He came out to me almost three years ago and we have been so fortunate to have a pediatrician and medical team who have been supportive of his gender identity and our family. He has now completely socially transitioned. We're starting a medical transition. He is in honors classes, college

classes. He is in five extracurricular activities, three of which he holds leadership positions. And this is in a very stark contrast to before he started his transition. As a pediatrician, my focus is on helping parents raise their children to be the happiest, healthiest versions of themselves they can be. As a parent, my focus is on raising good, upstanding, healthy members of society who have the chance to reach their full potential. Enacting LB574 would be harmful to the children and families of Nebraska. Enacting LB574 would be harmful to my 16-year-old who just wants to live his life like any other kid. Please oppose this bill and thank you so much for your time and listening.

HANSEN: Thank you. Good timing. All right. Any questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. And thank you, Dr. Haines, for being here today. I am going to ask the same question I asked of an earlier testifier. You have a few things that you handed out here.

SHANNON HAINES: Yes.

DAY: Can you help me sift through them?

SHANNON HAINES: Yes. One of them is my letter. One of them is a letter from another med ped resident who wasn't able to attend today. There are four articles that I printed out for you. The first one is an article about puber suppression for transgender youth and the risk of suicidal ideation. I highlighted, this is the first pages in the abstract, and there's more in the article. But basically it's saying that when compared to those who wanted pubertal suppression but did not receive it, the people who did receive pubertal suppression had lower odds of lifetime suicidal ideation. I mean, no suicidal ideation and suicide, suicidal ideation of a plan is the highest predictor for completion of suicide. The next, another article they've put in is young adult psychological outcome after puberty suppression and gender reassignment. And this one, I thought was important because they found that there was similar or even better than same age young adults, sorry mental health outcomes from the same age, young adults in the general population. And as you heard before, we don't use control groups anymore because it's unethical to prohibit gender affirming care. So we compare these children before and after they have puber suppression, just the general baseline population data. The next, one of the next ones is about just anti-trans legislation in general and how it affects transgender and gender diverse youth when it's brought

up. And it is a great read for people who need to know what we're subjecting these children to over and over again when we introduce anti-trans bills. And finally, the Association of Gender Affirming hormone therapy with depression and thoughts of suicide attempts at suicide among transgender and binary youth is a good article. Again, just supporting the use of gender affirming care for this population to protect their mental health.

DAY: Thank you.

SHANNON HAINES: Yeah.

HANSEN: Any other questions? Seeing none, thank you very much. Appreciate--

SHANNON HAINES: Thanks for your time.

HANSEN: --your coming. We'll take our next testifier in opposition. Welcome.

SPENCER ROBINSON: Hi. Thank you, members of the committee. My name is Spencer Robinson, S-p-e-n-c-e-r R-o-b-i-n-s-o-n. I'm a physician here in the state of Nebraska, training in internal medicine and pediatrics like Dr. Gallett. I'm here to testify in opposition of LB574. My opinions are my own and do not reflect those of my employer or my colleagues. That being said, several of my colleagues have come up here and testified on their perspective in this bill from the perspective of a pediatrician. But I think that my standpoint is a little bit unique because I provide health care to both children and adults. Lots of statistics have been thrown at you. I've got most of them written down in my testimony. I won't waste your time by reciting them. But there are some statistics that have not been said yet that I do think are very important. Many of the patterns of mental health disorders that we see in transgender youth continue into adulthood and they actually and oftentimes can get worse. Furthermore, adults who are gender non-conforming have an increased, all cause mortality compared to cisgendered people. In lay terms, that means that almost every single age group, if you are transgender, you are more likely to die, including age 18 to 29, which is encompassed by this bill. The exact cause of death, the exact cause of that increased mortality is not known, but a direct medical link has not been established, leading some experts to attribute this to suicidality and homicide of transgender individuals. The bottom line of my testimony is that gender affirming health care, including social, psychological, medical

and surgical interventions with the goal of reconciling a person's sex assigned at birth with their gender identity is essential health care. LB574 aims to restrict trained medical professionals from providing gender affirming care to the children of Nebraska, and it is my professional opinion that the passage of LB574 will harm the children of Nebraska. LB574 states in Section 3 that the state has a compelling interest in protecting the citizens of Nebraska. You know, in the same document, LB574 seeks to restrict health care that has been shown to reduce the burden of mental health and decrease suicide attempts in this population, knowing that suicide attempts are a major cause of mortality in adult transgender individuals. Make no mistake, gender affirming care is an essential part of improving the health and well-being of non-gender conforming youths, and that I urge you to please let this die at committee.

HANSEN: Thank you for your testimony. Senator Riepe.

RIEPE: Thank you, Doctor. Thank you for being here. You said that gender identification or I.D. Is essential health care. Is that out of the Nebraska Medical Association, or the,

SPENCER ROBINSON: Nope. That is just of my opinion, that gender affirming care is essential in all of its facets medical, surgical, even social. I think if you look at Section 4, paragraph 5, it actually defines gender alteration as involving medical, surgical and social interventions, which my reading of that sentence tells me that I won't be able to socially interact with my patients unless I'm using the pronouns that are given to their assigned sex at birth rather than their preferred pronouns, which would limit my ability to take care of them.

RIEPE: OK. Thank you.

HANSEN: Any other questions? Seeing none, thank you for coming.

SPENCER ROBINSON: Thank you.

HANSEN: We'll take our next testifier in opposition on this side. Welcome.

RON FUSSELL: Excuse me, Ron Fussell. Senator Hansen and members of the committee, thank you for this opportunity to offer this brief but important testimony regarding LB574 to Let Them Grow Act. My name is Dr. Ron Fussell, a Nebraska Citizen, an educator by training and a parent of a child who is receiving gender affirming health care. I'm

here with my wife, Tina, who's in the overflow lounge, to stand in opposition to LB574. As parents of a transgender child, my wife and I have experienced firsthand how Raven's, and that's our daughter's name, gender dysphoria tightened its icy grip on the very core of her personal identity and led Raven, who had always been a happy child into a dark and distressing state of repair. And it led us to wonder how to best support her. Along the way, we were fortunate to have had the resources and support of medical professionals who joined us in thoughtful and careful dialogue about appropriate therapeutic interventions. These interventions have helped Raven to blossom and grow into the human being that she was intended to be. Years later, Raven is now 18 years old, preparing for college and is happy, healthy and thriving. She has a bright future ahead of her, and for that we owe a great deal of gratitude to Raven's doctors who connected her with the gender affirming therapy that she was so fortunate to receive. If you are a lawmaker who is considering supporting LB574, I have only one request. It is to speak with families of transgender children in your legislative district who have received gender affirming therapy and health care. Listen to their stories with an open heart. Learn about the challenges that those transgender children and their families face on a daily basis. Take the time to see their world through their eyes. You can even contact me, and my contact information is on the written documentation. I'd be so happy to share with you more details about Raven's story and to explain how gender affirming therapy that Raven is receiving may very well have saved her life. And I'm happy to answer any questions the committee might have.

HANSEN: Thank you for coming to testify. Are there any questions from the committee?

RON FUSSELL: Thank you, guys.

HANSEN: I don't see any. Thank you. We'll take our next testifier in opposition from this side of the room.

MAEVE MALISE: Before anybody says-- I say anything, I just want to say I asked this lovely person if I could jump before them. Thank you.

HANSEN: Thank you. Welcome.

MAEVE MALISE: Hello. My name is Maeve. That's M-a-e-v-e, Malise, M-a-l-i-s-e. My friends are she, they and I am a black transgender woman from Omaha. And I'm just going to get into this. As trans people, we are facing a genocide. I have not seen anybody really talk

about this, but if you don't believe me, there are some key markers of genocide that we are meeting. Classification, discrimination and dehumanization and polarization. Bills like these that help create a fascist society that only straight, white, cis men are able to live in. And if you don't see what's wrong with that, you are a part of the problem. I've been on estrogen for almost nine months now, thanks to Dr. Amoura, and let me tell you, I would not be here without it. And I don't think anybody, anybody at all deserves to go through the mental anguish and torment that so many of my friends, loved ones and people I care about are going through and continue to go through. If you truly care about the youth, if you truly care about the youth, then you'll vote no to this bill and to all the LGBT people who aren't standing up for trans people. Marsha P. Johnson once said, no pride for some of us without liberation for all of us. Thank you. I yield my time.

HANSEN: Thank you. Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. May I call you Maeve?

MAEVE MALISE: Yes.

M. CAVANAUGH: Thank you, Maeve. Thanks for being here today. I just wanted to tell you and all those sitting behind you that I see you, that you are loved, that you are important, and that I am grateful for you being here today.

MAEVE MALISE: Thank you. Any questions?

HANSEN: For the record, she's never said that to me once. (LAUGHTER).

M. CAVANAUGH: That is a fact.

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

MAEVE MALISE: Thank you.

HANSEN: We'll take our next testifier in opposition on this side of the room, please. Welcome.

SAPPHIRE SMITH: My name is Sapphire Smith, S-a-p-p-h-i-r-e S-m-i-t-h. My pronouns are they, them. I live in Lincoln, Nebraska, and I oppose this bill. I'm tired of my identity being considered political. I hate that my medical options are being debated not by doctors, but by

politicians. Politicians have no right to make my medical decisions for me. I know what I want for my body and I've known since the moment I learned what a period was. I've been on puberty blockers for eight months. If I'm forced to stop, then my period will return and puberty will resume. Everyone knows that periods are painful, but I don't think that people who don't experience them have any idea how painful. I have chronic pain and my particular pain is constant. Peered cramps are ten times worse than my everyday pain, which is already bad enough that I can't go to school. When I had cramps before, I was unable to do anything, not even read books. Forcing me to go through puberty and have periods is cruel. One thing that people are concerned about is surgeries being performed on kids. That simply isn't happening. I'm 16 and the only medical part of my transition so far is the puberty blockers. I have an appointment with a surgeon coming out to discuss top surgery or breast removal. Since before my breasts even started growing, I've wanted to be completely flat chested. For five years now, I think about how much I wish I didn't have breasts multiple times per day, every single day of every single week, month and year. Top surgery is mainly for 18 year olds and above, but a few doctors are willing to operate on 16 to 17 year olds. Bottom surgery, which can refer to many different procedures involving genitalia, is strictly 18-plus. Once I meet with the surgeon, it's likely that I'll be put on my years-long waiting list and required to provide multiple letters from psychologists to prove that I'm really trans enough to get surgery. It's hard enough to get the health care that I need without it being banned. What most people don't realize is that cisgender people get gender affirming care all the time. Breast enhancements, breast reductions, liposuction and so many more popular procedures are all gender affirming care. When people talk about banning this sort of care they mean only for trans people, that is the most blatant that discrimination can get. This is exactly how genocides start dehumanization, separation laws, limiting their rights. Also that killing them is justified. This is not an exaggeration. In the first large book burning that the Nazis held, they burned upwards of 25,000 medical books and journals from a sexology institute, which included works on homosexual and transgender topics. Leading up to the Holocaust, there are more than 400 decrees and regulations that strip Jews of their rights. Pass this bill if you want to genocide on all transpeople, including kids. Vote no on this bill, if you don't want to kill kids.

HANSEN: All right. Are there any questions for the committee? Thank you for coming by the way. Are there any questions from the committee?

Seeing none, thank you. We'll take our next testifier in opposition on this side of the room.

DAVID GREINER: Hello. My name is Dr. David Greiner, D-a-v-i-d G-r-e-i-n-e-r, and I'm a resident OB-GYN physician training in Omaha, but today I represent myself. This bill has many flaws, which you've heard many people before me talk about. But today I want to talk specifically about an OB-GYN training physician and the training that this might impact on me. With gender affirming health care becoming more readily available and less stigmatizing, it's critical that physicians like myself get this training experience. In the near future I think the initial workup for gender dysphoria and counseling about the use of hormones is one that will be routinely performed by general OB-GYNs, some pediatricians and family medicine doctors. Without this training, we're setting up the next generation of physicians for failure. I've had the amazing opportunity to work in the gender care clinics, and this has overall made me a more well-rounded physician and has been some of the most educational and fulfilling opportunities that I've had during my residency training. Much of the training that I've gotten in the gender clinics isn't something that I can learn from a textbook. Many, as you know, many patients who are cis or trans male, they don't go undergo bottom surgery, but they still need routine pelvic exams and performing a pelvic exam on somebody who has been through already so much trauma and has so much dysphoria on their body can be traumatizing. And I think it's important to train physicians to have a welcoming environment so these patients can get the routine health care that they need. Thank you. I strongly support you-- or want you to oppose this bill.

HANSEN: OK. All right. Thank you for testifying. Are there any questions from committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. And feel free not to answer this question, but I am noticing a pattern in our testifiers today in the medical community that they are testifying in their own capacity, but no one is saying where they work or where they study. And I was wondering if you were willing to share where you study or if you were directed to not share that information.

DAVID GREINER: I was not specifically not told I couldn't do it, but I have worked in the gender clinic with Dr. Amoura.

M. CAVANAUGH: OK. Thank you.

DAVID GREINER: Yes.

HANSEN: Any other questions? Seeing none, thank you for coming.

DAVID GREINER: Thanks.

HANSEN: We'll take the next testifier on this side. Welcome.

MARY SULLIVAN: Hi. My name is Mary Sullivan, M-a-r-y S-u-l-l-i-v-a-n, on behalf, behalf of the Nebraska Chapter of the National Association of Social Workers. I'm testifying in opposition to LB574. This bill demonstrates the Legislature should not be deciding what medical treatment individuals need and when they should receive it. It demonstrates a deep disrespect some people have towards people who are not like themselves. It also shows disrespect for expertise in the medical, psychological and mental health professional communities in Nebraska. As described earlier in this hearing, LB574 puts mental health professionals in conflict with their code of ethics. By prohibiting referrals and recommendations for needed treatment, this bill violates one of the most important ethical principles in health care. We're asking you, please, to vote in opposition to this bill. But the antidote to ignorance and fear is rational study and consideration. If our state senators are serious about understanding this issue and behaving constructively instead of ramming this naive, excuse me, an uninformed bill through committee, they should support an interim study to learn about transition, transgender issues, including needs and treatment. It should include learning about biology and human development. It should include all stakeholders concerned about ensuring that all transgender Nebraskans receive the treatment and care they need in a timely basis. The leaders of the interim study must provide time necessary to ensure that individuals are listened to and their experience and needs are understood. The interim study should also have the experience of family members and health care professionals with experience and expertise in this area. The study should inform our legislators about the health care services currently in place in Nebraska to meet treatment needs and the ways the system currently, the system of care currently works and can be improved. It must identify the effective ways to educate states, senators and all of Nebraskans about the human development and psychology of gender and the experience of transgender individuals. This is what it's going to take to eliminate stigma, prejudice and cruelty that LB574 reflex.

HANSEN: Did a good job, red light went off. You're doing great. You were close though. Are there any questions from the committee? All right. Seeing none, thank you.

MARY SULLIVAN: Thank you.

HANSEN: We'll take our next testifier in opposition from this side of the room. Welcome.

ELIANA SIEBE-WALLES: Thank you. Hello. My name is Eliana Siebe-Walles, spelled E-l-i-a-n-a S-i-e-b-e, hyphen, W-a-l-l-e-s, and I am a 20-year-old Nebraskan from District 49. Please refer to me with they, them pronouns. The proposed bill horrifies me. It is clear that the senators who endorse it have no idea how cruel banning any form of transition care to trans youth is. Trans children deserve to have the resources available to them so that they can grow to be adults. Many people bring up the fear that these treatments will cause permanent damage just to the children who ask about them. However, medications such as puberty blockers and replacement hormones have repeatedly shown to be not only safe but reversible. Additionally, the surgeries that you are attempting to ban simply are not happening. It takes years and years to diagnose, schedule and plan out a gender affirming surgery by consenting adults. This type of transition care simply isn't being approved for minors and therefore attempting to ban it is straight up fearmongering about what transition care is to those who need it. As explained by the Journal for Interpersonal Violence in March 2022, 82 per cent of trans people will consider completing suicide in their lifetime, 40 per cent of trans people attempt suicide in their lifetime. The gender affirming medication that you are trying to ban significantly lowers the risk of suicidality in trans teens. Puberty blockers and replacement hormones are lifesaving pieces of medication. If you want to actually let children grow, please oppose this bill and stop trying to take away the resources keeping trans children, children alive. Thank you.

M. CAVANAUGH: Thank you so much for your testimony. Are there any questions? Senator Day.

DAY: Just one. You said you are from District 49.

ELIANA SIEBE-WALLES: I am, correct?

DAY: I'm also your representative.

ELIANA SIEBE-WALLES: I understand that, yes.

DAY: I wanted to meet a constituent here. Thank you for being here today.

ELIANA SIEBE-WALLES: Thank you.

M. CAVANAUGH: Any other questions? Thank you so much for your testimony.

ELIANA SIEBE-WALLES: Thank you.

M. CAVANAUGH: Thanks for being here. I believe we're on this side.

JEREMY ERIKSEN: OK, my name is Jeremy Erikse n. I do prefer Julia. Spelling the name is J-e-r-e-m-y, last name Eriksen, E-r-i-k-s-e-n. I am 42 years old. I started transitioning here in a few days will be three years and four months ago. I experienced hardships going through this. Growing up, being trans but not identifying, I experienced a lot of bullying and I've definitely suffered a lot of repercussions that have been mentioned here of what could happen if not properly affirmed. I have also met several kids that I even personally know would probably even try to kill themselves if they were no longer allowed to receive treatment. So I want to be here in opposition to LB574 and support my trans family.

M. CAVANAUGH: Thank you so much. Are there any questions? Thank you for being here. And we will go to this side now.

STEPH ENGELBART: Hi. My name is Steph Engelbart, S-t-e-p-h E-n-g-e-l-b-a-r-t, and I am an independently licensed clinical social worker in Lincoln and an employed with Kindred Psychology. I have served in this role for 18 years and for the past 10 years have largely worked with the LGBTQ communities, specifically the gender diverse people. It is a humbling experience to support these individuals and their families as they navigate the transition process, process. These are some of the best humans I have met, and I am honored to even be a small part of their journeys. Further, these families are some of the strongest, bravest, most supportive, loving people who only want the best for their children. The youth that I work with face more challenges than you and I will ever experience on a day-to-day basis. They navigate acceptance and inclusion, bullying, discrimination, school and family pressure, societal expectations, and often anxiety, depression or other mental health concerns. Trans youth who are exploring identity, identity on top of all of these factor, these other factors face enormous amount, amounts of pressure. It is

my job to help them navigate these concerns and I must stress that navigating gender identity as an adolescent is an overwhelming and difficult experience. It is incredibly important for the overall well-being and health of our trans youth that we as mental health and medical providers can, continue to provide gender affirming care. This includes therapy or the use of puberty blockers and hormones. Sometimes for our youth, starting hormones is the only way for them to successfully navigate adolescence. I want to make sure you understand that these treatments do save lives. I also want to stress that this is not something that happens on a whim. This is a very detailed process that each youth and their family must go through in order to begin puberty blockers and/or home, hormone therapy. It is a carefully thought out process that includes several evaluations from mental health and medical perspectives, as well as consistent care and coordination with both the youth and their family. A mental health provider that needs to provide a letter of affirmation, affirmation to the medical provider. This letter is prepared according to the ethical guidelines as set forth in the World Professional Association for Transgender Health.

M. CAVANAUGH: I'm sorry to interrupt, but.

STEPH ENGELBART: I know I'm out of time.

M. CAVANAUGH: Thank you so much. Are there any questions? Thank you.

STEPH ENGELBART: Thanks.

M. CAVANAUGH: And I believe it is your turn. Welcome.

KADENCE TOMASCH: Oh, one second here. All right. Hello, my name is Kadence Tomasch, K-a-d-e-n-c-e T-o-m-a-s-c-h. I'm a daughter to a loving mother, wife to a loving husband and an aunt to several amazing children. I believe in Nebraska their respects and honors its own values. Values like integrity, respect, compassion, growth, and excellence. Values that I pledge to uphold as a corrections corporal. Values that you laugh at and disregard in front of me here today. I'm urging you to oppose LB574 and other anti-transgender legislation to prove me wrong. This bill references biologically healthy. What does that mean? I'll tell you what it means. It's being used as a way to refer to us as a disease that we are unhealthy. It is referring to eugenics. It is calling us a disease and is trying to get rid of us. I'm trying to shorten this down, but fellow Nebraskans, ask yourself if going down a eugenic super fascist rabbit hole is really growth, is

it compassionate to see children not be able to access WPATH guidelines, guidelines that are evidence-based medicine. No one here wants babies mutilated at birth. All I ask is that you respect everyone's rights and everyone's lifestyles. If nothing else, have some integrity and listen to reason and logic and not to money someone is paying you. The excellence of our state is determined by all of its citizens, not just the privileged majority. Respectfully, I would like to use the remainder of my time to list the names of transgender citizens across America that were killed in 2020 due to hate crimes. Connie Read, 29, black trans woman stabbed to death in Kansas City, Missouri. Acey D. Morrison, two spirit member of Dakota Tribe, fatally shot in Rapid City, South Dakota. R.E. Rage, 21, found dead in Pittsburgh for, Jacksonville, Florida, sorry. Naomi Skinner fatally shot. Cypress Ramos, 21, was found dead in a storage unit.

M. CAVANAUGH: I'm sorry. I'm sorry, but please feel free to send that to the committee, that list, because it is, of course, important. Are there any questions from the committee? Thank you so much for your testimony. And again, please feel free to follow up with us with the list that you have.

KADENCE TOMASCH: Thank you.

M. CAVANAUGH: Thank you. We'll take from this side. Welcome.

TIFFANY WEISS: Chairman Hansen and members of the Health and Human Services Committee, my name is Tiffany Weiss, spelled T-i-f-f-a-n-y W-e-i-s-s. I live in District 37 in Kearney. Today, I'm here as a parent in opposition to LB574 and I'll be sharing my family's personal experience with you all today. I'm the proud mom of five amazing children, two of whom are transgender. My oldest son finally got us to understand that he was trans when he was nine years old. This was after he had already attempted suicide and had to be kept in an inpatient psychiatric hospital for three weeks. Before he came out to us he was the saddest, quietest child. He never made eye contact. He hardly talked. He would rarely smile. My ex-husband and I attributed all of that to the trauma that he had before we adopted him at age three, but we were mistaken. After our son came out to us, we talked to a counselor about his gender identity. They recommended someone else who focused on gender therapy. With the help of this therapist, we learned how to navigate the world with our transgender son. We watched and waited for him to be insistent, consistent and persistent about his gender identity. We started at home by calling him his new name and pronouns, and by the second month we could hardly recognize

the child that we had before. There were smiles and there was laughter, and there was finally joy. When our son turned 11, two years after coming out, he started to show signs of puberty. We were lucky enough that we were able to put him on blockers. The blockers were a way for us to push pause. They gave us time and him time to explore his gender identity. The best news was that even if he changed his mind, which we didn't think was going to happen, the worst thing that would happen is that he would go off the blockers and go through female puberty. Without blockers, our son would have developed breasts. He would have started a menstrual cycle. These are two big things that his body and mind would not be aligned on. I have talked to him at length about where he thinks he would be today if those things had started to happen to him. And he told me without blinking an eye here would be dead. Here--

M. CAVANAUGH: I'm sorry.

TIFFANY WEISS: OK.

M. CAVANAUGH: Yeah, your time is up. I'm sorry. Any questions? I'll turn it back over to you.

HANSEN: Glad you're the one who said that, not me.

M. CAVANAUGH: Sorry. Any questions?

HANSEN: Thank you. Thank you for coming to, let's see if there's any questions real quick. Any questions from the committee? Just want to make sure. Thank you for coming. Appreciate it.

M. CAVANAUGH: We're on the right track.

HANSEN: And we'll take our next testifier in opposition. Welcome.

ECHO KOEHLER: Hi. Thanks for having me. My name is Dr. Echo Koehler, E-c-h-o K-o-e-h-l-e-r. I have a doctor in nursing practice degree, have been a registered nurse for 20 years and a nurse educator for the past 15 years. I am here on behalf of the Nebraska Nurses Association, speaking in opposition of LB574. My comments are based upon the American Nurses Association's position statement opposing restrictions on transgender health care and criminalizing gender affirming care in October of 2022. The following statements represent the NAA's. position. The American Nurses Association Code of Ethics outlines the ethical values and duties of nurses and calls for nurses to respect human dignity and the right to self-determination. Nurses must always

stress human rights protection with particular attention to preserving the human rights of vulnerable populations, including transgender and gender diverse youth. Nurses provide gender affirming care, including social, medical, surgical and legal affirmation, interventions to transgender and gender diverse individuals across varied settings, and in collaboration with other health care professionals. This bill threatens health care professionals, including nurses and advanced practice nurses who provide gender affirming care to do judicial process and other legal action. This restrictive law interferes with the trust and confidentiality between patients, parents, guardians, clinicians and the delivery of evidence-based care. Legislative interfering with gender affirming care will be devastating to transgender and gender diverse youth as they experience higher rates of depression, anxiety and suicide as you've heard. The legislative intent and medical claims behind this law is not grounded in reputable science in conflict with the nurse's obligation to promote, advocate and protect the rights, health and safety of patients. The Nebraska Nurses Association is the overarching organization of 30,000-plus registered nurses in Nebraska. We ask you to please oppose this bill. Thank you.

HANSEN: Thank you for coming in to testify. Are there any questions from the committee? Seeing none, thank you very much.

ECHO KOEHLER: Thank you.

HANSEN: We'll take our next testifier in opposition from this side of the room. Welcome.

SAM WHITT: Thank you. My name is Sam Whitt, spelled S-a-m W-h-i-t-t. I live in Kearney District 37. I'm just going to jump to the third paragraph. I didn't have blockers or trans care as a youth. And now I have to bind every day more than 12 hours and I have to go through puberty twice. Binding is an article of clothing that suppresses the chest to flatten it. It is only recommended to bind for 8 hours a day and to take one day off a week. I worked night shift 12 hours and I've been up since 3:30 yesterday so I can make it here today in this binder. It's not comfortable, let me tell you. I cannot, let's see, I cannot-- I lost where I was --without taking a chance of outing myself at work. So instead, I, like many trans males bind for more than recommended time. Also, being denied trans care as a youth increases the cost of trans as an adult. In order for me to stop binding, I would have to have top surgery for six to $10,000, which does not include the loss of income, missing work, recovery, or the consolation

fees. Most insurance companies won't pay for top surgery either. As a trans male, I have to get a hysterectomy. During a hysterectomy, the cervix, flipping tubes and/or ovaries are being removed. That cost in Nebraska is $6,357 cash price at a surgery center and $11,971 cash price at an outpatient hospital. I don't have that money. I also have the costs of being off work for six weeks, the cost of the visits before and after the surgery. I just want to say, I hope you guys don't go with this bill.

HANSEN: Thank you for coming in to testify. Are there any questions from the committee? Seeing none, thank you. I'll take our next testifier in opposition on this side. Welcome.

JESSIE McGRATH: Good evening. Chairman Hansen and members of the committee. My name is Jessie McGrath, J-e-s-s-i-e M-c-G-r-a-t-h. I traced my Nebraska heritage back to 1887, when my great-great grandmother homesteaded in the Dundy County area. I'm a graduate of a Nebraska High School, the University of Nebraska-Lincoln and the University of Nebraska-Lincoln College of Law. I'm also a transgender woman. I came out eight years ago and transitioned on the job as a deputy district attorney for the Los Angeles County DA's Office, but make no mistake about it, I bleed Husker red. I'm tired. I'm tired of the attacks on trans people and trans youth that is going on across this country. It's organized. It's grouped together. And we see the same people coming and testifying at these hearings across the country. And none of them come from the state that they're testifying in. How many Nebraskan youth that feel that they were hurt by transition care testified here today? Very few, if any. How many trans youth who are receiving this gender affirming care are here to tell you that it works. I'm tired. I'm tired of being attacked, but I'm a proud trans person, and I knew when I was young that I was trans. If the information that exists today, the technology and this treatment existed when I was that age, I would have, I would have transitioned them because I knew and I have talked to so many people that are my age or younger that have transitioned later in life. We all knew. These kids know, and you should know that we exist and that we are people and that we deserve appropriate medical care to treat the condition that we have. And I want to thank you for allowing me to come back to my home state and if you have any questions, I'll be glad to answer them.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you. We'll take maybe probably about two more testifiers depending on the time, but we'll take the first one from here.

EVELYNN FREEMAN: Greetings. I'm Evelyn Freeman. That's E-v-e-l-y-n-n, Freeman, F-r-e-e-m-a-n, and I was born and raised in Omaha, Nebraska. I'm trans and I don't plan on leaving anytime soon. I'm a mental health therapist. I work primarily with transgender adults and adolescents. Accordingly, you could say LB574 certainly affects my business, but I'm not worried about the lack of patients. What I am worried about is minimizing harm. Medical transition can be lifesaving. That's true in both adults and adolescents. A 2022 study, which you've already heard many times, indicates that gender affirming hormones and/or puberty blockers reduced rates of suicidality and depression compared to transgender adolescents who did not have access to those resources. This is not isolated data and represents the current understanding of the benefits of gender transition, which would be prohibited under LB574. As a professional, I can attest to this. What I can also attest to is that many of the adolescents and adults I work with now are scared. They're worried about what this could mean for their friends and their community. Harm has already been done, but it's not gender affirming care that's causing it. The harm is the threat of dishonest government overreach that will remove these lifesaving options from our residents. As a mental health professional, I want to clarify that no competent professional is going to hand a letter to a child who walks into a clinic without a thorough evaluative process. Critically, absent in LB574 is the recognition of the benefits of gender affirming care. I've already discussed the reduction in depression and suicidality, but I will also attest to the joy, euphoria and relief people feel from living authentically. I get to see this in my job and I've experienced it personally. If I had the opportunity to start gender affirming care in my adolescence would have allowed me the opportunity to spend years enjoying my adolescence rather than retreating from the world due to gender dysphoria and induced depression. Please oppose LB574. Thank you for your time. And if you have any further questions, I invite you to speak to me in my practice where I can tell you more about why I do what I do.

HANSEN: Thank you for coming in and testifying. Are there questions from the committee? Seeing none, thank you for coming. We'll take one more from this side of the room.

JUNIPER MEADOWS: Hi, you all. My name is Reverend Juniper Meadows. We share pronouns. That's J-u-n-i-p-e-r M-e-a-d-o-w-s, and I am an ordained minister of the living tradition of Unitarian Universalism and serve as the Minister of Second Unitarian Church of Omaha. And I'm a trans woman. I like to think that I am an example of what happens

when you love people, when you love people when they're hard to love, when you love across misunderstanding, we love one another inter realism, right? This legislation LB574 chases problems that do not exist as health care professionals have told you, as trans people have told you, your family as children. Y'all, nobody wants to fight this culture war. Nobody wants to fight this culture war. And you all in Nebraska would not be the first state power to push down the reasserts of the health care provided to trans people. I think we had a friend recently who mentioned in Germany the Institute for Sexual, Sexualwissenschaft, which was established over 100 years ago at the turn of the 20th century, lasted about 40 years before it was put to the fire by the Third Reich. I don't think that's the spirit any of us want to live into. I think we here in Nebraska can open our hearts up to difference diversity and other ways of being recognize that trans people are a way that people get to participate in the act of creation for the same reason God made grapes, but not wine, or grain, but not bread, so that we get to participate in the process and the beloved joy of characterizing and qualifying our life on our terms. And to take that decision from families and children and doctors and that sacred relationship that they have and to interject once the state's role and that relationship as something other than fiscal is irresponsible, and ultimately friends, unkind. Follow the call of love. Say no to this. Thank you.

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

M. CAVANAUGH: Thank you. Thank you, Reverend Meadows, for being here. I did want to, I haven't said this for a while, so I'm just going to take a moment to remind anybody that's watching in this room or at home that if you are struggling, you are not alone. And please, you can text START 2678 678, or you can call 1-866-488-7386. You are not alone. And there are people here that want to help you and care for you, so please reach out. Thank you for bearing with me on that, Reverend.

JUNIPER MEADOWS: Thank you, Senator.

M. CAVANAUGH: I've never heard the expression God made grapes, but not wine.

JUNIPER MEADOWS: I still have some of them on Twitter. (LAUGHTER) But it does, it does speak to me. It speaks to my understanding of theology and our role as the created beings and also the co-creators

of this world and the co-creators of our own lives. We all are telling stories here.

M. CAVANAUGH: Yeah.

JUNIPER MEADOWS: We're all co-creators in this world.

M. CAVANAUGH: I really appreciate that. It feels like it can be applied to so much in society. I just, I, your testimony and everyone's testimony spoke so much to me and I believe your last testifier, correct? Yes. And so I just felt like I would be remiss. I didn't ask questions to a lot of our testifiers, not because I didn't have questions to ask, but I wanted to make sure and I think we all want to make sure that as many people got to share their voices today. And so I just very much appreciate that you came not only for your congregation, but for the people that you represent as a person and your congregation and for sharing yourself. That's a lot of grace that you've given us today. So thank you.

JUNIPER MEADOWS: Thank you for your grace, Senator.

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

JUNIPER MEADOWS: Thank you all.

HANSEN: Thank you for coming too. For those of you who were not able to testify, make sure you have that white sheet filled out.

_____: Where? Where?

HANSEN: We'll, make sure-- so what this does is for people who are here unable to testify, it still records your presence here and asks you to record your position on this, which is just as important so then, it's on the record, letting everybody know how many people were here and then what position they were at. So we'll have those white sheets filled out those, so you can grab one and fill it out, make sure you turn it in. That way,.

_____: Where do we get the green sheets?

_____: There's somebody will be out there that will provide the green sheets as well.

KAUTH: RECORDER MALFUNCTION] Finland the same thing. And Finland goes further and says, we advise people under age 25 not to because their brains are not yet developed. We have to pay attention to that. There's a lot of discussion and dissension among medical providers about this. We heard it today. We heard doctors from both sides, both equally convinced that they are right. We've seen associations, the APA, the AAP, all sorts of different associations dissenting with each other. They're having discussions about it. They don't agree. So this is an abundance of caution to do what is right for kids and give them that time to grow.

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

RIEPE: I have a question. I assume that in the bill, the original put 19 years of age was because that's the age [INAUDIBLE].

KAUTH: That's the age of majority here in Nebraska. Right. My kids are very, very [INAUDIBLE]

RIEPE: Because I know we talked a lot about 21, 25 for males.

KAUTH: Right. Yes.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: [INAUDIBLE]

HANSEN: Senator Day.

DAY: Thank you. I absolutely understand what you're trying to do here in terms of protecting kids from potentially harmful practices. And my question is who-- so I understand your perspective of, you know, kids are not old enough to make these decisions, but it's not the kids that are making the decision. It's the physicians with-- in combination with the families. And that is based on a body of research.

KAUTH: It is.

DAY: So I don't-- I guess my question for you is, why do we as senators feel like we have more of an understanding of medical research and best practices to be able to step in the middle of that relationship?

KAUTH: Well, Senator Day, that-- the decisions the doctors are making and the parents are making are decisions for the child based on what a child is saying. And the child is the one who has to live with those decisions for the rest of their lives. The child is directing the treatment, and we've already established children cannot make those kinds of decisions. So we have a child telling people, this is what I want and this is what I need. As parents and as-- as medical professionals, we need to step in and say, you are still a child. There are other things we can do. There are other options that we can take to work on the issues that you're facing.

DAY: And so in the case-- so from the testimony that I heard, it sounds like there is kind of an arduous process from when a child says, this is what I want to getting any kind of significant medical intervention in terms of hormone treatment or surgery.

KAUTH: And that's-- that's part of it is stretching that process out so those hormones and the surgeries don't start until there are adults, because that gives them time to really work through all the other problems that they're having.

DAY: And so I guess my question is then what happens then if-- if that family and that doctor and that child have worked through that process and they have come to an agreement about what the the appropriate care is for that child and it would be hormone therapy or it would be surgery and that child is not 19? And why-- why do we need to-- to then say, sorry, you have to wait?

KAUTH: For the same reason we say kids have to be in seat belts, for the same reason we say kids can't drink alcohol, kids can't smoke cigarettes, can't buy drugs. We step in because there are guidelines that need to be established and this is one of them.

DAY: But whose? I guess my question is who-- who is best suited to establish guidelines as related to medical care? Is it senators or is it doctors?

KAUTH: I think that senators are responsible for looking at what's going on around the world. And Florida has-- their medical board has evaluated all of this and said the same thing: no gender surgeries, no puberty blockers, no hormones. Other states are stepping in and saying, hey, we're paying attention to what's going on around the world when people say that this was really, really bad and we have suicide rates 19 times greater for people as they've gone through this

process, they finished all the surgeries, they've gotten done, they've healed, and it can be a 7- to 10-year process to go through all of this, and then even after that, 19 times greater chance of suicide.

DAY: I'll let somebody [INAUDIBLE]

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Kauth. I have been making notes throughout the hearing, but I did want to ask a question in response to this exchange that you just had. And I don't mean this as a flippant question. I really do mean this. But we allow circumcision of infants and that is not reversible and that is literally taking off a part of your genitalia.

KAUTH: That is something that's come up quite a few times. We don't allow female genital mutilation.

M. CAVANAUGH: That is-- that is not actually outlawed in Nebraska because I've looked at bringing a bill about it.

KAUTH: Say that again.

M. CAVANAUGH: That is actually not outlawed in Nebraska because I've looked at bringing a bill about it.

KAUTH: OK. Very good.

M. CAVANAUGH: But-- but it's not a common practice.

KAUTH: Right, right.

M. CAVANAUGH: But-- but circumcision is a common practice. And it seems like we are gendering what medical procedures we're allowing and what medical procedures we're not allowing for children. And personally, my family, my husband and I, we talked about what we were going to do when we knew we were having a son and whether or not we were going to circumcise him or not. But that was our choice as to what we decided to do with our son. And I've never heard of anyone thinking that it was their-- their right or their position as a legislator to get involved in that. And and so--

KAUTH: But with that kind of procedure, there are not lifelong--

M. CAVANAUGH: There are lifelong--

KAUTH: --medical complications.

M. CAVANAUGH: There can be.

KAUTH: There can be, but it's not likely.

M. CAVANAUGH: Well, I mean, based on the decision that my husband and I made and I didn't get his permission or my son's permission to disclose what decision we made, but based on the decision that we made, we made it looking at medical evidence and based on our concerns of outcomes in either direction. And so there can be. There can be very serious outcomes whether you do it or whether you don't do it. But we still don't legislate that for parents. We allow parents to make that decision with their medical provider. And we did. We made it with our pediatrician's guidance. So I guess I don't-- I don't see as a parent, I don't see the difference between you telling me that I can't make these decisions with my-- my medical provider and my child as I did when I decided whether or not to circumcise.

KAUTH: I believe it's the scope. The scope of this is so much more severe.

M. CAVANAUGH: That brings me to another question, scope. When we change the scope of any medical practice, what is best practice in the state is to go through what is a credentialing review scope of practice through the Department of Health and Human Services and the Board of Health. This has not gone through any of that, which means it has not been vetted by our-- our medical Board of Health. We don't know all of the risks and implications of such a legislation. Is there a reason that you decided not to do that or-- or perhaps sometimes a bill is introduced with the intention of going through the scope process to then be reintroduced at a later date after it's gone through the scope process?

KAUTH: Didn't know we needed one so it's--

M. CAVANAUGH: They're the worst.

KAUTH: Thank you.

M. CAVANAUGH: No, scope of practice are the worst is what I mean.

KAUTH: So and that is--

M. CAVANAUGH: Just for committee hearings.

KAUTH: I didn't know we needed one so we'll have to look at doing that, whether or not that's necessary.

M. CAVANAUGH: OK.

KAUTH: Thanks for the heads up.

M. CAVANAUGH: Yeah, they're really [INAUDIBLE] I mean, we love them. We love scope of practice bills in the Legislature.

RIEPE: Uh-huh [INAUDIBLE]

M. CAVANAUGH: I have more questions.

KAUTH: Ben's going to have a heart attack.

HANSEN: Any other questions? Just making sure. Senator Day.

DAY: I promise I won't keep us here too long. The other thing that I'm concerned about that I did hear was I did look at the Arkansas bill that a few people on both sides referred to and the language in these bills is very similar.

KAUTH: Um-hum.

DAY: And Arkansas is currently having to deal--

KAUTH: The litigating, correct.

DAY: --with the legal challenges to that that we know taxpayers will end up paying for. Do you think it's good practice to put a bill into place knowing that there will be legal challenges that taxpayers are going to have to foot the bill for?

KAUTH: I think that there are things worth fighting for, and this is one of them.

DAY: OK. Thank you. Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. OK, so to my long list of questions, we heard from a lot of medical experts in this state. And one of the overarching themes that I heard and is a concern for me as well, is that we are asking if we were to-- if we as a Legislature were to pass this, we are asking our medical professionals to choose, I believe one

person said between practicing ethically or being within professional code of conduct. And that seems problematic to me that we are asking. And-- and I guess I would like to give you the opportunity to speak to, because that is a national code of ethics that we are asking them to violate.

KAUTH: Well, and as far as which national code of ethics?

M. CAVANAUGH: I mean, by not-- by not allowing them to refer, not allowing them to practice the scope, not allowing them all of the things on page 6.

KAUTH: And when we're talking about referring, it's referring for specific procedures. So someone could refer a child for I think I heard someone talk about they're out in Kearney and they want to refer to an Omaha gender clinic. They could still refer them for that affirmative care. It's when you refer for those specific procedures or medications.

M. CAVANAUGH: But if they refer the way this is written, I would say that that is not clear--

KAUTH: And we can clear that.

M. CAVANAUGH: --that they cannot refer. But-- and you do have in here that it prohibits puberty blocking drugs.

KAUTH: Um-hum.

M. CAVANAUGH: So it is more than just procedures.

KAUTH: Procedures and medications.

M. CAVANAUGH: And medications. So when we're-- I guess I'm really struggling with listening to medical professional after medical professional who people who have practiced this in various forms and settings, when they say that this is not following a standard of care that is well established in this country and internationally, that we would be asking them to break their own code of ethics.

KAUTH: Again, they're looking at the standard of care as we know it now, not as-- as we look at the countries that are backing off and saying this did not work and this is not good, we need to back down. That is starting to filter through many different countries. We should not be following along in the path and go through every single thing

and then realize, oh, hey, we're going to keep following them and stop doing it in 20 or 30 years.

M. CAVANAUGH: I would say that our healthcare system is very different from other countries.

KAUTH: I would agree.

M. CAVANAUGH: And so it's not one of the examples, apples to apples, apples to oranges, all the things we've heard today.

KAUTH: It's not. That's just it. In those countries, this care was free. It's readily accessible. It was continuous. They had options, multiple doctors. I mean, they had lots more options. It was much more accessible. And they still are saying, wait a second, this didn't work. We're seeing very bad outcomes with this.

M. CAVANAUGH: And we did hear a testifier talk about that specifically in that they may have implemented it so broadly that it was being utilized not as appropriately. What I heard today was that we have very rigorous processes before anyone can go through surgery and even through medication, but that also this medication, the puberty blockers specifically.

KAUTH: And-- but when you heard our proponents, you heard Luka testify about how she had her breasts removed.

M. CAVANAUGH: Yes.

KAUTH: At UNMC and she had one visit.

M. CAVANAUGH: That is extremely, extremely unfortunate.

KAUTH: Right.

M. CAVANAUGH: But based on all of the testimony today, it-- it appears to be an outlier. I'm not saying that it definitely is an outlier, but it appears to be an outlier. And it-- to-- to change the entire medical system around gender affirming care for an outlier is not appropriate in my view. And I have very serious concerns about this legislation. And I really-- I asked you the question at the start, and I want to revisit it about the individuals or entities that you worked with. We have a very robust medical community here in Nebraska, and I didn't see that. And maybe, I apologize, I tried to ask people the

questions as much as I could, but I didn't see that represented in the proponent testimony. I didn't see--

KAUTH: So all the doctors that showed up?

M. CAVANAUGH: That they were from the Nebraska medical community.

KAUTH: They were almost all from Nebraska.

M. CAVANAUGH: OK.

KAUTH: Kearney, Omaha, Lincoln, Columbus, I mean, they were from throughout Nebraska.

M. CAVANAUGH: OK. Well, I guess-- I guess I missed that. But are they-- are they people that are practicing therapy? Are they people that are practicing hormone therapy? What kind of surgeries are they practicing? And not only did they testify, but did they help inform how this legislation was written?

KAUTH: Yes.

M. CAVANAUGH: Because on the alternative side, I hear people-- and this is a concern I had reading this by myself-- I had concerns over the state funds. I had concerns over the standard of care. And I feel that this-- this is extremely harmful to youth, but also problematic in its implementation. I guess that's not really a question so much as a statement. I apologize for not asking a question.

KAUTH: That's OK. I'm writing that one down though.

M. CAVANAUGH: But it-- I just-- we heard a lot from youth today, and I want to honor all sides of the-- the-- the proponents and opponents and their positions on this. But we did hear an extensive amount from youth and from their parents asking us not to do this, and especially when it comes to parents asking us not to get involved in parental medical decisions. I just-- I don't-- I don't know how you-- how we get around that. This feels like an enormous overstep in our role as a government into the family unit. And you don't see it that way.

KAUTH: Not in this instance, no.

M. CAVANAUGH: So to me, as a parent, this tells me that the state doesn't trust me to parent my family.

KAUTH: To me, it tells me that parents are being given information and being given terrible choices. You heard them talk about it's you're a dead son or a live daughter, that kind of phraseology. I think parents are being put into really, really bad situations where they don't have a choice but to affirm or not affirm to support whatever transition their child needs.

M. CAVANAUGH: That feels anecdotal.

KAUTH: It does.

M. CAVANAUGH: It doesn't-- It doesn't feel-- like, I'm swimming in research over here. It doesn't feel like this is based in something. And I don't normally ask questions to this degree, but I find that, I mean, we spent this many hours here and I very much appreciate your willingness--

KAUTH: Of course.

M. CAVANAUGH: --to have this conversation. But I find it really concerning and I am very concerned about the youth and they are watching us and they are hurting. And if we were to move this out of committee, I don't think the message youth-- the message you're telling me you're trying to send is not the message that I heard that is being sent. The message I'm heard-- hearing is that LGBTQ, specifically trans youth, feel like their state legislature is attacking them.

KAUTH: And that is certainly not the case. We are trying to protect them. And when you talk about the studies that are done, you had several of the opponents testifying that you can't do a randomized controlled trial because it would be so harmful to not give the placebo group a placebo.

M. CAVANAUGH: Right.

KAUTH: But we have no absolute proof. There's no evidence that this care that these puberty blockers and cross-sex hormones and surgeries actually affect the gender dysphoria. We don't know for sure. So when you look at those studies, they are weak and poorly designed and they cannot be held to the same standard as a randomized controlled trial.

M. CAVANAUGH: I-- I would push back on that they're weak and poorly designed. It sounded like just with diabetes as was is this example, that would be to say that the studies around diabetes are weak and

poorly designed. I think that they're not designed to this in the same way. But I take your point very much, and I appreciate the conversation.

KAUTH: Absolutely.

HANSEN: Senator Day.

DAY: OK. So the other concern that was brought up by some attorneys around the issue would be the-- if we were to pass this bill, we would be out of compliance with federal law and so potentially losing funding for Medicaid.

KAUTH: So none of the attorneys that I've run this by thought that that was a problem. And I've taken it through several different variations and several different attorneys. I can certainly check back with them and ask them that specifically, but it was never brought up as being an issue.

DAY: OK. And then the other I was looking at-- we've talked about Sweden a lot today, and I was just looking at their most recent February 2022 update, Swedish National Board of Health and Welfare related to gender dysphoria. It appears that in Sweden, the minimum age for puberty blockers is the suggested minimum is the age of 12, the minimum age for cross-sex hormones [INAUDIBLE].

KAUTH: Are you looking at the Karolinska?

DAY: I'm sorry?

KAUTH: The Karolinska?

DAY: No. This is just from the Swedish National Board of Health.

KAUTH: OK. I'll get you the Karolinska.

DAY: The minimum age for cross-sex hormones is 16. So this bill would be even more restrictive than even if they are pulling back, like you said, which it sounds like is the case, they're still allowing for the possibility that there are some kids that would need puberty [INAUDIBLE]

KAUTH: I'll get you my citation.

DAY: OK. Thank you.

HANSEN: All right. Any more questions? I have a, maybe not a question, more a comment. I think Senator Cavanaugh made a point about the 407 process. But I believe that's when we're increasing the scope of practice.

M. CAVANAUGH: It's a change.

HANSEN: Is it any change, even getting rid of something? OK. All right. And one more thing. Do we have-- out of the states that have passed legislation such as this, do we have any data yet from those states? I don't know, it's pretty early yet.

KAUTH: It's very, very early.

HANSEN: OK. Just making sure. OK, good. Well, seeing no more questions-- oh, Senator Riepe, yep.

RIEPE: Do you have any access to what Sweden and the other, what they're doing? I'm trying to see, you know, are we just behind the tail here, the curve? I mean, if there is-- I'd be interested out of curiosity. What--

KAUTH: I liked the idea of an interim study going--

RIEPE: --[INAUDIBLE] changing. I was putting a note to my AA to try to do a Google search to see what I can find too.

KAUTH: I'll send you some stuff over.

RIEPE: I just want this-- to me, that's a bigger picture saying that's what we do, what they do, but it's in there. Thank you.

KAUTH: Absolutely.

HANSEN: Senator Day.

DAY: I promise this is the last one. You mentioned the interim study and that was the question I wanted to ask

KAUTH: The which one?

DAY: The interim study.

KAUTH: Yeah.

DAY: We had a social worker that mentioned, would you be willing to hold on to this bill so we could do an interim study and get a better picture related to research and treatments and those types of things?

KAUTH: I'll certainly give it consideration.

DAY: Thank you. Appreciate that.

HANSEN: Senator Ballard, you good?

BALLARD: I am. Got to let my dog out at some point.

DAY: Oh, your poor dog.

KAUTH: Thank you guys all for staying and working through all of this. I appreciate it.

HANSEN: Thank you. Do have-- and I do appreciate all the people who did come to testify and the ones who weren't able to get heard. But I thought it would just be right to be fair to both sides--

KAUTH: Absolutely.

HANSEN: --if we gave both sides the right treatment. And so with that, there were some letters for the record. And I want to make sure we get this in the record, too, 925 record letters as opposed to this bill and 578 as proponents of the bill and 3 neutral. So with that, this will end the hearing for LB574--

KAUTH: Thank you very much.

HANSEN: --and end the hearing for the day.